Naciones Unidas A/AC.253/16/Add.5

Asamblea General

Distr. general
10 de febrero de 2000
Español
Original: inglés

Comité Preparatorio del período extraordinario de sesiones de la Asamblea General sobre la aplicación de los resultados de la Cumbre Mundial sobre Desarrollo Social y el estudio de iniciativas ulteriores
Segundo período de sesiones
3 a 14 de abril de 2000
Tema 2 del programa provisional*
Preparativos del período extraordinario de sesiones de la Asamblea General sobre la aplicación de los resultados de la Cumbre Mundial sobre Desarrollo Social y el estudio de iniciativas ulteriores

Informes analíticos y propuestas presentados por órganos y organismos especializados del sistema de las Naciones Unidas y otras organizaciones competentes con miras a la adopción de medidas e iniciativas ulteriores

Nota del Secretario General

Adición

Contribución de la Organización Mundial de la Salud**

1. En el párrafo 18 del anexo a su decisión 1[1] el Comité Preparatorio del período extraordinario de sesiones de la Asamblea General sobre la aplicación de los resultados de la Cumbre Mundial sobre Desarrollo Social y el estudio de iniciativas ulteriores invitó a la Organización Mundial de la Salud a que, en consulta con el Fondo de las Naciones Unidas para la Infancia (UNICEF), el Programa conjunto y de copatrocinio de las Naciones Unidas sobre el virus de inmunodeficiencia humana y el síndrome de inmunodeficiencia adquirida (ONUSIDA) y otras organizaciones competentes del sistema de las Naciones Unidas, presentara un informe sobre los avances logrados y los obstáculos que hubieran surgido en la consecución de la meta del acceso universal a los servicios relacionados con la atención primaria de la

* A/AC.253/12.

** El informe, que se adjunta al presente documento, se publica únicamente en el idioma en que fue presentado

[1] *Documentos Oficiales de la Asamblea General, quincuagésimo cuarto período de sesiones, Suplemento No. 45* (A/54/45 y corrección), cap. VI, sec. B.

00-28947 (S) 160200 160200

salud, como por ejemplo el agua potable, el saneamiento adecuado, los programas en materia de nutrición, la prevención del paludismo y de otras enfermedades, la atención de la salud reproductiva, en especial para la mujer y la niña, en el contexto de las iniciativas existentes, y a que hiciera recomendaciones sobre medidas ulteriores. El Comité Preparatorio pidió que dicho informe se presentara también a la Comisión de Desarrollo Social en su 38° período de sesiones.

2. Por consiguiente, el Secretario General remite al Comité Preparatorio y a la Comisión, con fines de información, el informe de la Organización Mundial de la Salud, preparado tras la celebración de consultas con el ONUSIDA, el UNICEF y la Organización Internacional del Trabajo.

CONTENTS

	Page
1. INTRODUCTION	
The Report	4
	5
SECTION A:	
	5
2. THE HEALTH REVOLUTION THAT LEFT OUT A BILLION PEOPLE	
Health Problems of the Poor	5
HIV/AIDS	6
Malaria	6
Tuberculosis	7
Malnutrition	8
Maternal Mortality	9
Water-borne Diseases	9
Respiratory Infections	10
Immunization	11
	11
3. HEALTH SERVICES IN CRISIS	
Growing Health Inequities	12
Financing, Distribution and Delivery of Health Care	12
	12
SECTION B:	
	14
MAKING HEALTH A FORCE FOR POVERTY REDUCTION – WHO'S PROPOSALS FOR ACTION IN FOLLOW-UP TO COPENHAGEN PLUS FIVE	14
Follow-up Action	14
Global Policy for Social Development	15
Integrating Health Dimensions into Social and Economic Policy	15
Health in Macroeconomic Policy	16
Trade in Health Goods and Services	16
Health and Promotion of Full Employment	17
Develop health systems, which effectively target resources on the most critical health problems affecting the poor and are financed and organized to address the determinants of health among the poor and vulnerable populations	17
Substantial reduction in the major diseases affecting the poor disproportionately, which themselves are often major causes of poverty	18
More Equitable Health Financing Systems	19
Promote Responsible Health Stewardship	19

1. INTRODUCTION

Five years after the World Summit for Social Development (WSSD) it is clear that progress in fulfilling the commitments made in 1995 has not been what was hoped for. Nevertheless, there has been tangible progress in international consensus on the essential elements of human development. There has been a shift from economic liberalisation to global social concern. There is growing consensus that effective human development policy must better integrate economic, environmental and social concerns. This includes recognition of the centrality of health: as a critical input to development; as an outcome of development which must be consciously pursued; and as a fundamental human right with a value in and of itself. Herein lies the opportunity which must be seized in Copenhagen Plus Five.

The wealth of poor people is their capabilities and "assets". Of these assets, health is the most important to the poor. A fit, strong body is an asset, while a sick, weak, disabled body is a liability, both to the person, as well as to those who must support them. Enjoyment of good health, or even mediocre health, is key to productivity. When breadwinners experience episodes of ill-health, long-term disability or death, the results can be disastrous - the entire household suffers due to loss of income combined with the cost of medical care. This is a common cause of impoverishment itself.

