WHO – a way to go?

The conference was co-hosted by the Government of Brazil and the World Health Organization (WHO).

We will first discuss the historical record of WHO in leading transformational change in the global health sector, then the reasons for the host nation's enthusiasm for this agenda.

The World Health Organisation has been struggling with progressing the agenda of health equity and the social determinants of health for some time, despite the strong grounding these issues have in its 1946 constitution.

The WHO constitution has a rights and equity focus:

> *The enjoyment of the highest attainable standard of health is one of the fundamental rights of* ***every human*** *being without distinction of race, religion, and political belief, economic or social condition.*[1]

WHO also sees its function as coordinating a multisectoral approach:

[1] *WHO Constitution,* World Health Organization, 1946.

> *to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene.*[2]

However there has been patchy progress in shifting these sentiments into the mainstream of the globe's health and health system thinking.

A breakthrough was the WHO's Alma-Ata conference in 1978. Halfdan Mahler, the DG at the time, later recalled:

> *Alma-Ata was, in my biased opinion, one of the rare occasions where a sublime consensus between the haves and the have-nots in local and global health emerged in the spirit of a famous definition of consensus: "I am not trying to convince my adversaries that they are wrong, quite to the contrary, I am trying to unite with them, but at a higher level of insight."*

PAHO/WHO

Dr Halfdan Mahler, WHO Director-General at the time of the 1978 conference on primary health care, sits at the podium of the Lenin Convention Center with US Senator Edward Kennedy at his side. (had bad hair back then too.)

Unfortunately the hard-won consensus was undermined within a year, when comprehensive approaches to health problems were undermined by 'selective' primary health care, championed by UNICEF at the time. This effectively marginalized the social and political element of the Alma-Ata declaration and replaced it with an increased focus on discrete

[2] *Article 2, WHO Constitution,* World Health Organization,1946.

technical interventions.[3] Although the declaration remained important as an ideal, in practice health equity was increasingly left out in the cold for the next two decades. When I first went to WHO in 2000, there was one depressed Spaniard in a back office who was responsible for primary health care, and no one in the organization would talk to him, especially the department concerned with healthy systems.

It is therefore no surprise that health equity and the SDH are such hard agenda items for WHO in 2011. Let us look at the reasons why.

Firstly, WHO has increasingly become a bit-player in global health, and is struggling to maintain its role as the global coordinator of health development and normative policy making. The decision by governments over the last two decades to create alternative global health policy and funding mechanisms (eg, UNAIDs, GAVI, Global Fund), alongside the rise of large philanthropies (eg, Gates, Bloomfield) has considerably diminished WHO's role.

Secondly, the WHO has a process to ensure global consensus among its 195 states and this can mitigate against the emergence of transformative ideas. Ground-breaking work therefore tends to be done outside the WHO institutional process. The Alma-Ata declaration was transformative, and the leadership of both Mahler and New Zealand's Ken Newell[4] was crucial in ensuring a progressive statement was presented before the world's health leaders. Similarly, the Ottawa charter in 1986 arose largely outside the WHO institutional processes.

But today things are organizationally much tighter. Agreements and statements emerging from WHO conferences are very tightly managed, the script monitored and agreed in advance by permanent officials of the world's most powerful nations (developing nations don't have the resources to do this despite being entitled to). Agreement is reached in Geneva, largely by career diplomats with little health expertise, in advance of any meeting or conference. So the idea that the world's public health great and good are coming together to advance global thinking and understanding is definitely not reflected in the official outcome statement of the meeting.

The third problem facing WHO is its inability to transform itself. It has not been able to significantly shift its focus from communicable disease to non communicable disease, despite the changing global disease burden, and it has not effectively embraced the social,

[3] Baum F, Sanders D. Can health promotion and primary health care achieve Health for All without a return to their more radical agenda? *Health Promotion International*, January 1, 1995;10(2):149-60.
[4] Consensus during the Cold War: back to Alma-Ata, *Bulletin of the World Health Organization*, 2008. http://www.who.int/bulletin/volumes/86/10/08-031008/en/index.html

political and intersectoral agenda required for health for all. This makes its leadership on the global stage in these areas somewhat hollow.

