Public health

Global health improvement and WHO: shaping the future

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A world torn by gross health inequalities is in serious trouble. The global health community can do much to reduce suffering and death among vulnerable groups. WHO is changing its way of working, alongside member states and financial and technical partners, to reach key national health goals and strengthen equity. The most urgent objectives include the health-related Millennium Development Goals, the 3 by 5 target in HIV/AIDS treatment (to provide 3 million people in developing regions with access to antiretroviral treatment by the end of 2005), and addressing the growing epidemics of non-communicable diseases. The key to achieving these objectives is strengthening of health systems guided by the values of Health For All.

Inequalities scar the world's health landscape. The newly released *World health report 2003—shaping the future* reveals that a baby born today in Afghanistan is 75 times more likely to die before age 5 years than a child born in Iceland or Singapore. Life expectancy at birth in Sierra Leone is less than half that in Japan.[1] The antiretroviral drugs routinely prescribed to people with HIV/AIDS in wealthy countries have greatly extended and improved life for many. But of the estimated 4·1 million people in sub-Saharan Africa in urgent need of such drugs, fewer than 2% have access to them.

A world torn by such inequalities is in serious trouble. By acting resolutely to correct these injustices we can do much to improve the collective future of humankind. Many of the determinants of unequal health outcomes—such as poverty, armed conflict, and levels of education in women—lie outside the control of the health sector. Yet the worldwide health community can do much to reduce suffering and death among vulnerable groups, if we are prepared to go beyond a "business as usual" approach. WHO is changing its way of working, alongside member states and financial and technical partners, to reach key national health goals and strengthen equity. The most urgent objectives include the health-related Millennium Development Goals and the 3 by 5 target in HIV/AIDS treatment: to provide 3 million people in developing regions with access to antiretroviral therapy by the end of 2005.

Are WHO and its partners up to these challenges? The answer is: we have to be. Two decades of experience in WHO give me a clear sense of the organisation's strengths and limitations. To meet urgent goals, we are making changes. But we will build on the past, reinforcing strategies that have brought results, expanding channels of communication and feedback to quickly measure the effects of innovation.

I began my WHO career working on leprosy control in Fiji. My years at country level and in WHO's western Pacific regional office in Manila shaped my vision of public health work and of WHO's role. Global norm-setting, research, and determined health advocacy within international forums are crucial. But the real test comes in countries—through technical cooperation and policy work with national authorities and communities. Health improvement in countries will be the criterion of WHO's success in the years ahead. Working to rapidly strengthen health-care systems is the key to meeting health goals and reducing inequalities in access and outcomes.

This article is not an exhaustive account of WHO's priorities. The focus is on themes that, in addition to their own intrinsic importance, illustrate broader changes in WHO's way of working. The article will: identify bedrock ethical values for international public health; describe some of today's main health challenges; and indicate specific actions WHO will undertake, in collaboration with partners, to address these challenges. The key message is that urgent action to meet targets such as 3 by 5 and the Millennium Development Goals must drive a horizontal strengthening of health-care systems. Sustained progress toward these targets will be impossible in many areas without a systematic reinforcement of basic health-care infrastructure. Scale-up of health systems should be guided by the principles and practices of primary health care, adapted to a rapidly-changing health landscape.

Core values for a global health partnership

Effective public health action needs an ethical position as well as technical skills. To shape a healthier future, we need to be clear about our values, as well as our science.

WHO's core values are those stated in its constitution, drafted in 1946. In the 1940s, as today, the world was deeply concerned with questions of security. Indeed, "to maintain international peace and security" was the primary purpose assigned to the newly-created UN.[2] But the founders of WHO and the UN system clearly saw the relationship between security and justice. The preamble to the UN charter says security depends on "conditions under which justice . . . can be maintained". The authors knew that security without justice is unsustainable. We must rediscover this truth today—and act upon it.