From this perspective protecting and promoting health are central to the entire process of poverty eradication and human development. As such they should be goals of development policy shared by all sectors - economic, environmental and social.

The Copenhagen Declaration and Programme of Action accorded responsibility for health to basic health services. This narrow perception of health grossly undervalues the contribution of improved health status of populations to development, and the potential of many sectors to foster the health of poor people in the interests of furthering human wellbeing. It is improved health status of populations and not merely the output of the health services industry, that is responsible for the positive contribution to human and social capital and hence sustainable livelihoods and human development.

Universal access to health services is important, but for health to fulfil its potential contribution to human development, the services need to have the capacity to improve health status *and* reduce health inequities which, in themselves, contribute to ill health.

The World Health Organization believes that the Special Session of the UN General Assembly in Geneva in June 2000 offers an extremely timely opportunity to build on the commitments of Copenhagen by obtaining endorsement for a more robust, multidimensional approach to human development and its social components, particularly health.

WHO will promote a more strategic approach to health within the global and national development agendas. That approach has four components:

- Promoting an effective health dimension to social, economic, environmental and development policy

- Developing health systems that equitably improve health outcomes; respond to peoples' legitimate demands and are financially fair
- Reducing risk factors to human health that arise from environmental, economic, social and behavioural cause
- Reducing excess mortality and disability, especially in poor, vulnerable and marginalized populations

Spurring us forward will be the realisation that progress since Copenhagen has not been what was hoped for and that new collective action is urgently required. Inspiring us in this action are new insights in development thinking that are opening windows of opportunity.

The Report

This report is necessarily brief and selective, responding to the request of the Preparatory Committee for information on progress in achieving universal access to primary health services. It also includes a summary global update on the main conditions and diseases which disproportionately affect the health of the poor. The final section sets out a number of proposals for action, within the Copenhagen framework, which WHO believes can make health a significant force for poverty reduction.

The information in this brief report will be supplemented by the World Health Report 2000 and an additional special report on Health in Poverty Reduction, both of which will be available by the time of Copenhagen Plus Five.

SECTION A:

2. THE HEALTH REVOLUTION THAT LEFT OUT A BILLION PEOPLE

The 20th century has seen a global transformation in human health unmatched in human history. However, overall improvements in health and human development over the past three decades can be illustrated by the following:

- Infant mortality rates have fallen from 104 per 1,000 live births in 1970-75 to 59 in 1996. On average, life expectancy has risen by four months each year since 1970.
- Per capita income growth in developing countries has averaged about 1.3 percent a year, bringing relief from poverty for millions of people.
- Governments report rapid progress in primary school enrolment. Adult literacy has risen, from 46 to 70 percent.[1]

We can soon expect a world without poliomyelitis, no new cases of leprosy, and no more deaths from guinea worm. But over one billion people will enter the 21st century without having benefited, their lives short and scarred by a ruthless disease. WHO's International Classification of Diseases classifies it under the code Z59.5. It stands for extreme poverty.

1 World Bank. Poverty Net. http://www.worldbank.org/poverty/data/trends/income.htm

Unacceptable and growing disparities in health between rich and poor countries, rich and poor people, between men and women, are the main characteristics of human kind at the start of this new millenium.

Health Problems of the Poor

It is hard to give a detailed, up to the minute, account of what has happened to the health of poor and vulnerable populations since 1995. We must frankly acknowledge the poor quality or, in some instances, absence of data is a significant obstacle to tracking the trends in health status, particularly of the poor.

However, it is now generally recognized that the many dimensions of poverty including lack of basic education, inadequate housing, social exclusion, lack of employment or opportunities, environmental degradation, and low income each pose a threat to health. On all health indicators studied by WHO, the poor within a given society fare worse than the better off. Compared to their fellow citizens, those living in absolute poverty are, on average:

- Five times more likely to die before reaching the age of 5;
- Two and a half times more likely to die between the ages of 15 and 59.

Deadly infectious diseases such as HIV/AIDS, Malaria, Tuberculosis, and diarrhoeal diseases, disproportionately affect poor people. They exert devastating effects on households and national economies. WHO therefore accords high priority to controlling them, a task made especially difficult by the evolution of drug resistant microbes.

HIV/AIDS[2]

The number of people living with HIV exceeds 33 million, increasing by 10% in the one year up to the end of 1998. 13.8 million (43%) of these were women, and 1.2 million were children. Virtually every country in the world continues to see new infections.

- More than 95% of all HIV-infected people now live in the developing world, which has likewise experienced 95% of all deaths to date from AIDS, largely among young adults who would normally be in their peak productive and reproductive years.
- Sub-Saharan Africa is home to 70% of the people who became infected with AIDS in 1998. It is also the region in which four-fifths of all AIDS deaths occurred in 1998. Since the start of the epidemic, 83% of all AIDS deaths so far have been in the region. Among children under 15, Africa's share of new 1998 infections was 9 out of 10. At least 95% of all AIDS orphans have been African and orphan families are becoming commonplace.
- The multiple repercussions of these deaths are reaching crisis level in some parts of the world. Whether measured against the yardstick of deteriorating child survival, crumbling life expectancy, overburdened health care systems, increasing orphanhood, or bottom-line losses to business, AIDS has never posed a bigger threat to development.

