Education and debate

An ethical dilemma

Should egg donors be paid?

The Human Fertilisation and Embryology Authority advises clinics not to use donors who they suspect have been paid. Donors are currently entitled only to reasonable expenses plus up to £15 in payment per donation. The director of a fertility clinic argues that egg donors should be more actively recruited and at least receive a sensible allowance for their inconvenience; a member of the HFEA replies that the strong cultural preference in Britain for unpaid donation should be reinforced. From the United States, a professor of obstetrics and gynaecology reminds us that even commercial enterprises depend on their core of doctors—who must decide such ethical challenges for themselves.

An "inconvenience allowance" would solve the egg shortage

Ian Craft

London Gynaecology and Fertility Centre, 112A Harley Street, London W1N 1AF

Ian Craft, *director*

BMJ 1997;314:1400–3

I favour egg donation without financial reward, but the demand for eggs far outstrips the supply from women who donate for altruistic reasons. The end results are an inordinate delay, often of 1-2 years, for treatment for women who are destined to be barren, and the proliferation of private organisations that put donors and recipients in contact for financial reward.

My preference is probably unrealistic in today's world, where money determines health care. Our prime concern is to provide an efficient clinical service. The principle of payment for donation is enshrined in the Human Fertilisation and Embryology Act 1990 since sperm donors are allowed £15 ($24) per donation. They can earn hundreds of pounds over several months for acts of transient pleasure. Concerns that egg donors were receiving £750 per treatment cycle led to the Human Fertilisation and Embryology Authority hosting a conference on payment to donors in June 1995. Delegates pointed out that egg donation required greater involvement and invasive treatment than did sperm donation and that the acts were hardly comparable.

HANK MORGAN/SCIENCE PHOTO LIBRARY

Egg retrieval is an inconvenient procedure

> *"Egg donation required greater involvement and invasive treatment than did sperm donation"*

I have argued for the setting up of a national body of paid officers (counsellors, doctors, and nurses) to recruit egg and sperm donors nationwide.[1] A body organised along the lines of the blood transfusion service would gain public acceptability and respect. High professional standards and accountability would be essential. Inclusion criteria for donors should be set up and data kept on screening and treatment outcomes.

I now believe that payment of an "inconvenience allowance" would be a practical way of solving the problem of profound shortage. Within such a framework, donation could be made without recompense or for a realistic reward without abuse. Is £15-£35 for a sperm donation and £350-£450 for an egg donation unreasonable? What price do infertile people already pay for their continuing infertility? Infertility can destroy relationships and break up families, and every so often it leads to suicide.

I do not believe that it is amoral for donors to receive an "inconvenience allowance." We know already that more donors would come forward if there

were some recompense for the trouble involved. Medicine is failing the public by its inability to implement an efficient donor gamete service. Indeed, I believe a national organisation should advertise for donors in the media, allowing the whole issue—including payment—to be brought out into the open. The public is generally supportive of new humanitarian concepts when the details are fully and honestly discussed.

So what is the official position with regard to payment? Our centre assumed that differential payments for egg, as opposed to sperm, donation were being considered following the Human Fertilisation and Embryology Authority's conference, especially when one of the officials requested that we forward "tariff" details, depending on whether egg donation was completed or was interrupted for various reasons. However, this consideration was abandoned when the BBC screened a sensational television programme (*Here and Now,* 1 November 1995) that reported payments between recipients and donors.[2]

> *"The acts [of egg donation and sperm donation] are hardly comparable"*

Within weeks the Human Fertilisation and Embryology Authority issued a policy statement on payments to egg donors which insisted that clinics not use donors who received payment of more than £15 from an agent, agency, or from any other source.[3] Despite this edict some clinics still use donors recruited by private agencies.

More recently, a new document from the authority has indicated that an even more restrictive policy will be implemented, preventing any payment whatsoever for future donors.[4] The Human Fertilisation and Embryology Act 1990 allows directions to be made that alter existing law without the need for further parliamentary debate. Media reporting of fertility issues often results in immediate changes in policy, or in law, which disadvantage infertile people.[5]

Such a policy has other consequences for donor sperm banks that operate commercially. The Human Fertilisation and Embryology Authority may dislike the pragmatism of offering money to overcome a donor shortage but it seems to be less concerned about which "expenses" are remitted, provided they are not seen as payment. When we met to discuss this matter they were unable to indicate clearly which expenses are considered to be reconcilable.

> *"The sham of what is deemed acceptable is what upsets the public and our profession"*

The public knows that payment still occurs with some treatments that are licensed by the authority. Surrogacy involves donating the eggs and sperm of an infertile couple to the host. Call it "expenses" if you will, but the £10 000 that is usually paid to a woman for carrying a child for nine months is in reality payment. So what will the authority do now? Ban surrogacy? Surrogacy now falls within its remit after a ruling that a couple requiring this treatment be considered as donors to the host. Presumably the authority has until now condoned this arrangement provided it was "parcelled up" as a £15 payment for the nine month carrying fee and £9985 for expenses. The need for egg and sperm donation for couples who do not require surrogacy is not different in principle—only in degree.

Surely the Human Fertilisation and Embryology Authority must realise that the sham of what is deemed acceptable is what upsets the public and our profession. We can start to remedy this by promoting the concept of a publicly accountable national egg and sperm donor organisation—infertile people deserve at least that.

1 Craft I. Who puts the price on infertility? *Independent* 1994 August 21.
2 Craft I. The generous gift of life. *Independent* 1995 November 2.
3 Human Fertilisation and Embryology Authority. *Policy update.* London: HFEA, 1995. (CH(95)4, 27 November.)
4 Human Fertilisation and Embryology Authority. *Policy update.* London: HFEA, 1996. (CH(96)6, 22 July.)
5 Craft I. Fertility, the media and the law. *Medico-Legal Journal* 1994;62:81-3.

