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COMMITTEE B

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PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

Palais des Nations, Geneva
Friday, 5 May 1995, at 14:30

Chairman: Professor A. WOJTCZAK (Poland)

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THIRD MEETING

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WHO RESPONSE TO GLOBAL CHANGE: Item 22 of the Agenda (continued)

RENEWING THE HEALTH-FOR-ALL STRATEGY: Item 22.2 of the Agenda (Document EB95/1995/REC/1; Resolution EB95.R5; Document A48/24)

The CHAIRMAN, opening the discussion, referred delegates, *inter alia*, to the relevant pages of documents WHA47/1994/REC/3 and EB95/1995/REC/2, respectively the summary records of debates at the Forty-seventh World Health Assembly and at the ninety-fifth session of the Executive Board.

Dr OMRAN (Bahrain) said that since it had become clear that it would be impossible to attain the original health-for-all objectives in the majority of developing countries within the initially allotted time, the Organization was trying to update and renew the strategy by trying to set health in a social context. WHO was endeavouring to implement the strategy with the driving force of equality and solidarity, but it was by no means clear what equality in regard to health actually meant. There was great diversity between countries and regions, and equality did not necessarily mean equality of distribution. It was important to allocate more funds and resources to those areas which were in greatest need, and if the equality being sought was not seen as cost-effective it was probably not wise to allocate such resources to the achievement of objectives that were intangible. It was easier to achieve equality on paper than in reality, and easier at the national than at the regional level. There was clearly a need for the strategy to be given more thought.

Because of different levels of development it was not feasible to apply general indicators to all regions and countries. With regard to infant mortality rates some countries were already well ahead of the targets set for the year 2000, while others would find it impossible to achieve them. Greater flexibility was needed, and indicators should take account of the actual ability of countries and regions to reach the various goals.

Mr KASTBERG (Sweden) described the widening gaps in health as veritable time bombs of social instability and conflict both within and between countries and regions. Health inequalities could become a route to war, but the report regarded health as a bridge for peace, embracing other sectors and actors not normally involved in the health arena. Sweden was supportive of the need to mobilize non-health sectors.

Renewal of the health-for-all strategy was central to the development of a common vision of WHO's policy and mission among Member States, and if the leadership of WHO received confused or contradictory signals and messages from Members, then the policy and mission would be unclear and unfocused as well. The Secretariat could do much to promote a consultative process that would enable countries to reach common ground marked out by a shared analysis of data. What was proposed was a process involving the broadest possible range of actors in a dialogue that would lead to a country consensus statement on health challenges and major policy orientations. The feedback from that process would in turn help to shape a common vision of WHO's role.

Sweden welcomed such a process, and to ensure its participation and ownership in the new strategy and its implementation, had established a national task force involving various agencies and ministries to follow and mobilize support for the global change process. However, bringing together different sectors and actors took time, though that time did enable bridges to be built. For that reason, Sweden wished to propose two amendments to the resolution recommended in resolution EB95.R5. The first was to replace the words "organize a high-level world conference, by the end of 1997, to adopt" in operative paragraph 4(8) with the words "secure ministerial-level endorsement in 1997 of"; the second was to replace the words "arrangements for such a world conference" in operative paragraph 4(9) with the words "plans for this endorsement". Those

proposed amendments had the support not only of Sweden but also of Argentina, Australia, Austria, Belgium, Bulgaria, Canada, Denmark, Egypt, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, New Zealand, Norway, Slovakia, South Africa, Spain, Switzerland, the United Arab Emirates, the United Kingdom, the United States of America and Zimbabwe.

If WHO were now to embark upon a world conference, a great deal of energy and a large amount of funds and human resources would be expended on its practical preparation and negotiation. It would be much better to focus on the primary goal of renewing the health-for-all strategy. A special event could be organized in conjunction with the World Health Assembly in 1997 at no extra cost and if that process succeeded, the time might then be ripe for considering a world conference which set goals for 2000 and beyond.