2 Source for data in this section: UNAIDS. "AIDS epidemic update: December 1998. UNAIDS/WHO, Geneva, 1998.

- The economic effect of HIV/AIDS on households is devastating: from household surveys in Africa and Asia we know that families living with HIV/AIDS have a substantial income reduction of 40-60%. This loss is compensated through spending of savings, borrowing, and reduction of consumption.[3]
- HIV/AIDS illustrates the effect of multidimensional poverty on health. Socioeconomic factors contributing to the spread of HIV/AIDS include: income poverty, illiteracy; gender inequality; increased mobility of populations within and between countries; and rapid industrialization involving the movement of workers from villages to cities, and consequent breakdown of traditional values.[4]
- HIV/AIDS also illustrates the equity gap. Successful public health measures have stabilized the epidemic in most developed countries, but this is true of only some developing countries. Many developing countries are experiencing exponential growth of HIV/AIDS cases and yet developing countries only receive about 12% of global spending on HIV/AIDS care, research and prevention, despite having 95% of cases.[5]

Malaria[6]

Malaria flourishes in situations of social and environmental crisis, weak health systems and disadvantaged communities. Its ability to develop resistance makes malaria a formidable adversary. Effective interventions are available but they are not reaching the people with the greatest burden of malaria because the capacity for malaria control is inadequate in endemic countries, where health systems are often weak.

- Almost 300 million clinical cases of malaria occur world-wide each year and over one million people die.
- Almost 90% of these deaths occur in sub-Saharan Africa, where young children are the most affected.
- Malaria is directly responsible for one in five childhood deaths in Africa and indirectly contributes to illness and deaths from respiratory infections, diarrhoeal disease and malnutrition.
- For reasons which are not fully understood, women are more susceptible to malaria during pregnancy. This is particularly so during the first pregnancy. Fetal growth, and the survival of the new-born, may be seriously compromised.[7]

The scale of the problem in many countries appears to be increasing. Furthermore, the number of malaria epidemics is growing both because of climatic and environmental changes; and as a result of human migration, often caused by military conflicts and civil unrest. There has been a recent resurgence in Africa, mostly due to the spread of chloroquine-resistant *P. falciparum* across the continent.

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3 UNAIDS. A review of household and community responses to the HIV/AIDS epidemic in the rural areas of Sub-Saharan Africa. UNAIDS, Geneva, 1999.

4 UNAIDS. "Handbook for Legislators on HIV/AIDS, Law and Human Rights." UNAIDS/IPU, Geneva, Switzerland, 1999.

5 idem

6 Source for data in this section: World Health Organization. "World Health Report 1999." WHO, Geneva, 1999.

7 Steketee et al, 1994. Malaria prevention in pregnancy. CDC Atlanta

The severity and urgency of the problem has led to the formation of global partnerships to control malaria. **Roll Back Malaria** a WHO initiative, is a global coalition involving UNDP,UNICEF, WHO and the World Bank. Roll back Malaria assists health systems to deliver cost effective interventions to control malaria in all countries where malaria is a health problem. The initiative also harnesses the support of the private and public sector in developing new malaria drugs and vaccines.

Tuberculosis[8]

Tuberculosis and poverty are closely linked. Both the probability of becoming infected, and the probability of developing clinical disease are associated with malnutrition, crowding, poor air circulation and sanitation; factors also associated with poverty. Given the often crowded conditions in which poor populations live, they are more likely to contract tuberculosis, and those who contract the disease are also more likely to fall into poverty given the economic consequences of the disease.

- In 1997, there were an estimated 7.96 million new cases of tuberculosis world-wide and 16.2 million existing cases.
- Among adults, tuberculosis is the largest single infectious cause of death in the world, accounting for about 2 million deaths per year.
- 95% of cases and deaths occur in developing countries.

In many regions of the world, tuberculosis is a growing problem. Due to a combination of economic decline, insufficient application of control measures, and the HIV/AIDS epidemic, tuberculosis is on the rise in developing and transition economies. People whose immune defences are weakened by HIV infection become an easy prey for other microbes, including the bacillus that causes tuberculosis. The resulting infections (along with some cancers) are responsible for the recurring illnesses which in their late stages are called "AIDS", and which ultimately lead to death.[9]

- Between 1993 and 1996 there was a 13% increase in estimated tuberculosis cases world-wide, one third of which can be attributed to HIV.[10]
- Around 30% of all AIDS deaths result directly from tuberculosis.[11]
- WHO estimates that by the end of the century, HIV infection will cause an additional 1.5 million cases of tuberculosis annually.[12]

Concerted efforts to end social apathy towards TB, expand a global coalition of partners involved in TB control and to advocate for TB to be placed high on the international agenda is currently being mounted through the **STOP TB Initiative** based at the WHO. The initiative involving a broad range of partners is creating a social and political

8 Source for data in this section: Dye et al. "Global burden of tuberculosis: Estimated incidence, prevalence and mortality by country in 1997." **JAMA**. 1999; 282:677-686.
9 UNAIDS/IPU. "Handbook for Legislators on HIV/AIDS, Law and Human Rights. UNAIDS/IPU, Geneva, 1999.
10 World Health Organization. "Tuberculosis." WHO Fact Sheet No. 104. WHO, Geneva, 1998
11 UNAIDS/IPU. "Handbook for Legislators on HIV/AIDS, Law and Human Rights. UNAIDS/IPU, Geneva, 1999.
12 Ahlburg, Dennis A. "The Economic Impacts of Tuberculosis." A report prepared for WHO, October 1999.

movement against TB by promoting the use of cost effective Directly Observed Treatment Short Course.