Nancy's summary of the meeting describes how these tensions (between the conference participants and their insights versus the organization's official position), are emerging. They can be seen reflected in the two approaches we are seeing in the SDH and health equity debate more generally.

The official view is health equity is good for us all, rich and poor, and let's all work together to achieve it. The alternative view is that health inequities are the result of the powerful playing the game to their advantage – and their power needs to be exposed and moderated. This latter view is unlikely to be articulated by the powerful in a WHO statement.

The two views differ on whether we are all in this boat together or we are all being sunk by the heavyweights at one end.

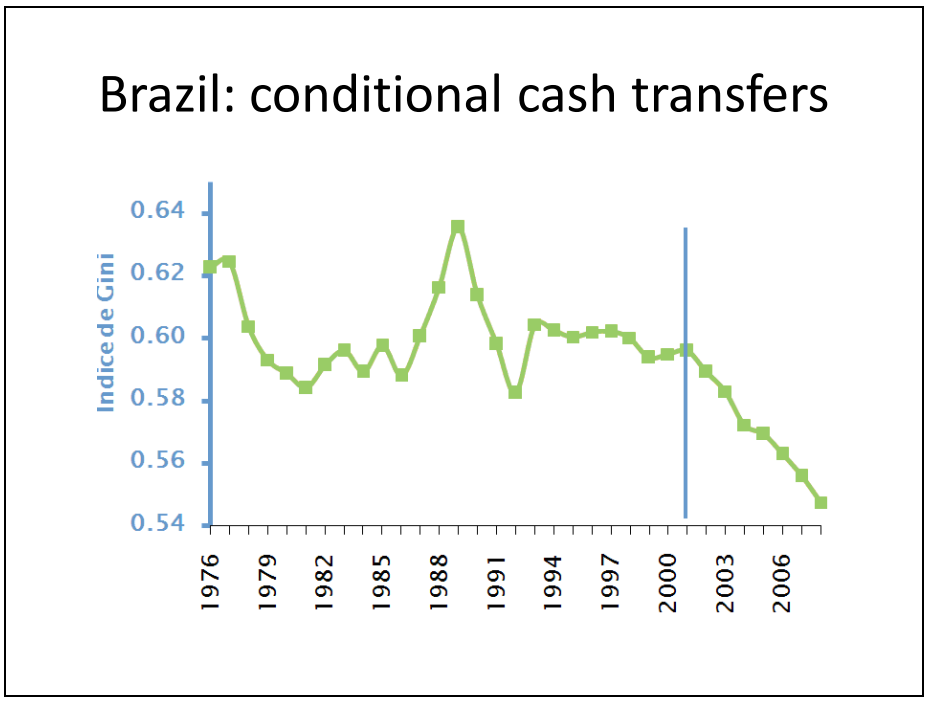
However, whether or not WHO as an organization takes up these 'big ideas' for health development, parts of the world are listening. Primary health care and the agreements at Alma-Ata did find resonance, particularly in Africa and South America. It is from these quarters that health equity has found its way back onto the global agenda. Similarly, the Ottawa charter did inspire health promotion, particularly in Australasia, Canada, and parts of Europe.

