Radical new approach to global health

Health for all

Despite major advances in knowledge and unprecedented gains in global wealth, health inequities between the rich and poor are increasing, both within and among countries. Poverty, poor living and working conditions and the inability to influence these conditions are directly related to poor health. The 2008 report of the World Health Organization's (WHO) Commission on Social Determinants of Health observes that 'social injustice is killing people on a grand scale'.

The WHO report is one of three recent publications that highlight the urgent need to improve universal access to health care by means of a new approach to health. This approach, which is gaining momentum among specialists worldwide, involves addressing health issues in a comprehensive way – with a focus on systems instead of sectors – and tackling head-on the socio-economic causes of poor health and health inequity.

It is not the first time that such a proposal has been made. The Alma Ata Declaration of 1978, which established the 'Global Strategy for Health for All (HFA) by the Year 2000', emphasizing the need for a new international economic order as a prerequisite to reducing health inequity. This new order was not realized. Today's call to revisit the essence of Alma Ata assumes special urgency as governments rethink the operations of the global economy in the wake of the 2008 financial crisis. Moreover, it comes at a time of profound changes in the global health policy landscape, as private funders take an increasingly influential role.

Based on the insights of the three recent publications – the Commission on Social Determinants of Health report, the *World Health Report 2008* and *Global Health Watch 2* – this special report analyzes the current situation and points to approaches to reduce health inequities, including what needs to be done, how, and by whom. It highlights the need, not only for a reorientation of global health policies and priorities, but also for fundamental changes to the global economy and genuine democratization of global governance.

Alamy / Iain Masterton

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From Alma Ata to Almaty

Summary

- Health inequities between the rich and poor are growing, despite an increase in knowledge and unprecedented gains in global wealth.
- The global health landscape is changing. Private foundations have become the big health spenders. The Gates Foundation contributes more than double the budget of the WHO to health care worldwide.
- Public and private aid budgets for health care have doubled, yet results of this increase leave much to be desired.
- Three recent authoritative reports call for a radically new global approach to health policy in order to achieve health equity: tackling social and economic causes of poor health and being comprehensive instead of singularly focused on specific diseases.
- The need for drastic change in global health policy represents a broad trend among international health experts.
- Comprehensive Primary Health Care (PHC) is the way forward: a reorientation of health care systems toward the primary needs of a population with inter-sectoral action at all levels to improve the social determinants of health.

The global health policy landscape has changed considerably over the past decade. There is more money available to allocate to health initiatives than ever before, a large percentage of which has come from private funds and public private partnerships (PPPs). Some experts have welcomed these changes, while others have had considerable reservations. Despite positive developments, such as increased access to antiretroviral therapy for patients with HIV/AIDS, the health situation in poor countries and for the poor communities of rich countries remains abominable. It is often in the world's poorest countries that the highest percentage of health costs is met with private, out-of-pocket spending. This creates poverty traps that can be impossible for people to escape.

It has been widely recognized that the health of a population is influenced by factors that extend beyond the provision of health care. Social and physical environments are important determinants of health. People are exposed to a wide variety of health risks, the effects of which often lead to multiple diseases. Health inequality refers to the different levels of exposure, risks and effects on health depending on geographic location, social class, gender, age, occupation, education, migrant status, ethnicity, race and so on. For instance, in sub-Saharan Africa, HIV prevalence in the urban population is on average 1.7 times that of rural areas. In Kenya, average infant and child mortality rates are lower in modern Nairobi than in rural areas, but in the informal settlements of Kibera and Embakasi in the same capital, they are three to four times the Nairobi average. It is a great concern that in most developing countries urban services have not kept pace with the rapid urban population growth.

Placing more emphasis on the many interrelated social causes of health problems is a central element of the recent

Three reports for a change of approach

In its 2008 World Health Report, *Primary Health Care: Now More Than Ever*, the **WHO** makes explicit its renewed commitment to the principles and moral values of the Alma Ata Declaration of 1978. The report reasserts the need for universal coverage reforms to ensure health equity; service delivery reforms to make health services people-centred; public policy reforms to protect and promote health; and leadership reforms to make public health authorities more accountable. Fragmentation, excessive specialization, commercialization and the human resources crisis are highlighted as problems to be addressed. The report was launched in Almaty (formerly Alma Ata), Kazakhstan on 14 October 2008. To read the report, go to www.who.int.