Malnutrition[13]

Malnutrition accounts for 15.9% of the global burden of disease.[14] Nearly 30% of humanity are currently suffering from one or more of the multiple forms of malnutrition. Some 49% of the 10 million deaths among under-five children each year in the developing world are associated with malnutrition. Currently, 26.7% of the world's children under 5 years of age are still malnourished when measured in terms of weight for age. Progress in reducing protein-energy malnutrition (PEM) among infants and young children is exceedingly slow.

- Iodine deficiency is the greatest single preventable cause of brain-damage and mental retardation world-wide affecting a total of 740 million people, or 13% of the world's population. Remarkable progress has been made in controlling iodine deficiency disorders (IDD) in the last decade. Overall, more than two-thirds of households living in IDD-affected countries now consume iodized salt, and 20 countries have reached the goal of universal salt iodization (USI) defined as more than 90% of households consuming iodized salt.

- Vitamin A deficiency (VAD) remains the single greatest preventable cause of needless childhood blindness. An estimated 250 000 to 500 000 VAD children become blind each year, and about half of them die within a year of becoming blind. There has been progress since 1990 in combating VAD. In 1997, it was estimated that in about 30 countries vitamin A supplement coverage among children or widespread access to fortified food was greater than 50%.

- Iron deficiency anaemia, the world's most widespread nutritional disorder. While anaemia affects nearly 2000 million people world-wide, or about a third of the world's population, iron deficiency is estimated to affect nearly 5000 million. Anaemia affects 39% of pre-school children and 52% of pregnant women, more than 90% of whom live in developing countries. Little progress has been made in effecting appreciable change over the last two decades in reducing the prevalence anaemia.

Maternal Mortality

Every year 585 000 poor women die from the complications of pregnancy and childbirth. In developing countries this is by far the leading cause of premature death and disability amongst women aged 15 to 44 years. It represents at least 18 per cent of their disease burden. Almost 90 per cent of these deaths occur in sub-Saharan Africa and Asia.

In October 1999 WHO, UNFPA, UNICEF and the World Bank jointly undertook to combine forces in order to fight maternal mortality more effectively.

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13 Source for data in this section: World Health Organization. "Nutrition for Health and Development. Progress and Prospects on the Eve of the 21st Century". WHO, 1999.

14 Murray C. and Lopez A. "The Global Burden of Disease." Harvard University Press, 1996.

Women in Northern Europe have a one in 4000 risk of dying from pregnancy–related causes. For women in Africa it is one in 16. There could hardly be a more striking disparity between North and South than this.

The death of a mother is a catastrophe in any family. In many developing countries it deprives households of income as well as love and affection. But in poor countries it can also spell death for her children.

The target of the International Conference on Population and Development (ICPD) was to reduce by half in the year 2000 the 1990 levels of maternal mortality - this target will not be met – and by a further one half by the year 2015 (in countries with the highest levels of maternal mortality, to below 60 per 100 000 live births).[15]

There is a strong relationship between maternal mortality levels and coverage of care The five-year review of the ICPD in 1999 agreed on new benchmarks to measure progress on reducing maternal mortality. It was agreed that at least 40% of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80% globally, by 2005; these figures should be 50% and 85% respectively, by 2010; and 60% and 90% by 2015. [16]

Water-borne Diseases[17]

Diarrhoeal diseases, largely preventable through access to adequate clean water and sanitation, claim nearly two million lives a year and account for 1.5 billion bouts of illness a year in the under-five age group. Diarrhoeal diseases impose a heavy burden on developing countries. WHO estimates that diarrhoeal diseases accounted for 73 million disability adjusted life years (DALYs)[18] lost in 1998.[19] More than 1 billion people do not have ready access to an adequate and safe water supply and a variety of physical, chemical and biological agents render many water sources unhealthy.

- Approximately 3 billion people lack access to any form of improved excreta disposal services.
- Today, more than 800 million of those unserved live in poor urban neighbourhoods and rural areas.

There are some indications that there has been an overall increase in the 1990's in both water supply and sanitation coverage percentages with estimates suggesting increases in total percentage water coverage in Asia, Africa and Latin America. In terms of absolute numbers, there has been an increase in unserved populations in Africa, Latin America and urban parts of Asia. If investments for sector development and coverage trends remain the same, the gap between served and unserved will continue to increase. Even within served populations, the poor often have access only unsustainable and ineffective technologies which present a high rate of disruption, or are provided with insufficient

15 UNFPA. "State of the World's Population 1999." UNFPA, New York, 1999.
16 idem
17 Source for data in this section: World Health Organization, EOS/WSH.
18 DALYs express years of life lost to premature death and years lived with a disability, adjusted for the severity of the disability.
19 World Health Organization. "Removing Obstacles to Healthy Development." WHO/CDS/99.1

quantities of poor quality water; increasing the health risks to which these populations are exposed.