The founders of these international institutions also realised the close connection between health—understood as "a state of complete physical, mental and social well-being"—and the core values of justice and security. The WHO constitution identifies the "enjoyment of the highest attainable standard of health" as "one of the fundamental rights of every human being without distinction". A crucial part of justice in human relations is promotion of equitable access to health-enabling conditions. The

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constitution warns that the non-respect of some people's right to health may put the security of all at risk. "The health of all peoples is fundamental to the attainment of peace and security"; whereas, "Unequal development in different countries in the promotion of health and the control of disease . . . is a common danger" for humankind as a whole.[3]

During the last decades of the 20th century, health and security were often separated in national and international debates. At the national level, these two areas were assigned to different branches of governance, specifically ministries of health and the military, whose objectives and activities were seen as unrelated.[4] Increasingly, however, the connections are reemerging. The UN Security Council and national bodies acknowledge the growing effect of HIV/AIDS on security.[5] The threat of new infections, arising naturally or as a result of human action, demands new forms of cooperation between security and public health.

Questions of health equity and the empowerment of the poor have a personal relevance for me. As a Korean born in 1945, I grew up in a country impoverished and torn by war. Our people suffered the afflictions known to many other poor countries then and now. Koreans of my generation have not forgotten the lessons of that earlier time. We know what it means to face conflict, poverty, and widespread sickness. We know what it means to suffer injustice and to lack security. This formative experience has spurred my determination to place the health needs of the most vulnerable at the heart of WHO's agenda.

I began working for WHO in 1983, during the early years of the Health For All movement. Like many colleagues, I was inspired by the commitments to equitable health improvement outlined in the 1978 declaration of Alma-Ata.[6] The declaration challenged gross inequalities in health status between and within countries as "politically, socially and economically unacceptable". Setting 2000 as the ambitious target year, signatories pledged to pursue the attainment by all peoples of a level of health that would enable a dignified and productive life. Strengthening primary health care was identified as the way to attain this objective.

Much was accomplished in the decades following the Alma-Ata conference, but progress toward Health For All was slow in many countries. Reasons included insufficient political commitment, the constraints of persistent poverty, difficulty in achieving intersectoral action for health, continuing disempowerment of women, weaknesses in human resources and health information systems, and demographic and epidemiological changes including the assault of HIV/AIDS and the expanding burden of non-communicable diseases and injuries in low-income and middle-income countries.[7]

The scope and content of primary health care generated frustrating debates. In some places, primary health care became a euphemism for cheap, low-quality care—second-rate health services for poor people. Meanwhile, the economic and institutional context of health-service delivery changed swiftly. The delegates at Alma-Ata could not have anticipated today's complex service delivery landscape, in which non-governmental organisations and the private sector operate in the gap left by states' withdrawal from health-care provision—a withdrawal often encouraged by international financial institutions and interests uncritically supportive of health-care privatisation.

The Alma-Ata goal of Health For All was right. So were the basic principles of primary health care: equitable access, community participation, and intersectoral approaches to health improvement. These principles must be adapted to today's context. Recent World Health Assembly resolutions show enduring commitment to Health For All and primary health care in the worldwide health community, as confirmed by the results of a WHO-led global review of primary health care, involving inclusive consultations at national, regional, and international levels.[8] To attack worldwide health inequalities and meet goals for today and tomorrow, we must carry forward the primary health care experience and the commitment to health equity and social justice that inspired Health For All.[9,10]

Global public health: major challenges

The *World health report 2003* provides a detailed picture of the current worldwide health situation. From these findings, urgent challenges emerge, to which WHO will lead an aggressive response.

Although aggregate global health indicators have improved substantially since the middle of the past century, the gross health inequalities highlighted in the Alma-Ata Declaration persist. Indeed, the gaps are widening between the world's poorest people and those better placed to benefit from economic development and public health progress. Over the last 50 years, average life expectancy at birth has increased worldwide by almost 20 years, from 46·5 years in 1950–55 to 65·2 years in 2002. The large gap in life expectancy between developed and developing countries in the 1950s has changed to a gap between the very poorest developing countries and all other countries. Thus, life expectancy at birth in 2002 ranged from 78 years for women in developed countries to less than 46 years for men in sub-Saharan Africa—a 1·7-fold difference in total life expectancy.

Of the 57 million deaths in 2002, 10·5 million were among children younger than 5 years, and more than 98% of these deaths were in developing countries. Worldwide, substantial progress has been made since 1970, when more than 17 million children died. In 14 African countries, however, current rates of child mortality are higher than they were in 1990. Overall, 35% of children in Africa are at higher risk of death today than they were 10 years ago. Across the world, children are at increased risk of dying if they are poor and malnourished, and the gaps in child mortality between the haves and the have-nots are widening in many regions.