The Commission on the Social Determinants of Health (CSDH), an independent group of scientists and politicians chaired by epidemiologist Sir Michael Marmot, was established by in 2005. The central aim of the CSDH was to improve health and promote health equity in countries at all levels of income and development by addressing the conditions in which people live and work. The process involved nine knowledge networks in a global collaboration of policymakers, researchers, civil society representatives, the WHO and national governments. The final report, *Closing the Gap in a Generation*, was presented at a conference called 'Closing the gap in a generation: health equity through action on the social determinants of health' (6-7 November 2008, London). For more information, go to www.who.int/social_determinants.

Global Health Watch (GHW) represents a collective of 131 individuals and 76 organizations that share a desire to improve the state of global health and tackle the social and political injustices that lead to poor health. The first GHW report was published in 2005 by the People's Health Movement, Medact and Global Equity Gauge Alliance. The second GHW report, *Global Health Watch 2*, published in 2008, covers a comprehensive range of topics including medicine, water and sanitation, migration, urbanization, war and conflict and a critical assessment of the policies and actions of key agents. The report was launched on 16 October 2008 at University College London and has since been launched in many other countries. Go to www.ghwatch.org.

World Health Day, Calcutta, India, 7 april 2008

call for a new international health strategy. This approach must be comprehensive rather than technocratic and sectoral. Capacity strengthening and local ownership of national development processes must replace the mere implementation of disease-specific interventions designed externally. This concept echoes the Alma Ata Declaration of 1978. Alma Ata has been given a strong new impetus by the publication in 2008 of three prominent reports by the World Health Organization (WHO), the WHO Commission on the Social Determinants of Health (CSDH), and the Global Health Watch (GHW). The challenge is one for all agents: donor governments, multilateral institutions, governments of developing countries and the new private donors.

A changing landscape

Between 2000 and 2007, worldwide development assistance for health nearly doubled, from just under US$ 7 billion to more than US$ 13 billion. Long-established players, such as the WHO and bilateral aid agencies, were joined by a proliferation of PPPs, including the Global Alliance for Vaccines and Immunization (GAVI Alliance) and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (also called the Global Fund), following a previous increase in the role of the World Bank over the previous 10-20 years. In its first five years of operation the Global Fund, which was set up by the G8 and the United Nations Special Session on HIV/AIDS in 2002, disbursed US$ 2.6 billion of donor funds in grants to sub-Saharan Africa and probably could have achieved far more had donors been willing to supply the necessary resources. The Bill and Melinda Gates Foundation has resources that place it in a category of its own. In 2006 alone, it contributed US$ 2.25 billion toward health care, more than double the core budget of the WHO.

Health promotion pioneer Ilona Kickbusch and colleague Lea Payne described this as 'a scandal of global health governance' in which the WHO member states 'are giving up their major instrument to drive health policy and ensure health security'. In a less normative vein, David Fidler of Indiana University, US, describes a generic shift 'from a Westphalian to a post-Westphalian context in which both states and non-state actors shape responses to transnational health threats and opportunities'. Explaining the shift would go beyond the scope of this article, but major influences include

- the inherently greater complexity of today's global health issues, when viewed in contrast to earlier generations of communicable disease control challenges;
- The WHO's budget limitations and bureaucracy;

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- accumulations of private wealth that make possible an initiative on the scale of the Gates Foundation;
- the rise of civil society organizations with resources and sophistication that enable high-level participation in global policy discussions (the GHW reports instantiate this trend); and
- an ideological shift, aggressively promoted by right-wing governments in the industrialized world and transnational corporations, that is succinctly described by historical sociologist Margaret Somers as 'romancing the market, reviling the state'.