Mr CRONIN (Canada) submitted that the necessary revision of the health-for-all strategy should begin with an evaluation of the current strategy so that its weaknesses could be dealt with and its strengths built upon. Singling out for favourable comment the references in the Director-General's report (Annex 5 of document EB95/1995/REC/1) to safe water and adequate sanitation and to mental illness in aging populations as particularly important issues that would persist beyond the year 2000, he suggested that more consideration might be given to quality-of-life indicators, including that of "life expectancy in good health". Canada favoured the process outlined by the delegate of Sweden, believing that it would enable the timetable put forward by the Director-General to be advanced. The regional committees might be invited to discuss a draft resolution so that the Board could adopt a final draft in January 1996 for consideration by the Forty-ninth World Health Assembly. Canada also supported the draft resolution recommended in resolution EB95.R5, and associated itself with the amendments proposed by Sweden.

Professor ORDOÑEZ (Cuba) stressed that preparation of a new global health policy based on the health-for-all strategy should aim at the consolidation and development of primary health care, with more active participation of an intersectoral nature. Recalling the reference in paragraph 178 of the third report on monitoring health progress (document A48/4) to "three possible ways forward", he observed that most countries were struggling with the constraint of limited economic resources; optimum use must be made of all available human, material and financial resources in the development of primary health care, the focus being on whatever *could* be, rather than what *should* be done.

In all countries, irrespective of their degree of economic development or political colouring, the state had a vitally important role to play in the preparation of health policies, notably in the area of pharmaceuticals, where the industry, worldwide, was extremely powerful. In the matter of controlling the production, distribution and use of medicaments, political will was not sufficient. Action was called for to ensure that commercial considerations did not assume more importance than therapeutic concerns.

Since Alma-Ata, the basic theoretical approach and focus of the health-for-all strategy had been towards primary health care, but most countries in fact spent most of their health budgets on secondary and tertiary care. Spending often went beyond their means, which meant that most people did not have access to basic health care because it was too costly.

Cuba was a poor, small country suffering the effects of an immoral economic blockade, yet it was in a position to achieve health for all by the year 2000, notwithstanding restrictions and difficulties of all kinds. Cuba had met all the strategy's indicators, with the consolidation and the development of primary health care as its main priority. In 1983 there had been no family doctors in Cuba; there were now more than 25 000, serving 93% of the country's 11 million inhabitants. In 1983 the mortality rate for children under the age of one year had been 18 per 1000 live births; the figures for 1993 and 1994 were 9.4 and 9.9 respectively. In all modesty, he wished to submit that his country provided a good example of how the consolidation and development of primary health care permitted advances in the health-for-all strategy to be made, even in a context of political, social and economic crisis.

Dr JAKUBOWIAK (Poland), after commending the Director-General's report, endorsed the proposal to develop a new 25-year global health policy, subject to periodic evaluation and modification if the need should arise. He stressed the importance as policy priorities of primary health care, health promotion and

prevention activities as opposed to costly and specialized in-patient care, as well as the assessment of environmental influences on health. The countries of Central and Eastern Europe, whose economies in transition suffered from resource constraints, were well aware that meeting those priorities would require the definition of detailed targets and objectives, to be followed up by regular monitoring.

The Polish Ministry of Health intended to establish a new intersectoral health policy, to be accompanied by state guarantees, so as to ensure universal access to basic health care services. His country was open to suggestions in that connection and was in turn ready to share its experience with other Member States.

His delegation supported the draft resolution recommended by the Executive Board in resolution EB95.R5.

Dr ONO (Japan) said in connection with the updating of the health-for-all strategy described in document A48/24 that, it was important for the preparation of the proposed high-level conference to start as early as possible, in view of the rapid pace of changes in the world. He felt that since the current health-for-all strategy had been very successful, WHO's initiative to convene such a conference was not only appropriate but essential. The Japanese Government fully supported that proposal and endorsed the recommended resolution.

