WHO/DGH/94.3
Original: English
Distr.: General

Health in Development

Prospects for the 21st century

Background paper for
the Task Force on Health and
Development Policies

World Health Organization
Geneva
June 1994

Design by WHO Graphics
Printed in Switzerland

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This background document was prepared for the first meeting of the Task Force on Health and Development Policies, 27-30 June 1994

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WHO acknowledges the generous contribution received from the Sasakawa Health Trust Fund for the preparation of this background document

INTRODUCTION

The establishment of the multi-disciplinary Task Force on Health and Development Policies is an initiative taken by the World Health Organization (WHO) to respond to a range of critical issues concerning health which have moved to the top of the social and political agenda of countries. The basic rights of persons and the responsibilities of states are being re-examined and assessed in relation to the security that people should enjoy in maintaining, protecting and promoting their health. This process is being accelerated as a result of the increasing awareness of health needs and the enhanced demand for **health security**. The latter is an outcome of social, economic, political, demographic and environmental changes that are affecting all societies, both industrialised and developing. These needs and demands are transforming continuously as societies move along the transition in health and development to greater life expectancy and higher levels of per capita income.

The present paper is organized along the following lines:

Part I introduces the rationale for health in development and provides a framework within which the Task Force may wish to operate. Moreover, it underlines the reasons why health in development has not progressed at the speed anticipated and, in identifying these main issues, highlights some of the more significant repercussions of this prolonged process on health.

In **Part II**, the paper examines the scenario of change in the development process as a whole and the emerging problems and priorities that are likely to define the goals and strategies of development for countries and international agencies for the rest of the decade and beyond.

In **Part III**, the paper considers the main features in the health scenario, which is unfolding as a result of the global changes in health. The two scenarios provide a broad framework within which it is possible to identify and select a few strategic areas in which the major development issues are integrally linked to and closely interact with the critical health problems and issues.

Part IV reviews some of the past efforts and the context in which the Task Force begins to work. It discusses briefly some of the basic conceptual issues involved, and the evolution in thinking on intersectoral action for health, and points to problems of a fundamental nature which the Task Force may address.

Part V of the paper proceeds to identify some of the strategic areas which can be considered by the Task Force in formulating its agenda. However, identifying the ways in which health issues and objectives are integrated into development strategies is not sufficient. It is essential to examine what needs to be done to ensure that the efforts of the Task Force will be more effective than past initiatives and have a more positive impact on development strategies and policies at the global and national levels.

Part I
HEALTH NEEDS AND POLICY PRIORITIES

The Health for All movement launched at the 1977 World Health Assembly promulgates, as the primary goal of all societies, universal attainment by the year 2000 of a level of health permitting a socially and economically productive life. This goal is more relevant today than ever before and is captured in the concept of "health security". Health security rests on equity. Health security encompasses the principle of universality in health care, so that all human beings may live with the knowledge that they can seek health care which is accessible, affordable, relevant and of quality.

Health security in its widest sense goes beyond the mechanisms and schemes which guarantee access to health care. Health security traces the entire life span of human beings. It encompasses all aspects of the basic human right to health, including the right to freedom of choice and personal security, the right to food in sufficient quantity and of good quality, the right to live and work in environments where known health risks are controlled, and the right to have access to education and information and decent housing. As such, health security also means the empowerment of people through various forms of societal and economic support and fuller knowledge and awareness, thus enabling people to make the right choices, cope with the changing patterns of vulnerability and keep healthy.

Many people enjoy health security throughout their lives. They benefit from the fruits of development and a physical and cultural environment containing few health risks, they have access to services, and they have acquired the information necessary to enable them to make informed choices. This health security manifests itself in good health status and a sense of well-being.

This situation can be contrasted with the millions of human beings who do not enjoy "positive" health due to a lack of health security. Their poor health status is manifested in conditions which can appear at any stage of the life span and at different stages of development. These conditions include high infant and child mortality, infectious diseases, drug abuse, violence, rising rates of suicide and HIV/AIDS among the young, and the psychiatric and degenerative ill-health of the aging. They are often

closely associated with urgent social and economic problems which contribute to the health problems. Such problems can be as varied as the persistence of extreme poverty, the high level of youth unemployment, the increasing burden of dependency and its demands on the public budget, or the absence of political processes which secure the individual's right to health.

Policy makers are being called upon increasingly to respond to the demands of those who do not have health security, and who consequently suffer from poor health status. The responses to these demands cannot be approached in isolation from the solution to the underlying social and economic problems. The challenge of satisfying the changing needs and demands of health security is becoming an increasingly complex and difficult task for policy makers.

A profile of ill-health for developing countries

Estimated burden of disease from poor household environments in demographically developing countries, 1990, and potential reduction through improved household services, and malnutrition in life years lost adjusted for disability (DALYs)

Principal diseases related to poor household environments	Relevant environmental problem	Burden from these diseases in developing countries (millions of DALYs per year)
Tuberculosis	Crowding	46
Diarrhoea*	Sanitation, water supply, hygiene	99
Trachoma	Water supply, hygiene	3
Tropical cluster	Sanitation, garbage disposal, vector breeding around the home	8
Intestinal worms	Sanitation, water supply, hygiene	18
Respiratory infections	Indoor air pollution, crowding	119
Chronic respiratory diseases	Indoor air pollution	41
Respiratory tract cancers	Indoor air pollution	4
Malnutrition		44**
Total		**382**

* includes dysentery, cholera and typhoid.
** direct effects of protein-energy malnutrition, vitamin A deficiency, iodine deficiency and anaemia only.

Source: based on *World development report 1993 – Investing in health*, New York, Oxford University Press for the World Bank

Health is a societal issue as the conditions which promote health or cause ill-health are being produced by society and the economy as a whole. Provision of health security for all people therefore needs to be seen as a societal challenge. For example, in a global climate of economic restructuring, lack of health security arises not only from macroeconomic policies which reduce people's purchasing power and thereby their options and choices to promote and protect their own health, it is also present when these same economic policies impoverish the health system itself and reduce its capacity to respond to health needs.

When health is seen as a societal issue, accountability for health also takes on a new dimension. Although accountability for health has always been a sensitive issue, it has taken on greater proportions in recent years. In a climate of privatization with emphasis on the use of the market mechanism as an objective regulatory device, individuals have been made increasingly responsible for their own health. Where the role of the State has been diminished, nongovernmental organizations (NGOs) have been relied upon to fill the gap in providing essential services, especially for the disadvantaged. This has led to an expansion of the accountability gap. Filling this gap is vital in order to provide health security. Health security and health accountability are complementary aspects that are at the heart of the health-development link.