Exposure to water-borne disease is often mediated by gender roles; women may be more exposed through household chores or child-care, and men through occupation or leisure activities. Pressure on women□s time and energy may affect family health if a closer source of impure water is used in preference to cleaner water at a greater distance.

Respiratory Infections

Acute respiratory infections (ARIs) were responsible for approximately 3.5 million deaths among people of all ages world-wide in 1998. Almost 2 million of these deaths were in children under age 5. Pneumonia kills more children than any other infectious disease, and 99% of these deaths occur in developing countries.

WHO estimates that acute respiratory infections accounted for 83 million DALYs lost in 1998.[20] An overwhelming proportion of this burden of disease is attributable to environmental factors. In addition to malnutrition, chilling and crowding, often aggravated by indoor air pollution, all of which are factors associated with poverty and poor housing, that are killing children the world over.

In addition, hundreds of millions of adult women in developing countries are exposed to extremely high levels of airborne particulates when cooking with biomass fuels. Studies in India and Nepal have shown that chronic obstructive lung disease and cor pulmonale are common, and develop at an early age, in women exposed to high levels of indoor smoke.[21]

Immunization

Globally, immunisation coverage has continued to increase slowly. Yet one in five children are still not fully immunised against the six major killer diseases: diphtheria, whooping cough, tetanus, polio, measles and tuberculosis.[22] The result is that more than 2 million children are still dying every year from diseases that can be prevented by currently available vaccines and several million more lives could be saved if there were effective vaccines against AIDS, TB and malaria.

Immunization in Africa lags behind Asia and Latin America. In some African countries immunization rates are actually falling, reflecting the disruptions arising from civil strife as well as crumbling, underfunded health systems. Immunization rates are also dropping in some industrialized countries. This is worrying trend, particularly in an increasingly global economy and the concurrent increasing movements of people in search of livelihoods, within and across national boundaries.

On 31 January 2000 the new Global Alliance for Vaccines and Immunization (GAVI) will be formally announced at the World Economic Forum in Davos. It represents a new commitment by WHO, UNICEF, the World Bank, industry, philanthropic foundations,

20 World Health Organization. "Removing Obstacles to Healthy Development." WHO/CDS/99.1
21 Health and Environment in Sustainable Development. WHO, 1997:159
22 World Health Organization. "Removing Obstacles to Healthy Development." WHO/CDS/99.1

and public sector agencies to work together in partnership to work towards the protection of all children against all children against major vaccine-preventable diseases.

3. HEALTH SERVICES IN CRISIS

The two decades since the Alma-Ata Declaration have not seen the realization of the wished-for rapid and sustained progress towards health for all. The global picture is very uneven and figures which give reliable, comparable and recent estimates of health care coverage and access to care are not readily available. However, the fragmented picture which does emerge is profoundly disturbing. In too many countries health systems are ill-equipped to cope with present demands, let alone those they will face in future. The call at Copenhagen for universal access to basic health services has been ignored.

Growing Health Inequities

The inequities are striking, both between countries and within them. In developed countries there may be one nurse for every 130 people and one pharmacist for every 2000 to 3000 people. A course of antibiotics to cure pneumonia can be bought for the equivalent of 2 to 3 hours' wages. One-year treatment for HIV infection costs the equivalent of 4 to 6 months' salary. And the majority of drug costs are reimbursed.

In developing countries there may be only one nurse for every 5000 people and one pharmacist for 1 million people. A full course of antibiotics for pneumonia may cost one month's wages. In many countries, one year of HIV treatment – if it were purchased – would consume the equivalent of 30 years' income. And the majority of households must buy medicines with money from their own pockets.

Financing, Distribution and Delivery of Health Care

A persisting reality in poor countries is that total *government expenditure on health services* is too low, even though allocations in some countries may reach over 20 per cent for social services as a whole, in terms of proportion of total government expenditure. A serious aggravating factor has been the low level of international aid during the past decade. The absolute levels of resource transfers required to help the poorest countries attain the international development goals will not be achieved on current trends.

The *distribution of services* in most countries of the world remains highly skewed in favour of the better-off. Recent studies have underlined that current patterns of resource allocation, both human and financial, are de facto anti-poor. The majority of health personnel is found in urban areas, while the great majority of the poor live in rural areas. Financial resources favour hospital-based curative care, when the poor need accessible and affordable primary health care. Allocations also favour personal medical care when the poor get the most benefit from actions, both within and outside the health sector, which target broad public health, such as clean water and sanitation.

The *delivery of health care* itself is often profoundly anti-poor. There is rarely, if ever, a focus on the risk factors that are the root causes of the ill health of the poor. And services are rarely designed with the poor in mind. For the poor, time is truly money and opportunity lost. This is reflected in how far they have to go to obtain a service, how

they get there, how long it takes them, how much it costs, being able to obtain only one service on a given day, and waiting in line. These are, in addition, financial barriers to services themselves - official and non-official fees, costs of medications. For women, who face particular constraints of time, mobility, and decision-making ability regarding their health and that of their children, these barriers represent a clear obstacle to health.[23]

A number of studies have brought to light the lack of dignity and respect with which the poor are met by health personnel. One study of a primary health care centre in a developing country serving a primarily poor population highlighted that an average 54 seconds was spent with each patient.[24] No time for dialogue, no time for explanation, barely the time for a human contact.

