How did we get here?
A critical analysis of WHO's World Health Reports (1995-2013)

Mudasar Iqbal

Masters in Global Health (2020-22)

Supervisors

Magnus Vollset
Associate Professor, Department of Global Public Health and Primary Care
University of Bergen

Ana Lorena Ruano
Researcher, Centre for International Health
University of Bergen

Centre for International Health

Faculty of Medicine

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This thesis is submitted in partial fulfilment of the requirements for the degree of Master of Philosophy in Global Health at the University of Bergen **(60 ECTS credits).**

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Abstract

This thesis explores the process through which the World Health Organization (WHO) establishes its priorities and how some of the major health issues have been conceptualized in the aftermath of the cold war, the period where our current framework was developed. It does so primarily through analysing the World Health Reports, which were the flagship publications of the organization between 1995 and 2013.

Priorities of global health are shaped by a range of factors, including economic, political, and strategic interests of governments, tangible outcomes desired by funders, and desire for returns on investments in health. Based on systematic document analysis, the thesis uses the health policy triangle as a lens to investigate the context, content, processes, and actors, that together shape global health policies. The analysis was done using the READ approach, which includes content and thematic analysis to identify analytical themes informed by the policy triangle, identification of recurrent patterns and themes, narration of these recurrent themes while consulting existing literature, and finally analysing the findings across the World Health Reports to identify shifts in framing and priorities.

The study found that World Health Reports have remained of significant importance in shaping the global health agenda by highlighting one health issue at a time, while also ensuring certain health concerns remain relevant over time. The WHO's priorities display a combination of continuity and change. The study found that certain health challenges have remained a priority, especially poverty and health system development, due to their relevance for ensuring health for all. On the other hand, the Organization has shifted its focus from regional health issues to health concerns relevant for whole world, affirming its position as a custodian of global health. This shift began in the late 1990s with non-communicable diseases taking priority over infectious diseases. Another change was increased advocacy for integrated healthcare services and emphasizing the importance of investment in sustainable health systems to achieve Universal Health Coverage. The Organization has called on governments for developing financial risk pooling mechanisms to eliminate out-of-pocket health expenditures and ensure equitable access to healthcare for all, a reaction to the ideology that dominated in the decade prior to the first report.

The study contributes to the understating of priority setting process of global health and will help scholars from different disciplines understand how the conceptualizations of health have evolved at a global level.

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Abbreviations

BMGF ------ Bill and Melinda Gates Foundation
CSDH ------ The Commission on Social Determinants of Health
DALYs ----- Disability-adjusted life years
DG ---------- Director General
GMEP ------ The Global Malaria Eradication Program
HICs -------- High income countries
ILO --------- International Labour Organization
IMF--------- International Monetary Fund
LMICs ----- Low- and middle-income countries
MDGs ----- Millennium Development Goals
NCDs ------ Non-communicable Diseases
NGO ------- Non-governmental Organization
OECD ----- Organization for Economic Co-operation and Development
OIHP ------ Office International d'hygiène publique
PAHO ----- The Pan American Health Organization
PHC ------- Primary Health Care
QALYs --- Quality-adjusted life years
SAPs ------ Structural Adjustment Programs
SDGs ----- Sustainable Development Goals
SDOH ---- Social Determinants of Health
UHC ------ Universal Health Coverage
UNICEF --United Nations International Children's Emergency
US -------- United States
USAID --- United States Agency for International Development
WHO ----- World Health Organization
WHR ----- World Health Reports

Acknowledgements

to my mother, Irshad

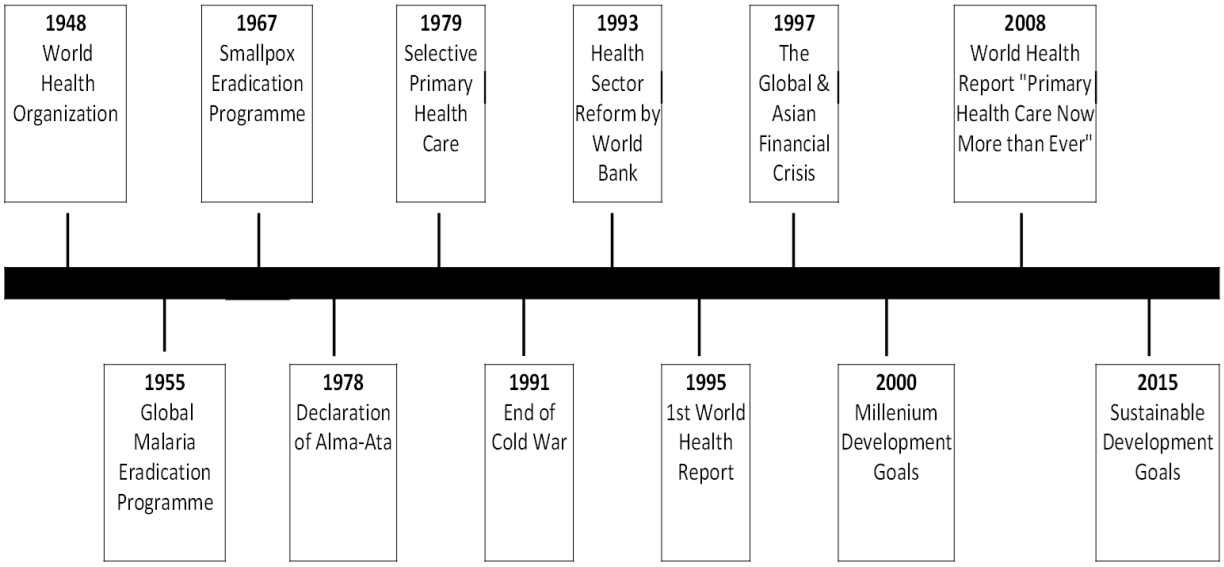
1 Chapter 1: Introduction

The objective of the World Health Organization (WHO) is "the attainment by all peoples of the highest possible level of health" (WHO, 1948). What this entails, the strategies to achieve it, and what to prioritize has changed over time. The impact of health extends beyond just physical and mental well-being, as it plays a significant role in the socio-economic development of individuals and society. It is the responsibility of every state to provide health services that cater to the needs of its population. While national health policies are structured within countries, they are influenced by global organizations, with the WHO serving as the primary organization to identify health needs and priorities of people around the world. Documents that frame and reframe the roles of stakeholders, global actors, and organizations provide valuable insights into how global health agendas evolve over time.

As specialized agency of the United Nations (UN) for health, the WHO was given the mandate to direct and co-ordinate international health work (WHO, 1958). To fulfil the given role, the WHO has been continuously defining the priorities for international health work and advising actions needed to address these priorities. The organization has changed its priorities many times since its existence to meet the health needs of people around the globe. Figure 1 shows the major events in global health along the timeline since the establishment of the WHO. Among these are the publication of the World Health Reports (WHRs). Between 1995 and 2013, the WHO published a total of sixteen WHRs, aimed at providing evidence-based recommendations in setting the agenda of global health.

Out of these sixteen reports, some highlighted health problems and diseases in need of immediate attention, others advocated global financial and strategic cooperation to improve health outcomes, yet others provided an overview of lessons learned from past experiences as well as roadmaps for the future. The WHRs were flagship publications from a time when global initiatives like Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) were being formulated.

Figure 1: Timeline of major events in global health



This thesis focuses on the process through which the WHO establishes its priorities in pursuit of its objective. Through analysing the WHRs, this thesis contributes to the understanding of health at a global level, and how knowledge and recommendations changed during a period when the current SDG agenda was shaped. Specifically, the thesis examines the role of the WHRs, a series of flagship monographs published between 1995 and 2013, in shaping the Organization's agenda.

1.1 Aim of the study

The aim of this study is to show how authoritative global health advice has changed over time, and continue to change, and how some of the major health issues have been conceptualized in a period where our current framework was developed.

1.1.1 Research Questions

1. How does the WHO set its priorities, and what factors play a decisive role in identifying the global health agenda?

2. What have been the rationale for the priorities set and actions recommended by the WHO?
3. How does the WHO convince funders and other stakeholders to engage with health, and particularly with the organization's agenda?

1.2 Justification and Structure

Through analysing the World Heath Reports, I hope to identify major changes in health-oriented global policy advice that have impacted the shifts in health-oriented policies and initiatives that lead to our current SDG agenda. The findings of my thesis would add to the understanding of role played by stakeholders (both national and international), and global political and economic scenarios in shaping our health framework. The complete set of WHRs consist of 2506 pages of condensed text, addressing a wide range of health issues. I have chosen to analyse only a selection of these issues, namely child health, maternal health, health of poor, communicable diseases, non-communicable diseases (NCDs), financial risk, health systems development, and human resource crises in health sector. This choice was made for practical reasons, but also because I believe they provide a good and representative balance between in-depth analysis and width of scope. My ambition is not a summary, but to discuss key changes in the global health landscape, and I believe these themes are best suited to for this purpose.

The thesis is structured in the following way. The thesis consists of 7 chapters, where chapter 2 presents a literature review that explores the historical antecedents of the WHRs, seeking to understand how and why they came about. Chapter 3 outlines theoretical framework, "Health Policy Triangle", that worked as a lens for me to look what goes in for constructing the priorities and policies for global health. The chapter also explains the procedure of my data collection, selection, and analysis. Chapter 4, 5, and 6 constitute the results section originating from the analysis of the WHRs. Chapter 4 delves into the significance of the WHRs in setting the WHO's agenda, shedding light on how decisions are made regarding the prioritization of health needs of particular population groups. Chapter 5 provides answers to the question how the WHO develops a rationale for priorities and suggested actions to address global health issues. Chapter 6 provides insights into the dynamics of developing an accessible and sustainable health system, including fundamental principles and the human resource a health

system needs to achieve the overarching goal of global health, namely Universal Health Coverage (UHC).

Literature Review

2 Chapter 2: Why World Health Reports?

The chapter will outline history of the World Health Organization from its inception in 1948 to the last World Health Report published in 2013, with particular emphasis on how the WHO has conceptualized and operationalized its mandate. Highlighting key events, documents, and debates, the chapter will show how efforts to fulfil the WHO's mandate changed over time and provides a backdrop to the deeper analysis of the selected themes from the WHRs in the following chapters. Emphasizing how the global health landscape changed over time, I will, in this chapter, describe the context in which the monograph series was introduced.

2.1 Establishment of the World Health Organization

After World War II, the United Nations was established as the main intergovernmental organization tasked with maintaining international peace and security, developing international cooperation and being a centre of harmonizing the actions of nations (United Nations, 1945). In February 1946, the Economic and Social Council of the United Nations established a Technical Preparatory Committee of Experts to prepare an agenda for the International Health Conference in New York, to be held from 19 to 22 July 1946. The agenda included the preparation of a constitution for the WHO. On the last day, the Conference approved the WHO Constitution and designated an Interim Commission to carry out essential public health activities until the new organization was established (WHO, 1958). The WHO was formally established in 1948 as a specialized agency of the UN to establish international cooperation for improving the health of people around the globe. The organization's broad mandate includes advocacy for universal healthcare, monitoring public health risks, coordinating responses to health emergencies, and promoting human health and well-being (WHO, 1989). The WHO inherited general framework of the League of Nations Health Organization, established in the immediate aftermaths of the First World War, which had played an important role in the control of epidemic diseases in the 1920s and 1930s through the creation and sharing of epidemiological data, and knowledge of communicable diseases (Howard-Jones, 1978). Alongside, a separate health agency did exist in the Western Hemisphere, the Pan American Health Organization (PAHO) established in 1902, to coordinate health issues of the region

(Basch, 1991). The PAHO maintained its autonomous status even after the establishment of the WHO but was also a regional office of the WHO. This illustrates the WHO as a pragmatic organization, aimed at achieving and maintaining a role as the international body in global public health (Duffy, 1977; Siddiqi, 1995).

2.2 The vertical approach and lessons learned

During the first decades of its establishment, a vertical approach to the delivery of health services remained prominent in the WHO's strategy. The vertical programmes are characterized by having specific, defined objectives usually quantitative and short- or mid-term, and targeting a single or a small group of health problems to be solved through centralized management with discrete means (staff, funds). Vertical approaches can be considered a component of the health system rather than a fully integrated part of it (Cairncross, Periès, & Cutts, 1997). This was a continuation of the League of Nations Health Organization's work providing technical and intellectual support to nations in their fight against specific communicable diseases(Brown, Cueto, & Fee, 2006). The WHO's first large undertaking was two global eradication initiatives. The Global Malaria Eradication Programme (GMEP) in 1955, which ended in 1969 with failure in most of the countries, and the Smallpox Eradication Programme in 1967, which ended in 1980 as a notable success by making the world free of a deadly disease (Fenner, Henderson, Arita, Jezek, & Ladnyi, 1988; Nájera, González-Silva, & Alonso, 2011).

The Global Malaria Eradication Programme was a purely vertical intervention. Rather than integrating into the existing country's health services, the campaign worked as an independent, autonomous entity with its own personnel, without community involvement, and using a standardised manual of operations irrespective of the diverse nature of national health structures (Henderson, 1998). The failure of the malaria programme highlighted the fact that no single strategy can be universally applicable, and led to a call for a long-term commitment with a flexible strategy that included community involvement, integration within health systems, and the development of surveillance systems (Nájera et al., 2011). In the same vein, the success of the Smallpox Eradication Programme was explained by the fact that the programme had built on existing health service structures, continued disease surveillance, and ongoing research which helped to improve the programme strategy from a regional perspective(Henderson, 1998). Later lessons from the smallpox programme have been

incorporated into other disease control programmes such as poliomyelitis, dracunculiasis and Ebola (Henderson, 1998).

2.3 The horizontal approach and lessons learned

The horizontal approach of health services comprises of delivering services to people through publicly financed health systems and are commonly referred to as comprehensive primary care (Msuya, 2004). Primary Health Care (PHC) is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford (Bryant & Richmond, 2017). In the early 1960s, lessons from the failure of the malaria programme and the interest of the United Nations International Children's Emergency Fund (UNICEF) in helping countries develop health services through the technical support of WHO had sowed seeds of change in organization's strategy, the WHO began to shift its focus from vertical programmes to horizontal programmes aimed at strengthening comprehensive health services (Litsios, 2004). The WHO presented a model in 1964 to elaborate the hierarchy of health facilities for developing basic health services (Litsios, 2004). Between 1967 and 1975, the Organization's research focused on organization and strategies for health services, and new programmes were initiated in the WHO to change the Organization's working strategy with governments (Litsios, 1969; Litsios, 2002).

In the 55th session of the Executive Board held in January 1975, a report was submitted by the WHO on its performance in assisting governments to direct their health programmes towards major health objectives and development of comprehensive health delivery systems. In the same session Dr Halfdan T. Mahler, the then Director-General (DG) of the WHO, presented the concept of the PHC and argued that the conventional health services approach needed to be changed to establish harmony between resources available to health services and resources available to community. The PHC was to be achieved through active involvement of local populations (Litsios, 2005). Although the "bottoms-up orientation" was not welcomed by all within the WHO, Dr Mahler was determined to pursue the idea of community participation in the PHC and many non-governmental organizations (NGOs) joined hands with the WHO to promote the PHC (Litsios, 1974; Litsios, 2004).

Primary Health Care got to the top of the WHO's agenda in 1978 when a conference, sponsored by the WHO and UNICEF, was held in Alma-Ata. The goal "Health for All by the Year 2000"

was set, and development of comprehensive Primary Health Care was identified as the backbone of national health systems (Ata, 1978; Rifkin, 1986). The Declaration of Alma-Ata encouraged involvement of other sectors in the promotion of health, focused on achieving equity in health status and participation of community in planning, implementing and regulating health services (World Health Organization, 1978). But it was not clear how the PHC was going to be financed. Unlike other international campaigns, such as the malaria eradication programme, where UNICEF and United States (US) bilateral assistance provided funding, the WHO lacked a plan and sufficient resources for financing its comprehensive primary health care agenda. In addition, it was difficult to convince developing countries to change their already committed health budgets. On top of that, in the 1980s most countries were confronting inflation and recession or economic adjustment policies and mounting foreign debts (Cueto, 2004). A study in 1986, which examined primary health care in developing countries, concluded that "the wide range of costs… is indicative of how little is known about this area" (Patel, 1986).

2.4 Selective Primary Health Care and lessons learned

The Alma-Ata Declaration was criticized for being too broad, idealistic, and having an unrealistic timeframe (Rifkin, 2018). Soon the concept of Selective Primary Health Care (SPHC) emerged as a more feasible and cost-effective approach contrary to the declaration's galvanising vision of health for all through comprehensive primary health care (Tejada de Rivero, 2003). The concept was presented in 1979 at a conference in Bellagio, Italy, sponsored by the Rockefeller Foundation and backed by the World Bank. Rather than being comprehensive, the SPHC was designed to target specific areas of health through low-cost and measurable result-oriented interventions, such as interventions for children under five, and women of reproductive age (Roalkvam & McNeill, 2016; Walsh & Warren, 1980). The attendance of international agencies at the conference, such as the president of World Bank, the vice president of Ford Foundation, the executive secretary of UNICEF and the administrator of United States Agency for International Development (USAID), strengthened voice for the SPHC as a more feasible alternative to that of Alma Ata Declaration (UNICEF. & United Nations Children's Fund, 1996). The programme was put into practice through stand-alone vertical programmes, such as a cluster of programmes commonly known as GOBI-FFF (Growth Monitoring, Oral Rehydration, Breast Feeding, Immunization, Female Education,

Family Spacing, Food Supplements) by UNICEF, and increased the influence of these agencies in international health. Pursuing the concept of selective primary health distorted the Alma-Ata vision of developing health systems as a platform for improved health services for all and a citizenry empowered to improve their health. In the 1980s, the SPHC succeeded in replacing the idea of comprehensive primary health because it was feasible to achieve with the limited resources available, and the programs did save millions of lives through targeting health problems that required urgent attention. Further, as it came with measurable results which provided accountability for funders, it was attractive for donors. However, as Paul Farmer and others have pointed out, this put the WHO in a precarious position (Farmer, Kim, Kleinman, & Basilico, 2013). The WHO had very little, or no control over the funds awarded to these earmarked projects. By the end of 1980s, the funding awarded to earmarked projects outgrew the regular budget of the WHO which the Organization had control over. Such a situation limited the ability of the Organization to effectively address global health challenges and pursue its own strategic priorities (Farmer et al., 2013). The WHO was relegated to a mere administrative role facilitating donor's agendas and priorities.

2.5 Neoliberalism and Global health

In the late 1980s and 1990s, the world saw a transition in political and economic philosophy which changed the pattern of government-delivered services. The cold war ended with the fall of the socialist bloc and the concept of liberal economy, known as "Neoliberalism", from the capitalist bloc prevailed on the global horizon. During the 1980s, the Washington, D.C. based institutions, the World Bank, the International Monetary Fund (IMF) and the United States Department of the Treasury, prescribed a set of economic policies, later known as the "Washington Consensus", to constitute the standard reform package for crisis-wrecked developing countries (Arestis, 2004). The prescription of the Washington Census was based on a neoliberal economic approach that saw health as best served through competition in free markets. The agenda was implemented by the World Bank and the IMF through the Structural Adjustment Programmes (SAPs). A compulsory condition for countries to get loans from these financial organizations was a policy change, centred around privatization, liberalizing trade and foreign investment, and balancing government deficit through free markets policies (Farmer et al., 2013). Consequently, national investments in strengthening health systems

decreased due to public sector restrains and market-driven reforms to facilitate for-profit services financed by user fees (Cueto, 2004; Labonté et al., 2007; Qadeer & Nayar, 2001).

Against this background, health sector reforms were introduced by the World Bank through its World Development Report of 1993, "Investing in Health", which reflected a change in the orientation of how healthcare services in resource-poor countries would be delivered. The report suggested a three-pronged approach for interventions in the health sector. Firstly, governments should provide relatively few health-related activities, the main being information to health providers and individuals so they could make informed market choices. Secondly, they called for governments to subsidize or promote activities, which benefits the patient as well as others in the community such as control of communicable diseases. Thirdly, governments should control or offset "market failures" that readily occur in health care, particularly in health insurance to counteract higher cost, poorer health, and less equity. Thus, governments need to concern themselves less with providing health care and more with regulating providers and insurance companies to assure a functioning health market (Lea, 1993). The report was mostly about the activities of the healthcare sector in improving health, and it barely recognized the role of other sectors in achieving health goals, which is contrary to the original PHC's multisectoral approach(Lea, 1993). The World Bank's approach later known as "Health Sector Reform", introduced user fees, decentralization of the health service system and public-private partnerships as the focus for delivering healthcare services (Baru & Mohan, 2018). This had serious consequences for the availability, accessibility, affordability, acceptability, and quality of health services.