But it is difficult to give full expression to the multiple dimensions of health security without a better system of accountability for health. And here the problems are manifold. Most often there are no compelling motivations for policy makers outside the health sector to identify and track the health implications of their policies. Neither are the professionals and policy makers in the health sector motivated to analyse the multiple factors outside their immediate medical and epidemiological field that create the conditions for persistent ill-health.

A large part of the inertia may be due to the assumption on the part of professionals and policy makers, both in the health sector as well as in other development sectors, that most of the time the interaction between development and health takes place by itself, that the benefits of the interaction will accrue to society without any special interventions and that the negative health outcomes can be dealt with as and when they emerge in specific projects and activities. This indifference ignores situations in which managing

the health-development link becomes critical and neglecting it results in heavy costs to both health and other components of development. Therefore in dealing with the health-development link it is these situations which should be identified and it is in them that the link has to acted upon and reinforced.

A profile of ill-health for a developed country

"The close interrelationship between health problems such as HIV/AIDS, tuberculosis, substance abuse, infant mortality, and violence highlights the importance of pursuing integrated approaches that cut across individual problems and that unite the personal care and public health systems.

Substance abuse is not only an epidemic in and of itself; it is also at the root of other public health problems. Substance abusers are the fastest growing segment of the HIV/AIDS population, and substance abusers with AIDS are a major factor in the spread of multi-drug resistant tuberculosis. Fifteen percent of women delivering babies in Harlem hospitals use cocaine. According to the Center on Addiction and Substance Abuse at Columbia University, substance abuse is currently estimated to add $140 billion to our country's direct and indirect health care costs every year including $500 million to treat cocaine-affected infants during their first month of life.

Every year, an estimated 900,000 people fall ill – and 900 die – from contaminated drinking water. In Wisconsin alone, a failure to protect the quality of drinking water, and to detect and control Cryptosporidium, caused over 350,000 people to fall ill – 4,000 of whom required hospitalization – and led to over $15 million in medical care costs.

An outbreak of E. coli linked to a restaurant chain recently resulted in 500 laboratory-verified cases of bloody diarrhoea in Washington State, Idaho, California, and Nevada. The costs of treatment were $100-$200 for every case not requiring hospitalization and much more for those young children and frail elderly who had to be hospitalized.

Hepatitis B infects up to 300,000 people each year in the United States, at a cost of $750 million per year, despite the fact that a vaccine to prevent the disease has been available for the past decade. Yet only one percent of the estimated 28 million young adults at risk for hepatitis B have received it."

Source: extracted from statement by Dr Philip R. Lee before the United States Senate, November 17, 1993

What is more important is that these situations do not exist in isolation they seem to be part of a "fissure" or "fault line" that extends through the whole of the development process and seems to flow from the failure to give health an equal place among the objectives of development.

There are no strong constituencies to deal with the health-development link, either within the health sector or outside it. The problem is compounded by the fact that the link is sometimes so pervasive and so inextricably a part of a network of other numerous factors that it is not easily amenable to policy interventions. Even so it is widely recognized that the health effects resulting from this link can at times be more significant and lasting than the impact of the conventional interventions in the health sector. Designing the systems and policy interventions for managing this link is a high priority for achieving both the development goals as well as the health goals. In such an effort, health security and health accountability could serve as the over-arching issues under which health and development policies are better integrated.

In terms of the mandate of the Task Force, its primary responsibility is to examine how existing development strategies and policies of countries can be strengthened to protect and improve the health status of their people. As the terms of reference are very wide and open-ended, the Task Force would need to identify the strategic issues which can bring the health objectives into the centre of current development strategies. For this to happen, health issues and objectives must be perceived and must become an integral and vital part of many of the political, social and economic issues which are emerging as the major priorities of development policy makers.

In carrying out its work, the Task Force may need to examine how it should deal with the fundamental problems of **implementation.**

One of most demanding challenges that will face the Task Force is that of building consensus among policy makers, health and development professionals on:

- the nature of the development and health scenarios;
- the value which health has both in the processes as well as the outcomes of development;
- the need to reshape health policies and development policies to deal with the emerging problems.

For this to be done, a sufficiently strong constituency has to be identified within the health sector as well as within the apex agencies responsible for macro-development planning and policy making. This constituency has to perform the catalytic role of

developing the larger multi-sectoral constituency in all important parts of the decision-making system both within and outside government which would be looking after the health development links as a whole and ensuring that there is health accountability throughout society.

In dealing with the issues the Task Force will have to identify the key actors in relation to each issue which, in turn, will have its multi-sectoral constituency of different combinations of key actors. These may include the relevant professionals and policy makers, the NGOs working in the relevant field, the media, and the private sector concerned with the issues. The international development agencies can play an important role in this process; the Task Force may need to examine what initiatives it needs to take towards that end.

In the larger perspective, the work of the Task Force would help to demonstrate the centrality of health in the whole of development. By so doing, it will contribute to the transformation of development values and goals and to the new vision needed to guide the processes of development towards protecting and enhancing the quality of life for the individual and society.

Part II
CRITICAL ISSUES IN THE EMERGING DEVELOPMENT SCENARIO

The last four decades have witnessed economic, political, social, technological and environmental changes on a scale rarely seen in the history of human beings. These changes, and the way in which they are shaping the future of the global human community, have resulted in a continuous redefinition of the processes and goals of development.

Critical issues in the emerging development scenario will encompass the prospects of the global economy and their impact on regions and nations, and the major adjustments in the international trading system following the recently concluded global GATT negotiation. It will also include the political scenario at the end of the Cold War, the decline in military spending, opportunities for disarmament, the resolution of longstanding conflicts and emerging arenas of conflict. Such a scenario will not bypass the environmental degradation which is taking place at an alarming rate, and which threatens the very survival of the planet.

The changing development scenario has many dimensions. Human health is being, and will continue to be, profoundly affected during the continual process of change. In a world where technology has brought people closer to one another, the effects of change will touch men and women, wherever they live in the world. As these changes unfold they bring with them both threats to, and opportunities for human health. The opportunities may include the release of substantial resources for human development including health, and the potential for a progressive decline in expenditure on armaments. The possible threats may centre around the social consequences of adjusting national economies to the global changes and the demands on the health sector arising from the continuing violence or the displacement of large numbers of persons, including environmental refugees.