The culture of unpaid and voluntary egg donation should be strengthened

Martin H Johnson

Department of Anatomy, University of Cambridge, Cambridge CB2 3DY

Martin H Johnson, *professor of reproductive sciences; member of HFEA*

mhj@mole.bio.cam.ac.uk

It is prohibited by law to give or receive money for gametes and embryos unless authorised by the Human Fertilisation and Embryology Authority. The authority issued directions in respect of payments[1] when the Human Fertilisation and Embryology Act 1990 came into effect on 1 August 1991.[2] These directions permitted "monies or monies worth" to be given and received in respect of gametes only, up to a maximum of £15 per donation. The actual amount given by any licensed treatment centre was to be the rate in place at the time the act came into force. These limits also apply to payments or benefits that a treatment centre knows have been given, or will be given, through the involvement of an agency or intermediary. Thus, payment of any kind is prohibited for embryos at all treatment centres. It is also prohibited for gametes at any treatment centres which were licensed to use gametes in donation since the act came into force. Moreover, the level of payment made in clinics which were licensed at the time the act came into force varies from no payment to £15. Most egg donation programmes have been set up after the act, which means that payment is prohibited for most acts of egg donation in the United Kingdom.

The authority made it clear that, in issuing directions, it was simply regularising the status quo. It revisited the issue of payment in 1993, mindful of the clear presumption in the act that payment should not be given. After a long period of research, consultation,

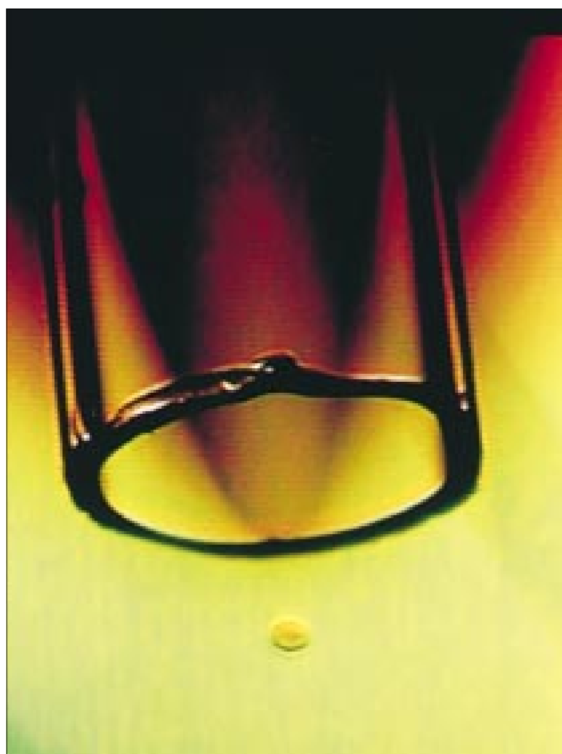
and discussion, the authority said in 1996 that payment of any kind for gametes (other than necessary, verifiable, and consequential expenses) would be prohibited at a time and in a manner to be determined.

> *"The quality of consent is important if donors are not to regret the act of donation"*

This conclusion was built on two broad principles: firstly, that fully informed consent, free from any inducement and pressure, is fundamental to gamete donation; and, secondly, that the potential for human life inherent in a donation made with the specific intent of producing children should be respected. These principles were applied in the interests of the donors and recipients of gametes, the children produced, the licensed centres offering treatment, and society at large.

The authority felt that there was clear evidence[3-5] that payments to egg donors (including compensatory payment for inconvenience or suffering) could induce women to donate and could prejudice fully informed, freely given consent. The quality of consent is important if donors are not to regret the act of donation. There was also concern from the experience of egg sharing schemes (in which infertile women give up some of their eggs to other women in return for their own free treatment)[6] that the quality of consent of the donating women might be compromised. The clinic may also find it hard to separate the interests of the donor from those of the recipient.

The authority was also mindful of recommendations from a Royal College of Physicians Working Group[7] on the potentially adverse effects that compensation for risks might have on the quality of consent to take part in clinical trials. The authority considered that payments to donors could lead to the development of attitudes that might fundamentally change the relationship of donors to the treatment process. Donors and recipients should be given equal status and consideration in the process of donation. To pay donors might lead them to be marginalised by both the clinics and recipients as being simply a means to an end.



HANK MORGAN/SCIENCE PHOTO LIBRARY

Ovum meets pipette prior to fertilisation

The authority was impressed by research that indicated overwhelmingly that women in Britain preferred unpaid egg donation.[8 9] It sought to strengthen this strong cultural preference, since the involvement of payment might affect the culture of donation adversely, reducing openness and honesty about genetic origins and family relationships. There was also concern that payment, particularly large payments of the sort seen elsewhere, might induce donors to hide factors that could be detrimental to recipients and their potential children.

> *"Payments to donors could lead to the development of attitudes that might fundamentally change the relationship of donors to the treatment process"*

The authority was also concerned to protect the physical and psychological wellbeing of children born from egg donation. Children produced by egg donation could be adversely affected psychologically if they knew that payment had been made as part of their creation. It seemed preferable to be cautious about introducing payment into a culture that preferred otherwise until there was research available on children born elsewhere.

There is a strong social ethos in Britian of voluntary unpaid donation, such as blood and tissue donation. The value of this ethos has been reinforced by the report of the Nuffield Council on BioEthics.[10] Overall, the authority is concerned not to erode in any way the culture of voluntary unpaid donation that currently exists for egg donation. Rather, it wishes to strengthen and develop this culture.

1. *Directions issued under the Human Fertilisation and Embryology Act 1990.* London: Human Fertilisation and Embryology Authority, 23 July 1991. (Ref D.)
2. *Human Fertilisation and Embryology Act 1990.* London: HMSO, 1990. (Section 12e.)
3. Robertson J. Ethical and legal isues in human egg donation. *Fertil Steril* 1989;52:353-63.
4. Sauer MV. Oocyte donation: reflections on past work and future directions. *Hum Reprod* 1996;11:1149-50.
5. Ahuja KK, Simons EG. Anonymous egg donation and dignity. *Hum Reprod* 1996;11:1151-4.
6. Ahuja KK, Simons EG, Fiamanya W, Dalton M, Armor NA, Kirkpatrick P. Egg-sharing in assisted conception: ethical and practical considerations. *Hum Reprod* 1996;11:1126-31.
7. Royal College of Physicians Working Group. *Research on health volunteers.* London: RCP, 1986.
8. Cook R, Golombok S. A survey of semen donation: phase II—the view of the donors. *Hum Reprod* 1995;10:951-9.
9. Abdulla HI. A national oocyte donation society is needed. *Hum Reprod* 1996;11:2355-6.
10. Nuffield Council on BioEthics. *Human tissue: ethical and legal issues.* London: The Council, 1995.

