Editorial

PROGRESS TOWARD "HEALTH FOR ALL BY THE YEAR 2000"[1]

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The goal of "Health for All" is not merely a health sector objective; it is a fundamental symbol of mankind's determination to close the poverty gap that divides nations and peoples throughout the world.

Each passing day demonstrates with greater clarity that "Health for All by the Year 2000" is an essential part of the global struggle for development, peace, and justice.

The philosopher Spinoza wrote centuries ago that "peace is not an absence of war, it is... a disposition for...justice." For countless millions around the globe, justice remains a dream deferred—and so too is peace deferred.

In proclaiming the Third Development Decade and adopting the International Development Strategy for the 1980s, the United Nations General Assembly called for renewed commitment to that struggle for justice and for peace; and it incorporated within that development strategy, as an essential component, the achievement of "Health for All." By so doing, the United Nations reaffirmed the World Health Assembly definition of "Health for All by the Year 2000" as access to that level of health that would enable all people of the world to lead socially and economically productive lives.

"Health for All," Equality, and Development

"Health for All" is not a goal of the health sector alone, nor can it be achieved by the health sector alone. It is part of the fabric of socioeconomic development. For that reason, this goal is a fundamental symbol of mankind's determination to close the poverty gap that divides nations and peoples throughout the world.

One hundred years ago an American economist, Henry George, wrote, "So long as all the increased wealth which modern progress brings goes but to build up great fortunes, to increase luxury and make sharper the contrast between the House of Have and the House of Want, progress is not real and cannot be permanent." Today there is a growing awareness that the gap between the House of Have and the House of Want is threatening not only the progress of all but the peace of all as well. That recognition is reflected not only in adoption of the International Development Strategy, but in the New International Economic Order as well. It is also at the core of north-south dialogue and was the motive force behind the Cancún meeting.

[1] From an address delivered at the Meeting of Health Experts of the Non-Aligned Countries on Health for All by the Year 2000 held in Havana, Cuba, on 15-18 March 1982.

A renewed effort to end inequalities between nations and within nations is thus the dominant task before the nations of the world during these next two decades. The Thirty-third World Health Assembly (Geneva, Switzerland, 5-23 May 1980) recognized this and emphasized that "health is a powerful lever for socioeconomic development and for peace." It is also worth recalling that the global commitment to "Health for All" occurred four years ago at Alma Ata because of the recognition that four-fifths of the world's population—despite nearly a quarter-century of development efforts—remained without access to health care and that existing health services could not be extended to cover the population at any affordable price.

As WHO Director-General Halfdan Mahler noted, the conclusions were clear:

- Too few resources were being invested in the health sector.
- Those national resources being expended for health were channeled in large part to the more affluent sectors of the population.
- Many health professionals from the poor countries were being drawn to developed nations.
- The vast majority of men and women had little or no control over their own health care.

Regional and Global Strategies

From those conclusions, the Alma-Ata conference determined that the key strategy to achieve "Health for All" must be to provide primary health care. (It is fitting to note that the Regional Committee of the Americas approved regional strategies for the achievement of "Health for All" in 1980, and that these became our contribution to the design of the global strategies.)

In September 1981 the Member Governments of the Pan American Health Organization passed another hurdle when they approved the Regional Plan of Action translating the regional strategies into a detailed blueprint for action within the Americas. That plan has become part of the global strategy of Health for All approved by the Thirty-fifth World Health Assembly last May.

We are convinced, as professionals, that the goals adopted by the Member Governments are essential to achieve adequate health conditions. Yet we also are convinced that if we rely on the health sector alone, we will fall short of our objectives. Only integral development—coherent, comprehensive, and balanced to assure economic and social progress—is capable of carrying us forward to these goals. Furthermore, all of our people, both the haves and the have-nots, must be part of that process.

The challenge is to expand the circle of development to encompass those marginal groups that were excluded in the past. A few years ago, slum dwellers in a capital city of the Americas petitioned their Congress to permit them to remain in shanties they had built on vacant land. Their petition read, "It's not the slums that are marginal. It's the people; it's us. We are on the margin of health, the margin of education, the margin of work. We cry to the four winds that we do not want to be marginal. . . ." Let us offer those people born into marginal lives of despair and misery the opportunity to enter the circle of development.

To reach these priority groups—and particularly the children, women of child-bearing age, the elderly, and the disabled within them—fundamental changes in national priorities must occur. Those changes depend on comprehensive social and economic development; and this in turn requires that those at the decision-making levels of the national economy recognize that their actions directly influence and affect the health and well-being of their people. We know now that economic growth alone is inadequate. Social development must be an equal concern in our development strategies.

The Plan of Action for the Americas requires that health system resources shift to reflect the new concerns of "Health for All." The engine to propel that shift is the primary health care strategy designed to extend coverage to those without access, strengthen the linkages between health and other sectors, increase community participation, expand regional and interregional cooperation, and develop research, technology, and human resources that will support the primary health care focus. These are the key concepts of the primary health care approach, concepts directed at fulfilling the three critical objectives of the Plan of Action, objectives whose deeper purpose is to contribute to the reduction of social and economic inequality through a basic reordering of national priorities. These principal objectives are as follows:

1) Our health service systems must be restructured and expanded to become more equitable, more efficient, and more effective.
2) The implications of economic policies and projects for the health of people must be understood, and linkages between health and other sectors must be promoted and improved.
3) Regional and interregional cooperation, both north-south and east-west, must be promoted and expanded.