BRICS[5] – building a new world

Brazil

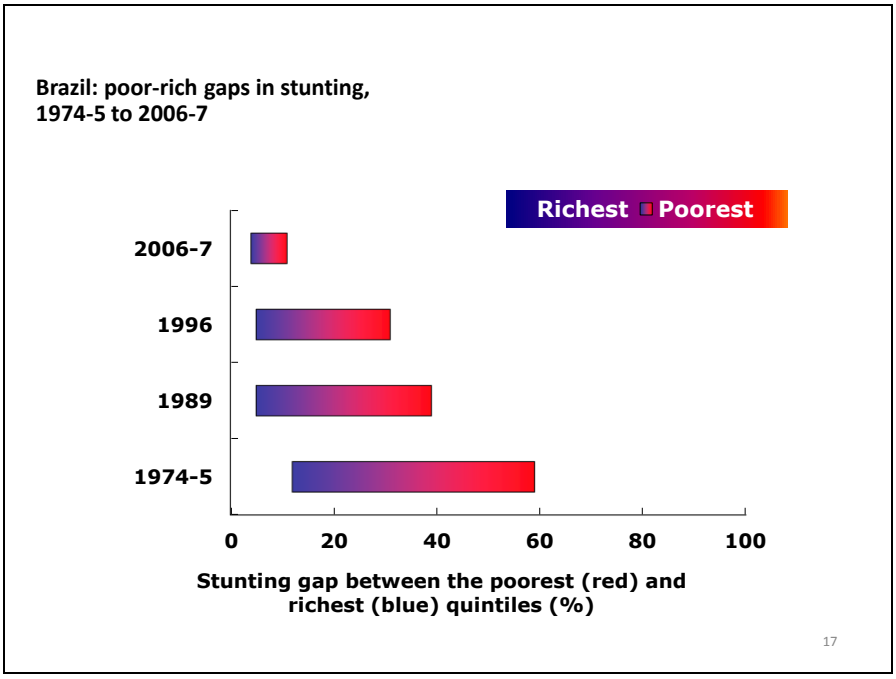
The other important aspect of the meeting was the role of the host country Brazil[6] and the story it was keen to tell on how it is addressing health inequity.

[5] BRICS: Brazil, Russia, India, China and South Africa
[6] Santos L et al. The Brazilian experience with conditional cash transfers: A successful way to reduce inequity and to improve health. 2011.
http://www.who.int/sdhconference/resources/draft_background_paper1_brazil.pdf



Brazil has the dubious distinction of being one of the world's most unequal societies. Over the last decade this has begun to change significantly, with the Gini Index dropping from .60 to .54 – still large inequalities (NZ's Gini is .36) but impressive progress over a short time. Central to this has been the *Bolsa Familia Program*. This transfers cash to poor families on the condition that they make investments in human capital, such as sending children to school regularly and taking children to regular health and nutrition checkups. Up to a quarter of the Gini change has been attributed to this program alone.

The impact of this on the inequalities in children's access to nutrition is equally impressive, with a huge reduction in the inequalities in stunting between rich and poor populations.



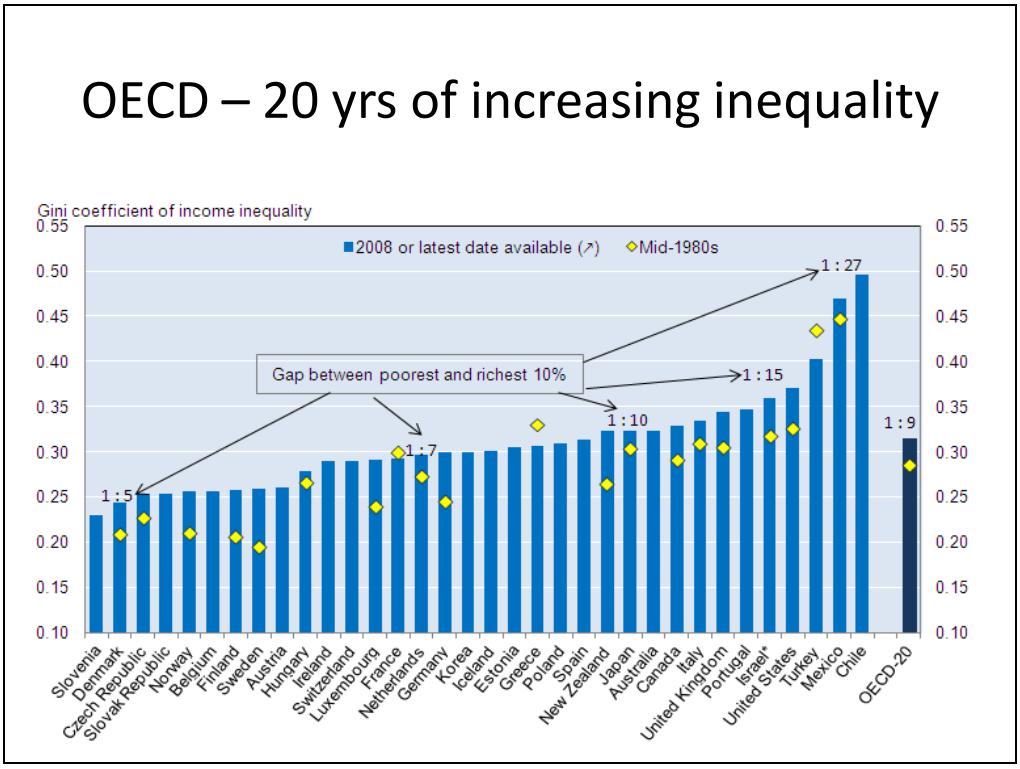
One element that has been important in bringing about this change is the establishment in the 1988 constitution of access to health and education services as a basic right of all citizens. Another is the dynamic leadership of President Lula who, having promised to eradicate hunger and fighting, conferred high priority to a zero hunger strategy. The effective use of regulatory powers has also been effective in ensuring implementation.