Exploitation or a woman's right?

Mark V Sauer

Division of Reproductive Endocrinology, College of Physicians and Surgeons, Columbia University, New York, NY 10032-3784, USA
Mark V Sauer, *chief*

Correspondence to: Professor M V Sauer, Columbia Presbyterian Medical Center, Sloane Hospital for Women, 622 West 168th Street, PH16-28, New York, NY 10032-3784

Paying women to donate oocytes has sparked much controversy. Interestingly, a duality of practice has evolved. In many parts of the world compensation is prohibited, while in some countries, particularly the United States, donating gametes is handsomely rewarded. It seems naive to presume a consensus will be reached regarding the correct approach. Furthermore, the United States is highly unlikely to curtail or regulate payments by law. Thus, supply and demand will inevitably continue to dictate policy, and the price of oocyte donation will escalate along with donor fees.

There exists an inherent moral ambiguity in a practice of medicine that simultaneously places young women at risk of infertility while treating the childlessness of other women. Which need is paramount? Do benefits to one group far outweigh the risks posed to the other? These issues fascinate medical ethicists but torment practitioners who choose to provide services to women needing donor eggs.

"Supply and demand will inevitably continue to dictate policy"

Initially, reproductive medicine was viewed with fascination by the public, but with the dark realities of cloning, genetic engineering, and mishandling of embryos the pendulum of opinion has taken a swing backward. Mistrust has grown, and many people believe that fertility specialists are incapable or at least unwilling to regulate themselves. This has led to the passing of legislation in the United Kingdom and more recently the United States to oversee practices and regulate laboratories. However, these safeguards neither dictate how oocyte donors should be recruited nor outline how they are to be compensated. Individual programmes are still charged with deciding whether or not to provide the service and how to manage it fiscally.

Many doctors and patients question why payment for services ever arose. Yet as a profession we have encouraged compensation of men involved in gamete donation, paid for vital organs, and regularly reimbursed individuals to take part in research trials. In fact, I would argue it was from a "research" clinical trial that the actual practice of paying oocyte donors originally arose. Although the $250 remunerated to women undergoing uterine lavage in Los Angeles in 1984 is rather less than the $2500 regularly received in 1997 by oocyte donors in New York, the complexity of the procedure and the time required of women who are prescribed drugs for ovarian hyperstimulation merits this increase.

Where we go from here is largely dictated by where you live. In the United States the overwhelming majority of women are paid for donating eggs; this is the established and accepted method. In places where payment is limited or prohibited, the practice of oocyte donation will continue to be plagued by a shortage of available donors. Payment has fostered the growth of fertility treatment and continues to make it a viable therapy. A programme is only as strong as its donor pool. Without a registry, long waiting lists are inevitable and compromised matches replace thoughtful choices. The need is great, and without solicitation it is doubtful that programmes could be initiated or maintained.

Whether a 21 year old student has gained enough perspective to make an informed decision is arguable. However, this same individual has every right under the law to make autonomous choices, including issues of medical proxy, abortion, and organ donation. Perhaps our preoccupation should be redirected at the programmes offering the services rather than the women enrolling for treatment. The challenge lies in ensuring that all medical groups practise with the same rigorous attention to informed consent necessary for recruiting donors and truly educating women to the risks of participation.

We should not delude ourselves as to our role in this evolution. As doctors we are responsible for promoting the fee for service approach, and we have profited handsomely from this practice. Although commercial ventures have introduced aggressive solicitation by newspaper and media advertisements, no enterprise is without its core of doctors. Doctors involved with oocyte donation must decide for themselves how to deal with the multitude of ethical challenges that this treatment demands. Payment of donors is only one of many difficult issues.

One hundred years ago

Nursing in rural districts

The nursing of the village folk is a problem which has not yet been solved, but we are by degrees working towards a solution. Such schemes as are at present in favour are lacking in continuity, and when we consider the multifarious needs of the rural poor it is evident that unless a scheme of nursing is complete in itself it fails of its purpose. The best plan yet suggested appears to be the formation of a centre for a grouped district, let it be a cottage hospital, a workhouse hospital, or a county infirmary, as the base of operation, to which should be attached the trained nurse, the district nurse, and the cottage or village nurse; these nurses working together, their services being available as need required. The cottage nurses would receive such training at the centre as would enable them to attend on all simple cases, but at the other end of the chain would be the skilled nurse, whether district or hospital, whose services could be at once requisitioned by the medical officer of the district in the event of the nursing being beyond the powers of the cottage nurse. This is an outline of the scheme which seems to offer the most satisfactory solution of the problem, but it must be worked out in each locality.
(*BMJ* 1897;ii:1286.)

The future of world health

The new world order and international health

Julio Frenk, Jaime Sepúlveda, Octavio Gómez-Dantés, Michael J McGuinness, Felicia Knaul

See editorial by Godlee

Center for Health and the Economy, Mexican Health Foundation, Periférico Sur 4809, Tlalpan, 14610 México, DF
Julio Frenk, *executive vice president and director*
Octavio Gómez-Dantés, *project coordinator*
Michael J McGuinness, *research fellow*

National Institute of Public Health, Cuernavaca, Mexico
Jaime Sepúlveda, *director general*

Program in Health Economics, Center for Economic Research and Education, Mexico City
Felicia Knaul, *professor and coordinator*

Correspondence to: Dr Frenk.

BMJ 1997;314:1404–7

Health systems in countries all over the world are undergoing intensive reforms. Internationally, the existing institutions for multilateral cooperation are facing unprecedented challenges. Many are finding it increasingly difficult to fulfil their mandates. There is inefficient overlap of efforts among various multilateral organisations, while, paradoxically, there are voids of responsibility in executing some key functions. At the same time, other players, such as non-governmental organisations and transnational corporations, are gaining prominence.