Impact of additional funding

What has this doubling of the total of bilateral, multilateral and private funds achieved? There are signs of improvement in global health. Provision of malaria treatment and control interventions has achieved major improvements in parts of Ethiopia, Rwanda, Zanzibar and Kenya, but across Africa as a whole, four out of five children lack insecticide-treated bed nets. Notable achievements have been made by integrating provision of insecticide-treated bed nets into existing measles vaccination campaigns, and increases in measles immunization coverage since 2000 are directly related to a decrease in estimated measles-related mortality from 750,000 in 2000 to 197,000 in 2007. Furthermore, the number of patients receiving antiretroviral therapy for HIV/AIDS has increased more than seven-fold since 2002, to just under 3 million at the end of 2007. But this represents fewer than one in three people who are in need of antiretroviral therapy. The gap between treatment need and delivery is largest in absolute terms in sub-Saharan Africa, the region with by far the highest number of AIDS cases, but is comparably large in percentage terms in Asia. In some regions the impact of the HIV/AIDS pandemic, in combination with increasing poverty, food insecurity, long-term violent conflict and migration, has led to a reversal of previous improvements in health and health provisions.

Although a shortage of funds is far from the only reason for this, it is an important factor. In 2007, it was estimated that US$ 40 per person annually would be required to support what the WHO's Commission on Macroeconomics and Health called a 'rather minimal health system'. In comparison, annual health spending in the least developed countries – where 770 million of the world's people live – averages US$ 15 per capita from all sources both public and private. During the 1990s in Tanzania, public spending on health averaged US$ 3.46 per person per year. This means, among other things, that talk of making health systems sustainable without relying on external resources is delusional. That is especially true in sub-Saharan Africa, where health systems that have already been weakened by long-term underfunding – often mandated under structural adjustment programmes – are further compromised by a brain-drain of health professionals to high-income countries where they are in great demand.

Private funds: friend or foe for global health?

How do informed observers judge the newer agents involved in global health policy? Some are positive about the change, and view the infusion of private finance – such as from the Gates Foundation – as a welcome addition to still-meagre resources for improving the health of the world's poor. Moreover, they consider PPPs not only as a way to mobilize additional resources, but also to make design and delivery of the programmes more effective. If only the existing agencies (notably the WHO) had been more credible and quicker to respond to emerging challenges, they argue, there would have been little incentive to set up the Global Fund. Continuing criticism of the WHO is reflected in a 2008 article in *The Lancet* that accused the WHO's African regional office of 'failing the region'.

However, there are also numerous criticisms directed at private donors and PPPs. Many of these arise from the frequent preference of such donors for disease-specific 'vertical' programmes that some experts believe contribute little either to strengthening health systems or to addressing the underlying conditions of health inequity. In some cases, disease-specific programmes may actually weaken national health systems. For example, a study of Tanzania's health sector commissioned by the Danish International

The Alma Ata Declaration of 1978

In 1978, world leaders gathered at the 'International Conference on Primary Health Care' in the former Soviet Union, now Kazakhstan. The result was the Alma Ata Declaration of 1978, which denounced the widening health inequities within and among countries as morally, socially and politically unacceptable. The declaration defined primary health care (PHC) as not merely a level of care and a set of activities, but as a philosophy, a strategy and a new approach to health. This represented a radical shift in thinking about health, health care and health development. It propagated the need to combine a reorientation of health care systems toward the primary needs of a population with intersectoral action at all levels to improve the social determinants of health. For instance, addressing lead poisoning of children living in cottage factories in the rapidly growing informal settlements of Managua, Nicaragua, or in dilapidated inner-city houses in Paris, requires more than adequate medical care. Living and working conditions must be improved, and economic and social policy must be able to influence the nature of the urbanization process and labour rights. The Alma Ata Declaration emphasized the need for a new international economic order as a prerequisite to increasing health equity. As a means of achieving 'health for all', the WHO decided to adopt a PHC strategy as its core policy. However, the implementation of the strategy left much to be desired, and a truly comprehensive PHC policy was never put into practice.

Health inequities

The final report by the WHO's Commission on Social Determinants of Health (CSDH) highlights the fact that health and illness follow a social gradient at all levels of income: the lower a person's socio-economic position, the worse his or her health. It summarizes the impact as follows:

'The poor health of the poor, the social gradient in health within countries and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services, globally and nationally, and of the consequent unfairness in the immediate, visible circumstances of people's lives – their access to health care, to schools and education, their work and leisure conditions of work, their homes, communities, towns or cities – the chance of leading a flourishing life. This unequal distribution of health damaging experiences is not in any sense a "natural" phenomenon, but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad undemocratic politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries'.

