The plan of action for implementing the regional strategy for health for all by the year 2000 was accepted by the Regional Committee in its resolution WPR/RC32.R5 in 1981. The plan of action stipulates that an evaluation of national strategies will be done every six years, with a monitoring report every three years. The last evaluation was carried out in 1991.

As with previous evaluation and monitoring exercises, a common framework for evaluating the health-for-all strategies was used to guide the national evaluation process. Countries and areas were requested to submit their reports to the Regional Director by March 1997 for eventual incorporation in the Third Evaluation of the Implementation of the Strategy for Health for All by the Year 2000. This document was then examined and approved by the Sub-Committee in accordance with its terms of reference.

In light of the approaching 21st century and the many changes and influences which will potentially have an impact on the health sector in the next century, the World Health Assembly (WHA48.16) has called upon WHO and Member States to consider Renewing the Strategy for Health for All.

The Sub-Committee was asked to review a draft regional document on Renewing the Policy for Health for All, in light of the experiences and evaluation included in the Third Evaluation.

A report which includes the Third Evaluation of the Strategy for Health for All by the Year 2000 and the Renewing the Policy for Health for All is now submitted for consideration by the Regional Committee. This report will be submitted to the Director-General for eventual inclusion in the global evaluation of the health-for-all strategies and the global document on Renewing the Health-for-all Policy. This will then lead to A Global Health Charter for the 21st Century.
The Sub-Committee had before it for review the draft regional Third Evaluation of the Strategy for Health for All by the Year 2000 (See Annex 1)\(^1\). This document provided a synthesis of findings from the reports which had been received from 16 countries and areas in the Region. These reports were based on the common framework for evaluation of the health-for-all strategy.

The majority of reports were very comprehensive and provided a great deal of valuable information for the Third Evaluation. In addition, the reports will provide a reference for anyone interested in a better understanding of health development in these countries. For those countries which had not submitted reports by the time the Third Evaluation was reviewed by the Sub-Committee, it was anticipated that they would do so with the same thoroughness.

In reviewing the Third Evaluation, the Sub-Committee noted that most countries were well aware of the changing patterns of disease taking place in their countries. The Sub-Committee was very encouraged by the many efforts that are already taking place to meet the challenge of this epidemiological transition.

The Sub-Committee went on to review the Report by the Director-General on the Renewed Health-for-all Strategy: Draft Policy for the Twenty-first Century (Document EB100/2) and the draft regional document on Renewing the Policy for Health for All (see Annex 2)\(^2\).

The Sub-Committee noted the appropriateness of such a process, namely, reviewing the strategy for health for all in light of the experiences detailed by countries in their evaluation reports followed by a review of the renewal of the policy in light of the potential health problems of the 21st century.

The Sub-Committee noted that the draft document Renewing the Policy for Health for All was the basis upon which Member States in the Region could be guided to review their individual needs for new and revised health policies for the 21st century. However, the Sub-Committee made particular note of the need for countries to ensure that the policies themselves can be reviewed more effectively and regularly than in the past. This was one of the lessons from the health-for-all monitoring and evaluation experiences. It was proposed that these policy processes will need to make more efficient use of indicators for evaluating policy effectiveness and that this needs to be incorporated into the next cycle of health-for-all monitoring.

\(^1\) Presented to the Sub-Committee Members as document WPR/PTC/12/97.3a.
\(^2\) Presented to the Sub-Committee Members as document WPR/PTC/12/97.3b.
The Sub-Committee found a strong compatibility between the Third Evaluation and the draft document Renewing the Policy for Health for All in that the needs expressed in the Third Evaluation could find solutions or recommendations in the renewal process. The Sub-Committee found that, by incorporating the regional document *New horizons in health* into Renewing the Policy for Health for All, a clear picture emerged which described the health needs for the future, the many issues that will influence the ability of the health sector to respond to these needs and provided a guideline for how health policy for the 21st century may be formulated to meet these challenges.

The Sub-Committee recommended that the draft Third Evaluation of the Implementation of the Strategy for Health for All by the Year 2000 and the draft document Renewing the Policy for Health for All, which are attached as Annex 1 and Annex 2, respectively, should be accepted by the Regional Committee for submission to the Director-General.

Activities in the Region with regard to the renewal of the health-for-all policy mirror those at the global level. In resolution WHA50.23 (Annex 3), the Fiftieth World Health Assembly considered the report of the task force on health in development and requested the Director-General to continue to support the work of the task force. In resolution WHA50.28 (Annex 4), the Fiftieth World Health Assembly agreed that the renewed health-for-all strategy should become the principal guiding framework for the translation of WHO’s constitutional mandate into the development of the Tenth General Programme of Work.
DRAFT

THIRD EVALUATION OF THE IMPLEMENTATION OF THE STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000
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INTRODUCTION

In 1979 the Thirty-second World Health Assembly launched a Global Strategy for Health for All by the year 2000, and invited the Member States of WHO to formulate national policies and plans of action to attain this goal. A regional strategy for health for all was formulated and adopted by the WHO Regional Committee for the Western Pacific at its thirty-first session in 1980. The revised strategy was adopted by the Regional Committee at its thirty-second session in September 1981.

The plan of action to implement the global strategy calls on Member States to review and periodically assess their national health strategies and plans of action. Monitoring of progress is to be done every three years, and an evaluation of effectiveness made every six years.

A common framework and format were prepared for the monitoring and evaluation of national, regional and global strategies and policies. The results of national monitoring were to be used to prepare regional and global reports on progress in implementing the global strategy. The first regional monitoring report was reviewed by the Regional Committee at its thirty-fourth session in 1983, the second at the thirty-ninth session in 1988, and the third at the forty-fifth session in 1994.

The global plan of action stipulates that an evaluation of national health-for-all strategies should be carried out every six years. The first evaluation took place in 1985 and the second in 1991. This document summarizes the third evaluation of national strategies in the Western Pacific Region.

Health for all is the basis for national health development in all countries and areas in the Region. In the management of their health-for-all policies, countries and areas have already established routine monitoring and evaluation processes. The present report attempts to summarize the evaluations of the health activities currently being conducted in the countries and areas of the Region. It assesses progress towards achieving the health-for-all goals that were established for the Region in 1981. Particular attention is given to progress made since the second evaluation report in 1991. Most of the information for the evaluation comes from national reports on evaluation of health-for-all policies received from 16 of the 36 countries and areas of the Region, but some of it comes from other sources. The report highlights three important themes: (1) health-for-all activities which have been started since 1985; (2) the processes being used to plan, implement and evaluate health-for-all policies; and (3) emerging trends in health development.
CHAPTER 1. TRENDS INFLUENCING HEALTH POLICIES

Political

Since 1991, there have been two primary trends influencing health policies in the Region: the evolution of new organizational structures in the former centrally-planned economies and initiatives in most countries and areas to strengthen individual and community participation in development.

The most challenging political initiatives are those taking place in the former centrally-planned countries. In all of these countries, there has been a recent trend towards devolving and decentralizing decisions on political, social and economic issues. There have been significant achievements in all of these countries. Some of the most dramatic initiatives have been taken by Mongolia, which has decentralized organizational aspects of public services and has privatized services with the long-term goal of driving development through the principles of the market economy. Similar initiatives to explore the potential for an expanding role for the private sector are being actively carried out in Cambodia and Viet Nam. In the Lao People's Democratic Republic, more community planning is emerging at the local level. China, with its many diverse areas and economic regions, continues to make significant progress in redefining the role for central guidance in conjunction with high levels of local autonomy and responsibility, with particular emphasis being placed on central government support for lesser developed provinces and regions.

Decentralization and an expanding role for the private sector are not just themes for the former centrally-planned countries, they dominate the development agenda in many countries. For example, in Papua New Guinea, the new Organic Health Act redefines the roles of central and the provincial governments with resulting organizational adjustments; individual hospital authorities have been established in Hong Kong; New Zealand is developing its hospital authorities and reforming its regional health authorities; and Malaysia is embarking upon a significant initiative to corporatize hospital services. At the same time, there have been some concerns about the devolution of public services, for example in the Philippines.
Social

The dominant social theme of development in the Region since 1991 has been a significant trend towards empowering individuals and communities to influence those developments and services which most affect their families.

Strengthening community organization is a priority message in countries and areas such as Fiji, Kiribati, Federated States of Micronesia, Niue, Tuvalu, and Vanuatu, particularly in light of the new initiatives being started under the banner of Healthy Islands initiatives. In Viet Nam, a focus on the people’s committee has made many significant contributions to development in general and particularly to health. In Guam and Palau, specific mechanisms are being used to involve the community in health planning.

There is a clear trend at both national and local levels to focus development on the individual. For example, the theme of consumers’ choice in the service sector is strong in Hong Kong and New Zealand. The role of women in development, both as a collective point of view and as participants in management decision-making, is growing, for example in Malaysia. The emphasis on the individual in Marshall Islands and Singapore (particularly through its healthy lifestyle initiative), mirrors similar efforts in New Zealand and Malaysia.

With all of these dramatic and exciting developments, it is noteworthy that the impact on an individual’s potential and ability to participate equally in socioeconomic development is a dominant issue. For many countries with successful economies, the equity issue is not pressing in the short term, rather, equity is seen as a medium- and long-term concern.

With regard to the more general role of health in development, there are new initiatives in Malaysia and New Caledonia to strengthen the role of health in general development policies. In Malaysia an expansion of the role of nongovernmental organizations in planning and execution of health activities is being attempted. In Fiji and Samoa, the government policy is that development must include priority initiatives in health and education.
Economic trends

All of the larger developing and emerging economies in the Region continue to support high levels of annual growth. The Philippines has now joined these high-growth economies. Most of the countries which only recently embarked on market-oriented economics have successfully concluded the initial transition period of this process. As the most recent country to embark on this process, Mongolia is still experiencing some of the initial negative impacts of the transition. The overall lowering of availability of some basic commodities affects many communities, and high levels of unemployment and underemployment will be experienced until the new economic and productive institutions have stabilized. Nevertheless, even the less developed countries in this group, such as Cambodia and the Lao People’s Democratic Republic, are realizing slow but progressive rates of economic growth.

The smaller island states continue to move steadily ahead, with modest but stable economic growth. The smallest of these states, such as Niue, Tokelau and Tuvalu, remain reliant on external financial support for more than 70% of their income.

However, in almost all states of the Region there is a significant and increasing role played by the private sector and consequently a reduction in the economic role played by the government. This has resulted in many cases in a relative decrease in government funds for health in relation to increasing needs and a subsequent search for multiple funding. This is a matter of concern for governments faced with social issues in the fields of environment, employment, income distribution and ageing. For the large rapidly growing economies like China, central government must play a leadership role to ensure a reasonable balance between urban and rural development.

As discussed in the draft paper on Renewing the Policy for Health for All (hereinafter the Renewal Document, see Annex 2), even for the largest countries such as China, and more so for those with limited resources, trade is the driving force behind economic progress. Trade as an economic instrument has social implications which are quite different from those generated by either traditional economies based on agriculture or economies based on industrialization.
The role of tourism continues to receive more and more attention in most countries as a necessary component of economic development. Even many of the societies which had not previously encouraged tourism are beginning to develop tourism initiatives in the hope that these will produce economic benefits without necessarily producing negative social and environmental consequences.

Demographic trends

The Renewal Document provides details on significant demographic trends in the Region.

The main trends in population change are now becoming apparent. Many countries have pursued effective population management programmes in the last two decades, but a few have not been able to reduce population growth as quickly as had been hoped. Fortunately, for most countries economic growth has meant that, despite population growth, significant improvements have been realized for the population in general. However, judicious efforts and resources will need to be placed on population management for most countries for the foreseeable future. This is of particular concern for China, which is constantly concerned with natural resource management.

A central concern for all but a few countries at the lower end of the economic scale is the significant increase in the ageing population. Plans for this emerging social group are discussed throughout this report.

As in previous evaluations, urbanization continues to be a concern, not so much because of the potential social problems of a migrating population (with the possible exception of China where internal migration is still high) but because rural-urban migration will increase the dominance of major cities. To counter this, several countries have initiated policies to provide incentives for economic growth outside the major population centres, which may relieve pressure on the huge conurbations that are emerging in the Region. The emerging issue of the general mobility of individuals and families as a result of more open economic systems will need to be addressed.
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Social trends

Most countries of the Region are concerned to strengthen the role of the family. Women, education and lifestyles are also leading social themes. There has been a significant increase in the number of women playing a role in political, economic and social development in most countries, although in some this trend is starting from a relatively low base. Explicit policies on the role of women in development in countries such as China, Malaysia, Mongolia and Samoa are clearly exemplary initiatives, and will be followed by other countries.

Singapore continues to lead many countries with its emphasis on education as the highest social value and its clear message that “an educated family is a healthier family”. The Philippines has traditionally placed a very high value on education in social development and this trend continues to receive priority attention. China’s social policy includes a significant emphasis on science and technology, education and communications.

As is discussed throughout this document, the concern for lifestyles which have a negative impact on health, such as poor nutrition, substance abuse and insufficient exercise dominate the social agenda in most countries. Countries such as Singapore are very visibly trying to influence lifestyles. Similarly, in island states such as Cook Islands and Niue, emphasis is being placed on nutritional habits and on changing lifestyles which have had significant negative impacts. These countries are placing a very high priority on reversing these trends.

For some years, Cook Islands, Fiji and Samoa have, like other countries in the Region, given priority attention to adolescents, particularly in the areas of teenage pregnancies, substance abuse and accidents. As can be seen from the epidemiological trends described in the Renewal Document, social programmes that can reach and have an impact on adolescents remain an important health and social challenge for the 21st century.

Nutrition

Medical concern about the effects of under- and overnutrition is growing more acute. For the large segment of society that shares in economic progress, the concern is with short-term responses to disposable incomes that exceed basic needs. These short-term responses can result in lifestyles and
behaviours which have significant negative impacts, at least in body-mass indicators. Most public health specialists are convinced that overnutrition has multiple negative side effects although the long-term health impacts of overnutrition have not been fully clinically verified. In the Region, the effects of overnutrition can be seen in the increases in diabetes and hypertension that have been seen in most small island states. Consequently, countries are rapidly adopting national food and nutrition policies to address this issue. Most Pacific island countries have for some time had specific programmes on the importance of a balanced diet. More emphasis is being placed on the content of foods in many countries such as Cook Islands and Singapore. Some countries, such as Singapore, are directly addressing the longer-term issue of lifestyles associated with different stages of the life cycle. Such policies are facing opposition in a few societies, where body bulk has traditionally been seen as a sign of health and a high social status.

At the other end of the nutrition spectrum, in a few countries, such as Cambodia and the Philippines, where pockets of poverty remain a social concern, national nutrition programmes may be a part of the social safety net for the disadvantaged, and are often aimed at children. China has made great progress in the reduction of iodine and vitamin A deficiencies through government programmes.

Lifestyle

An increasingly important health issue in the 21st century will be the adoption of positive lifestyles as the most effective way to sustain social and economic progress. Again, a few countries such as Australia, Japan, Malaysia, New Zealand and Singapore at the higher end of the economic scale are already taking measures to influence the lifestyles of their populations.

Singapore's "National Healthy Lifestyles Programme" places strong emphasis on promoting health in the long term by providing people with as much technical and social information as possible. China places a high priority on its physical culture movement. There is strong government backing in New Zealand for similar policies. Mongolia is placing a strong emphasis on lowering fat content in diets, reducing smoking and alcohol consumption and informing people of the need for regular exercise. Since 1991, Malaysia has engaged in health promotion and improving lifestyles. These countries are beginning to see some positive signs of the effectiveness of their progressive
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Lifestyle programmes and are witnessing overall decreases in smoking and alcohol consumption and increases in the number of people in regular exercise programmes. It is interesting to note that the success of these efforts can be attributed to very focused goals and targets. Clearly, the managers and participants need readily recognizable and definable goals to reach a critical mass and eventually to achieve sustainable results.

The need for reduced smoking is a lifestyle change that must be realized as soon as possible. In many developing countries, the number of smokers is rising, particularly among women. Major efforts in China are being made to reverse this trend and are targeted at younger age groups.

CHAPTER 3. PROTECTION OF THE ENVIRONMENT

Environmental health planning

There is an increasing awareness among decision-makers in all countries that protection of the environment has a very significant impact, not only on the immediate quality of life, but on the attainment of a long-term sustainable future for the nation as a whole. As demonstrated by the marked decline in those diseases attributable to poor water quality and sanitation, the Region has achieved many collective goals. Consequently, for those countries that have shared in the economic progress, the vast majority of families are reasonably well protected from diseases attributable to poor water quality and inadequate sanitation. Only in those few countries in the lower economic strata, and, of course, in all countries that have marginalized individuals and communities, are people significantly affected by poor water quality and sanitation.

Consequently, for the majority of developing countries, environmental protection efforts focus on the emerging physical hazards associated with chemicals, air pollution, large construction projects and radioactive materials. Of greater long-term significance is the wider definition of a healthy environment, which now includes issues associated with, among others, resource conservation, development technology, housing, workplaces and soil erosion.
Many countries are attempting to address these expanding environmental issues by establishing broad-based environmental health planning mechanisms. New Zealand's Resource Management Act legislates the need for explicit analysis on the impact of development activities on the health and safety of those affected. Singapore provides an excellent example of a country level initiative to promote the protection of the environment. Through its "Green Plan for the Next Century", efforts are being made to educate the public on individual and collective responsibility for issues affecting the environment. The Government of Singapore also promotes the development of environment-friendly technology, the use of local environmental standards for conservation measures and awareness on how activities carried out in Singapore may affect the global environment. Australia provides a third example of an initiative exemplifying a national role in environmental protection, in this case the establishment of monitoring measures.

Environmental protection is obviously a priority for the environmentally precarious populations of the Pacific islands. Cook Islands has demonstrated particular concern for the environment. Strong political and administrative initiatives on public education are coordinated with public and private bodies and facilitated by legislative measures. Special efforts to combat pollution continue in Fiji, the Federated States of Micronesia and Tonga. Similarly, in larger countries where increased economic activity has the potential to lead to extensive environmental damage, planning procedures emphasizing multisectoral involvement in development activities have been promoted in Malaysia, Mongolia and the Philippines.

Specific environmental issues

As noted above, the environmental challenge is more acute in countries with rapidly developing economies, as illustrated by Malaysia where there are concerns about air pollution and pollution from industrial chemicals. Malaysia also exemplifies a country which has placed increasing emphasis on environmental improvements in housing and the workplace. The same trend can be seen in China, Marshall Islands, New Caledonia, and the Philippines, where increased attention has recently been given to housing as an environmental factor.

Viet Nam has recognized the danger of pollution arising from rapid economic development and is attempting to mitigate its impact. Soil pollution is a specific concern for Mongolia. Similarly,
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in countries with deforestation concerns, such as Cambodia, the Lao People’s Democratic Republic, Papua New Guinea and the Philippines, deforestation is regarded not merely in terms of soil erosion, but also as a cause of overall environmental degradation. Environmental degradation caused by agricultural chemicals is a concern in a number of countries and areas in the Region.

Water and sanitation continue to be issues of collective concern. Water is a quantity issue in some island states, but quality is emerging as an issue in many countries. Community sanitation and waste management are high priority concerns in most island states, notably Niue, Solomon Islands and Tonga. In Tonga and Wallis and Futuna, national and village sanitation programmes have been shown to have had a positive impact on sanitation.

CHAPTER 4. HEALTH RESOURCES

Human resources

A few key issues dominate current human resource planning. These include decentralized management of services, downsizing and, in some countries, labour shortages.

The impact of the increasing trend towards decentralization and the growth of private sectors in many countries have posed a challenge to national planners to ensure the availability of an appropriately distributed quality workforce. Human resources are often concentrated in urban areas where conditions of work are typically better. The Philippines and the Republic of Korea provide good examples of such countries. In some countries, such as Cambodia, Cook Islands and Mongolia, critical national public service downsizing measures are being implemented, with consequent effects on distribution of the workforce. China’s economic growth is exacerbating the imbalance between urban and rural areas in terms of the quality of human resources. Regional planning and improved licensing are being used to help resolve the problem.

Shortages of skilled workers continue to be a concern in many island countries and areas, such as American Samoa, Niue, Palau, Papua New Guinea, Tonga, Vanuatu and Wallis and Futuna. Shortages have been noted in Brunei Darussalam, Macao and Malaysia - where overseas workers are
now employed in health sector. Human resource issues in the Region’s health services mirror many of these general trends.

Training of health sector workers

The main strategy for resolving many of the above issues is continually to upgrade the skills of the workforce through education and training, with particular emphasis on continuing education. This is especially true of the health sector. Upgrading is seen as a particularly important issue in China and Hong Kong. Cambodia is revitalizing its health system through a national continuing education programme. The programme is progressing satisfactorily. Continuing education is an explicit priority in American Samoa, Kiribati and the Philippines. Particular emphasis is being placed on management skills in China, Malaysia, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia and Mongolia. Malaysia has one of the most developed programmes to develop an educated health workforce, with special initiatives in both formal education and in-service training. Major changes are taking place in formal health education in Mongolia, with fewer students and a new education programme to train family practitioners.