Multiple forces are transforming the shape of the world and patterns of disease and health—creating a need for new institutional arrangements. Just as governments are reinventing their respective national health systems, so international health must be rethought so that it can respond effectively to the emerging challenges.

Summary points

International cooperation for world health faces unprecedented challenges

The health situation in nations is increasingly influenced by global determinants such as environmental threats, the expanded movement of people and goods that facilitates the spread of pathogens across national borders, and the trade in legal and illegal hazardous substances

After nearly 50 years of activity, the major agencies involved in international health cooperation have not responded adequately to the new picture of change and complexity

Just as national health systems across the globe are engaged in reform efforts, so it is time to reform the world health system

The first step in reform is to achieve a consensus about the essential core functions of international health organisations and about a coordinated division of labour among them

The new shape of the world

Nations no longer represent truly independent, sovereign countries. New global forces have eroded national borders, facilitating the transfer of goods, services, people, values, and lifestyles from one country to another. Countries are increasingly dependent on international trade. Transnational corporations control a large portion of the world's capital. Currencies leap from one financial market to the next, often defying national regulation.[1]

Political movements also generate transnational forces that place external pressure on individual nations. Interest groups organised around issues such as sex and sexual orientation operate transnationally in order to exert change at the national level. The continuing ties among related groups in different nations produce networks of communities with similar values and customs, which operate at both the local and international levels. These act as one more force pulling towards meta-national integration.

Certain forces resisting this globalisation have recently risen to prominence. At its extremes, this process has led to the development of religious fundamentalism. Recently, some of these fundamentalist movements have sought to give their "awareness" a political expression, creating intolerant and antidemocratic currents.[2] In countries all over the world ethnic and linguistic minorities are demanding increasing autonomy, even to the extent of fracturing the integrity of a nation state. The clash between these new forms of "tribalism" and the forces of globalisation has become a major source of tension in the world.[3]

As humanity enters the 21st century, its crucial challenge is to build a global civilisation based on respect for multiculturalism. Universal civilisation should seek to establish a code of mutual coexistence which respects differences while also preventing the outbreak of hostilities resulting from desperation or intolerance.[4,5]

Growing complexity of health

Countries must confront a vast array of challenges in order to make their health systems meet population needs. The populations of developing countries continue to suffer from common infections, reproductive health problems, and malnutrition, which keep infant and maternal mortality at unacceptably high levels. On the other hand, they are also facing the emerging challenges of non-communicable diseases and injuries.

In the past two decades new diseases such as AIDS or new variants of old diseases have emerged and are generating a new world epidemiological profile. The AIDS epidemic is the most notorious example of these emerging infections. It is estimated that by the year 2000 there will be more than 20 million people infected with HIV, most of them in developing nations.[6]

Healthcare systems absorb an increasingly large share of resources. In 1990 public and private expenditures on formal health services worldwide reached $1700bn or 8% of total world product.[7] Industrialised countries spent almost 90% of this amount, with average per capita expenditure on health care of about $1500. In contrast, developing countries spent the remaining 10%, with per capita expenditures of only $41.

In developing countries health systems must be designed to implement more efficient ways of dealing with the backlog of common infections, reproductive

International transfer of health risks

- Global environmental threats—For example, ozone depletion, caused by actions such as the use of aerosols in some countries may increase risks of skin cancer in others
- Overuse of resources—Poor societies have relatively modest per capita consumption of food, fuel, and other goods compared with rich countries, but as developing nations harness the power of their markets and increase their consumption patterns they too will pose a threat to the earth's environment
- Cross border movement of people—Nearly 20 million people are currently displaced by war, environmental crisis, or economic collapse,[10] and over 400 million people will travel internationally this year, contributing to the international spread of infections and disease
- Trade in harmful legal products—Tobacco use is rising as a result of widespread marketing campaigns, and by the year 2050 annual tobacco related deaths will reach 12 million[11]
- Traffic of illicit drugs—Worldwide consumption of heroin and cocaine has grown 10-fold in the past 20 years
- Diffusion of medical technologies and treatment policies—Developing nations rely heavily on imported medical technology, some of which has adverse health effects and is unnecessarily costly

health problems, and malnutrition while also developing affordable and effective interventions for non-communicable problems.[8] Most countries lack adequate training for health staff and acceptable certification procedures for facilities. Sizable sums of public money are spent on tertiary level hospitals at the expense of cost effective interventions delivered at the primary level. Finally, access to basic health services and essential drugs remains a pervasive problem in rural and dispersed communities.[9]

Global phenomena with health consequences

Among the most powerful global forces affecting health conditions are the international transfer of risks and liberalisation of trade. These forces work transnationally, blurring the boundaries that once shaped the nature of health at the national level (see box).

The world health system

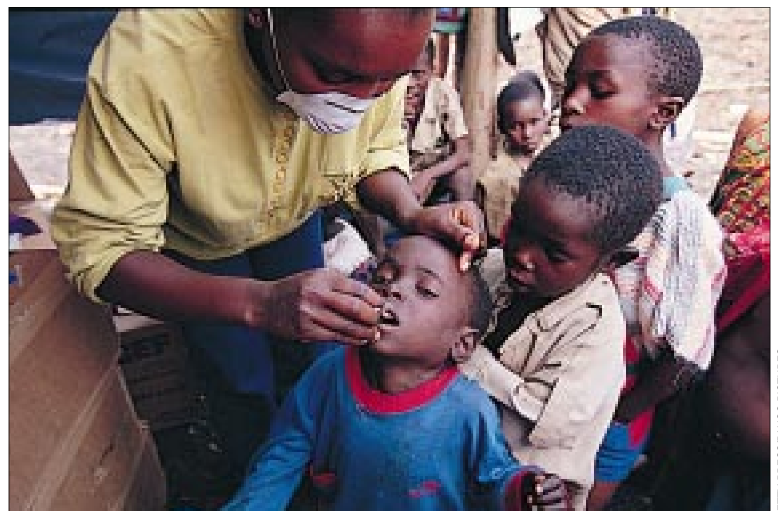
National governments can no longer deal on their own with the determinants of health that arise from interactions at the global level. The technologies to satisfy health needs are being produced and traded through global processes that often transcend the regulatory capacity of individual governments. The right to quality health care is incorporated into the global movement for human rights, and governments are facing increased demands for better services.