Dr TAPA (Tonga) noted with satisfaction the emphasis laid on the continued validity of the health-for-all goal beyond the year 2000 and accordingly welcomed the proposal for the elaboration of a new global health policy for equity, solidarity and health, with a 25-year horizon. He accepted the framework for consultation on the proposed new policy and the specifications for the consultation mechanism, to ensure that that policy reflected the consensus of Member States, together with international and nongovernmental organizations. His delegation appreciated the proposal for a high-level conference in 1997 in order to adopt a health charter and also endorsed the resolution recommended in resolution EB95.R5.

Dr KHOJA (Saudi Arabia) said that WHO had a preponderant role to play in ensuring an improved health status throughout the world. However, in view of the difficulty of achieving such a goal, a number of health workers had experienced considerable frustration, particularly given the disparity between the strategy and its implementation.

Saudi Arabia supported the recommended resolution, together with the amendments proposed by the Swedish delegation. It further believed that a new slogan was required to replace "Health for all by the year 2000", taking greater account of existing realities and ongoing developments in the health field.

Greater financial resources as well as more intensive training of health personnel were essential to cater to the needs of vulnerable and high-risk groups in addition to those of workers. Those constituted achievable goals for WHO, which were in line with the health-for-all concept.

Ms LOBBEZOO (Netherlands) remarked that the Declaration of Alma-Ata, on which the health-for-all strategy was based had been a source of inspiration for the past 20 years; therefore it was a challenge to reformulate such a strategy. But renewal was essential, and should not be considered as an internal WHO process. In order to avoid excessive vagueness, the roles and tasks of all the participants in the strategy at global, regional and national level had to be clearly defined.

However, she felt that the necessary strengthening of the management component was not evident in the proposals and might be conducive to creating problems when the policy was implemented. The third monitoring report on the implementation of the health-for-all programme would serve as a useful guide in determining a new strategy as well as helping to constitute a link between the update and the contents of Agenda 21. The latter stressed the need for a multisectoral approach to development, which was not given a high profile in the current health-for-all programme, so that cooperation with other international organizations was not as satisfactory as it might be.

Her delegation would welcome clarification as to how the launching of the new health-for-all strategy was to be financed, in view of the fact that she was unable to identify any provision for it in the budget proposals. It supported the recommended resolution as amended by the delegate of Sweden.

Mr CHAE THAE SOP (Democratic People's Republic of Korea) said that in the 20 years since the adoption of the health-for-all strategy at Alma-Ata, much had been achieved; but unfortunately there was a great deal of ground to be covered before the targets were reached. Extreme differences still existed, not only between countries, but even within certain developed countries.

His delegation approved the recommended resolution and was in favour of a world conference to be convened in 1997. In renewing the health-for-all strategy, stress should be laid on embodying the principles of equality, solidarity and social justice, as well as on intersectoral and international cooperation.

Dr ADAMS (Australia) said that although his country favoured a new global health policy, involving close consultation with Member States, and although it did not underestimate the value of such consultation, it would be uneasy if that process were to extend too far in time, complexity or cost, or if it were to distract from the work of priority setting and resource allocation. His delegation strongly supported Sweden's proposed amendment to the draft resolution recommended in resolution EB95.R5.

However, it was apparent from the Director-General's report that in some areas, the goals were regrettably moving further away. In view of the fact that some of the far-reaching implications of WHO's response to global change might go beyond its present legal framework, Australia had initiated a draft resolution, cosponsored by 24 other countries, proposing that the World Health Assembly should call upon the Executive Board to assess whether the Constitution still remained appropriate and relevant. If the Executive Board were to conclude that a review of the Constitution was necessary, it should consider how that should best be accomplished. The Australian draft resolution also proposed that the Assembly request the Director-General to report on progress to the World Health Assembly in 1996.

Dr QUAUNINE (Bangladesh) pointed out that despite considerable progress in health-related technology and research, the health situation in a large number of developing countries had failed to improve. Hence the renewal of the health-for-all strategy was crucial.

