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Task Force on Health in Development

Highlights of the fifth meeting

Geneva, 18 and 19 November 1996

At its ninety-ninth session, the Executive Board discussed the report by the WHO Task Force on Health in Development, entitled "Reflections of the past - visions of the future",[1] and adopted resolution EB99.R8. The present document reports on highlights of the fifth meeting of the Task Force (Geneva, 18 and 19 November 1996), and contains the views of the Task Force on key issues affecting the future of the Organization. It both encompasses and amplifies the information given to the Executive Board.

Concerned for the protection and improvement of the quality of life of all populations, the Task Force (established by the Director-General in response to resolution WHA45.24) surveyed the health situation, its trends and determinants. It used all available opportunities to call attention to the central place of health in the development process, and to the moral and intellectual obligation of society to ensure health promotion, protection and maintenance. The Task Force also examined the role of WHO as the leader in world health. It outlined ways in which WHO could retain and strengthen its leadership in critical areas in health, and embrace the challenges of the twenty-first century. It is urgent for WHO to advance towards human health development in the coming century, and to assume fully its leadership role by launching the health-for-all strategy for the twenty-first century, thus preserving the health gains achieved since its establishment.

[1] Document EB99/40.

INTRODUCTION

1. The fifth meeting of the Task Force on Health in Development (Geneva, 18 and 19 November 1996) was convened in order to consider the work accomplished by the group throughout its mandate.

2. The Chairman of the Task Force stressed the importance of achieving a balance when "investing in health" by both controlling the causes of ill-health and investing in health care - preventive, promotive, curative and rehabilitative - to meet people's priority needs.

3. He observed that health was not a commodity, and could not be left to chance. He was therefore all the more concerned about the increasing use of "market language" within WHO. Those key remarks set the tone for the subsequent discussions.

4. Since adoption of resolution WHA45.24 recommending the creation of the Task Force in 1992, to its establishment at the end of 1993 and its first meeting in 1994, the world climate and perceptions of health in development have changed markedly.

5. The Task Force interpreted its mandate in light of the unforeseen results of rapid economic and social change produced by war, regional conflict and ethnic strife; the shift from centrally planned to market economies; globalization of the economy and the increasing trend towards privatization worldwide; and the conclusion of the Uruguay Round of GATT negotiations.

6. Consequences of the above on health included a worsening of health status, especially of the most vulnerable and disadvantaged groups, and the emergence of new vulnerable groups, often barely able to survive.

7. The Task Force reflected on crucial questions with regard to the past and current situation and to future scenarios for global health leadership: What kind of health leadership was required for the twenty-first century? Was WHO currently equipped and ready to fulfil a leadership role for global health? If not, what kind of changes were necessary? What critical capabilities should WHO have in the next century? It observed that although WHO was provided by its mandate with a unique opportunity to exercise this leadership and to enjoy an outstanding association with the scientific community, the Organization still rested to a certain degree on its past achievements. Therefore WHO's leadership and health advocacy role needed strengthening to ensure that no opportunities were missed, and that health issues were given their due consideration. WHO's approach to health needed to be coherent in order to prevent parts of the health agenda from being implemented out of context by others. Leadership involved the whole Organization - Member States and Secretariat. Member States should assume their share of responsibility and pursue the policies that they had formulated.

8. In reviewing the evolution of the world health situation since WHO's establishment, the Task Force concluded that today's world was very different from the one which existed when the founding fathers of WHO crafted the Constitution in 1946. Although the Constitution was visionary in its broad definition of health and in its approach to health as a human right, there were many elements of today's world that could not be foreseen at that time.

9. Among the most far-reaching changes are the following:

- in 1948 there were 50 Member States, today 190;
- the post-war world was concerned with establishing a system to ensure that global conflicts never reoccurred. Today's world is different, with a multitude of regional and small conflicts and institutionalized violence in societies which need an innovative response;

- a relatively "small" world has been turned by the demographic explosion into one where the sheer weight of population in some countries is a driving force behind many economic and political decisions;

- although human rights were being enshrined in many of the important international documents of the time, including the Charter of the United Nations and WHO's Constitution, a global system of human rights had not yet been established. Efforts to find common ground for understanding of human rights issues are likely to intensify and lead to broader and deeper perception in the next century;