2.6 Emergence of World Health Reports

It was during the transitional political and economic era of the 1990s, that the WHO introduced its first World Health Report in 1995. The report focused on the widening gaps in health status between rich and poor, and on gaps in access to health care due to increasing poverty and emphasized the need for cross-border cooperation to reduce the mounting inequities in access to health (WHO, 1995).

The report can be read as a response to the World Bank's notion that the existing health systems were often wasteful, inefficient and ineffective, and argued in favour of greater reliance on

private-sector and public-private partnerships to ensure the greatest possible gains for the limited available resources (Bank, 1987).

In doing so, patients had become clients, and health care as a social good had become a commodity, granted to those with the financial means to pay for it. As a result, out-of-pocket expenditure in health increased and a large proportion of the population was left without access to health services, leading to a further increase in health inequities. The World Bank became one of the largest funders of global health programmes worldwide and its ability to mobilize large financial resources provided a comparative advantage over the WHO (Bank, 1987). The World Bank initiated numerous vertical programmes more or less independently of the WHO's programmes and decision-making structure. The vertical approach, based on the notion of the SPHC targeted specific areas of health with set quantified targets to achieve, further burdened both the WHO and resource-poor national health systems in developing countries. Rather than states, the non-governmental organizations (NGOs) were given priority by the World Bank in implementing the programmes. The NGOs got a special place in policy and programme implementation as greater importance was given to their role as facilitators and representatives of the people. A later expression of this is the emphasis on public-private partnerships in national disease control programmes like HIV/AIDS, tuberculosis and malaria (Kapilashrami, 2010).

At the end of the 20th century, the global and Asian financial crisis challenged the World Bank policies leading to a decline in power and influence and opened a space for new actors in global health. In the health sector, the adverse effects of the World Bank's policies were being seen in developing countries in the shape of increased inequities in access to health services. Due to increasing resistance to Structural Adjustment Programmes the United States, which was a major contributor to the multilateral organizations, including the WHO, started reducing its share which resulted in a financial crisis within these organizations (Cornia, Jolly, & Stewart, 1989). At the same time, the World Health Assembly reached outside the ranks of the WHO for a new leader who could restore the lost relevance of the Organization and provide it with a new vision and Dr Gro Harlem Brundtland, former prime minister of Norway and a physician and public health professional, was given the task (Kickbusch, 2000). Brundtland took the helm as DG of the WHO in 1998 and succeeded in repositioning the WHO as a credible and highly visible contributor to global health by moving it beyond state ministries of health and gaining a seat at the table where decisions were being made (Kickbusch, 2000). Brundtland strengthened the financial position of the WHO by establishing global partnerships and global

funds to bring together stakeholders including private donors, governments, and bilateral and multilateral agencies (Reid & Pearse, 2003). Under her leadership, the WHO continued to publish the WHRs as a flagship publication to establish the Organization as the ultimate authority and global leader in matters of global health.

Around the turn of the millennium, new actors based on capital from the pharmaceutical industry and philanthrocapitalists groups, like the Bill and Melinda Gates Foundation (BMGF), entered global health. They pushed the WHO to restructure several of its disease control and vaccine development programmes into Global Public-Private Partnerships (Birn, 2014). The goal of the financial multilateral organizations and donors was to save as many lives as possible for the least amount of expenditure by targeting the specific health problems. However, a lack of interest in investing in national health systems, the emergence of HIV/AIDS and the resurgence of tuberculosis and malaria moved the focus of global health away from the strengthening of public health systems and towards the management of high-mortality emergencies.

The World Health Organization kept publishing its WHRs annually until 2008, each focusing on a specific theme in the health sector. The reports also showed the standing of member nations in terms of mortality and life expectancy, which served to focus national health policies on averting deaths by promoting curative services for diseases with high mortality. At the global level, the use of measurable targets and indicators have remained important for maintaining the commitment of the world's political leaders and resource mobilization as they set a tangible endpoint against which progress can be shown. The terms DALYs (disability-adjusted life years) and QALYs (quality-adjusted life-years) were developed in the 1990s and have become increasingly used in public health to forecast the possible impact and cost-effectiveness of health interventions and to formulate new targets (Augustovski et al., 2018). The most important use was in setting the health targets developed under the MDGs. Measurable targets were used both to measure state progress, and to facilitate comparison and competition between countries. The target-oriented vertical programmes with measurable impacts have also proven to attract both donors and political leadership. Out of 8 MDGs, 3 goals (number 4, 5 and 6) were related to health issues specifically, and each targeted specific health areas (child and maternal health, and few communicable diseases) (World Health Organization, 2018).

2.7 Back to Alma-Ata

Between 1978 and 2015, despite the prominence of the SPHC in the global health agenda, the vision outlined in the Declaration of Alma Ata has maintained its currency. Marking the 30-years anniversary in 2008, the WHR "Primary Health Care Now More than Ever" reaffirmed the importance of comprehensive primary health care and called for a reorientation of national and global efforts to build health systems that put people at the centre of health care (WHO, 2008). The report was published in a context with increased global health expenditures, but where health inequity was not decreasing and where an increasing number of disease-specific global health initiatives were putting considerable pressure on weak health systems of low- and middle-income countries (Group, 2009). In the 2008 report, Dr Margaret Chan, the then DG of the WHO, called for "Universal Coverage Reforms" that ensure that health systems contribute to health equity, social justice, and the end of exclusion, primarily by moving towards universal access and social health protection (WHO, 2008). The underlying causes for health inequity and the inability of health systems to address the health needs of all, issues that had set "Health for All" on the top of the global health agenda in the Alma-Ata Declaration, are still unaddressed, and misinterpretation of community participation and social control has left the major proportion of societies without essential health care (Tejada de Rivero, 2003). Dr Margaret Chan, in the WHR from 2008, presented the UHC as the single most powerful concept that public health has to offer (World Health Organization Media Releases, 2008). Also, the next two WHRs by the WHO, published in 2010 and 2013, focused on providing an actionable agenda for countries to achieve universal coverage, with an emphasis on the importance of research in advancing the progress.

The contemporary extension of the vision of comprehensive primary health care is "Universal Health Coverage", which came to the top of the global health agenda to address the gaping inequities and social injustice in equal access to health by all. The UN's SDGs, adopted in 2015, have a comprehensive health goal, "to ensure healthy lives and promote the well-being of all" (WHO, 2017). The health goal has nine substantive targets and four additional targets which are identified as means of implementation (WHO, 2017). Among all these targets, emphasis is on the UHC and is considered central to achieving all other targets. As stated in the SDGs, the UHC includes financial risk protection, access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines. Major health and development agencies, including the WHO, the UNICEF, the World Bank

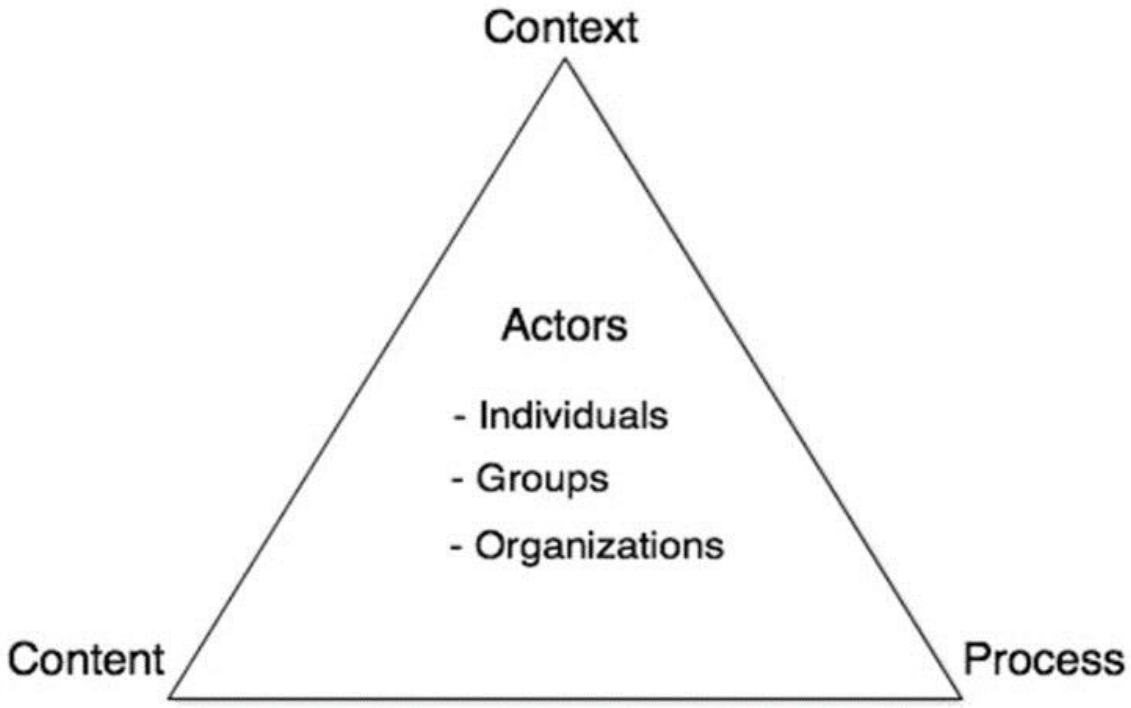
Group, the Rockefeller Foundation, Oxfam, the Gates Foundation, and the International Labour Organization (ILO) have endorsed initiatives promoting the UHC (Abiiro & De Allegri, 2015).

3 Chapter 3: Methodology

3.1 Theoretical framework

The study uses the framework developed by Walt and Gilson in 1994, known as "The health policy triangle", to explore the process of setting global health agenda through the World Health Reports. This framework explains and organizes key factors, concepts, and stakeholders of the process. The health policy triangle (Figure 2, below) shows that several components go into any health policy: the context, the content, the process, and the actors. All of these come together to show how policies contribute to, and are shaped by, the context, the use of power through influence or resources and are shaped in part by internal or external factors that might seem unrelated to the policy process itself (Buse, Mays, & Walt, 2012). The context of policies is shaped by situational, structural, cultural, and even international factors that contribute to building a unique setting where different actors or stakeholders meet and work together in the process of developing and implementing policies.

Figure 2: The health policy triangle



Source: (Buse et al., 2012)

The health policy triangle can be used either to understand a particular policy or to plan a particular policy. The former can be referred to as analysis *of* policy, and the latter as analysis *for* policy (Buse et al., 2012).

For my thesis, I used the "analysis of policy" approach, that is generally retrospective. It looks back to explore the determination of policy (how policies got on to the agenda, were initiated and formulated) and what the policy consisted of (content). It also includes an element of evaluation: - did the policy achieve its goals? Was it seen as successful?

3.2 Data collection

The data for the study is World Health Reports published by the World Health Organization between 1995 and 2013 (Table 1). The reports are available from the website of WHO (https://www.who.int/whr/previous/en/). The study does not include the WHR published in 1996 because the complete report is not available on the above-mentioned website. The WHRs are selected for the study because these were the lead publications for agenda setting by the WHO during the period 1995 to 2013, the period where our current framework for global health was shaped. In addition to the main dataset, I also consulted the "Global strategy on human resources for health: Workforce 2030" report, published in 2016, that was a continuum of the plan of action set in the WHR from 2006, "Working together for health", to address the human resource crisis in health sector. This provided a chance to look at changes in the understanding of an ongoing global health issue.

Table 1: List of World Health Reports

Report year	**Report name**
1995	Bridging the gaps
1996	Fighting disease, Fostering development
1997	Conquering suffering, Enriching humanity
1998	Life in 21st century, A vision for all
1999	Making a difference
2000	Health Systems: Improving performance
2001	Mental Health: New understanding, New hope
2002	Reducing risk, Promoting healthy life

2003	Shaping the future
2004	Changing history
2005	Make every mother and child count
2006	Working together for health
2007	A safer future: Global public health security in the 21st century
2008	Primary Health Care: Now more than ever
2010	Health Systems Financing: The path to universal coverage
2013	Research for Universal Health Coverage

3.3 Data analysis

In the study, "Systematic Document Analysis" was used for analysing the collected data. Document analysis is one of the most commonly used method in health policy research; it is nearly impossible to conduct policy research without it (Dalglish, Khalid, & McMahon, 2020). Document analysis is a systematic procedure for reviewing or evaluating documents, which can be used to provide contexts, generate questions, supplement other types of research data, track changes over time, and corroborate other sources (Bowen, 2009).

I used the READ approach to document analysis for this thesis. The READ approach is a systematic procedure for collecting documents and gaining information from them in the context of health policy studies at any level (global, national, local, etc.) (Dalglish et al., 2020). READ stand for ready your materials, extract data, analyse data, and distil your findings.

The analysis was done in five steps. The first step was "Content Analysis", where the documents were analysed superficially to categorize information according to the research questions. In the second step, each report was read thoroughly, and analytical themes informed by the health policy triangle were identified. The third step was "Thematic Analysis", in which a focused and careful analysis of each analytical theme was done, with special emphasis on identifying recurrent patterns. In this step, one monograph was read at the time, detailed notes were taken, and the health policy triangle was used as lens. In the fourth step, these recurrent patterns were narrated, and existing literature was consulted to do a critical analysis. In the final step, findings were analysed across the set of WHRs, including but not limited to introduction of new concepts in each report, to identify the shifts in framing and priorities during the period 1995 to 2013.

3.4 Ethical approval

The study relies on published information available in the public domain. Studies that identifying shifts in public policies do not require approval from an ethical committee.

Results

4 Chapter 4: The WHO as agenda setter

This chapter examines how priorities in global health are identified, as well as the actions aimed at meeting them. The chapter contains three sections. The first section explains the role of the WHO in defining the global health agenda. To do this, I analyse the WHRs, which were flagship publications of the WHO between 1995 and 2013. As outlined in the previous chapter, the WHRs were part of the organization's efforts to reclaim and maintain a leadership position when it comes to defining the global health agenda over time. The second section explains the process of constructing the rationale for the health problems and how they find their place at top of the global health agenda. In the third and final section, I discuss the dynamics of the actions to tackle these health problems and highlights the importance of galvanizing support for global action, that is shifting from seeing their mandate limited to specific regions and/or populations, to tackling health problems of the world as a whole.

4.1 Role of the WHO and World Health Reports in agenda setting

World Health Reports are flagship publications of the WHO since 1995 and have proven to be of vital importance in defining the global health agenda. In addition to the numerical data of several health indicators, such as health expectancy, child mortality rates, maternal mortality rates, and others, the reports provide insight for understanding the complex nature of health determinants, including those which lie beyond the health sector. Each WHR focuses on a specific health issue and provided research- and data-based arguments for the need to address it. Even though each report showcases a specific health problem that should be at the top of global health agenda (see Table 2 below), the WHRs have reoccurring themes. Some health-related issues, prominently poverty and health systems development, are discussed thoroughly in almost every report providing the most recent and updated knowledge about them.

Table 2: World Health Reports and their goals

Report: Year and Name	**Overarching goals**	**Report summary**
1995-Bridging the gaps	Through this report, the WHO explained the root causes of health disparities within and across the countries, arguing that the biggest one is poverty. The report motivated the member states to invest in health by arguing the fruits of investment are beneficial to the economy, and that healthcare goes beyond just health.	The report is not merely a statistical report card. Rather than an overview of diseases from which people suffer, it is about people's health and how it impacts their quality of life. The report documents stark and often shocking inequities in health and in access to even basic services. Growing inequities is a matter of life and death for many millions of people since the poor pay the price of social inequality with their health. Poverty, according to the report, is the world's deadliest disease. The most important task of the WHO is to impress upon the international community the need for political commitment to placing health and human beings at the centre of development goals.
1997-Conquering suffering, Enriching humanity	Through this report, the WHO changed the conventional mindset about the disease burden of two worlds. The report argued that neither certain infectious diseases are limited to poorer countries, nor NCDs are limited to only developed countries, therefore, we need to address both disease burdens with equal importance at the same time.	The report claims the term "double burden" can no longer be confined to developing countries alone, it has expanded into a double burden to international health. The claim is based on evidence of international resurgence of infectious diseases such as intercontinental spread of AIDS and the emergence of NCDs in poorer regions at alarming rates. The epidemiological polarization has shifted from between the hemispheres to between population groups within countries. The poorer an individual is, the more probable it is that he or she will die young of an infectious disease, the richer the person, the greater are the odds of suffering and dying from a chronic disease at an advanced age.

1998-Life in the 21st century-A vision for all	By highlighting the dark side of longer life, the WHO put chronic non-communicable diseases on the global agenda. NCDs were no longer understood as health problem for only developed countries, it was also a major concern for developing countries.	The report suggests that increased longevity without quality of life is an empty prize. The WHO argued that the global leadership needs to recognize the NCDs as a shared problem and are needed to be addressed globally. Further, the WHO pushed health as a matter of concern beyond just its own domain and argued it should be part of new arrangements being done in an emerging globalised world. The report suggests that health should be included as an equally important component as trade and other services in the process of globalization.
1999-Making a difference	Through this report, the WHO brought forward the health of whole societies as a prerequisite for development. This was a departure from earlier conceptualization where global health was understood in terms of specific arenas or specific target population groups. The report argued that positioning health at the core of the global development agenda will benefit not only health of the people, but that it will lift people out of poverty by increasing their productivity and ultimately the economy of nations.	The report provided an account for the health gains during the last five decades, especially since the historical conference of Alma-Ata in 1978. At the same time, it explained the challenges global health was facing and will continue to face in the new millennium. The report is unique in its context as compared to other WHRs because it provides an explicit and detailed discussion of the WHO's standing and role as an agency in the health of people worldwide.
2000-Health Systems-Improving performance	Through this report, the WHO conveyed the importance of one of the fundamental blocks of primary healthcare movement, health systems performance. The report argued that "Health for all"	The report argues that the ways in which health systems are organized, financed, and react to their population's need cause differing degrees of efficiency, and that this explains much of the widening gap in death rates between the rich and poor within and

	cannot be achieved until health systems perform at their best and warns that a vertical approach- interventions targeting one or a few diseases at a time- cannot meet the healthcare needs of all.	between countries. As the world was reaching to the deadline of its goal "Health for all by 2000" set out in the Alma-Ata Declaration, systematically investigating the performance of health systems provided information on what worked in the favour of this goal, and what nations could learn from these experiences. Further, at a time when the world was facing an economic recession, the WHO called on the national and international policymakers to get the maximum health outcomes for each dollar being invested in healthcare by improving the performance of health systems.
2001-Mental Health	Through this report, the WHO positioned mental health among the very top priorities of the global health agenda, not only because it has been neglected for so long, but because it stands fourth in the ten leading causes of the global burden of disease and expected to raise to the second place within the next 20 years.	This report states that "there is no justification for excluding people with a mental illness or brain disorder from our communities- there is room for everyone". We have enough scientific knowledge to understand and accept that genetic, biological, social, and environmental factors come together to cause mental and brain illnesses. The WHO argues that mental health has been neglected for so long and is crucial to the overall well-being of individuals, societies, and countries. The report marked the ten-year anniversary of the United Nations principles for the rights of the mentally ill to protection and care, adopted in 1991.
2002-Reducing risk- Promoting healthy life	Through this report, the WHO highlighted "prevention and health promotion" as an important component of the healthcare, and argued it was not given the attention deserved due	The report argues that public health leadership has been focusing too narrowly on the curative part of healthcare. While this does have its own importance, through this report, the WHO argued that if policymakers make rational choices for reducing risks to health and for impacting public behaviour