His delegation was pleased to ascertain that the appropriate recommendations had been taken up by the WHO development team, and hoped that the new global health policy would be geared to pragmatic objectives. Such targets should be achieved through appropriate resource mobilization by WHO headquarters, regional and country offices.

In view of its special relevance for countries such as Bangladesh, he was circulating some minor amendments to the resolution recommended in resolution EB95.R5, with the aim of reflecting the special situation in the least developed countries.

Dr STAMPS (Zimbabwe) noted that there was a tendency for vertical programmes to creep into an overall primary health care policy because of the excessive dependence on extrabudgetary resources and the ease of donor control of allocations and follow-up of effectiveness indicators in such activities; there was thus a risk of easy options taking priority over urgent needs, a syndrome highlighted in the Director-General's report, which ascribed it to poverty.

The health-for-all concept emphasized the holistic nature of health needs, and he therefore proposed the insertion of the word "holistic" before "global health policy" in operative paragraph 4(1) of the resolution recommended by the Executive Board for adoption by the Health Assembly. He also endorsed the amendment to operative paragraph 4(8) proposed by Sweden, subject to the insertion of the words "by July 1995" so as to incorporate a specific time-frame.

Dr LIU Hanlin (China) commended document A48/24 since it showed how changes in the world could be confronted, taking into account the diversity of the situations existing in countries. The health-for-all policy had played a major role in mobilizing action for a decade; the slogan had played a decisive part, and the new policy should be formulated on similar lines.

The basic structure of the Director-General's report was satisfactory, and the new policy should emphasize continuity of health development and fully reflect the principles of equity and solidarity on the basis of an assessment of existing health policy at country level. Furthermore, a global dialogue should be

instituted on new partnerships in health policy. WHO should provide consultants to countries needing them to assist in providing information and training in regions and at global level.

Mr FILHO (Brazil) endorsed the amendment proposed by Sweden to the recommended resolution, and agreed that obstacles to health for all stemmed from failure to implement the agreed policies. The document made it clear that partnerships must be sought in implementing policies; WHO already had appropriate structures for that purpose and had conducted consultations in the past, e.g., in connection with the International Conference on Nutrition. Advantage should be taken of such structures, and WHO should consider strengthening them.

The document stressed the importance of involving other organizations, but it was necessary to go further and approach them directly. As far as revising the strategy was concerned, that should be a constant concern. What was important was to ensure that the Organization could respond to change. At various meetings, questions had been raised by WHO's national partners about the methods of implementing policies. In particular, the decision to convene a world conference should not be taken by WHO without consulting its national partners, if only because of the enormous burden that it would impose on the public services in general and the various ministries involved in countries that were already in greatest need.

The amendment to the recommended resolution proposed by Sweden was a good one but the most important issue was to implement decisions already taken.

Dr JEAN-FRANCOIS (France) said that the document on renewing the health-for-all strategy contained much that was of vital importance, in particular the need to involve all partners at all decision-making and implementation levels. The key to success lay in ensuring that, once the new charger was adopted, all concerned felt that they had a share in it. Her delegation was therefore fully committed to the consultation process proposed in the document and wished to participate in it. It also endorsed the resolution recommended in resolution EB95.R5, with the amendment proposed by Sweden, which seemed to satisfy the concerns regarding the time and cost factors expressed by a number of delegations. Indeed, the operation should be carried out with the least possible additional strain on WHO's limited resources.

Dr MZIGE (United Republic of Tanzania) said that his country was now embarking on cost sharing in health, not cost recovery. It had realized that the target of free health for all resulted in health for none and that the private sector also had a role to play. The salaries of health personnel were meagre and doctors in the government sector were being allowed to hold clinics after office hours so as to reduce economic hardship. Moreover, traditional healers, who numbered some 40 000 as compared with less than 5000 medical doctors, had formed a society, and the Ministry of Health was finalizing a policy on traditional medicine.