- the world was still a long way from the communications and technology revolution which characterizes today's world, and will continue to intensify and transform the way we see, live and work in the next century;

- concepts ruling relationships between countries tended to reflect paternalistic colonial patterns, evidenced by the notion of "technical assistance" as compared to today's "technical cooperation". These concepts will change even more in the years to come;

- health was seen largely in technical or medical terms, rather than as a state influenced by a multiplicity of factors often beyond the competence and reach of health professionals. Scientific knowledge of the impact on health status of the physical, political, economic and social environment had not yet been acquired;

- concepts of global solidarity, equity, and bioethics (as opposed to "classical" medical ethics) had not come to the fore;

- the "gender" factor in health and development was not even referred to, let alone understood or addressed in policy and programme design.

10. One factor that has not changed substantially, but has become all-pervasive, is the reliance on economic responses to development concerns. Today, more than ever, the market mechanism reigns unchallenged.

11. The above developments have had, and will continue to have, an enormous impact on health status, health services and the health sector. Change can have both positive and negative effects on human health. The challenge for WHO is to harness change so that it improves health status. This also requires visionary leadership attuned to fluctuating realities and needs. It requires the solid capacity to project, to analyse trends, and to provide advice on directions and responses, all based on the most up-to-date scientific information. It requires advocacy to ensure that health is not compromised in the development process, and that all opportunities for health in development are exploited to the full. Given these substantive changes and projections for the future, how can WHO ensure appropriate health leadership?

12. In the course of the Task Force's work, the main lines of action of a World Health Organization for the twenty-first century emerged:

- advocating a global culture of health based on the concept of health security, in which health becomes a powerful contributor to social cohesion, peace and a better quality of life;

- convening experts to determine global standards and norms on technical and ethical questions and criteria to guide policy- and decision-making in matters related to health;

- acting as a catalyst in health policy-making, as a "strategic referee" for the establishment and implementation of a global health agenda with and through a worldwide network of partners from both public and private spheres;

- monitoring health status, projecting and analysing health scenarios, and developing proactive courses of action to address known or potential threats to health;

- reducing inequities in health, health status and services through promotion of the right to the highest attainable standard of health.

WHO'S ROLE FOR THE TWENTY-FIRST CENTURY

13. Health is a fundamental priority for all societies, since the underlying purpose of development is to improve the health status and quality of life of all human beings. The reduction in morbidity and mortality in population groups most in need, the rescuing of lives from fatal conditions, the halt to epidemics, the countless lives saved from communicable diseases, the conquest of scourges, must continue to be the centrepiece of WHO's efforts.

14. In the age of high technology and global economic competition, WHO must be the first to invest in creative and prospective approaches to the problems of human health. WHO can take a lead in monitoring changes in health status of disadvantaged groups as a significant, but often neglected, indicator of the outcome of development strategies.

15. The true value of health, in and for itself, must be upheld constantly. As said by one of the Task Force members, "When a machine is out of order it is simply repaired without justification, so why should people's health need justifying?" Seeking to buttress WHO's position as the global health leader, the Task Force cautioned that health must not be seen as a market commodity. WHO must ensure that health is not compromised in the development process and must highlight the fact that health is everyone's concern.

16. Ambiguous language must be avoided, such as making sure that "health status", "health services" and the "health sector" are not used interchangeably, playing into the hands of those who believe that health only represents consumption.

■ ***Promote a global agenda for health***

17. WHO should set the global agenda for health with all partners with direct or indirect links to health, and invite development partners to implement that agenda. It should:

- provide up-to-date information on the health situation in all regions of the world on a 24-hour-a-day basis to all partners;

- continuously analyse health determinants (human health being considered in its total environment: physical, biological, social, political, economic and cultural);

- examine the outcome of different health scenarios in the development process in order to provide guidelines for strategic planning initiatives in both public and private sectors at all levels;

- promote research, scientific knowledge and development of technology related to human physiology, diseases, disabilities and well-being;

- monitor the extent to which population-based care is addressing the needs of all people, reducing inequities in health and contributing to overall well-being;

- support capacity-building in countries in order to adapt the global agenda to their own needs.