Other BRICS countries

Large scale state-led interventions to address inequities are not just confined to Brazil. In India, the Rural Health Mission has increased funding for rural primary health care by 200% over four years, and the funding is now $US3.5b annually. Similarly in China, rural PHC is now a major government investment.

Not so developed after all?

This renewed emphasis on addressing inequity seen in the BRICS countries is not however mirrored in the 'developed' world. A recent report by the OECD notes that income inequality has been rising for all but 3 of 35 countries.



On the positive side, the report is evidence that the issue of inequity is now on the agenda for groups such as the OECD,[7] who previously believed that growing GDP was all a country really needed to worry about:

> *The economic crisis has added urgency to the debate. The social contract is starting to unravel. Youths who see no future for themselves feel increasingly disenfranchised. They have now been joined by protesters who believe that they are bearing the brunt of a crisis for which they have no responsibility while people on high incomes appear to have been spared.*

We have been through a period where having global and national systems solely designed around values such as 'greed is good' and the 'efficient market hypothesis' is seriously being questioned. The importance of governance is now being given greater prominence. Current global arrangements are clearly failing to achieve complex social and environmental outcomes (despite the persistence of these now dead ideas or

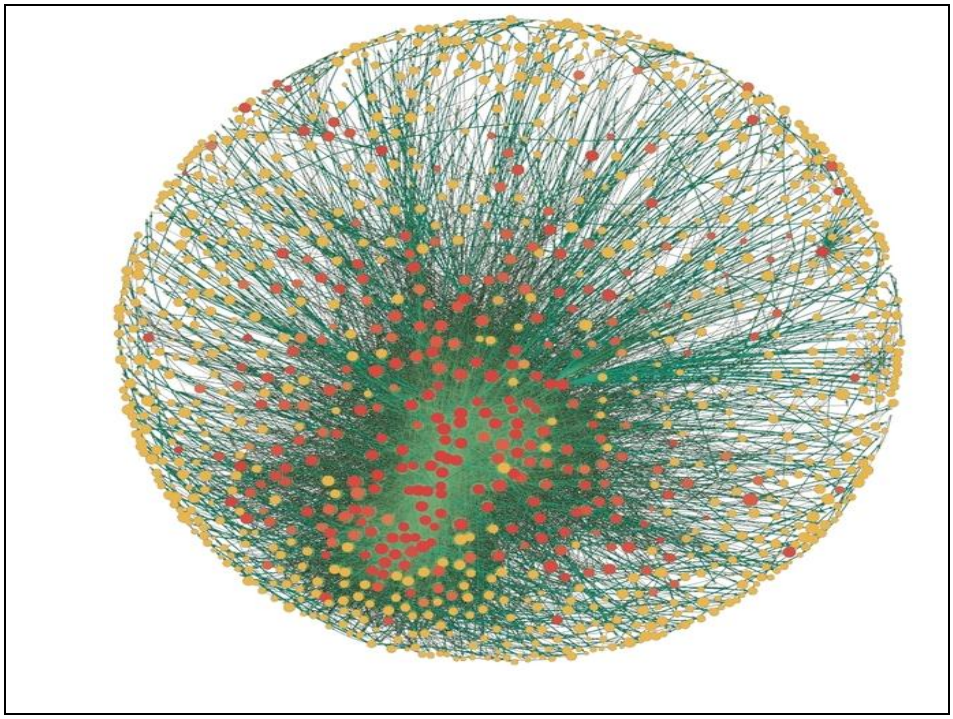
[7] *Divided We Stand: Why Inequality Keeps Rising*. OECD, 2011. Available from: http://www.oecd.org/document/51/0,3746,en_2649_33933_49147827_1_1_1_1,00.html