	to its potential to improve people's health.	towards health threats through improved and fact-based communication, the world would see a sharp decrease in global disease burden, and thus lead to a decrease in the need for curative care. The report shows how one of the most important health threats, namely malnutrition, is affecting not only those who lack enough food but those too who have an abundance of it.
2003-Shaping the future	Through this report, the WHO tried to convince the global leadership about the urgence of response needed to assure the availability of HIV/AIDS treatment to the people infected with the deadly virus. In doing so, the WHO suggested utilizing existing national health systems instead of initiating new stand-alone programmes.	The report came out when, earlier that year, the WHO had already declared HIV/AIDS a "global health emergency", which elaborate how serious the threat is to global health. At the same time, the WHO suggested we should not forget our bigger goal, set earlier, "Health for all". Learning from past experiences, we should not target global health threats through individual interventions/programmes. Rather, to ensure the process of health system strengthening to continue, emphasis should be on local health systems, and on channelling support for existing healthcare structure. This, they argued, is necessary for achieving the bigger targets, especially the health-related MDGs and the vision of health for all.
2004-Changing history	Through this report, the WHO pushed the agenda set in the previous year to combat the HIV/AIDS epidemic further, balancing this with the development of national health systems to keep the advancement towards health for all on track.	This report argues that most of the increased international investment in health is in the fight against HIV/AIDS, which brings an overdue improvement in the prospects for controlling the worst global epidemic. By providing the number of people living with AIDS (34-46 million), the WHO pushed the need for resources and what work needed to be done in order to improve the most neglected part of the HIV/AIDS strategy,

		namely “treatment”. The responsibility of the WHO and its partners in this effort was to ensure that increased funding is used in such a way as to enable countries to fight HIV/AIDS and at the same time strengthen their health systems
2005-Make every mother and child count	Through this report, the WHO re-emphasised a goal agreed to in the MDGs, namely the improvement of maternal and child health. The WHO proposed that the delivery of maternal and child healthcare services should be organized as a part of the national health systems instead of building a parallel delivery setup.	This report focuses on maternal and child health within the broader prospect of Health for all. It provides an account of the barriers that limit access to health care for mothers before, during, and after pregnancy and to their children after birth. The priority status of maternal and child health has strengthened over time, as exemplified in the MDGs. To provide families universal access to a continuum of care during each step of pregnancy, childbirth, and after childbirth, requires programs to work together, but is ultimately dependent on extending and strengthening health systems. The WHO suggests that the only way forward is to ensure that mothers and children are not just targets of some well-intentioned programmes, but instead that they are entitled to quality care guaranteed by the state.
2006-Working together for health	Through this report, the WHO brought to the table a matter of real concern for healthcare sector, namely the shortage/crisis of human resources. The WHO highlighted the urgency of the issue also in the perspective of health systems strengthening because health systems cannot achieve the goal of health for all, if they do not have the required	This report claims that there is a chronic shortage of well-trained health workers globally, most acutely in countries that need them the most. Among the reasons for this are migration, illness or death of health workers, and that countries are unable to educate and sustain health workers. The distribution, density, and quality of healthcare professionals have a direct impact on the indicators of health, for example the impact of skilled attendant childbirth on maternal

	well-trained personnel, no matter what advanced technology and medicines are made available.	mortality is well documented. The problem is not limited to only poor countries, but the developed world, too, has been facing a shortage of health workers, and there is need for even more workers in healthcare due to increasing proportion of elderly population who need continuous care.
2007-A safer future	Through this report, the WHO, tried to galvanize attention of the public health community to matters of global health security related to the spread of communicable diseases, as well as natural and man-made disasters including bioterrorism.	This report explains the price the world has paid with the health of people for globalization. The easiness with which disease spreads has increased due to extensive intercontinental travel, population growth, rapid urbanization, intensive farming practices, environmental degradation, incursion in previously inhabited areas, and disrupted microbial equilibrium due to misuse of antibiotics. The report presents a shift from focus on passive barriers at borders, airports, and seaports to proactive risk management strategies to handle challenges to global health security, as outlined in the revised International Health Regulations of 2005**.** The report mainly tried to convince the global leadership to take steps for the implementation of the International Health Regulations.
2008-Primary Healthcare-More than ever	Through this report, the WHO brought forward a long-discussed agenda for global health, "Primary Health Care". The report suggests four sets of reforms for health systems, including universal coverage reforms, service delivery reforms, public policy reforms, and	This report explains that globalization is putting the level of social cohesion all across the world under stress, and health systems, as a key constituent of the architecture of society, are clearly not performing as well as they could or should. Rather than improving its response capacity and anticipating future challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear

	leadership reforms, to give life to the PHC.	sense of direction. Awareness of people for their social rights has shaped their demand for a health care responsive to their needs, and they no longer consider themselves a target of some well-intentioned individual intervention. Furthermore, countries, which were left behind in the progress towards the globally agreed goal of Health for all, were under mounted pressure both nationally and internationally to align their national policies to the goal of the UHC. The WHO, being the leader of global public health, provided a single answer/solution to all these problems, "Health systems based on Primary Healthcare". The report marked the 40-year anniversary of the Alma-Ata Declaration.
2010-Health Systems Financing	Through this report, the WHO put the topic of health system financing on the table as the most important pre-requisite for ensuring universal access to health services. After putting the PHC on the top of global health in 2008, the WHO now presented evidence-based recommendations such as pre-payments and pooling of funds for generating the financial resources to fund health systems.	The most notable criticism of the concept of primary healthcare set forward in the Alma-Ata Declaration was the lack of guidance by the agency to the national governments on how to manage the cost of services for everyone. This report provided the governments with a set of options for raising sufficient resources and removing financial barriers to access, especially for poor, and positioned this as a key step towards the UHC. The reports strongly criticized the out-of-pocket expenditures and user fees and labelled them one of the greatest barriers towards the UHC. Additionally, the WHO put the topic of finance in discussion at the time when countries were recovering from the economic recession of 2008 and needed the policy guidance to make best use of available tight budgets.

2013-Research for Universal Health Coverage	In this report, the WHO emphasized the importance of investing in the generation of knowledge as a top priority for global health, as this will provide a basis for making informed policy decisions to ensure the universal health coverage.	According to the report, as the world nears the 2015 deadline for achieving the targets set in the MDGs, there was a need to reflect on how we made progress until now, how we could do better, and most importantly, why there are still equity gaps in access to healthcare. Through studies of past interventions, the report provided evidence-based knowledge to shape the policies for moving towards the UHC and through better health achieve the bigger goal of human development. The WHO was further taking the agenda of the UHC, revitalized in 2008, through this report by establishing the fact that while the WHO could provide universally applicable policy recommendations, the Organization cannot formulate a blueprint of policies to be adopted by all countries. The details needed to give these policy recommendations a life in each setting must be driven by specific conditions and contexts, drawing on the best available evidence. Therefore, it is equally important for every country to invest, motivate, and facilitate research at home. Further, the report identified gaps in knowledge to provide directions for future research.

4.2 The making of global health problems

It is within the WHO's mandate to direct international health work (WHO, 1998, p. 10). As such, the organization exercised de facto leadership in the field of health. However, as outlined in the previous chapter, starting in the 1980s, its authority began to be challenged by the rising influence of other global institutions such as the World Bank and UNICEF (Irwin & Scali, 2007). This shift in power started with the controversy over comprehensive primary health care

and selective primary health care, where the former was backed up by the WHO and the latter by the World Bank, UNICEF, and US based agencies such as the USAID and the Rockefeller Foundation. Further, the WHO, during the 1980s, was facing financial crisis due to shortages in its regular budget, which the organization receives from member states based on their population size and gross national product (Brown et al., 2006). One of the major reasons for this financial crisis was the United States withholding of its contribution to WHO's regular budget (Brown et al., 2006). In contrast, the World Bank had greater ability to mobilize huge financial resources, and this allowed it to establish its population, health, and nutrition department in 1979. Further, the World Bank adopted a policy to finance both stand-alone health programs and health components of other programs (Brown et al., 2006). Theodore M. Brown and co-authors in their research paper "International to Global Public Health" published in 2006 mentioned that the World Bank started investing in population control, education, and health in 1970s and by 1990 the Bank's total lending in population and health sector surpassed the WHO's total annual budget (Brown et al., 2006). Another reason for the WHO's decreasing authority was its increasing dependence on "extrabudgetary funds" which were coming from donations made by donor nations and multilateral agencies such as the World Bank.

By 1990s, extrabudgetary funds accounted for 54% of the WHO's total budget and the World Bank's cumulative loans for the health sector surpassed the total budget of the WHO (Brown et al., 2006). The World Health Assembly had the authority over regular budget, while wealthy donor nations and agencies like the World Bank were calling the shots on the use of extrabudgetary funds. The lack of trust by the donors and the placing of such a large proportion of budget outside of central management's control further side-lined the Organization in international health policy debates. Yet although the Bank gained huge influence in international health due to its greater economic strength, the WHO still had the considerable expertise in health sector. And so, the World Bank's landmark World Health Report from 1993, named "Investing in Health", credited the WHO as "a full partner with the World Bank at every step of the preparation of this report" (Brown et al., 2006).

During the late 1990s, the WHO started to reorient itself to gain its lost status in international health by expressing its strength, which was the knowledge and expertise in the field of health and medicine. Part of these efforts include the initiative the WHO took to present an annual overview of world's health situation beyond the statistics and set the instant and long-term priority domains for the international health work through the publication of the World Health Reports. The WHRs are based on research-based knowledge and the data collected provided

the rationale for national and international political leadership to address the health problems being identified by the Organization. The construction of some of these health problems will be explained in the following section.

4.2.1 The children

The differences in infant- and child survival that exist between a developed and a developing country is one of the bitter truths of health inequity. The WHR from 1995 “Bridging the gaps” mentioned, while only 6 out of 1000 liveborn die before reaching the age of 5 in the developed world, over 200 per 1000 livebirths die in the least developed countries (WHO, 1995, p. 4). In 1993, more than 12.2 million children under the age of five died, a number equal to the entire population of Norway and Sweden combined and twice as many living souls as there were in Switzerland and Hong Kong (WHO, 1995, p. 4). Although 1993 also saw the number of children dying from vaccine-preventable diseases reduced by 1.3 million compared to 1985, around 2.4 million deaths among children under age 5 were caused by vaccine-preventable diseases particularly measles, neonatal tetanus, tuberculosis, pertussis, poliomyelitis, and diphtheria (WHO, 1995, p. 5).

Vaccination programs have made the biggest difference to children's health in decades. Some vaccines represent the cheapest, and most effective, public health intervention, yet vaccines are underutilized globally. Although the effectivity of immunization in reducing child mortality is well established, the tangible and measurable targets are two of the major reasons for persistent focus of the WHO and partner agencies on vaccination, which cannot be overlooked. Agencies and donors providing funds for the immunization of children need to document the numbers at the end of programs to show their contribution to global health and it is quite easy to measure the number of children being vaccinated. The preference of donors is to fund interventions that provide quick quantitative results, and this seems to have been one of the major driving forces behind the consistent focus on immunization of children during the last decades of 20th century.

Children, even those who received vaccinations, still have another burden to bear as they grow, namely malnutrition. Childhood mortality and morbidity are significantly impacted by malnutrition, yet it is frequently not identified and addressed. Undernutrition retards the development of the child’s immune system leading to inadequate response to vaccines and stunts physical and intellectual growth. In 1990, more than 30% of the world’s children under

the age of 5 were underweight for their age (WHO, 1995, p. 6). The proportion ranges from 11% of children in Latin America to 41% in Asia and 27% for Africa (WHO, 1995, p. 6).

As the world entered the 21st century, the number of children saved has been increased but these improvements were not uniform across the globe. According to the WHR 2003 "Shaping the Future", approximately 10.5 million children under 5 years of age still die every year and almost all these deaths occur in the developing world (WHO, 2003, p. xii). Africa accounts for nearly half of these deaths (WHO, 2003, p. 7). Although some African countries have shown considerable reduction in child mortality, most of these children live in countries where these improvements had been hampered by the HIV/AIDS epidemic. Infectious and parasitic diseases are still the major causes of child deaths in developing countries, partly due to HIV/AIDS epidemic (see Table 3, below). Apart from considerable success in some arears, for example polio, communicable diseases still count to 7 out of top 10 leading causes of child mortality and accounts for 60% of all child deaths (WHO, 2003, p. 11).

Table 3: Leading causes of death among children in developing countries,2002 (WHO, 2003, p. 12)

Rank	**Cause**	**Number (in thousands)**	**% of all deaths**
1	Perinatal conditions	2375	23.1
2	Lower respiratory infections	1856	18.1
3	Diarrhoeal diseases	1566	15.2
4	Malaria	1098	10.7
5	Measles	551	5.4
6	Congenital anomalies	386	3.8
7	HIV/AIDS	370	3.6
8	Pertussis	301	2.9
9	Tetanus	185	1.8
10	Protein-energy malnutrition	138	1.3
	Other causes	1437	14.0
	Total	10263	100

At the end of the 20th century, the HIV/AIDS epidemic emerged as a threat to public health around the world, but the epidemic affected the work in child health in two ways, as it has not

only halted the progress but reversed past achievements. According to the WHR from 2004 "Changing History", every year out of 2.2 million children born by women who tested positive with HIV, around 700,000 new-born contract the virus from their mothers (WHO, 2004, p. 12). In the absence of any intervention, 14-25% of children born to HIV-infected mothers get infected in developed countries and 13-42% in other less developed countries (WHO, 2004, p. 12). In addition to being a direct cause of death, HIV/AIDS also had an indirect impact on slowing or reversing the trends in child mortality. HIV/AIDS came with additional burden on fragile health systems by creating demands for additional services including services needed for prevention of mother-to-child transmission of HIV, for testing and counselling, and complex diagnostic and screening procedures (WHO, 2005, p. 24). Countries with insufficient funds were forced to redirect the already limited resources available for child health to address this call for additional resources for development of infrastructure, provision of equipment and drugs, and recruitment of human resources.

Statistics explain the magnitude of problem as well as importance being given to child health. But other forces also contributed to putting the children among the top priorities of the global leadership. These forces included economic and political "interests" or "needs". At the end of 19th century, the world had seen that the creation of health programs in Europe improved the health of mothers and children (WHO, 2005, p. 2). At that time, many European politicians believed that their cultural and military aspirations would be threatened if the nation's children had ill-health (WHO, 2005, p. 2). This perception strengthened when countries like France and Britain faced difficulties in finding soldiers in their countries fit for war. Dr Sara J. Baker, chief of the division of Child Hygiene of New York, is quoted at length in the WHR from 2005.

> *"It may seem like a cold-blooded thing to say, but someone ought to point out that the World War was a back-handed break for children ... As more and more thousands of men were slaughtered every day, the belligerent nations, on whatever side, began to see that new human lives, which could grow up to replace brutally extinguished adult lives, were extremely valuable national assets. [The children] took the spotlight as the hope of the nation. That is the handsomest way to put it. The ugliest way – and I suspect, the truer – is to say flatly that it was the military usefulness of human life that wrought the change. When a nation is fighting a war or preparing for another ... it must look to its future supplies of cannon fodder" (WHO, 2005, p. 16)*

Though the reasons for this concern may look cynical, children became the "target" of public health actions for good reasons. National leaderships perceived it a necessity of their nations to invest in the health of their children so they could become healthy workers and soldiers. This had been true in the 19th century, and it was equally true now.

4.2.2 The mothers

Pregnancy is not just a matter of giving birth to a baby, it is a characterizing stage of a woman's life that should be filled with happiness and satisfaction as an individual as well as a member of society (WHO, 2005, p. 41). But in many countries, pregnancy can easily turn into suffering and misery if it is unwanted or mistimed, or when there are complications and adverse consequences that can lead to ill-health or even death. In 1991, out of 2.4 million deaths of women aged 15-44 in the developing world, 500,000, almost one-fifth, were due to pregnancy-related causes, in comparison to 4,000 out of total 200,000 deaths in developed countries (WHO, 1995, p. 35). Even more disturbing is that most of these deaths were preventable. There is an unacceptable gap in maternal mortality rates between countries, the 1995 WHR argued. In Europe, the maternal mortality rate for 1991 was 50 per 100,000 live births, while in Africa the figure was over 670, almost 13.5 times greater (WHO, 1995, p. 36). For the 47 least developed countries, the maternal mortality rate stands more than 700 per 100,000 live births (WHO, 1995, p. 36).

Apart from these deaths, there are millions who suffer from complications during pregnancy and childbirth. These complications include haemorrhage, sepsis, hypertensive disorders, and obstructive labor which results in the long-term or permanent disablement of some 18 million women annually (WHO, 1995, p. 36). The major reason behind these complications was identified as the lack of access to antenatal and postpartum care. According to the WHR from 1998 "Life in the 21st century", in developing countries, 65% of the pregnant women received at least one antenatal visit during pregnancy, 40% of the deliveries took place at a health facility and just over half of all deliveries were assisted by skilled personnel(WHO, 1998, p. 154). The conditions in the least developed countries were even worse, where only 50% of pregnant women received antenatal care, and about 30% of deliveries took place in health facilities or with skilled attendants present (WHO, 1998, p. 155). Due to lack of attention from national and international public health community, access to postpartum care is much poorer. Less than

one third of the developing countries, covered in this WHR, report national data and level of coverage could be as low as 5% (WHO, 1998, p. 155).

Other indicators of maternal health paint the same picture. According to the WHR from 1998 "Life in the 21st century", more than half the number of pregnant women in the developing world were anaemic (WHO, 1998, p. 7). Malnutrition, a major reason for anaemia, could be fatal for the mother. It also has life-threating and life-long impacts for new-borns. Babies born to malnourished mothers are more likely to be under-weight. Moreover, studies have established the strong co-relation of frequent pregnancies with malnutrition. In resource poor settings, women do not receive the required nutritional intake during pregnancy and, if the pregnancies are not sufficiently spaced, it can worsen the nutritional status of women. Despite the well-established excessive burden of frequent pregnancies on woman's health, the prevalence of contraceptives in developing countries was 59% at the end of 20th century (WHO, 2005, p. 49). According to the 2008 WHR "Primary Healthcare, now more than ever", improvements in contraceptive use were not even across the regions, and contraceptive prevalence in sub-Saharan Africa stood at just 23% in comparison to the 61% in other developing regions (WHO, 2008, p. 3). Compromised access to contraceptives leads to an undue burden of unsafe abortions. According to the WHR from 2005 "Make every mother and child count", there were more than 18 million unskilled abortions performed by providers who lack the minimum required medical training, facilities, or medications (WHO, 2005, p. 50). Almost all these unsafe abortions took place in the developing world. Unsafe abortion rate was 34 per 1000 women in south America, 31 per 1000 women in eastern Africa, 25 per 1000 women in western Africa, and 22 per 1000 women in central Africa and south Asia (WHO, 2005, p. 50). Women's desire to end their pregnancies by any means possible in situations where abortion is risky, unlawful, or both shows how important it is to be able to control their own fertility. Unsafe abortions cost women dearly, both monetarily and in terms of health and lives.

The premature mortality and suffering associated with maternal health are not a fundamental part of being human, rather, these find their roots in the social, cultural, and economic contexts in which the women live. In most of the countries where women experience low health status, access to care has been made more challenging and even impossible to receive due to a systemic lack of infrastructure, financial resources, and skills among providers (WHO, 1995, p. 37). Even if the services are available, women's lower socioeconomic position, lack of finances and decision-making power, and low level of education, can hinder them from using the appropriate

maternal health care services (WHO, 2005, p. 26). Further, being a woman is frequently grounds for discrimination, which too often lead to mistreatment, abuse and neglect, as well as poorly described treatments, made worse by the perception of some medical professionals that women are ignorant (WHO, 2005, p. 28). Even if health care services are available on ground, such internal barriers in healthcare services may play a significant role in limiting the access of mothers to the care they are entitled to receive.

In many nations, women already experience problems because of social injustice and discrimination. Being HIV/AIDS positive frequently makes these sufferings worse. In fact, these very causes contribute to the explanation of why the disease affects women disproportionately. Women make up around 58% of all HIV/AIDS patients in the WHO African Region, and they contract the disease, on average, 6–8 years earlier than men do (WHO, 2004, p. 8). Young women commonly find themselves in unequal and abusive sexual relationships because they are unable to negotiate safer sex.

In addition to the impacts of bad health for women themselves, there is another reason for making health of mothers important for the societies, that is *"being a mother"*. For a woman, becoming a mother entails the responsibility to take care of her children and to ensure their better health and growth. According to the WHR from 1997 "Conquering suffering, enriching humanity" the chance of a child's survival to get to the age of one is halved if the mother dies during childbirth (WHO, 1997). As every society needs healthy children who can grow into healthy and sound adults that contribute to their nation's economy through their productivity, they needed to ensure that mothers do not die during and after childbirth. Looking back at the history of public health programs, which were first developed in Europe at the end of nineteenth century, targets were developed to improve the health of children and women (WHO, 2005, p. 2). As explained earlier in this chapter, children had been seen as a source of manpower, not only economically but also with regard to national defence. Public health officials have long been known that the health of children cannot be assured if their mothers are not healthy.