Consequently those without assets do not even attempt to seek treatment and those with some assets raise money for care by selling assets or borrowing from moneylenders at high rates of interest. Herein lies the route from sickness or injury to poverty and destitution, particularly when costs are incurred together with loss of income, when a breadwinner falls ill.

Unfettered market intervention in health care is anti-poor. A recent review of health services in one country concluded "Due to the prevailing situation in the government sector, there has been an unprecedented growth of the private sector, in both primary and secondary health care all over the country. Given the current ethical standards of the medical profession and totally free market technology-driven operational principles, the private sector generally does not provide quality health care at reasonable cost. Before this sector becomes a public menace, it is necessary to introduce participatory regulatory norms."[25]

A clear historical lesson emerges from health systems development in the 20th century: spontaneous, unmanaged growth in any country's health system cannot be relied upon to ensure that the greatest health needs are met. In any country, the greatest burden of ill-health and the biggest risk of avoidable morbidity or mortality are borne by the poor. Public intervention is necessary to achieve universal access. While the equity arguments for universal public finance are widely accepted, what is less well known is that this approach achieves greater efficiency as well.[26]

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23 Vlassof, C et al. "Towards the Healthy Women Counselling Guide." UNDP/World Bank/WHO, 1995.

24 UNICEF 1992 as quoted in Barkat, Abul, "Crisis in Governance of Public Health System in Bangladesh: A Challenge of Humane Governance." Paper prepared for presentation at the Special Symposium on Poverty and Health in South Asia – Crisis and Challenge – Bangalore, India, 16 November 1999.

25 Report of The Independent Commission on Health in India. Voluntary Health Association of India, 1999.

26 World Health Organization. "World Health Report 1999." WHO, Geneva, 1999.

SECTION B:

Making Health a Force for Poverty Reduction – WHO's proposals for Action in Follow-up to Copenhagen Plus Five

The ultimate objective of development is improvement in the human condition, of which enjoyment of good health is an essential part. However, while improving health status is an essential objective of the development process, the capacity to develop is itself dependent on good health.

Ensuring a maximum contribution to development requires that health interventions are planned and implemented within an integrated development framework. Today's reality remains that health components of poverty reduction programmes are largely absent or marginal. On the one hand health authorities limit their responsibility to the production of publicly funded health services. On the other the architects of poverty reduction policies neglect the human and social capital contributions of health to sustainable livelihoods.

Universal access to basic health services is important, and achieving that goal in a way which will make a significant input to poverty reduction will require a massive international effort in itself. However, the fact remains that leaving health to the health sector, alone, will not work. The major determinants of health, including poverty itself, are beyond the control of health services.

Copenhagen Plus Five can set future development policy on a new, more effective track by recognising the value good health status as one of the most important assets of the poor. On the that basis the meeting should recommend that the protection and improvement of health status of poor and vulnerable populations be adopted as a core international development strategy to be shared by all actors in the development process – social, economic and environmental.

Follow-up Action

As its particular contribution to this new strategy WHO proposes the following areas of action, to be pursued as integral components of the follow-up to Copenhagen Plus Five.

- **Global Policy for Social Development**
- **Integrating health dimensions into social and economic policy**
- **Developing health systems which can meet the needs of poor and vulnerable populations**

These initiatives will require action at global regional and country levels, in close collaboration with a range of partners, including the World Bank and IMF. In addition and in view of the need both to ensure holistic and integrated approaches to poverty reduction and take account of significant differences in health issues between regions, it is suggested that some activities should take place under the auspices of the UN Economic and Social Commissions. ECA and ESCAP would be particularly important

partners since their responsibilities span the regions with the greatest concentration of the extreme poor. In addition to their regional specificity they can serve as fora to bring together national social and economic ministries and sectors.

1. Global Policy for Social Development

The growing international concern for accelerated social development, initiated at Copenhagen, has given rise to still-early-steps towards defining the principles of future global policy for social development. Much work remains to be done to bridge the gap between current social concerns and global practice, particularly in global trade and international relations.

Reducing the striking health inequities between and within countries requires determined international action to turn globalization to full advantage of poor and marginalised populations. The concepts, content and strategies for a global social development policy require further development, moving beyond traditional concepts of provision of basic social services to define an explicit pathway to the creation of social wellbeing, social capabilities, livelihoods and human development.

WHO proposes to engage in the UN-wide process to help take forward the process of global policy development. WHO's particular contributions will include:

- **building country capacities to assess the impact and design responses to economic, technological, cultural and political aspects of globalization on health equity and the health status of poor and vulnerable populations**
- **building a global knowledge base on social development with regard to health inequities, health risks and good practices in protecting and improving health status of poor and vulnerable populations**
- **strengthening global governance for social development, including development and advocacy of health protection norms and standards for the guidance of the international and national business sectors**

2. Integrating Health Dimensions into Social and Economic Policy

Macroeconomic policy has a major impact on countries' abilities to protect and improve the health status of their citizens, particularly the poor and vulnerable. Recent econometric studies and the experiences of the East Asian countries have brought out the important role of good health status in economic as well as social development. Good health is also known to be crucial to effective learning and, for example, improving the effectiveness of microcredit programmes.