The state of adult health at the beginning of the 21st century is characterised by two major trends: slowing of gains and widening health gaps; and the increasing complexity of the burden of disease. The most disturbing sign of deteriorating adult health is that adult mortality rates in Africa have reversed so drastically that, in parts of sub-Saharan Africa, they now exceed those of 30 years ago. The most important cause of the reversal is the HIV/AIDS pandemic. Worldwide in 2002, despite trends of declining burden of communicable disease among adults, HIV/AIDS was the leading cause of mortality and the most important contributor to the burden of disease among adults aged 15–59 years.

The outbreak of severe acute respiratory syndrome (SARS), in early 2003, reminded the world of our shared vulnerability to new infections.[1,11] In addition to the human tragedy of more than 8000 cases and more than 900 deaths, SARS caused serious economic damage. International travel to affected areas fell by 50–70%. Businesses, especially those related to tourism, failed, and some large production facilities were forced to suspend operations when cases arose among workers. The Asian Development Bank estimated the total cost of the

epidemic to Asian economies at US$60 billion.[12] Such effects show the importance that a severe new disease can assume in a closely interdependent and highly mobile world. And while SARS was the first major lethal infection to emerge in the 21st century, it will not be the last.

Meanwhile, the burden of non-communicable diseases is increasing, especially in developing countries. Almost 50% of the adult disease burden in the high-mortality regions of the world is now attributable to noncommunicable disease; most of this burden is preventable on the basis of existing knowledge—the challenge is to convert this knowledge into effective national prevention policies and programmes. Today, the commitment to Health For All must include intensified work with countries to confront and reduce the double burden that threatens already fragile health systems.

New approaches at WHO

To meet these challenges and accelerate progress on global health equity, WHO is fundamentally changing its way of working. This change builds on past innovations and accumulated knowledge, such as the experience gained through the polio eradication campaign and WHO's coordination of the SARS battle. Now our approach to HIV/AIDS embodies the paradigm shift. The idea is to synergise swift responses to health emergencies with long-term strengthening of health infrastructure.

On Sept 22, 2003, I declared lack of access to effective HIV/AIDS treatment a worldwide health emergency. This declaration is a commitment to extraordinary action. It is linked to a practical objective, the 3 by 5 HIV/AIDS treatment target. This goal was originally proposed by scientists working at UNAIDS and other agencies.[13] The global community is uniting around this objective and driving toward its fulfilment, on the way to the final goal of universal access to antiretroviral drugs for all who need them. During the SARS outbreak, WHO personnel and our national and international partners worked in crisis mode to assess the epidemiology of the disease and arrest its spread. Scaling up antiretroviral treatment demands the same intensity of response.

As we take urgent action to bridge the treatment gap, we continue to emphasise a comprehensive approach to HIV/AIDS control, insisting on the fundamental importance of preventing new infections. We need a balance between prevention and treatment, for both to work optimally. In many countries, the balance has been skewed because antiretroviral treatment has simply been unavailable, especially for the poor. There is growing evidence that provision of antiretroviral therapy in resource-poor settings can actually facilitate and strengthen HIV-prevention in several ways: increasing demand for voluntary counselling and testing; reducing stigma and promoting greater openness on HIV/AIDS; and helping to keep families intact and economically stable, thus slowing the growth of at-risk populations such as orphans and sex workers.[14,15] WHO will not cut back on its prevention efforts. Instead, we are seeking new and additional resources to facilitate treatment scale-up.

Within days of the September emergency declaration, the first of a series of WHO country emergency missions was implemented (in Kenya) preparing a detailed country-level analysis and working with national and local partners on plans for HIV/AIDS treatment scale-up. On Dec 1, 2003, WHO's HIV/AIDS department, in collaboration with UNAIDS and other partners, unveiled a global strategy for reaching 3 by 5. The strategy covers 14 areas of work, grouped under five headings: international partnership and advocacy; direct support to countries; simplified and standardised instruments to identify patients, deliver antiretroviral therapy, and track progress; measures to ensure a reliable supply of effective medicines and diagnostics; and rapid identification and dissemination of new knowledge to improve programme quality.