4.2.3 The poor

Poverty wields its destructive influence at every stage of human life from the moment of conception to the grave (WHO, 1995, p. 1). It conspires with the most deadly and painful diseases to bring a wretched existence to all who suffer from it. During the second half of

1980s, the number of people living in extreme poverty increased and was estimated to be over 1.1 billion in 1990, more than one-fifth of humanity. Poverty is defined as having a per capita income of less than or equal to $1 per day, expressed in American dollars and adjusted for purchasing power parity (WHO, 1999, p. 19). Poverty is the main reason why babies are not vaccinated, clean water and sanitation are not provided, curative drugs and treatments are unavailable, and mothers die in childbirth (WHO, 1995). The co-relation of poverty and health can be traced back to the time of the WHO's establishment when the WHO in its constitution defined health as "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*" (WHO, 1948). The inclusion of social well-being established the importance of Social Determinants of Health (SDOH) for public health, which received increased attention from the mid-1990s. The SDOH are the non-medical factors that influence health outcomes and include conditions in which people are born, grow, work, live, age, and the wider sets of forces and systems shaping the conditions of daily life (Hahn, 2021). However, the post-World War 2 context of cold war politics hampered the implementation of social model of health. Further, major advances in medicine research resulted the development of new antibiotics, vaccines, and other drugs. This favoured the notion that technology held all the solutions for the world's health problems. Following the temporary withdrawal of the Soviet Union and other communist countries from the United Nations and its agencies in 1949, the dominance of the US over the UN's organizations, particularly the WHO, increased (Irwin & Scali, 2007). In the 1950s, American policymakers were apprehensive about promoting a social model of health and favoured a strategy that relied more on health technology disseminated through focused interventions (Irwin & Scali, 2007).

A. Irwin and E. Scali in their article "Action on the social determinants of health: A historical perspective" published in 2007 noted that in the late 1990s and early 2000s, there was a growing momentum for governmental action to tackle health inequalities and address the SDOH in many countries of Western Europe. For example, in 1997, the explicit commitment of the Labour government in the United Kingdom to reduce health inequalities started a new era of action on the SDH (Irwin & Scali, 2007). Public health experts argued that global health inequalities may worsen if wealthier nations take serious action on their own determinants of health without commensurate actions in the developing world. In view of the increasing recognition of the significance of the SDOH, the idea for a global commission on the SDOH emerged and the WHO formally established The Commission on Social Determinants of Health (CSDH) in March 2005 (Irwin & Scali, 2007). Before that, the WHO, in its first WHR

"Bridging the gaps" in 1995, brought health inequities to the foreground of the global agenda for health, and declared poverty the world's deadliest disease.

Poverty brings with itself two burdens. The first one is bad health, and second one more poverty/extreme poverty. Both burdens are interlinked and keep the poor in a vicious cycle of ill-health and poverty. The Commission on Macroeconomics and Health has drawn attention to the two-way causal link between economic development and health in order to emphasize the critical role that health plays in achieving economic progress. (WHO, 2003, p. 26). The poor have no other option but to live in over-crowded housing conditions with unsafe water, insufficient sanitation, and indoor air pollution, all of which contribute to the occurrence of infectious diseases. At the time of need, the poor either get very limited access or very often do not get any access to health services because they cannot pay for them. This is when the second phase of the cycle begins, where diseases reduce the productivity of the poor and make them unable to work at all or not in their full capacity. The lack of productivity then brings with itself further poverty, which facilitates the existence of bad health, and the cycle continues and pushes the poor into extreme poverty.

The poverty-ill health cycle puts an increased burden on the health system, as the poor need the services again and again. Therefore, the poor need to be prioritized while planning health policies. It is not just a matter of providing health services to ones who need it. Investing in the health of the poor has the real potential to bring them out of poverty, which will eventually reduce the continuous burden on health systems and will add to the nation's economy. Hiroshi Nakajima, the then Director General of the WHO, addressed the importance of investing in health of the poor explicitly in the WHR from 1998.

> *The prime concern of the international community must be the plight of those most likely to be left behind as the rest of the world steps confidently into the future. They live mainly in the least developed countries where the burdens of ill health, disease, and inequality are heaviest, the outlook* is *bleakest, and life is shortest. (WHO, 1998, p. vi)*

The disparities in health status existed not only between poor and rich countries but also within them. Within countries, the disadvantaged performed much worse than the advantaged on several health indicators. An individual living in absolute poverty is five times more likely to die before the age of 5 and 2,5 times more likely to die between the age of 15 and 59 years (WHO, 1999, p. 19). Table 4, below, demonstrates the disproportionate burden of disease on

the poor in selected countries. Overall, the poor perform worse than those better off in society on all health indicators investigated.

Table 4: Health status of the poor versus the non-poor in selected countries, around 1990 (WHO, 1999, p. 19)

Country	**Percentage of population in absolute poverty**	**Probability of dying per 1000**								**Prevalence of tuberculosis (per 10 000)**	
		Between birth and age 5				Between age 15 and 59				Non-poor	Poor: Non-poor ratio
		Males		Females		Males		Females			
		Non-poor	Poor: Non-poor	Non-poor	Poor: Non-poor	Non-poor	Poor: Non-poor	Non-poor	Poor: Non-poor		
Chile	15	10	7.1	7	8.3	12	3.7	3	12.3	2	8.0
China	22	23	5.9	28	6.6	12	3.4	4	11.0	14	3.8
Ecuador	8	58	4.2	45	4.9	18	2.7	11	4.4	25	1.8
India	53	33	4.5	40	4.3	16	2.1	8	3.7	28	2.5
Kenya	50	43	3.7	41	3.8	24	2.1	13	3.8	21	2.6
Malaysia	6	13	13.7	10	15.0	18	3.1	10	5.1	13	3.2

According to the WHR from 2002 “Reducing risks, promoting healthy life”, the level of risk for ill-health increases as poverty increases. For unsafe water and sanitation, the relative risk for households living with $1 per day in comparison to homes living with $2 per day ranged from 1.7 to 15.1 with considerable variation between the WHO regions (WHO, 2002, p. 50). If people living on less than $2 per day had the same risk factor prevalence as the ones living with more than $2 per day, there would be an approximate reduction in protein-energy malnutrition by 37%, indoor air pollution by 50%, and unimproved water and sanitation by 51% (WHO, 2002, p. 51). The report argues that the results of the analyses have shown a correlation exists between socioeconomic status and the prevalence of non-communicable diseases, and their determinants as well. The analyses carried out in a sample of developing countries have shown that the prevalence of risk factors such as obesity and tobacco consumption were initially high among the non-impoverished population within the regions,

and later the prevalence was reduced among non-impoverished but began to increase among the impoverished (WHO, 2002, p. 51). This trend was consistent with regions at different stages of this transition. Without public health interventions, these risks will accumulate and increase among the poor, especially in the poorer regions of the world.

Poverty is not just the lack of money, it is also the inability to be heard, to tell their story in their own words. Though the numbers speak loudly, national, and international leaderships bear a moral obligation towards those who are most disadvantaged in society even if their needs are high. The WHO, being the custodian of a better health for all, is pledged to be the voice of those who lack the representation in decision-making spaces.

4.3 The importance of shared problems, goals, and solutions for galvanizing support

At the first international sanitary conference held in Paris in 1851, the topic of public health across national boundaries was discussed (WHO, 1998, p. 9). Following a series of international sanitary conferences, 12 states signed on the Rome Agreement in 1907, which called for the establishment of an international office of public hygiene in Paris (Office International d'hygiène publique-OIHP) (WHO, 1998, p. 9). The office was responsible for providing general information about public health to member states with special focus on infectious diseases. Later, in the aftermaths of the first World War, the League of Nations was founded. There was a discussion on whether to transform the OIHP into the health organ of the League, but this initiative failed (WHO, 1998, p. 9). Instead, "The Health Organization of the League of Nations" was established in 1920 with its headquarters to be based in Geneva. Both organizations worked independently until the end of second World War. At this time, the idea of combing the functions of both organizations into a single international entity was considered at a United Nations conference held in San Francisco in 1945 (WHO, 1998, p. 9). As a result, the WHO was established as the single body responsible for world health matters and as the one able to deal with the world's public health problems through a coordinated international effort (WHO, 1998, p. 10).

Though the WHO was constituted with a mandate of directing and coordinating international health work, it was decided during the conference that the Organization would not intervene in the internal affairs of a state and its assistance to governments would be subject to those

governments' requests and acceptance (WHO, 1998, p. 10). The WHO, with its mandate of leading the international health, bears the responsibility of identifying problems relevant to everyone. However, this mandate does not mean that the Organization is not responsible for addressing the issues threating the health of any specific region, nation, or population group. Having said that, the threats relevant to the public health internationally creates an opportunity for the Organization to get support from stakeholders across borders and set the targets that benefits all around the globe.

4.3.1 Non-communicable diseases

After its establishment in 1948, the WHO's work was focused primarily on a few communicable diseases, the ones seen as the biggest contributors to mortality at the time. Most developed countries, through immunization and improved socioeconomic conditions, showed marked improvements in overcoming the threat of infectious diseases to public health. Contrary to the developed world, the developing and under-developed world did not show impressive improvements during the initial decades of the second half of 20th century, and most of the Organization's activities were focused on this part of the world to help them cut the number of deaths caused by deadly infectious diseases. Starting in the 1970s, a shift in the evaluation of social development and well-being through non-monetary indicators began, and there was less reliance on monetary indicators such as per capita gross national product (WHO, 1998, p. 15). Non-monetary indicators such as life expectancy, infant mortality, maternal mortality, physical access to healthcare, literacy rates and other social indicators were being used to construct composite indices of social progress (WHO, 1998, p. 15). The shift also influenced the ways of measuring the impact of health actions on the well-being of people.

During the 1950s and 1960s, reductions in mortality rate and improvements in life expectancy were considered mostly while measuring the impact or outcome of health interventions (WHO, 1997, p. 1). However, at the end of 20th century, the WHO argued that quality of life is as important as its quantity, leading to the concept of "health expectancy" as a major indicator of health status of people (WHO, 1997, p. 1). According to the WHR from 1997 "Conquering suffering, enriching humanity", health expectancy can be defined as "life expectancy in good health and counts to the average number of years an individual can expect to live in a favourable state" (WHO, 1997, p. 1).

Health expectancy, being measured by number of years lived with good health, is reduced by chronic diseases which usually arise later in life. Industrialized countries, where infectious diseases were well under control, experienced the increasing burden of NCDs including circulatory diseases, mental disorders, chronic respiratory disorder, and musculoskeletal diseases which pose the greatest threat to health in terms of life lost and disability. On the other hand, developing countries were experiencing an "epidemiological transition", which means the burden of diseases was shifting from conventional infectious diseases to non-communicable diseases (WHO, 1997, p. 2). Out of more than 50 million deaths worldwide in 1997, three-quarters were due to NCDs and injuries. In the developed world, circulatory diseases accounted for 46% of total deaths and cancers accounted for 21%, while in developing countries circulatory diseases were responsible for 24% of total deaths and cancers for 9% (WHO, 1998, p. 44). In terms of DALYs, according to the WHR from 1999, an estimated 43% of DALYs globally were attributable to NCDs. In low- and middle-income countries (LMICs), the figure was 39% and in the high-income countries (HICs) it was 81% (WHO, 1999, p. 15). DALYs were introduced during 1990s, as a new approach to measure the health status of populations. It is a single unit of measurement that quantifies not merely the number of deaths but also the impact of premature death and disability on populations due to a disease (WHO, 1999, p. 15).

Risk factors responsible for the most NCDs were once known as "western risks", or the problems of wealthier nations. These factors may include increased use of processed food, tobacco and alcohol, obesity, higher cholesterol levels and blood pressure, and physical inactivity. But with economic development in LMICs, the living and working pattern of people has changed and the lifestyle of wealthier nations is being adopted by the people in these countries (WHO, 2002, p. 5). On the other hand, due to a sustained reduction in fertility rates in HICs, they were experiencing a "demographic transition". Societies which used to have more young people were facing an increase in the number of elderly people. As mentioned above, the probability of chronic diseases increases alongside longer lives, and therefore, soon NCDs accounted for most of the disease's burdens for the HICs as well (WHO, 2002, p. 4). The health risks associated with NCDs, which used to be a matter of concern for only wealthier nations are now global risks and pose a serious threat to the health of people in all socioeconomic settings.

At the end of 20th century, chronic diseases started to take over infectious diseases in terms of their share to the global burden of diseases. At that time, they got the attention of the public

health community, and the WHO in its 1997 WHR, “Conquering suffering, enriching humanity”, provided a detailed overview of the rapidly increasing burden of chronic diseases and the ever-rising threat they pose to the health of the rich as well as the poor. The WHO undertook one of the largest research projects ever to quantify some of the most important risks to health, and the project was primarily focused on chronic diseases (WHO, 2002). In 2002, at the annual meeting of the World Health Assembly in Geneva, findings of this project were presented to the ministers of health of almost all member states. They agreed that the lifestyle of different populations is changing around the world, and these changes pose a mounting threat to the health of individuals, families, communities, and societies, and therefore, demand a combined effort to deal with them (WHO, 2002, p. x).

The WHO continued its work to address the common problem and provided research-based recommendations for policymakers as well as the public. One such effort was development of guidelines for healthy eating to combat obesity, diabetes, and cardiovascular diseases (WHO, 2002, p. x). The Organization planned to take on board other stakeholders such as key players in the food industry to develop a better consensus on the actions to address the threat to global health (WHO, 2002, p. x).

4.3.2 The Millennium Development Goals and the World Health Reports

The Millennium Development Goals adopted by the United Nations in 2000 offered a possibility for collective efforts to improve global health (World Health Organization, 2018). They created a revolutionary international agenda that united developed and developing nations by unambiguous, reciprocal commitments and places health at the core of social development. The MDGs stand for pledges made by governments all around the globe to do more to combat environmental degradation, gender inequality, lack of access to safe water, and to act to reduce ill-health, poverty, and hunger. They also included promises to lower debt, boost technological transfers, and create partnerships for development. Out of the eight goals, set to be met by 2015, three were directly related to health and the remaining 5 had an indirect impact on the health of people.

The WHO, from time to time, kept promoting the MDGs at various global platforms by extolling on national and international leadership the importance of the Millennium Pact to harness human development. In order to meet the health related MDGs, the WHO placed a

high priority on supporting developing nations and other development partners. The WHO positioned health goals achievements as fundamental to reach other MDGs. The WHR from 2003, “Shaping the future” argued that the MDGs were interrelated and interdependent (WHO, 2003). According to the report, without adopting actions to guarantee a healthy population, it would be very difficult to reach the target to reduce income poverty by 50% (MDGs Goal 1, Target 1) in many nations (WHO, 2003, p. 26). Likewise, there is a central health component for Goal 2, increasing the rates of enrolment for primary education, and Goal 3, eliminating gender inequalities, and meeting them is essential for improving health outcomes (WHO, 2003, p. 27). Environmental sustainability, Goal 7, cannot be separated from public health as we come to understand the complexity of the interrelation between environmental changes and the health of people. It is crucial, therefore, that the health related MDGs be not viewed in isolation but an outcome or intended goal of a development strategy of numerous interconnected components (WHO, 2003, p. 27).

Eradication of poverty stands at the top of list of the MDGs and as it has been an area of high priority for the WHO even before the Millennium Pact. The WHO has continuously, in almost every WHR, underlined the crucial role of health in economic development by highlighting the two-way causal relationship of poverty and human development, that is also a key message of the MDGs. The Organization refers to poverty not just as low income but as the degradation of human capacities, including health. Human poverty is then defined as a lack of resources to accomplish capacities (for example, physical access to health care) as well as of fundamental "conversion" variables that aid in this attainment (for example, social access to health care) (WHO, 2003, p. 26). The WHR from 2003 further claimed that the achievement of other health related goals linked to child mortality, maternal mortality, and combating HIV/AIDS, malaria, and other diseases demands technical interventions coordinated by public and private delivery systems and reinforced by actions such as those to ensure greater food security, access to education, safe water, essential medicines, and improved public expenditure management. The domestic and global policy and trade contexts, as well as the accessibility of external financial aid in poorer nations, will all have an impact on governments' capacity to fund these initiatives (WHO, 2003, p. 27).

Also Goal 8, where developed countries pledged to ensure a better trade environment, that benefits developing and under-developed countries as well. In addition, providing debt relief to poorer countries and providing developing assistance to nations in the dire need of it frees resources that could and should be used on health. Although defining indicators for Goal 8

(Developing a global partnership for development) was difficult, there was reluctance from some developed countries, who did not want to include it (WHO, 2003, p. 30). Even the commitment made by the Organization for Economic Co-operation and Development (OECD) countries in the early 1970s to transfer 0.7% of their annual GNP to low-income countries as apart of development assistance has been met by very few (WHO, 2003, p. 31). A thorough assessment of development needs an examination of both sides (developing and developed world), and thus, the WHO called on the rich countries to take responsibility for their role as partners for development which include trade, debt relief, and development assistance, which are all crucial for poor economies (WHO, 2003, p. 31).

The WHO defined its role for reaching the health-related goals of the MDGs and categorized them into three sets. Firstly, the WHO would collaborate with nations to assist them in creating and pursuing a more comprehensive set of health objectives that are pertinent to their specific situations (WHO, 2003, p. 36). Secondly, in order to guarantee that disadvantaged groups fully participate in progress towards the health related MDGs, the WHO will place specific emphasis on assisting countries in developing objectives and strategies. One way to do this is to make sure that the percentage improvement for those living below the poverty line is at least as great as the percentage increase for the country as a whole (WHO, 2003, p. 36). Thirdly, the WHO will adamantly urge developed nations to uphold their end of the bargain, particularly by implementing those aspects of Goal 8 that are crucial to achieving the MDGs (WHO, 2003, p. 36).

Over time, new challenges emerged halting the progress towards the MDGs. The WHR from 2006, “Working together for health”, mentioned that one of the most serious obstacles to reaching the three-health related MDGs was the severe scarcity of health personnel in many areas (WHO, 2006, p. 19). There was not only a shortage of health services providers, but of supporting health workers including laboratory technicians, pharmacists, logisticians, and managers. The report highlighted some of the major constraints the health workforce face in the delivery of services positioned at achieving the health related MDGs. These constraints include inappropriate or insufficient training and access to information and knowledge, inadequate numbers of skilled health workers, uneven distribution of workers at different levels of service delivery, low morale and motivation, unsafe work conditions, poor policies and practices for human resource development, lack of supportive supervision, lack of integration of services with private sector, high attrition of health workers as a consequence of death from the very disease they work to cure, and migration of health workers towards developed

countries (WHO, 2006, p. 21). It is unlikely to be adequate to merely train staff to offer disease-specific interventions but designing multidimensional human resources strategies that can be put into practice quickly would be essential to achieve the MDGs (WHO, 2006, p. 20). The WHO recommended a scaling of the workforce by calling on the political leadership to consider it as an investment to nurture, not as a cost to be minimized (WHO, 2006, p. 22). To accomplish this, the WHO argued, countries need to devote enough funding to not only cover health services providers but also the management and support staff, who are equally crucial for health systems.

The MDGs were a tremendous driver for improving health and for tracking progress towards better health with clearly delineated metrics, data collected in standardized methods, and with globally agreed upon objectives, though not all health issues were addressed while adopting these goals. The investigation of progress towards the MDGs could help the global community to see how far we stand from the goal of achieving the UHC, therefore, the MDGs should not be seen in just their own context but a step for moving further to the post-2015 development agenda (WHO, 2013, p. 16). The WHO's emphasis on the need of investments in research stems from the certainty that it would inform policymakers and provide them with rationales for "*making better choices"* to reach the health-related MDGs. The WHO pledged to prioritize the type of research that has the maximum potential to improve global health security, accelerate health-related development, and redress health inequities as all of these are crucial to attain the MDGs (WHO, 2013, p. 96). The research would not only help the world to attain goals set in the MDGs but will also be of greater use for the post-2015 development agenda (WHO, 2013, p. 22).