A major problem at present was the arrival of over 600 000 refugees from Rwanda and Burundi, and his country was therefore requesting the help of international organizations to repatriate them as a long-term measure. Political stability was of great importance in the development of any sustainable health programme.

His country's health policy was geared towards improving the health of women and children, and free health care was still being provided to the vulnerable under-five group and pregnant women, who constituted 40% of the population. Despite a meagre budget, resource mobilization and reallocation was an important factor in sustainable health.

Professor CALDEIRA DA SILVA (Portugal), after commending the work done on WHO's response to global change, and especially the new health-for-all policy, said that, although the strategy of health for all by the year 2000 was vitally important and had borne fruit, it was no longer attractive. Something completely different must now be offered to communities, authorities and politicians. There was at present a great deal of talk about rights, but what was important was to translate rights into realities. As far as health was concerned, there was also a need to talk about duties, not only of the State, but also of individuals, families, groups and communities.

His delegation therefore supported the new ideas on which the new policy and new global strategy proposed by the Executive Board were based. The idea of the State as universal provider had been relatively

successful for over 40 years but new policies were now necessary; he had great expectations of the proposed charter based on equity, responsibility, commitment and security, and which assigned great importance to health for development. Solidarity was a key factor, and his delegation supported the idea of inviting as partners not only politicians, the authorities and countries, but also and above all civil society. His delegation was concerned that the consultation mechanism envisaged would be very complex and demanding for the authorities and institutions involved. In addition, the new policy and global strategy should not only take into account the primary health care approach but also globally integrated health care.

Dr EL-KHAYATT (Jordan) thanked WHO for its endeavours to improve health throughout the world. Discussion of the new health-for-all strategy was vital and must be given due importance in health strategy plans. An attempt must also be made to improve health management and quality of care. That approach had been adopted in her country at both national and district level, and its consolidation would assist health services and promote the involvement of other sectors in health care.

Funding was a fundamental concern in health care sectors everywhere, and financial services in Jordan would be mobilized to provide fresh resources. In fact, health must be viewed as a crucial component of all development programmes, and her country's activities would bring it closer to the goal of health for all.

Dr JAFFER (Oman), after commending the report, fully agreed that the health for all strategy needed to be reviewed and revitalized at national, regional and international levels. Clear goals had to be identified, taking into account the social, economic and cultural characteristics of each region, but the process must begin at national level as it would be to the benefit of Member States. Similarly, targets should be analysed at regional level in order to facilitate the work.

Many recent international conferences had been on topics closely related to health, and it was therefore of paramount importance for the results of those conferences to be taken into consideration and WHO's strategy brought into line with them.

He endorsed the draft resolution before the Committee, as amended by Sweden.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) endorsed the draft resolution recommended in resolution EB95.R5, as amended by Sweden, and stressed both the importance of Member States being closely involved in the development of the new health strategy and its common ownership. He understood that a glossary was being produced which would assist in defining precisely such terms as equity and solidarity, since they were open to different interpretations. He asked whether any estimate of the costs of the proposed world conference had been made.

Dr SHRESTHA (Nepal), after welcoming document A48/24, which contained many new ideas including the proposal for a worldwide consultation, strongly supported the renewal of the health-for-all strategy, as well as the resolution recommended in resolution EB95.R5.

Mrs VOGEL (United States of America) said that her delegation firmly supported the effort to renew the health-for-all strategy, recognizing the profound global changes affecting health that had occurred since the Declaration of Alma-Ata, together with the proposal to prepare a new document that would delineate WHO's philosophy more clearly, emphasizing intersectoral and international approaches to complement country-level primary health care. Her delegation also welcomed the proposed broad consultative process to develop the new global policy, a process which would assist countries in solving their health problems. Although recognizing the importance of involving leaders at a high level in order to ensure political commitment, her delegation did not believe that it was necessary to convene a world summit on health, especially in view of the tight budgetary constraints that all countries were having to face. It therefore supported the resolution recommended in resolution EB95.R5, as amended by Sweden. She suggested that, as considerable support had been expressed for the Swedish amendment, it might be preferable to take a decision in the Committee rather than set up a drafting group.

