



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



**REGIONAL CONSULTATION OF THE AMERICAS ON THE  
11TH GENERAL PROGRAMME OF WORK OF THE WORLD  
HEALTH ORGANIZATION**

*Washington, D.C., USA, 14 - 16 February 2005*

---

**11GPW/BACKGROUND PAPER 1  
9 February 2005**

**BACKGROUND PAPER 1: POSITIONING HEALTH IN THE POLITICAL,  
ECONOMIC, SOCIAL AND DEVELOPMENT AGENDA**

## **Key Concept: Changing Climate of the World and Health's Place In It**

### **The Repositioning of Health**

1. The world has moved to a point that health extends beyond itself in its own right. We must realize the influence of health on many other issues. Health is not a single discipline. It borrows methodologies from and applies results to many other areas. In the last decade, we have witnessed the expanse of globalization at speeds not imagined at the first World Health Assembly. The international community is managing globalization through an array of forums, and health is often now regarded as a path for achievement as well as an outcome in its own right. For example, in the WTO Ministerial Conference (Doha, 2001), health was prominently considered, and the first international treaty that focused on health, WHO's Framework Convention on Tobacco Control, will come into force 28 February 2005. Multidisciplinary ways of thinking about health have always been important and often discussed in theory, but are critical for progress now and in the years ahead.

### ***How We Arrived at Where We Are Now: A Look Back at the Changing Approaches to Health***

2. Although WHO's Constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease," a significant portion of the work of WHO has focused on the identification, eradication or elimination, and treatment of diseases, particularly communicable.<sup>1</sup> Notable achievements and efforts include the eradication of smallpox in 1979, standardized treatment of tuberculosis, and most recently efforts to bring efficacious and affordable treatment to millions of people living with HIV and AIDS. This inarguably critical work has saved millions from premature death and better assured quantity and quality of life across all nations. Yet, medicine can not excel outside a supportive infrastructure, nor indeed be the only answer.

3. During the 1974 United Nations General Assembly, developing country delegations pushed for "radical reorganization of international economic relations on the principals of justice and equality, elimination of all elements of exploitations in international relations, and ensuring conditions for eliminating the gap between developed and developing countries, as well as promoting [the] world's speedy economic and social development." By the mid-1970's, the world began to collectively realize the importance of placing health care into a greater policy framework, particularly for developing countries. In 1978, the concept of Primary Health Care (PHC) was codified in the Declaration of Alma-Ata.

---

<sup>1</sup> WHO Constitution.

4. The landmark Declaration of Alma-Ata changed the way health care was viewed in the world, bringing health as a human right to the attention of an international audience. It set the much-referenced goal of “Health for All by the Year 2000.” The strategy aimed to provide for basic health care needs, as well as address the underlying social, economic, and political causes of poor health. The strategy was in line with the basic needs approach of the development movement of the 1970’s, which emphasized social investment, integrated development, and collective self-reliance.

5. Health promotion gained attention as a way of achieving the Health for All goals set the previous decade. Health promotion was defined as the process of enabling people to increase control over and to improve their health. It had a focus on achieving equity in opportunity, resources, and basic conditions so that people could make informed choices regarding their health and lives in general. Combined with growing demand on financing of health systems, the onus of responsibility became greater and greater on the individual rather than the community, particularly in poor areas.

6. In the 1990s, governments were facing important demands for social services, but revenues from which they could be financed were limited. The World Bank, through a series of influential publications (World Bank Development Report 1993: Investing in Health), had a strong influence on world health policy matters. Solutions for health crises and systems management were found through economic rationalism and technocratic solutions. The issue of user fees for health came to the foreground. And while the goal of cost-effective interventions seems reasonable, the gap between the rich and the poor, and the diseases of the rich and the poor continued to grow.

7. At the end of the 1990s, under the direction of then Director-General, Dr. Gro Harlem Brundtland, a strong case was made that greater investment in health would pay economic dividends and thus make a significant contribution to poverty reduction, and the Commission on Macroeconomics and Health was formed in WHO. With rights-based approaches to development starting to gain ground again after some years of being sidelined by economic development interests, the perspective is changing and health is regarded as a human right worth attaining on its own accord, as well as a component to many other global factors, like economic and social development, security, and global governance.

8. Our understanding of health has changed over time, and with it how we focus our research attention and which methodologies we choose to employ to promote health. In one sense, health will always remain a technical issue. Our understanding of disease, cause, prevention, and cure is, and should continue to be, firmly based on the rigorous application of science. While this remains our bedrock, we no longer limit scientific research and application to that of biology. Economics, political science, human rights, development,

and even issues of global and national security now challenge us to consider not only the causes of disease, but the “causes of the causes.”<sup>2</sup>

Text Box 1.1

**A Look Back at Global Strategies for Health**

1978: Alma Ata – Comprehensive PHC – HFA 2000  
1982: UNICEF Child Survival Revolution – Selective PHC  
1993: U.N. Millennium Development Goals  
2000: Commission on Macroeconomics and Health

***New and Reenergized Developments***

9. Our understanding and striving for health continues to evolve. So does the application of our knowledge. It is not enough for health to be accepted as a multi-faceted discipline needing cross-sectoral approaches to be taken only by the health community. Although health today remains attached to the concepts stated in the WHO’s Constitution: the “highest attainable standard of health” and “one of the fundamental rights of every human being without distinction,” its role in the world has changed due to new global dynamics and interdependence.