The Philippines is finding an acute mismatch between what educational institutions are producing and what the service needs. Among its many health initiatives, New Zealand is attempting to address this issue with specific purchasing agreements for educational institutions. Singapore has found that it must place a special emphasis on supporting the training of nurses to address similar concerns. China is exploring market mechanisms to meet health service needs. This entails encouraging practitioners to run their own clinics or consultations, and encouraging healthy competition between medical institutions to improve efficiency and reduce costs, thus matching demand for care at different levels.

Services and public health

Mongolia is redirecting services by prioritizing a new type of family-oriented practitioner. This is also being done in some island states such as Cook Islands, Samoa and Vanuatu where nurse/community practitioner programmes are being pursued. China is placing special emphasis on human resources in public health and research. One of Australia’s national priorities is to revitalize public health services.
Planning

The vast majority of countries in the Region have sufficient resources devoted to the health sector and subsequently express their priority concerns in terms of issues of equity, appropriate allocation of the resources and efficiency. However, there are a few less developed countries, for example Cambodia and the Lao People’s Democratic Republic, where the allocation to the health sector is 2% or less of gross national product and where the allocation is not sufficient to meet basic needs.

For the Region as a whole, enjoying the benefits of strong economic growth, the issues of equity and appropriate allocations continue to be addressed through health financing mechanisms. This has become an important issue for China, where central funds are used to balance regional and rural funds, special activities and issues. Malaysia recognizes that, as the market economy strengthens, the public system has an increasing responsibility to ensure that appropriate social safety nets are in place for those who, for economic reasons, have difficulty accessing appropriate care. Therefore, in most countries of the Region, basic care for children, older citizens and those with other special needs is met by governments.

Few countries, even the most prosperous, are satisfied with the distribution of financial resources between promotive and curative services. With a significant increase in most countries in the role of the private sector in the delivery of services, both equity and allocation issues are receiving more attention. Australia, New Zealand and the Republic of Korea continue to look to payment mechanisms for answers to these issues. In New Zealand, an emphasis on outcome measures as well as the clear separation between the purchaser and provider of services holds much promise for breakthroughs in countries and areas in similar situations. The use of diagnostic-related groups as a method of paying for services, compared to traditional fees for services, is being used more extensively in Australia and the Republic of Korea.

Singapore stresses the efficiency of its delivery system and its ability to manage resources. Similarly, in Hong Kong, Japan and Malaysia, where rising costs are central issues, efficiency measures receive significant attention.
Sources of finance

For most health systems of the Region, the majority of funds are raised through central taxation. However, countries where the tax-based systems are projected to be not sufficient are reviewing the option of health insurance. For example, major initiatives are being pursued in China on the most effective insurance or cooperative mechanisms to use in rural areas, particularly in the poorer rural regions. The Philippines has adopted an expanded comprehensive national insurance system. Like so many of these initiatives, the need to subsidize the poorer segments is limiting its implementation success. The Republic of Korea’s comprehensive insurance system continues to evolve and progress has been made in expanding benefits and in allocating resources more efficiently. Similarly, in Singapore, which has a very successful individual saving account fund, the government continues to explore new ways to get resources to priority needs and to utilize overall resources more effectively. Other countries with health insurance initiatives include the Federated States of Micronesia, Mongolia, Papua New Guinea, Solomon Islands and Viet Nam.

A central issue for many countries, particularly China, is improved coordination and management of multiple funding sources. Many health systems struggle to keep up with rising costs or are affected by national decisions to constrain the share of national expenditure on health. Various cost recovery mechanisms are therefore being explored. Many island states such as Fiji, Niue and Solomon Islands are in this situation. Malaysia and Mongolia are investigating user charges to finance certain health services, although possibly not critical care services.

In many of the small island states such as Cook Islands, Niue, Papua New Guinea, Samoa, Vanuatu and in the less developed states of Cambodia and the Lao People’s Democratic Republic, external sources of funding support disease control activities and critical health promotion services, such as campaigns related to maternal and child health and immunizations. In these countries aid coordination remains a concern.

International partnerships

There are two issues driving initiatives to expand and strengthen the role of international partnerships for health: the growing complexity of the health system, both in delivery type and in technology, and the concern for diseases that need cross-border surveillance and control.
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It is becoming quite apparent that the rate of growth in the complexity of the health system requires that policy and planning mechanisms also be expanded. International partnerships are emerging to support the increasing need for technical sharing and for exchanges in the areas of private sector development, corporatization and contracting. In the same way, financing issues ranging from sources to allocation to efficiency can only be thoroughly reviewed by exchanging experiences with neighbouring countries and others with similar concerns.

Malaysia, for example, has defined a very explicit role for international partnerships and exchanges in the areas of training, quality of care and health systems research. New Zealand has established an international health policy framework as an integral part of its development planning to ensure the incorporation of knowledge and experience from around the globe. Singapore is focusing increasing attention on the use of worldwide networks of technical exchange. Mongolia has included an explicit role for international partnerships in policy and coordination inputs. China attributes many of its successes to the effective use of international cooperation and partnerships, particularly in areas of policy formulation and legislation. Technical exchanges remain a key theme in China’s health development.

Disease control and surveillance measures require cross-border initiatives. Such initiatives are being carried out in areas of malaria and poliomyelitis control. The battle against HIV/AIDS necessitates an international approach, as do campaigns against emerging and re-emerging communicable diseases.

CHAPTER 5. DEVELOPMENT OF HEALTH SYSTEMS

Policies and strategies

As countries reflect on the achievements of the past two decades of health for all, there is a general recognition that the primary health care approach as a fundamental value for health policies will remain valid well into the 21st century.
However, a number of dominant themes are emerging from the many new initiatives on national health policy formulation. These include the use of more comprehensive frameworks for planning, new structures for the delivery of care and the involvement of the community.

Malaysia and Singapore have recognized that, for the issue of sustainability to be more firmly rooted in health development, a more comprehensive planning process must be put in place. Fiji has recently started a new planning process in its health sector review. This theme is also manifested in a belief in several countries that comprehensive health planning must be more directly related to overall national socioeconomic planning. Legislation plays an increasingly significant role in this process, for example in laws that are attempting to influence the resource allocation process in American Samoa. These efforts are being supported by the framework provided in *New horizons in health* and the Healthy Islands approach, which are finding more explicit expression in national health development policies.

Some of the most interesting and challenging recent developments relate to the promotion and support of new structures for the delivery of health services. For example, in China various new cooperative mechanisms for rural areas are being tried. Some of the most extensive changes in this regard have taken place in New Zealand, where recent initiatives have aimed to remove profit incentives for delivery organizations.

Decentralization is being adopted by a number of countries, such as Cambodia, China, Mongolia, Papua New Guinea and Viet Nam. The local government movement in the Philippines is also encouraging decentralization. Experience has shown that policy-makers must not only provide guidelines for the new administrative entities but must also guide the technical, professional and administrative development of the new structures. Some worthwhile lessons are emerging, for example in Malaysia, as more effort is placed on attempting to institutionalize alliances and partnerships. The goal in many cases is to create a district focus in the health system.

In support of this district focus, new approaches are attempting to distinguish clearly between central and provincial roles. This is an important issue in Cambodia, Mongolia and New Zealand. Mongolia’s new structures will use health volunteers, an approach which may not be easily implemented by older institutions.
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Structural issues have implications for specific health programmes. This is illustrated by more extensive use of targeting to improve the efficiency of the system. In Japan care of the elderly is being targeted. In New Zealand there is an emphasis on outcome measures and the system specifically targets care for the child. Targeting is also being applied in Mongolia.

Continued interest in integrating Western and traditional care has been expressed in many countries. This is being addressed in China, Mongolia and Viet Nam, for example.

Community

There is a regionwide trend for health policies to involve the community more explicitly. This is illustrated by Guam’s initiatives for more community participation in the planning process. In Malaysia measures have been promoted to increase the role of women in development and in Hong Kong increased attention is being paid to consumers’ expectations of their health service.

Interest in ensuring that people and their communities are more involved in health is illustrated by the promotion of a healthy lifestyle in Niue and Singapore. In New Zealand, this theme is implemented through legislation that ensures that the community is aware of its rights, namely, the “Code of Health and Disability” which defines the rights of the consumer.

An issue related both to people and to service aspects is the increasing concern for quality at the community level. Quality is more than a technical or administrative matter, it is becoming as important a variable as costs in health care evaluation. Again, Singapore illustrates some of the specific measures being taken in this regard. However, most countries recognize the importance of quality as a moral issue and for many it is the underlying force driving development.

Intersectoral cooperation

The need for intersectoral cooperation in the health-for-all era is accepted by most politicians and managers. However, all previous health-for-all evaluations have noted that it has been one of the hardest to implement of all health-for-all principles. This trend seems to have been reversed, at least in terms of attitudes. There has been an acceptance that different sectors must work as equal partners. For example, intersectoral cooperation is being addressed in Malaysia, which continues to
strengthen its administrative coordination mechanisms, and in Mongolia, which is attempting to define roles for each government ministry involved in a particular programme more precisely. Mongolia also issues joint communications, while still employing ministerial councils and various types of working groups to plan and programme detailed activities. China is using a multisectoral approach to develop rural health insurance schemes and six key ministries to strengthen rural cooperative structures. The Philippines uses working groups and committees at all levels of government to ensure coordination. Collaboration between selected functional areas such as research, policy development and legislation may be added to this process.

In New Zealand improved coordination is being used to address many emerging issues. This has involved many sectors, including education, justice, transport, Maori affairs, police and many family-centred organizations.

Healthy Islands initiatives are being used as a framework to achieve more effective sectoral coordination. For example, in Niue the Healthy Islands approach has become a holistic planning concept used by the ministerial council. In Samoa and Tuvalu, a number of committees are working on Healthy Islands approaches. China's Healthy Cities approach also places emphasis on the intersectoral nature of cooperation.

**Organization of the health system**

The organization of health systems parallels overall policy formulation in terms of the issues being debated. Initiatives in planning health system organization can be seen in Cook Islands where attention is being given to the use of more formal and structured management plans of action. Using a "business plan" format, objectives are based on outcomes, how financing sources are used is more explicit and there are closer links with the private sector.

The district as a focal point for the organization of health systems has provided a framework for the various support functions of the health system. For example, in Cambodia and Malaysia the district focus for service delivery has affected training programmes, which now use district disease patterns as the basis for situational analysis. Similarly, in Mongolia, the district emphasis has brought out the need to strengthen referrals and secondary care in order to support the district. A comparable planning assessment in Niue has highlighted the use of the hospital as the centre of
health care, including community health activities. The hospital is a key part of organizational reform in China, where attempts are being made to strengthen district hospitals, to make urban hospitals more community-oriented and to encourage a shift away from large hospitals to systems of care involving several institutions. The aim is to enhance the three-tier system, from the grass-roots level in rural areas to specialized hospitals for the treatment and operation of severe cases.

Efficiency initiatives drive many attempts to strengthen the organization of health systems. For example, in Singapore, health leaders are attempting to nurture improved attitudes on the part of public services. Other measures include improving the efficiency of the MEDISAVE administration as a way to strengthen the overall health system. MEDISAVE is a scheme whereby funds are regularly put into a medical savings account which can be used to pay medical bills. Similar efforts in the Philippines address efficiency issues which arise from the major devolution of services to local governments. Specific efficiency issues arise, for example, in the allocation of resources between central and local levels. Efficiency drives also affect staffing, technical needs, accounting and reporting issues.

Managerial process

Changes to the planning process represent a significant trend in health services management. These changes mirror social changes acting on the health sector. Malaysia, for example, which has always placed a heavy emphasis on planning, is stressing the need for more flexibility in its planning, with a wider spectrum of community and political participation. Extending involvement in planning beyond health staff can be seen in a number of countries. Guam is involving the community in planning, while in small island states such as Palau, Samoa, and Solomon Islands, there is a strong trend towards intersectoral planning. Even within an institution or government sector, more levels are becoming involved in the planning process. Alternatively, in recognition of the changing roles and responsibilities brought about by decentralization, different planning purposes depending on the level are being defined. For example, in Cambodia, central level planning produces national goals and general details on health policy. At provincial and district levels, the plans are strictly operational and follow the national health policy. This reflects another aspect of the trend in health planning: the need to become more adaptable to changing situations, such as increased local
government services or multi-agency delivery systems. This is reflected in the Philippines, where local government units now have more responsibility for service delivery.

A second major trend is the development of more precise management tools to administer new organizational structures, such as decentralized services. In Singapore, two clinical units have been established as autonomous organizations. This has required special management procedures and training of staff.

Management training is an issue in most countries. In some countries, such as the Federated States of Micronesia and Mongolia, there is still a high demand for training in the basic management functions: accounting, personnel and logistics. However, more often, training needs reflect responses to major structural changes or changes in the focus of service delivery, as in the increased importance of the district in Cambodia, the Lao People's Democratic Republic and Viet Nam. There is also an increasing emphasis on new issues which are emerging in management, such as supervision and interpersonal skills. Again, this is clearly reflected in Singapore's development plans.

The trend towards more evidence-based decisions has emphasized the importance of a reliable health information system. Developed countries have recognized this for many years. New Zealand, for example, routinely produces reports on the effectiveness of care outcomes, consumer issues and quality of care. Singapore now has a comparable system which can produce productivity indicators, quality and level of services measures and staff performance reports. Singapore is also in the process of implementing a computer-assisted ICD-10 system. Similarly, the Republic of Korea is placing a very high priority on a new comprehensive information system. China also has an extensive information system.

The majority of countries, however, are still struggling to develop health information systems that are sustainable. As noted in other sections, the changing structure of care, such as the role of local government in the Philippines, will have a significant impact on the performance of the health information system. Of the other less developed countries, Mongolia has put a major effort into its new systems.
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Community action for health

Throughout this evaluation it has been observed that, after lagging behind in the health-for-all movement, community action in health is now far more prevalent. New mechanisms are being used, first, to channel community participation and second, to change the attitudes of health administrators from an all-knowing approach to one of partnership.

Malaysia provides an example of a country using a new approach that is proving to be effective, namely, targeting groups in need of special care. Professional organizations and volunteer groups with unique interests and skills are matched with health issues and needs. Similarly, the Philippines has also found that a targeted approach is a more effective way to work with volunteers and clubs. Targeting is specifically featured in Singapore’s community action planning.

Cook Islands continues to place strong emphasis on community participation in health, particularly in the areas of education, promotion and protection of the environment. This approach reflects the view of most island countries. In most Pacific island countries, the community is integrated into all social and political structures and consequently there is a strong sense of responsibility towards social service programmes. This is also the approach of New Zealand, where, as structures become more complex and the role of central government has changed, mechanisms are being used to involve the community in more aspects of public and social services, including the actual delivery of services. Similarly, in China, which continues to have a strong community-oriented education focus, this message is being expanded to include community delivered services.

Emergency preparedness

Emergency preparedness and response is receiving increased attention, not only in those countries which regularly suffer natural disasters such as China, Japan, the Philippines, Viet Nam and South Pacific island countries, but also in countries which do not experience frequent natural disasters, but which face potential man-made disasters due to development programmes.

Most countries have national and health contingency plans for disasters, but, with increased attention given to multisectoral and community involvement in general, they find that their disaster management can be strengthened through these means as well. For example, in the Philippines the
health disaster management unit has strengthened the involvement of other agencies and bodies. In Pacific island countries, such as Cook Islands, Niue, Samoa, and Tuvalu, significant efforts are underway to strengthen preparedness through organizational and training initiatives. Disaster management has received a significant amount of attention in China. Malaysia is an example of a rapidly developing country which is recognizing the need to review and upgrade its capacity to respond to various disasters.

In some countries, such as Mongolia, legislation and intersectoral collaboration are being used to strengthen disaster preparedness.

Health research and technology

The increasing complexity of the health system and emerging issues are reflected in the increasing role of research in most countries.

Significant efforts are being made to structure the coordination of research more effectively. Malaysia provides an excellent example of how to manage the research function effectively in an expanding sector. A central body prioritizes and coordinates research efforts. The specific topic of the research focuses on priority concerns, such as quality of care, outcomes of care, behavioural aspects of care and impacts on policy. The National Medical Research Council serves a similar purpose in Singapore, where priorities include clinical practices, changing epidemiology and health systems. The Philippines also has a coordinating body to prioritize and fund research. Its current priorities include development of new vaccines and traditional medicine. Mongolia has recently established a mechanism to improve coordination of research that is being carried out in a number of institutions.

In New Zealand there is a focus on development of knowledge bases. Such knowledge bases include, for example, child development and mental health. The very high priority placed on science and technology to support development in China is reflected in the health research and technology programmes, from priority setting to coordination and dissemination of information.
CHAPTER 6. HEALTH SERVICES

Health education and promotion

One of the more significant efforts in most countries in the Region is the strengthening and realigning of health promotion programmes to meet the challenges posed by emerging health conditions associated with lifestyle and individual behaviour. It is apparent from the leading causes of mortality and morbidity that the priority of the health sector must be to promote ways to prevent or at least delay these noncommunicable conditions. Consequently, countries have to find new messages and ways to deliver these messages so that they can have both short- and long-term impacts on new and emerging health conditions.

Singapore has one of the strongest health promotion programmes in the Region. It is focused on the comprehensive concept of healthy living. In Malaysia, the Healthy Lifestyle Campaign aims to strengthen health education activities at national, state and district levels. The objective is to ensure better awareness, understanding and participation of the community in the campaign to adopt better health practices and lifestyles.

In the Philippines, efforts are being made to promote the hospital as a community resource through the Hospitals as Centers of Wellness programme. Further community involvement is being pursued through promotion and use of networks and active collaboration with specific community programmes.

China has recently established a National Institute of Health Education. This Institute is the centre of activities on research, training and technical assistance on health education and promotion.

Most island countries have traditionally used the community as an integral part of health promotion efforts. This emphasis continues in the strong community programmes in Cook Islands and Niue.

In New Zealand the local purchasing authorities include health promotion as one of their services. Messages and services are targeted, for example, by subject (e.g. tobacco), by age (e.g. 15-17 years old) and sometimes even by locality.
Mongolia is an excellent example of comprehensive health promotion where use is made of all media. A number of target issues - tobacco, alcohol, early childhood - have been set and the community has been closely involved in setting priorities and developing plans of action.

Family and reproductive health

Most countries are reasonably satisfied with their family and reproductive health programmes. Such programmes have contributed to significant declines in illnesses and accidents affecting mothers and children. However, it is recognized that this area must continue to receive due attention. Two issues are driving most new initiatives: expanding services and improving quality.

Malaysia's approach illustrates the expanded services issue. Reproductive health services are networking with other service agencies to ensure that new services are compatible with the new structures and ways of providing care. Similarly in Singapore, the new structures, such as neighbourhood clinics, will offer family and reproductive services. Baby-friendly hospitals have helped to promote improved maternal and child health in some countries, such as the Philippines.

Quality is the priority concern for antenatal services in Mongolia and efforts to improve under-five care in New Zealand. In China, traditional maternal and child health services have reached a level of maturity and are being refined. China also uses legislation to govern the optimum number of children per family.

Most countries report that they are satisfied with the development of their immunization services, with the exception of immunization against measles in some countries.

Disease control

The generally high level of basic health service coverage in most countries covers the control and treatment of the most common diseases. However, in some countries traditionally common diseases persist among the poorer segments of the population. In the Philippines, even though per capita gross domestic local product is now over US$ 1000, there are still major concerns with malaria and tuberculosis. Schistosomiasis and dengue may even have increased when functions were transferred to local government, indicating the need in some situations to maintain central control for
certain disease conditions. In Cook Islands, common diseases and illnesses include dengue, conjunctivitis and diarrhoea.

HIV/AIDS is a concern across the Region and treatments remain very expensive. Improving the quality of management for acute respiratory infections is an issue in Mongolia. Malaysia is strengthening its epidemiological unit and emphasizing prevention and treatment of HIV/AIDS and noncommunicable diseases.

CHAPTER 7. PATTERNS AND NEEDS IN HEALTH STATUS

The health status of the people of the Region varies considerably. Some traditional communities in Cambodia, the Lao People’s Democratic Republic and Papua New Guinea experience infectious diseases and high maternal mortality ratios and infant mortality rates that are typical of the earliest phase of the health transition. Others - typically rural communities in Cambodia, China, the Lao People’s Democratic Republic, Mongolia and Viet Nam - experience a comparatively high incidence of communicable disease and maternal morbidity and at the same time experience strokes and a variety of cancers. Such populations in the middle stage of the health transition present a complex challenge to health care strategies. The majority of the populations in Australia, Hong Kong, Japan, New Zealand, the Republic of Korea and Singapore have experienced the full health transition and, with the important exception of HIV/AIDS, have an extremely low incidence of infectious disease, and low levels of maternal and infant mortality. However, these advances are to an extent counter-balanced by ageing populations who suffer from chronic degenerative illnesses, placing a considerable burden on the health service.

Populations experiencing the early stage of the health transition

Cambodia, the Lao People’s Democratic Republic and Papua New Guinea all contain segments of the population who are experiencing the early stage of health transition.