zombie economics as they have been aptly named[8] in many quarters). People are realising that governance is important – whether in relation to the social sector or, more recently, the governance of national and international banking and financing institutions themselves.

What the new approach to global governance looks like will need to be informed by previous governance attempts, as well as the nature of global power in 21st century. We have been through a period where the best governance of markets was seen as no governance. Before that, the creation of Bretton Woods institutions were instruments of global governance. As a starting point, this new attempt needs to engage with and at the same time change the nature of existing systems of global power.

[8] Quiggin J. *Zombie Economics*: *How Dead Ideas Still Walk Among Us*. Princeton University Press, 2011.

A recent study by Vitali[9] and others examined the networks that control transnational companies (TNCs).



The ownership networks of TNCs

They found that the control of 40% of the economic value of TNCs is held, via a complicated web of ownership relationships, by a group of 147 TNCs. These core members are represented in red on the system map above. The intensity of control by a small number of actors was ten times greater than their wealth suggests.

The top holders within the core can thus be thought of as an economic 'super-entity' in the global network of corporations. Three quarters of the core are financial intermediaries – the very institutions at the heart of the global financial crisis. Core members are the main beneficiaries of the state funded rescue 'packages' whose leadership and reward structures are rightly now being questioned.

[9] Vitali S, Glattfelder J, Battiston, S, 2011. The network of global corporate control. ETH - Chair of Systems Design - Glattfelder, James B. [Internet]. [cited 2012 Feb 25]. Available from http://www.sg.ethz.ch/people/formercoll/jglattfelder

What is interesting about the core is not only its tight concentration of power (what hope have free markets against this?) but the almost invisible nature of its institutions and processes and its apparent disconnection from formal mechanisms of global governance.

The challenge for the next iteration of global governance is the need to develop ways of ensuring that the direction of this super-entity does not continue to threaten society's social and environmental goals.

Emerging movements for equity

The Commission on the Social Determinants of Health (CSDH) and the recent Rio conference can be seen as evidence of a growing global movement to address health equity, which now has also caught the interest of establishment players such as the OECD.

However, this renewed interest owes much to the grassroots movements such as Occupy.[10] The Occupy movement has named the source of the crises of our time:

> *Wall Street banks, big corporations, and others among the 1% are claiming the world's wealth for themselves at the expense of the 99% and having their way with our governments.*[11]

Occupy has helped define one stream of the egalitarian movement which is confrontational[12] in nature, as opposed to politically acceptable, evidence-based egalitarianism such as that of the WHO Rio Declaration.

These streams are not necessarily convergent because the occupiers generally see the constitutional protection of governments from corporate influence as a prerequisite to further trust in government.

[10] Occupy George. 2011. www.occupygeorge.com
[11] Van Gelder S,(ed) 2011, *This changes everything Occupy wall St and the 99% movement*, San Francisco, Berrett-Loehler, 2011. Go to Yes magazine to see an excerpt.
[12]The 99 Percent Working Group. (2011). The 99% declaration, from www.the99declaration.org/

Within New Zealand, there are also the stirrings of a more populist focus on a fairer society. The leadership of the New Zealand Council of Christian Social Services has made an unequivocal stand on this issue:[13]

KETE KUPU

WORD BASKET ISSUE 19 NOV 2011

New Zealand Council Of Christian Social Services

Church Leaders Call for Shared Responsibility Toward a Fair Society

All political parties need to acknowledge their shared responsibility to provide a just share of society's wealth and resources for all its citizens - especially the most vulnerable. In a joint statement, released 30th October, church leaders say this provision includes adequate income for everyone, fair taxation policies and access to good health care, affordable housing, and the ability to live sustainably.