International health organisations seem to be the ideal vehicle for contending with health problems that go beyond the capacity of national health systems. Current international health agencies, however, were designed for a different world, where few problems needed global action. One single organisation could manage world health affairs, especially given the clear priorities that characterised that time. Today, the world is a different place. The development of international health agencies has not kept pace with the evolution of new health challenges, and some agencies have adopted functions that exceed their original mandates.

As a result, international health agencies are being pressed by their member states to adopt new organisational structures, redefine their basic priorities, and develop new forms of international cooperation in order to meet the health challenges of the next century. The reform of national health systems finds its logical extension in the reform of the world health system. As products of the era after the second world war, the agencies forming the world system have developed human, organisational, and technological capacities that have enabled them to fulfil such ambitious goals as the eradication of smallpox. As this century comes to a close, however, they are experiencing a serious crisis. The efficacy of international health agencies has been diminished by lack of coordination, overlapping mandates, and the duplication of efforts.

Paradoxically, this duplication takes place while certain essential functions are not being carried out (see box). The failure of international health agencies to perform these and other functions represents a major obstacle to social wellbeing as well as to economic development.

Many of the problems affecting the world health system arise from a variety of limitations that are internal to each agency, most notably the World Health Organisation (WHO). Established in 1948, the WHO is primarily dedicated to the "attainment by all people of the highest possible level of health."[12] It has advised member states on technical health matters, financed the training of health professionals, and worked to influence the development of health policy. Despite its achievements, the WHO has been under increasing scrutiny by commentators, who point to a number of shortcomings. Firstly, the WHO's activities are disparate and often uncoordinated. Secondly, the agency's priorities often follow donors' preferences and the amount of available resources, rather than rational evaluations of health problems.[13] Thirdly, the effectiveness of its regional structure has been called into question.[14 15] Fourthly, the organisation is facing



BETTY PRESS/PANOS PICTURES

Disposed communities still suffer poor access to basic healthcare

Essential functions neglected by international health agencies

- International monitoring of emerging diseases
- Setting standards to protect consumers' health against potential abuses arising from international commerce
- International coordination for controlling the transfer of health risks
- Coordination of research efforts and technological development
- Design of information systems to facilitate elaboration of health policies at national as well as global levels
- Accumulation of knowledge about cost effectiveness of medical technologies and interventions
- Creation of a process for shared learning about experiences of reforming national health systems

competition and new challenges to its traditional role in leading international health iniatives.[16]

Part of these challenges arise from the growing pluralism that characterises international health care. In addition to the WHO and its regional offices, there are several specialised United Nations agencies and programmes participating in health related activities, such as Unicef, United Nations Development Programme, the Food and Agricultural Organisation, and Unesco. At the same time, multilateral development banks have achieved a growing financial and technical presence in the international health field.[17] Another new set of influences in the global health field are non-governmental organisations, a broad term encompassing a variety of non-profit making groups that devote themselves to a specific cause through research, building awareness, or direct action. Finally, there are the transnational private companies responsible for the worldwide production of goods and services that are related to health care.

Reforming the health system

Until now, the variety of groups working on international health care have not been able to develop an effective world health system with the capacity for concerted action. Just as national health systems must confront reform, the disarticulated world health system must reinvent itself to meet the challenges of the future.

The agenda for reform is indeed broad, as it includes key issues like redefining mandates, identifying priority functions, redesigning structures of governance, developing efficient mechanisms of coordination, and adopting reliable means of assuring accountability in each agency. Among these issues, one of the most controversial is identifying priority functions, which is also a prerequisite for effectively dealing with the other issues. At the moment, there is little consensus about the core functions of international health organisations. In fact, there seems to be a broad spectrum of views with respect to the scope of responsibility that international health agencies should assume in the coming years.

At one end of the spectrum is the "essentialist" point of view, which seeks to identify the core functions for which international organisations have a comparative advantage over national entities. What functions can the international health system perform better than individual countries—either because it can be more cost effective or because these functions fall outside the sovereignty of any one nation? The essentialist identifies those functions where international collective action is needed either because they require production of international public goods or management of externalities that transcend the borders of any given nation. According to this point of view, five core functions meet such criteria (Jamison D, personal communication) (see box).

At the other end of the spectrum is a view that assigns a much more expansive role to international health organisations. Based on arguments of social justice and the transferability of experiences, this view identifies several functions in addition to the essential core. These include redistribution of resources from rich to poor countries, political advocacy in favour of certain national health policies, direct regulation of transnational corporations, and intervention in planning or implementing national health projects.

Building a consensus about the functions of international health organisations is a prerequisite for designing the structural reforms that will best allow those organisations to fulfil their mandates.

The essential five core functions of international health agencies

- Surveillance and control of diseases that represent a regional or global threat
- Promotion of research and technological development related to problems of global importance, including establishment of mechanisms for sharing information
- Development of standards and norms for international certification
- Protection of international refugees
- Fulfilment of a moral imperative to act as an agent of assistance and an advocate for extremely vulnerable populations that have no other recourse

Conclusions

World health has reached a moment when strategic definitions are required. The 50th anniversaries of the United Nations and the World Health Organisation serve as a reminder that it is crucial for the international community to take stock of past achievements, examine present performance, and articulate a vision for future development.

A consensus must be reached about the core functions that international health organisations must perform in order to respond to the new realities. The consensus on essential functions must then guide the design and implementation of improved institutional arrangements. International organisations have projected the year 2000 as a milestone towards one of the most ambitious goals of humanity—health for all. The achievement of this objective will depend on the ability of the international community to create an effective world health system.

This paper is adapted from a background document for an informal meeting on the current state and future role of international health institutions, which was held at the National Institute of Public Health, Cuernavaca, Mexico, on 3-4 February

1997. The meeting, which was sponsored by the Rockefeller Foundation and organised by the National Institute of Public Health and the Mexican Health Foundation, served as the regional follow up to the Pocantico Retreat held a year earlier on the same topic. We are grateful for the valuable comments of the participants of the Cuernavaca meeting. Before the discussion of the paper there, we benefited from interaction with Lincoln Chen, Seth Berkeley, Catherine Gwin, Gill Walt, and Dean Jamison. The views expressed in this paper are the sole responsibility of the authors.