Professor AGBOTON (Benin) welcomed document A48/24, which reflected the need for Member States, under WHO leadership, to raise the health status of the people to the highest possible level. Five years from the year 2000, however, poverty was increasing and health status throughout the world was deteriorating. It was essential, therefore, to make an effort to avoid a catastrophe of almost apocalyptic dimensions. What proportion of national resources were countries prepared to invest in world health under WHO's leadership? What proportion of the expenditure on armaments or on matters of prestige were they willing instead to devote to improving health throughout the world? His delegation fully supported the renewal of the health-for-all strategy, as well as the resolution recommended in resolution EB95.R5, as amended by Sweden.

Dr OHN KYAW (Myanmar) said that, since the Alma-Ata Declaration, his country had adopted the health-for-all strategy with the primary health care approach, and had developed a national health plan to attain the goals of WHO's strategy for health for all by the year 2000. Experience over the last 15 years had shown, however, that the strategy required revision in the light of the socioeconomic changes that had taken place in the country. It was important that implementation of the health-for-all strategy should be in line with country needs and policies. His delegation supported the resolution recommended in resolution EB95.R5.

Dr SHONGWE (Swaziland), after welcoming document A48/24, said that his delegation supported the health-for-all strategy, but considered that new, more realistic targets were required that took account of the socioeconomic situation of each region. The new strategy must be based on the principles of equity, social justice, sustainable development and solidarity. His delegation strongly supported the amendment proposed by Sweden to the resolution contained in resolution EB95.R5, and believed that securing endorsement at ministerial level at the 1997 World Health Assembly would be cost-effective.

Dr ABELA-HYZLER (Malta) agreed that the health-for-all strategy should be revised and welcomed the emphasis on the validity of the health-for-all goals established in 1977. He also agreed that the new global health policy should be based on pragmatism rather than theory. He strongly believed that, in formulating the revised health policy, care should be taken not to alienate any section of the health professions. Although the focus should continue to be on primary health care, more attention should be paid to integrating secondary and primary health care, since failure to do so had created difficulties in the past. He was sure that all those points, as well as the lessons of past experience, would be taken into account in formulating the revised strategy.

While appreciating the views expressed by the delegates of Sweden, Netherlands and Brazil on the proposed world conference, he said that it was important to realize that one of the problems in the past had been that the health-for-all strategy had been regarded as simply a sectoral strategy to be implemented by the Ministry of Health; it was essential that the revised strategy should be intersectoral. While appreciating the Swedish proposal, he stressed that an intersectoral conference should follow the ministerial conference, if the health-for-all strategy were to be successfully implemented.

While supporting the resolution recommended in resolution EB95.R5, he suggested that operative paragraph 2(1), which was somewhat prescriptive or even alarming in tone, should be reworded by replacing the reference to alerting the general public by a phrase such as "raising the awareness of the general public to the need to place health high on the political agenda."

Dr DOFARA (Central African Republic) said that his delegation supported the recommended resolution, as amended by Sweden. Community participation in health costs had been widely accepted by the population as a means of improving the quality of health care. However, the current economic crisis was leading to increasing exclusion and marginalization, as purchasing power decreased, making the slogan health for all by the year 2000 an unattainable dream. His delegation therefore supported the renewal of the strategy but requested WHO, in doing so, to take into account the socioeconomic problems of the different countries and regions.

Mr DEBRUS (Germany) supported the proposed amendments put forward by Sweden to the resolution contained in resolution EB95.R5. Concerning the level of the proposed conference, he urged a realistic approach; despite the importance of the health sector, that of economics, finance or other sectors must also be taken into account.