The major political trends in the world today revolve around moves toward greater democratization and human solidarity to secure peace. Both of these are occurring in a climate of mounting recognition that striving for development goes beyond economic growth to ensuring social justice, respect for human rights,

and ecological stability for future generations. Human rights, freedoms, people's participation and good governance all enlarge the scope for collective action by allowing free associations of people, strengthening civil society and encouraging extensive processes of popular consultation.

Although peace is now consciously being pursued, the world is still racked with border conflicts, tribal strife, ethnic confrontation and civil war. Health and peace are inseparable partners in the creation of a harmonious and global human community. Development, peace, social justice and stability are essential in ensuring that human beings do not suffer or die unnecessarily.

The health sector can play a catalytic role in creating the environment for peace during situations of combat and conflict. Traditionally, health care has been one of the most preferred areas for humanitarian and philanthropic activity. Apart from the traditional humanitarian role where health care providers minister to combatants and civilians in time of conflict, there have been other innovative efforts, such as those made recently in Central America, where health interventions became a means of initiating and promoting processes which contributed to peace and resolution of conflict. Health initiatives for peace of this type may also require the strengthening of the international framework through relevant international covenants and conventions which provide protection for such initiatives.

Past development policies and economic strategies have contributed to an improvement in health status, especially where there has been simultaneous emphasis on social policies, in areas like health and education. These have invariably improved overall quality-of-life indicators such as life expectancy and infant mortality rates.

Economic growth has been accompanied in most places by the progressive development of a health infrastructure including secondary and tertiary care, as well as a wide primary health care system aimed at bringing health services to the community level.

However, there are a number of trends in global and national economies today which hold opportunities and threats for human health. Of these, four stand out: privatization and an increasing role for the market mechanism; global recession; structural adjustment; and global trade.

The rapid changes occurring in many places from a centrally planned to a market economy, and the increasing trend toward privatization worldwide, have implied a diminishing role of the State and greater leeway for the market to act as a regulatory mechanism. State responsibility in establishing norms and standards to be respected and cushioning the effects of economic adjustment on special population groups and the most vulnerable segments of society is being eroded, especially where the democratic process is in its infancy. Defining the roles and responsiblities of both private and public sectors has become more important than ever.

The recently concluded GATT Agreement on global trade, and the preceding protracted negotiations have exposed the self-interest of nations to secure the best trade conditions for their own goods, irrespective of the economic, social and political consequences for the world in general. Of particular concern are the health consequences in an increasingly competitive climate where safety standards and working conditions are sacrificed in the emphasis on cutting costs and producing cheap, tradeable goods. The poor, women and young people are the hardest hit.

The regional variations in the economic scenario will have different qualitative outcomes and affect the magnitude and nature of the qualitative changes. Within the scenario of economic growth, some of the more significant features need to be highlighted. The Asian region is likely to be the fastest growing and most dynamic part of the world economy, with South-East Asia in particular moving to higher rates of growth. The socioeconomic transformation of Asia holds out prospects for dealing effectively with the largest pockets of poverty, illiteracy and ill-health in the world. The Latin American region follows with rates of economic growth lower than those of Asia but showing a distinct improvement on the average performance of the 1980s. The developed countries are experiencing a mild recovery but it is unlikely to be adequate to make a significant impact on the problem of unemployment. The regions under greatest economic stress are likely to be Sub-Saharan Africa and Eastern Europe, which is restructuring away from its previous centrally planned economies.

This economic scenario could be relevant to the work of the Task Force in several ways. The Task Force may wish to place some of the issues relating to the health-development link in selected

Weakening social fabric – selected industrialized countries and regions

HDI rank		Intentional homicides (per 100 000 people) 1987–89	Reported rapes (per 100 000 women age 15–59) 1987–89	Drug crimes (per 100 000 people) 1980–86	Prisoners (per 100 000 people) 1980–86
1	Japan	1.5	5	31	—
2	Canada	2.6	23	225	94
3	Norway	0.9	20	116	—
4	Switzerland	2.5	18	129	54
5	Sweden	1.5	43	—	—
6	USA	8.0	118	234	426
7	Australia	2.0	44	403	60
8	France	4.6	17	—	40
9	Netherlands	—	26	38	27
10	United Kingdom	1.6	—	—	77
11	Iceland	—	—	—	—
12	Germany	3.8	26	—	77
13	Denmark	5.7	35	176	47
14	Finland	2.4	19	—	75
15	Austria	2.3	27	77	87
Aggregates					
	Industrial	4.9	48	—	—
	Developing	—	—	—	—
	World	—	—	—	—
	OECD	4.4	52	—	201
	Eastern Europe incl. former USSR	—	—	—	—
	European Community	3.4	17	—	58
	Nordic	2.5	32	—	61
	Southern Europe	3.3	7	—	—
	Non-Europe	5.4	75	179	371
	North America	7.4	110	233	394

[a] around 1970

Source: Human Development Report 1993, New York, Oxford University Press for the United Nations Development Programme.

Juveniles (as % of total prisoners) 1980–86	**Live births outside marriage** (%) 1985–89	**Single-parent homes** (%) 1980	**Divorces** (as % of marriages contracted) 1987–90	**Suicides** (per 100 000 people) 1987–90
—	1	5	22	17
—	23	—	43	14
—	26	4[a]	40	16
—	6	4	33	22
—	52	6	44	19
—	27	8	48	13
6	16	—	34	13
1	26	5	31	21
3	10	5	28	10
5	25	4[a]	41	8
—	—	—	—	16
12	10	7	30	17
—	45	6	44	24
8	—	10	38	29
—	22	7[a]	33	25
—	15	—	33	16
—	—	—	—	—
—	—	—	—	—
—	17	—	35	14
—	11	—	31	21
—	15	—	27	13
—	44	—	42	22
—	7	—	11	7
—	19	—	39	14
—	27	—	48	13

regional contexts where either useful lessons can be learnt, or where the problems are most acute or where there are new opportunities for rapid alleviation of poverty and improvement of health status. The scenario of economic growth also becomes important for the mobilisation and allocation of resources for the health sector both at the national and global levels.

In dealing with the health-development link, the Task Force may need to take account of this continuing process which has re-defined the nature of development. Issues may therefore be identified as they reflect the development priorities which have emerged and are currently high on the agenda of policy makers and international agencies. A selection of such issues is given below.