Most health authorities assume that all communities seek to remain healthy and to be free of premature death and disease. However, this reasonable assumption does not take into account the desire of some traditional communities to retain their traditional culture and way of life - which often
involves rejection of some health-related interventions, such as literacy and numeracy campaigns, immunization, modern transportation and, more generally, "economic development". Authorities are faced with problems whether they intervene or not. The number of such communities is steadily falling, so the problem is manageable if the communities can be encouraged to make their own decisions as to whether or not to accept changes which will inevitably alter their way of life. Several aboriginal communities in isolated parts of Australia have chosen to maintain their traditional way of life but have accepted interventions such as immunization and surgery. This compromise appears to offer a reasonable balance.

For those other communities at the early stage of the health transition which wish to pursue modern economic and health development, the priorities for action are well-established. As a first step they involve the provision of the essential elements of care through a district-oriented health system.

Populations in the middle stage of the health transition

Fiji, Malaysia, the Federated States of Micronesia, Mongolia, the Philippines, and rural areas in China and Viet Nam include populations in the middle stage of health transition.

Maternal mortality and morbidity remain problems in such populations. It is well known that many difficulties associated with maternal health occur during and immediately after birth. While the absolute number of women who die during childbirth is low, the loss of a mother is particularly tragic when it is possible for maternal mortality to be reduced to very low levels. All pregnant women must have access to appropriate care and the professional quality of that care should be substantially raised. In addition, it has been shown that a review of each individual maternal death can result in improved future outcomes. Communicable diseases also remain a problem in these populations. Tuberculosis, malaria and in some of these countries, HIV/AIDS are the most important. There are well accepted procedures for each of these problems, which need to be pursued with vigour.

In partnership, both the affected communities and the health authorities have to develop and implement strategies to deal with the emerging problems associated with the health transition - traffic accidents, ischaemic heart disease, stroke and cancer. This involves a major commitment to
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prevention through changes to the lifestyle of individuals. Experience in developed countries demonstrates that, while such preventive changes are difficult and long-term, they can be successful. A sound and acceptable starting point is the development of sustained anti-tobacco campaigns.

Populations approaching the later stage of the health transition

Australia, Cook Islands, Hong Kong, Japan, Nauru, New Zealand, the Republic of Korea, Singapore and urban China are all in or approaching the later stage of the health transition.

By many standards, the people of Japan are among the healthiest people on earth. Australia and New Zealand have long been at the late stage of the health transition, but Japan and the other populations in the Region at this stage have progressed through the health transition at an extraordinarily rapid rate. This is because they have achieved excellent health service provision for all citizens, including near universal immunization, plus education and health-related infrastructure (water, transport, sewerage, etc.). These countries have been so successful that the ageing of the population has become a very major problem.

In addition to the problem of ageing, new problems are emerging in all these countries apart from Australia and New Zealand (where they have been widespread for some time and are now starting to decline). In all other populations, incidences of ischaemic heart disease (Japan is an exception), hypertension, diabetes, lung, breast, colon and prostate cancer are rising. For example, during the past 40 years, deaths due to lung cancer in males in Japan have risen by approximately 800% and in the same period deaths due to breast cancer in Singapore have doubled. While lung cancer death rates in Japan and breast cancer death rates in Singapore remain less than in, for example, Australia, the trends are very worrying.

While death rates due to ischaemic heart disease, lung cancer and traffic accidents remain at high levels in Australia and New Zealand, those rates are declining and with respect to ischaemic heart disease have almost halved during the past 30 years. The reason is probably a combination of health promotion and treatment.
CHAPTER 8. OUTLOOK FOR THE FUTURE

Current situation

The assessment by countries of their current health situation is very closely related to their level of economic development. In general, there is a very positive view of the progress of health systems over the past few years. One significant finding of this review has been that overall economic status does not reflect the status of all segments of society. There are pockets of disadvantaged people in all otherwise well-off countries.

The less economically developed countries have shown excellent progress in some areas but many are still at an early stage of the health transition, where the major concerns are communicable diseases and maternal and child morbidity and mortality. Their basic primary health care policies are focused on the district as the centre of the health system, with strong vertical programmes for priority communicable diseases, along with child health and family planning programmes. These countries have not as yet developed long-term sustainable development mechanisms, but external support has been filling the most urgent gaps. Similarly, in the field of human resources, the long-term solution of a skilled workforce is a long way off, although the immediate policy of strengthened continuing education is proving effective. A very strong emphasis must be placed on strengthening management training for staff at all levels.

The vast majority of countries and areas in the Region continue to enjoy strong economic growth, which in turn typically means that the health sector itself has more resources with which to meet increasing demands. For these countries and areas, the overwhelming concern is how to respond to the rapidly changing patterns of health conditions. With the exception of South Pacific islands and those countries embarking on free-market-type reforms, there are the added challenges of evolving responses to new demands created by the new organizational structures associated with the trend towards privatization and decentralization.

For the developed countries of the Region, the mid-1990s have seen confirmation that some noncommunicable diseases and accidents can be reduced through lifestyle changes. The challenges for these countries are to ensure that progress is sustainable and to expand this progress into other
preventable conditions. Health systems in the developed countries are placing emphasis on outcome measures, quality of care and financial efficiency. They are more and more concerned with the care of the aged. It is now well documented that health interventions with costly technology provide very little return in terms of improved quality of life for the aged.

Visions for the future

The less developed countries in the Region are in a relatively better position than were countries of a similar status in the past. First, in general, the countries themselves are experiencing a period of relative political stability. Second, there is a very strong commitment by the international community to help as much as possible. The less developed countries in the Region are putting in place mechanisms which will ensure efficient use of expanding resources. These mechanisms involve improvements to the quality and quantity of care and managerial issues, particularly in the areas of supervision and financial procedures. There is a strong sense of awareness by the health leadership in these countries that, whatever structures and procedures are implemented, they should be sustainable over a reasonable period of time. Particular attention is being given to hospitals. Hospitals are being revitalized as the technical and managerial focus for the health system and a crucial part of the district development concept. Hospitals have traditionally consumed more than 50% of resources. The issue now is to ensure that appropriate technical resources remain in these centres and that these resources are used more efficiently. Hospitals will also remain as the managerial centres for planning and supervision of services for the community and for specific geographical areas.

The challenge in the less developed countries with strong decentralization and privatization policies is to achieve the full potential from opportunities created by these policies. They should be seen as part of a sustainable process that offers potential for flexibility in the use of specific policies determined by local communities and their managers.

For the majority of developing countries, the vision for the future is shaped by clear goals and the emerging structures that will carry out these goals. In terms of the policy process for fulfilling this vision, it is quite apparent in most countries that much more attention must be given to the issue of equity and to ensuring that health care is available to those who may not be able to pay
for it. The growing realization that not all will be able to participate equally in a free-wheeling market economy means that government policy must cater for the less affluent in society, possibly based on increased user fees for those able to pay or on health insurance schemes.

With regard to the changing pattern of diseases, there is full recognition that the current disease profile cannot be managed through the curative model of services. In fact, there are no cures for many of the noncommunicable diseases which are increasingly occupying health services in the Region. The exception is accidents, where through the use of very expensive technology, a damaged body in reasonable health can be rehabilitated to virtually the same state as before the accident. However, for most chronic and degenerative noncommunicable diseases, traditional cures are typically applied at a later stage of treatment and the results are not very effective. Therefore, it is both a moral imperative as well as a financial necessity for these primarily preventable conditions to be addressed as such and not be allowed to develop into end stage life-threatening conditions. Promotion of health has become the theme for national health development and this will obviously continue into the future. There are two aspects to this new emphasis. First, health promotion must now have a significant operational role throughout the entire health system, rather than being merely a topic of discussion in small health education programmes. Second, health promotion should be targeted at different stages of life.

Lifestyle is clearly recognized as the key determinant if the current disease profile is to be changed. There are a few success stories, mostly from developed countries, that offer some hope for the future. These include reduced rates of HIV infection and reduced levels of alcohol and cigarette consumption. The *New horizons in health* approach recognizes that the various stages of human development offer different opportunities for lifestyle change. This understanding will grow in the near future.

Countries are also seeing the potential for gains in the implementation of health promotion through the major structural changes that are taking place, namely decentralization and privatization. Clearly, the essence of health promotion lies in the closeness and relevance of messages that can be easily assimilated into an individual’s routine. This can be assisted by structural change through partnerships and alliances.
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The themes for the future are individual- and community-oriented. Responsibility is the key concept. In the past there was a very strong sense that government must provide health leadership, leading to a long list of unsuccessful health education campaigns. Consequently, the assumption now is that an individual with a sense of responsibility will, if given the technical information and options, choose a lifestyle that maximizes health over his or her entire life.

Communities are a significant part of this vision. For example, there is a need for collective management of technical information, advisory mechanisms and the administration of operational activities. Thus, communities are in one sense an administrative arm of government.

This illustrates the emerging role for central governments in the new vision for health. Many management and policy issues remain to be resolved. Various financing mechanisms, for example, have revealed valuable lessons during the past decade which are now being implemented in many countries. However, financing mechanisms must now be adapted to meet the changing environment in terms of disease profile and structures.

With regard to management practices, the issue of quality will dominate formal delivery systems in the future. Targeting of at-risk groups is becoming more and more accepted as one of the most significant aspects of managerial efficiency.

The future brings with it a vision of health for the 21st century that is filled with challenges. The dilemma is that the environment for matching the technology to the need will be quite different from that in the past. Here lies the major challenge of the future. Simple modifications of behaviour, such as eating less fat, stopping smoking and taking more exercise will pose the biggest challenge for the health sector in the next two decades.

At the same time, we should not lose sight of one of the most fundamental goals of the health sector, namely to provide acute care. Acute care will for some time in the future still consume the vast majority of resources and be the primary concern of health workers. The point is that New horizons in health is not simply a planning timeframe. Like health for all, it is a system of values for individual workers as well as institutions. It provides a framework for making decisions on individual care that incorporates best practices of appropriate, good-quality, cost-effective care, but with a new emphasis on monitoring and assessment that creates an individual and institutional
learning environment. This new environment is able to increase the efficiency and effectiveness of health services on a continuous basis to meet today's needs and readily adapt to the challenges of tomorrow.
# Table 1. Demographic and social indicators

<table>
<thead>
<tr>
<th>Country/Area</th>
<th>Year</th>
<th>Population Total (000)</th>
<th>&lt;15 (%)</th>
<th>&gt;65 (%)</th>
<th>Rural (%)</th>
<th>Crude birth rate (000)</th>
<th>Crude death rate (000)</th>
<th>Adult literacy rate Total (%)</th>
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<tr>
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<td>1995</td>
<td>56.0</td>
<td>38.1</td>
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<td>52.0</td>
<td>29.9</td>
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<td>21.4</td>
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<td>14.0</td>
<td>14.1</td>
<td>6.9</td>
<td>&gt;95.0</td>
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<td>33.2</td>
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<td>33.4</td>
<td>24.8</td>
<td>2.9</td>
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<td>45.0</td>
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<td>17.1</td>
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Note: Names of countries/areas in capital letters refer to those which had submitted a report on the Third Evaluation of the Strategy for Health for All by the Year 2000 by 17 June 1997.
Table 2. Government expenditure on health

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<th>Country/Area</th>
<th>Per capita GNP (where noted, GDP) (US$)</th>
<th>Percentage of GNP (GDP) spent on health</th>
<th>Percentage of national health expenditure devoted to local health services</th>
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* Official data for GDP in Samoa does not presently exist and the summary based on data is prepared by the International Monetary Fund and World Bank.

Note: Names of countries/areas in capital letters refer to those which had submitted a report on the Third Evaluation of the Strategy for Health for All by the Year 2000 by 17 June 1997.
Table 3. Coverage of population by health care

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<th>Country/Area</th>
<th>% of population covered by health care</th>
<th>% of infants receiving routine care from trained health personnel</th>
<th>% of pregnant women attended by trained personnel during pregnancy</th>
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Note: Names of countries/areas in capital letters refer to those which had submitted a report on the Third Evaluation of the Strategy for Health for All by the Year 2000 by 17 June 1997.
### Table 4. Selected indicators of health status

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<th>Country/Area</th>
<th>% of newborns with birthweight of at least 2,500 grams</th>
<th>% of children whose weight-for-age and/or weight-for-height are acceptable</th>
<th>Infant mortality rate (per 1,000 live births)</th>
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Note: Names of countries/areas in capital letters refer to those which had submitted a report on the Third Evaluation of the Strategy for Health for All by the Year 2000 by 17 June 1997.

a/ Covers 855 million population in 81 cities and counties.
b/ 1991 census.

---

**Life expectancy at birth (years):**

- **Total:**
  - 1995: 72.0
  - 1996: 72.0
  - 1997: 72.0

- **Male:**
  - 1995: 70.6
  - 1996: 70.6
  - 1997: 70.6

- **Female:**
  - 1995: 72.8
  - 1996: 72.8
  - 1997: 72.8
### Table 5. Percentage of population with safe water in the home or within 15 minutes' walking distance, and with adequate sanitary facilities in the home or immediate vicinity

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<th>Sanitary facilities</th>
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Note: Names of countries/areas in capital letters refer to those which had submitted a report on the Third Evaluation of the Strategy for Health for All by the Year 2000 by 17 June 1997.
Table 6. Percentage of children immunized against the target diseases of the expanded programme on Immunization (EPI)

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<th>Poliomyelitis</th>
<th>Tuberculosis</th>
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Note: Names of countries/areas in capital letters refer to those which had submitted a report on the Third Evaluation of the Strategy for Health for All by the Year 2000 by 17 June 1997.
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Note: Names of countries/areas in capital letters refer to those which had submitted a report on the Third Evaluation of the Strategy for Health for All by the Year 2000 by 17 June 1997.
Table 8. Selected family health indicators

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Note: Names of countries/areas in capital letters refer to those which had submitted a report on the Third Evaluation of the Strategy for Health for All by the Year 2000 by 17 June 1997.
DRAFT

RENEWING THE POLICY FOR HEALTH FOR ALL
(Report of the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation, Part II)

This document reviews the Renewal of the Policy for Health for All in the Western Pacific Region. In particular, it looks ahead to the potential health problems of the 21st century, and highlights the linkage and the issues raised in the draft global document "Health for All in the 21st Century" (WPR/RC48/8 INF.DOC.1, PPE/PAC/97.5) and the regional policy framework New horizons in health.

The purpose of this document is to guide Member States in their review of health for all in the light of the new health policies which will be needed for the 21st century.

This renewal proposal, as approved by the Sub-Committee, is now submitted to the Regional Committee for review. It will then be submitted to the Director-General for eventual inclusion in the global document on Renewing the Policy for Health for All.

* Revised draft with suggestions of Members of the Regional Committee during its forty-eighth session.
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PREFACE

The International Conference on Primary Health Care, held in Alma-Ata in 1978, was a historic meeting which recognized the need for universal action directed towards the most urgent health needs of the day. There have been many achievements in the last 19 years, due both to the sound ideas of primary health care and the collective will of nations. There is solid evidence that the process as well as the technology of primary health care did contribute significantly to these successes.

The Western Pacific Region has changed dramatically in these 19 years. Comparing social, political and economic indicators of today with those of 1978, it is difficult to believe it could be the same place. Yet dramatic changes and continuity exist side-by-side. The theme of renewal is therefore appropriate since, while significant changes lie ahead, many ways of the past retain relevance.

The purpose of this document is to describe a proposal for renewal of health for all in the Western Pacific Region. Health for all has contributed greatly to improvements in health in the Region. The draft Third Evaluation of the Implementation of the Strategy for Health for All by the Year 2000 details these achievements. However, in many countries recent social and economic gains have outpaced the ability of the health sector effectively to respond to the needs of today. Consequently, it is essential that some new ideas and methods be incorporated into the health sector. This is why the theme of this document is the renewal of health for all for the 21st century.

Because it is such a fundamental part of the implementation of health for all in the Western Pacific Region, the document *New horizons in health* forms Part II of this document. *New horizons in health* is very specifically targeted at the health issues of the Region and therefore provides the focus for the general issues discussed in Part I. In particular, the indicators which form an integral part of *New horizons in health* provide a way of monitoring how overall health-for-all policy is being implemented at the country level.
Annex 2

The Third Evaluation of the Implementation of the Strategy for Health for All is an associated document which provides a regional overview of health development in terms of the original health-for-all goals. It will be the regional contribution to the global report on the Third Evaluation of Strategies for Health for All.

This document also highlights the issues raised in the draft global document “Health for All in the 21st Century” particularly the effects of demographic, epidemiological and environmental changes, urbanization and globalization to the health of the people with particular reference to the Western Pacific Region. The global document elaborates further on the role of the WHO in supporting Member States in their pursuit of health for all in the 21st Century.
PART I
CHAPTER 1. INTRODUCTION

The renewal of the health-for-all policy will provide Member States with an opportunity to formulate new health policies for the 21st century. This document is intended to provide Member States with a framework to guide health policy development.

The framework aims to present the challenges of the 21st century in epidemiological terms. This epidemiological focus is not meant to imply an orientation dominated solely by the control of disease. On the contrary, this measure of a health profile is used largely as a surrogate measure of quality of life, with the underlying message that disease is typically the focus for most decision-makers. It is the premise of this document that, although theoretically the quality of life may be independent of the presence of disease, the evidence suggests people and health systems are psychologically and culturally tied to disease control. A broader definition of quality of life will come only when health decision-making moves beyond this perspective. Thus the allocation of resources today is clearly driven by the disease profile.

The regional document New horizons in health stresses the individual's ability to avert diseases, when sufficient time and a supportive environment are present, and the individual's capacity to build up positive health.

New horizons in health will form the basis of much of the future health policy development in this Region. It is a framework which highlights a wide-ranging array of variables that have an impact on the state of a health profile. These variables will influence the status of health in either a direct way, or more indirectly by influencing the different stages of life, which in turn will have an impact on both the health profile and the disease profile.

One of the most important issues outlined in this document is the observation that the epidemiological transition is probably moving more quickly than most policy-makers anticipated and that health services are not responding sufficiently quickly to this transition. For example, in terms of the prime causes of death and disability, the transition from communicable diseases to noncommunicable diseases occurred for the Region as a whole in the late 1980s.
The next major transition point is likely to be early in the 21st century when injuries are projected to account for more death and disability in the Region than communicable diseases.

**CHAPTER 2. HEALTH POLICY**

The purpose of policy is to provide overall direction. The characteristics of individual policy instruments are influenced by the social and political context.

With the exception of a few countries, the Western Pacific Region has over the past 20 years experienced a very positive development of social and political systems in terms of their impact on health. There has been a continuous and steady improvement in the overall health status of practically all populations. However, there have been differences in health policies pursued by individual countries. The more centrally-controlled the political system, the more the social policies are integrated into economic policies. On the other hand, the more pluralistic and market-oriented the economy, the more the social policies will be independently derived. The important message is that health policies should not be evaluated in isolation. They should be assessed in relation to the overall development process.

In the 1970s, 75% of the countries in the Region were either very recently independent states, centrally-planned states or still colonies of metropolitan powers. Within these countries explicit social policy was typically linked with overall national development to a greater extent than in more pluralistic societies.

Twenty years later the social and political situation is markedly different; even those few states and areas that remain closely linked to a metropolitan power now manage their social policy independently. In general, before 1975, health policy was focused directly on health status; in the mid-1990s the focus is on health processes, which influence the health status. It is expected that by 2020, health policies will also reflect issues that are currently considered external to the normal health sector.

Before the primary health care era (i.e. before the mid-1970s), it was conventional wisdom that the answer to prevailing health problems in developing countries was simply to
Annex 2

deliver the basic health services more effectively. Such services covered areas such as water and sanitation, immunization, maternal and child care, nutrition and essential medical care.

It was at this time that the vision of primary health care and health for all was formulated. In essence, the founders of this movement could see that “more is better” would not be sufficient to achieve and sustain a health-for-all vision. The health-for-all movement offered a completely new and refreshing view of the relationship between people and medical services. While the essential elements of care, such as immunization, nutrition and child care, would remain, they would have to be formulated within the broader social, economic and political contexts.

The health-for-all approach implies significant organizational changes. For example, new organizations will be characterized by partnerships. While these alliances are not unique to health services, they are clearly different organizational forms from those which historically have characterized health services. The new organizations will be characterized by an interactive process in which there is a constant exchange of products, information, money and social symbols. Clearly these are fragile relationships, posing a critical challenge to management in such areas as commitment, control, performance, communication, participation and sustainability.

CHAPTER 3. NEW HORIZONS IN HEALTH

The Western Pacific Region has now developed economically and socially to the point where the basic health infrastructure in most countries is quite comprehensive. When preparing for the future, a key question is how to ensure that health and the environment are in harmony. *New horizons in health* is a vision for exploring the best ways to encourage and enable people to help themselves and to develop lifestyles and environments that support positive health. *New horizons in health* forms Part II of this document.