Maximising the positive opportunities of globalization whilst minimizing the negative impacts pose particular challenges e.g. identifying new sources of revenue for health services, regulating the trade of goods and services in the interests of health equity.

Human migration, rapid urbanization, increased road traffic, are both results of economic policy and, through their effects on the environment and on human health, are also massive drains on public expenditure. Road traffic accidents are predicted to become the second major global cause of injury and ill health by the year 2020.

New tools such as health impact assessment analysis need to be developed to help countries maximise the contributions of good health to economic, social, environmental and development policies as well as to minimise their negative health effects.

(a) Health in Macroeconomic Policy

There is now considerable international support for the inclusion of greater investment in social determinants of development within macroeconomic policy. The well documented experiences of the East Asian economies have contributed to this new awareness. The nature of investments will vary according to need. In sub-Saharan Africa and South Asia both health and education are important priorities.

With regard to health countries require considerable guidance on the specific mix of investments across a range of sectors in order to ensure optimum health impact on poverty reduction. WHO has established an international Commission on Macroeconomics and Health to provide advice and analyses for WHO and the international development community on how health relates to macroeconomic and development issues. These will include the economics of investment in protecting and improving health status; economics of incentives for new vaccine and product development; and international development assistance and health.

WHO proposes to provide the evidence for elaborating technical options and costs as the basis for more informed macroeconomic decision-making to impove the ealth of the poor by 2015 by governments, the World Bank, IMF, and Regional Development Banks.

(b) Trade in Health Goods and Services

Increasing trade in drugs, biological agents and health services, including private health insurance, have important implications for health equity. The international agreement on the trade-related aspects of intellectual property rights (TRIPS) could result in the development of new drugs and vaccines for treating the diseases of the poor. But it could also worsen access by poor people through price rises.

Trade in health services includes foreign direct investment, the movement of consumers and providers across borders to receive and supply health care and the emerging areas of e-commerce and telemedicine. In principle increased trade in health services could bring needed technology and management expertise and, for some countries, increased export earnings. But it could also deepen current inequities in access to services and promote the migration of skilled health professionals from already underserviced areas.

The new openness to trade in health goods and services presents a challenge to ensure that trade agreements improve access to good quality services particularly for poor and vulnerable populations.

WHO proposes to build upon its collaboration with WTO and other agencies to help strengthen the capacities of LDCs to analyse the consequences of agreements on trade in health services for health equity and the ability to meet the health needs of the poor, and to develop policies and collective negotiating strategies to ensure the promotion and protection of public health.

(c) Health and Promotion of Full Employment

Copenhagen Plus Five will focus particular attention on promoting full employment, including self employment and employment in the informal sector. Millions of people are unable to access livelihoods or compete for employment due to chronic ill health, undernutrition and disability.

For those who are employed, particularly in the informal sector, lack of occupational health and safety protection can lead to death, permanent disability and destitution. The ILO estimates that some 250 million workers suffer accidents at work and over 300 000 are killed every year. The annual death toll rises to more than 1 million when deaths due to occupational disease are taken into account.

WHO proposes to work with ILO and other agencies to promote health protection measures in future international and national policies for full and productive employment. These measures will include:

- **Improving and protecting the health status of poor and vulnerable people, including the disabled, as one means of improving their employability and access to livelihoods**
- **Promoting safe and healthy settings for work, particularly for women in informal employment**
- **Promoting social insurance and solidarity mechanisms, formal and informal, to protect households from the burden of health care costs arising from occupational causes, including in the informal sector**
- **Promoting the employability of women by creating community-based health and social services for sick and dependent family members.**

3. Develop health systems, which effectively target resources on the most critical health problems affecting the poor and are financed and organized to address the determinants of health among the poor and vulnerable populations

Many countries have fallen short of providing basic health services which are universally accessible. The majority of resources go to expensive curative care. Basic health services are not provided for free or low-cost to the poorest people. Public health programmes often ignore the health needs of household breadwinners. And national health systems generally fail to effectively manage private sector providers from whom the poor receive much of their care.

To halve the number of people in extreme poverty by 2015, health systems must be more effective in achieving greater equality of health outcomes and greater equity in health financing between rich and poor. Thus, renewed efforts must be made to build sustainable health systems for the poor that:

- aggressively prevent illness and protect health
- protect the poor and near-poor from impoverishing health costs,
- direct more resources to improving and maintaining the health of household breadwinners, and
- marshall the efforts of private providers towards improved health of the poor.

The World Health Report 2000, to be published in May, will address in greater depth what policy makers and program managers can do to create more equitable and effective health systems, based on evidence about alternative ways to deliver, finance, and "steward" or responsibly manage the health care system.

Based on what is known already about what works to improve the health of the poor, WHO urges the international community to join forces to develop sustainable, pro-poor health systems by focusing on the following three areas.

(a) Substantial *reduction in the major diseases affecting the poor disproportionately, which themselves are often major causes of poverty.*

A large proportion of the excess burden of disease among the poor can be attributed to a limited number of health problems – particularly communicable diseases such as HIV/AIDS, malaria, measles, and TB – as well as diarrhoeal diseases, respiratory infections, and complications from pregnancy and childbirth. For nearly all of these diseases or conditions, a set of cost-effective interventions exist.