18. Such a global agenda would strengthen the importance of health in the debates of interest groups, plans for political action and changing political and economic priorities (e.g. rapidly changing fiscal or electoral priorities among donor countries, vagaries of shifting global alliances or geopolitics).

19. The technological and communications revolution must be put to the service of health development. The appropriate use of up-to-date scientific information is WHO's most credible means for negotiating and promoting health development. However, WHO must be able to put this scientific information, linked to global concerns, at everyone's disposal, thus helping the agenda for health action to move forward logically. Behind each fact and figure are the stories of real people's lives, and WHO must be the link between these facts and figures and their reality.

■ ***Monitor changes in health status as the best indicator of the extent to which development strategies are reducing inequities***

20. WHO would fulfil two functions in its information role:

- act as an "information clearing-house", from which the most up-to-date scientific information would be available instantly at all times;
- act as a "health caretaker", whereby the underlying purpose of development is constantly ensured. In this capacity WHO would predict, alert, and advise on courses of action to ensure that public policy is always conditioned by health concerns.

21. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. In spite of its constitutional mandate, WHO has no coherent programme that deals with the protection of health rights. Its lack of leadership in this area is disappointing as it both reduces the efficacy of existing human rights and inhibits the evolution of more elaborate international standards. Referring to the enjoyment of the highest attainable standard of health as being one of the fundamental rights of every human being the Task Force cautioned that if immediate action was not taken to ensure the launching of a sound programme to protect health rights, involving institutions, networks, and collaborative work in conjunction with the United Nations Centre for Human Rights, one of the most important aspects of health protection would be left out. Moreover, when the basic human right to health and development is violated, sustainable development for all future generations is imperilled.

■ ***Work towards a universal ethic of health status protection and promotion***

22. WHO should advance the intrinsic value of health in and for itself. As the world's "health conscience" it would advocate:

- the dignity of all human beings through the protection and promotion of health status and quality of life in all circumstances;
- the ethical basis for protection of health and well-being, particularly in situations of conflict;
- a system for identifying situations where health status and well-being were being compromised. It would work with relevant partners to develop, apply and monitor the outcome of sanctions imposed where necessary to redress such situations;
- a framework for ensuring health accountability at all stages and levels of the development process and by all partners involved in this process;

- use of the ethics of health and human dignity to address the human rights violations associated with trafficking in human beings, modern forms of slavery, unacceptable treatment of refugees, gender discrimination, abuse of children, sexual abuse, etc.;

- availability of rapid and effective relief, including curative, preventive and rehabilitative health services, for those in need in times of crisis, i.e. when early warning signals indicate that health status and well-being are being compromised; and use of WHO's capacity for information collection and analysis.

23. Health and public health tools can be powerful means to reduce social tension and conflict, and provide a bridge to peace. WHO should build on its strengths and continue to advocate improved health status, services and care as an effective way to reduce inequities.

24. Reduction of inequities in health status also contributes to preventing and mitigating the health consequences of conflict, to negotiating an end to conflict and to rebuilding torn societies. WHO should pursue its action in health promotive and preventive diplomacy and implement the recommendations made by the Task Force throughout its mandate.

- ***Develop and use the potential of health promotive and preventive diplomacy***

25. Universal concern for health provides a potential value system and a neutral platform for contributing to social cohesion, reducing conflict and negotiating peace. Respect for the roles of health professionals, recognition of their traditional impartiality in situations of conflict, and a professional code of ethics that imposes fundamental obligations on physicians, nurses and other health professionals can contribute to peace processes. WHO would support further development in this area by:

- developing the use of public health tools, with particular reference to preventive medicine and epidemiology, and apply these to conflict prevention, mitigation and resolution;

- monitoring worsening health conditions as an early warning signal of national instability which could lead to international instability, using such information to alert the international community, and taking proactive measures to avert the outbreak of conflict;

- providing guidelines on safe zones in conflict, humanitarian corridors, and for analysing the dichotomy between ethical and political considerations in situations where embargoes and sanctions are being considered;

- promoting the training of health professionals, within the basic provision of public health services, to respect codes of ethics which require the medical treatment of all patients, irrespective of status.

WHO'S APPROACHES

26. WHO's reform should be a many-faceted and ongoing process. The root causes of health problems and consequent human stress are far too diverse and embedded in social change to be limited to narrow health programmes.