Privatization and the role of the market mechanism

The collapse of the centrally planned economies in Eastern Europe has left no competing alternative to the market economy model. This change has promoted the drive towards systems which are consumer-oriented, enlarges the field of choice and opportunity and is evaluated in terms of cost effectiveness. Most countries are in the process of restructuring their economies to adjust to the global market. Privatization of State activities and public responsibilities has been a major outcome of this process. This same process has also affected a wide range of public services, especially welfare-oriented programmes and interventions including health services and specially targetted programmes for the disadvantaged and the poor. However, the excessive use of market-driven policies and their negative social impact have prompted a reappraisal of the relative roles of the market and the State and the ability of market forces to ensure equity.

Political "goods" as an outcome of development

There is increasing recognition that the fruits of development go beyond economic growth and encompass social justice, respect for human rights and freedoms, ecological stability for future generations and the importance of democratic processes, people's

participation, and good governance. These "political goods" have become important criteria for assessing development and the quality of life it produces.

The WHO initiative for Health for All, with its goal of universal attainment by the year 2000 of a level of health permitting a socially and economically productive life, was the first attempt to define health as a universal human right. In the present climate of widespread democratization, the right to health as expressed in equity of access to health care, and individual and community participation in promoting and protecting health have become increasingly important goals. Primary health care, and attention to the needs of the most vulnerable and disadvantaged, have demonstrated the way in which health can be a powerful means of social mobilization and participatory action.

Multi-dimensional poverty

In the process of development, new vulnerable groups and new forms of social exclusion and deprivation emerge. Approximately 800 million people continue to exist in conditions of extreme economic poverty, without income to satisfy their minimum nutritional needs. However, poverty needs to be understood, not only in an economic sense, but in the sense of the multidimensional poverty that results from the lack of education and information which would enhance opportunities, and the poverty of denial and inequities which reduce access to resources, technology and essential services. Mainstream development strategies have not been able to reach these deprived and disadvantaged groups.

The emergence of youth unemployment as a widespread and deep-seated structural problem is perhaps the most stark manifestation of development failure. This type of unemployment is an acute form of social exclusion and manifests itself in different forms in both the developed and developing countries. It comes at the end of a long and demanding period of preparation for adult responsibilities and productive roles. The health implications of youth unemployment, and other problems of youth rooted in social contexts, are multiple and complex as seen in the problems of youth alienation, substance abuse, violence, mental ill-health, and youth suicide.

Rapid technological change

Rapid technological change continues to revolutionize the world and how human beings live in and consider their world. Advances in technology will continue to be the main lever of socioeconomic transformation. Technological innovation offers the opportunity for partnerships between health and development sectors to change patterns of work, human settlements, systems of transportation and communication and enhance health-promoting capacity.

Technological developments in the health fields in the 20th century have been an important tool in reducing morbidity and mortality. However, technological innovations have not benefited all people equally. Many people do not gain from available health technologies because of lack of accessibility, cost implications or legislative measures. The surveillance of technology for their health implications will become increasingly complex and challenging as major advances in such areas as biotechnology and biomedical engineering have legal, social and moral consequences which cannot be easily predicted. It has become more important than ever to ensure that ethical safeguards are put in place to guarantee that the safety and rights of both individuals and communities are adequately protected in health-related areas.

The crisis in value systems

The current economic, political and social systems functioning in most societies, and the underlying values rooted in the market model, have contributed to a weakening of relationships based on sharing and caring, the bonds sustaining and controlling intergenerational relations, and the institutions which governed and preserved primary units such as the family in the past. The unlimited pursuit of material well-being has eroded value systems and beliefs which gave primacy to spiritual well-being and is increasingly contributing to the rise in fundamentalist reactions to societal problems.

The environmental crisis has created a growing awareness of the need to change the life-styles that have lead to excessive consumption, extravagance and waste which characterize the dominant pattern of development.

Part III
THE EVOLVING HEALTH SCENARIO

The World Development Report 1993 presents the global health scenario which estimates the burden of disease for different regions in 1990. In collaboration with WHO, the World Bank has designed a measurement of the disease burden in terms of life years lost due to premature mortality, adjusted for disability. The disease structure that is presented has two main features. First, there is the shift in the disease burden from communicable diseases to non-communicable diseases. The share of communicable disease declines from 71% in Sub-Saharan Africa to 9.7% in the developed market economies, while the share of non communicable diseases rises from 19.4% to 78.4% for the two groups respectively.

Second, the disease burden declines from 575 disability adjusted life years (DALYs) lost per 1000 of population for sub-Saharan Africa to 117 DALYs lost per 1000 for the developed market economies. According to these measurements the changes result in a significant reduction of the disease burden.

The contribution of environmental factors to the burden of disease and disability is growing in importance as indicated in the reports of the WHO Commission on Health and Environment, which reviewed this complex subject over a two-year period prior to the United Nations Conference on Environment and Development. The outcome was a series of reports concerning the health effects of various aspects of the environment - energy, transportation, industrialization, urbanization, and water development. Major environmental health hazards include air pollution from the combination of fossil fuels; polluted water; and work-related exposure to occupational diseases and unsafe working conditions (e.g. chemicals and exhausts). In addition to the direct effects of the environment on human health, health vulnerability is increased where secure access to natural resources is undermined. For example, degraded lands deprive people of food, plants, fuelwood, and other products essential for the well-being of local communities. The current and projected impact on the global health scenario of direct and indirect environmental changes has not been well-documented. It is clear, nevertheless, that in

Distribution of the DALY loss by cause and demographic region, 1990
(percentage, except where noted)

Cause	World	Sub-Saharan Africa	India	China
Population (millions)	5 267	510	850	1 134
Communicable diseases	45.8	71.3	50.5	25.3
Tuberculosis	3.4	4.7	3.7	2.9
STDs and HIV	3.8	8.8	2.7	1.7
Diarrhoea	7.3	10.4	9.6	2.1
Vaccine-preventable childhood infections	5.0	9.6	6.7	0.9
Malaria	2.6	10.8	0.3	—
Worm infections	1.8	1.8	0.9	3.4
Respiratory infections	9.0	10.8	10.9	6.4
Maternal causes	2.2	2.7	2.7	1.2
Perinatal causes	7.3	7.1	9.1	5.2
Other	3.5	4.6	4.0	1.4
Noncommunicable diseases	42.2	19.4	40.4	58.0
Cancer	5.8	1.5	4.1	9.2
Nutritional deficiencies	3.9	2.8	6.2	3.3
Neuropsychiatric disease	6.8	3.3	6.1	8.0
Cerebrovascular disease	3.2	1.5	2.1	6.3
Ischemic heart disease	3.1	0.4	2.8	2.1
Pulmonary obstruction	1.3	0.2	0.6	5.5
Other	18.0	9.7	18.5	23.6
Injuries	11.9	9.3	9.1	16.7
Motor vehicle	2.3	1.3	1.1	2.3
Intentional	3.7	4.2	1.2	5.1
Other	5.9	3.9	6.8	9.3
Total	100.0	100.0	100.0	100.0
Millions of DALYs	1 362	293	292	201
Equivalent infant death (millions)	42.0	9.0	9.0	6.2
DALYs per 1 000 population	259	575	344	178

Source: World development report 1993 – Investing in health, New York, Oxford University Press for the World Bank, p. 27.