Even the simplest health actions, such as taking children for immunization, or boiling drinking water, can start from the earliest days of life, and can have a related effect on health protection or healthy lifestyles throughout life. Technologies to prevent or cure most diseases or
disabilities are available. The challenge is to make sure that people are interested in doing something about their health and that they are helped to achieve it. There are hundreds of thousands of insecticide-impregnated mosquito nets in households in many malarious countries of the Western Pacific Region. The nets alone, however, cannot save lives or prevent disease. It is the family members themselves who decide to use them, and who thereby protect their health. People can make a difference to their own health. Whenever there is a choice, people should be helped to make decisions that will help them to lead longer and healthier lives. This requires, at country level, sound public policies that support these aims. It requires multisectoral and multidisciplinary approaches that mobilize the many different segments of society in coordinated ways. These are some of the health and human development aspirations that underlie New horizons in health.

New horizons in health is organized around three themes based on different stages of life: preparation for life; protection of life; and quality of life in later years.

Preparation for life. The aim of this theme is to ensure that infants and young children not only survive the first years of life, but are suitably prepared to enable them to realize their health potential throughout their lives.

Protection of life. Having progressed through childhood and adolescence, individuals must then be supported in fully developing and maintaining healthy lifestyles, and be protected from illnesses caused by a potentially hazardous and degraded environment. The overall aim of this theme is to prolong productive, healthy and disability-free lives in the most cost-effective and equitable ways possible.

Quality of life in later years. The aim of this theme is to enable all individuals to acquire and maintain the physical, social and mental capabilities required to lead fully creative, productive and meaningful lives.

The next few chapters outline in some detail the specific issues of New horizons in health which are most relevant for 21st century health solutions. The contents of these issues will then need to be further refined in each country.
CHAPTER 4. EMERGING ISSUES

One of the major lessons from the recent past is that there is a strong relationship between people and their health services. However, a simple supply and demand strategy is no longer an option as a health development approach, because it is now recognized that demand for health services is nearly infinite. Not even the richest of nations could afford the cost of a limitless health service. Indeed, it could be argued that excessive expenditure on health services may even reduce the health status of the population, because money spent on health services would not be available for education, housing, or social security. Therefore, the purpose of this section is to describe the most significant issues which currently have an impact on health and to project to 2020 how these issues may be addressed in the evolution of health policy for the 21st century.

4.1 Demography

In terms of overall population growth there are some remarkable changes taking place (see Figure 1). It should be remembered that China alone makes up 76% of the total population in the Region. The most significant feature of the demographic picture is the projected fall in the rate of population increase, although the total population will continue to rise. Between 1975 and 1995, the Region's population grew by 32.1% or 1.6% per year. It is projected that by 2020 the population of the Region will have grown by over 24% or by 1% per year. This projection is based on an assumption of continued positive gains in population management, remembering that the regional picture is heavily influenced by China.

This is the picture of the Region as a whole. But significant population increases are possible in some countries unless sound population policies are implemented.
The second significant demographic feature of the Region is the age distribution. The often cited issue of “ageing” in the Region can be illustrated by Table 1, which shows that between 1975 and 1995 the age distribution did not change significantly. However, progress in reducing infant mortality and gains in population management mean that significant differences in the demographic picture will emerge by 2020 for the Region as a whole. Table 1 shows, for example, a most dramatic reduction in the under-15 year age group and a rise in the over-65 age group.

Table 1. Age distribution (percentage) of population in the Western Pacific Region (1975-2020)

<table>
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<th>Age group</th>
<th>1975</th>
<th>1995</th>
<th>2020</th>
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<tbody>
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</tr>
<tr>
<td></td>
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<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Annex 2

Despite substantial successes in population management in most countries of the Region, the Region's population will increase by approximately 400 million people by 2020. Although improvements in technology and liberalization of trade will probably ensure sufficient funds to support such populations, there are doubts that current quality of life standards can be sustained. Because land and other resources especially food are finite, ultimately excessive population numbers will become a major threat to public health. Health sectors will need to devote considerable resources, management skills and research to population management for many years to come.

4.2 Epidemiology

Most countries of the Region have experienced, to a greater or lesser extent, the "health transition"; a change in the disease profile from communicable diseases, such as diarrhoeal disease, poliomyelitis, and respiratory infections, to chronic disabling conditions often associated with excess nutrition, sedentary life styles and increased consumption of tobacco, alcohol and drugs. These conditions include atheromatous cardiovascular diseases (mainly ischaemic heart disease and stroke), chronic respiratory diseases, diabetes and increases in bowel, breast and prostate cancers. The two countries in the Region with predominantly European traditions - Australia and New Zealand - experienced the earliest transition in this direction. However, many other countries and areas in the Region - including Hong Kong, Japan, Malaysia, the Republic of Korea, Singapore, and urban areas of China and Viet Nam - have experienced a dramatic transition during the past 50 years, from high to low burdens of infectious diseases. While there has been an increase in chronic lifestyle-related conditions, such as ischaemic heart disease, the mortality and morbidity associated with these conditions has remained low in these countries. However (with the possible exceptions of Japan and the Republic of Korea) this is likely to change for the worse: For example, current per capita consumption of fats in Hong Kong has reached similar levels to that in Australia, the United States of America and European countries. This will lead inevitably to increased ischaemic heart disease and diabetes.

A continued quantitative measurement of the disease impact of the disease profile is an important part of the New horizons in health life cycle approach. If such a measurement tool was integrated into health strategies, the Western Pacific Region would become a global leader
in monitoring health outcomes. Disease impact is measured in years of life lost. It is the sum of
years lost due to mortality plus years lost due to morbidity. Mortality years lost is the difference
between year of actual death and expected time of death. Morbidity years lost is measured by
disability due to disease or injury.

The epidemiological transition in the Western Pacific Region has been evolving for
many years. As Figure 2 shows, as long ago as 1975, the disease profile transition was already
well advanced. By the late 1980s, the profile was dominated by noncommunicable diseases.

**Figure 2. Disease profile in the Western Pacific Region (1975-2020)**

![Disease Profile Chart]

This figure illustrates the major changes have already occurred between 1975 and 1995. The rates of change projected for the next 25 years from 1995 to 2020 are less dramatic than those experienced during the previous two decades. The next significant milestone will occur early in the next century when accidents and injuries are expected to place a greater burden on health services than the traditional concerns of communicable diseases, nutrition, perinatal and maternal conditions (Figure 3).

As Figure 2 shows, the total impact of disease (years lost) dropped by about 50% between 1975 and 1995. Figures 4, 5 and 6 show the distribution of the disease profile for 1975.
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1995 and 2020 by condition and age. As noted, most of the disease conditions in 1975 were in the under-five age group and were mostly mortality. By 1995, the disease profile had shifted and was now more evenly distributed throughout the age groups with a significant increase in conditions affecting the over 25 age group. It is in the 25-65 age group where the disease profile consists mostly of morbidity and is manifested in a high demand for health services.

Figure 3. Changing profile of disease (1975-2020)

![Graph showing disease conditions as percentage of total disease from 1975 to 2020.]

Figure 4. Disease profile in the Western Pacific Region (1975)

![Bar chart showing disease impact (years lost) by age group in 1975.]

CNPM - Communicable diseases, nutrition, perinatal and maternal conditions

Figure 4. Disease profile in the Western Pacific Region (1975)
Figure 5. Disease profile in the Western Pacific Region (1995)

Figure 6. Projected disease profile (2020)

Figure 2 contains a projection that the amount of disease for 2020 compared with 1995 will drop by another 23%, based on current technology and health system effectiveness. By
2020, the 45-65 age group will be most affected by disease (see Figure 6). So, even though the absolute burden of disease will continue to drop significantly, as most of the drop is due to lessening mortality, especially in the under-five age group, there will continue to be an increased burden on the health system unless something is done to prevent the diseases that will occur.

The disease profiles of individual countries and areas very clearly illustrate the transition. In Figure 7, the ‘Asia I’ countries and areas are Brunei, Hong Kong, Macao, Malaysia, Singapore and Republic of Korea; ‘Asia II’ countries include Mongolia, the Philippines and Viet Nam; ‘Pacific islands I’ are American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Northern Mariana Islands, Nauru, New Caledonia, Niue, Palau, Samoa, Tokelau, Tonga, Tuvalu and Wallis and Futuna; ‘Pacific islands II’ countries include Kiribati, Marshall Islands, the Federated States of Micronesia, Papua New Guinea, Solomon Islands and Vanuatu. ‘Cam/Lao’ is a small group containing only Cambodia and the Lao People’s Democratic Republic.

Figure 7. Disease profile by country grouping

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1 The grouping of countries used for this report is based, first, on geography and population size; second, on health criteria, including health information (e.g. infant mortality rate and life expectancy) and disease profile.
There are two groups at the early stage of the transition: Cam/Lao and Pacific II countries. For these countries, 50%-60% of total disease conditions affect the under-five age group. Mortality in this group is nearly 90%. The main diseases affecting this group are communicable diseases, nutrition, perinatal and maternal conditions.

The next stage of the transition is illustrated by the Asia II and Pacific I countries. China is epidemiologically very close to this group, but shows signs that it is moving to the middle stage of the transition. Fewer than 20% of disease conditions in China now fall into the category of communicable diseases, nutrition, perinatal and maternal conditions. The features of this stage are that the proportion of the total disease profile has dropped significantly to 30% in the under-five age group, and that mortality in this age group has dropped to 70%. In this group of countries, the emergence of noncommunicable diseases can be observed, particularly in the 35-44 age group. Within this age group, around 70% of the burden is now due to morbidity.

The middle stage of the transition is very clearly illustrated by the countries of Asia I. In these countries 20% of the total disease profile is in the 35-44 age group and 75% of the conditions affecting this age group are noncommunicable diseases. However, there is also a very rapid increase in the burden caused by injuries (mostly in males) in this age group. In the 35-44 age group, morbidity accounts for 75% of the total burden of disease and is leading to an increased demand for expensive health technology.

The late stage of the transition is illustrated by Australia, New Zealand and Japan. Just as the first phase of the transition is characterized by infant deaths, this phase is partially explained by deaths in later years. However, the most distinctive feature of this phase is the prevalence of noncommunicable diseases in middle age in the 35-44 age group, for example. While mortality accounts for 70% of the burden in the over-75 age group, it is 30% in males and 20% in females in the 35-44 age group. The high level of morbidity in middle age places a major burden on the health system. There is a relatively high rate of injuries in Australia and New Zealand in the 15-35 age group, mostly affecting males. This is a striking difference between these two countries and Japan, which has a much lower rate of injuries.

It is important to remember that this discussion is based on aggregate analysis for a country as a whole. An epidemiological analysis must also include detailed data and
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descriptions of population groups which have particular problems. Therefore, some countries may have populations in three or four phases of the transition.

4.3 Environment

There have been warnings for many years that an unhealthy population and a damaged environment hinder progress towards development goals. It has become apparent that growth in the Region is already being constrained by water and energy shortages which affect agriculture and industry. An inability to cope with mountains of domestic and industrial waste is also a significant problem.

Understanding the links between health and many other areas will enable health professionals to become more involved and influential in developing and implementing action programmes. In most countries, water authorities will monitor water quality, environment department specialists will monitor air quality, and so on. An important task for health authorities will be to link environmental indicators with health status and to collaborate closely with the other agencies. To keep decision-makers and the public informed of health trends, continual epidemiological surveillance and monitoring of environment-related diseases must be carried out. Health agencies need to collaborate with all other agencies to prepare an overall environmental health policy incorporating such areas as housing, environment, water resources, agriculture, industry, transportation, schools, etc.

Efficient environmental health programmes depend on convenient access to information about a large variety of hazards, ranging from biological hazards in food and water to chemical hazards such as those posed by pesticides. The health sector needs to undertake educational and awareness raising programmes targeted at government authorities and workers, nongovernmental organizations, community groups, schools and private sector organizations.

4.4 Health economics and financing

As a result of the fiscal problems facing transition economies, social sectors must seek new sources of funding, and improve the efficiency and quality of the services they provide. Attempts to increase cost recovery, encourage private sector participation, and promote health insurance are being experimented with in almost all countries. These efforts should continue.
At the same time, the allocation of resources must change because in most transition economies too large a share of budgetary resources is allocated to advanced service levels, such as hospitals, rather than to basic services such as primary health care or health worker education.

With regard to health insurance, several countries in the Region have started to implement health insurance or repayment schemes. One of the main features is that the cash income position of an insured person no longer needs to be an obstacle to access health services. It is important that health insurance schemes that are in their early stage, bear in mind that their final purpose is improvement of health of all the population. The situation of the marginalized groups has therefore been especially addressed.

Spending more on health, however, does not necessarily equate to better health or increases in longevity. There are two main reasons for this. First, government spending may not be allocated to areas where it can produce the most benefits in particular - preventive and promotive areas. Second, in more developed countries, a large percentage of health funding goes to the elderly in their last few years of life. Typically, the bulk of expenditure is for expensive tertiary-level hospital care. This care is often unlikely to have much of an impact on healthy longevity. In the recent past, these issues have mainly affected developed countries in the Region, but they will become matters of concern for all countries and areas in the next century.

The majority of countries in the Region have been able to maintain a reasonable balance between revenue available to the health sector and expanding needs. This has been possible because of the Region’s economic growth. However, two factors may change over the next two decades. First, overall economic growth in the Region may not be as robust as it has been over the past two decades. For the newly emerging market economies like Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam, above average growth will still be possible for some more time. However, for the remaining countries, more moderate growth patterns seem likely to prevail.

The second factor that will affect the cost of health services is the epidemiological transition. The past two decades have seen lower mortality rates, which significantly reduce the overall burden of disease on a country. However, health and lifestyle changes will now have an
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impact on the health system, leading to a significant increase in demand for services, particularly in the 45-64 age group.

Therefore, the health sector will be facing two major challenges: first, how to reorientate the health system, so that resources are targeted to preventive care and, second, how to ensure that high-quality but cost-effective care will be going to the expanding 45-64 age group.

Economic growth and epidemiological changes will have a direct influence on both the funds available to and the needs of health systems. In addition, there are political and social changes that will have a significant impact on the financing of health services. Political factors include trends in privatization and decentralization. These developments have the potential to ease the transition in financing, if they are planned and managed effectively. Privatization, for example, offers the potential to keep the cost of care down through competition, although this process must target the appropriate needs and ensure that equity is maintained. Decentralization also has the potential to facilitate system efficiencies by targeting local needs and maintaining equity.

Social changes can have both negative and positive influences. There is a trend throughout the Region towards a more highly educated population. In the past, more education led to an increase in people demanding more expensive health care. This trend must be reversed. Education programmes must transmit the message that highly sophisticated technology is effective only in very particular situations. Furthermore, it is really only individual preventive measures leading to lifestyle changes which will enable current resources to cover the needs of everyone. For example, there have been many attempts to implement user charges as a means of limiting use of health services. This has been shown to be only a short-term measure, which does nothing to address the issue of promotive care and is questionable from the point of view of equity.

The increased involvement of individuals and communities has the potential not only to provide a mechanism to increase the effectiveness of resource allocations, but also to increase the overall knowledge of the public on both short- and long-term health issues.
Various options of financing health care, such as the introduction of compulsory or voluntary health insurance systems, contracting health services, introducing user fees, etc., need to be carefully analysed and discussed. While discussing the health financing options and strategies, the diversity and uniqueness of Member States in the Region should be stressed. This simply implies that what is an effective strategy in one country or area may not be appropriate or feasible in another. The importance of policy research and analysis should be highlighted. Its aim should not be to just identify what works but rather to understand the conditions and issues that make a policy effective in some countries but not in others.

4.5 Culture

Culture is generally thought of as a shared collection of concepts, rules and meanings. Culture is expressed in society as a whole or in subgroups of the society, such as professions, religions and various organizations. Each organization has its own culture that drives planning methods, communications and values for rewards and incentives. When these values are not clear there can be confusion, conflict and less effective performance. This has profound implications for the delivery and organization of health care services.

The skills necessary for cross-cultural understanding are communicating an appreciation of other people's perspectives: confronting, testing, and giving feedback; and identifying actions and appropriate management support.

4.6 Gender

Gender roles are the socially specified roles that are accorded to men and women irrespective of their skills and capabilities.

The actions of men and women have different impacts on the health of others. For example, women's health often has intergenerational effects. It is generally the case that women make decisions on health behaviour and seek health services for the family. Women are increasingly subject to the health risks inherent in the new environment of sedentary occupations, excessive consumption and stressful lifestyles. In both developed and developing nations their new status means that they often adopt similar lifestyles to those of their male
counterparts, and they are increasingly suffering from the same illnesses. Their growing economic power and independence has made women the targets of advertising, often of unhealthy products, in the new market economies.

Gender is an issue that is bounded by both social and health factors. Disease profile data seem to indicate that the health of women has and should continue to improve. However, there is concern that information on women's health is not reliable because of underlying gender bias. Reproductive health issues are still a serious concern in a number of countries. In Cambodia, rural China, the Lao People's Democratic Republic and Papua New Guinea, maternal mortality is still high. In such situations, there is bound to be very high morbidity.

It has been well documented that there is a strong positive correlation between female literacy and the health of the family. Therefore, policy measures must continue to support female literacy.

A gender-sensitive approach to health policy development considers the roles of both men and women in the development of policy and its implementation. It also considers their respective roles in health service delivery, the organizational structures for health management and delivery and the differential impact which health policies may have on men and women. It looks at the needs of both men and women and reviews approaches when it appears that one gender is not receiving appropriate levels of care. This strategy relies on women at a number of critical points, so the empowerment of women becomes an essential component of the health strategy.

There is evidence that generally men and women have different management styles. There are roles and places for each of these styles in a health system.

It is important that men and women have equal access to the delivery system. This applies also to the delivery of care.

4.7 Technology

Technology development in prevention, early detection and treatment activities will continue to have a major impact on health services in the future. Such developments will raise questions about who will have access to new technological developments; to what degree the
decision to use new technology will be decentralized; what effect new technology will have on provider-patient relationships; and what new ethical considerations must be considered.

New developments will change the concept of disease. Diagnosis and treatment will be partially replaced by prediction and early stage management of illness. Geneticists hope to be able to predict disease risk based on our genetic inheritance and to manage that risk before symptoms emerge.

Although not as dramatic as developments in genetics, significant technological progress is also occurring in the control of hypertension, coronary disease, cancer, and certain disabling forms of mental illness. New screening technologies are enabling earlier detection of some cancers.

Developments of basic health protection and promotion technologies will be accompanied by greater concern for cost and efficacy. Increasingly, attention will be given to outcomes assessment and outcomes management. Outcomes assessment focuses on the relative effectiveness of different interventions. Outcomes management is concerned with how this information is used within an operational setting to eliminate unnecessary procedures and to improve quality of care.

For managed individual care to be successful:
- the general population should have access to regular technology information;
- monitoring systems should focus on the cost and contribution of the technology component of care; and
- quality of care programmes should be a priority management function.

These specific health system responses for managing technology will be guided by the related principles of evidence-based decision making for health policy development.

Some countries in the Region are already striving to improve the evidence base for their decision-making. For example, best practice models for health services that are based on a review of scientific evidence are being developed. Some of these activities have included approaches for HIV/AIDS prevention or mammographic screening, cervical smear, etc.
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4.8 Globalization

Globalization refers to ideas, processes or products. Examples of global products and ideas include the rapid increase in information technology and marketing of pharmaceuticals and foods that are applied or used around the world and which appear to have universal values associated with them.

International competitiveness is now generally seen as the key to economic growth. International competitiveness implies trade. Trade is thus essential to economic growth. Economic growth will be achieved by decentralization, privatization, corporatization, strengthened financial and monetary regulations, reduced government spending, improved government transparency and improved economic indicators linked to further policy development.

Yet globalization has a cost in health terms. Nowhere is this seen more clearly than in the spread of emerging and re-emerging communicable diseases. International migration, tourism and business travel all facilitate the transmission of pathogens across international borders.

While trade and greater national wealth do not necessarily lead to improvements in equity, national competitiveness is a precursor to breaking the cycle of poverty. The uneven distribution of wealth within countries fuels poverty and social discontent. Poverty results in consumption at subsistence levels. This perpetuates a cycle of low income, low savings and low investment. With no investment there is no development and no trade. Individual poverty is a key determinant of health and well-being, with nutrition, self-esteem and communicable diseases being key issues. Globalization holds out the promise of increasing income in the aggregate; however, it may create additional poverty if the gaps between the rich and the poor are widened.

Evidence is emerging that high inequality within a country reduces its growth prospects. That is, growth is slower in countries where there is unequal wealth distribution. Therefore poverty reduction makes sound economic sense as well as being an important way of improving health status.
4.9 Reform process

The Western Pacific Region has developed economically and socially to a point where the basic health infrastructure and educational levels are now more or less in place. This now allows for an approach that emphasizes individual responsibility in the context of supportive environments. A more people-centred health-promoting approach is evolving from the former disease-centred approach. This new approach includes a commitment to equity, intergenerational sustainability and gender sensitivity. There are, therefore, a number of areas where reforms are needed.

First, it is clear that, while the provision of health services is of critical importance to the achievement of health outcomes, it is not the only factor. For example, the conditions under which people live and travel and work have a great impact on their health.

The first item on the reform agenda is, therefore, widening the consciousness of other arms of government about health matters in relation to:

- the physical environment (e.g. water supply and sanitation); and
- the social environment (e.g. the Healthy Cities approach, health consequences of the increasing spread of urban areas, the adequacy of public transport and the conditions under which people work).