The renewal of the strategy and its implementation at ministerial level was a major undertaking calling for thorough and comprehensive discussions with all Member States. To ensure the full participation of Member States, WHO must prepare documents for endorsement at ministerial level; circulate final documents to Member States for comments at least six months before endorsement, to allow time for internal discussion; and fully involve Member States in the entire preparation process. Unless WHO incorporated Member States' proposals into the strategy in the course of its preparation, they would not identify with the Organization. The comprehensive consultations, preparation, endorsement and follow-up of the strategy would provide WHO with an opportunity to enhance its position and international leadership.

Dr PRETORIUS (South Africa), after commending document A48/24, said that South Africa was pleased to be part of the process of renewing the health-for-all strategy, as it had not been present at the Alma-Ata Conference. After April 1994, his country had embarked upon a review of its own health care system, using the primary health care approach and the health-for-all strategy and principles. All the communities and population groups in the country had been involved in the consultation and policy development process, based on an intersectoral approach. His country supported the recommended resolution, as amended by Sweden and Zimbabwe. He supported the view expressed by many speakers that the new global health policy should include clear guidelines for implementation.

Mr AL-THANI (Qatar) said that his delegation endorsed the new health-for-all strategy outlined in document A48/24, together with the proposed world conference for which high-level preparation would be necessary.

Dr LEPPO (Finland) said that Finland had always believed in the principles and goal of health for all. The renewal of the health-for-all strategy was an important step in the revitalization of health policy thinking and action throughout the world.

Some of the concepts central to the new strategy deserved emphasis, in particular the consultative process; broad consultation would ensure the level of commitment necessary for implementation. Consultation would achieve the consensus which was essential in the challenging task of developing a global policy; such consensus might be reached first and foremost on the proposed amendments to the draft resolution contained in resolution EB95.R5 by establishing a drafting group. It was essential to achieve consensus on that resolution, and thus to give a good start to what was the most important policy process ever undertaken by the Organization.

Dr PICO (Argentina) said that it was appropriate to renew the health-for-all strategy so that it could be adapted to the ever-changing political, economic, social and health situation. Such renewal should be achieved through an integrated and strategic system-based approach that would respect the cultural values of the populations concerned and the position in the different regions of the Organization. In that connection, regional offices had a major role to play in critically examining the problems and in evaluating both achievements and failures, with the greatest possible participation of Member States. He supported the basic idea of improving health activities with a view to achieving equity, solidarity, effectiveness, efficiency, and essentially what was socially feasible; in the past, many problems had been caused because that had not been taken into account and because the views of the people for whom the health care was intended had been ignored. His delegation therefore endorsed the recommended resolution, as amended by Sweden, believed that the health-for-all strategy should be renewed, and that the proposed world conference should take place so that an effort could be made to reconcile the different positions on the matter.

Mrs HERZOG (Israel), responding to a remark made by the delegate of Germany, wondered whether there was indeed anything more important than health. She repeated what had been said in previous Health

Assemblies, namely that health was not everything, but without health, everything was nothing. She commended the Director-General on his report on renewing the health-for-all strategy and supported the resolution contained in resolution EB95.R5, with the linguistic amendments proposed by the delegate of Malta.

Mr KASTBERG (Sweden), responding to remarks made by the delegate of Malta, said that he fully agreed that an intersectoral approach was needed. In fact, he had stated that progress in health today required mobilizing sectors outside the field of health. However, bringing together different sectors took time. He had also said that, if the process succeeded, then, in conjunction with the Health Assembly in 1997, a high-level international conference might be convened to set the goals for the year 2000 and beyond. He hoped that the views of all delegations on the recommended resolution might be accommodated in order to avoid the establishment of a drafting group.

Professor FIKRI BENBRAHIM (Morocco), after commending the work done by the Director-General and the Executive Board in renewing the health-for-all strategy, said that his delegation fully supported the proposed method of consultation on the new policy and consequently the resolution contained in resolution EB95.R5. He suggested, however, that operative paragraph 2(2) should include the final date by which countries should communicate the results of their consultations to WHO. A suitable date might be suggested by the Secretariat.