4.4 Summary

The World Health Reports have remained a vital tool for the WHO in highlighting global health priorities. Each report has brought attention to a particular health issue, while some issues, such as poverty and health system development were included in almost each report. The WHO has persistently kept these issues valid for global health due to their magnitude and the need for continuous efforts to address them. To establish these priorities, the WHO needed to identify valid health problems. In addition to the potential of saving lives by tackling the identified health problems, factors such as political and strategical interests of national governments,

economic gains for stakeholders on investments in health, and achievement of tangible results by addressing any specific health issue played decisive roles in deciding which health problems should be prioritized. In addition to prioritizing specific populations and regions, the WHO has periodically raised health concerns that were relevant to all parts of the world. This served to reaffirm the Organization's validity for global health and to rally support from all stakeholders for the priorities it set.

5 Chapter 5: Data for action

The role of collecting data and generating information is of special importance for the WHO in initiating and directing actions to address concerned health issues. How is data used to decide what health issues to address? How does information shape prioritization? How does the WHO balance cost-benefit for everyone, with giving emphasis to prioritized groups? The chapter consists of three sections. The first section "Producing data for action" reflects on generation of information by the WHO, and how this information plays an important role in prioritizing health issues to be addressed. The second section provides an overview of what financial mechanism are recommended by the WHO for ensuring access to health by all. The third and final section explains how and when health needs of some population groups are prioritized.

5.1 Providing data for action on health issues

A core function of the WHO is to act as the directing and coordinating authority on international health work (WHO, 1948). In the first part below, "Generating information", I will outline how their strategy for gathering health information has changed over time. What is the relationship between collecting data and ensuring commitment to act on the health issues? In the second part, "Goal driven data collection", I will explain how the strategy of the WHO to gather health information about a specific health issue brought attention to that health issue. What role can data play in highlighting a health problem and initiating action against that health problem?

5.1.1 Generating information

Activities in epidemiological surveillance and health statistics were carried over from the WHO's predecessors. The League of Nations started publishing weekly, monthly, and annual "epidemiological reports" in 1922 and continued until 1938, later the job was taken over by the WHO, which published its first "annual epidemiological and vital statistics" in 1951 (WHO, 1998, p. 30). The interwar epidemiological intelligence service had focused mainly on surveillance of contagious diseases, but the league also took over the responsibility for the international mortality statistics from the OIHP. Like with its predecessor, the annual publication by the WHO was based on a periodical named "weekly epidemiological report",

which from 1947 provided uniform periodic data (as opposed to episodic data) to teaching institutions and health administrations (WHO, 1998, p. 30).

The duty to produce and gather data is reflected in the constitution of the WHO, which mandates that the organization develop and operate any administrative and technical services that may be necessary, including epidemiological and statistical services (WHO, 1998, p. 30). This extends the work of the WHO to the collection of data about health metrics and validation of data if the data is being collected by national governments or any other national or international organization (WHO, 1998, p. 30). Based on the data given by member states, the WHO has historically published multiple statistical reports.

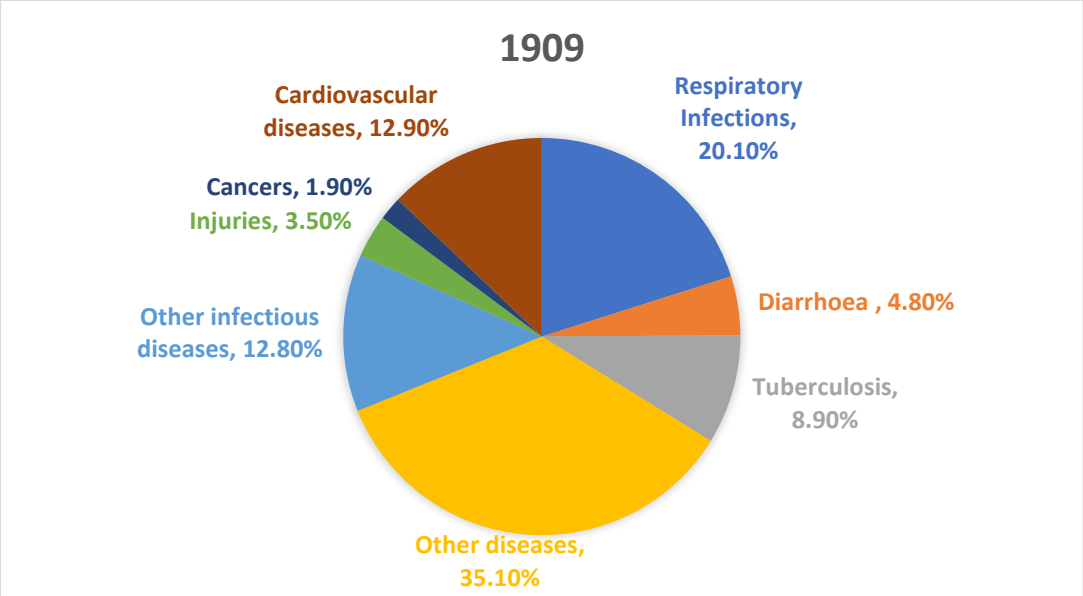
In 1979, the monthly epidemiological report was replaced by a quarterly one called "World health statistics quarterly" (WHO, 1998, p. 31). During the 1960s, the WHO had realised that some countries provide reliable data for mortality rates and its causes, while others lacked a strong national system for collecting health statistics. This meant that the information about population health was not capturing health-related data accurately. Soon afterwards, the WHO started to focus on providing advice and assistance to member states to strengthen their national systems for epidemiological and statistical data collection (WHO, 1998, p. 31). While not entirely successful, the efforts ended up generating an understanding among health planners that epidemiological and statistical data is not enough for planning programs to improve health. Data from other sectors, those that influence health, should also be collected. This includes the population's education status and literacy, economic development, unemployment, and food supply (WHO, 1998, p. 31).

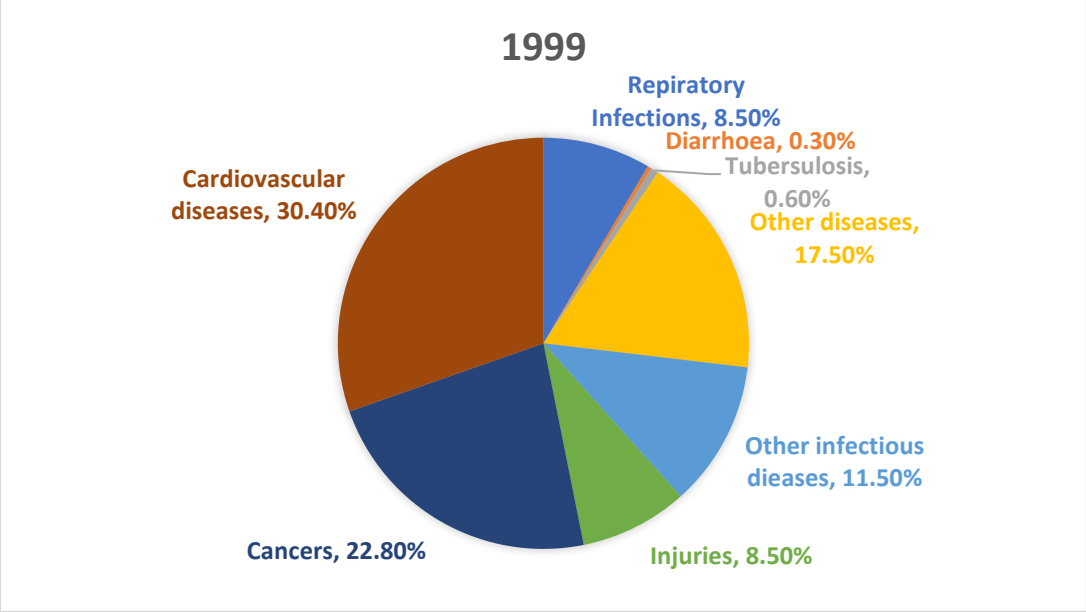
Since its inception, epidemiological information about infectious diseases of international interest have been a special focus of the WHO. This data was received, processed, and quick feedback was provided by the Organization to all countries to get them prepared for action. For example, the WHO has an influenza surveillance network of specialized laboratories which detect influenza viruses that could trigger pandemics and provide the data to a central system in the WHO which the Organization share further with countries for preparedness of necessary actions (WHO, 1998, p. 32).

At the end of 20th century, most countries experienced a shift in the burden of disease, particularly an increase in NCDs. Figure 3, below, provides an overview of such country, namely Chile. Both the developed and developing world, as it was referred to during this

period, had an increased proportion of older or middle-aged adults who required continuous care for chronic diseases, and an increased burden stimming from unhealthy lifestyles.

Figure 3: Distribution of deaths by cause for two cohorts from Chile, 1909 and 1999 (WHO, 1999, p. 13)





It was soon assed by the WHO that health care systems would face significant challenges because of the change, and that this would necessitate difficult choices about the distribution of limited resources (WHO, 1998, p. 14). To keep policymakers informed through reliable and consistent data on health threats, new approaches to measure the health of populations were

needed. This required more than just quantifying the number of deaths; it also required measuring the impact of premature death and disability on populations. In response, health metrics such as DALYs and QALYs were developed. The DALYs are used to measure the burden of disease, and QALYs are used to measure the gains from an intervention (WHO, 1999, p. 15).

These tools were adapted at a specific moment in time. Coming out of the cold war, the WHO needed to rethink and establish a "non-ideological" approach to health and priority setting. Experiences from GOBI-FFF in the 1980s, had shown that approaches with measurable effects, such as reaching vaccination targets, raised awareness and funds, and had measurable impact on health outcomes. The approaches were particularly popular among donors, and by the late 1980s, the WHO's extrabudgetary expenditure had grown larger than its core budget. The WHO eagerly embraced the new methodological tools, as they allowed expanding the toolbox to other health issues, and to calculate and compare the potential impact of competing health interventions in various settings somewhat objectively. A tool like this was immensely useful, but empty without real world data. The WHO, in collaboration with partners agencies, prepared the initial assessment of global disease burden in 1993 (WHO, 1998, p. 15). The introduction of new health metrics provided national policy makers with rationales for deciding priority areas, especially when it came to chronic diseases, for action to improve the health of their populations.

The “vertical approach” had remained prominent throughout the second half of the 20th century. As discussed in Chapter 2, characteristically for this approach, health interventions and most of the investment in global health was done through stand-alone programs, generally targeting either specific infectious diseases or specific populations, particularly maternal and child health. This included influential campaigns, such as GOBI/GOBI-FFF (Brown et al., 2006). As the world began to face an epidemic of NCDs at the end of 20th century, the global health community realized that any time-bound stand-alone health program were in-sufficient when it came to providing the continuous care that chronic diseases demand. The continuous nature of this demand strengthened the need to develop sustainable national health systems able to provide health care services according to the needs of their communities. Further, the goal of “health for all” identified at the Alma-Ata conference in 1978 could not be achieved by either a single or a set of vertical health programs. Instead, it requires strong national health systems.

It was with the 1998 appointment of Dr Gro Harlem Brundtland as the DG of the WHO, that health information systems, and their development, became a focus for the WHO work (WHO, 2000, p. vii). The WHO in its World Health Report "Health systems, improving performance" (2000), provided member states a detailed analysis of why health systems in some countries were not performing up to their real potential, and recommendations for how they could improve it. The WHO designed a framework to assess health system performance, which eventually informed national-level decision-makers about areas for actions within their health systems to meet their goals (WHO, 2000, p. xii). By explaining and quantifying the targets of health systems and connecting them to fundamental functions, the framework was intended to assist member states in measuring their own performance, understanding the elements that contribute to it, improve it, and better respond to the needs and expectations of their populations (WHO, 2000, p. xii).

A major determining factor for the probability of occurrence of chronic diseases, commonly called "lifestyle diseases", are the individual choices people make regarding food, physical activity, and risky behaviours like tobacco smoking and drinking alcohol. The WHO addressed this through providing information to governments about the health threats and communicating directly with the public through "risk communication" (WHO, 2002, p. xi). The WHO argued for the importance of informing people directly about their health risks and stated that doing so was a decisive factor in building trust between public and their governments, as well as for sharing the responsibility for managing these health risks (WHO, 2002, p. xi). Risk communication has evolved from the mere communication of information using health education-style messages, to a structural strategy which includes promotion of public dialogue between different stakeholders (private for-profit corporations, public health campaign organizations, civil society representation, media etc.), resolution of conflicts between stakeholders, and agreement on the need for interventions to prevent the risks (WHO, 2002, p. 39). According to social scientists, risks cannot be deemed "real" irrespective of their societal environment (WHO, 2002, p. 38). Therefore, the WHO argued that risk communication needs to include goals and objectives; the messages and the content should target specific audiences and consider their demographic context, the sources of information, how it is presented, its distribution and circulation, as well as channels for discussion and dispute resolution (WHO, 2002, p. 39). The greater responsibility for informing the population about health risks falls upon the national governments. It is them, who should "translate" the scientific data, received

from the WHO and other credible agencies, into actionable information that reflect their local sociocultural context, thus making it accessible and understandable for their population.

5.1.2 Goal driven data collection

The World Health Organization is the lead agency for global health, and as such, it bears the responsibility of advising on the actions needed for the betterment of the health of people around the world (WHO, 1998, p. 10). The interventions and policy choices recommended by the organization to national and international leaderships needs to be validated through rational data about the health problems that interventions and polices will target. Before the advent of tools like DALYs and QALYs in the early 1990s, assessment of health conditions relied on looking at life expectancy and counting deaths caused by any ailment. Recommendations for interventions were based on the number of lives these interventions could avert. In the 1990s, the WHO realized that this was not sufficient. The WHR from 1998, "Life in the 21st century, a vision for all", phrased it as follows:

> *"This assessment of health trends uses conventional indicators such as life expectancy, mortality, and morbidity. Efforts are under way, however, to develop indicators of positive health such as health expectancy and its variants." (WHO, 1998, p. 39)*

As discussed in chapter 4, the WHO inherited the understanding that infectious diseases of international interest needed to be dealt as a priority area for action from its predecessors. Communicable diseases, as well as child and maternal health remained a top priority of the international health community throughout the 20th century. These priorities reflected in the first classification of health problems by the WHO. In this classification, health problems were divided into 6 groups according to their priority. These groups were malaria, maternal and child health, tuberculosis, venereal diseases, nutrition, and sanitation; public health administration; parasitic diseases; viral diseases; mental health; various other activities (WHO, 1998, p. 11).

In this context, the major focus of the WHO, when it came to data collection, remained on indicators which were relevant to the areas of interest for international health such as life expectancy, immunization, and infant and child mortality. This can be observed in the first WHR from 1995. The report primarily concentrated on the fatality count attributed to each health problem, when taking into account the burden of diseases. In case of child health, the

report claimed that around 2.4 million children died needlessly due to vaccine-preventable diseases (WHO, 1995, p. 4).

Until the end of the 20th century, life expectancy improved significantly, but the debate about the burden of diseases beyond mortality was growing. With the increasing prevalence of NCDs, it also became important to consider the impact of disabilities caused by these diseases. Chronic diseases come with burden of living with bad health for many years, and life-long demand for healthcare services put pressure on health systems (WHO, 1997, p. 1). As quoted in the WHR from 1998, by the then DG of the WHO, Hiroshi Nakajima,

> *"We are slowly learning one of life's most important lessons, not just how to live longer, but also how to stay longer in good health with less dependence on others." (WHO, 1998, p. v)*

Industrialized countries, a term used in the 20th century to describe sovereign states with a developed economy, advanced technological infrastructure, and a high quality of life, have an ever-increasing proportion of older adults. Infectious diseases were well under control in these countries, and the greatest threat to health in terms of life lost and disability came from non-infectious diseases (WHO, 1997, p. 2). On the other hand, in the developing countries although infectious diseases remained major killers, the prevalence of non-infectious diseases was rising sharply (WHO, 1997, p. 2). The kind of health matrix used to determine priority areas could change the priorities set by policymakers, as they could lead to different recommendations for what health threats to address in a given population (Table 5, below). Therefore, it was necessary for the WHO to provide data about health indicators other than mortality, as this would provide the foundation for advising on policy choices to countries with different socioeconomic settings. A direct or indirect goal of most of the WHO programs during the 1990s was data and knowledge expansion (WHO, 1998, p. 14). For this, the WHO has always utilized national centres and institutions already in existence, whose services are made accessible by the relevant national authorities (WHO, 1998, p. 14).

Table 5: Leading causes of mortality, morbidity, and disability, selected causes for which data are available, all ages, global estimates for 1997 (WHO, 1998, p. 48)

Rank	Leading causes of mortality	Leading causes of morbidity	Leading causes/conditions of disability (permanent and long-term)
1	Ischaemic (coronary) heart disease	Diarrhoea (including dysentery)	Mood (affective) disorders
2	Cerebrovascular disease	Malaria	Hearing loss (41 decibels and above)
3	Acute lower respiratory infection	Acute lower respiratory infection	Schistosomiasis
4	Tuberculosis	Occupational injuries	Lymphatic filariasis
5	Chronic obstructive pulmonary disease (COPD)	Occupational diseases	Cretinism

Since the last decade of 20th century, the WHO has widened its scope of collecting data to health indicators of NCDs and developed a new matrix, one that includes DALYs and QALYs, which quantifies the burden of disease for NCDs. In its effort to provide data for risk factors associated with chronic diseases, one of the initial efforts of the WHO was data collection on tobacco use. Tobacco use is one of the very important risk factors for multiple chronic diseases, including lung cancer, coronary obstructive pulmonary disease, and heart diseases (WHO, 1999, p. 16). The WHO provided extensive data about the economic and health burden of the tobacco use in its WHR from 1999 "Making the difference". The organization further extended its effort for collecting data on risks factors associated with chronic diseases. In the WHR from 2002 "Reducing risks, promoting healthy life", the WHO reported the results of one of the largest-scale projects it had ever undertaken. The project did not focus on risk factors associated with infectious diseases such as viruses, bacteria, and antimicrobial resistance, but quantified the risks associated with chronic diseases such as high blood pressure, high cholesterol level, obesity, use of tobacco and alcohol, physical inactivity, malnutrition, and indoor air pollution due to solid fuels (WHO, 2002, p. x). This, too, can be seen as part of WHO's active attempts at remaining relevant in a changing world. Shifting from focusing solely on contagious diseases to including NCDs, meant the advice was equally relevant to all parts of the world.

Mental health was included in the very initial classification of health problems by the WHO around the time of its establishment, but throughout the second half of the 20th century it neither received the attention it needed, nor did the WHO focus on collecting and providing data about the magnitude of the problem. This changed when the WHO brought mental illness as a top priority for global health by including it in the agenda of the World Health Assembly meeting in 2001. The same year, the World Health Day with the theme "Stop exclusion- Dare to care" was arranged (WHO, 2001, p. ix). The theme's main objective was to raise awareness, increase knowledge, and change attitudes about mental health issues, in particular to de-stigmatize mental illness (WHO, 2001, p. 58). The WHO provided detailed data for the disease burden of mental illness in the WHR from 2001 "Mental illness: New understanding, New hope". According to the report, mental disorders accounted for 12.3% of global DALYs (WHO, 2001, p. 152).

The WHO increasingly used its position to take global leadership on specific health issues, and this was also the case for the HIV/AIDS epidemic. In the 1990s, the WHO extensively collected data on the availability of antiretroviral drugs to highlight the scope of problem. According to the WHR from 2004 "Changing history" there were 36-46 million people living with HIV/AIDS at that time. The report states out of 6 million who needed urgent treatment with antiretroviral drugs, only 400 000 (7%) received the drugs during 2003 (WHO, 2004, p. 6).

5.2 We need to pay for it

As information about a growing number of health issues was increasing, how should states prioritize? This section provides an overview of role of cost and benefit of the intervention in guiding actions to target the health needs of populations. In the first part, "cost-effectiveness", I will explain the emergence of cost-benefit analysis as one of the decisive factors for policymakers to choose health interventions. In the second part, "financial risk", I will explain the backlash to the idea that had dominated in the 1980s, that healthcare users needed to pay for services to understand their value. Instead, financial cost of ill-health was identified as a major barrier for access to healthcare, and this barrier was keeping the world away from achieving its goal of Universal Health Coverage.