27. Many health problems do not advance in a linear fashion but as a complex configuration. It may take the mere increase in the price of staple food to trigger off social unrest of enormous magnitude, with such health repercussions as population exodus, epidemics, malnutrition, and other health conditions that frequently appear on the agenda of international organizations such as WHO. A different outlook is needed on preventive

programmes that have more than a single purpose and that require a more integrated approach to health in development.

28. WHO is an international organization, it must now become a truly global organization. WHO is the only organization whose entire agenda is dedicated to health, and it must therefore encompass all partners involved in one way or another in health. It must embrace the best expertise and foster collaborative work.

29. In view of the place of health at the centre of human development, WHO's partnerships should encompass for instance bodies within civil society, nongovernmental organizations, private sector, communities and academia.

30. Use of the term "leadership", does not imply that WHO will actually undertake itself all the proposed functions; rather, it will ensure that each is undertaken for the promotion and protection of health. It will be necessary to reach out to a wide range of partners; WHO leadership in the twenty-first century will embrace rather than replace.

- ***Work with key international actors such as UNESCO, the World Bank, IMF, UNICEF, UNFPA, OECD and WTO, as well as regional economic forums, to ensure that health status is promoted and protected in economic policies and development strategies***

31. WHO should take the lead in:

- developing a broad consensus to ensure that economic policies and development strategies do not have negative effects on health status and quality of life;

- working towards adoption of chief health status indicators of the most disadvantaged groups in all societies as benchmarks against which to measure the quality and outcome of economic policies and development strategies.

- ***Embrace and work through the widest range of partners to take advantage of the technological and communications revolution***

32. WHO should ensure that the best technical competence and the most up-to-date scientific information in all spheres of activity (public and private sectors) are harnessed to promote improvement of health status in the development process, and to buttress a global health agenda. A vast worldwide network of centres of excellence and collaborative institutions, linking countries, private sector partners, nongovernmental organizations and others, would be set up to this end. WHO would have a special role to ensure that countries most in need are fully included in this process, thus accelerating the improvement of their health status and services.

33. Partnerships for health with nongovernmental organizations and the private sector may play an important role in widening the social basis of responsibility for health, but they must never function directly or indirectly at the expense of those most in need. Task Force members welcomed the WHO working paper on ethical guidelines on relationships between WHO and the private sector, and made constructive suggestions for its improvement and for fulfilling a continuing high ethical standard and code of conduct for relationships with the private sector. Moreover, WHO's fundamental premises and commitments must be ensured when envisaging partnerships: equity, solidarity, sustainability and universality in access to health care. Any potential benefits of a project must significantly outweigh any potential disadvantages, and the principle of transparency should be respected. Guidelines on partnerships were seen by the Task Force as educational tools for the corporate sector.

34. Criteria for partnerships with the private sector are:

- the health impact of products or services produced;
- the occupational health conditions under which they are produced;
- the environmental commitment of the partner;
- the marketing and advertising practices of the partner;
- the regulatory compliance of the partner;
- the overall philanthropic commitment and record of the partner;
- the environmental and human rights commitment of the partner.

35. The ethical basis of health and health care is not negotiable. To ensure the highest standard of ethics in health, WHO must act as a catalyst in health policy-making, and as a moral conscience and a "standard referee" in setting universal standards, norms and guidelines.

■ ***Continue to be the standard-setter in health***

36. WHO should work with all relevant partners and "shareholders" in health to develop and promote the use of standards for health. In this way all those concerned stand to gain by adhering to standards and norms.

RESOURCES

37. Health must be seen as a responsibility for all members of society; partners then become "shareholders" in health. Within the framework of enhanced partnerships in health, an improved financial structure must be found to guarantee that health priorities, including rapid reaction services in times of crisis, are not jeopardized for short-term economic concerns.

38. The Task Force saw the need to examine many options which could potentially mobilize resources for the improvement of health status, while firmly recalling that these do not in any way free Member States from their financial obligations. Some of the options are:

- sale of licences for health-promoting products, conferring a "seal of approval";
- health lotteries, sweepstakes and competitions whose proceeds are destined for promotion of health or specific health causes;
- provision of tax exemptions or other incentives to "healthy industries" or those industries which contribute resources, financial or in-kind, for health;
- setting up of a trust fund for health development, devoting interest received to specific health purposes;
- exploration of alternative assessment mechanisms;
- special interest rates on health savings accounts;
- health levies.