The second area for reform is the question of centralization and decentralization. Traditionally, government policy and health regulations have tended to be centralized, while the actual provision of health services has been relatively decentralized. There is widespread recognition of the need to decentralize responsibility for health services, so that planning is more closely linked to provision and outcomes. However, staff in regional centres have been accustomed to running services rather than planning for outcomes, so there is a particular need for new management skills and/or a reallocation of management capacity from the centre.

In this process of organizational and geographical decentralization, questions of finance and responsibility become increasingly important. Central governments find it easier to devolve responsibility than to give up financial control. A critical reform in making decentralization work, therefore, will be to devise a financial link between resources and responsibilities, while the central government retains accountability.
New organizational and partnership arrangements mean that the location of power becomes more diffuse and there is a commensurate loss in unified management and control of events. It is anticipated that this loss of control will need to be rectified through legislation. This can be achieved at the macro and at the micro level. It can take the form of legislation or of authority given to peripheral levels to give orders and make regulations. The most critical will be legislation that defines guidelines for the process functions of policy formulation, planning, implementing, monitoring and evaluation.

Human resource development is one area that is yet to be clearly defined in a market-oriented, decentralized social system. Human resource development need not necessarily be a more complex issue than financing; however, it does have unique features that make sustainable solutions quite difficult. The trends governing human resources in health sector development are reasonably clear. First, the dramatic epidemiological transition is well advanced in most countries, consequently at least the broad areas of health needs are known. Therefore, basic educational and training needs are also emerging. However, two areas continue to experience rapid change: the evolving types of care and the technology supporting this care. Consequently, in terms of educating a work force, it is clear that all workers need a solid grounding in scientific and technological fundamentals, but that early in the educational process continuous learning behaviour must be acquired.

The second significant influence on human resource development is the institutional aspect. The complex organizational arrangements which will follow the decentralization of responsibilities within a competitive environment with cost constraints will have multiple implications for the use of human resources. The skills required of workers may change significantly throughout their careers. Workers must be able to perform effectively under various institutional arrangements. Health staff may need to carry out many functions in addition to their traditional technical role. These functions may include supervising volunteers, facilitating teams of care, negotiating contracts and simply being a part of many loosely aligned partners.

These trends have a major influence on human resource plans. Health staff will need to see their basic technical training in a broader perspective than in the past and will require basic education in fields such as economics and business. Continuous learning opportunities must be made available to health staff.
A critical question in the renewal of the health-for-all policy is to ensure that marketization of health care services does not restrict access to good health care or negatively affect health status. The strategy urges the merits of a holistic approach to health questions. Health authorities will need to find ways of developing a shared health consciousness across organizational boundaries.

Multisectoral and multidisciplinary actions and strengthening partnerships for health are fundamental for moving from policy to action. These directions are essential in the future action, as is well highlighted in the *New horizons in health* approaches.

**CHAPTER 5. THE FUTURE**

*New horizons in health* foreshadows a new orientation to addressing current and anticipated health issues. To arrive at new ways of providing health services requires new thinking and new ways of putting that thinking into practice, as new connections are made between areas which were previously seen as unconnected. The health sector's general conservatism and resistance to systemic change means that specific organizational and cultural strategies will be needed to start the change process. The move from a series of individual health care providers to a large, complex part of a country's economy will be profound.

### 5.1 Health policy

Any new health policy must be precisely focused on a health condition or the profile of disease. This would seem to be obvious, but, as this document has shown, the reality has been that in the past specific policies have not had as much influence on implementation as had been expected. Much more is now known about the process of implementation. This is not to suggest that health service organizations and human resources are not important, but to argue that more emphasis should be placed on the details of health conditions.
5.1.1 Demography

There are two major issues resulting from current demographic trends in the Region: the rate of population growth and the increasing number of people in the over-65 age group. Most countries and areas are satisfied with their population planning. However, although rates of increase will slow, the Region's population will continue to rise and this, combined with rapid economic growth, will place significant pressure on natural resources. In some countries, rural-to-urban migration remains a concern. Therefore policy decisions must continue to weigh the implications of demographic influences, particularly those related to issues of equity in terms of access to health care.

An additional issue of concern for most countries is the number of people in the over-65 age group. It seems certain that information on the number and details of particular age groups will play an increasing role in situational analysis.

5.1.2 Epidemiology

Issues of epidemiology, environment and demography have the most direct influence on disease conditions. One of the most important themes of this document is the observation that the epidemiological transition is probably moving faster than most policy-makers anticipated and that health services are not responding sufficiently quickly.

It may be useful to recall the traditional approaches to fighting disease. In the 1950s, the emphasis was on applying the best technology to a specific disease, such as malaria or smallpox. It was assumed that the right technology would give a total cure and would require limited involvement on the part of the individual. In the primary health care era of the 1970s the approach was to view the individual as a whole and to emphasize his or her participation and involvement in the care process. It had been realized that technology alone was not sufficient without the full participation of the patient. The current renewal of the health-for-all concept places emphasis on the stages of life approach to care. The vision is for people to be able to reach a high quality of life throughout their lives including improving the quality of life in later years. Furthermore, technological solutions are becoming very expensive. Therefore, emphasis must be placed on preventing diseases, or at least diagnosing them at an early stage of development.
Countries are in different phases of the transition and therefore have different priorities. However, in all cases it is important that countries in one phase should learn as much as possible from other countries which have passed through this phase in order to enhance their transition to the next phase.

5.1.3 Environment

In the New horizons in health approach to health strategy formulation, the issue of the environment has an expanded role. Traditionally, the priority environmental concerns with a direct impact on health were water and sanitation. While both have improved dramatically for the vast majority of people in the Region, water and sanitation continue to be important where poverty is prevalent. Urban industrial growth, particularly in relation to water and foodborne diseases, is particularly significant for the most disadvantaged in society.

Familiarity with the issues linking health, environment and sustainable development will enable health professionals to implement health programmes more effectively. Health agencies need to collaborate with all other agencies whose activities have an impact on environmental health. This will assist in the development of intersectoral policies.

Environmental issues in the context of New horizons in health are associated with settings. What in the past were considered aspects of pollution and environmental hazards are now looked at as issues constraining a positive environmental setting, such as a school, or factory.

New horizons in health adopts an integrated approach to the environment. The Healthy Cities and Healthy Islands approaches are good examples of this.

5.1.4 Health economics and financing

The economic issue will, by definition, have an enormous impact on future health care, from the individual level to national planning. When an individual does not have enough money to pay for care, the impact could be quite immediate. On the other hand, an allocation of money to promote healthy lifestyles could take many years before it has an impact on the health system. Therefore, there are many challenges ahead for the mobilization and utilization of financial
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resources. Not only are there changing needs owing to the epidemiological transition, but social and political developments have an impact on financial allocations.

5.1.5 Culture

Culture influences health on several levels. First, culture may determine the attitudes and responses of individuals, families and communities to specific types of therapy and to the organization of health services. The example of child-birth practices is often cited. However, culture also plays an important role in the way patients and practitioners behave towards each other.

Similarly, within health organizations, culture plays a significant role in defining appropriate and effective methods for managing communications and information among health workers.

Culture also plays a role in how organizations are structured and in how planning, managing and supervision are carried out.

5.1.6 Gender

Gender has at least three levels of impact on the disease profile. The most direct is within the context of reproductive health. Reproductive health remains a concern in the developing countries of the Region. Only in more developed countries is reproductive health not a major health issue, although attention still needs to be given to the area.

Gender will play a significant role in many health strategies based on New horizons in health because of the stages of life approach. It is well documented that women play a highly significant role as the intergenerational link in the family. Consequently, for health messages to have a positive impact they will have to be managed predominantly by women.

The third aspect of gender in health-for-all renewal is the role of women as decision-makers in development. More positive outcomes can be achieved through a gender balance in decision-making process. This issue will need to be integrated into all health-for-all renewal strategies.
5.1.7 Technology

One of the principles of the primary health care approach was the issue of appropriate technology. The belief was that, in addition to cost benefits, such technology could be sustained under various cultural or social conditions. Although this issue is still very much on the agenda of health policy-makers, new issues related to technology have also arisen.

The most significant of these is the relationship between people and technology. Primary health care policy towards technology was often phrased in such a way that providing the most appropriate technology became an objective in itself. Today policy towards technology emphasizes its availability and accessibility to those in need and stresses that it must be a rational choice on the part of the public. Thus, by far the most significant and sustainable achievements in the selection and use of appropriate technology have been achieved by educating individuals and communities.

This applies to most aspects of health technology, from vitamin supplements to brain scans. Technology concerns are most acute for the over-65 age group. Some estimates in developed countries suggest that 50% of technology expenditures are for this target group. A strong case could be made that these resources would have greater effects if they were applied to the other age groups.

As in most aspects of efficiency achievements, improved management and targeted application hold the potential for greatest gains. Undoubtedly, a major goal must be to reduce the morbidity burden of the 45-65 age group by applying diagnostic or predictive technology in the 20-44 age group.

Even greater gains are achievable with the application of additional technology to disease prevention. However, this will be effective only in combination with significant behavioural changes on the part of the public.

5.1.8 Globalization

There are many aspects to globalization. For the purpose of this document, only trade and travel have been selected to illustrate how health system policy development and implementation are influenced by globalization.
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As the currency of global power, trade influences all aspects of life. It drives economic growth, particularly for such countries and areas as Hong Kong, Japan and Singapore. It has a direct impact on health, particularly with regard to both personal and organizational consumption.

Travel also has an influence on health, both as a social process and more directly as a medium for transmitting disease. This is particularly important for the programmes on emerging and re-emerging communicable diseases. The globalization process is creating a more fertile environment for the transmission of new pathogens, although, in most cases, the technology to reduce the potential impact is known if not fully developed. To counter these trends, managerial efficiency needs to be improved, especially with regard to global surveillance activities.

Increased attention and resources devoted to sharing and participating in international information and technical exchanges are not confined to concerns related to emerging diseases. All aspects of globalization need to be addressed in a much more active way. Technical exchanges should become as significant a learning medium as medical journals are today.

5.1.9 Reform process

The reform process should reflect the values of society as a whole. One of the most significant features of effective reform is the emphasis given to clarity of roles and accountability. This is expressed, for example, by the desire to define separately the functions of political policy-making and administrative implementation. This is probably one of the most significant initiatives in public administration to be addressed in some time.

For the health system, there are a number of new structures and procedures to be considered. For example, the executive policy unit is becoming an institutionalized entity, rather than simply a task to be performed by a senior member of staff or committee in addition to other primary duties. Such developments are regular features of leaner public service organizations, which focus on the role of providing a vision, coordination, monitoring and facilitating the development of implementation processes and institutions.

Staffing will be significantly influenced by the forces responsible for reform. A number of countries and areas in the Region that are addressing public service reform have already
evolved more effective human resource strategies, namely Australia, Hong Kong, Malaysia, New Zealand and Singapore. Emphasis on seniority and employment security is being replaced by increased attention to competence and results. These values not only require attitudinal changes on the part of staff (such as an acceptance of mobility and life-long learning), they also mean that institutions must improve the clarity of job expectations, performance review mechanisms and learning opportunities.

5.2 New horizons in health: Actions for the future

*New horizons in health*, which forms Part II of this document, has two essential features: the importance of the stages of life approach and a focus on settings.

The stages of life approach incorporates the concept that prevention must be an aspect for all health strategies. However, the significance of *New horizons in health* is the awareness that age is more than just a definition of a special target group, rather it defines a boundary that has unique social and cultural features. It is the recognition of these social and cultural features and their impact on etiological processes of disease that makes the *New horizons in health* approach meaningful.

The focus on settings (e.g. Healthy Cities) is also more than a definition of a critical environment for the growth of selected diseases. The concept of a setting is used as a managerial tool to provide boundaries for resource allocation according to the purpose of the location. Hence, *New horizons in health* focuses on, among others, the workplace, the school and the city. The school contains children who can learn new things; the factory contains workers who may become injured; and a city has many needs for a healthier environment. However, the concept of a setting need not be confined to these obvious examples. It is just as likely that an association of retired public workers could become a setting. The criterion is that for a particular health need, attention is given to mobilizing available resources to a specific place or group.

This document outlines the elements of a vision statement that not only sets specific goals, but also provides a value system for health systems. In policy formulation, there are two essential aspects. The first will be a much greater emphasis on evidence-based decisions. The second is that the boundary of health concerns will be expanded to include a wider spectrum of
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issues. The following section provides a list of health strategies that can be initiated today. These all have sound evidence-based experiences to support them. However, their most significant aspect is the potential they offer for learning. It is imperative that the health sector significantly improves its ability to adapt and respond to change.

5.2.1 Developing health promotion and prevention capacities and strategies

Each country needs a central health promotion organization, which has the capacity to organize social marketing campaigns and to interest and influence other governmental and nongovernmental organizations about health-related issues. Such a health promotion organization should also have a research and development capacity. In addition, there should be professional health promotion staff at the district health service level.

Health promotion is best developed on a stages of life basis. It is known that people are receptive to particular health-related activities at specific stages of their lives. For example, during pregnancy, most prospective mothers are anxious to adopt healthy practices such as stopping tobacco smoking and alcohol drinking so as not to harm their unborn infant. Mothers are also particularly anxious to accept and practise advice concerning the health of their children, e.g. with regard to immunization and healthy nutrition. At around the age of 35 many adults consciously realize they are not immortal and can therefore be successfully encouraged to adopt healthy lifestyles (the same person at the age 20 was not nearly as interested in such issues). Examples of such lifestyle changes include adopting healthy diets, participating in exercise, stopping smoking and reducing alcohol consumption. Many impending retirees are extremely anxious about early death and are very susceptible to health interventions such as breast cancer screening, blood pressure measurement and, generally, advice on adopting healthy lifestyles.

5.2.2 Creating a health services research capacity

Raw data has little meaning unless it is analysed and developed into information which can be used as the basis for future planning. This requires a health services research capacity. There are sound arguments for developing such a capacity, either within health departments or as an independent organization. In-house research capacity has the advantage to governments of being able to provide information upon request.
5.2.3 The provision and organization of health services

As chronic diseases become the dominant priority, health services need to be reorganized so that patients may be cared for over prolonged periods in a range of settings and facilities. For example, the need to provide and organize health services capable of providing emergency care to a child with diarrhoeal diseases has substantially diminished. This is in marked contrast to the complexity of organizing care on behalf of a chronically ill elderly patient, or a person with schizophrenia. Such care commonly involves medical and nursing services in domestic settings, rehabilitative services, hospital inpatient services and specialized hostel and nursing home services and community-based care.

There are a number of soundly based strategies for the organization of health services to meet the needs of emerging populations. For example, health services should be organized into networks based on district populations; medical services should be developed into balanced two-level systems (one level should be general medical practitioners, the second level should be a range of specialists); and there should be a balance between private and public provision of health services. There is also a strong case for continued strong support for public provision by government agencies.

5.2.4 Quality of hospital and health service provision

As populations in the Region experience the health transition, expectations for an ever-increasing quality of care will rise. Better-educated populations will question, expect and demand high-quality health care. For example, there is evidence that, in some populations of the Region, existing maternal health services are incapable of preventing considerable maternal mortality and morbidity. Experience suggests that a substantial commitment to the education of health professionals in this area will be required.

As the health transition progresses, there will be benefits for communities in having a high-quality general medical practitioner (GP) service. There are several reasons for this. Aged persons develop multiple disabilities which are best treated by a general practitioner rather than by a fragmented array of expensive specialists. GPs can readily offer preventive services relevant to diseases typical of the late stage of the health transition: e.g. detection and early treatment of hypertension, diabetes, breast and prostate cancer, and melanoma.
Reforms to the provision of hospital services can achieve much higher-quality service at a lower cost. For example, hospitals should be organized and managed within networks of other hospitals and linked to community-based services. Efforts should be made to ensure hospitals are the optimum size. Specialist hospitals should be developed. With regard to outpatients, completely different alternatives to hospital outpatient departments should be sought and hospitals without beds should be created for the specific purpose of caring for ambulatory patients. This concept includes facilities for day-surgery and other procedures.

5.2.5 Population management

Continued population growth is a direct threat to the quality of life of whole communities. In some nations and communities, overpopulation is the leading public health issue.

Education of women plus the availability of affordable and effective contraception are the most influential factors on fertility. However, the culture of a particular community and the attitude of governments to population management are also highly influential.

5.2.6 Chronic degenerative conditions associated with ageing

The morbidity and consequent dependency of extremely elderly people is largely due to: (1) cerebrovascular disease and hypertension leading to stroke; (2) chronic bronchitis and emphysema; (3) Alzheimer's disease and atherosclerotic arterial disease leading to senility; (4) osteoporosis leading to fractures; (5) arthritis; (6) loss of visual and hearing acuity; and (7) dental problems.

With the exception of Alzheimer's disease and loss of visual and hearing acuity, these conditions can be wholly or partially prevented. Hence, there is a need for a range of appropriate health promotion strategies before people become elderly. Care of the aged has become such an important issue that some countries have established ministerial committees to develop and implement aged care policies. Health promotion activities aimed at all age groups are the main strategy for a successful, high-quality life in later years.
5.2.7 Specific health problems

Traffic accidents and industrial injuries

The incidence of death and injury associated with traffic accidents can be significantly reduced by: (1) the separation of vehicular from bicycle and pedestrian traffic; (2) speed restrictions, combined with effective monitoring and policing; (3) prohibitions on driving vehicles or riding bicycles while under the influence of alcohol; (4) construction of one-directional roads so as to avoid head-on collisions; (5) compulsory wearing of safety helmets by bicycle and motorcycle riders and compulsory use of seat belts for car drivers and passengers; (6) safety requirements for vehicles; and (7) minor modifications of road “black spots” where accidents occur frequently.

Industrial injuries may be less frequent than road accidents but they are an important health issue. The following measures are recommended: detailed monitoring of the incidence and nature of industrial accidents, followed by restructuring of industrial processes in order to reduce hazards; education of managers and workers on industrial safety; and the introduction of legal requirements for safe work practices, which incorporate a system of incentives for safety and penalties for failure to meet standards.

Regional objective: Progressively reduce the rate of increase of traffic and industrial accidents. By 2020, show a decline of 1%-2% per year.

Maternal and infant mortality

While the absolute numbers of mothers in the Region who die due to conditions associated with pregnancy and child birth are at historically low levels, levels of maternal mortality in Cambodia, rural China, the Lao People’s Democratic Republic, Papua New Guinea and the rural Philippines are of continuing concern. Most of these deaths appear to occur during or immediately after birth. Although reliable data are not available, it is probable that such comparatively high maternal mortality indicates considerable maternal morbidity, such as vaginal and rectal fistulae and other pelvic damage. As good obstetric care can almost totally prevent maternal deaths, the organization of service needs to be reviewed, levels of risk considered and best practices adopted. Future policies should embrace the essential concept that
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Appropriate high-quality professional obstetric staff supported by modern technology — access to blood transfusion service, antibiotics, surgery and transport — should be available in the case of emergency, regardless of the place of birth. Infant mortality rates show similar regional trends to those observed for maternal mortality.

Regional objective: By 2020, reduce incidence of maternal mortality to almost zero. Reduce infant mortality to a range of 5-10 per 1000 live births.

Mental illness

Although reliable detailed data are not available, it is known that there is a considerable burden of serious mental illness in all countries of the Region. The most important mental illnesses are schizophrenia and serious depression, neither of which is preventable.

Sound alternative community-based approaches to the care of the seriously mentally ill have become available with the continued development of effective psychopharmaceuticals. Such community-based approaches have been shown to be more humane than institutional approaches. The cost of psychopharmaceuticals can be high, but it has been established that the overall cost of such community-based care approximates the cost of institutional care. Such services for the seriously mentally ill are best organized into district networks serving defined populations. Regardless of the form of care for the seriously mentally ill, the cost will be high.

Regional objective: Access to community-based health services should be made available to all mentally ill patients to enable them to achieve the highest standard of living possible within the constraints of their illness.

Circulatory diseases

The most important circulatory diseases are ischaemic heart disease and stroke. As the health transition progresses, both conditions substantially increase in importance. Both conditions are almost completely preventable because they are mainly a consequence of diet — consumption of excess fat (particularly animal fat) with respect to ischaemic heart disease and consumption of excess salt with respect to stroke. Tobacco smoking and a sedentary lifestyle are also associated with circulatory diseases. Incidence rates of circulatory diseases have flattened out in some developed countries.
Regional objective: Reduce the rate of increase of circulatory diseases and eventually show a decline in incidence.

Diabetes

Adult onset diabetes is another illness associated with diets which contain excess fat. The adoption of healthy nutrition and lifestyles will help to reduce diabetes in the Region.

Regional objective: By 2020, reduce incidence and prevalence by 50% and prevent complications with proper treatment.

Cancers

A significant percentage of cancers are preventable through changes in health-related behaviour. Such behaviour includes cessation of tobacco smoking, reduced exposure to the sun in childhood (in the case of melanoma), improved nutrition, and modified sexual practices (cervical cancer). In addition, much of the burden of liver cancer can be reduced by appropriate immunization. Again, the creation of a sophisticated health-promoting capacity at both central and peripheral levels is required. Health promotion is not expensive, and there is solid evidence that it can be very effective, particularly if there is no addiction involved.