Three things must happen for more of these health interventions to improve the health of the poor. First, prevention and treatment resources must be redirected to focus on cost-effective interventions for the diseases and conditions that disproportionately affect the poor. These include the Expanded Program on Immunization, the Integrated Management of Childhood Illness, the Adult Lung Health Initiative, Integrated Management of Pregnancy and Childbirth, and targeted interventions for HIV/AIDS and malaria – many of which have been jointly developed and implemented by WHO in collaboration with UNICEF.

Second, efforts must be made by health systems to better target the poor and vulnerable, by directing funds, staff and supplies to facilities that are located near where they work, live and learn. Better targeting can also occur by designing systems to protect the poor from out-of-pocket costs (see below) and by linking the delivery of these services with other poverty reduction programs, such as microcredit and employment training. The third essential ingredient to improve the health of the poor is to mobilize resources for the purchase cost-effective medicines and supplies, such as mosquito nets, anti-TB and anti-malaria drugs, treatments for sexually transmitted diseases, vaccines and oral rehydration therapy. These can be considered global public goods to the extent that they are directed to low-income countries contributing most to the spread of communicable disease.

(b) More *Equitable Health Financing Systems*

Achieving greater fairness in health financing is not just a laudable goal of the health system. It is also key to protecting the income of the poor and insulating them from economic shocks. One of the major factors leading to poverty is illness, which prevents people from working and earning income, and in some cases leads to high health spending that deplete household savings or assets.

To increase financial risk protection of the poor, WHO endorses several key principles of health system financing. Countries must seek to **increase the level of pre-payment** for health care via general taxation or mandated social health insurance contributions, in order to spread the costs according to ability to pay. This will help to reduce dependence on out-of-pocket financing, which restricts health care access to those who can afford it and tends to exclude the poor from health services. Efforts should be made **to subsidize the poor by expanding the pool of contributors widely**, so that the rich are not able to "opt-out", and by **setting progressive taxes or contributory rates**. While multiple pools may be organized for particular groups of contributors, **subsidies across the pools** should be used to ensure fair financing.

Many low-income countries have institutional constraints – high levels of informal work and weak revenue collection systems -- that make it difficult to develop pre-payment systems (taxes or social insurance). In the short-term, community-based pre-payment schemes can be promoted by WHO, ILO, and other UN agencies. But, in the long-term, health officials must work closely with other sectors in developing the financial infrastructure to promote greater social solidarity in health financing.

(c) Promote *Responsible Health Stewardship*.

Health systems of the 20th century have grown to encompass multiple actors, agencies, and institutions. As a result, they have become more fragmented, and narrow, self-interested goals often are pursued at the expense of overall population health objectives. This has made it critical for states to ensure that the key *functions* of the health system – raising and pooling funds, purchasing health services and providing care – work in harmony to achieve overall health system goals. This role can be called **stewardship** – the responsible management of the functions and interactions among a health system's multiple actors and interests to achieve societal goals.

Responsible health stewardship implies two key attributes. One is a duty to engage in **cross-sectoral advocacy to influence policy on the wider determinants of health of the poor**. When the policies and practices of other sectors of the economy present both risks and opportunities for improving health, it is not enough for Ministries of Health to concern themselves only with the delivery of publicly provided health services. Thus, Ministries of Health should be strong advocates for better nutrition by participating in policy discussions regarding access to land, choice of which crops to subsidize, and other agricultural issues. Likewise, the Ministry of Health must support efforts to raise the level of female education and advocate for more equal distribution of incomes, based on compelling evidence that both are positively related to better health outcomes.

Another attribute of responsible stewardship is **oversight of all components of the health system**, rather than a focus on publicly provided services. Efforts to engage the resources of the private sector are especially important for the poor, given their high reliance on the private market for health care in many low-income countries. A combination of approaches can be employed to harness the resources of the private sector, ranging from financial incentives, use of purchasing power via contracts with private providers, consumer information, and government regulations. Government oversight and intervention in sub-sectors of the private market, e.g. insurance, pharmaceuticals, human resource production, are necessary to ensure their contribution to overall health system goals.

To carry out these stewardship responsibilities implies a fundamental shift in the focus of Ministries of Health. It means a shift from directly providing health services to broad oversight, advocacy, strategic purchasing, setting rules for financing and delivering health care by multiple actors, and assessing overall system performance. **This shift – from rowing to steering – must be accelerated through training and technical cooperation**, to build the skills needed to carry out these functions. Ministries of Health must be better at consensus-building, negotiation and mediation among all relevant actors – in, across all levels, and outside government – in order to create stronger partnerships and coalitions across diverse interests and sectors. They must be able to hold all actors accountable for country performance on agreed-upon national and international health goals. This requires stronger systems for monitoring trends in health status, health care use and health care spending, not just on the average, but by socio-economic status.

WHO believes that this vision of strengthened health stewardship must be realised for health to fulfil its potential contribution to poverty reduction and human development. It is particularly needed in those countries where health governance is weak. Thus, strong international political, financial and technical support will be required, especially in sub-Saharan Africa and South Asia.