5.2.1 Cost-effectiveness

The 20th century saw significant improvements in human health, although serious health disparities still exist. If we are to improve health outcomes, take on new challenges, and address inequities, resources need to be used wisely. This calls for understanding which interventions are most effective, awareness of their costs, and practical expertise in their delivery and execution. This was particularly pertinent as new technologies and new medicines made a number of new treatment options available at a steep premium. Health planners needed to choose among possible interventions considering the limited resources available. Furthermore, the world was experiencing an epidemiological transition, with aging populations and increasing health burden due to NCDs. Chronic diseases demand a continuous healthcare service; therefore, it was important to look at which services could benefit the most population and provide the maximum value for money.

To make the health systems as cost-effective as possible, policymakers need to prioritize interventions which offer the most value for money and not focus on those that, though potentially benefiting individuals, make insignificant contributions to population health improvement per dollar invested (WHO, 2000, p. 52). Shifting resources from cost-ineffective interventions to cost-effective ones might improve the health system's allocative efficiency. The significant benefits of doing so can occasionally be quite substantial because the current pattern of interventions includes ones that are expensive and whose outcome is modest number of additional years of life (WHO, 2000, p. 52). For instance, in the US, a set of 185 publicly supported interventions cost around $21.4 billion yearly, saving an estimated 592,000 years of life (considering only premature deaths prevented). Re-allocating these funds to the most cost-effective initiatives might save an additional 638,000 life years, if all likely beneficiaries were approached (WHO, 2000, p. 52).

Identifying services which will add most to health given the resources at hand requires a cost-effectiveness evaluation. The differences in cost and effectiveness of interventions are especially important when a mixture of numerous interventions may be effective against a specific issues, therefore, analysis must be used on individual interventions, not generally on illnesses or their causes (WHO, 2000, p. 54). Services can be categorized based on how significant they are to the burden of disease for specific age and sex groups as well as how cost-effective they are for those groups (WHO, 2000, p. 53). Further, services should ideally be affordable as well, allowing them to be used by broad benefit groups while yet implying fair

total costs. However, there is no guarantee that low cost per life saved, or healthy life year gained will mean low cost per person: some cost-effective interventions can be very expensive, with great variation between one health service and another, for the same disease (WHO, 2000, p. 54). For example, in case of malaria two interventions are proved to be equally cost-effective, chloroquine prophylaxis and two rounds of insecticide sprays every year. But in terms of how much it would cost to implement each of them over the whole impacted population in low-income African nations, the amount of money needed vastly differ. For interventions to treat an infection, price variations are considerably more pronounced (WHO, 2000, p. 54). On the contrary, even though health interventions are meant to help a significant number of people and are remarkably inexpensive, they still may not be cost-effective. For example, while it is well recognized that antibiotics are useless for treating viral diseases, many healthcare providers still frequently use and prescribe them. In low-income countries, where the spectrum and cost of potential remedies greatly exceed the resources available, such inefficient practices can deprive other patients of vital care. Even for richer countries, it is important to ensure that the objective of the health services remains focused on effective and affordable public health and clinical interventions.

Earlier, cost-effectiveness analysis was used mostly in low-income countries to evaluate certain disease control programs. However, the technique's scope expanded following publication of the World Development Report by the World Bank in 1993, and subsequent work by the WHO (WHO, 2000, p. 53). In order to compare the cost and population-health effects of existing and potential future interventions, the WHO created a standardized set of methodologies and procedures in a project named WHO's CHOICE project (WHO, 2002, p. 101). The goal of the CHOICE project was to offer frequently updated datasets on the costs and outcomes of a wide range of health promotion, prevention, treatment, and rehabilitation interventions (WHO, 2002, p. 101). As a part of the CHOICE project, the WHO did a region-based cost-effectiveness analysis for selected interventions. The six WHO regions were further categorized into fourteen epidemiological subregions based on mortality strata (WHO, 2002, p. 101). The results were used to identify and classify interventions as highly cost-effective, cost-effective, and not cost-effective for each subregion (WHO, 2002, p. 101). The epidemiology, pricing models, and starting points (such as the availability of trained health workers and the history of health initiatives) differ less within each subregion than throughout the world as a whole, making this study far more policy-relevant than a global one. National analysts can use subregional analysis as a useful starting point to adjust the findings to their own contexts.

The Commission on Macroeconomics and Health, which was launched in 2000, classified interventions as very cost-effective if they cost less than GDP per capita for each addition averted DALY, and cost-effective if they cost between one- and three-times GDP per capita for each additional averted DALY (WHO, 2002, p. 18). According to the commission, if a country cannot manage to implement all such interventions with its own resources, the international community should provide support. Although policymakers need to consider other development goals, such as equity and poverty reduction, decision makers can use the classification as a starting point for policy-debates about priorities for allocating health resources in a resource-constraint setting.

5.2.2 Financial risk

Health expenditure had risen from 3% of world GDP in 1948 to 7.9% in 1997 (WHO, 2000, p. 95). The enormous increase in health expenditure has spurred communities around the globe to look for health finance solutions to ensure that individuals do not go without the treatment they need because they are unable to pay for it. This does mean that health systems organize their financing to reduce or eliminate the likelihood that a person will not be able to pay for care when it is needed or will not be impoverished in doing so. Health systems use various methods to raise money, including general taxes, compulsory social insurance contributions (typically linked to salaries and, seldom if ever linked to risk), voluntary private health insurance contributions (generally linked to risk), out-of-pocket payments, and donations. Commonly, high income countries mostly rely on general taxation or compulsory social health insurance. On the contrary, LMICs depend heavily on out-of-pocket expenditure (Table 6, below). Out of pocket expenditures represent more than 40% of total health expenditure in 60% of countries with an annual income of less than $1000 per capita, while only 30% of the LMICs depend on such financing (WHO, 2000, p. 96).

Table 6: Global estimates for out-of-pocket share in health spending by income level, 1997 (number of countries in each income and expenditure class) (WHO, 2000, p. 96)

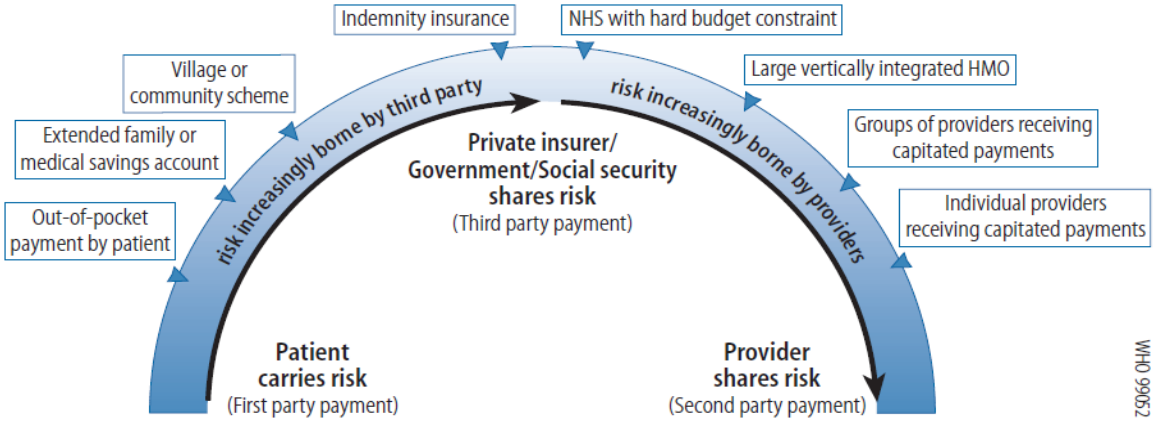
Estimated annual per capita income. (US$ at exchange rate)	**Estimated share in total expenditure on health (%)**						
	Under 20	20-29	30-39	40-49	50-59	60 and over	Total
Under 1000	7	10	9	7	11	19	63
1000-9999	16	18	23	15	8	8	88
10 000 and over	19	7	4	5	2	2	37
All income classes	42	35	36	27	29	29	188

Out-of-pocket expenditure or direct payments refers to the payments that individuals make when accessing or after receiving health care services (WHO, 2010, p. 5). These health expenditures exert a huge financial burden over individuals and their families. Data available for 89 countries, representing around 90% of the world's population, showed that in some of these countries, over 11 % of population suffer financial catastrophe (defined as paying more than 40% of the household income directly on healthcare after basic needs have been met) due to out-of-pocket health expenditure (WHO, 2010, p. 5). Data further provided evidence that 5% of these people are forced into poverty because they must pay at the time when they need services (WHO, 2010, p. 5). As a result, only those who can pay, get access to services and the poor are either denied of the services due to inability to pay or face catastrophic impoverishment. This explains, to an extent, the increasing disparities in health between the poor and well-off, especially in poorer countries. Most social insurance-schemes and voluntary private insurance programs combine income collection and pooling into a single entity. This single entity provides care and procures all goods and services needed for this provision. This pooling ensures that risk of paying for healthcare at the time of need is borne by the whole of the population and not by the individual.

The WHO in the WHR from 1999, "Making the difference", explains how various financing models allocate the risk of healthcare expenditure (see Figure 4, below). In the "first party payment" scheme (bottom left segment), the individual or the family pays the whole cost for healthcare services when he or she is ill (WHO, 1999, p. 38). In this case, the financial risk of being sick does not get shared by the population or community, but entirely by the individual

or his/her family. This type of health financing is most common in the poor countries for the delivery of primary health care.

Figure 4: Who bears the risk of healthcare cost? (WHO, 1999, p. 38)



Moving clockwise from the lower left are the family, the kinship-based, and other forms of voluntary risk sharing. These are ways in which financial risk is shared by larger population groups. The element of pre-payment is a sign of shifting the focus of risk from the individual to a group or fund. Systems that pool risks among big populations are shown in the top of the diagram; systems to the left of the apex, where private insurers handle money on behalf of large groups of people and pay providers accordingly, whereas systems to the right are those where national health systems and social insurance programs are financed by general taxes and payroll taxes, respectively (WHO, 1999, p. 38). Most health services are covered by one of these substantial funds, which are also called "third party" payers.

Within this variety of organizational configurations, there are several alternatives for paying providers. Although myriad methods may make sure that the patient also participates, or that some of the risk is transmitted to providers, either individually or in groups, there is still a third party (the health fund or budget-holder) that bears the financial risk. As we move down the right segment, the supplier of care as a “second party” share the risks associated with health care expenditure (WHO, 1999, p. 38). While managing the population's health demands within a certain budget, the type and quality of treatment that providers (hospitals or individual practitioners) deliver may have an impact on their compensation. By doing this, providers are becoming active participants in the management of a population's health requirements and vulnerabilities.

The system's predominant method for collecting funds largely determines the prepayment level. In contrast to out-of-pocket payments, general taxation provides for the greatest possible segregation between contributions to and use of healthcare services. Why then is the former more commonly practiced, especially in developing countries? The WHO provides the answer in the WHR from 2000; the segregation of utilization of healthcare from financial contribution to the healthcare demands that the entities in-charge of collecting revenue are institutionally and structurally well-equipped, and most developing countries lack such entities (WHO, 2000). Relying on prepaid payments, especially general taxes, is systemically quite demanding. General taxes as the primary source of funding for healthcare necessitates efficient tax or contribution collection capabilities. This is typically linked with countries who largely report a formal economy, which is mostly common in developed countries; while in developing countries, it is the informal sector that most frequently dominates. At the turn of the millennium, general taxes accounted for more than 40% of GDP on average in OECD countries, whereas in low-income nations, it made up less than 20% (WHO, 2000, p. 98).

All other prepayment frameworks, including social security and voluntary insurance premiums, are simpler to collect since the reward of participation is tied to real contributions(WHO, 2000, p. 98). Most often, only employees in the formal sector who pay through payroll deductions at work are eligible to participate in social insurance programs. This makes it simpler for the social security agency to locate users, collect contributions from them, and if no payments are made, possibly disqualify them from benefits. Similarly, identification and collection are simpler for voluntary health insurance and community-based pooling mechanisms (WHO, 2000, p. 98). However, these prepayment schemes also need significant organizational and institutional capacities.

Having enough funds is vital, but if individuals face financial difficulty or are discouraged from utilizing services because they must pay up front, it will be impossible to achieve anything close to universal coverage (WHO, 2010, p. xiv). Where fees are levied, everybody is charged the same amount regardless of their financial situation. There is no formal representation of solidarity between the sick and the well, or between the wealthy and the destitute. Such financial arrangements prevent individuals from distributing healthcare costs across their life-cycle, meaning they cannot contribute to financial pool while they are young and healthy, and in case of disease there is not financial pool to cover their healthcare expenses (WHO, 2010, p. xiv). As a result, there is a substantial chance of financial disaster and poverty, making the attainment of universal coverage unachievable. Nearly every state imposes some kind of direct

payment, also known as cost sharing, though the percentage of overall spending that is funded in this way increases with the level of poverty in the nation. The most extreme incidences may be seen in 33 primarily low-income nations, where direct out-of-pocket expenses made up more than 50% of all health spending in 2007 (WHO, 2010, p. xiv).

According to the WHR from 2010, the likelihood of financial disaster and destitution becomes insignificant only when direct payments remain between 15% and 20% of overall health costs (WHO, 2010, p. xiv). This could be an unrealistic target for many governments. For that reason, the WHO suggests starting with a more modest target, as some countries in South-East Asia and Western Pacific regions did by setting an initial target of between 30% and 40% (WHO, 2010, p. xiv). The only possibility for the government to reduce dependence on out-of-pocket payments is to opt for risk-pooling and prepayment plans, the strategy followed by most of the countries that have achieved or are close to achieve universal coverage (WHO, 2010, p. xiv). These are based on contributions paid ahead of a disease, gathered in some form, and used to cover health services for all who are enrolled; treatment and rehabilitation for the ill and disabled, as well as prevention and promotion for everyone. The WHO argued, when prepayment and pooling arrangements are available to a community, the goal of universal coverage becomes more feasible (WHO, 2010).

5.3 Who are we focusing on? How and when are special populations are prioritized?

While the WHO constitution sets as its goal the highest possible level of health for all people, there has still been a need to give priority to specific population groups. This section explains why the health of some groups is being prioritized, and what factors push the multilateral agencies and political leadership to address the health needs of these populations. In Chapter 4, I discussed the overarching rationale for prioritizing specific groups. In the following, I will explain how the economic, political, and ethical factors play a role in prioritizing health needs of specific populations.

5.3.1 Health of Poor

The 1995 WHR, "Bridging the gaps" states that poverty is the world's deadliest disease (WHO, 1995). Every stage of human existence is affected negatively by poverty, and for many of its victims, there is no way out other than a premature death. Though on average global life expectancy is increasing, when disaggregating the data, we could see it decreasing in some of the poorest countries (WHO, 1995, p. v). The number of humans living in extreme poverty is disturbingly high, reportedly over 1 billion in 1995 (WHO, 1995, p. v). For millions of those who live everyday of their life in a battle for survival, the prospect of living longer is nothing but a punishment. As explained in the chapter 4 of this thesis, it is not only poverty that brings itself with illness and bad health, but illness is also a precursor to poverty. Why are these millions of people stuck in the cycle of ill health and poverty? The answer is not that they get sick more often compared to their well-off counterparts, but they remain in ill-health because they do not have access to healthcare services when they need it. This happens either due to inability to pay for these services, or because, in many cases, there are no services available near their homes. The achievements in health made by the world during the second half of 20th century cannot be denied, but at the same time it is a reality that the fruits of these advancements have not been enjoyed by all. As the then DG of the WHO, Hiroshi Nakajima, wrote in WHR 1998: -

> *"The gaps between the health status of rich and poor are at least as wide as they were a half century ago and are becoming wider still" (WHO, 1998, p. vi).*

In parallel with understanding of health expanding from contagious diseases and life expectancy to NCDs and disabilities since the early 1990s, the definitions of poverty and development have expanded to encompass a more comprehensive understanding of human well-being rather than focusing solely on income (WHO, 2003, p. 26). According to this new understanding, poverty encompasses more than just a lower economic status; it also entails the deterioration of fundamental human capabilities, including health. The state of human poverty is marked by the absence of resources needed to acquire capabilities, such as access to healthcare services, as well as the absence of critical transitional factors that make such achievements possible, such as social support for accessing healthcare. In contrast, human development is the progression of increasing individuals' choices so they can enhance their capabilities, such as having freedom to opt for a healthy lifestyle. This more nuanced understanding of poverty and development takes into consideration the interacting mechanisms

that are essential to the social dynamics of health improvement, such as how economic capacity affects health, and how low-income limits access to health care (WHO, 2003, p. 26). Equally significant, ill-health decreases individuals' productivity and chances to earn higher income, which eventually exacerbates poverty. This close interaction of poverty and human development confirms that health improvements for the poor are needed for bringing them out of impoverishment. The very first of Millennium Development Goals called for the eradication of poverty and hunger, which cannot be a reality in many of the countries unless health needs of millions living in poverty are addressed (WHO, 2003, p. 27).

The cost of health services could easily be one of the greatest barriers to achieving better health outcomes. In most HICs, the establishment of social security has ensured access to basic healthcare for almost everyone, though there are still gaps in the health status of rich and poor. The magnitude of the problem is enormous in LMICs; where, according to the International Labour Organization, any kind of formal social protection coverage ranges from 20% to 60% (WHO, 2010, p. x). The situation is even worse in sub-Saharan Africa and Southern Asia, where only 5-10% of the population is covered (WHO, 2010, p. x). In these countries the proportion of health expenditure paid out-of-pocket ranges from 50% to 70% (WHO, 2010, p. 42). Where the burden of cost is paid by the individuals, access to healthcare becomes limited and covers only those who have the ability to pay. The poorer are then pushed to choose between paying for food, shelter, or other necessary things, and healthcare. The data provided in the fourth chapter of the thesis about the health of poor explains, why most of the time health could not be a priority for them.

The WHO has kept the health of the poor among its top priorities and has provided data-based arguments to impress on national and international leadership the need for placing the health of the disadvantaged at the top of the development agenda. The very first WHR which was issued in 1995, "Bridging the gaps", put forward a single agenda for international health "the health of the poor needs to be addressed by redirecting the available resources towards those who needs it the most" (WHO, 1998, p. 7). Further, in the WHR from 2010, "Health systems financing", the WHO provided detailed arguments that the long- awaited achievement of global health: - "Health-for-all", and the overwhelming goal of UHC will not be a reality until health of those who cannot pay for it will be given a priority in national as well as international policy choices and development goals.

5.3.2 Occupational health

Occupational health is an area of public health which deals with the attainment of highest possible physical, mental, and social well-being of workers in all occupations (WHO, 2022) . The WHO categorizes risks to health at workplace into two categories (WHO, 1997, p. 65). First, an association of a specific occupation with an ailment, which appears in its workers to a larger extent than would normally be expected. Second, a worker is exposed to any risk of disability due to unexpected exposure to any kind of energy (mechanical, chemical, electrical, radioactive, and others), which accounts for accidents. The prevalence of injuries related to work is greater among men than among women, though differences are negligible in a few industries (WHO, 1997, p. 65). Among male workers, the injury rates are highest among males in their late teens and lowest in those who are in their middle age (WHO, 1997, p. 65). The risk of getting injured increases again among older workers.

The health of the workforce is important for any country, regardless of its economic standing, as the workers are the ones who fuel the economy of the nation. Low level of occupational health and increased occupational injuries effect a country's economy in two ways. First, ill-health of workers and increased incidences of injuries at the workplace put an extra burden on the health system. Second, they have a strong impact on nation's economy due to lost work capacity of workers. According to the WHR from 1998, "Life in the 21st century", occupational injuries were the cause for 38 million working days lost every year during the 1980s in 14 countries of Latin America and Caribbean alone (WHO, 1998, p. 96). If the pattern is extended to the entire subregion, an estimated 95 million working days were expected to be lost each year (WHO, 1998, p. 96). The cost of absence due to work-related illness and injuries was estimated to represent around a 3% loss of GNP for a society and if all direct and indirect losses are considered, the figures go up to 20% (WHO, 1997, p. 66). if we tallied the data from all countries, the magnitude of economic loss to the global economy would be enormous. The loss of work productivity affects individual's earnings, which then reduces the overall earning power of the family and pushes the whole household towards poverty.

Apart from economic cost, the health cost of occupational illness and injuries is also considerable. According to the WHR from 1997, "Conquering suffering, enriching humanity", every year over 200,000 deaths and 120 million injuries world-wide are attributable to work-related health hazards (WHO, 1997, p. 64). It is worth mentioning that this is a calculation that does not encompass the entire impact of all work-related health hazards. Estimates suggest that

about 160 million cases of work-related diseases occur every year globally (WHO, 1997, p. 65). Out of these, about 30-40% lead to chronic diseases, and about 10% to permanent work disability. The hazards to health at work ranges from heavy physical workload to exposure to chemical and biological agents which results in musculoskeletal, respiratory, cardiovascular, psychological, and other health problems. These health problems put a huge burden over the health systems and especially in resource constraint settings these chronic illnesses could be of considerable concern.