Other Asia and islands	Latin America and the Caribbean	Middle Eastern crescent	Formerly socialist economies of Europe	Established market economies
683	444	503	346	798
48.5	42.2	51.0	8.6	9.7
5.1	2.5	2.8	0.6	0.2
1.5	6.6	0.7	1.2	3.4
8.3	5.7	10.7	0.4	0.3
4.5	1.6	6.0	0.1	0.1
1.4	0.4	0.2	—	—
3.4	2.5	0.4	—	—
11.1	6.2	11.5	2.6	2.6
2.5	1.7	2.9	0.8	0.6
7.4	9.1	10.9	2.4	2.2
3.3	5.8	4.9	0.6	0.5
40.1	42.8	36.0	74.8	78.4
4.4	5.2	3.4	14.8	19.1
4.6	4.6	3.7	1.4	1.7
7.0	8.0	5.6	11.1	15.0
2.1	2.6	2.4	8.9	5.3
3.5	2.7	1.8	13.7	10.0
0.5	0.7	0.5	1.6	1.7
17.9	19.1	18.7	23.4	25.6
11.3	15.0	13.0	16.6	11.9
2.3	5.7	3.3	3.7	3.5
3.2	4.3	5.2	4.8	4.0
5.8	5.0	4.6	8.1	4.3
100.0	100.0	100.0	100.0	100.0
177	103	144	58	94
5.5	3.2	4.4	1.8	2.9
260	233	286	168	117

regions of the world where the availability of life-supporting natural resources is threatened, the burden of ill-health will be severely increased.

There are however two important annotations to this global overview of changes. It reflects a static picture of the health situation and not a dynamic one. Whereas the World Development Report deals only with incidence, the prevalence of diseases is also important. Diseases such as tuberculosis have reappeared as a serious health hazard on a global scale. There has been a recrudescence of malaria with both the vector and the parasite developing resistance against the available preventive and curative technology. Plague continues to lurk in parts of both the developed and developing regions.

The measurements of DALYs do not take into account the impact of environmental degradation, neither as currently existing, nor as part of projections for the future. Nor do DALYs seem to be entirely adequate for ascertaining the quality of health in the life span after 60 years. The disability and ill-health of the elderly gets heavily discounted which brings down the disease burden for conditions which do not result in severe disabilities such as allergies, asthma, and rheumatic disorders which may continuously impair the quality of life. These have not been given appropriate weight in the measurement of DALYs. This impairment in the quality of life cannot be adequately expressed in terms of life years lost. Better indicators are therefore needed to reflect the changes in the quality of life which result from the change in the health situation that follows the transition to old age.

Health care systems in many parts of the world have come under severe stress as a result of global political and economic changes. For example, countries which have undergone structural adjustments have had to make cutbacks for debt servicing. The hardest hit have been the social sectors. Health programmes have shrunk, quality of care has suffered, and the importation of essential drugs requiring foreign currency has been drastically reduced in many cases. The debt burden has had severe impacts on the health sector, and the outcomes have been seen in the poor health status of the poorer sections of society.

As in the case of the development scenario, what is needed for the purpose of identifying the issues relevant for the Task Force is a scenario of the major qualitative changes in the health situation.

This is especially important as there **are** health-development scenarios which have led to positive health **and** development outcomes.

There is a great deal to be learned from the way in which the health-development link has been managed in low income countries with exceptional outcomes, as in the case of China and Sri Lanka. Similarly, countries such as Brazil which have sustained high growth rates over long periods and continue to have health indicators which are well below the average for their levels of per capita income, point to the strategies that should be avoided.

A common feature of successful approaches to health development is that they are not based on a disease-specific approach which examines changes in health status in relation to well-defined groups of diseases. Instead, emphasis is placed on examining critical conditions of health risk and vulnerability that are closely associated with the changes caused by the ongoing processes of social and economic development. This provides the critical links with the development scenario. When the two scenarios are taken together, the points of entry for both the health sectors and development sectors to reshape their policies and work simultaneously toward the same goals may be identified.

Some of the critical health outcomes in the emerging development scenario are highlighted below and may be used as essential guides for the work of the Task Force and a vision for the future.

The global burden of disease

In developing countries, communicable diseases, and the ill-health associated with poverty, illiteracy and unhygienic environments account for the major share of the global burden of disease. This means that many developing countries are still in the early phases of the health transition and the main thrust of the health strategy will be on the acceleration of the transition. Mainstream development strategies however have not as yet been able to reach a large section of people living in conditions of extreme poverty and illiteracy, which fuel their continuing poor health status. It will be necessary to build on innovative experiences in health and development which put simultaneous emphasis on economic growth, including improvement in standards of living, and improvement in health status and quality of life.

Living longer but not better

With longer life and higher capacity for survival the disease burden shifts to the last quintile of the life span. This prolongation of the average life span is generally characterized by the degenerative ill-health and organic disorders of aging, as well as by the psychological ill-health on a scale not encountered before. The problems are aggravated in societies where the value system tends to be materialistic and centred on youthful active life, and where institutions, such as the family, which provided a meaningful role for the aged in the past, are being eroded.

The protection and improvement of the quality of life of this quintile of the average life span will be crucially important for the quality of life in general in societies where the demographic transition has taken place. While the problem is already being taken up in the developed countries, it will be even more acute in the developing world as a result of the absolute numbers of the elderly in this part of the world in the 21st century. These countries will need to cope with the problem on a large scale and long before they reach the levels of affluence of the developed countries. The implications for public expenditure and fiscal policies will be far-reaching and will have an important bearing on the choice and implementation of development strategies.

Life-style related health conditions

Ill-health linked to new and changing life-styles and patterns of consumption has become an important part of the disease burden in developed countries and is growing in developing countries. The market is creating new opportunities for life-styles and choices but does little to provide the health literacy and value systems which are necessary to make rational, informed and health-promoting choices among the many options available. Rapid socioeconomic change, breakdown in value systems and traditional social controls, and rapid urbanization are contributing to the disease burden. These have been major factors in the spread of sexually transmitted diseases (STDs), including HIV/AIDS.