1 Kennedy P. *Preparing for the twenty first century.* New York: Vintage Books, 1994.
2 Bell D. El fundamentalismo islámico. ¿Cuán grave es la amenaza? *Vuelta* 1994;213:15-8.
3 Barber BR. *Jihad vs. McWorld.* New York: Ballantine Books, 1996.
4 Havel V. A courageous and magnanimous creation. *Harvard Gazette* 1995 Jun 15:15-6.
5 Berlin I. The pursuit of the ideal. In: *The crooked timber of humanity.* New York: Vintage Books, 1992:1-19.
6 Zacarías F. El SIDA en el mundo. *Gac Med Mex* 1996;132:25-8.
7 World Bank. *World development report 1993. Investing in heath.* Oxford: Oxford University Press, 1993.
8 WHO Ad Hoc Committee on Health Research Relating to Future Interventions Options. *Investing in health research and development. Summary.* Geneva: WHO, 1996.
9 World Health Organisation. *The world health report 1995. Bridging the gaps.* Geneva: WHO, 1995.
10 Gellert GA. International migration and control of communicable diseases. *Soc Sci Med* 1993;37:1489-99.
11 Warner KE. Tobacco taxation as health policy in the Third World. *Am J Public Health* 1990;80:529-31.
12 World Health Organisation. *Basic documents.* 39th ed. Geneva: WHO, 1992.
13 Sterky G, Forss K, Stenson B. *Tomorrow's global health organization: ideas and options.* Stockholm: Ministry of Foreign Affairs, 1996.
14 Godlee F. WHO in crisis. *BMJ* 1994;309:1424-8.
15 Godlee F. WHO in retreat: is it losing its influence? *BMJ* 1994;309:1491-5.
16 Walt G. International organizations in health: the problem of leadership. In: *Pocantico Retreat. Enhancing the performance of international health institutions.* Cambridge, MA: Rockefeller Foundation, Social Science Research Council, Harvard School of Public Health, 1996: 23-37.
17 Frenk J, Gwin C, Nelson J. The multilateral development banks and health. In: *Pocantico Retreat. Enhancing the performance of international health institutions.* Cambridge, MA: Rockefeller Foundation, Social Science Research Council, Harvard School of Public Health, 1996: 39-48.

Health care systems for the 21st century

Seventh Consultative Committee on Primary Health Care Systems for the 21st Century

See editorial by Godlee

Seventh Consultative Committee on Primary Health Care Systems for the 21st Century
A list of participants is given at the end of the article.
Correspondence to: Paul Ress, health correspondent, 22 Chemin Briquet 1209, Geneva

BMJ 1997;314:1407–9

Health services in many countries are in turmoil. The abrupt shift to a market approach taken by many governments has given rise to the notion that health is just another commodity to be bought and sold. It was against this background of upheaval that the World Health Organisation recently held a meeting on health systems for the 21st century. At the heart of the conference were two questions. "What will the challenges be in the 21st century?" and "How will they affect the organisation and functioning of future health services and systems?" The meeting of the Seventh Consultative Committee on Primary Health Care Systems And Services for the 21st Century brought together health professionals from many developed and developing countries, such as Mexico, Britain, South Africa, and the Republic of Korea. Their findings have far reaching implications for WHO's 191 member states and the committee decided to summarise their conclusions to facilitate widespread dissemination and discussion.

The change to a market approach

Health systems worldwide have failed to recognise the fundamental change in the world that has come to dominate economic and social development over the past decade. This model can be paraphrased as "the market approach." It poses a number of basic challenges to the World Health Organisation's long term strategy of Health For All. One of these challenges is the notion that health is merely a commodity and, as such, has a price. It can be traded off against other commodities.

At the same time there is a growing acknowledgement that good health is a prerequisite for human development and for maintaining peace and security, without which economies cannot thrive. In the face of this contradiction health systems have adopted an approach characterised by passive reaction. In the public sector reduced budgets for health have been condoned while poverty and inequalities in access to health care have been increasing. The long term goal of improving the health of the entire population, especially the most needy, has too often given way to delivering medical technology to those who can pay for it. It has been done in the name of cost effectiveness.

The meeting of the WHO's Seventh Consultative Committee on Primary Health Care Systems and Services for the 21st Century concluded that the primary health care approach is perilously close to being overtaken by events. Countries need to know what options they have. Either they continue the current trend of diminishing access to comprehensive health services though a market approach to financing, provision, and allocation of medical services or they embrace a radical reorientation towards the development of health systems whose goal is the improvement of the health and wellbeing of entire populations, giving priority to those with the greatest need.

Need for values and visions

The value of the primary healthcare approach lies in its recognising that health is a central part of human development and not simply the technical process by which health professionals deliver medical care. It is a social and political process that involves people, enabling them to take more control over their own health. It also acknowledges that the health of individuals and communities depends on healthy environments, the development of which all sectors of society share responsibility for.

Many countries have formally adopted policies on Health For All and health sector reform, often with little coordination between the two. Furthermore, many reformers in the healthcare sector have bought the concept of "efficiency." National as well as donor policies now place cost effectiveness above equity and health.

PETER BARKER/PANOS PICTURES

New health services must be proactive and holistic

The committee rejected the false distinction between efficiency and equity. In the present context of scarce resources it is the poor, above all, who cannot afford inefficiency. The committee also observed that the health financing options that are currently available would be inadequate to meet the future costs of health systems that had the capacities to fulfil the Health for All policies, particularly in those countries with high levels of poverty and dependency.

In this regard WHO has an important part to play in creating awareness that public expenditure on health must be increased in many poor countries. This will require more support from donors and seeking new sources of financing.

Strong leadership for health

National governments must take responsibility for ensuring equity in health and access to health care in the 21st century. This is the only way adequately to ensure accountability to citizens in an epoch when health systems and services will involve a multitude of players: private companies, non-governmental organisations, and the public. The policies and practices of other sectors of the economy will continue to create both risks and opportunities for improving health; market forces will continue to create a dilemma with regard to choices on resource allocation; and decentralised authority on the one hand, and supranational forces on the other, can offer no guarantee of equity.