Although acknowledging that the best development is that in which people face their issues and find solutions,

Church leaders and advisors 2011: (left to right) Rev. Anthony Dancer, Most Rev. David Moxon, Rev. Charles Waldegrave, Most Rev. John Dew, Rt Rev. Peter Cheyne, Commissioner Donald Bell, Katherine Noble, Pastor Rodney Macann (seated) Betsan Martin, Trevor McGlinchey

Earlier this year we have also seen a plucky teenager's efforts catapulted into the national limelight:[14]

Teen becomes leader in child poverty fight

She used to live in a state house -a house that was so damp and cold she developed respiratory problems.
"Some of my friends went to school hungry," Jazmine says.
"I can relate when children say how they live – in my heart I understand."

LAWRENCE SMITH/Fairfax NZ

[13] *Kete Kupu*, issue 19 November 2011. www.nzccss.org.nz/
[14] Support Jazmine Heka's campaign on: http://dl.dropbox.com/u/52374050/Children%20Against%20Poverty%20-%20Petition%20.pdf

We are witnessing the re-awakening of public interest in equity. It is becoming once again a mainstream issue.

The agreement of the new government to hold a Ministerial Committee on poverty is further evidence of this shift. This is a quote from the speech from the throne, 2011 [emphasis added]:

> *As agreed with the Maori Party, a Ministerial committee on poverty will be established to improve the co-ordination of government activity in alleviating* ***the effects*** *of poverty.*[15]

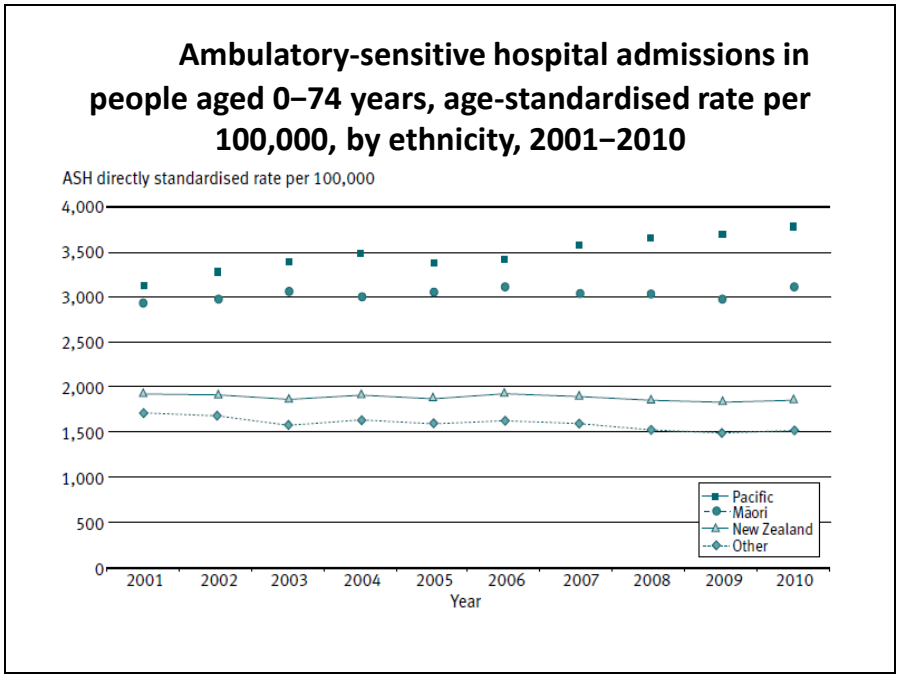
Years of work by child health advocates has finally reached the political agenda and public consciousness. However, the framing of the issue will be the next focus. The Ministerial committee is implicitly accepting a 'the poor are always with us' framework with its focus on the effects of poverty, rather than directly asking the question of why these children are poor in the first place.