The main recommendations are:

- Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age. Key areas for action include child development and education; healthy places (social and physical environment); fair employment and decent work; social protection across life; universal health care.
- Tackle the unequal distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally. Key areas for action include health equity in all policies, systems and programmes; fair financing; market responsibility; gender equity; political empowerment; good global governance.
- Measure the problem, evaluate the action, expand the knowledge base, develop a workforce that is trained in the social determinants of health and raise public awareness about the CSDH.

Development Agency (DANIDA) warned in 2007 that 'the large increase in external funding for HIV/AIDS sometimes distorts priorities and draws staff away from, for example, maternal and child health'. Similar criticisms have been made of some bilateral programmes, such as the US President's Emergency Plan for AIDS Relief (PEPFAR). Preference for vertical programmes can be traced to donors' understandable interest in seeing tangible, positive outcomes in a relatively short time. The myriad of new global partnership initiatives and private funds that now exist have also been criticized for their limited accountability. At the same time, disease-specific, vertical programmes can be highly effective, especially in the short and medium term. Increased access to antiretroviral treatment, which improves the survival rates of parents, teachers and doctors, is one positive result. However, it is increasingly acknowledged that this is insufficient when newly infected patients continue to outnumber patients receiving treatment. It is also sometimes argued that programmes that focus on single issues can help free health system resources to be used to combat other conditions.

A promising development is the so-called 'diagonal approach', in which disease-specific initiatives are carefully designed to strengthen the health systems in which they are implemented – in the context of substantially increased development assistance for health. However, such programmes ultimately cannot make up for the lack of initiatives that simultaneously strengthen health systems and address the social determinants of health that are beyond the control of health ministries.

The impact of the *Jornadas Populares de Salud* in the early years of the Nicaraguan Revolution is a highly relevant example. Applying the successful multiplier strategy (training of trainers) of the *Cruzada Nacional de Alfabetisación* (national literacy campaign), thousands of *brigadistas de salud* were trained and involved in regular vaccination, oral rehydration and cleaning-up campaigns that contributed within a few years to the eradication of polio and reducing child mortality. It is important to recall, however, that the campaigns in Nicaragua were embedded within a broader context of a national development plan, a universal health care system, literacy campaigns, 'whole of policy' and area-based approaches, and that the WHO considered Nicaragua a model in PHC. This is the crux of the matter, and the very notion that is back on the table: the need for a *comprehensive* approach to health.

The way forward: revisiting old lessons

PHC is back on the global agenda, but it must be *comprehensive* PHC. Sustained improvements in health and health equity demand not only changes in quality of life and lifestyle but also improved access to care and healthier social and physical environments. The latter in turn demand a long-term approach that takes into account socio-economic and contextual factors affecting health and health inequities. To address the social determinants of health, intersectoral action is needed. For example, national institutions for making trade policy decisions must be organized to ensure that direct and indirect health implications are taken into account. And social and labour market policies must be designed in collaboration with health ministries and health professionals to ensure that the health benefits of poverty reduction and strengthened labour standards are considered – an issue of special importance against the background of the current economic downturn. This is the essence of the 'new' approach that is now being promoted, and which in fact is 'old'. After all, it has all been said before in the Alma Ata Declaration. Why then did it not happen?

According to Dr Halfdan Mahler, who was elected in 1973 for the first of three consecutive terms as Director General of the WHO, the initiative to implement PHC was aborted within months of its conception. This was due in part to promotion of a 'selective' PHC strategy by the Rockefeller Foundation, mostly directed to child survival and later strongly endorsed by institutions like the World Bank. >

Though this led to some progress – it is important to acknowledge that overall life expectancy improved and that child-mortality has declined in most countries and regions, although not all, since 1978 – the implementation of selective programmes through cost-effective 'packages' of medical interventions ignored the social determinants of health. A truly comprehensive PHC strategy was thus never put into practice. An important contributing factor was the expenditure restrictions associated with the structural adjustment programmes by the International Monetary Fund (IMF) and World Bank in response to the debt crisis of many developing countries that began at the end of the 1970s and in the early 1980s, and the related promotion by many donors (particularly the World Bank) of health sector 'reform' programmes organized around cost recovery and the imposition of user fees, with public provision and financing of health services regarded as an exception to the normative preference for private purchase or private insurance.