The health hazards of these changing life-styles are greatest for youth and can manifest themselves in insecurity, alienation, drug abuse, promiscuity, senseless forms of violence and even suicide.

Health outcomes of the development process

Development has produced conditions of positive health as seen in population groups which enjoy a healthy life-style. Not only do they live better but they participate knowingly in keeping healthy through the adoption of appropriate diets, physical exercise and wise use of health and other services.

Similarly, there are certain economic activities that have contributed to the generation of ill-health. Changes in the physical environment and the application of technology have produced new health risks and conditions of ill-health ranging from occupational diseases to the effects of toxicity and pollution of various types.

Accidents and man-made disasters have grown in scale and intensity and have become one of the leading causes of death and disability. This trend is directly linked with development and technological change and includes transport, chemical industry, nuclear power and a host of other activities, with automobile accidents taking the lead in accidents in general. The health sector normally enters after the event when it has to provide care for the victims. The application and use of technology in pursuit of economic benefits without due regard to the high risk to human life and health is again symptomatic of the dehumanised character of the objectives which often drive the development processes. Reversing these processes would require an approach in which the concern for human safety and health governs the development and application of technology at all stages.

Challenges posed by the changing development and health scenario

In this changing development and health scenario, health care systems themselves are undergoing far-reaching changes. The market and the private sector are assuming an increasingly important role, from research and development to the delivery of health care services. On the one hand, these changes, if appropriately managed, can increase consumer choice and cost effectiveness in the health sector. On the other, some of the important values, ethics and objectives which governed the health sector and the practice of medicine in the past may be eroded.

At the same time, it is important to be aware that there are significant regional variations in this health scenario which follow broadly on the lines of the variations in the development scenario. There are however some special "irregularities" that are crucial. Improvement in health is not always closely associated with economic growth. Countries in different stages of the transition face different types of problems and challenges. The main challenge for the developing countries is to make the transition rapidly and in doing so avoid some of the patterns of ill-health that have emerged in the developed countries.

Part IV
AN OVERVIEW OF PAST INITIATIVES

A substantial body of work already exists on the links between health and development as a result of several major initiatives taken by WHO in collaboration with partners both within and outside the United Nations system. This will be built upon in the work of the Task Force.

The link between health and development has been recognized and observed over a long period, following the major improvements in the health status of the developed societies in the first half of this century. Scholars and policy makers have commented on the ways in which developments outside the health sector affected health outcomes, whether they were the positive effects of education, urbanization and overall improvement of living standards, or the negative impacts of industrial pollution and poor work environments.

Public health developed as a response to these links, but interventions were largely passive and reactive in character. They were not accompanied by an active and sustained policy response from the health sector as a whole, or from development planners and policy makers. Development strategies continued to focus on economic growth and the sectors directly linked to it, leaving health to pursue its own strategy. Health strategies continued to be disease-centred and primarily curative in their approach. The benefits and costs to health resulting from the processes of development were perceived as the "natural" by-products or outcomes of these processes to which the health sector had to adjust and adapt with responses which were essentially medical.

Intersectoral action for health

The Health for All movement launched at the 1977 World Health Assembly with its emphasis on primary health care and universal access to health marked a significant turning point. The Alma-Ata declaration of the following year further advocated a focus on the reordering of national health strategies from the curative to the preventive and proactive, entailing a shift in emphasis from treating disease to one limiting health risks and fostering health-promoting behaviours.

Cognizant that the health sector alone could not achieve these aims, the World Health Organization in 1981 began a series of studies and meetings to clarify the interplay between health status at different stages of development and its relationship with the processes of economic, social and political development. It was one of the early attempts to conceptualise and map the nature of the health transition across countries at different levels of development and examine the close interaction between the changes in health status and the processes of development in these countries.

These activities resulted in a framework for the critical analysis of intersectoral actions affecting health. They also formed the basis for the Technical Discussions at the 39th World Health Assembly in 1986 on "Intersectoral Cooperation in National Strategies for Health for All". The resolution adopted at the 1986 Technical Discussions included recommendations for achieving equity in the health of disadvantaged groups through appropriate intersectoral interventions, and for adopting the health status of such groups as an indicator of national development.

Following the technical discussions no major effort was made to put to task the collective decisions reached, neither by the international organizations and agencies that co-sponsored the Technical Discussions, nor by the countries themselves.

It was only much later that a renewed attempt was made. With the preparatory work for the United Nations Conference on Environment and Development (UNCED), WHO set up a Commission on Health and Environment. This Commission invested in establishing the links between health status and development activities as mediated through the environment and made a major contribution to UNCED.

Following UNCED, WHO developed a global strategy for health and environment which provides a new orientation for multi-disciplinary and multi-sectoral efforts to ensure that health considerations are fully incorporated and at the core of all development and environmental activities, from policy planning to project implementation, monitoring and evaluation. WHO was given responsibility for follow-up on the health aspects of Agenda 21 emanating from UNCED.

Parallel to this initiative, work was undertaken by WHO and the World Bank to illustrate the impact of development policies on health. The immediate and underlying causes of ill-health and

major gaps in existing studies were identified for five sectors - macroeconomics, agriculture, industry, energy and housing. This provided the basis for further studies examining the linkages across sectors, assessing sectoral connections that heighten health risks and identifying important areas for policy intervention.

The International Conference on Nutrition and the Ministerial Conference on Malaria were additional milestones in the follow-up to the 1986 Technical Discussions. All these initiatives contributed to a better articulation of the linkages between development sectors and health, and led to a more feasible strategy for intersectoral action for health. The revision in thinking came about due to the fact that it was neither necessary, nor desirable to expect all sectors to come together for health. Rather, the involvement of relevant sectors was dictated by the nature of the problems or issues arising where delineation of responsibility for action between the sectors was necessary for the solution of problems.

As work proceeded, especially in dealing with the vulnerable groups, came the further realization that economic development as such was not necessarily accompanied by good health. It is the manner in which resources are used, both at local and national levels, which will determine the effect on health and quality of life. Accommodating economic objectives (as measured by increase in net income at the household level) with health objectives (as measured by improvement in health status indicators), and grounding both of these in functional literacy, was found to be an innovative response to the development needs of the poorest and most deprived segments of society. This approach formed the basis of the international forum on "Health: A Conditionality for Economic Development". Here, for the first time, financial institutions were requested to modify their lending procedures to ensure that loans are made available to the poor and disadvantaged for improving net income, and at the same time incorporating health objectives. Such an approach ensures that increased income is reinvested both for economic gains, and also for improvement in health and overall quality of life.