Regional objective: Reduce incidence of certain cancers through early detection. Improve treatment of cancer through more widespread treatment facilities. Make pain relief available to all cancer patients.

Other diseases

STDs, including HIV/AIDS. HIV/AIDS is a major current or future problem for all countries in the Region, despite the reductions that have been achieved in several countries. The known and accepted preventive strategies include: health promotion related to sexual behaviour and careful screening of blood collected for transfusion services.

Regional objective: By 2020, for STDs, reduce incidence in the general population by 50% from present rates through use of technology and health promotion. Eliminate HIV/AIDS as a public health problem.
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Tuberculosis. Tuberculosis remains an important cause of adult death and disability in many developing countries. The most effective approaches are well established and include the establishment of publicly-financed specialist health organizations whose purpose is to ensure detection of all infectious cases and care of all detected cases. The provision of sound nutrition and adequate housing for the whole population is also an important element of tuberculosis control.

**Regional objective:** By 2020, reduce incidence rate by 75% from present rates.

Hepatitis. Chronic hepatitis due to viruses leads to cancer of the liver and also to liver failure. Viral hepatitis is a problem in many parts of the Region. The availability of comparatively low-cost (compared with previous animal-based vaccines) manufactured vaccines has offered the possibility of virtually eliminating many types of hepatitis. However, such vaccines have to be made available at affordable prices.

**Regional objective:** Reduce incidence of all kinds of hepatitis significantly. Eliminate all forms of hepatitis which can be prevented by immunization.

Malaria. Malaria remains a problem in several countries in the Region, for example, Cambodia, the Lao People’s Democratic Republic, Papua New Guinea and Solomon Islands. A concerted integrated approach using all available technologies has reduced the impact of the disease in some areas. Further progress against malaria is likely to be dependent on the development of new vaccines.

**Regional objective:** By 2020, reduce the number of microscopically diagnosed cases to 15% of 1995 levels and reduce deaths due to malaria to 10% of 1995 levels.

Tobacco, alcohol and drug abuse

As tobacco use is so harmful, there is a case for its total prohibition. Some strategies have been shown to be effective, such as health promotion for people of all ages; banning of tobacco use in all public buildings; and the imposition of high taxes on all tobacco products.
The harmful effects of alcohol use can also be profound. Reasonable strategies include: health promotion for all ages; taxation; and prohibition and monitoring of alcohol consumption while driving and operating machinery.

The widespread use of heroin, cocaine, amphetamines and other recreational drugs in some countries and areas of the Region also has significant adverse social consequences.

*Regional objective:* End tobacco advertising in the Region. Reduce smoking by men and eliminate increases in smoking rates by women. By 2020, reduce rates of alcoholism and drug dependence to 50% of present levels.

**Minority ethnic groups**

There are minority ethnic groups in many countries of the Region. These people very often experience lower socioeconomic and much lower health status than the average for a particular country. While substantial progress, particularly in child health, has been made with respect to minority ethnic groups, major problems remain. These include social alienation, unemployment, alcoholism and poor dietary practices. Policy approaches adopted in recent years have not substantially ameliorated these problems.

In collaboration with minority ethnic communities, trial policies need to be developed. Future policies might include: (1) the achievement of economic independence; (2) the effective introduction and maintenance of adequate housing, water and other infrastructure, provided communities have an economically viable future; and (3) the continued provision of sympathetic medical and health services.

*Regional objective:* For all minority ethnic groups ensure appropriate medical services are available.

**CHAPTER 6. SUMMARY**

Rapid economic growth in the majority of countries in the Region has provided most communities with significant improvements to their quality of life and has reduced the burden of
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disease from traditional communicable diseases and other conditions that typically affect young children. However, it is now apparent that this new prosperity has also led to many new influences that have the potential to reduce the quality of this new life.

There have been major changes in the way economic, social, political and public institutions are organized. Individuals and communities will clearly have a more influential and involved role, while the influence of governments will be less pervasive.

The epidemiological transition is one long-term trend directly influencing the needs of the health sector. The other is demographic changes, in particular the significant rise in the number of people living beyond 65 years.

The health sector in the 21st century faces three major challenges. First, there is a need to ensure that all citizens enjoy equal access to health care. Despite significant increases in national wealth, in some countries there has been a growing gap between the richest and poorest population groups. Consequently, in a market-oriented economy, special attention will need to be paid to ensure that health care is accessible for those unable to pay.

The second major challenge concerns the provision of quality of care. This is interpreted in a very broad sense to include all issues of effectiveness. For example, it could be argued that if any preventable health condition is not prevented, the health system has not provided quality of care. The issue of quality also applies to the best and most appropriate care given for acute conditions. However, even for acute care the definition of quality must address more than what is provided in a single acute care facility.

The third major challenge is that of costs. Even though as a whole populations are becoming healthier, acute conditions are becoming more expensive to manage. The health industry is very labour-intensive, so its costs will typically increase more rapidly than costs in the economy as a whole. In addition, the conditions that health systems are now faced with, such as noncommunicable diseases and injuries, are becoming very expensive to address.

The renewal of health for all presents a framework for reviewing health policy in the 21st century. It proposes that the basis for policy decisions must be supported on more evidence-based grounds than in the past. It also stresses that future health policy must recognize a rapidly changing social, economic, and political context for changing patterns of disease.
The renewal framework suggests that there is no unique solution that will achieve the best results in every situation. Nor is there even any ideal solution that can be foreseen. Rather, it is more likely that many unique solutions will evolve within countries and within groups of countries. The renewal framework is a guide for setting directions and an attempt to highlight the most significant issues. There are many positive areas upon which to build new learning institutions and environments that will be the building blocks for the health sector in the 21st century.

The next logical step would be to develop implementation plans for the movement from policy to action; a deliberative process of translating the ideals of policy to what is achievable in the various countries and areas in the Region. Policy development proceeds from an assessment to the development of options, to decisions and actions, followed by evaluation. The implementation of the policies in the 21st century call for the need of close monitoring of policies, further refinement and development of appropriate, useful and relevant indicators. It also calls for the need to support the implementation with an appropriate infrastructure, which includes standards, guidelines, workforce development and technical support.
PART II

NEW HORIZONS IN HEALTH
FOREWORD

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO Constitution)

"Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures." (WHO Constitution)

While the above statements might have sounded utopian in 1948, they have become more relevant. Now, towards the end of the century, our aspirations of ensuring the right of all people to realize their full potential for positive health seem more realistic. With conflicting claims on the attention and resources of governments, the need for reviewing our past work, assessing the parameters and targets for health set earlier and questioning the appropriateness of our directions has been intensified.

The Western Pacific Region has developed economically and socially to a point where the basic health infrastructure and educational levels are now more or less in place. This now allows for an approach that emphasizes individual responsibility in the context of supportive environments.

Many closely interrelated factors influence health and well-being. Our approach must reflect the recognition that lives are led in complex and ever-evolving circumstances. There is a growing role for the individual, the family, the community, and the nation to participate in health matters. Public policies must reflect this and must protect people from harmful elements in the environment.

Given the right circumstances, people have the potential to make long-term differences in their health. It is the role of WHO to support them in achieving this. A more people-centred, human-development approach is evolving from the former disease-centred approach.

A major question for the future is how to ensure that health and the environment are not damaged by the economic progress for which people have worked so hard. What is the best way to encourage and enable people to help themselves to avoid disease and disability and to develop
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lifestyles and environments that support positive health? Simple actions for health can start from the first days of life and have an impact throughout life.

All the vaccines in the world will not stop childhood disease unless parents want their children to be immunized, take them to health centres and ask for the vaccine. Impregnated mosquito nets will not stop malaria unless families use them. Whenever there is a choice, we must help people make healthy decisions and ensure that sound public policies support these decisions. These policies might concern health legislation; they might just as easily concern municipal planning or product labelling laws.

If we are to respond effectively to these developments, a change is necessary in our way of operating. It is not enough simply to realign, or even develop new programmes. It is unlikely that dealing only with individual elements will make a sustainable difference. We have to go further, recognizing the limitations of the traditional programme approach in responding to problems as they arise. We need multisectoral and multidisciplinary approaches that are mutually supportive in solving human development issues in sustainable ways.

The ideas in this document are presented to Member States as a catalyst for discussing and planning future directions. An earlier version was endorsed by the forty-fifth session of the Regional Committee for the Western Pacific in September 1994. Those initial discussions determined the steps now being taken to locate and structure the actual activities in countries through which this approach is taking shape in the Region. It is our intention that with this document and ideas for projects to realize the approaches, countries now take the lead, supported by appropriate resources from WHO and other agencies. The activities will be conducted by groups which cluster relevant skills. The assembling of the groups will provide a means for professionals in fields such as education, architecture, economic planning and development to identify with health issues and to recognize them as their concerns also. In the Western Pacific Region, groups are dealing with issues relating to three themes: preparation for life, protection of life, and quality of life in later years. The identification of particular lead issues for each country then becomes a way for the health sector to interact more closely with other sectors.

Working together within this framework, I believe that we can look forward to new horizons in health beyond the year 2000, where self-reliant individuals prepare themselves for
healthy living, are vigilant in protecting their environment, and continue to live comfortably and securely until the end of their lives.

People need not die prematurely; the living can lead productive lives, age gracefully, and die with dignity.

(sgd.) S.T. Han, MD, Ph.D. Regional Director
1. DIRECTIONS FOR THE FUTURE

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." (WHO Constitution)

Although health is a right, it is not automatically possessed. The human organism is vulnerable and the ecosystem appears increasingly hostile. As fast as control over diseases such as smallpox, poliomyelitis, or leprosy is reached, new threats such as AIDS appear or old threats such as tuberculosis and malaria recur. At the same time, as old environmental issues, such as sanitation, are successfully addressed, and nutritional issues, such as iodine deficiency disorders, are brought under control, new issues emerge: hazardous waste, air pollution in cities, and diets leading to heart disease, a variety of noncommunicable diseases, and early mortality.

The necessary basic health infrastructure is now in place in all countries and areas of the Region. A major concern is how to use this infrastructure more efficiently and effectively to deal with the new and emerging issues as well as the old. There must be a shift in emphasis from the illness itself, to the risk factors which contribute to the problem and further, to what will constitute good health. A single disease may be associated with many risk factors; and a single risk factor may cause or influence many diseases or conditions.

The definition of what causes ill-health has expanded. The scope of what is recognized as supporting good health has also grown. This enlarged view of responsibilities and involvement encompasses people outside the traditional health sector, including politicians, employers, planners, developers, economists, architects and teachers.

Health professionals must work closely with a wide range of other groups and disciplines to plan and execute health-related activities which ensure the best use of limited technical and financial resources; and to influence health-related considerations in development decision-making. Rather than simply responding to immediate needs, resources must be used for ensuring sustainable improvements in health and a better quality of life. Health interventions
must be people-centred and wellness-centred, not disease-focused and must focus on positive health as part of human development.

Two central concepts will be particularly important in meeting the challenges of the twenty-first century: health promotion and health protection.

Health promotion refers to measures that can be taken to encourage healthy behaviour and enhance what people can do themselves, in conjunction with their families, communities and nation, to improve and manage their own health. The focus is on intrinsic strengths enhanced by education and motivation, in the context of living and working conditions that foster improvements in health.

Health protection recognizes the fragility of human life, and the need to provide whatever reinforcement science and other advances in learning and understanding can bring. Its activities are based on the assumption that there is a constantly growing number of external factors that influence health status, such as the environment.

Increasingly, there are partners for health promotion and health protection in sectors which have not traditionally seen health as a priority issue in their work. The health sector must seek to combine its resources and efforts towards positive health and quality of life with those of other sectors. The combination of individual action with involved communities and supportive public policies is a key element in successful and sustained action. Increasing evidence shows that economic benefits result from improving quality of life, such as increased productivity and decreased costs to health care services. Gradually, a whole network of interrelated institutions and disciplines is forming, including schools, industry, transportation, energy, agriculture and environmental groups. There is great scope for effective complementary action among these. In the area of socioeconomic development, people are increasingly aware of the need for making thoughtful decisions on sustainable development, which fully integrates health and environment considerations. A more tangible example is provided by the many transportation companies which are vigorously implementing no-smoking policies. Many related parties are involved: individuals, families, communities, nongovernmental organizations, health services and others.
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The development of a multisectoral and multidisciplinary emphasis is an essential step in the movement towards integrated health promotion and health protection activities in countries.

2. THE REGION: EMERGING ISSUES AND THE NEED FOR A RESPONSE

"Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger." (WHO Constitution)

"The people have the right and duty to participate individually and collectively in the planning and the implementation of their health care." (Declaration of Alma-Ata, 1978)

One of every three people in the world today lives in the Western Pacific Region of WHO - approximately 1600 million people. No other region is developing economically and socially as fast, or raising as many expectations and questions for the future.

The health profile of this Region reveals a combination of diseases associated with poverty and those associated with affluence.

Malaria, tuberculosis, diarrhoeal and parasitic diseases, micronutrient deficiency disorders; these and other afflictions traditionally associated with the developing world, are being joined now by lifestyle-related diseases - heart disease, cancers and diabetes.

Even within the broad category of “developing countries”, there is a tremendous divergence in the pace of improvement among and within countries. While there are significant health benefits associated with socioeconomic development, levels of diseases and conditions related to population growth, rapid urbanization, unhealthy behaviours and lifestyles, and a damaged and damaging environment are emerging as formidable obstacles. This is particularly the case in those situations where development is not proceeding in balanced, sustainable ways.

Although the basic health infrastructure is now in place throughout the Region, there are still urgent health needs in many countries. Many people are living and working in seriously
polluted environments, without adequate food and shelter. High fertility in some countries is leading to high mortality among women and children.

The few affordable luxuries available to people in these conditions often have serious long-term health sequelae leading to further ill-health. Tobacco and alcohol use is rising throughout the Region, despite intensive health education campaigns against smoking and drinking.

<table>
<thead>
<tr>
<th>Key indicators for selected countries in the Region</th>
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<tr>
<td>Infant mortality (per 1000 live births)</td>
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<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Japan</td>
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<tr>
<td>Lao PDR</td>
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<td>New Zealand</td>
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<td>Papua New Guinea</td>
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Source: Western Pacific Region databank on socioeconomic and health indicators (June 1994).

Adult literacy, especially among women, is one of the most telling indicators from the point of view of assessing development and likely health needs. In the countries with the highest morbidity and mortality rates, female literacy is commonly less than 50%. In the other countries, however, this polarization is not so extreme.

Heightened educational levels and decreased infant mortality rates correlate well with not only absence of disease but with good health. These indicators depict a steadily improving health situation in most countries of the Region.

However, although in general the picture has improved, there are still major inequities. Infants, children and pregnant women in some of the poorest countries in the Region are dying
at more than twenty-five times the rates of those in the wealthiest countries of the Region. Differences in life expectancy at birth can be as much as thirty years.

Several of the major targets for health for all by the year 2000, such as infant mortality rates, maternal mortality ratios, life expectancy and adult literacy, have been reached by most countries and areas of the Region. Only three countries have maternal mortality ratios higher than the global target of 300 per 100,000 live births, and in all but nine countries and areas, the rate of infant death is below the global target of 50 per 1000 live births. Adult literacy ranges between 32% and 100% in the Region. The average life expectancy in the Region has increased, from 63 years in 1980, to 68 in 1990. Similarly, the average infant mortality rate has decreased, from 40 per 1000 live births in 1980, to 31 per 1000 in 1990.

Where life expectancy has increased, new areas of need have emerged, coupled with other demographic changes. The rapid increase in numbers of the elderly raises significant issues, including their health care, the financing of their needs, their accommodation, and their role in a fast-changing and increasingly urban community.

Japan provides an example of this kind of situation. In 1977, the aged accounted for 8.4% of the total population, and 27.1% of the nation’s health care costs. In 1985, although the aged accounted for only 10.3% of the population, the percentage of health care costs attributable to them rose to 37.5%.

Urban populations are growing at many times the rates of populations in rural areas. Rapid population growth, overuse or misuse of the land, and environmental degradation in rural areas have resulted in significant lifestyle changes and have prompted increasing numbers of the rural population to move to larger towns and cities in search of better opportunities and
improved standards of living. For some, this has resulted in positive contributions to health associated with increased personal incomes and improved services. However, this urban migration is also accompanied by tremendous overcrowding and poor living conditions which are destroying the lives, health and social values of millions of people.

Low incomes, inadequate access to health care services, daily exposure to pollution and toxic substances, and a highly stressful environment have made these disadvantaged populations especially vulnerable to disease and ill-health.

While the most impact is seen on the urban poor, the stresses of urbanization are also seen in more affluent sectors of society. Poor environmental conditions and other urban pressures (such as noise and heavy traffic) also contribute to stress, mental problems, accidents, violence, antisocial behaviour and drug and alcohol abuse.

Representative examples of disease trends in the Region

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Figure 3. Reported diphtheria cases
Western Pacific Region
1984 - 1994

*Provisional data based on annual trends and information available as at June 1996. (Source: CEIS/MPRO 1995)
Urban migration separates people from the stabilizing influence of their cultural background and traditions, encouraging new lifestyle patterns. These patterns, compounded by persuasive marketing, promote poor nutrition and detrimental habits such as smoking and excessive use of alcohol. These, in turn, can lead to undernutrition in lower age groups and increasing rates of degenerative disease in the middle-aged and elderly.

As a general trend in the Region, vaccine-preventable communicable diseases are decreasing sharply, while the noncommunicable diseases are increasing. This strongly suggests what interventions have been successful, and where future action needs to be directed.

Looking at the health issues emerging in the Region, it is clear that the responses must be timely, creative, and an integral part of public policy. Rather than tackling each issue separately, on a programme-by-programme basis, the issues must be looked at holistically, taking into account the larger context in which people live and work and which helps to shape their health status. Management of problems arising from man-made or natural disasters is one instance of this.

As well as involving other non-traditional partners in health and human development, this approach will require different ways of using resources and expertise. It also requires
willingness and interest to look for, or create, opportunities to work with each other in new ways. An example of this is to group activities by issues which deal with specific aspects of health promotion and health protection. These groupings would not necessarily affect the existing structures but would link them into a common approach. They provide a means of coordinating and implementing joint approaches and activities on particular issues. Through such groupings, the health sector would have a natural interface with other sectors on issues of common concern.

This is the approach that the WHO Regional Office for the Western Pacific has been exploring, and is inviting the countries of the Region to join.

The factors that influence the achievement of health have been analysed, in an attempt to minimize and even prevent the impact of detrimental elements and support the positive ones. This approach requires specialist groups to work together.

Three such groupings are proposed and elaborated in section 3 of this document: the first aims to direct resources to aspects of preparation for life, focusing on the child. It seeks to encourage what the child and family can do themselves, and stimulates them to seek support from the health services. Interventions are analysed and planned that influence later years such as antenatal care, nutrition during pregnancy, safe delivery, immunization and child development.

In the same way, the factors that suppress or inhibit good health throughout life, such as poor eating habits, lack of recreation and exercise, unsafe sexual behaviour, alcohol or drug abuse, etc., coupled with environmental factors such as unsafe working conditions, polluted air and water etc., need to be addressed. The second grouping tackles issues such as those relating to prevention of diseases and the protection of life.

Thirdly, the importance not just of survival, but of quality of existence is recognized. With the increasing proportion of elderly populations, ways of sustaining and preserving health in this large group are becoming an even more significant consideration. It is not enough just to live longer; the concept of adding life to years, and increasing the number of years lived free from ill-health, needs to be addressed. The third grouping deals with later years of life and quality of life.
Each of these three groupings requires core support from specialists skilled in health infrastructure and human resources development. This approach builds on current programmes and resources available in countries, emphasizing the whole individual and the measures each individual can take to protect and improve his or her life.

**Indicators**

The proposed new approaches to health do not require extensive structural changes within health systems. To ensure a fully supportive health infrastructure, however, the health sector needs to view its activities from a new perspective. In particular, health information systems have to be modified to take into account the different components that make up the physical, mental and social well-being of individuals at different times in their life.

Thus, while traditional health indicators such as infant mortality rates, maternal mortality ratios, and life expectancy at birth will continue to be useful, these must be supplemented by measures of the different factors which make up the complex concept of quality of life. In the preparatory stages of life (childhood and adolescence), educational and social factors must be incorporated in the assessment of health. During adulthood, opportunities for social and cultural advancement as well as the provision of harmonious work surroundings should be included in the evaluation of healthy lifestyles. In later years, healthy ageing must integrate freedom from disability with continued productivity and the ability to make meaningful contributions to society.

Activities to develop traditional and non-traditional indicators have begun and will continue in preparation for the 21st century. This document focuses on the quality of life of the individual during preparation for life, infancy, youth and adulthood to culminate in a high quality of life in old age. Many influences on the individual which are not directly related to health but have a considerable impact on quality of life will have to be monitored and evaluated.