39. A small group was entrusted with a review of health lotteries. After carefully considering the pros and cons of lotteries as a potential financial resource, the Task Force concluded that the lottery option represents a good opportunity to establish a mechanism for people to participate actively with WHO in attacking local, regional, national and global health problems; and that WHO could move to establish a partnership with national lotteries.

40. The Task Force urged WHO to consider the lottery option as a potential element for resource mobilization to enable it to enter the twenty-first century with an economic basis as strong and creative as its health mission is challenging and uplifting.

CONCLUDING REMARKS

41. For the above approaches to health development for the twenty-first century to be adopted, WHO would need not only the courage and vision to forge ahead in new areas, but also a completely new approach to the way it functions and the way it secures resources for additional support to its mission.

42. WHO would work to prevent disease, reduce preventable mortality, protect and promote health and well-being, assure health services - curative and rehabilitative, alleviate suffering and reduce health inequities, using strategies to ensure sustainability. It would strive towards the well-being of individuals and families - an objective clearly stated in its Constitution. It would do this as part of a global network of health-promoting institutions and services, exerting leadership and providing support for others to lead as appropriate to achieve better global health for the current, and future, generations.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

43. The Health Assembly is invited to consider the resolution recommended by the Executive Board in resolution EB99.R8.

ANNEX 1

MEMBERS OF THE TASK FORCE ON HEALTH IN DEVELOPMENT

Dr Jo Ivey Boufford, Principal Deputy Assistant Secretary for Health, United States Public Health Service, Department of Health and Human Services, Washington, D.C., United States of America

Mr Göran Dahlgren, Assistant Director-General, National Institute of Public Health, Stockholm, Sweden

His Excellency Mr Assane Diop, Minister of Labour and Employment, Dakar, Senegal

Dr Julio Frenk, Executive Vice-President of the Mexican Health Foundation and Director of the Center for Health and Economy, Mexico City, Mexico

Dr Dharam Ghai, Director, United Nations Research Institute for Social Development, Geneva, Switzerland

Professor Godfrey Gunatilleke, Director, Marga Institute, Colombo, Sri Lanka

His Royal Highness El Hassan Bin Talal, Crown Prince of the Hashemite Kingdom of Jordan, The Royal Court, Amman, Jordan

Ms Julia Häusermann, President, Rights and Humanity, London, United Kingdom of Great Britain and Northern Ireland

The Honourable Mr R.C. Hove, Planning Commissioner, National Economic Planning Commission in the President's Office, Harare, Zimbabwe

His Excellency Dr Jorge Jiménez de la Jara, Ambassador, Embassy of Chile, Rome, Italy

The Right Honourable the Lord Judd, House of Lords, London, United Kingdom of Great Britain and Northern Ireland.

Professor Emilia Kováčová, Chancellery of the President of the Slovak Republic, Bratislava-Hrad, Slovakia

Dr Huguette Labelle (**Vice-Chairman**), President, Canadian International Development Agency, Quebec, Canada

Madame Anne-Marie Lizin, Sénateur Bourgmestre de Huy, Sénat de Belgique, Brussels, Belgium

His Excellency Mr Hugo Lodrini, Ambassador, Permanent Mission of the Commonwealth of Dominica to the United Nations, Geneva, Switzerland

His Excellency Dr Pascoal Mocumbi, Prime Minister of the Republic of Mozambique, Maputo, Mozambique

Her Excellency Mrs Suzanne Mubarak, Office of the President, Cairo, Egypt

Mrs Ana Milena Muñoz de Gaviria, Office of the President, Organization of American States, Washington, D.C., United States of America

Her Excellency Mrs Janet K. Museveni, Office of the President, State House, Entebbe, Uganda

The Honourable Julius K. Nyerere, Chairman, Advisory Committee, The South Centre, Geneva, Switzerland

Dr Adepeju A. Olukoya, Women's Health Organisation of Nigeria, Lagos, Nigeria

Mr Johannes P. Pronk, Minister for Development Cooperation, The Hague, Netherlands