Due to its enormous economic and health cost, the WHO, from time to time, highlights the importance of minimizing health hazards at all workplaces. The history of the WHO's work in occupational health goes back to 1950s, when the organization constituted a committee in collaboration with the ILO for defining health concerns at the workplace (WHO, 1998, p. 99). During the 1990s, the WHO added health at the workplace to the top of its agenda, aiming for better work environment, more development, and health improvements. This led to a worldwide call for action named "Global Strategy for Occupational Health for All" (WHO, 1998, p. 99). Further, most work-related illnesses are relatively simple to avoid due to straightforward identification, measurement, and control of causal agents, and easy identification of the population at risk (WHO, 1997, p. 66). Targeting a population whose problems are easy to identify and address could be an edge for technical agencies such as the WHO, but for national and international leadership it was the economic losses due to the bad health of workers that mattered most. All these confounding factors made the health of workers an area of concern for the WHO and for political leadership across all country contexts.

5.3.3 Health of elderly

Ageing is a normal dynamic process and not a disease, but it does bring reduced physical productivity and many illnesses. Most of these ailments are chronic and exerts a need for continual supply of healthcare services. As the world has made remarkable improvements in life expectancy during the 20th century, the number of people living over 65 years have increased more than ever. From 1990 to 1995, the global population increased at an annual rate of 1.7%, while the population aged 65 years and over had increased at an annual rate of 2.7% (WHO, 1995, p. 37). This demographic change was not restricted to developed countries but developing ones as well. In 1993, out of 335 million people over 65 years in the world, 200

million were living in developing countries, which makes 4.6% of the whole population in these countries and these figures for developing countries were expected to increase by 400% during the next three decades (WHO, 1995, p. 37). This means that older people made up a larger and larger proportion of the population across the globe. The increasing proportion of elderly population mounted pressure on health planners and politicians to allocate funds for providing the healthcare services to the elderly. One important reason for doing so was the fact that old age brings financial hardship and poverty, as even well-provided pensions are less than the people earned when they were working (WHO, 1995, p. 38).

Remarkable achievements in the control of infectious diseases and developments in health technologies have increased survival rates and extended life expectancies, but it did not assure a longer life with the enjoyment of good health. Life expectancy does not consider the disease burden in old age. Data from many countries have shown that, among elderly people there is a high co-occurrence of conditions including arthritis and rheumatism, deafness and poor vision, and specific chronic diseases of heart, brain, and lungs. This makes them high consumers of health services. In some countries, people over 65 years make up 10% of the total population, but they use about 30 % of the healthcare services (WHO, 1995, p. 39). Along with chronic illness, old age brings with itself financial hardships and poverty due to an inability to work. This makes it harder for the elderly to pay for the services they require, and that should be provided regularly. So, who is going to pay for the services? One option is to put extra taxes on the working population to generate funds for the provision of adequate services to the increasing number of elderly people, which for most governments is a politically unpopular move (WHO, 1998, p. 103). The WHO suggests that countries organize a social mechanism for the support of elderly population and to generate the means to not let the elderly become destitute (WHO, 1998, p. 104). The most sustainable way of constituting such a social mechanism, recommended by the WHO, is pooling funds and pre-payments, as described earlier in this chapter (see “financial risk” above). In such a mechanism, individuals pay when they are healthy and young, and can use the services when they are ill and/or old, and unable to pay. Through the pooling of funds, healthy subsidize the sick and young people subsidize the older ones.

The WHO promotes the concept of healthy ageing by providing scientific and research-based guidelines for individual choices throughout the life course. One such initiative was taken by the organization in collaboration with Institute of Gerontology of the University of Heidelberg, Germany, in the 1990s, where a series of guidelines on healthy ageing were published (WHO,

1997, p. 80). Endorsed by the scientific community, these guidelines were translated into different languages and adapted to different cultural settings. They are meant to steer individuals into behaviours that limit health risks (WHO, 1998, p. 80). In the 2002 WHR, "Reducing risks promoting healthy lifestyle", the WHO provided a detailed overview of the lifelong impact of personal choices, including food, physical activity, and use of alcohol and tobacco, during young age. Although there is considerable impact of individual choices made during young age on the health later in life, young people still look to their governments and community when it comes to meeting their health needs as they age. Maintaining health and quality of life in an ageing population is vitally important both socially and economically (WHO, 1998, p. 102). The adults of today are the older people of tomorrow. They are asking, what kind of old age will we have? What will be our place in society? What will be our quality of life? The WHO argued that the answers largely depend on the policy initiatives of governments for ensuring the social support and providence of healthcare services for older people.

Adults make up the larger part of the working group of any nation and are therefore the most important for the economy of the nation. Governments collect most of their financial resources through the taxes paid by the working population and use these resources to provide social and health needs of the whole population. It is important for the governments to build an environment based on trust that, when these adults get older, they will be taken care of. This can only be done by not compartmentalizing the older people of today. When the adults see that the society is taking care of the elderly, they will have a trust in the systems and keep participating financially to it. Consequently, the health of elderly becomes a matter of concern, not only for the sake of older people but for the well-being of the whole society (WHO, 1998, p. 101).

5.4 Summary

The WHO was entrusted with leading international health efforts by offering guidance on global health issues, supported by data it had gathered to rationalize its recommended actions. Initially, the focus of the WHO was on reducing deaths due to infectious diseases. Data provided by the Organization showed that investing in these areas would save the most lives, leading stakeholders to prioritize infectious diseases. However, in the 1990s, new health

perspectives emerged, and NCDs became the leading cause of global disease burden. To address this shift, the WHO began actively collecting data on NCDs to prioritize them in the global health agenda. In providing guidance on healthcare financing, the WHO advises governments on resource generation and advocates for financial risk pooling to ensure universal access to healthcare. Investment in certain population groups brings economic and political benefits. These benefits help the WHO to convince stakeholders to invest in the health these population groups and as a results the health needs of these groups get prioritized.

6 Chapter 6: Strengthening and reforming health systems

This chapter will discuss the dynamics of developing a health system responsive to the health needs of its population and aligned with the objective of achieving Universal Health Coverage. The chapter consists of three sections. In the first section, I focus on the components required to establish a healthcare system that is both accessible and sustainable. In the second section, I explain how focusing on human resources in healthcare can impact the overall health system. In the third and last part, I explore the journey towards the UHC and the necessary steps to navigate this path.

6.1 What makes a strong health system?

In the past thirty years, the world has changed. One of the changing trend is that in the past three decades, the proportion of the world's population residing in cities has increased from 38% to over 50%, which amount to 3.3 billion individuals as of 2008. It is anticipated that by 2030, the numbers will exceed 5 billion (WHO, 2008, p. 7). Most of the growth has been seen in the smaller cities of developing countries and metropolises. Although on average health indicators in cities score better than in rural areas, the enormous social and economic stratification within urban areas results in significant health inequities (WHO, 2008, p. 7). In many countries urban health by and large revolves around hospitals, while the rural poor are increasingly confronted with the progressive fragmentation of their health services as "selective" or "vertical" approaches focus on individual disease control programs and projects (WHO, 2008, p. 12). A focus on vertical programs and projects is particularly attractive to an international community (i.e., donors and funding agencies) concerned with getting a visible result and measure impacts, and initially it was thought that this would somehow strengthen health systems as interventions are usually delivered to large numbers of people or would be the entry point to building health systems where none existed (WHO, 2008, p. 13). Often the opposite has proved true. Short-term advances have been short-lived and have fragmented health services to a degree that it is now of major concern to health authorities. With parallel chains of command and funding mechanisms, duplicated supervision and training schemes, and multiplied transaction costs, they have led to situations where programs compete for scarce resources, staff, and donor attention (WHO, 2008, p. 13). In the WHR from 2008, "Primary Health Care, Now more than ever", the WHO argued that the insufficient allocation of

resources and fragmentation of healthcare services have expedited the growth of commercialized healthcare in the majority of LMICs. Unregulated commercialized health systems have likewise proved highly inefficient and costly, they exacerbate inequality, they provide poor quality and, at times, dangerous care that is bad for health (WHO, 2008, p. 14). Health systems are also a reflection of a globalizing consumer culture and are organized around hospitals or are commercialized. This is largely because they are supply-driven and correspond to demand, genuine as well as supply induced.

As people become more knowledgeable, they expect their families and communities to be protected from risks and dangers to health. They want health care that deals with people as individuals with rights and not as mere targets for programs or beneficiaries of charity. When people are ill, they want help to come from providers with the integrity to act in their best interests, equitably and honestly, with knowledge and competence (WHO, 2008, p. 16). This fuels the health economy with steadily increased demand for professional care. To measure the efficiency of a health system the WHO has identified the following indicators as crucial:

- How well is it accessible?
- How large a percentage of the population is it covering?
- How well are its organizations, institutes, HR & systems ensuring equity?
- Is it ensuring acceptable quality & quantity of healthcare services?
- How does it protect financial risks for its end user?

The principals set by the declaration of Alma-Ata conference on Primary Health Care in 1978 i.e., equity, people centeredness, community participation and self-determination provided foundation for a comprehensive and stronger healthcare system (WHO, 2008, p. 18). It opened fresh opportunities for generating social and political momentum to move health systems in the direction people wanted them to go and by strengthening the PHC a health system can be made stronger and aligned with these principles. The PHC reforms are thus important for a health system as they aim to channel society's resources towards more equity and to end to exclusion; towards health services that revolve around people (WHO, 2008, p. 25). By strengthening primary healthcare, a country can promote health equity and achieve universal coverage. However, it takes a wide range of interventions to tackle social determinants of health and to make health systems contribute to more health equity. For example, pooling pre-paid contributions, collected on the basis of ability to pay, and using these funds to ensure that services are available, accessible and produce quality care for those who need them, without

exposing them to the risk of catastrophic expenditures (WHO, 2008, p. 25). There is now widespread consensus that providing such coverage is simply part of the package of core obligations that any legitimate government must fulfil vis-à-vis its citizens (WHO, 2008, p. 26).

In itself, this is a political achievement that shapes the modernization of society. Industrialized countries began this social health protection in the 19th century and made considerable progress to universalism in the 20th century (WHO, 2008, p. 26). LMICs can opt to walk in the same footsteps. Costa Rica, Mexico, the Republic of Korea, Thailand, and Turkey are among the countries that have already introduced ambitious universal coverage schemes, moving even significantly faster than industrialized countries did in the past (WHO, 2008, p. 25). The WHO recommended that when implementing universal coverage reforms, it is crucial to strike a balance between the speed of expanding coverage and the scope, quality, and inclusivity of the coverage being provided. In poor countries, most people live where health infrastructure merely exists or have less access. Universal coverage reforms required to move towards greater equity demand enduring commitment from the highest political levels of society. Two steps are important to tackle the inequities in the health. The first is raising the visibility of health inequities in public awareness and policy debates (WHO, 2008, p. 26). The second is the creation of space for civil society participation in shaping the PHC reforms that are to advance health equity (WHO, 2008, p. 34).

Most health needs do not fit specifically into the discrete diagnostic textbook categories of promotive, preventive, curative or rehabilitative care (WHO, 2008, p. 48). Comprehensiveness and integrated care are very important. People take up services more readily if they know a comprehensive spectrum of care is on offer. Specialization has its comforts, but the fragmentation it induces is often visibly counterproductive and inefficient. Comprehensive and integrated care for the bulk of the assorted health problems in the community is more efficient than relying on separate services for selected problems, partly because it leads to a better knowledge of the population and builds greater trust (WHO, 2008, p. 49).

Health services that offer a comprehensive range of services increase the uptake and coverage, for example, preventive programs, such as cancer screening or vaccination. Comprehensive services also facilitate early detection and prevention of problems, even in the absence of explicit demand (WHO, 2008, p. 49). Effective implementation of such interventions necessitates proactive healthcare teams that provide a wide range of services. This relies on

establishing a strong and trusting connection between health services and the communities they serve, which, in turn, depends on healthcare workers who have knowledge of the people within their community. The WHO, therefore, recommends that the entry point must be relocated from specialized healthcare settings and out-patient treatment to close-to-client settings. This move also reduces intensive interventions, produces fewer and shorter hospitalizations and a greater focus on preventive care ultimately result in lowering the cost of healthcare (WHO, 2008, p. 53). In Thailand, generalist ambulatory care outside a hospital context has been shown to be more patient-centered and responsive as well as cheaper and less inclined to over-medicalization (WHO, 2008, p. 53). The relocation of the entry point into the system from specialist hospital to generalist ambulatory care creates the conditions for more comprehensiveness, continuity, and person-centeredness. However, teams require relational and organizational capacities as much as the technical competencies to solve the bulk of health problems locally (WHO, 2008, p. 53). In the healthcare sector, adopting a passive approach that only responds to demand can result in adverse consequences as it fails to address the underlying social, environmental, and occupational determinants of poor health. This represents lost opportunities for generating health: providers that only assume responsibility for their customers concentrate on repairing rather than on maintaining and promoting health (WHO, 2008, p. 54).

An alternative approach is to entrust each primary-care team with the explicit responsibility for a well-defined community or population (WHO, 2008, p. 54). By holding them accountable through contractual arrangements or administrative measures, they can be expected to deliver comprehensive, continuous, and patient-centric care to the population they serve. Identification of well-defined populations is important to assign responsibilities. Some countries find geographical criteria of proximity the most appropriate, others rely on active registration or patient lists (WHO, 2008, p. 54). It compels the primary-care team to collaborate with individuals and organizations in the community. It requires the team to extend their efforts beyond the confines of their consultation room and engage with individuals in the community. This has been found effective from the US to Nepal, for instance in reducing neonatal mortality rates (WHO, 2008, p. 54). It compels the team to implement focused measures, in partnership with other sectors, to reach out to marginalized and under-served populations and address the underlying factors contributing to poor health outcomes. The 2003 heatwave in western Europe, for example, highlighted the importance of reaching out to the isolated elderly and the

dramatic consequences of failing to do so: an excess mortality of more than 50.000 people (WHO, 2008, p. 54).

Having said that, primary-care teams require support from specialized services, organizations, and institutions located outside the community they serve in order to fully assume comprehensive responsibility for their population. In conventional settings, hospitals and specialized care have difficulty judging their contribution to health. This changes if they are entrusted with responsibility for a defined population and are recognized as the regular point of entry for that population. The coordination (or gatekeeping) role this entails effectively transforms the primary-care pyramid into a network, where the relations between the primary-care team and the other institutions and services are no longer based only on top-down hierarchy and bottom-up referral, but on cooperation and coordination (WHO, 2008, p. 55). The primary-care team then becomes the mediator between the community and the other levels of the health system, helping people navigate the maze of health services and mobilizing the support of other facilities by referring patients or calling on the support of specialized services (WHO, 2008, p. 55).

The World Health Report from 2008 mentioned that people desire a society that ensures and safeguards their health, and they anticipate that governments will safeguard their well-being by implementing a variety of efficient public policies. These include the policies required to make health systems function properly; to organize public-health actions of major benefit to all; and, beyond the health sector, policies that contribute to health and a sense of security, while ensuring that issues, such as urbanization, climate change, gender discrimination or social stratification are properly addressed (WHO, 2008, p. 65). Effective public-health policies that address priority health problems are a second group without which primary care and universal coverage reforms would be hindered (WHO, 2008, p. 65). There is growing awareness that when parts of the health system malfunction, or is misaligned, the overall performance suffers.

As usually assumed, there are five building blocks of healthcare system: infrastructure, human resources, information, technologies, and financing (WHO, 2008, p. 65). Coordination and alignment of these building blocks is crucial for the PHC and UHC, and this alignment requires deliberate and comprehensive policy arrangements (WHO, 2008, p. 65). Experience in promoting essential medicines has shed light on both the opportunities and obstacles to effective system policies for the PHC (WHO, 2008, p. 66). Therefore, the WHO recommends

that initiatives and policies formulated by healthcare authorities at the local level must be backed by policymakers at the national and global levels. Likewise, the implementation of international policies should be adjusted to suit the specific circumstances of the local context. However, traditional domains where public health interventions beyond the local level could be advantageous involve modifying individual behaviours and lifestyles, managing and preventing diseases, addressing hygiene issues and broader determinants of health, as well as implementing secondary prevention measures such as disease screening (WHO, 2008, p. 68).

Well-designed public-health policies can reduce inequities when they provide health benefits to entire populations or when they explicitly prioritize groups with poor health. The Commission on Social Determinants of Health, established by the WHO in March 2005, recommended following policy actions to reduce the inequities (WHO, 2008, p. 68):

- Improve daily living conditions.
- Tackle the inequitable distribution of power, money, and resources.
- Measure and understand the problem and assess the impact of action.

Health sector activities are not solely responsible for the health of the population. Health determinants includes societal and economic factors, and hence rely on policies and actions that are not within the remit of the health sector (WHO, 2008, p. 69). When faced with such phenomena, health authorities may feel that the sector is incapable of doing more than just attempting to alleviate the repercussions. For example, health authorities cannot increase taxes on alcohol, impose technical norms on motor vehicles or regulate rural migration and the development of slums although all these measures can yield health benefits (WHO, 2008, p. 69). Therefore, the WHO recommends, the health sector must collaborate with other sectors, not only to secure their support in addressing recognized health issues, but also to ensure that health is acknowledged as a socially esteemed result of all policies (WHO, 2008, p. 69).

6.2 Focusing on human talent

The providers of health services embody the fundamental principles of a system - they provide healing and care, alleviate pain and suffering, prevent illnesses, and minimize risks - serving as the critical link between knowledge and action towards good health. The healthcare industry relies heavily on labour-intensive services. There is significant evidence indicating that the quantity and quality of healthcare workers have a positive correlation with immunization

coverage, outreach of primary care, and survival rates for infants, children, and mothers (WHO, 2006, p. xv). In the WHR from 2006, "Working together for health", the then DG of the WHO, Dr Lee Jong-wook, mentioned that a prevalent topic discussed by leaders and decision-makers in the healthcare sector, both in developed and developing nations, was the shortage of human resources. While the scarcity of human resources in healthcare is a global issue, it is especially severe in the countries that require them the most (see Table 7, below). Countries with a lower relative need tend to have a higher number of healthcare workers, whereas countries with a higher burden of disease have to manage with a significantly smaller healthcare workforce. The Americas region, comprising of Canada and the US, has a meagre 10% share of the world's disease burden. However, it accommodates almost 37% of the world's health workers and spends over 50% of the global financial resources for health. On the other hand, the African region, which bears over 24% of global burden of disease, has access to merely 3% of the world's healthcare workforce and less than 1% of the financial resources for health, even with the aid of foreign loans and grants (WHO, 2006, p. 8). The significant disparities in the distribution of healthcare personnel across various regions present a compelling rationale for the very slow progress in improving health outcomes in impoverished regions and the inadequate access to healthcare services experienced by many individuals.

Table 7: Estimated critical shortage of doctors, nurses, and midwives, by WHO region (WHO, 2006, p. 13)

WHO region	**Number of countries**		**In countries with shortage**		
	Total	**With shortage**	**Total stock**	**Estimated shortage**	**Percentage increase required**
Africa	46	36	590,198	817,992	139
Americas	35	5	93,603	37,886	40
South-East Asia	11	6	2,332,054	1,164,001	50
Europe	52	0	NA	NA	NA
Eastern Mediterranean	21	7	312,613	306,031	98
Western Pacific	27	3	27,260	32,560	119
World	192	57	3,355,728	2,358,470	70

According to the WHR from 2006, brain drain is one of the primary causes for the inequitable distribution of healthcare workers among nations. This phenomenon is characterized by the migration of healthcare professionals from lower-income countries to higher-income countries, driven by factors such as superior wages, access to the latest knowledge and practices, and better career security (WHO, 2006, p. 101).