The above are but a few examples which illustrate the evolution in the thinking surrounding intersectoral action for health. The solid technical groundwork in these and other initiatives will be built upon in the work of the Task Force.

Management of the health-development link

The changes in the health status in the five countries - Jamaica, the State of Kerala in India, Norway, Thailand and Sri Lanka, selected for study are the outcome of long and complex processes of socioeconomic development. This has been the case not only in relation to improvements in wellbeing, but also in relation to the changes of a negative character that have produced new patterns of ill health. In the course of these processes, national policies and strategies aimed at realizing a wide range of social and economic goals have interacted with, and contributed to, the policies and programmes of the health sector itself. Other processes that did not form parts of consciously pursued strategies also had a profound effect on social conditions, the quality of life, and the health of the population. The cultural transformation that accompanied socioeconomic development changed the value systems governing human behaviour and life-style. Together they produce new patterns of consumption and new conditions of morbidity. The changes in political structure and the increasing participation of the people in social decision-making had inevitable consequences for the distribution of power and income, access to resources, and the improvement of wellbeing.

Source: based on an extract from Intersectoral linkages and health development, WHO Offset Publication No. 83, 1984

Valuing health for itself

Today the effect of development on the environment has become a central concern, both globally and nationally. For this to happen, environmental stress had to reach a point where it was perceived as approaching the limits of sustainability. On the other hand, the effect of development on health still remains secondary to most other development concerns. The tendency has been to approach it as a part of other issues as, for example, the health effects of development as byproducts of environmental degradation, or of poor health as an indicator of poverty. In these issues health still remains instrumental, a means to another development objective. As such it is undoubtedly important and necessary. But it is when health is valued for itself as an indispensable part of the quality of life, to be achieved through the processes of development, that it assumes its true role in development and the other sectoral objectives become aligned to essential health goals.

Source: Health Dimensions of Economic Reform, WHO, Geneva, 1992

Health essential for sustainable development

A broad-based health reform is required as a contribution towards the achievement of a sustainable development in which health aspects are given their due weight. Four "lines of reform" have been identified as being a suitable programme of action for countries to pursue in the framework of their national sustainable development programme:

1. Community Health Development; undertaking health promotion and protection as part of more holistically conceived community-based development programmes;
2. Health Sector Reform: Ministries of Health increasing allocation of resources to most cost-effective health-protecting and promoting programmes, as seen in the longer run and in the interest of obtaining sustainable development;
3. Environmental Health: increasing understanding of the impact of policies and programmes of other sectors upon human health and mobilizing financing and action in those sectors accordingly;
4. National Decision-Making: health impact assessments, accounting and other means of promoting the integration of health, the environment and sustainable development into national decision-making with a view to strengthening health sector representation and incorporating health and its financing in development planning.

Source: WHO background paper on "Health, Environment and Sustainable Development" prepared for the Commission for Sustainable Development, March, 1994

All these initiatives sustained the effort to promote policies and actions to deal with health as an integral part of both the process of development as well as the condition of well being which is achieved by it. But as yet, policy making both in the health sector as well in other sectors and the macro-economy do not adequately reflect the approaches that were advocated in the WHO initiatives. The causes for the slowness of response to past initiatives seem to go beyond mere shortfalls in implementation and lie in a more deep seated inertia and lack of commitment. Despite the recognition of the health-development link, the economic outcome of development appears to continue to have greater value for policy makers and take precedence over the health outcome.

If, in fact, this is the case, the roots of the failure would lie in the development paradigm and the value systems which sustain it. The problem of integrating health into development, then, has to be dealt with at a deeper level. The Task Force would need to inquire into these larger dimensions of the problem.

Part V
AGENDA FOR HEALTH AND DEVELOPMENT

For the purpose of demarcating the area of work for the Task Force, it is useful initially to distinguish between two types of development impacts on health. One type has dealt with the impact which development has on the environment and through this on the health of human beings - the health/environment/development triad. This covers a very wide range of links and includes several sectors. Many of these links are of a technological character, are mediated through the environment and lend themselves to identification and quantification. However the policy responses and programmes needed to avoid the costs or realize the full benefits can range from straightforward technological solutions to more complex adjustments in development policies and changes in human behaviour.

Since the health/environment/development triad is addressed by the ongoing programmes of WHO, it will not be addressed by the Task Force on Health and Development Policies.

The second type of linkage is less readily quantifiable; it deals with social, economic and political processes which affect the availability of health care and health-related goods and services on the one hand, and patterns of health-related behaviour on the other. These links might arise from institutional and societal changes that have occurred over a long period of time. They also arise from specific macro-economic policies and interventions which affect the flow of health goods and health resources, as well as people's capacity to promote and protect their own health. The task of managing these links in a manner which is beneficial to health requires methods of analysis, policy responses and monitoring systems which are very different from what is generally needed for the first type of linkage. The solutions to the second type are primarily societal in character.

The contribution of health to economic development

Past work on the health-development link has often focused on the flow of costs and benefits from health to economic growth and other processes of development. In some cases these flows are

clearly identifiable and interventions which strengthen the health-development link are easy to design and implement. This is the case when an endemic disease is acting as a serious impediment to growth. An example of the solving of a health problem leading to economic benefits can be seen in Sri Lanka when the programme of agricultural settlement was launched in the malaria-ridden dry zone in the 1940s and the decades that followed. A more recent example is the onchocerciasis eradication programme which liberated productive land to be used for development.

In other cases the link is not so evident or perceived as readily when changes in health occur over a period of time and have either positive or negative impacts on productivity and output. While an improvement in health status will most often result in greater economic activity, a reduction in the loss of working time due to ill-health, and less expenditure on curative health care, these economic benefits are often taken for granted and treated as the natural by-products of human beings acting in their own self interest to safeguard and improve their health. On this premise there is no need for special policy initiatives which identify these links between health and productivity and actively undertake efforts to strengthen them. Such an approach which attempts to apply economic principles to health outcomes, and justify the allocation of resources to health on this basis, has not had a lasting impact on policy and decision-making processes.

Impact of the development process on health status

It is, however, the flow in the other direction, i.e. the impact which the entire development process has on health status, which raises most of the crucial issues presented in the development and health scenarios. Policy makers tend to treat the health benefits which are brought about by economic development in the same way they treat the economic benefits brought about by health improvement. They generally assume that these benefits flow automatically from the processes of interaction between health and development processes. They seldom see the need for special interventions.