As the 3 by 5 plan unfolds, WHO will send emergency response teams to all high-burden countries that request them, to work with treatment implementers on identifying and overcoming barriers to national antiretroviral treatment objectives in line with 3 by 5. WHO is also launching an AIDS medicines and diagnostics service to expand patients' access to high-quality, low-cost drugs and commodities. This will be similar in some respects to the Global TB Drug Facility whose creation I oversaw when I directed WHO's tuberculosis programme. The service will help countries and implementers to navigate drug purchasing and financing while considering best prices and ensuring quality, thus helping to overcome one of the greatest barriers faced by countries in HIV/AIDS treatment scale-up.

To reach 3 by 5, sustained cooperation among many partners will be needed. Most fundamentally, countries must be ready to acknowledge the emergency and respond with exceptional measures. Demand from countries and communities must drive the process. We are encouraged by the degree of commitment WHO's 3 by 5 country support teams have found among national health officials and political leaders. As we strengthen our cooperation with countries, WHO, UNAIDS, and the Global Fund must also coordinate with other multilateral institutions, including the World Bank's Multi-country HIV/AIDS Program, with bilateral treatment initiatives, such as the US Presidential HIV/AIDS initiative, and with private foundations. Some employers have taken a bold lead in launching treatment programmes for their workers, opening new ground for public-private partnerships. Success depends on our ability to work together.

Rolling out 3 by 5 will raise difficult issues of equity, such as how communities will be prioritised, which patients to enrol first, and how to handle questions of confidentiality and stigma. We need to ensure that programmes maintain a focus on reaching the poor and other vulnerable groups. As antiretrovirals become more widely available, monitoring and responding to drug resistance will be a key responsibility. For more than a year after the 3 by 5 target was first widely publicised, at the July, 2002, International AIDS Conference in Barcelona, enrolment of patients into treatment was slow. To many, perhaps, the obstacles seemed too daunting and the risks too great. Now WHO and its partners are breaking the inertia and facing the risks. The alternative—to watch millions more human beings die when therapies exist to treat them—is simply unacceptable. With determined action by all partners, the 3 by 5 objective can be reached. If the 34 countries with the highest rates of HIV infection each provided antiretroviral treatment to 50% of those who need it by the end of 2005, 92% of the target would be attained.

The HIV/AIDS fight is vital in itself, and as a test for new work patterns at WHO and new forms of cooperation across the global health community. The sense of urgency, clear goal-setting, intensified cooperation with countries, and do-what-it-takes mindset that characterise WHO's HIV/AIDS team are echoed in more and more parts of the organisation. The effects of this new approach will be felt in WHO's many other focus areas, including expanded action against a range of non-communicable diseases and cooperation with countries to achieve the health-related Millennium Development Goals. Not only for WHO, but

for other health and development institutions and member states, 3 by 5 is a proving ground that will tell us whether we really have the stomach to tackle tough challenges. If we cannot reach 3 by 5, there is no reason to believe we will achieve the Millennium Development Goals. On the other hand, the innovative work strategies and results-focused partnerships we are building to move toward 3 by 5 can enable progress on other key objectives in line with Health For All.

Strengthening health systems

We are embracing 3 by 5 and Health For All simultaneously. To link these two agendas necessitates a comprehensive engagement with health systems. Most countries will make only small advances in population health in the years ahead without substantially strengthening their health-care systems. Work toward specific targets such as the Millennium Development Goals and 3 by 5 must be organised so as to drive a broad build-up of health-care systems capacities.

To improve health-care access and outcomes while narrowing equity gaps, WHO will promote the scaling-up of health-care systems based on the principles of primary health care. In the *World health report 2003*, the model of health-care system development led by primary health care is discussed. The report emphasises both the broad ethical commitment to equity which grounds a system based on primary health care and such a system's integrated service structure—"principled, integrated care". From a systems perspective, the potential conflict between primary health care as a discrete level of care and as an overall approach to responsive, equitable health-service provision can be reconciled.[1]

The political, socioeconomic, and epidemiological contexts of primary health care have changed dramatically in a quarter of a century. Yet these changes render the fundamental ethical commitments of Health For All more important than ever. WHO reaffirms the aims and values of Health For All and will work with countries to develop health systems strategies for translating these values into sustained action. The way to Health For All is through strengthening of health systems. Panel 1 shows the aims of a health system based on primary health care.