The Maori Party's last major initiative of using select committee inquiries to examine public health issues was exemplary because they focused the inquiry on the actions of tobacco companies, rather than the effects of smoking. A similar approach will be required to address the causes of child poverty – to look at its causes rather than just moderating its effects.

[15] Matepare, the Rt Hon Sir J. Speech from the Throne, 21 December 2011. http://www.beehive.govt.nz/speech/speech-throne-1 Accessed 29 February 2012.

The equity debate within health services themselves also needs re-invigorating. The focus has fallen away from addressing equity as targets have been narrowed to achieve simplistic political goals.[16]

An examination of one of these narrowed targets, ambulatory sensitive hospitalisations, shows that the primary health care system is still failing to make progress on addressing equity. There are flat or growing disparities in the ability of the system to address health conditions before they require hospitalisation. Keeping people out of hospital is a goal that stacks up on economic grounds let alone on fairness considerations



What then for the future?

Collective puzzling

There is a need to create space for collective puzzling over the complex issues that we face. Policy, that process where one identifies society's problems to seek out approaches and solutions, has become devalued in the last few years. Institutions that used to provide this function (such as the National Health Committee) have had their terms of reference

[16] Matheson D, and Loring B., 2011. Hitting the target and missing the point. *New Zealand Doctor*, 29 June 11.

truncated. Government instructions such as targets, that allowed room for local contextualized responses, have been narrowed so the health response is increasingly micromanaged from the centre.

I recently witnessed a process that has developed in Thailand where health issues of the day such as disasters, illicit advertising and food policy (well beyond our narrow focus on hospital waiting lists) are identified at the community level. They are discussed and solutions are developed, incorporating expert advice, though a regional and national assembly. They are then presented to the Prime Minister and Cabinet.[17]

Such a process creates a space for all players, (including the private sector and academics) to share views and understandings and forge a consensus approach to topical issues. The absence of such a forum in the current NZ context is of major concern. Firstly, it really limits our ability to grasp and act on the difficult issues we face such as obesity. Conversations with the 'industry' are never conducted within hearing of researchers (and vice versa) which limits new understandings and approaches emerging from either side.

Secondly, the expression of societal values needs to dominate system behavior. We need to move beyond GDP as a societal goal,[18] and explore ways that core societal values (including health equity and environmental sustainability) pervade our institutions and structures, private and public, local and global.

The changes we need

In conclusion, we have used the Rio meeting to highlight wider issues. WHO is slow to respond to the change processes required:

- the transition from seeing health as a technical intervention to a partnership approach with people to achieve social justice (Alma-Ata)
- the need to focus on NCDs in addition to communicable diseases, following the changing global disease pattern
- the need to focus on health in addition to health services – tackling the social determinants of health.

[17] Innovation and participation for healthy public policy: the first National Health Assembly in Thailand. Rasanathan K et al. http://www.ncbi.nlm.nih.gov/pubmed/21281413

[18] For discussion on moving beyond GDP see: Commission on the measurement of economic performance and social progress. http://www.stiglitz-sen-fitoussi.fr/en/index.htm

WHO is no longer built for purpose. However, despite this, it does successfully launch these ideas into global consciousness, as evidenced by the resurgence of interest in primary health care.

Following the leaders

I have also highlighted where pProfound pro-equity actions are happening. There are outstanding examples of actions being taken by countries that are positively impacting on global health equity – especially in Brazil, India and China. Other innovative approaches are also emerging of ways to engage in complex issues – the Thai National Health Assembly being an example.

There is also a hopeful re-emergence of a stronger global movement for equity, including but not focused on health equity; a re-think of GDP; and the Occupy movement. Locally, the NZCCSS and Jazmine campaigns, and the focus of a select committee on child poverty, give us hope for health equity in New Zealand.

We have discussed the disconnect that has occurred between society's values and the institutions of power – and the need for deeply-held societal values to be asserted by actions such as re-setting societal goals on outcomes beyond GDP growth.

Post script:

An up to date report on progress on health equity in the Asia Pacific Region can be found at ***healthgaen****.org*

Acknowledgements;

This presentation was prepared with the assistance of Daniel Matheson and Sarah Maclean.