10. Health is now recognized as a key component of social and economic development, governance, justice, and security, as well as a dynamic instrument for achieving them. It is recognized as an important component of policies traditionally belonging to other disciplines, such as economics, security, trade, and development. This new centrality of health is also confirmed in a wide range of international agreements and developments of the last 20 years and by a very wide set of stakeholders far beyond ministries of health (see Box 1A).

11. When SARS in Hong Kong impacts Canada; when polio cases in Nigeria jeopardize the polio-free status of nations close and far; when biological weaponry is a real threat; and when AIDS so threatens the stability of an entire continent that it is a focus of the U.N. Security Council, we can no longer rely on biomedical definitions and solutions, nor can we depend solely on the old and established partners and ways of framing health.

---

<sup>2</sup> Sir Michael Marmot, WHO Executive Board seminar, Reykjavik, Iceland, December 2004.

*Health is a matter of gender; equality between women and men is a key to achieving good health.*

12. Women and men are different as regards their biology, their roles and responsibilities that society assigns to them, and their position in the family and community. These roles and responsibilities have a great influence on causes, consequences, and management of diseases and ill-health. Women and men, boys and girls, need to be treated equally by health policy and health systems when they share common needs. When their needs are different, these differences need to be addressed in an equitable manner through prevention, treatment, and care services. Not doing so may negatively impact the health of both women and men and/or the effectiveness of health systems and far reaching impacts into the development of a community.

*Health is political and a key component of many interdisciplinary policies.*

13. Access to health is something around which people can unite and make demands on the State. Failures can bring down governments. Successes can win elections. Health care is expensive, and the fight for resources will always be hard fought—by political means. Inequity in access to health systems results in disparate health outcomes, regardless of national GNP. Those with limited political voice are also those without the protection of a suitable infrastructure in which to thrive, coupled with the worst access to the benefits of health care. The temptation to save national resources by cost-shifting health care to the consumer via user fees, and promoting policies that put the onus of responsibility on individuals to make healthy lifestyle choices only serves to result in higher expense to both the consumer and government.

*Health is a global public good.*

14. One important argument for public subsidy of health is that there are strong societywide benefits from environmental health and disease control interventions. Reduced levels of infection and of the vectors of disease are pure public good, being something that the entire community benefits from and something to which an individual cannot be excluded from benefit. Traditional market economies do not support such public goods as there is an inherent disincentive for profit.

*Health is intricately linked to economics.*

15. Healthy people learn better, can more easily earn an income, contribute further to society, care for the elderly and children, and lead healthier lives. Health and income is cyclical in nature. Those with higher income have better access to health information, health care, nutritious foods, safe water and sanitation, and live in healthier communities. When they do get sick, they can immediately access health care, and often afford high-tech

diagnosis and treatment. To prevent illness, they have themselves and their children regularly vaccinated. Poor people are limited in obtaining many if not all of these things. When illness does inevitably strike, access to the health system is delayed and often rudimentary, and consumes a greater proportion of the family's income. Diagnoses are made at a later stage of disease progression; consequently, poorer people have poorer morbidity and mortality statistics. In many areas, a catastrophic illness can actually drive a family barely surviving into poverty. The synergistic effect between income and health is not limited to developing countries. The same factors hold true to the poorer and minority communities in highly developed nations.

*Health is influenced by social status.*

16. Even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than the rich. These differences show the sensitivity of health to the social environment. Much more than on medical care per se, population health depends on socially mediated factors and processes such as food security and nutrition; access to water and sanitation; children's early life environment; housing and habitat; transport; employment and working conditions; social support or social exclusion; and conflict, for example. It is undeniable that people's health status is powerfully shaped by their social status, including their location within social hierarchies based on wealth, education, gender, ethnicity, rural-versus-urban residence, and other factors.

*Health is a component of development.*

17. Like economic growth, health has a mutually reinforcing relationship with development. Wealth leads to health and health leads to wealth, not just in individuals, but in communities and nations. Good health is an integral part of a healthy and contributing society, which is paramount for advancing development. Major progress on achieving development goals, including the MDGs, is inconceivable if there is no improvement in the health of the world's poor.

*Health is critical for security—collective and individual.*

18. It is not just the AIDS epidemic that has been critical for security, although it is this epidemic that was given prominence in the U.N. Security Council. Further, the relationship between the health and security issue is not confined to biological threats. Extreme poverty and infectious diseases threaten many people directly, but they also provide a fertile ground for other threats, such as civil conflicts, and terrorism, and interpersonal violence. Health care facilities at one time were respected as nontargets during armed conflict, but more and more often now, these facilities and the personnel in them find themselves as targets. Health and civil infrastructure, such as water treatment plants, is vulnerable to attack with consequences great within the respective communities. When communities are ill, they do

not have the strength for defence, whereas collective health can be a safeguard from many of the insecurities that leave people and regions vulnerable.

*Health is a key element of human rights and social justice.*

19. This is true not just in an abstract sense, but in terms of instruments of international and, in an increasing number of cases, national law. The progressive realization of the right to health is something that most, but not yet all, countries have signed up to and can be held accountable for. The Hunt report (2003) states clearly that the right to health is an inclusive right, extending not only to the timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, etc. Nondiscrimination and equal treatment are among the most critical components of the right to health.

***What Does All This Mean for Today and the Future?***

20. This new place for health and this new understanding has implications on how we, as the global health community, attempt to influence health outcomes. It has the potential to bridge the gap that exists between what we know to be possible and what we are faced with in the world we observe. This position we assign to health in relation to other matters of global, regional, and national concern will necessarily influence how we choose to act in the name of health and the way we organize ourselves to do it.