In the years ahead, WHO's cooperation with countries on health-care systems improvement will be intensified as part of a broad strategic reconfiguration of the organisation's work in measurement, evidence, and health systems analysis. The *World health report 2000* did much to focus the world's attention on the issue of health systems performance.[16] Although methodological and process problems sparked criticism, WHO's assessment framework for health systems performance is an important instrument. Moving forward, our efforts will focus on practical work with countries to strengthen their health systems. Cooperation with countries in equitable health systems development will be an increasingly important part of WHO's mission.

Panel 1: **Features of a health-care system based on primary care**

A health-care system based on primary health care will

- build on the Alma-Ata principles of equity, universal access, community participation, and intersectoral approaches
- take account of broader population-health issues, reflecting and reinforcing public-health functions
- create the conditions for effective provision of services to poor and excluded groups
- organise integrated and seamless care, linking prevention, acute care and chronic care across all components of the health system
- continuously assess and strive to improve performance

Health-care systems in low-income and middle-income countries face a wide array of challenges. The *World health report 2003* takes up four of the most pressing issues: the global health workforce crisis; the need for improved health information; sustainable financing; and the stewardship challenge of implementing pro-equity health policies in a pluralistic environment.

Many countries face a workforce crisis in the health sector. The shortage of qualified staff slows progress toward health targets and contributes directly to the HIV/AIDS treatment gap. In some instances, workforce constraints threaten to undermine the benefits of new financial resources and technologies becoming available to the health sector. WHO will expand its technical cooperation with countries to build the health workforce using innovative methods of training, deployment, and supervision of allied and community health workers. For example, WHO's 3 by 5 emergency mission in Kenya found that about 4000 nurses, 1000 clinical officers, 2000 laboratory staff, and 160 pharmacists or pharmacy technicians are currently unemployed in that country (WHO, unpublished). Many of these health workers could quickly receive training that would enable them to take part in HIV/AIDS treatment scale-up. WHO will assemble and disseminate emerging evidence on best policies and practices for human resources. The organisation will use its global health advocacy position to seek solutions to the brain drain problem, which by its nature demands an international strategy.

In most countries stronger, more integrated information systems are needed at district and national levels to better assess health status and trends, track health system performance, and monitor progress toward health goals.[17] One example is vital registration systems—the ability to count births and deaths. Such systems are still missing for a large proportion of the world's population, especially in countries with high disease burdens. Strengthening these systems requires a collaborative effort. The Health Metrics Network, to be launched in 2004, is a broad partnership including WHO, other international organisations, bilateral agencies, foundations, ministries of health, statistical organisations, academic institutions, and civil society organisations. It will improve the availability and use of health information for policy-making, programme monitoring and assessment, monitoring of international goals such as the Millennium Development Goals, and health equity assessment.

Fundamental requirements for health-care systems guided by primary health care principles also include pro-equity financing and stewardship mechanisms that can ensure that quality health-care services are accessible for the whole population, including poor and marginalised groups. Solutions to these challenges must take account of national and local specificities and should negotiate a health-care delivery landscape that is more complex than at the time of Alma-Ata. WHO will work closely with countries to shape health-system development strategies that are pro-equity and driven by primary health care. Excellent work in this direction has already been done in some countries, and lessons can be more widely applied. For example, Chile is carrying through a promising reform of the health-care system, with a primary health care focus

and explicit strategies for improving equity. These strategies could be applicable in other middle-income countries (see panel 2).

Strengthening of health systems is pivotal to the effort to put countries back at the centre of WHO's work. This was one of my pledges when I sought the post of Director-General. In cooperation with member states, Regional Directors, and WHO country staff, we are taking steps to ensure that all WHO representatives in countries have the resources and the authority to run their offices as efficient, accountable units responsive to local needs. Additional resources are being deployed to priority country offices for building capacity in HIV/AIDS control and development of health-care systems. Further, all Assistant Directors-General have been asked to assess the work of their respective clusters and to propose specific steps for moving resources from headquarters to regions and countries. WHO will remain a strong voice in international debates on all issues that affect health. But results in countries will be the primary measure of the organisation's success—on 3 by 5, the Millennium Development Goals, control of non-communicable diseases, and health systems.

Panel 2: **Health-system improvement based on primary health care in a middle-income country: the example of Chile**

Since 1990, building on Alma-Ata principles, Chile has progressively implemented a primary-health-care approach focused on the community and the family. The country's current health sector reform is explicitly based on primary health care and a pro-equity orientation. Reform measures aim to equip primary care establishments throughout the country as family and community health centres (*centros de salud familiar y comunitaria*) able to bring complete, integrated care within reach of the whole population. Innovative measures to promote equitable access for marginalised and vulnerable groups have been built in—for example through outreach programmes aimed at rural and indigenous populations. Epidemiological data on usage patterns have been used to redistribute staff and other resources at health facilities to provide more efficient service to vulnerable groups (such as children and older adults), reduce waiting times during peak usage periods, and increase client satisfaction.[18] In 2000, 265 health centres (*consultorios*) extended their opening hours to better meet client demands, enabling a 23% increase in the number of patients seen. By the following year, a total of 483 public-sector health-facilities had adopted the same system. In 2000, 550 primary-care facilities throughout the country improved their responsiveness through measures including remodelling of reception and clinical spaces, introduction of priority service windows, extended opening hours, and prioritisation of clients based on clinical criteria rather than order of arrival. These measures enabled 97% of the facilities to eliminate early morning waiting lines (http://www.minsal.cl).

Chile's health sector reform has been combined with decentralisation and has generated a model of local network management (*gestion en red*) that gives increased autonomy to closely integrated local networks of primary care centres and referral facilities. These locally networked facilities coordinate their activities to achieve service improvements such as minimising the length of time patients must wait for referral appointments. Strong commitment from the country's political leadership has accelerated the reform process. Recently passed legislation guarantees universal access to treatment for 56 conditions which together account for 80% of Chile's mortality. The law stipulates that a patient's total annual copayment will not exceed 20% of the cost of services, nor surpass the equivalent of 1 month's family income (http://www.minsal.cl).

Conclusion

To shape a better future for the global community, health gaps between rich and poor need to be closed. To achieve progress in health equity, strong ethical and scientific leadership is needed in the sphere of international health. WHO is the only agency with responsibility for improving the health of all populations. At its best, WHO unites effective measures at country level with the exercise of worldwide authority and coordination functions. It bonds the most advanced science to a normative commitment to justice and human rights.

Of course, as an intergovernmental organisation accountable to 192 member states, WHO also faces unique difficulties. Tensions emerge between WHO's need to be responsive to the agendas of member states and its mandate to provide leadership based on scientific evidence. Likewise, the interests of different countries clash. When such difficulties arise within WHO, they must be resolved through painstaking compromise, rather than by unilateral executive decision. Yet democratic processes remain preferable to any known alternative, when we are concerned with the promotion of such fundamental rights as health. As we focus on overcoming global health inequalities, it is more important than ever that strategies be debated in a forum in which all countries are heard.

The ambitious programmes WHO is launching will need substantial new resources. We must be clear about this. Military hardware is expensive. So is building equitable health infrastructure. Neglect of the latter leaves the world less just and ultimately less secure. As of this writing, funding must still be secured for the bulk of WHO's projected expenditures on 3 by 5, as for numerous other crucial programmes we want to initiate or continue in the years ahead. We must rely on member states and other donors to supply these urgently needed resources. Yet I am confident that the money will come. The crucial thing is to get started. As 3 by 5 and other initiatives begin to show results—in deaths averted, quality of life and economic productivity restored, families and communities preserved—the resources to continue this work will be forthcoming.

The global community must confront today's emergencies while laying sustainable foundations for a healthier future. This means synergising targets such as 3 by 5 with the broad scale-up of equitable, integrated health systems that can meet the needs of communities and make quality health services available to everyone. No single institution can accomplish such a task. But, working closely with countries and partners, WHO will lead the way. 20 years with WHO in countries, regions, and headquarters give me a clear sense of the challenges we face on the ground, but also of this organisation's unique strengths—above all the skills, dedication, and ethical commitment of its people. Working together, WHO and its member states and partners will shape a better future in global health.

Lee Jong-wook is Director-General of WHO.

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