New indicators will therefore assume an important role in meeting the challenge to enhance quality of life. There are many types of indicators which reflect quality of life in terms of physical, mental and social well-being. Some examples are: health status indicators (e.g. mortality, morbidity, nutritional status and disability); health services indicators (e.g. percentage of health budgets spent on care of the elderly); environmental health indicators...
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(e.g. availability of safe water, sanitation and adequate housing); population and socioeconomic indicators (e.g. percentage of families with adequate child timing and spacing; percentage of all children by gender completing a primary and secondary education); psychosocial indicators (e.g. incidence of suicide among elderly); and healthy lifestyles indicators (e.g. the number of people taking regular exercise).

In this document, a representative selection of the indicators necessary to obtain baseline data, monitor progress and evaluate outcomes are listed under the specific objectives of each theme group. However, adapting and refining existing indicators and identifying new indicators to meet these objectives is a continually evolving process. The indicators listed are not intended to be prescriptive, but exploratory. Work is in progress, particularly to develop new indicators to reflect those non-health components that contribute to quality of life, such as the environment, socioeconomic factors and healthy lifestyles. New targets will be required for the indicators set out in this document.

The process of identifying indicators and setting targets will be participatory between the Regional Office and individual countries. Some indicators and targets will be set for the Region, while others will be decided on by individual countries, taking into account a variety of factors such as the culture of the country, and the human and financial resources required for the population to be covered. It is therefore expected that the range of indicators and targets applied for each country will not be uniform throughout the Region, but will reflect the particular situation of each country.

By the end of 1995, it is anticipated that a sufficient number of indicators will have been identified to begin data collection. Targets can then be defined for the year 2000 and beyond.

3. OPERATIONALIZATION

This section outlines the main issues to be confronted and resolved in the Region, grouped into the three concerns of: preparation for life, protection of life, and quality of life in later years. Each of these concerns has a rationale outlining the main issues, the aims and objectives, and samples of the types of indicators that might, after fuller specialist development,
be used in countries. The approaches to be taken in achieving the aims and objectives are also outlined.

It is clear that every country has different needs. It is likely that the activities undertaken in each country will draw on different combinations of resources, in response to the particular level of development and scale of the problems to be approached. The emphasis of the approach is not on individual programme elements, but on the priority issues to be addressed and on the need to arrive at a situation where people are better able to take care of their own health.

This document suggests that each country should carefully assess the scope of activities needed for their particular situation in the light of the themes proposed. Each country will have a range of possible activities, among which there will be one or more most appropriate to launch the initiative, and gain familiarity and experience in the practice of working in multidisciplinary groups. These “entry point” projects will be very carefully selected by countries themselves in collaboration with WHO and other agencies.

1. Preparation for life

Rationale

Historically, the principal goal of health programmes concentrating on children has been child survival. As soon as life is conceived, it needs supportive physical and social environments. Survival alone, however, cannot be an acceptable aim of health policies.

Health policies and practices have to ensure that a child’s health potential and psychological development are strengthened in the course of the growth process.

A healthy mother, able to breast-feed the child and give emotional security within a supportive family, lays the foundation of healthy development.

A low-birth-weight child or a child exposed to environmental pollution and poor living conditions is more susceptible to diseases which have a substantial influence on physical, mental and social growth. Infectious diseases such as poliomyelitis or streptococcal infection can permanently reduce a person’s health potential.
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The ways of life which shape health-related behaviours during childhood and adolescence are likely to influence behaviour patterns in other stages of life. A child which grows up with an adequate education, a balanced diet, safe space for play and exercise, and emotional support for the development of his or her personality is best equipped to meet the challenges of later life. An informed young person will be more likely to have self-esteem and respect for his or her own body and to avoid tobacco, drugs and alcohol abuse. A young person who understands the close linkage between health and the environment will help the family and community to engage in activities contributing to the reduction of health hazards.

Therefore, it is appropriate, and essential, that health services extend their scope of activities and ensure, in collaboration with other sectors, that children not only survive but are then given the best support possible for developing healthy behaviour in environments conducive to health.

Identification of major issues

In spite of the progress made during the last decade, maternal, infant and child morbidity and mortality are still high in many of the developing countries in the Region. Ignorance and certain damaging traditions still take a high toll of potential future life years.

1. One of the major health problems is a continuing high level of maternal and infant morbidity and mortality. High fertility, a serious problem in several countries, contributes significantly to the loss of lives of mothers and children. The vicious cycle of poverty, infectious diseases and malnutrition, leads to infants and children failing to develop fully their physical and mental potential. A high rate of disability among mothers and children, mostly as the result of unplanned, unwanted or badly timed and spaced pregnancies, malnutrition, inadequate care, including unsafe delivery and abortion, and economic and environmental influences, also suppresses the quality of life in several of the countries and areas of the Region.

2. Continuing high levels of morbidity from infectious diseases among infants and children are also causing concern. This includes vaccine-preventable diseases such as measles, neonatal tetanus, and Hepatitis B, as well as acute respiratory infections, diarrhoeal diseases, and malaria, which remain leading problems. Particular attention is often required for the prevention and management of diseases with epidemic potential, such as dengue fever. The increasing threat of HIV infection and other sexually transmitted diseases is a major new challenge. Rapid uncontrolled urbanization is bringing degradation of
living environments in its wake, with environmental pollution, and disruption to traditional societies. All of these elements have an impact on children and future generations. Inadequate sanitation and water supply, often compounded by poor hygiene, still pose threats in many areas.

3. Children and adolescents are not achieving their full physical, mental and social potential. They are exposed to stressful environments and factors such as inappropriate nutrition, lack of exercise, and may develop risk-taking behaviours and harmful habits, which prevent them from achieving their full potential as adults. Health and behavioural problems among adolescents are increasingly a cause of considerable concern. It is in childhood and early life that many lifestyle patterns are developed that subsequently either support healthy ageing or lead to the development of chronic degenerative diseases in adulthood.

Aim

To ensure that infants and young children not only survive the first years of life, but are suitably prepared to enable them to realize their health potential throughout their lives.

Objectives

1. To ensure that every mother has the best opportunities for appropriate timing and spacing of pregnancies, safe delivery of a healthy infant in an environment conducive to health, with adequate antenatal care, sufficient nutrition and preparation for breast-feeding her child.

2. To increase child survival and decrease infant morbidity by promoting healthy environments, immunization, and by providing adequate case management for communicable diseases which are the major causes of mortality.

3. To support the development of healthy lifestyles through promoting education, supportive and safe environments for health and healthy behaviours during childhood and adolescence to establish lifelong healthy practices.

Operations

Objective (1) - To ensure that every mother has the best opportunities for appropriate timing and spacing of pregnancies, safe delivery of a healthy infant in an environment conducive to health, with adequate antenatal care, sufficient nutrition and preparation for breast-feeding her child.
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Indicators

- infant mortality rate
- maternal mortality ratio
- percentage of pregnant women within the normal range of weight for height specific for the country
- percentage of pregnant women with anaemia
- percentage of adolescent pregnancies
- percentage of infants in the healthy birth-weight range
- percentage of infants exclusively breast-fed for four to six months after birth
- percentage of children with normal weight and height for age
- coverage of antenatal, delivery and postnatal care by trained personnel
- percentage of families with adequate child timing and spacing
- percentage of couples using modern contraceptive measures
- percentage of children attending school by gender at the ages of 12, 15 and 18 years
- proportion of complicated obstetric cases managed at health centres and district hospitals providing essential obstetric care (EOC) facilities
- proportion of caesarean-sections to all births
- gender-specific literacy rate
- micronutrient status of mothers and children

Approaches

Responsible parenthood will be promoted through information and education. Community awareness, especially among adolescents, women and their husbands, and community leaders, will be increased with regard to reproductive health and child health issues. This awareness will be maintained at a high level so that women can access and utilize quality clinical services, be aware of the consequences of pregnancy and high fertility, and can go safely through pregnancy and childbirth. The community will be mobilized to provide necessary services and care for mothers and children. All infants born should be wanted children whose parents take them for immunizations and other health protecting activities, and ensure that they are adequately nourished and securely nurtured.
Provision of quality health care for women, children and adolescents will be promoted and supported through better training of health staff and dissemination of up-to-date technical knowledge and information. This will particularly apply to management of pregnancy, delivery practices and the care of the newborn by qualified and well equipped personnel.

The mother will be made sufficiently aware of safe food preparation and good nutritional practices so that she will take the initiative to obtain vitamin A and iodine supplements when necessary, seek out and comply with iron supplementation regimens during pregnancy, and decide to breast-feed her infants.

Appropriate educational material will be developed to help women identify their own risks during pregnancy and to seek medical advice accordingly.

At the same time, steps will be taken to equip medical staff better to deal with normal and high risk pregnancies, and to perform the required procedures for a clean and safe delivery, including tetanus toxoid immunization during pregnancy. Joint activities will be undertaken to inform women and their partners of the consequences of unprotected sexual behaviour and to encourage the use of safe - and culturally acceptable - contraceptive methods.

Empowering women to make their own fertility choices - and providing the means to do so - will significantly reduce the recourse to abortion (and to the related maternal mortality) as well as the number of unplanned pregnancies and unwanted children.

Existing health policies and practices will be reviewed and revised, bearing in mind the changes required to improve the “preparation for life” period.

Objective (2) - to increase child survival and decrease infant morbidity by promoting healthy environments, immunization, and by providing adequate case management for infectious diseases which are the major causes of mortality.

Indicators

- infant mortality rate
- under-five mortality rate
- percentage of children with normal weight and height for age
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- incidence of measles and malaria among children
- incidence of severe acute respiratory infection and severe diarrhoeal disease treated at health facility
- case-fatality of severe acute respiratory infection and pneumonia admitted to health facilities
- percentage of children fully immunized
- knowledge, attitude and practice of mothers regarding infant and child diseases, nutrition and healthy lifestyles
- percentage of children six months to six years with adequate vitamin A status in suspected high-risk areas, based on clinical symptoms
- health-related quality of life indicators, such as DALY, DFLE, and WHOQOL

Approaches

Prevention of disease and disability in infants and young children will be enhanced by immunization against the target diseases of the expanded programme on immunization (including hepatitis B); provision of safe water and adequate sanitation; appropriate weaning and nutrition practices, and adequate diet; and protection from insects and other disease vectors by use of insecticide-treated mosquito nets, destruction of breeding sites and other environmental health measures.

Promotion of better care of the sick child will be achieved by improving health services; early diagnosis and treatment; and the knowledge and ability of individuals (i.e. caretakers and other family members) to give appropriate home care, recognize severe illness, and take such children promptly to health services for treatment.

Both the preventive and curative approaches are best achieved by increasing the awareness of the caretakers, family and the entire community of how prevention and case management measures have an impact on the health of their children.

1 DALY - Disability-adjusted life years.
DFLE - Disability-free life expectancy.
WHOQOL - WHO Quality of Life Assessment.
Where appropriate, multiple disciplines will coordinate the approach to specific problems affecting child health and survival. For example, in the effort to eliminate neonatal tetanus, immunization teams and maternal and child health personnel will work together to ensure that pregnant women are immunized with tetanus toxoid during antenatal visits and that birth attendants are identified and trained during neonatal tetanus case investigations. Similarly, cooperation between immunization teams and nutrition personnel is needed to develop the most efficient means for the delivery of micronutrients (i.e. Vitamin A and iodine).

As regards promoting healthy environments, individuals and public health authorities, supported by related disciplines, will share responsibility for reducing environmental risks. Safe water and food, adequate sanitation, appropriate shelter, clean air and soil, open green spaces to play for recreation, are all important elements of this.

Objective (3) - To support the development of healthy lifestyles through promoting education, supportive and safe environments for health and healthy behaviours during childhood and adolescence to establish lifelong healthy practices.

Indicators

- percentage of primary schoolchildren with normal height and weight for age
- percentage of adolescent pregnancies
- incidence rates of sexually transmitted diseases, including HIV, in adolescents
- healthy teeth index (index of decayed-missing-filled teeth - DMF)
- percentage of recognized health-promoting schools
- gender-specific literacy rate
- suicide rates among youth (10-24 years of age)
- extent of selected healthy behaviours, including safe sex practices, a balanced diet and physical activities among adolescents
- percentage of injuries and death due to road-traffic accidents involving children and adolescents
- percentage of children and adolescents in adequate housing with safe water and sanitation
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Approaches

Learning about health, which includes establishing positive concepts about one's body during childhood and early life and taking care of the environment, will be emphasized with the aim of stimulating a sense of responsibility for health in all individuals in the Region.

A major thrust will be to ensure that adolescents are secure enough and properly informed so that they can make their own choices about lifestyles relating to drugs, diet, and sexual behaviours, despite peer group pressure to indulge in high-risk behaviours. Another principal emphasis will be to develop suitable educational and health promotional materials, with particular emphasis on adolescent health as an integral part of secondary school curricula.

Achieving a tobacco-advertising-free Region will be a major emphasis. This will help young people not to start smoking and will make smoking less attractive for women. Comprehensive national policies and programmes need to be established which address alcohol, drug and tobacco issues, especially with regard to children and adolescents.

Another emphasis will be the development of awareness in adolescents and adults of safe sexual behaviour, including the understanding of sexually transmitted diseases and condom promotion.

Through health promotion, the majority of children and families will take the initiative to seek annual dental check-ups for their children. They will have easy access to affordable basic curative services, and adequate knowledge of sound preventive dental practice.

Other major health promotion activities will focus on appropriate food and eating habits in early life, including attention to micronutrient deficiencies and obesity; mental health and mental development of the young; and prevention of accidents among young people.

These approaches have practical implications and require new forms of multisectoral cooperation. Children and adolescents can be very well prepared for life in schools. Schools and communities can be encouraged to support children with disabilities. Integration of health issues into the curriculum, extracurricular activities, a supportive school environment and appropriate school health services, will all contribute to the development of children's health potential. This requires that the health and education departments work together and that the
school community, through school staff, students and parents, is actually involved with the wider community in issues such as the provision of basic sanitation facilities and safe water. Health-promoting school projects would provide a framework for collaboration and encourage the optimal use of scarce health and education resources.

2. Protection of life

Rationale

Rising standards of living and health care have resulted in improved health and increased life expectancies throughout the Region. However, these same changes have led to a demographic shift to older populations and an epidemiological transition to changing lifestyles. These changing lifestyles and unhealthy environments are major factors in the dramatic rise in the Region of the chronic and degenerative diseases. These are now the commonest causes of death in most countries.

Giving a child the best start in life will prepare the young adult for the most productive and creative phases of his or her life. However, the maturing adult is also under considerable stress, in both physical and mental terms, from the environment and the workplace. Where there is an emotionally supportive environment, rates of mental illness are likely to be lower. To promote mental well-being, it is necessary for young adults to learn to be sensitive and responsive to their own and others’ feelings and to have adequate access to emotional help when needed. Early adult morbidity and mortality takes some of the most economically productive and experienced people from the community. It is also the time when the quality of life in older age is being prepared for, and the results of earlier and present lifestyles become evident.

The emphasis will therefore be on health promotion, encouraging healthy lifestyles to prevent disease and disability, and on the protection of life through promoting healthy environments and reducing the impact of disease. Several countries have already experienced declines in deaths from some of the noncommunicable diseases, especially cardiovascular and cerebrovascular disease. It is therefore clear that public health measures can have a significant impact. Other countries, on the other hand, have not yet experienced rising noncommunicable diseases rates, the result of changing diets, lifestyles and smoking patterns. It may be possible to avert this rise if action is started now.
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Identification of major issues

1. Diseases caused by changing lifestyles are increasing, including those related to different stresses, resulting from high-risk behaviours, such as alcoholism, smoking and the psychosocial problems of cultures in transition.

2. The prevalence of obesity is increasing and levels of physical activity are decreasing. At the same time, women in the reproductive age group continue to be at risk for nutrition-related diseases such as anaemia and iodine deficiency disorders.

3. In over two-thirds of the countries and areas in the Region, the noncommunicable diseases are the commonest causes of adult mortality. Prevention of noncommunicable diseases needs to be confronted as a major public health concern.

4. Sexually transmitted diseases, including newly emerging diseases such as AIDS, are a growing problem in this Region among young adults.

5. People in the workforce continue to be at risk from accidents, injuries and occupational diseases. Suicide rates appear to be increasing among middle-management in highly industrialized countries.

6. Death and disability, in poor urban communities, continue to be from infectious and environmental causes e.g. tuberculosis, other chronic lung diseases and malaria.

7. In virtually all countries and areas, there are limitations on the resources that can be devoted to health care. Issues of allocation of resources, quality of care and equity need to be confronted.

8. All societies, but particularly the most disadvantaged segments, face increasing problems of toxic wastes, environmental degradation, and ingestion of chemical residues or contaminants through food and water.

Aim

Having progressed through childhood and adolescence, individuals must then be supported in fully developing and maintaining healthy lifestyles, and be protected from illnesses caused by a potentially hazardous and degraded environment. The overall aim is to prolong productive, healthy and disability-free lives in the most cost-effective and equitable ways possible.
Objectives

1. To establish comprehensive national policies and programmes which promote healthy lifestyles throughout the lifespan of all individuals.

2. To improve the nutritional status of all sectors of the population, especially mothers and other vulnerable groups, and to promote appropriate, balanced diets and safe food preparation.

3. To decrease the transmission, morbidity and mortality rates of diseases such as tuberculosis, malaria and other diseases of public health importance, including vectorborne diseases.

4. To prevent or delay the onset of the noncommunicable diseases, including reduction in occupational diseases, in order to maximize disability-free and productive lives in older age.

5. To promote environmentally sound practices and technologies for the effective prevention and management of environmental health-related disease and disability.

6. To enhance people's quality of life by preventing disability, including blindness and deafness, and by rehabilitating the handicapped, infirm and disabled.

Operations

Objective (1) - To establish comprehensive national policies and programmes which promote healthy lifestyles throughout the lifespan of all individuals.

Indicators

- percentage of countries with legislation, promotive, preventive and corrective programmes relating to environmental pollution, water quality and food safety
- number of countries with environmental health policies incorporated into national development plans
- prevalence of the use of alcohol, addictive drugs and tobacco use, by age and gender, social class, education, occupation, employment status and other relevant social factors, including data on economic impact
- incidence and prevalence of sexually transmitted diseases
- incidence and prevalence due to HIV/AIDS
- days of absenteeism from work
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Approaches

Support for health goals will be enlisted from all government sectors, nongovernmental organizations and the private sector to strengthen health promotion activities and health-supporting living conditions and environments.

Focus will be directed towards individual behaviour change and will aim to support health through a variety of measures. These will include improved health legislation; health sector reform; strengthening supportive environments for health through a strategy focused on settings for health, such as healthy schools, health-promoting workplaces and healthy cities; ensuring community involvement, and intersectoral action. Health education and health promotion components will be incorporated in all other health programmes. Policies and programmes will be established to deal with priority psychosocial and behavioural problems, including the development and implementation of comprehensive national policies and programmes to increase awareness of problems related to alcohol, drugs and tobacco.

Achieving a “tobacco-advertising-free Western Pacific Region” will be one major thrust of implementing the Regional Action Plan on Tobacco or Health for 1995-1999. This will help young people not to start smoking and will make smoking less attractive for women.

Learning about health, which includes establishing positive concepts about one’s body and taking care of the environment, will be emphasized.

Sexually transmitted disease activities will aim to develop the individual’s responsibility for, and awareness of, safe sexual behaviour and the role played by individual behaviour in disease transmission. Interventions will be specifically targeted at youth, who represent a highly vulnerable group with regard to HIV infection. Safe sex behaviours will be promoted, including condom promotion and avoidance of injecting drug use.

The promotion of mental health in youth will be addressed. Special emphasis will be placed on the further development of community-based mental health services and related family training, to help the patient and the family to understand the disease treatment, patient care and rehabilitation and to take an active part in it. The role of leisure activities, including sport and entertainment will be addressed, as will the importance of supportive social networks.
Objective (2) - To improve the nutritional status of all sectors of the population, especially mothers and other vulnerable groups, and to promote appropriate, balanced diets and safe food preparation.

Indicators

- percentage of men and women, by ten-year age groups, overweight and obese
- number of people taking regular exercise
- percentage of women of child-bearing age with iron deficiency anaemia
- percentage of women of child-bearing age with evidence of iodine deficiency disorders
- incidence of air, water and foodborne diseases

Approaches

The major thrust will be to develop programmes which promote the benefits of healthy diets and exercise and help lead to healthy older age with improved quality of life. These measures will start in childhood, as well as targeting adolescents and adults. Community-based programmes for the prevention and control of cardiovascular and cerebrovascular diseases will be strengthened. There will be a special emphasis on adults and the elderly taking active and continuing responsibility for appropriate exercising, not smoking, and eating a healthy diet. Food safety measures will be promoted through improved information on issues for both consumers and providers. Priority will be given to improving technical capabilities for monitoring, assessing, preventing, controlling and managing food-related risks to health; to the development of national and city-specific health and environment plans; and the formulation or revision of food safety policies, strategies and legislation, adopted into administrative regulations.

Objective (3) - To decrease the transmission, morbidity and mortality rates of diseases such as tuberculosis, malaria and other diseases of public health importance, including vector-borne diseases.
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Indicators

- the number of users of insecticide-impregnated mosquito nets
- malaria morbidity and mortality
- incidence and prevalence of other diseases of national or local significance
- coverage of BCG
- incidence, prevalence and mortality due to tuberculosis
- cure rate of smear positive tuberculosis
- prevalence of leprosy
- case fatality rate (CFR) of cholera

Approaches

Mothers will be stimulated to ensure that their infants are immunized with BCG. All adults will be encouraged to ensure that those with a persistent cough are investigated for tuberculosis. If found to have tuberculosis, all adults should complete the full short-course chemotherapy treatment. For malaria control, the focus will be on individual behaviour and on promoting national, regional and community action for controlling malaria (e.g. use of impregnated mosquito nets, destruction of breeding sites and environmental control). Revitalization of malaria control programmes will include efforts to reduce morbidity and mortality through improving early diagnosis and treatment of the disease; improving appropriate and sustainable community-based vector control measures; and greater community involvement and awareness of the life-threatening nature of Plasmodium falciparum. Efforts to prevent the re-establishment of diseases in countries or areas where they have been eliminated will also be important.

Objective (4) - To prevent or delay the onset of the noncommunicable diseases, including reduction in occupational diseases, in order to maximize disability-free and productive lives in older age.

Indicators

- Disability-Free Life Expectancy (DFLE)
- life expectancy at birth
• percentage of countries with legislation relating to:
  • occupational health and safety; and incidence and prevalence of hypertension
  • age-standardized cardiovascular disease mortality
  • age-standardized cerebrovascular disease mortality
  • incidence and prevalence of diabetes mellitus
  • incidence and mortality due to cancer
  • percentage of countries which have screening programmes for common country-specific illnesses
  • the prevalence of work-related diseases, disabilities and accidents

Approaches

Three principles will be used in addressing noncommunicable diseases:

1. healthy lifestyles at all ages, including during pregnancy, have an impact on both present and future health;

2. the purpose of health promotion activities is to extend both the quality and length of life, by compressing the period of disability; and

3. reduction in noncommunicable diseases prevalence requires healthy and health-promoting environments, including the control of stress, pollution, advertising of harmful products, and the management of preventable cancers.

Links will be strengthened between nutrition and noncommunicable disease activities, such as reductions in intake of fats, encouragement of individual behaviours such as eating of fresh fruits and vegetables rich in antioxidants, avoidance of smoking and known carcinogens, taking exercise, etc.

Activities will be developed to address lifestyle factors which, if moderated, will help lead to healthy older age with improved quality of life. Health-promoting and health protecting activities will be important, such as improving working conditions, particularly in small-scale enterprises and agriculture. This will help to protect and promote the health of working populations. Industrial accidents will be reduced through comprehensive occupational health and safety measures and workplace health promotion.
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Objective (5) - To promote environmentally sound practices and technologies for the effective prevention and management of environmental health-related disease and disability.

Indicators

- extent of resources in countries to effectively implement health and environment plans
- extent of environmental health indicators such as those for pollution levels, and blood lead levels in vulnerable groups to monitor progress in resolving health, environment and development issues
- percentage of countries with legislation relating to:
  - tobacco and alcohol advertising; tobacco and alcohol purchase by minors; tobacco smoking in public places; acceptable alcohol blood concentrations while operating a motor vehicle
- percentage of countries with legislation in regard to occupational health and safety
- percentage of population with access to a twenty-four-hour supply of drinking-water through a reticulated system available in the home or within reasonable access
- percentage of population with access to excreta disposal facilities
- percentage of population with access to waste disposal facilities

Approaches

The awareness of individuals and communities will be increased regarding the interaction between the environment, health and socioeconomic development. This will enable them to act individually and collectively in efforts to improve the environment, and to participate more effectively at all levels in socioeconomic decision-making.

Apart from advocacy and informative activities, another focus will be on improving technical capabilities for monitoring, assessing, controlling and managing the health risks resulting from the environmental consequences of socioeconomic activities, and enhancing methods of protection from such health risks.

Consistent with Agenda 21 (the global plan of action from the 1992 United Nations Conference on Environment and Development), emphasis will also be placed on further
developing and implementing approaches which ensure that health and environment issues are integral to national and urban plans for sustainable development.

Objective (6) - To enhance people's quality of life by preventing disability, including blindness and deafness, and by rehabilitating the handicapped, infirm and disabled.

Indicators

- prevalence of people with handicaps, impairments and disabilities using a database on rehabilitation
- percentage of countries with defined welfare services for the physically and mentally handicapped and disabled
- percentage of countries with legislation in regard to the safe use of motor vehicles including: road worthiness; overcrowding of motor vehicles, the compulsory use of seat belts, and permissible blood alcohol levels while driving
- percentage of persons disabled due to a work injury
- percentage of patients with access to rehabilitation services

Approaches

There are two principal directions for the activities. One is to prevent disabilities, including those due to unnecessary injuries, through health promotion activities, (e.g. road safety campaigns) aimed at reducing disability from injuries, diseases and accidents, and from preventable and curable blindness (e.g. cataract). The other is to promote individual actions that maximize quality of life. This involves using the best methods to live productively with handicap and disability (e.g. hearing impairment and deafness) through community-based rehabilitation services and appropriate rehabilitation technology. Particular emphasis will be given to underserved rural and urban communities.
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3. Quality of life in later years

Rationale

While organized interventions by governments and communities at all levels can partially alleviate many of the problems associated with illness, disability and old age, much more can be achieved if such efforts emphasize ways of enabling individuals to contribute to the improvement of their own health status. Individual contributions to quality of life in the later years of life should begin even before older age is reached.

A healthy childhood and adulthood is probably the most important determinant of healthy ageing. Likewise, healthy living prevents many illnesses, and the disabilities resulting from them. Individuals must provide for their own future health care while they are still in their economically productive years.

As the percentage of the elderly in the population is increasing, the health costs (proportionately higher for the elderly) will necessitate reform in financing health systems. Thus, the maintenance of a high quality of life is directly linked to many of the issues being addressed in the current debates on health systems reforms.

The projected increase in the Region of life expectancy at birth from 67.7 years in 1990 to 74.7 years in 2020 has heightened concern for maintaining a high quality of life for the elderly. In addition, many of the emerging disease problems are chronic in nature and associated with increased levels of disability. The detrimental effects of these on the physical, mental and social capacities of individuals are associated with losses of productivity, creative opportunities, and increased vulnerability to further illnesses.

Even as the technologies and knowledge to deal with the many biomedical problems of the chronically ill, the disabled and the elderly are developed, high costs have kept them from being equitably accessible to all but the most affluent. Also, urbanization of rapidly growing populations has further reduced the social and material support mechanisms available through the extended families of formerly rural societies.

Thus, while modernization has brought gains to individuals in terms of the prolongation of life, for many it has taken a toll in terms of perceptible reductions in the quality of living.
Identification of major issues

1. The elderly population is expected to increase as promotive, protective and curative health interventions continue to have a positive impact on the life expectancies of populations.

2. Urbanization, population growth and other socioeconomic changes have altered the level and character of family, community and institutional support which enable individuals to attain a high quality of life.

3. The numbers of people with chronic illness and disabilities in all age groups are increasing due to the rise of degenerative diseases, accidents and other health problems associated with modernization.

4. Technology-based interventions required to allow individuals to live lives of good quality are expensive, complicated and, in many instances, of doubtful effectiveness.

Aim

To enable all individuals to acquire and maintain the physical, social and mental capabilities required to lead fully creative, productive and meaningful lives.

Objectives

1. To improve the well-being and quality of life of the elderly.

2. To ensure that health systems are organized, managed and sustained so that appropriate, accessible and affordable services, including those that promote the achievement of personal health potentials and a high quality of life, are available to all people.

3. To develop the potential for healing and health in people who live with chronic illness and disabilities, including their supporters.

4. To ensure the rights of everyone to enjoy a good quality of life, and to promote equity in access to resources necessary for optimal health.

5. To provide a physical and social environment that enhances quality of life.
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Objective (1) - To improve the well-being and quality of life of the elderly.

Indicators

- Percentage of countries with national policies for the elderly
- Percentage of countries with a focal person, department or unit within a government ministry to care for the elderly
- Disability-Free Life Expectancy (DFLE)
- Incidence of suicide among the elderly
- Incidence of major depression among the elderly
- Incidence of senile dementia
- Number of community facilities available to the elderly
- Percentage of health budget spent on care of the elderly
- Percentage of non-health budget spent on care of the elderly
- Percentage of elderly who receive retirement benefits from the government or private sector

Approaches

Countries and areas will be supported in the formulation of policies and implementation of programmes focusing on the concerns of the elderly. In particular, the strengthening of social and community support systems will be encouraged. For example, healthy community, city and island projects will especially focus on the well-being of the elderly as the outcome of community interventions in particular, availability of opportunities for appropriate exercises, smoking cessation courses, or classes in the conditions requiring self-management of care and maintenance. This will require collaboration between different sectors and the involvement of local governments, as well as communities such as other elderly people.

Care of the elderly will be stressed in the curricula for all levels of health workers. Special attention will be paid to development of skills that will support continued productivity and participation of the elderly in community and family life.
Objective (2) - To ensure that health systems are organized, managed and sustained so that appropriate, accessible and affordable services, including those that promote the achievement of personal health potentials and a high quality of life, are available to all people.

Indicator

- availability of quality of care instruments and their use in hospital services

Approaches

Health systems reform will be encouraged to emphasize orientation of health services and facilities to people-centred health maintenance and improvement through the promotion of healthy lifestyles, in addition to traditional goals of disease prevention, treatment and rehabilitation. Activities will aim to support implementation of plans to achieve national health development goals. This will emphasize three concerns: equal access to and use of facilities; improved quality of care; and containing the cost of care.

At the country level, health sector reform approaches will concentrate on three areas; finance, organization and management. The financial measures include resource allocation schemes and health insurance or other financial incentives to direct resources towards desired facilities and services. The organizational measures involve defining responsibilities by central or district level; optimally balancing the provision of services by the public and private sectors; and using internal markets. The management measures will typically relate to quality of care and accountability or transparency issues.

Training programmes will be encouraged to strengthen health promotion and protection of present and future health personnel, and will focus on the need to enhance health workers' abilities to transfer health knowledge and skills to individuals and communities, recognizing the limited impact of traditional biomedical technology on emerging health problems.

For example, as concerns heart disease, health systems need to have health workers who can provide not only care for the treatment and rehabilitation of heart disease, but can also provide community leadership and support to promote behaviour that prevents disease, and yet leads to increased positive health and well-being. These programmes and resources need to be in place not only for treatment and rehabilitation but for prevention and promotion. Additionally,
health workers need to look beyond the specific disease to provide holistic leadership and support for positive health and well-being.

Objective (3) - To develop the potential for healing and health in people who live with chronic illness and disabilities, including their supporters.

Indicators

- extent of community-based rehabilitation programmes in countries and areas throughout the Region
- number and extent of domiciliary-care facilities in communities and countries
- number, type, and periodicity of services provided for the disabled, and elderly with chronic illness

Approaches

Greater involvement of the community and employers in health care will be promoted in order to facilitate the rehabilitation and reintegration into society of the disabled, and people living with chronic illness including psycho-social disorders.

Professional support to the public by initiating self help and self care activities will be increased through the transfer of knowledge and skills according to their needs to families and self-help groups, supporting the community in rehabilitation activities for the disabled, caring for people suffering from illness and providing support to the individual and community livelihood projects.

Objective (4) - To ensure the rights of everyone to enjoy a good quality of life, and to promote equity in access to resources necessary for optimal health.

Indicator

- availability of adequate health care facilities within a reasonable distance from the elderly person’s residence
Approaches

Individuals' awareness of how better health is achieved will be increased, as well as increasing the resources available, encouraging lifestyles that promote health, and practices that result in health. These include clean air, nutritious food, adequate recreation, protection from infection due to unsanitary conditions and access to adequate economic resources. Legislative support will be provided when necessary to avoid discrimination due to a past or present health condition.

For individuals with debilitating chronic diseases such as cancer, the emphasis will be on achieving maximum quality of life through appropriate supportive and palliative treatment including monitoring and controlling pain relief.

All health professionals will be encouraged to promote healthy behaviours in all settings of the community and act as role models for personal health improvement.

Quality of care begins with the individual and in the community although support will be encouraged at all levels. The principal emphases will be on training and the establishment of quality assurance activities in different health care settings such as hospitals, clinics, health centres and home-based care in communities. In addition, models need to be developed for evaluation of quality of care procedures in order to improve existing procedures and facilities.

Research will be promoted in critical areas related to improving the quality of life of individuals and communities and strengthening institutions to carry out these activities.

Objective (5) - To provide a physical and social environment that enhances quality of life

Indicator

- the number of specialized welfare services available for the elderly in the community

Approaches

Activities will aim to support the development and implementation of plans which integrate physical and social environment considerations in ways that achieve health-related
quality of life goals throughout the Region. Emphasis will be placed on creating and sustaining physical and social environments that enhance the quality of life of the elderly, particularly those experiencing chronic illness. Among other things, this would involve promoting efforts to develop living and working conditions that are safe, stimulating, satisfying and enjoyable; and changing social attitudes to help ensure the integration of the elderly (particularly those experiencing chronic illness, their families and support systems) with the rest of society.

Examples of activities that reflect these approaches include the following:

- Comprehensive health care facility planning that recognizes the physical and social environment needs of the elderly. This approach is being successfully implemented in a number of communities. Architects, health care providers, community leaders and the elderly themselves work together to establish a more user-friendly, restorative and supportive atmosphere.

- The integration of health and environment issues in the development planning and decision-making process. This involves not only developing comprehensive health and environment plans, but also ensuring that the health and environment components of all development plans adequately address these concerns. Quality of life issues figure prominently in this process. Projects to encourage this type of systematic approach have been initiated in a number of countries throughout the world.

CONCLUSION

The issues discussed in this document are by no means all new. What may be of interest is the modus operandi proposed. This is a time to take stock of what needs to be achieved, in the light of what is known, and what can be predicted.

Looking towards the 21st century, we cannot be certain what the challenges in the health field will be. Strategic changes can, however, be made now which provide direction for WHO and countries to respond quickly and effectively to those future challenges. These changes are evolutionary, not revolutionary. They have wide-ranging consequences for the Organization's role as the directing and coordinating authority on international health work. They also have
important consequences for the way in which countries think about, discuss and plan their programmes, not just in health but in human development.

A new pattern of threats and opportunities for health in the Western Pacific is emerging. It is influenced by many factors, including the continuing improvement of health status in most countries, achieved through collaborative health-for-all efforts. Human behaviour is being recognized as one of the primary determinants of health, while the often-hostile changes taking place in the environment have recently regained prominence as external influences. In view of this, it is clear that the framework for meeting the health challenges of the future must emphasize health promotion and protection, which will result in improving the quality of life. Individuals must be convinced to take charge of their own future by behaving in healthy ways. Their social and physical environments must be made less hostile to and more supportive of human development through better health.

The resulting need for a process of developing new indicators for achievements in health must be a participatory one. It will require multidisciplinary work as well as close interaction and communication between WHO and countries.

If together we succeed in fostering and managing all these developments, we have a chance of securing a future where we live longer, healthier, and better quality lives.

ACKNOWLEDGEMENTS

At the global level, the necessity for assessment and re-evaluation has been reflected in a number of major exercises. Important among these have been the deliberations of the governing bodies of the World Health Organization on the WHO Response to Global Change which recognized the need for organizational reform. There have been several specialized forums in which aspects of this document's concerns have been raised, such as the 1990-1992 work of the WHO Commission on Health and Environment; the 1992 United Nations Conference on Environment and Development; the 1992 Ministerial Conference on Malaria; and the 1992 International Conference on Nutrition. Each of these forums, as well as others, have emphasized the critical need to move in a new direction.
A great deal has been written on health promotion and protection. This document does not quote directly except from WHO’s own basic documents, but the existence of many learned debates on the subjects is acknowledged. The source material for the observations and plans made is the work of WHO in the Region, present and past.
Report of the task force on health in development

The Fiftieth World Health Assembly,

Noting that the WHO Constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition";

Recalling resolution WHA45.24 on health and development, requesting the Director-General to establish a task force to undertake a comprehensive review and analysis of factors which could improve the health of the most vulnerable and disadvantaged populations;

Having considered the report by the task force on health in development;

Acknowledging that the development of the Tenth General Programme of Work should take into account matters concerning vision and mandate raised in the report;

Recalling resolutions WHA48.14 and WHA48.16 concerning review of the Constitution of the World Health Organization and renewal of the health-for-all strategy;

Deeply concerned about the worsening health status of many of the world's most disadvantaged and vulnerable groups;

Recognizing that poverty, unemployment, economic adjustment, and the emergence and re-emergence of new health problems add to the health crisis;

Reaffirming that public health measures can be a powerful bridge to peace by helping to mitigate the negative effects of conflict and social and economic inequities;

Aware of the need for global health leadership to provide guidance in responding to the worsening health crisis in a rapidly changing world;
Convinced that WHO is in a unique position to lead and advocate for global health, and that in this role of global leader WHO will interact with a variety of partners in implementing global health initiatives and programmes;

Convinced also that WHO must continuously adapt its work in order to respond to the public-health and development exigencies of the twenty-first century,

1. COMMENDS the members of the task force on health in development for their commitment and creativity;

2. APPRECIATES the task force's vision for health leadership in the twenty-first century so WHO can act as the world's health conscience;

3. URGES Member States to consider the task force's report in the planning of development strategies, in accordance with the conditions prevailing in each region and country:

4. REQUESTS the Director-General:

   (1) to take into account the recommendations of the task force in the preparatory discussions for the Tenth General Programme of Work and in the renewal of the health-for-all strategy;

   (2) to work with the governing bodies, Member governments and partners in health and development to consider taking into account relevant recommendations of the task force to strengthen WHO's role as the leader in global health in the twenty-first century;

   (3) to continue the existing focus within the Organization on health in development, including the articulation and promotion of health rights and health equity for women, disadvantaged and vulnerable population groups;

   (4) to continue to support the work of the task force on health in development including provision of appropriate financial and human resources;

   (5) to report to the 101st session of the Executive Board on the above;

5. DECIDES to keep the work of the task force under continuous review and requests the Director-General to report to the Fifty-first World Health Assembly, in order to enable it to consider the renewal of the mandate of the task force.

Ninth plenary meeting, 13 May 1997
A50/VR/9
WHO reform: linking the renewed health-for-all strategy with the Tenth General Programme of Work, programme budgeting and evaluation

The Fiftieth World Health Assembly,

Recalling resolution WHA48.16, which requests the Director-General to take the necessary steps for renewing the health-for-all strategy together with its indicators, by developing a new holistic global health policy based on the concepts of equity and solidarity, emphasizing the individual's, the family's and the community's responsibility for health, and placing health within the overall development framework;

Recognizing that the new global health policy should be based on an intensive consultation process with Member States, and on a practical and socially feasible approach with a view to achieving equity, solidarity, effectiveness and efficiency, paying attention to the rational use of resources;

Recognizing that the attainment of health is greatly influenced by environmental, social, economic and demographic factors which often lie outside the domain of the health sector, and that whereas the link between poverty and ill-health is well established, the fact that rapid urbanization, population movements and environmental degradation are all also likely to contribute to the future burden of disease is less well recognized;

Aware that more realistic targets are required that take into account the social and economic situation of each region;

Anticipating that the renewed health-for-all strategy will concentrate on improving life expectancy and the overall perceived quality of life, reducing morbidity and disability associated with ageing;

Thanking the Director-General for the progress made.

1. PROPOSES that the renewed health-for-all strategy, when adopted, taking into account regional differences and respecting cultural values should:

   (1) inspire and guide health programme priorities nationally, regionally and globally;
Annex 4

(2) become the principal guiding framework for the translation of WHO's constitutional mandate into the development of the Tenth General Programme of Work, strategic budgeting and evaluation;

2. URGES all Member States:

(1) to ensure that future health policies include a commitment to equity, "gender sensitivity" and sustainability for future generations, and that implementation of such policies takes into account scientific progress and cultural values and is guided by reliable data and valid assessments to ensure the achievement of objectives;

(2) to make the necessary changes in health services with special emphasis on prevention, including the control of communicable diseases;

(3) to develop and implement integrated strategies, when adopted, for health, focusing on intersectoral initiatives, cost-effectiveness, accessibility, quality and sustainability of health systems: the use of existing, appropriate and affordable new technology; and the use of initiatives based on scientific knowledge or practical evidence;

3. REQUESTS the Director-General:

(1) to use the renewed health-for-all strategy to enhance WHO's leadership in global health matters;

(2) to continue the preparation of the Tenth General Programme of Work, which should clearly and concisely set out strategic priorities and targets for WHO and should be subject to periodic evaluation. The Tenth General Programme of Work should be derived from and be closely linked to the new policy for health for all for the twenty-first century;

(3) to link the preparation of subsequent general programmes of work to the evaluation of the health-for-all policy, taking account of social, economic and health developments;

(4) to ensure that priorities and targets of the Tenth and subsequent General Programmes of Work are reflected in development, implementation, monitoring and evaluation of programme budgets;

(5) to optimize the management and use of WHO's human resources to enhance efficiency.

Ninth plenary meeting, 13 May 1997
A50/VR/9