A new momentum?

Despite the differences in the processes through which they were produced, the central message of the three recent reports is similar. Taken together, they provide compelling evidence that 'health for all' is possible – not by focusing on disease-specific initiatives, but rather by emphasizing systems, power and the imperative to address the underlying and structural causes of health inequity. The renewed interest in PHC/health for all (with ideas such as equity, social justice, participation, intersectoral approaches and social determinants of health) spans the WHO, the CSDH, the People's Health Movement, professional associations and academia. It is expressed in resolutions, statements, conferences, publications and special issues of journals dedicated to PHC, and made explicit in global research initiatives. Yet different agents may still think of PHC differently. There is indeed a wide spectrum of perspectives on PHC and of key principles such as community participation. Is participation understood primarily as a means to an end (to efficiency and effectiveness) or is it also acknowledged as an end in itself (empowerment) and as a premise for sustainability and equity? Clearly, the complexity of poverty, environment and health issues demands sustained political commitment and a long-term strategy. Even when formal democratic institutions exist, the timeframe within which action must be planned and implemented is far longer than the electoral cycles in which governments typically are politically able to respond. This implies a need for ways to institutionalize and sustain long-term participation on the part of civil society. That is important because the key question now is: who is to do what and how? How can we ensure that the renewed interest in a comprehensive approach to health doesn't die a silent death as it did three decades ago?

Who must act?

The agents on whom this comprehensive approach ultimately depends are governments, multilateral institutions and the new private fund donors. The Gates Foundation has been criticized for its strongly biomedical and technology-focused orientation. Thus, its influence does not necessarily bode well for the future of policies to reduce inequities by addressing social determinants of health. Yet it is possible, though not easy, to envision PPPs organized around reducing inequities in access to key social determinants of health. For example, by making funds available for participatory design and implementation of coordinated interventions in health care, income support, housing and provision of water and sanitation infrastructure, with scientific review and performance reporting requirements broadly analogous to those now attached to grants administered by the Global Fund.

As for governments, at the national level it is important to reverse the trend of privatization and corporatization of

Health and urbanization

As of 2009, half of the world's population is urban, and the locus of poverty has shifted toward urban areas.

Throughout history, cities have provided new opportunities for income growth, improved living conditions and health development. However, current urbanization differs from that of the now-industrialized countries in the late 19th and 20th centuries in that the speed of change is unprecedented. At the end of the 19th century, less than 3% of the world's population was living in towns and cities, and Africa and Asia were still almost wholly rural as late as 1950. The pace of urbanization over the past 20 years has been especially rapid in less developed regions, and this trend is expected to continue. Over the next two decades, cities in developing countries will account for 95% of all urban growth worldwide; by 2030, they will be home to almost 4 billion people.

However, urban services and infrastructure development have not kept pace with urban population growth. According to recent projections, the populations living in informal settlements in low- and middle-income countries, currently one billion people, is likely to double in less than 30 years. In Africa, the growth rate of the urban population is twice the global average, and comparable with that of towns in 19th century Europe. From the role that public health and progressive social movements played in that period of history in improving health and reducing inequities, important historic lessons can be drawn. The role of public investment in services was crucial in ensuring clean water, adequate sanitation and improved housing, but progressive public health policy only became possible in a context where people had the ability to demand their rights (through the expansion of the franchise). Thus, the renewal of interest in research by communities and civil society on the structural (social, economic, cultural, environmental, political) determinants and conditions of daily life that are responsible for a major part of health inequities is especially relevant.