While this may be true for most of such health benefits, there are special situations where the beneficial links need to be identified and reinforced. This is particularly true when dealing with vulner-

able and disadvantaged groups where the deprivation in health and in economic resources exist together, reinforcing each other, and where integrated strategies are needed to break the vicious cycle of poverty, ill-health and illiteracy. All development strategies need to identify these situations and reinforce and act on the health-development link.

Trade-offs between health and economic aspects

What has not been sufficiently addressed is the whole range of issues which arise when health objectives come into conflict with other development goals such as increased output and economic growth.

Managing trade-offs

Integration of health goals and improvement of health status in development strategy and policy depend crucially on capacity to effect trade-offs between health and economic development. Trade-offs will be inevitable. In some cases health costs may have to be incurred in the short term to secure substantial economic gains that bring major long-term health benefits. In others it may be necessary to forego some part of potential economic gains to avoid serious long-term impairment to health. What is necessary is a system of choice and decision-making ensuring that choice is constantly disciplined by efforts to achieve the health and economic goals simultaneously. If trade-offs become inevitable, they should be short-term and made good as quickly as possible so as to restore the conditions for good health. Adequate information has to be provided for the choices. This process of decision-making implies that a national account of the trade-offs is maintained and closely monitored. There is a growing body of knowledge on the health costs of economic development programmes and policies and it will enable governments to begin working towards these objectives.

Source: Health Dimensions of Economic Reform, WHO, Geneva, 1992

The decision to incur a loss in health for a gain in some other condition of well-being is normally guided by the knowledge that the non-health gain is too great to forego for a small loss in health. The health loss also might occur in the distant future and is therefore subject to heavy discounting in current methods of

cost-benefit appraisal. Individuals and societies pay little heed to the fact that they are storing health losses for the future by their present behaviour. On the other hand, the non-health gain such as an increase in the output of goods and an increase in purchasing power may contribute to health in other ways and offset the health loss it causes directly.

In trade-offs of this nature, the immediate economic gain or other non-health benefit often tends to override health considerations when they are not manifestly severe or incapacitating. The lack of information on the health implications tends to accentuate this behaviour.

The national development calculus has to give a different value to health losses. The loss in health has always to be made good with the least possible delay. It is necessary to develop methods of identifying the health liabilities that are being incurred that would have to be paid off or settled in the future. These methods could then be put to use by governments, communities and individuals to enable them to make informed choices that protect and promote health when trade-offs are required.

However, a system of accounting and information of this nature, though necessary, cannot by itself deal with the deep-seated problems outlined in the development and health scenarios. Health goals are ignored, partly due to ignorance regarding all the health implications in the present and the future, and partly because of the lower value attached to the state of health. The latter is the outcome of the value systems and life-goals which guide choices; it is the product of the development paradigm and the vision of life which sustains it. Therefore giving health its due place in development requires an overarching consensus on the goals of development and the values concerning human life which should govern it.

When health is seen as a societal issue, and an intrinsic value is accorded to health itself, without relying upon economic values, then health is made a major goal of development and given an equal place with other development objectives. Implicit in such an approach is the premise that health improvements are necessary and valuable for themselves and that the outcome of development is assessed by the well-being and quality of life it produces. This is the vision which will guide the work of the Task Force on Health and Development Policies.

The agenda for the Task Force in terms of a work plan for a period of two to three years could be developed around the issues that have been discussed as they fall into four main areas:

Equity in health and market forces

The quality of life and health security of specific population groups

Accountability for health

Health as a bridge for peace

Equity in health and market forces

Discussion of this theme could focus on several key issues arising out of prevailing development policies – the increasing emphasis on the role of the market and privatisation, the radical restructuring of many political and economic systems and approaches, and uncertainty regarding the domain of public responsibility in sectors such as health care.

The quality of life and health security of specific population groups

There are two population groups whose health has been particularly neglected, and thus require urgent attention: adolescents and the elderly. The health of both of these groups is threatened in different ways and, likewise, the health consequences suffered may be quite distinctive. The Task Force may wish to concentrate in its first session on youth, since the health of this group is of increasing concern globally, and consider the health of the elderly as the core of a future meeting.

The cluster of inter-related problems linked to unemployment, changes in life-styles and the breakdown of value systems often lead to serious health problems for adolescents, including drug

addiction, crime and violence, STDs, HIV/AIDS, and even suicide. The strategies needed to deal with these will have to extend far beyond approaches centred on medical care to include the social and cultural dimensions of development and change, as young people's behaviour is a reflection of society and its values. Shortcomings in all sectors of society, especially in health and education – lack of opportunities to gainful and meaningful employment for instance – lead to a state of hopelessness and insecurity among young people, the origins of which often emanate as far back as early childhood, or even before.

Accountability for health

The Task Force would need to consider here the critical conditions of health insecurity arising out of the lack of accountability for the health impact of a wide range of socioeconomic activities and development processes. With the expansion of social and economic opportunity and rapid technological change, the opportunities and choices leading to ill-health, injury, violence and disaster are increasing. In regard to many of these changes, accountability for health impact is often non-existent and access to knowledge and information on the health implications of choices is poor.

Health and Peace

Health should increasingly be used as a mechanism to build dialogue, even in the midst of ideological, political and military conflict. Positive results have been obtained not the least of which is the recognition that improving public health, and particularly the health of particularly vulnerable groups, constitutes a shared international value which can bridge even the most virulent forces of conflict.

A number of overarching issues exist which the Task Force may wish to address.

- What should be the strategy at the global, regional and national levels to build consensus on development goals which give a central place to health?
- Regions are currently at different points of "health transition" in terms of their demographic and socioeconomic situations and therefore face different opportunities and challenges. How can the critical issues under consideration by the Task Force be translated into regional priorities in the evolving global health scenario?
- The issues under health security, health accountability and health as a bridge for peace could be discussed in typical country or regional situations, and combinations of policies and interventions identified. Lessons could then be drawn and replicable models developed that could be of use to policy makers. How can the Task Force help in the design and direction of country case studies on the regional and national variations?
- Is there a need for a global initiative such as a World Health Watch?

The Task Force would also need to consider the role of the World Health Organization in this entire field, covering the issues of health and development. What are the areas which are within its mandate, and others which lend themselves better to being administered by other specialized agencies and organizations with the contribution of or advocacy from WHO. In dealing with development sectors other than health, what is the nature of the partnership which WHO should attempt to foster with the institutions and decision-makers responsible for other sectors?