Health Service Modification

To fulfill the first principal objective, the health sector itself must develop fundamentally new approaches to its own management and operations. It must develop and apply appropriate technology; and it must maximize its own productivity through adequate planning, improved administration, and better coordination with the social security system and the private sector.

Only by organizing health services according to increasing levels of complexity and making them accessible to all can the objectives of equity, efficiency, and effectiveness be fulfilled. The same need to strengthen the health infrastructure requires development of a diverse range of human resources with a massive increase in the training and use of paraprofessionals and a targeting of research on new priorities.

In addition, at every step of the way we must include full community participation, so as to ensure that our services are relevant to community needs, that they are properly used, and that they are understood by the community. Community participation also affords an important way of meeting the financial requirements of "Health for All," and it is the most effective cost-benefit tool we have for accomplishing our objective of meeting the health needs of all our people. Nevertheless, the human resources involved must be mobilized before they can achieve their potential as a fundamental component of each nation's contribution to "Health for All."

Intersectoral Development

The second principal objective of intersectoral development reaches out beyond the health sector to touch every aspect of the socioeconomic development process. Health sector authorities understand full well that literacy and education, decent housing, and increased food production are directly related to health conditions. That is, the health of individuals is part of the human capital of development, a fact that should be recognized in all sectors. Therefore, intersectoral development is not a fanciful desire but an absolute necessity. The goals and objectives of the Plan of Action must be known, understood, and shared by national planning agencies and by the ministries of finance, agriculture, and industry. For without the health sector's full participation in the pro-

cess of socioeconomic development, without health being bound into the national development process, the plan of action will be crippled and the process of development weakened.

Regional and Interregional Cooperation

The third principal objective of expanding regional and interregional cooperation seeks to promote external support as a supplement and complement to national programs. In this regard, the destiny of each nation, as well as final responsibility for implementing the Plan of Action, rests mainly in each nation's own hands. To each nation also falls the task of determining how best to reorganize its health infrastructure and reallocate resources. That being the case, each nation must come to realize that its own decisions ultimately will determine whether the goals of "Health for All" will be achieved. For in the future, as in the past, external cooperation is likely to account for a relatively small part of the total resources dedicated to the development process.

Nevertheless, there are specific problems whose most efficient solution depends on joint action by various countries. In this vein, the Plan pinpoints ways in which bilateral, subregional, and regional approaches—each emphasizing technical cooperation among developing nations—can join in providing enduring solutions to those problems.

The Region of the Americas is proud to have been designated as the global focal point for WHO in promoting Technical Cooperation among Developing Countries (TCDC). It is clear that we have barely scratched the surface of the vast potential for cooperation among ourselves. Yet the experiences of the past few years have already confirmed the inestimable value of this contribution to international development.

One of our most vital needs is the preparation and training of the human resources needed to achieve extension of primary health care. In the Caribbean, PAHO is working with countries in a program to prepare health auxiliaries and paraprofessionals. Five training centers are preparing teachers, who then return to their own countries to continue the process needed to produce the required numbers of auxiliaries and paraprofessionals. A similar program now underway is designed to prepare water system managers for the Caribbean Area.

In other WHO regions as well, TCDC directed at human resources development has already begun. In the Southeast Asia Region, for example, a program to train national malaria experts is in progress; and in Africa the regional office is coordinating training information and compiling up-to-date lists of national health experts that will be available for use by neighboring countries.

Perhaps one of the most important new areas of TCDC relates to the global concern with environmental protection. Increasingly, developing nations are determined to avoid the ecological destruction that accompanied so much of the industrial growth in the developed world. The Pan American Center for Human Ecology and Health (ECO) and the Brazilian State Company for Environmental Health Technology (CETESB) both provide technical cooperation to nations for environmental protection within the spirit of TCDC.

Our own regional library, BIREME, has attempted to give all countries in the Americas access to available and appropriate technology and is working to strengthen the existing national centers of biomedical information. A similar information service dealing with environmental engineering has been developed at the Pan American Center for

Sanitary Engineering and Environmental Sciences. This service has provided assistance to more than 10,000 users in recent years.

In every Region of the world, TCDC in pharmaceuticals is a matter of both deep interest and active intercountry participation. In the African Region, a series of bilateral agreements between developing countries have produced cooperation to control the quality of pharmaceuticals, as well as general cooperation in disease surveillance and control activities. Here in the Americas, the Revolving Fund of the Expanded Program of Immunization provides a practical example of intercountry cooperation, while the program itself depends on intercountry development of techniques and cooperation. Also in the Americas, three countries have carried out joint investigations into Chagas' disease and leishmaniasis, exchanging both advisers and fellowships.

But we are just beginning. Around the world, the potential for expanding TCDC is virtually unlimited and the potential benefits are immense. Moreover, as the Conference of African Government Experts on Technical Cooperation has noted, the most important requisite for promoting TCDC is political will and resolve. With political leadership supporting TCDC, I am convinced that WHO, in conjunction with its Member Governments, could expand TCDC significantly and, by so doing, speed the pace of development.

Gabriel García Márquez wrote in *One Hundred Years of Solitude* that "races condemned to one hundred years of solitude do not have a second opportunity on earth." We, in the developing world, have been condemned to one hundred years of solitude. We have this single opportunity to think, to speak, and to act in pursuit of justice and in pursuit of peace. Our own efforts and our own priorities will outweigh all other factors in determining whether we attain our goal of Health for All by the Year 2000, whether we achieve comprehensive social and economic development, and whether we close the gap between the House of Have and the House of Want. This is our opportunity; let us use it well.