From health research to research for health

- **The Global Forum for Health Research** was established in 1998. Its main aim is to promote more health research that focuses on the needs of low- and middle-income countries. The forum analyzes the flow of resources for health research at global and national levels; develops tools for policy makers and researchers; and works with partners to set the research agenda for neglected areas. Its annual meeting is the only international forum that specifically addresses health research for development. The most recent meeting, the Global Ministerial Forum on Research for Health (Bamako, Mali, 17-19 November 2008) focused in particular on multisectoral and transdisciplinary research. More information is available at www.globalforumhealth.org.
- **The Council on Health Research for Development (COHRED)** was initiated in 1993 in order to promote essential national health research in all countries, regardless of their status of economic development. COHRED has since broadened its perspective and agenda to facilitate and ensure strengthening national health research systems, so that countries can optimize the use of health research for equity and development. In practice COHRED focuses on the lowest-income countries. For more information see www.cohred.org.
- The initiative to establish the **Netherlands Platform for Global Health Policy and Health Systems Research** was taken after the Mexico Ministerial Summit on Health Research in 2004. The objectives of the research programme are to contribute to better health through strengthening health systems in low-income countries (LICs); strengthen research capacity in LICs; and strengthen collaboration within the Dutch research and knowledge community. A first call for proposals will be issued in 2009. More information is available at www.globalhealthplatform.nl/.

public services essential for health, such as water supply, sanitation, waste collection and social services – a trend that tends to exclude the poor and deepen inequalities even when the services remain nominally under government control. More fundamentally, as the CSDH report emphasizes, 'implementation of the Commission's recommendations is critically dependent upon changes in the functioning of the global economy'. This point was emphasized by the WHO's Director-General Margaret Chan in a speech to the UN General Assembly in October 2008. If the WHO is to be relevant to the commission's perspective and is to be an effective advocate for such changes, it will need to reinvent itself and adopt a transdisciplinary orientation. Its personnel are mainly physicians and other health professionals with a strongly biomedical orientation. The WHO will need not only to add social scientific expertise to its staff, but also to engage strongly with international economic organisations such as the IMF, the World Bank and the WTO, and with other UN system agencies that have considerably greater expertise in the social sciences and development policy. It will also need to help build coalitions to mobilize additional resources for new kinds of operations and to secure the changes in the global economic system and global governance which are essential to achieving global health equity and health for all.

Seizing global change

The renewed interest in Alma Ata in 2008 has emerged in a context of unprecedented global change and challenges, including the worldwide financial crisis, climate change, food insecurity, long-term and emerging conflicts, rapid and uncontrolled urbanization and increasing migration. Most, if not all, of these challenges will be felt first and worst by socially and economically marginalized populations, especially in low- and middle-income countries. But the effects can quickly spread into the industrialized world – for example, in the form of increased flows of migrants who occupy (often literally) the interstices between the towers where the rich and powerful live and work. This interconnectedness has important implications for health and development, and for their relation to the urgent need for global economic reform. The civil society voice represented in the GHW report is eager for clear action. It outlines an alternative model of economic development and the changes needed at the global level – including genuine democratic reform of global economic governance. ■

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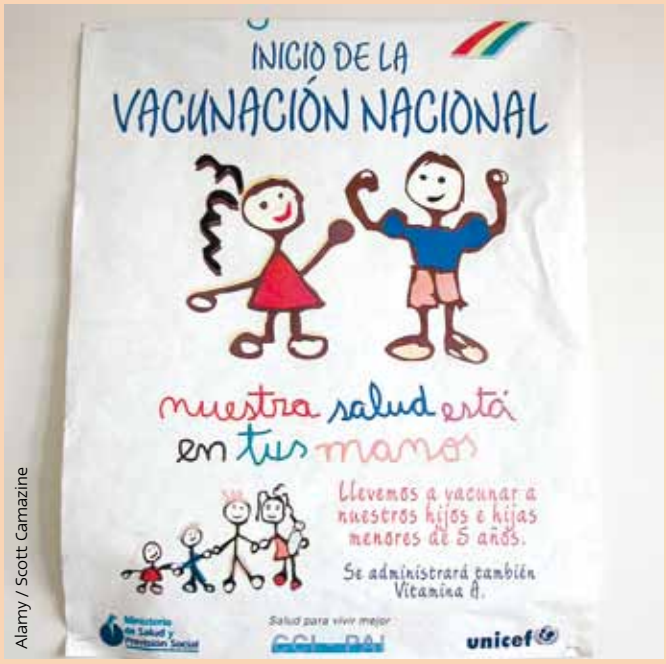
Readers are encouraged to join the debate on the future of health care. Read or add comments on this special report at www.thebrokeronline.eu. A longer version of this article, with notes and references, can also be found on the website.



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