Dr Rosalia Rodriguez-Garcia, Professor and Director, Center for International Health and Development, George Washington University, Washington, D.C., United States of America

Dr Emil Salim, Centre for Policy and Implementation Studies, Jakarta, Indonesia

Dr Conrad Shamlaye, Special Adviser, Ministry of Health, Mahé, Seychelles

The Honourable Branford M. Taitt (**Chairman**), Member of Parliament, St Michael, Barbados

Madame Simone Veil, former Minister of State, Ministry of Social, Health and Urban Affairs, Paris, France

Mr Helmut Voigtländer, Director, International Health Relations, Federal Ministry of Health, Bonn, Germany

ANNEX 2

LIST OF SELECTED PUBLICATIONS AND DOCUMENTS RELATED TO THE WORK OF THE TASK FORCE ON HEALTH IN DEVELOPMENT

Constitution of the World Health Organization. Date of adoption: 22 July 1946. Date of entry into force: 7 April 1948.

Cahill, K. M., ed. *Preventive diplomacy: stopping wars before they start.* New York, Basic Books, 1987.

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Cahill, K. M. *A bridge to peace.* New York, Haymarket Doyma, 1988.

Report of the International Forum on Health: A Conditionality for Economic Development - Breaking the Cycle of Poverty and Inequity, Accra, Ghana, 4-6 December 1991 (document WHO/DGO/92.1).

Health dimensions of economic reform. Geneva, World Health Organization, 1992.

Report of the Interagency/Interregional Meeting on the Global Commission on Women's Health, Geneva, 8-10 March 1993.

Women's health: towards a better world (Report of the First Meeting of the Global Commission on Women's Health, Geneva, 13-15 April 1994). Geneva, World Health Organization, 1994 (document WHO/DGH/94.4).

Cook, R. J. *Women's health and human rights: the promotion and protection of women's health through international human rights law.* Geneva, World Health Organization, 1994.

Health in development: prospects for the 21st century (Report of the First Meeting of the Task Force on Health in Development, Geneva, 27-30 June 1994). Geneva, World Health Organization, 1994 (document WHO/DGH/94.5).

Cranna, M., ed. *The true cost of conflict.* London, Earthscan Publications, 1994.

Ninth General Programme of Work covering the period 1996-2001. Geneva, World Health Organization, 1994.

Report of the Second Meeting of the Global Commission on Women's Health, Washington, D.C., 3-6 October 1994 (document WHO/DGH/95.3).

WHO position paper on "Health, population and development" for the International Conference on Population and Development (Cairo, September 1994). Geneva, World Health Organization, 1994 (document WHO/FHE/94.1).

Adolescent health and development: the key to the future (paper prepared for the Global Commission on Women's Health, 3-6 October 1994, Washington, D.C.). Geneva, World Health Organization, 1994 (document WHO/ADH/94.3/Rev.1).

Report of the Second Meeting of the Task Force on Health in Development (Amman, Jordan, 17-19 December 1994). Geneva, World Health Organization, 1995 (document WHO/DGH/95.4).

Declaration on the Centrality of Health in Social Development. Adopted by the Task Force on Health in Development at the meeting "Health, Development and Poverty" (Paris, 17 February 1995). Geneva, World Health Organization, 1995.

Report of the Third Meeting of the Task Force on Health in Development (Geneva, 1-2 December 1995). Geneva, World Health Organization, 1996 (document WHO/HPD/96.1).

Report of the Fourth Meeting of the Task Force on Health in Development (Geneva, 13-14 May 1996). Geneva, World Health Organization, 1996 (document WHO/HPD/96.6).

Report of the Consultation on Health as a Bridge for Peace (Geneva, 15 May 1996). Geneva, World Health Organization, 1996 (document WHO/HPD/96.7/Rev.1).

WHO position paper on "Health in social development" for the World Summit for Social Development (Copenhagen, March 1995). Geneva, World Health Organization, 1995 (document WHO/DGH/95.1).

Guidelines on the acceptability of donations from commercial enterprises. Revised draft, 25 October 1996 (internal WHO document).

"Partnerships for health in the 21st century". Working paper prepared by the Working Group on Partnerships in the Context of Health-for-All Renewal. Geneva, World Health Organization, 1996 (document HPR/96.3, draft No. 3).

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