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General) said that all the speakers had stressed the importance of consulting Member States and particularly of the consultation process within Member States between health ministries and their partners in economic and social development. The representatives of Sweden, Tonga, Canada and Zimbabwe had recalled that, before the Alma-Ata conference, consultations on future action over 20 or 25 years had already taken place. As she had already mentioned, she would be preparing a document suggesting various methods of consultation. Intersectoral consultation, as several delegations had pointed out, would take some time to be completed. Canada had suggested that the consultation period should be shortened, but to allow countries only a matter of months to determine policy for the following 20 years might be rather too short a time. She therefore appealed for the consultation period to remain at between eight and ten months at country level.

Bahrain and Cuba had spoken of the problem of equality in health. Neither WHO nor its Member States could ensure equality in outcomes as health also depended on economic, social and cultural conditions which WHO could not influence. However, what the Organization and Member States could endeavour to provide was equality of access to health and access to equal distribution of health goods. That was why a strategy for closing the gap between rich and poor was to be proposed to alleviate the plight of those most affected by poverty and marginalization. Such remedial policies would continue to be based on primary health care. Yet two major events had taken place in the previous 20 years. New forms of treatment had emerged, even among the poorest populations, and that would mean that the concept of primary health care and the framework for the strategy would have to be widened. Secondly, one of the stumbling blocks in implementing the strategy of health for all by the year 2000 had been the failure to take into account the financial aspects. In the future, at national and international level, economic strategy would have to be linked more closely to health problems.

One of the results of drafting the new policy would be the redefinition of WHO's mission, as described in section IV of document A48/24, as the Director-General had decided that the mission should be redefined in the context of the new health-for-all policy. A re-evaluation of WHO's mission in the Constitution would be something for the Executive Board to consider at a later date.

There was a need for periodic evaluation of strategies and as simple a system as possible would be set up, with indicators linked to the programme budget indicators so that the Organization's activities could be evaluated in relation to national and international strategies.

Both Portugal and the United Kingdom had indicated that the title of the strategy was neither elegant nor practical; however, the title was only provisional and a new one would be found.

The budget for both the consultation period and the development of the policy was not large. It would come mostly from extrabudgetary funds. The details could be passed to interested delegations.

There were very few funds in the regular budget to finance the conference itself and it had been envisaged that it could be financed almost wholly from extrabudgetary sources. However, the conference was important because it would give visibility to the new policy. A formal setting for a conference such as the Alma-Ata Conference to which many delegations had referred, would provide a showcase for the strategy. In order to save funds, it might be possible to hold such a conference in the place of an Executive Board meeting or World Health Assembly, perhaps in 1998. Further thought would have to go into the type of event to be held, but it would have to be a suitably solemn occasion, marking the launching of the new strategy.

The DIRECTOR-GENERAL said that all new strategies had to be well communicated through Heads of State and through provincial leaders, in order to sensitize public opinion. At the World Social Summit, Mme Simone Weil, Minister of Social Affairs, representing the European Union had said that health policy had become one of the priorities in public policy in the European Union. The renewed health strategy of WHO would require an extremely high level of endorsement. If Member States wanted the new strategy to succeed, they would have to promote it through a conference. The Constitution of the Organization required that a Health Assembly take place each year, but that Assembly could be replaced in 1998 by a high-level ministerial meeting of two or three days, followed by a Conference of Heads of State, thus achieving the joint goals of promoting the policy while avoiding an additional financial burden. Such a conference would give new visibility to the governing body and would be a fitting celebration of WHO's fiftieth anniversary.

The CHAIRMAN, after noting that discussion of item 22.2 had been completed, suggested that a drafting group composed of the delegations of Canada, Bangladesh, China, Sweden, Malta and Benin and any other interested delegations should meet to discuss the proposed amendment to the draft resolution contained in resolution EB95.R5.

It was so agreed.

The meeting rose at 17:00.

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