The World Health Organization in its WHR from 2006 presented a comprehensive strategy to tackle the crisis through policies and actions implemented at both national and international levels. The organization emphasized that this plan of action needs to be maintained for at least a decade to ensure its effectiveness in mitigating the human resources crisis (WHO, 2006, p. 150). At national level, the WHO advised governments to focus on managing their healthcare workforce more efficiently by minimizing the loss of human resources and aligning the distribution of healthcare professionals with the demand for their services. Additionally, the governments should rejuvenate their education strategies, enhance the work environment, and improve wages to guarantee the financial security of the healthcare workforce. While at international level, the WHO argued that there is need for establishing a global solidarity. HICs have a responsibility to create mechanisms for disseminating up-to-date knowledge and evidence-based practices, provide financial assistance to countries facing significant healthcare workforce crises, and encourage the adoption of ethical recruitment practices (WHO, 2006, p. 150).

In anticipation of the approaching deadline for the WHO's plan of action to address the human resource crisis, set out in the WHR 2006, the World Health Assembly, in May 2014, made a request to the DG of the WHO to create a new global strategy to tackle the ongoing issue. The initiative was also in response to the Recife Political Declaration on Human Resources for Health, which aimed to improve access to healthcare for everyone (WHO, 2016, p. 7). More than 200 experts from all regions of the WHO provided their input in consolidating the evidence on a comprehensive health labor market framework that would be suitable for achieving the UHC. The WHO published the report in 2016 with the title “Global strategy on human resources for health: Workforce 2030”. In the report, the WHO argued the mere availability of healthcare workers is insufficient in ensuring effective healthcare delivery. Equitable distribution and accessibility of healthcare workers to the population, coupled with the necessary competencies, motivation, and empowerment to provide quality care that aligns with the sociocultural expectations of the population, as well as adequate support from the healthcare system, are crucial factors that must be in place for theoretical coverage to translate

into actual effective service coverage (WHO, 2016, p. 10). However, all countries, regardless of their level of socioeconomic development, encounter challenges to varying degrees in educating, deploying, retaining, and ensuring the optimal performance of their healthcare workforce.

The ongoing health workforce deficits coupled with ageing populations and changing epidemiology calls for a new agenda to address these challenges. In 2016, the WHO argued that an integrated, people-centered approach to healthcare, with team-based care at the primary level, can improve cost-effectiveness while better meeting population needs (WHO, 2016, p. 16). This involves utilizing different types of health workers, collaborating closely and operating within their full scope of practice to avoid skills being underutilized. In the past, nursing and midwifery had shown particular success in delivering services to vulnerable populations, with midwifery capable of providing essential care for sexual, reproductive, maternal, and new-born health services (WHO, 2016, p. 16).

In order to fulfil the population's needs for achieving the UHC and other health related SDGs, it is crucial to optimize the utilization of scarce resources. This can be accomplished by implementing evidence-based health workforce policies that are tailored to the specific context of the national health system at every level (WHO, 2016, p. 17). To bring this agenda into effect, the WHO advised governments to take certain actions, such as implementing better and more efficient strategies, regulating health workforce education appropriately, creating a sustainable and adaptable skills mix, utilizing the potential of community-based and mid-level health workers, improving deployment methods and working conditions, establishing incentive systems, increasing social accountability, encouraging inter-professional collaboration, providing continuous professional development opportunities, and creating career paths that cater to gender-specific requirements (WHO, 2016). These measures will not only increase the capacity of the health workforce but also enhance their motivation and performance.

6.3 The path to Universal Health Coverage, with some stops along the way

The notion of healthcare has undergone a transformation over the years. At first, it focused on particular diseases that had significant morbidity and mortality rates. As discussed in Chapter 2, the strategies of vertical programs were especially emphasized by international donors or partners to combat these diseases because they guaranteed visible targets-based results. But

this approach had various drawbacks i.e., HR and resources diverted to achieve specific targets instead of developing or strengthening the overall health care delivery system. While the Alma-Ata Declaration (1978) encompassed similar ambitions, it was not until the start of 21st century that policy makers started to think actively about strengthening of primary healthcare with objective to achieve Universal Health Coverage. In 2005, the member states of the WHO committed to the UHC for sustainable human development, though implementation of this commitment requires a powerful and comprehensive mechanism (WHO, 2013, p. xi).

Universal Health Coverage has several key components, including access to high-quality services for health promotion, prevention, treatment, rehabilitation, palliation, and financial risk protection. As per the WHR from 2010, "Health systems financing", the UHC has three dimensions: the health services that are needed, the number of people that need them, and the costs(WHO, 2013, p. 6). Resources are always limited and therefore, it is the responsibility of governments to decide or prioritize what health services are needed, and how to make sure they are universally available, affordable, efficient, and of good quality. There are individuals in every nation who lack the financial means to pay for the services they require out of their own pockets, or whose situation would be significantly worsened if they did so. One way to attain comprehensive financial risk coverage is by employing different methods of advance payment for services. Prepayments allow funds to be pooled so that they can be redistributed to reduce financial barriers for those who need to use services they could not otherwise afford (WHO, 2013, p. 7).

Governments, being the stewards of nations, have the moral and ethical responsibility to decide the scope of health services, include marginalized and poor people and to ensure their financial protection. Governments especially of poorer nations have limited resources and it's a highly technical matter to allocate resources for health services. Therefore, the WHO recommends adopting three approaches for spending: maximize the proportion of the population covered by existing services, diversify health services by offering more types of intervention, or use the money for financial risk protection, thereby reducing cash payments for health care (WHO, 2013, p. 7). For example, to tackle spread of tuberculosis or to reduce the risks from smoking, governments intervene by adopting multiple approaches (i.e., providing medical treatment, mitigating risks in general population, financial protection and most importantly tracking the progress of interventions). Therefore, research is important to understand the concepts of financial risk protection, health service coverage and methods to track progress of interventions (WHO, 2013, p. 9).

Healthcare service delivery is complex and multidimensional, starting from primary level to tertiary care and includes preventive and regulatory services. In an ideal scenario, we would evaluate the coverage of all healthcare interventions. However, even in high-income nations, this is frequently not feasible. Instead, it is feasible to take a selection of interventions and indicators and use them as "tracers" of the overall progress towards universal coverage (WHO, 2013, p. 16). The interventions selected should be accessible to everyone who is eligible to receive them under the UHC in any setting. For example, even in the case of the comprehensive MDGs 4–6, only a few indicators of services are measured to judge the progress. The indicators were usually selected because they were precisely defined, the data collected in standard ways, and with internationally agreed targets. The same principle lays behind the goals for HIV/AIDS, "universal access" to antiretroviral therapy, access to safe drinking water in MDG-7 etc.

Coverage of availability of services and data accuracy play an important role in measuring out-of-pocket expenditure and financial risk protection. For example, in a study, coverage of maternal health services was found to be the same in Ukraine and Philippines but incidence of poverty due to out-of-pocket payments was higher in Ukraine (WHO, 2013, p. 18). Quality of healthcare is also as important as quantity or coverage. The OECD has created quality metrics for specific interventions, such as cancer and mental health, preventative measures, health promotion, and patient experiences and safety. However, when an indicator, "risk of death in a hospital following ischemic stroke in people who die within 30 days of admission", was observed, significant differences in case-fatality rates were discovered across countries. Nonetheless, some of the variation observed may be attributed to local practices regarding hospital discharge and patient transfer to other facilities (WHO, 2013, pp. 17-18).

To achieve universal healthcare, proper financing of the system is of crucial importance. According to the WHR from 2010, "Health systems financing: the path to universal coverage", in striving to allocate financial resources for the UHC, governments usually face three fundamental question (WHO, 2010, p. ix). These questions are as follows.

- How is such a health system to be financed?
- How can they protect people from the financial consequences of ill-health and paying for health services?
- How can they encourage the optimum use of available resources?

Further, governments must also ensure coverage is equitable and establish reliable means to monitor and evaluate progress. The WHR from 2010, "Health systems financing: the path to universal coverage", outlines how countries can modify their financing systems to move more quickly towards universal coverage and to sustain those achievements. As per the said report, three fundamental, interrelated problems restrict countries from moving closer to universal coverage (WHO, 2010, p. xi). The foremost barrier is the availability of resources. Regardless of their wealth, no country has been able to guarantee universal access to every technology and intervention that can enhance health or extend lifespans. Conversely, in the most impoverished nations, few services are accessible to all. The second obstacle to achieving universal coverage is the excessive reliance on direct payments at the time people need medical care. These payments can take the form of out-of-pocket expenses for medication, consultation fees, and medical procedures. Even if individuals possess some type of health insurance, they may still be required to make contributions in the form of co-payments, co-insurance, or deductibles. The requirement to make payments directly for medical services at the point of need, whether through official or unofficial (under the table) means, prevents millions of people from accessing healthcare when they require it. For those who do manage to seek medical care, it can lead to severe financial difficulties and even impoverishment. The third barrier to achieving universal coverage is the inefficient and inequitable utilization of resources. It is estimated that between 20-40% of healthcare resources are wasted, which hinders the ability of healthcare systems to provide high-quality services and enhance overall health. Addressing this inefficiency would greatly enhance the effectiveness of health systems and allow for better allocation of resources. Additionally, improved efficiency can facilitate the ministry of health in securing additional funding from the ministry of finance. The path to universal coverage, then, is relatively simple – at least on paper (WHO, 2010, p. xi).

Several low- and middle-income countries have demonstrated in the last decade that achieving universal coverage is not exclusive to high-income countries. For example, Brazil, Chile, China, Mexico, Rwanda and Thailand have recently made great strides in addressing all three challenges described above. Gabon has introduced innovative ways to raise funds for health, including a levy on mobile phone use; Cambodia has introduced a health equity fund that covers the health costs of the poor and Lebanon has improved the efficiency and quality of its primary care network (WHO, 2010, p. xi). Meanwhile, it is evident that every country has the potential to do better in at least one of the three crucial areas. Even high-income countries now realize that they must continually reassess how they move forward in the face of rising costs

and expectations. Germany, for example, has recognized its ageing population means wage and salary earners have declined as a proportion of the total population, making it more difficult to fund its social health insurance system from the traditional sources of wage-based insurance contributions (WHO, 2010, p. xii). As a result, the government has infused extra funds from general revenues into the system. To ensure the sustainable health systems and universal coverage, the WHO recommends countries need to generate adequate funding, reduce their dependence on immediate payments to fund healthcare services, and enhance their efficiency and equity (WHO, 2010).

6.4 Summary

Primary healthcare is crucial for building a strong and efficient healthcare system, as it provides the first point of contact for individuals seeking medical attention. Primary healthcare encompasses prevention, treatment, and rehabilitation services and addresses social determinants of health. Achieving Universal Health Coverage requires adequate funding, infrastructure, and human resources for primary healthcare. It is essential to prioritize the recruitment, training, and retention of healthcare professionals and invest in healthcare workforce to ensure the delivery of sufficient and quality healthcare services. By investing in primary healthcare, we can build a comprehensive, effective, accessible, and sustainable healthcare system.

7 Chapter 7 Conclusion

7.1 Overview of findings

The WHRs have remained the flagship publications of the WHO since 1995 and played a crucial role in setting the global health agenda. In these reports, there are both change and continuity in the ideology of the WHO in terms of its agenda and priorities. The early WHRs (prominently WHR from 1995) primarily focused on the burden of infectious diseases. In the 1990s, infectious diseases were more prevalent in the poorer countries, while developed countries were grappling with the burden of NCDs. The focus of the WHO on infectious diseases reflected the prevailing perception that global health was primarily concerned with addressing the health needs of underdeveloped and developing countries, and developed countries either did not have any health issues or they had solutions for all of their health problems. However, in the later WHRs (starting form 1997), there was a shift in priorities of the WHO. These reports focused more on the NCDs and argued that the growing burden of chronic diseases is not limited to a specific region or socioeconomic group, but it is a health concern of both poor and rich countries. This shift in priorities signalled a change in the way global health was conceptualized and addressed. By placing NCDs at the top of global health agenda, the WHO sent out a message that work in global health is not only about the shortcomings of under-developed and developing countries, but it is equally concerned about health issues of developed countries.

While each World Health Report centred on one health issue/topic to bring it at the forefront of global health agenda for a certain time frame (the report year), the Organization consistently prioritized some broader issues, such as health of vulnerable groups, and health systems development, by including them in nearly each report. As discussed in chapter 4, the WHO consistently prioritized the health of children, mothers, and poor. The WHO argued that prioritizing the health of mothers and children is important not only for economic outcomes but also because of their vulnerability. Due to their lower economic status, mothers and children often have less decision-making power in society, making them more susceptible to the health risks and inequities. Further, the WHO emphasized that improving the health of children is crucial for the future of societies. Children are the workforce of society, and ensuring their health is essential for having a health workforce. However, the health of children cannot be guaranteed without improving the health of their primary caregivers, who are mostly

mothers. Therefore, improving the health of mothers and children is not only essential for their immediate well-being but also for the long-term health and prosperity of societies. Similarly, the WHO continuously emphasized the importance of addressing health inequities and prioritizing the health needs of individuals living in poverty due to a very strong correlation between poverty and poor health outcomes. As discussed in chapter 4, individuals who live in poverty often have limited access to healthcare services, which can lead to untreated illness and chronic health conditions. Chronic illness decreases productivity and ability to earn more which further push poor into extreme poverty. The WHO argued improving access to healthcare services and addressing social determinant of health, such as poverty, would reduce disparities and promote overall economic well-being of individuals as well as of society as a whole. Additionally, promoting health equity can lead to a more just and fair society, where everyone has the opportunity to achieve their full potential.

The World Health Reports also galvanize support, both financial and political, for the central issue they cover. In that way, the reports serve as a way for the WHO to channel attention, resources, and time into addressing the issues in each report. Being a technical agency, the WHO need both financial and political support for its priorities and agenda from other stakeholders including national and international political leadership, state governments, donor agencies, civil society, and other technical agencies. To ensure the support of other stakeholders, the WHO provide legitimate rationale for its agenda. As discussed in chapter 5, health of special population groups got prioritized due to their moral, political, and economic relevance. Prioritizing the health of elders, workers, and poor individuals is crucial for political leaders to gain and maintain legitimacy among their constituents. Elders, who have often contributed significantly to their communities and societies, deserve to receive proper healthcare and support in their later years. Workers, who form the backbone of many economies, must be protected from health hazards in their workplaces, and provided with fair compensation and access to healthcare. The poor, who are often the most vulnerable and marginalized of society, require greater investment in healthcare and social protection. When leaders prioritize the health and well-being of these groups, it sends a strong message that they value the lives and dignity of all members of society, regardless of their socioeconomic status. Further, prioritizing health of these groups also contribute to the reduction of inequality and social exclusion, which are major sources of political instability and unrest in a society. Similarly, The WHO emphasized need to prioritize the investment in the health of workers and poor as a means of promoting sustainable economic development. Poor health can have a

significant impact on individuals, families, and communities, resulting in decreased productivity, increased healthcare costs, and lost income. Healthy workers are more productive, which translates to high incomes and increased tax revenues for government. Additionally, a healthy population can attract investment and enhance the overall economic competitiveness of a region.

The World Health Organisation has been committed to improving healthcare access for all individuals through the development of robust and sustainable health systems. One of the key priorities of the organization is to shift from providing care for only selected sub-populations and/or selected disease burdens to integrated healthcare services. The WHO has argued that the focus of health systems should shift from specialized services to primary healthcare., prioritizing provision of care where people reside. This approach would not only enhance the accessibility of various populations to healthcare but also guarantee delivery of services to communities at their doorstep. This objective is rooted in the belief that everyone has the right to access quality healthcare services and should not be excluded due to any factors. To achieve this goal, the has been actively developing and providing policy guidelines that address the significant barriers to healthcare access, including financial risk and shortage of human resources. The organization has recognized that financial barriers are a major obstacle for many individuals in accessing healthcare services, particularly in low- and middle-income countries. The WHO has criticized the reliance on out-of-pocket health expenditure, namely direct payments, which often lead to catastrophic healthcare costs and push individuals and families into poverty. To mitigate this issue, the WHO has recommended strategies that aim to protect individuals from financial hardship at the time of healthcare need. As discussed in chapter 5, one such approach is the promotion of financial risk pooling through subscription payments. This involves pooling financial resources from individuals and communities to create a fund that can be used to provide healthcare services to those in need. This approach can help reduce the financial burden on individuals and ensure that healthcare services are accessible to all, regardless of their ability to pay.

In addition to financial barriers, the WHO has also identified the shortage of human resources as a significant challenge to healthcare access. This issue is particularly acute in low- and middle-income countries, but the problem is gradually becoming significant in high income countries also. To address this challenge, as mentioned in chapter 6, the WHO has recommended policies that focus on strengthening healthcare workforce capacity, including

investing in training and education, improving working conditions, and addressing retention issues especially in low- and middle-income countries.

7.2 The changing role of WHO from the first report to the last one

The overarching goal of the World Health Organization's work is achievement of better health by all around the globe. Though the goal has remained same since the birth of the Organization, the role played by the WHO for achieving this goal has changed over time. In the first WHR, "Bridging the gaps", published in the 1995, the WHO seemed more authoritative while presenting recommendations for health issues. Later, the WHO present itself as an organization more willing to learn. This can be seen in the WHR, "Research for universal health coverage", published in 2013, where the WHO emphasises the importance of research to pave the way for reaching goals set for global health.

In the very early World Health Reports, the WHO categorized the world by dividing countries into developed, developing, and under-developed countries. This categorization seemed disrespectful towards countries. Being called developing and under-developed posed that developed countries had solutions for every problem and countries in the other two categories needed to follow pathways adopted by developed countries to flourish. In the later reports (starting from 1998), the WHO started to use a new monetary classification for categorizing countries into high-, middle-, and low-income based on their gross income per capita. This classification seems more rationale as it divides countries based on their economic standings which is being calculated through a common process of calculation.

As mentioned in the first chapter of the thesis, the WHRs were one of the efforts by the WHO to regain its position as the leader of the global health during the 1990s. To achieve its objective of securing its leadership position within the field, the WHO posed itself as a United Nations agency that could have solutions for the world's health-related problems. However, in the later WHRs the WHO seemed more open to collaborate with other stakeholders.

In the early World Health Reports (first two reports), health was viewed as a commodity that could be quantified in terms of its financial cost. However, in the later reports there was a growing recognition over time that health systems are complex and multidimensional and cannot be reduced to a series of financial calculations. One of the key changes in the approach to health systems has been a greater emphasis on the role of human expertise. It is now

recognized that health systems are only effective as the people who work within them. Skilled and dedicated healthcare professional are essential for providing high-quality care and for developing and implementing effective public health interventions. Another shift has been a recognition of the role that populations can play in shaping and improving health systems. By engaging with communities and promoting greater public involvement in health decision-making, it is possible to create more responsive and effective health systems.

In the very early reports, the WHO focused on showcasing the health problems of poorer countries. This sent out the message that international health work is all about the health issues of poor countries and developed countries either do not have any health issues or they can deal with them on their own. Having said that, the Organization, in the later WHRs, brought forward health concerns that were equally important for developed as well as developing countries, as they were called at that time. One of these important issues was NCDs. By calling attention to this issue in all settings, the WHO established that global health is not only about work for the betterment of health of people living in poor countries, instead, it is equally concerned about the health challenges of developed countries.

7.3 Recommendations for future reports

As this thesis has shown, the WHO uses various parameters to categorize health needs of the world. These changes over time. Earlier, we used mortality rates to measure the disease burden and health interventions were planned to avert deaths caused by a disease. Later in the 1990s, we started using QALYS and DALYS to calculate the burden of ill-health. Based on this trajectory, it is to be expected that we in the future will need new parameters, for instance to address health issues targeting new regions or new vulnerable sub-populations. One trajectory that might influence this, is that of participation. In the first two WHRs, health was presented as a list of price tags, whereas the later have put a premium on health systems being made up of people with expertise, and that populations rather than being passive recipients, can be enlisted as active participants in health systems. While these changes in approach represent important progress, there is still much that we do not know about the optimal way to design and implement health systems that are truly responsive to the needs of communities. Further academic research is needed to better understand the factors that contribute to effective health systems, and to identify new approaches that can help to ensure that all people have access to

high-quality healthcare. By continuing to invest in research and innovation, we can work towards a future in which everyone has access to the healthcare they need and that is our overarching goal Universal Health Coverage.

7.4 Limitation of the study

The World Health Reports discuss a lot more health issues than those discussed in this thesis. These could, and should, be used in further research. For instance, I found the debates on primary health care, especially interesting. The thinking and experiences, especially on community participation, has changed a lot over time. Unfortunately, I could not go through all doors in this thesis, but this would be the next chapter had I had more time and space.

8 References

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