In such a setting future ministries of health must be leaders for health. They must be able to lead partnerships with all health care providers; influence the policies and actions of other sectors; and inspire, support, and collaborate with community organisations, the media, and business leaders to create an informed, supportive, and healthy environment. In other words, future ministries of health will not resemble their counterparts of today. Their functions, skills, and capacities will include: advocacy, consensus-building, negotiation and mediation, formulating and advocating health policies, influencing the policies and monitoring the health effects of the activities of other sectors, and providing technical guidance to all participants of national health systems and services. The ability of ministries of health to fulfil these roles effectively will depend on strong systems for monitoring health trends and performance of health systems, close collaboration in national health systems research, and the power (based on national and international legislation and conventions) to regulate and enforce adherence to agreed national standards.

Priority to countries and peoples in greatest need

The 21st century will be greatly influenced by the success or failure of poor people and poor countries to make progress in human development. A top priority for the international community, led by WHO, will be to strengthen the institutions of the poorest countries to enable them to implement healthy public policies and develop sustainable health services and systems.

WHO is already pursuing initiatives in this area. But such initiatives must be strengthened to respond to the growing number of needy countries. The willingness of the global community to act through solidarity with poor countries will be essential to achieving health for all.

Increasing poverty and inequity are also tragic features in many other countries, including the most affluent. Here the issue is not primarily weakness of institutions but weakness of will. The culture of equity, so prevalent at the birth of primary health care, has been seriously diluted.

WHO has an important part to play in ensuring that future health services and systems are led by policies that are focused on equity and poverty and are equipped with the organisational structures and functional responsibilities to ensure real improvements in the health of the most needy sections of the population. As a first step, for example, WHO can report health data desegregated by income, just as they are now desegregated by sex.

Role of the international community

The conventional image of the global community as a combination of international and bilateral agencies and non-governmental organisations must be expanded to incorporate what is now known as civil society. This includes supranational business. WHO should take the lead in bringing representatives of this community together to foster a deep appreciation of the importance of health systems as producers of human development rather than just as consumers of resources.

There is a tremendous need for consistent, coherent, unambiguous global consensus on the principles for organisation of sustainable health services and systems. All people, irrespective of their socioeconomic status, have the right to a range of services, including the relief of pain and support for a dignified death. The epidemiological transition and aging of the world's population underlines the importance of this basic need. WHO should encourage the health leaders of the world to endorse and advocate such a position.

The prevailing healthcare model for poor countries, based on a "package" of minimum services does not address this issue and even perpetuates the belief

that very low public expenditure on health is adequate. The challenge for the 21st century is to develop health systems and services that are proactive and holistic; the piecemeal approaches that have characterised the development of health systems for the last 50 years must end. WHO should take the lead in building consensus within the international community that all countries must provide access to a wide range of services.

The committee was concerned by the continued divide between well intentioned statements and policies and what is actually being done at the community level. The primary healthcare approach evolved from review and analysis in different places of various ways to improve health and provide health care. Considerable experience has now been acquired on how to overcome obstacles and implement primary health care under different socioeconomic conditions. This experience must be reviewed and used to enhance the implementation of health for all in the 21st century.

This text is an adaptation of the committee's declaration.

Members of the committee: Mohamed El-Amin Abdel-Fattah (Alexandra University, Egypt), G M Biscoe (Hobart, Tasmania), Dulitha N Fernando (University of Colombo, Sri Lanka), Miguel Kiasekoka (Ministry of Health, Angola), M Koivusalo (Ministry of Social Affairs and Health, Finland), K Leppo (Ministry of Social Affairs and Health, Finland), Cormac Macnamara (European Union of General Practitioners, Dublin, Ireland), D McIntyre (University of Cape Town, South Africa), A Pavlov (Permanent Mission of the Russian Federation to the United Nations Office, Geneva), Hugo Salinas (Ministry of Health, Chile), Richard Saltman (The Rollins School of Public Health of Emory University, Atlanta, Georgia), Y-S Shin (Korea Institute of Health Services Management, Seoul, Republic of Korea), T J Stamps (Ministry of Health and Child Welfare, Harare, Zimbabwe), Manuel Urbina (Ministry of Health, Mexico City), Morton Warner (Welsh Institute for Health and Social Care, University of Glamorgan, Wales), Widyastuti Wibisana (Ministry of Health, Indonesia), H Yadav (Family Health Development Division, Kuala Lumpur, Malaysia), Tesfamicael Ghebrehiwet (International Council of Nurses, Geneva), Peter A Heimann (African Federation for Technology in Health Care, Tygerberg, South Africa), Daleep S Mukarji (World Council of Churches, Geneva), Judith Oulton (International Council of Nurses, Geneva), E Ram (World Vision International, Geneva).

The World Health Organisation needs to reconsider its definition of health

Rodolfo Saracci

See editorial by Godlee

National Research Council, Pisa, Italy

Rodolfo Saracci, *director of research in epidemiology*

BMJ 1997;314:1409–10

The World Health Organisation's definition of health seems to work against its effective functioning. When the WHO was established nearly half a century ago the text of its constitution defined health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."[1] This by now classical definition of health, conceived in the aftermath of the second world war, when peace and health were seen as inseparable,[2] had one merit lasting long beyond the circumstances of origin: it made explicit that disease and infirmity, when isolated from subjective experience, are inadequate to qualify health. Widening health to the psychological and the social dimension was a major advance, but although it was conceptually important, it had no direct operational value. As one commentator put it, "This [definition] is a fine and inspiring concept and its pursuit guarantees health professionals unlimited opportunities for work in the future, but is not of much practical use."[3]

Problems with the definition

However, it is at the conceptual level that the definition runs into the most serious problems, which impair its guiding role when the conflict between health needs and resources has become of paramount concern, nationally and internationally. In fact, a state of complete physical, mental, and social wellbeing corresponds much more closely to happiness than to health. These two words designate distinct life experiences. Sigmund Freud, an appropriate reference in psychological matters, saw it clearly when, after stopping smoking cigars for health reasons, he wrote: "I learned that health was to be had at a certain cost.... Thus I am now better than I was, but not happier."[4]

Not only are health and happiness distinct experiences but their relationship is neither fixed nor constant. Having a serious disease is likely to make you less happy, but not having a serious disease does not amount to happiness. Common existential problems—involving emotions, passions, personal values, and questions on the meaning of life—can make your days less than happy or even frankly uncomfortable, but they are not reducible to health problems.

The distinction between health and happiness is crucially relevant in terms of rights, in particular "positive" rights or entitlements requiring societal actions to ensure that they effectively and fully materialise.[5] Whereas it can be argued that health is a positive and universal human right, it seems impossible to construct an argument that happiness (though not its material and social preconditions) is a positive right simply because happiness cannot be delivered or imposed on a person by any societal action. Happiness is strictly subjective both as an achievement and an appreciation.

Consequences of the definition

Failing to distinguish health from happiness has four main consequences. Firstly, any disturbance to happiness, however minimal, may come to be seen as a health problem.

Secondly, because the quest for happiness is essentially boundless, the quest for health also becomes boundless. This legitimises an unlimited demand for health services. Of course, some people may legitimately decide that they want to pursue happiness as well as health by medical means, as other people may do through music, religion, or love. For example, some people may wish to have their features surgically redesigned to suit some aesthetic ideal. But this preference represents a personal way to happiness rather than a universal right to health.

Thirdly, a point rarely noted, annexing happiness to health and regarding health (in fact, happiness) as a universal positive right introduces an underlying prescriptive view of happiness in society.[6] This undervalues personal autonomy and could be established only in totalitarian regimes.

Finally, and by far most important, trying to guarantee the unattainable—happiness for every citizen—will inevitably subtract resources and jeopardise the chances of guaranteeing the gradually attainable—justice and equity in health. The necessary and formidable task of reducing inequalities and achieving equity in health, a growing point in the reformulation of the WHO's programmes of action,[7] becomes impossible if it is not even clear what needs to be equitably distributed.

Towards a solution

To remove the fundamental ambiguity of happiness versus health, a descriptor of health would be helpful—for example, "Health is a condition of well being free of disease or infirmity and a basic and universal human right." This description does not contradict the definition in the WHO's constitution: rather it provides an intermediate concept linking the WHO's ideal to the real world of health and disease as measurable by means of appropriate indicators of mortality, morbidity, and quality of life. By removing the ambiguity between health and happiness and emphasising health as a basic human right, it provides a reference criterion against which to gauge how far health programmes incorporate and meet the requirements of health equity.

1 World Health Organisation. *Basic documents.* 39th ed. Geneva: WHO, 1992.
2 Callahan D. *What kind of life. The limits of medical progress.* Washington, DC: Georgetown University Press, 1995: 34-40.
3 Doll R. Health and the environment in the 1990's. *Am J Public Health* 1992;82:933-41.
4 Freud S. Letter to Lou Andreas-Salome, 1930 May 8. Cited in: *Sigmund Freud house catalogue.* Vienna: Löcker and Wögenstein, 1975: 49.
5 Finberg J. *Social philosophy.* Englewood Cliffs, NJ: Prentice-Hall, 1973:59, 61.
6 Dahrendorf R. *La liberta che cambia.* Roma-Bari:Laterza, 1994:30.
7 World Health Organisation. *Ethics and health, and quality in health care—report by the director general.* Geneva: WHO, 1996. (Document No. EB 97/16.)

Doctors of the future

My job in 2020

Phew! What a day! How many times can you get called out in a day?

Today I was on call after seven; and you'll never guess what happened at six; I was shaving in the bathroom, tired and weary, with baggy eyes that weighed at least five tonnes, after getting home late last night, when the phone began to ring. The poor moaning woman asked for Doctor Conner. I wasn't on call until seven and on the phone was a terrified woman screaming as if there was a casualty.

So under the noise of my rioting children, smashing up my house, and screaming for breakfast, I asked her for the gruesome details.

"Oh! It's my George, my poor little George. He's come down with something horrendous, I think he might die!" This desperate patient, Mrs Barker, was crying for help; her 6 year old son seemed to be in great terrible pain.

I left my wife with the kids and drove 30 miles breaking the speed limit to this emergency; but before I even reached the house the police stopped me for breaking the 140 mile per hour speed limit and I got three points off my licence.

Finally, I reached the emotional mother waving outside her house. I ran in with my medical bag as fast as I could, and there in the upstairs bedroom I saw it. I saw the poor, extremely sick boy in bed. He had a terrible case of Rhino disease, or in other words a cold. At that moment I wished I was a police officer so I could charge the woman with wasting my time. Mrs Barker denied her son's illness being a cold; but to prove her wrong during my visit the young man had about three bowls of icecream.

Well, on the way to the surgery something had to go wrong; this time my flying car broke down and the AA ended up escorting me to the surgery and fixing the car there. When I got into the surgery crowds of receptionists swarmed around me with letters and lists of things to do. My first patient was Mr Illington, an elderly sick man, and at 95 years old he was on his last legs. On his last legs were the right words, he died half way through my visit. So next was all the hassle of the death certificate, because I had to certify his death.

While I was rushing up and down the surgery corridors and around the waiting area sorting out his death, some woman with outstanding cheek stopped me in the waiting area. She had been waiting for hardly 15 minutes; she was also a terrible hypochondriac. She stopped me to say the service here was rubbish and she demanded attention. So I asked her "What comes first, a hypochondriac with a sore throat or a dead patient?"

The rest of the day was horrendous. I got called out to six more emergencies, one of them visiting an old woman who had a fit and vomited all over my £150 new suit. Now I would not only have to change my clothes but look for a hospital bed. There was no bed anywhere, except the last place I tried had one after two hours of searching. Today everyone seemed to have a cold, it being winter, and God knows how many prescriptions I put out today.

I'm exhausted, all day I've been stressed and I never had so many letters to write. Yes, it was yet another late night but I enjoyed a long warm bath, while reading my *BMJ*. I hope tomorrow isn't the same.

Adrian Conner, *aged 11, is a general practitioner's son who attends Westcliff High School for Boys, Essex*

We welcome filler articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk.