3. 保健医療サービス

3.1 病院

2010年の病院数は1,632施設であり、国公立病院（軍・警察病院含む）794施設、私立病院838施設といずれも年々増加している。病床数も、2006年の138,451床（人口10万あたり62.3）から2010年は166,288（70.0）と増床している[2)]。

総合病院は国公立706施設（保健省管轄は506、うち高度な診療を行うAクラス病院は10）、私立593施設である。専門病院は333施設あり、主なものは母子関連病院107、産科病院65、精神病院51、ハンセン病院22、結核病院10、眼科病院13である[2)]。

また、国際基準を満たす病院（International Society for Quality in Health Care, ISQuaによる認定）を2014年までに5施設にすることが目標であり[12)]、現在は2施設である。

3.2 保健所

保健所は地域医療の中心であり、治療、分娩、予防活動等を行う。保健所における地域看護事業運営ガイドライン（2006）[13)]によると、保健所の業務を義務プログラムと発展的プログラムに整理し、発展的プログラムは各地方自治体で優先的なものを実施するとされている。義務プログラムは、保健の普及促進、環境保健、母子保健と家族計画、伝染病の予防と撲滅、栄養、治療（救急外来、通常の外来、入院）が指定されており、発展的プログラムに学校保健、地域看護、高齢者保健、伝統的治療指導、精神保健、職場保健、口腔保健、眼科保、スポーツ保健がある。

保健所は継続的に増設されており、2010年には全国に9,005施設（人口10万当たり3.79施設）ある。有床保健所2,920施設（全体の32.4%）とその割合も増加し、緊急産科ケアと新生児緊急ケアを提供できる保健所は1,579施設ある。医師（一施設当たり1.7名）、看護師（8.7名）、助産師（9.2名）等、いずれも配置される医療従事者数も増えている[2)]。

保健所へのアクセス改善のため、保健所支所、地域助産所/村保健ポストなどが整備されて機能を補完している。保健所の下部組織である保健所支所は医薬品供給も担っており、全国に23,049施設ある。

3.3 コミュニティー運営の保健施設

保健省はコミュニティーによる健康増進活動を奨励しており、村レベルで運営する保健施設として、村保健ポスト（Poskesdes）、地域助産所（Polindes）およびポシアンドゥの強化を推進している。

ポシアンドゥはインドネシア独自のシステムで、村レベルで運営される簡易保健施設又はその活動を意味する。月に1回、5つの優先課題（母子保健、家族計画、栄養発達、予防接種、下痢対策）に関する保健サービスを実施している。2010年には266,827ヶ所（村あたり3.6ヶ所）のポシアンドゥが活動している[2)]。

4. 保健人材

4.1 保健人材の育成

インドネシアの医療従事者の職種の多くは日本のような国家試験制度や免許制度はなく、大学や専門学校を卒業した時点で資格を取得する。2007年から医師国家試験を開始し、また看護師の国家試験制度を整備中である。

保健人材の不足を解消するために、保健省および地方政府、私立の教育機関（専門学校）が増設され、日本の高校卒業程度（Diploma III）の保健人材教育専門機関は2010年時点で1,229ヶ所（保健省管轄33ヶ所、その他986ヶ所）であり、うち看護師教育機関が709、続いて薬剤師151、技師84、作業療法士21と続く。上記公立・私立の専門学校の増設に伴い、2010年の卒業生は77,538名で、うち看護師が37,055名、次いで助産師、薬剤師、技師で全体で2006年から比較して83%増加している[2)]。

卒前教育の拡充とともに現任教育の整備の必要性も認識されている。特に看護師において、キャリア形成プログラムの欠如のみならず、地方政府の意思決定者のコミットメント、現場での責任者やその調整機構が不明確であること、医師不在の保健所での看護師に求められる実際の役割など、多くの要因が関与している[14)]。

4.2 医療従事者数

インドネシア全体の医療従事者数は、特に地方の保健省管轄以外の公的病院や私立病院に従事する人材の情報が完全でないことや、保健人材情報

管理に関する信頼できるシステムがないことから、保健人材全体を把握できておらず、正確なものはない。

保健人材開発委員会によると保健人材全体で501,052名、うち医療スタッフは391,745名（医師42,467、看護169,797、助産師96,551、薬剤18,022、公衆衛生34,869、技師17,216、栄養士12,823、作業療法士2,587）である[2)]。また公立施設に従事する数は医師33,736名、歯科医師8,731名、看護師160,074名、助産師96,551名、薬剤師6,264名（2009年）である[2)]。

表3は人口あたりの医療従事者数を日本、タイと比較したものである[5)]。

5. 医薬品供給

保健省および地方政府は、保健所等では原則的に無料で患者に医薬品を交付しているが、医薬品の予算は県により異なり多くは人口あたり年間10,000ルピア（約100円）以下である。そのため欠品で投薬が受けられない、一方で医薬品の適正使用が徹底されていないなど、医薬品の調達管理および適正使用に関して体制整備が必要である。保健省の調査によれば、必須医薬品の充足状況はおよそ15-50%程度であり、各州・県に医薬品調達・配布センターの設置を進めている。

国家医薬品食品監督庁（BPOM）及び地方事務所が医薬品全般にわたる規則や法令の施行や監督を行っている。BPOMの2010年の年報[15)]によると、市場の医薬品の1.04%がpHや剤型、含有量などで不適切と指摘されている。検査技術の向上や実施能力強化など、医薬品に関わる行政能力の向上が急務である。

6. 食品安全

BPOMが食品安全に関わる行政も担当している。インドネシアで食品の殺菌に広く用いられているホルマリンが食品に残存するなど食品の安全性に対する問題が指摘されている。BPOMの年報では、児童が学校に持参しているスナックの44%、市販の食品の17.3%に、基準以上の細菌、ホルマリンの残存、食品に使用されるべきでない色素の含有など安全性に何らかの問題があったと指摘している[15)]。食の安全を確保するための能力強化が課題である。

7. 社会保障

現在のインドネシアでは全国民を対象とした社会保障制度は整備されていない。業種毎に異なる組織が制度を運営し、各制度も保障内容がさまざまである。福祉サービスについては、児童、高齢者、障害者、貧困者等に対する支援策が個別に存在する。介護保険制度は存在しない。

しかし、昨年2011年10月に制定された「社会保障実施機関に関する」法律では、2014年1月1日から国民医療皆保険を実施するとされ、関係機関でその準備が進められている。これは社会保障制度全体を統一し、全国民を対象とした新たな制度を整備するため制定された「国会社会保障制度に関する2004年法律第40号」が基になっている。

インドネシアにおける健康保険制度は、労働者社会保障制度（JAMSOSTEK）、貧困者を対象とする社会健康保障制度（JAMKESMAS）、公務員医療給付制度（ASKES）、軍人及び警察向けの健康保険（ASABRI）などがある。

JAMKESMASは、一定の医療サービスが無償で受けられ、初期医療はプスケスマス及び関連施設（保健所支所、地域助産所、村保健ポスト等）、高

表3 人口当たりの医療従事者数（インドネシア、タイおよび日本との比較）
World Health Statistics 2011[5)] より抜粋

	インドネシア	タイ	日本
医師（人口1万対）	1	3	21
看護職（人口1万対）	8	14	95
歯科医師（人口1万対）	<0.5	1	7
薬剤師（人口1万対）	<0.5	1	19

度医療は1,020の病院で受診可能である。2010年時点で7640万人（全人口の約1/3）が加入している。

JAMSOSTEKは、労働者向けの総合的な社会保障制度であり、雇用主及び労働者が保険料を負担する。労災補償、老齢給付及び死亡給付は強制加入である一方健康保険は任意加入で、本制度より良い保障を会社が提供する場合には加入しなくてもよい。2009年には約20万の事業者、2900万人の労働者が加入しているが、任意加入の健康保険には約190万人の労働者（加入者の約6.4%）、家族を含めた被保険者としては約440万人しか加入していない。

直近の保健省の統計によれば図1に示すように加入率は増加しているが、それでも2011年6月の時点で全国民の約37%が保険制度に未加入である。加入している63%のうち、JAMSOSTEK 2%、JAMKESMAS 32.3%、JAMKESDA（地方政府による貧困者向け社会健康保障制度）13.5%、公務員向けの健康保険7.4%、民営の保険・その他7.7%）である[2)]。

今後、2014年1月に向け上記既存保険システムをいかに効率よく統合し、各国の教訓を活かしながらインドネシアの歴史や風土に合った国民皆保険制度を医療の質・アクセスの公正性・コストのバランスを鑑み醸成していくか、この壮大な国家プロジェクトは大変重要かつ今後も興味深く見ていく必要がある。

IV.　保健政策

1.　過去の保健政策の変遷

上原がまとめた資料によると[16)]、1970-94年の第1次25ヵ年計画の第1次5ヵ年計画（1970-74）では治療・予防・衛生を統合した保健医療サービスのネットワークを作り、重点疾患は感染症（天然痘・コレラ・性感染症）であった。次の5ヵ年計画（1975-79）には病院利用率が低いことからアクセスを確保するために保健所を増設し、第3次（1980-84）でその機能を高めて1,000ヶ所を有床にした。第4次（1985-89）では5つの取り組み＝持続的な地域保健活動、人材開発、食品医薬品管理、栄養・環境整備、保健医療法整備を行い、またこの時期にポシアンドゥが普及した。第5次（1990-94）では、「平等」「質」の確保が指摘され、保健分野（健康増進と予防）と医療（病院）とのリファラルシステム作りが重視された。また、村に助産師を配置する計画が実行に移された。必須医薬品の使用を優先課題とし、薬剤供給を安定化するために製造・普及を促進し、医薬品・食品・医療機器管理を強化するために品質基準、製造・流通の指針が作られた。

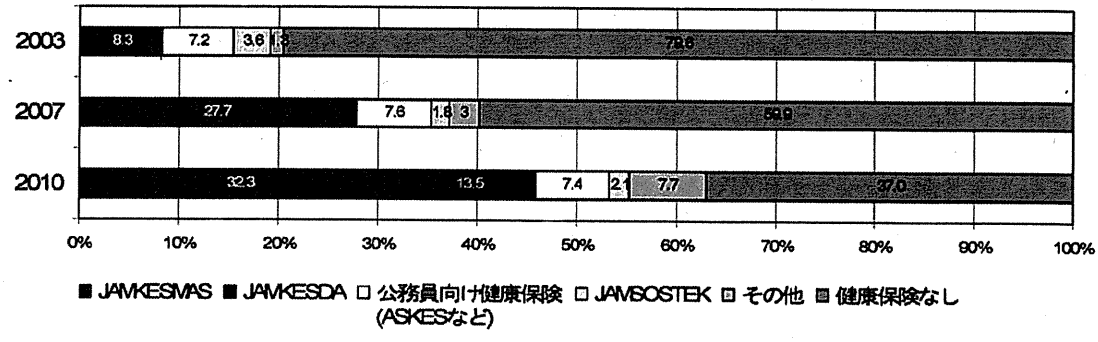
次の1995年からの第2次25ヵ年計画では、小さな家族、環境、栄養、疾病罹患率の低下、保健医療サービス、医療保険制度の充実を目標として掲げ、基本政策である保健医療サービスの「質」と「平等」の視点から「開発から取り残された村」に対する取り組みを行った。また、予算の一部が州・県の管理となり地方行政担当者の能力強化を行った。

2.　現在の保健政策

2.1　国家長期保健開発計画（RPJP-K）

現在のユドヨノ大統領が就任し、5つのアプローチ（政治・技術・参加・トップダウン・ボトムアップ）を掲げる国家長期開発計画（RPJP-N）の下で策定された国家長期保健開発計画（RPJP-K）

図1　インドネシアにおける健康保険加入率の変遷（2003年、2007年、2010年）



2005-25では、ビジョンを「Healthy Indonesia 2025」、ミッションを「保健を視野に入れた国家開発の促進」「健康に生きるコミュニティー」「質のよい保健」「保健財政の改善」としている[17]。

2.2 保健省戦略計画（RENSTRA DEPKES）2010-2014

インドネシアの保健政策は中央政府の5ヵ年開発計画（RPJM-N 2010-2014）に示され、それに応じてセクター戦略計画（RENSTRA）を作成し、実施指針としている。保健省戦略計画2010-2014[12]は保健省戦略計2005-2009の方針を継いで策定されている。自立した健康なコミュニティーと公平性をビジョンに、母子保健・家族計画、栄養状態改善、感染症・非感染症対策、保健人材の拡充、医薬品の安全性・調達・適正使用の促進、JAMKESMAS、コミュニティー・エンパワメント、保健サービスの改善の8項目を優先課題と位置づけている。

2.3 コミュニティーでの健康向上政策

国家長期保健開発計画（RPJP-K）や保健省戦略計画で述べられているように、中央政府および州政府は、コミュニティーを基本とした保健向上に力を入れている。MDGsの保健指標の達成を第一の課題と認識し、2006年から開始したDesa Siaga（Alert Village）プログラムでは、コミュニティー・エンパワメントを通じて地域保健の向上への取り組みを推進しようとした。各村で村助産師を配置し、保健ボランティアの確保・活用を推進し、コミュニティー運営の保健施設を強化するために、保健サービスのインフラを備えた村保健ポストを村で整備したが、中央から指示されたプログラムを必ずしも村で推進できず、村保健ポスト全国70,000を目標に対し2009年時点で51,996施設（村当たり0.69施設）[2]にとどまった。2010年には、達成目標をより具体的に示してプログラム効果の高まりを期待している。

2.4 2012年の課題

2012年の優先課題は、疾病予防と対策（特にNCD）、国民皆保険、妊産婦死亡の低下、栄養問題への対応、経済発展に伴う保健開発計画、早期対応のための情報技術の活用、などが提示されている[18]。

V. 結語

インドネシアの保健指標は政府およびパートナーの努力にもかかわらず依然改善が望まれる。多くの島で言語・文化・習慣の多様性を背景に、地方分権が有効に作用していないことや、行政・人材育成が効率的に行われていないことなどが原因として考えられる。インドネシアは疫学的かつ人口動態的な移行期にあり、感染症の負荷が大きく高い妊産婦死亡や栄養問題など発展途上国に典型的な保健問題が依然大きい一方で、成人病や事故など非感染症の増加への対応という二重疾病負担になっている。また、国民皆保険を目標としている現在、保険制度の拡充とともにその制度に対応できるだけの保健医療サービスの拡充も求められる。

現在のGDPの2%にすぎない保健予算を増額することが求められ、それとともに将来を見据えた保健医療サービスの拡充や人材育成を行っていく必要がある。

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[Information]

Health Situation of the Republic of Indonesia

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Abstract

Introduction

The economic situation of the Republic of Indonesia has been good with 6% economic growth in 2010. The health provision was affected by the decentralization after 2001, which has caused the prominent diversity in health condition. The health system and health situation in Indonesia are overviewed.

Health situation

The health indicators of Indonesia have been improving in general though maternal and child health (MCH) indicators are still not good enough compared to the surrounding ASEAN countries. The health budget has been increasing though up to 2% of GDP. The efforts by the Government have increased the number of health facilities as well as health workforce through it is yet to be improved. The Public Health Security Fund has extended its coverage with the target of universal health coverage. The health strategic plan 2010-2014 shows us the master plan of health development, whose vision is to encourage autonomous efforts by the community for health and the equity of health.

Conclusions

Indonesia is now on the epidemiological and populational transition with double burden of diseases. With the target of universal health coverage, it is urgent need to enhance the health service provision with development of health workforce in order to meet the demand along with enhancement of the health insurance coverage.

Keywords: Indonesia, Health Policy, Health System, Data collection, Health Indicators

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World Health Assembly Agendas and trends of international health issues for the last 43 years: Analysis of World Health Assembly Agendas between 1970 and 2012

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ABSTRACT

Objective: To analyse the trends and characteristics of international health issues through agenda items of the World Health Assembly (WHA) from 1970 to 2012.
Methods: Agendas in Committees A/B of the WHA were classified as Administrative or Technical and Health Matters. Agenda items of Health Matters were sorted into five categories by the WHO reform in the 65th WHA. The agenda items in each category and sub-category were counted.
Results: There were 1647 agenda items including 423 Health Matters, which were sorted into five categories: *communicable diseases* (107, 25.3%), *health systems* (81, 19.1%), *non-communicable diseases* (59, 13.9%), *preparedness surveillance and response* (58, 13.7%), and *health through the life course* (36, 8.5%). Among the sub-categories, HIV/AIDS, noncommunicable diseases in general, health for all, millennium development goals, influenza, and international health regulations, were discussed frequently and appeared associated with the public health milestones, but maternal and child health were discussed three times. The number of the agenda items differed for each Director-General's term of office.
Conclusions: The WHA agendas cover a variety of items, but not always reflect international health issues in terms of disease burden. The Member States of WHO should take their responsive roles in proposing more balanced agenda items.
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1. Introduction

The World Health Organization (WHO) has the objective of attaining the highest possible level of health for all [1]. The World Health Assembly (WHA) is attended by delegations from all 194 Member States in May each year, and functions as the supreme decision-making body of the WHO [2]. The main committees of the WHA are: Committee A – to deal predominantly with programme matters; and Committee B – to deal predominantly with administrative, financial, and legal matters [1]. Since the WHA determines the policies of the WHO and can influence the national policies of each member state, the WHA agenda have to be carefully selected to achieve the objective of the WHO.

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However, the WHA is not the only decision-making body of the WHO. The Executive Board has the responsibility to implement the decisions and policies of the Health Assembly and to act as its executive organ, but it also assumes the role of submitting advice or proposals to the assembly and preparing the agenda of its meetings according to the procedural rules of the WHA [1]. The Executive Board prepares the provisional agenda of each WHA session after considering the proposals submitted by the Director-General [1]. The agenda for the forthcoming WHA is agreed upon by the Executive Board and they adopt the resolutions to the forthcoming WHA in every January. The rules of procedure of the Executive Board say that the provisional agenda of each WHA session include any item proposed by a Member State or Associate Member of the WHO, and any item proposed by the Director-General [1]. The WHA has discussed a variety of health issues as "Technical and Health Matters" [3].

WHO has six regional offices for Africa, the Americans, South-East Asia, Europe, the Eastern Mediterranean, and the Western Pacific. Each Regional office holds a Regional Committees, which generally meets once a year [4]. The Regional Committees allow detailed discussions among Member States on specific needs, and they are considered platforms that can submit proposals to the Executive Board. They can tender advice, through the Director-General to the WHO on International Health Matters which have wider than regional significance [1].

In the history of international health, several landmarks are reflected in these WHA agendas. The typical ones are primary health care (PHC) at Alma-Ata in 1978, smallpox eradication in 1979, polio eradication launched in 1988, and the Framework Convention on Tobacco Control in 2004 [5]. Several articles have referred to the history and the policy of the WHO on international health issues [6–9]. However, there is no chronological analysis of the agenda items of the WHA from a long-term point of view. Also, there is no clear evidence and justification why certain agenda items were selected among the various important health issues in the world.

We assumed that the agenda items of the WHA would reflect trends and characteristics of international health. In this article, we will analyse the WHA agenda items between 1970 and 2012 from the viewpoints of chronological change, categories, and relationship with major health issues milestones such as the declaration of Alma-Ata and Millennium Development Goals (MDGs). This study will provide supportive evidence to set balanced WHA agenda items in the future.

2. Methods

We reviewed the agenda items in the WHA from 1970 to 2012. Two data sources were used: agenda items from 2004 (57th WHA) to 2012 (65th WHA) were extracted from the WHO internet site [10] and agenda items from 1970 (23rd WHA) to 2003 (56th WHA) were extracted from printed reports, namely the *World Health Assembly Summary Records of Committees*, published annually by the WHO (WHA23/1970/REC/3 to WHA56/2003/REC/3).

Agenda in the WHA consist of two areas: the Plenary and the Committees A and B. The Plenary decides on certain important items such as adoption of the agenda and allocation of items to the Committees A and B. Since the Plenary is not a place to discuss technical and health issues, agenda items in the Plenary were excluded in our analysis. Then each agenda item in Committees A and B was considered as data for analysis.

All agenda items in Committees A and B were labelled as Administrative Matters or Technical & Health Matters. We labelled the agenda items about financial, staffing, and legal matters, collaboration within the United Nations system, health conditions of the occupied Palestinian territory, and WHO organizational issues as Administrative Matters, regardless of whether they were in Committee A or B. Administrative Matters were analysed only quantitatively in this study. Other agenda items besides Administrative Matters were labelled as Technical & Health Matters. Then, we classified Technical & Health Matters into two groups: Health Matters and Progress Reports. Here, Progress Reports are follow-ups of the previous WHA agenda items, usually responding to the requests of previous resolutions adopted by the WHA in the past. We labelled other agenda items besides Progress Reports as Health Matters, which were discussed by the WHA as the important international health issues in that year.

For all Health Matters, categories and sub-categories were created in order to analyse Health Matters further. Categories and sub-categories are set out in Table 1. Categories were drawn from one of the 65th WHA agendas entitled "WHO reform" [11]. The five categories are (1) *communicable diseases*, (2) *noncommunicable diseases*, (3) *health through the life course*, (4) *health systems*, and (5) *preparedness, surveillance and response*. We added another category, (6) *others*, for agenda items which did not fit in these five categories. The sub-categories were developed with reference to the *Handbook of Resolutions and Decisions of the World Health Assembly and Executive Board, Volumes I, II, and III* [12–14], and also in light of the functions of the WHO according to its Constitution, Article 2 [1]. In this labelling system, the *health systems* category includes items related to health policies, such as PHC, health for all by 2000, and MDGs, since health systems are strongly connected to the health policies. The sub-category 'Strengthening health systems' was defined according to the concept provided by the WHO in the *Everybody's Business: Strengthening health systems to Improve Health Outcomes, WHO's Framework of Action* [15]. The *noncommunicable diseases* category consists of 10 subcategories. One of them that includes the agendas entitled "prevention and control of noncommunicable diseases" or similar titles, was named as "noncommunicable diseases in general" to avoid any confusion between category and subcategory. Health issue milestones in the each category were selected from several publications and web sites [16–19].

Each agenda item of Committees A and B from 1970 to 2012 was entered into Microsoft Excel. Then each item was classified under Health Matters, Administrative Matters, and Progress Reports. The number of Administrative Matters and Progress Reports were counted. The Health Matters were classified into the categories. A sub-category

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Table 1
Numbers and years of Health Matters by categories and sub-categories.

Categories of Health Matters	Sub-categories	No.	1970s	1980s	1990s	2000s	2010s
Communicable diseases (107/25.3%)	HIV/AIDS	14		86, 88, 89	92	00, 01, 02, 03, 04, 05, 06, 06, 06	11
	Tuberculosis	7		83		00, 05, 07, 09	10, 10
	Malaria	9	70, 75, 76, 78		97, 99	05, 07	11
	Smallpox	20	71, 72, 73, 76, 77, 78	80	96, 99	00, 01, 02, 03, 04, 05, 06, 07, 08	10, 11
	Polio	10			99	00, 02, 03, 04, 05, 06, 07, 08	12
	Neglected Tropical Diseases	23	76, 76, 77		94, 97, 97, 97, 98, 98	01, 02, 02, 02, 03, 03, 04, 04, 04, 07	10, 10, 11, 12
	Vaccination (EPI[a])	7	78			00, 02, 05, 08	11, 12
	Cholera	2	71				11
	Sexually transmitted infections	2	78			06	
	Disinsection of aircraft	2	70, 71				
	Others	11	70, 70, 76, 77, 78		98	01, 02	10, 10, 10
Noncommunicable diseases (59/13.9%)	Noncommunicable diseases in general	10			98	00, 07, 08	10, 11, 12, 12, 12, 12
	Cancer	6	73, 74, 75, 77	82		05	
	Mental health	5	77, 78	86		02	12
	Tobacco	10	70, 71	86	99	00, 01, 01, 03, 06, 08	
	Alcohol	6	79	83		05, 07, 08	10
	Road safety	2	76			04	
	Disability	8	72, 76	86		01, 03, 05, 06, 09	
	Policy/strategy of nutrition	4	77, 78			02, 04	
	Iodine deficiency	2		86	99		
	Others	6	76, 78			03, 06, 07	
Health through the life course (36/8.5%)	Infant and young child nutrition	12		80, 81, 82, 83		00, 01, 02, 02, 05, 06	10, 11
	Reproductive health	5	78		91	04, 08	12
	MCH[b] including newborn health	3	79		92	07	
	Birth defects	2	78				10
	Child and adolescent health	2				03, 06	
	Occupational health	4	71, 72, 76				07
	Ageing	2				02, 05	
	Others	6				04, 08	11, 11, 12, 12
Health systems (81/19.1%)	Primary health care	5	76, 76, 79			03, 09	
	Health for all by 2000	18	79	81, 81, 83, 84, 86, 86, 86, 86, 89	92, 95, 95, 96, 97, 97, 98		
	Millennium developmental goals	9				02, 03, 05, 08, 09	10, 11, 12, 12

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Table 1 (*Continued*)

Categories of Health Matters	Sub-categories	No.	1970s	1980s	1990s	2000s	2010s
	Strengthening health systems	32	70, 71, 72, 72, 75, 76, 78, 78, 78, 78, 78, 78	80		00, 01, 01, 02, 02, 03, 03, 04, 05, 05, 05, 06, 06, 07, 07, 07	10, 10, 11
	Rational use of drugs	3		86, 88		07	
	Policy/strategy of drugs	6	78		99	00, 01, 02, 03	
	Essential drugs	4	79	82, 84	92		
	Counterfeit medical products	4				08	10, 11, 12
Preparedness, surveillance and response (58/13.7%)	Influenza	10				03, 05, 06, 07, 07, 08, 09	10, 11, 12
	International health regulations	12	70	81	96, 99	03, 05, 07, 08, 09	10, 11, 12
	Surveillance	4	71, 73, 74, 77				
	Water	5	70, 71, 72	80			11
	Human environment	9	71, 72, 73, 74, 76, 78, 78, 79		92		
	Chemical management	2	79				10
	Climate change	2				08, 09	
	Nuclear issues	3			91, 93	01	
	Codex Alimentarius Commission	2				03, 06	
	Food safety	2				00	10
	Emergency	3				05, 06	12
	Others	4		87, 88	90	02	
Others (82/19.4%)	Health promotion	5				00, 01, 04, 06, 07	
	Psychosocial factors and health	2	75, 76				
	Dental health	2	75, 78				
	Intellectual property	7		82		03, 06, 07, 08, 09	10,
	Technical cooperation	4		81	90, 99	00	
	Development and coordination	3	77, 78				
	WHO's role and responsibilities	5	73, 74			06, 07	10,
	Others related research	3	73			05, 06	
	Quality/Safety of drugs	7	70, 71, 71, 72, 73		92	04	
	Narcotic and psychotropic substances	3	77	80, 86			
	Drug dependence	3	71, 72, 73				
	Cloning in human health	3			97, 99	00	
	Human organ and tissue transplantation	3		87		04	10
	Others related to drugs and biological products	15	70, 71, 72, 73, 75, 75, 76	84, 89		03, 04, 05, 05, 07	10
	Others related to social and environmental health	4	71			06, 09	12

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Table 1 (*Continued*)

Categories of Health Matters	Sub-categories	No.	1970s	1980s	1990s	2000s	2010s
International classification of diseases	2	76		90			
	World health situations	4	70, 72, 74, 76				
	World summit on sustainable development	2				02, 03	
	Others	5	74, 77			02, 07	12

Figure and percentage of each category show the number of agenda items for the category followed by it as a percentage of all agenda items for Health Matters. The numbers in the decades column are the last two digits of the year. Where the year is repeated, there was more than one agenda item that year.

[a] Expanded Programme on Immunization.

[b] Maternal and Child Health.

was created when there were at least two of the same agenda items within a category. Each Technical Matter item was classified in a relevant category and sub-category, then the number of agenda items in each category and sub-category was counted.

An agenda item covered by a single category was placed into the relevant category. In cases where an agenda item could apply to more than one category, we read the Report written by the Secretariat and related resolution of the agenda item, and decided on the most appropriate category for the agenda item. Therefore, no agenda item was placed in more than one category.

3. Results

3.1. Number of agenda items from Committees A & B by year from 1970 to 2012

There were 1647 agenda items in Committees A and B of the WHA from 1970 to 2012; they consisted of 605 Technical and Health Matters and 1042 Administrative Matters. Technical and Health Matters comprised 423 Health Matters and 182 Progress Reports.

3.2. Annual trends of numbers of agenda items in Committees A & B (1970–2012)

Fig. 1 shows the annual trends of numbers of agenda items in Committees A & B from 1970 to 2012, consisting of Administrative Matters, Health Matters, and Progress Reports. The average number of WHA agenda items per year was 38; the lowest number was 22 in 1984 and the highest was 67 in 2012. The trend of annual numbers of agenda items shows a gradual parabola whose lowest point was around 1984–1985. In most years until 1991, the number of Administrative Matters exceeded the number of Technical and Health Matters. However, after 1992, the proportion of Technical and Health Matters increased substantially.

3.3. Number of health matters by categories and sub-categories

As shown in Table 1, the numbers of Health Matters by categories and sub-categories are described as follows: 423 Health Matters were categorized into the categories: *communicable diseases* (107, 25.3%), *noncommunicable diseases* (59, 13.9%), *health through the life course* (36, 8.5%), *health systems* (81, 19.1%), *preparedness, surveillance and response* (58, 13.7%) and *others* (82, 19.4%).

In terms of characteristics of each category by decade from the 1970s to the 2010s, *communicable diseases*, *noncommunicable diseases* and *preparedness, surveillance and response* were mainly discussed in the 1970s, the 2000s and the 2010s. *Health systems* and *health through the life course* were continuously debated from the 1970s to the 2010s.

There were 11 sub-categories which were discussed over 10 times in the WHA between 1970 and 2012: strengthening health systems (32 times), neglected tropical diseases (23 times), smallpox (20 times), health for all by 2000 (18 times), HIV/AIDS (14 times), infant and young child nutrition (12 times), international health regulations (IHR) (12 times), polio (10 times), influenza (10 times), noncommunicable diseases in general (10 times) and tobacco (10 times). Among the sub-categories, noncommunicable diseases in general started being discussed eight out of 10 times after 2007.

3.4. Relationship between WHA agenda items and health issue milestones

To examine the relationship between WHA agenda items and health issue milestones, we analysed the number of agenda items and selected major health issues outside WHO (Fig. 2). Only the sub-categories of agenda items directly related to the health issue milestones were highlighted in Fig. 2. The other sub-categories shown in Table 1 were summarized as "others" in this figure. For the category of *communicable diseases*, the agenda item of smallpox was mainly discussed in the 1970s in order to eradicate the disease. This topic was then discussed after 1996 for destruction of variola virus stocks. The agenda of HIV/AIDS was started to be discussed from 1986 and frequently discussed after 2000. It corresponded with the period of accelerated response to HIV/AIDS such as UN Security Council discussed the effect of AIDS on peace and security in 2000 and the founding of the Global Fund to fight AIDS, Tuberculosis and Malaria in 2002. For the category of *noncommunicable diseases*, the sub-category of noncommunicable diseases in general was discussed in 1998 and

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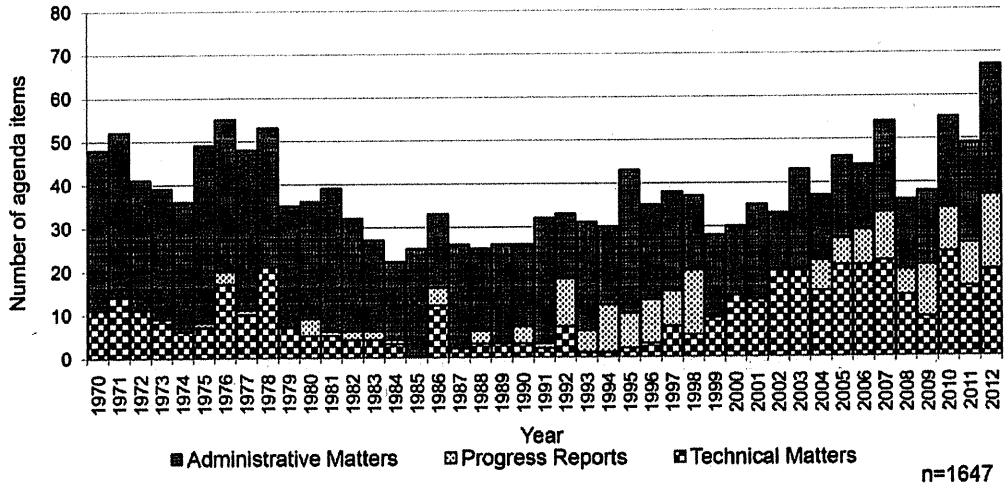

Fig. 1. Annual trends of numbers of agenda items in Committees A and B, 1970–2012.

2000 and frequently discussed after 2007. These discussions led to the United Nations General Assembly holding a High Level Meeting on the Prevention and Control of Noncommunicable Diseases. In the category of *health through the life course*, the agenda titled maternal and child health (MCH) including newborn health was discussed only three times in 1979, 1992 and 2007, even though there had been some important milestones such as the Safe motherhood initiative in 1987, International Conference on Population and Development (ICPD) in 1994, the Partnership for Maternal, Newborn and Child Health in 2005 (PMNCH) and UN MDG summit in 2010. For the category of *Health systems*, after the Alma-Ata Declaration in 1978, agenda items relating to health for all were discussed 18 times between 1979 and 1998. After 2000, the agenda items related to strengthening health systems and MDGs were discussed 19 and 9 times, respectively. The result indicated a shift in the major health issues from health for all based on PHC to strengthening health systems and MDGs after the UN Millennium Summit in 2000. After 2003, for the category of *preparedness, surveillance and response*, influenza and IHR were discussed 10 times and 8 times, respectively. It corresponded to Severe Acute Respiratory Syndrome (SARS) in 2003, the tsunami in the Indian Ocean in 2004, and Pandemic (H1N1) 2009.

3.5. Number of health matters & progress reports by Director-Generals' terms of office

Since the agendas for the WHA proposed by the Director-General are discussed by the Executive Boards, we examined the average numbers of Health Matters and Progress Reports by the term of office of Director-Generals (Table 2).

The average numbers of Health Matters per WHA were less than 10 during Mahler and Nakajima's terms of office, but they were over 15 during Brundtlant, Lee and Chan's terms of office. The average numbers of Progress Reports per WHA were 1.5 and 0 in Mahler and Brundtlant's terms of office, respectively. On the other hand, they were 7.3, 7, and 11 in Nakajima, Lee, and Chan's terms of office, respectively. These results indicated that there were different patterns of average numbers of Health Matters and Progress Reports in each Director-General's term of office.

4. Discussion

In this article, we reviewed and analysed the agenda items of the WHA from 1970 to 2012. We identified a number of trends and characteristics of international health which have been determined by the agenda items on health issues of the WHA. First, the number of Health Matters was low from the 1980s to the mid-1990s and that of Health Matters and Progress Reports varied for each Director-General's term of office. Second, among the five categories of the WHO reform, *communicable diseases* was the most discussed at 25.3%, followed by *health systems* at 19.1%, but *health through the life course* accounted for 8.5%, which was relatively small compared with the other categories. Third, among the sub-categories, HIV/AIDS, noncommunicable diseases in general, health for all, MDGs, influenza, and IHR discussed over nine times and appeared associated with the public health milestones, but MCH including newborn health was discussed only three times. Fourth, the sub-category of noncommunicable diseases in general increases after 2007.

A characteristic from the 1980s to the mid-1990s was the low numbers of Health Matters. This was during Mahler's second terms of office and Nakajima's first term of office. The period of low numbers of Health Matters corresponded with the period of a high number of agenda items for health for all in Fig. 2. Even when there were no Health Matters in the WHA in 1985, WHO documentation mentioned that Technical Discussions entitled Collaboration with Non-Governmental Organizations in Implementing the Global Strategy for health for all seemed to have taken place separately from the Agenda in the WHA (WHA38/1985/REC/2). Having many debates between selective and comprehensive PHC as well as considerable obstacles to progress towards health for all

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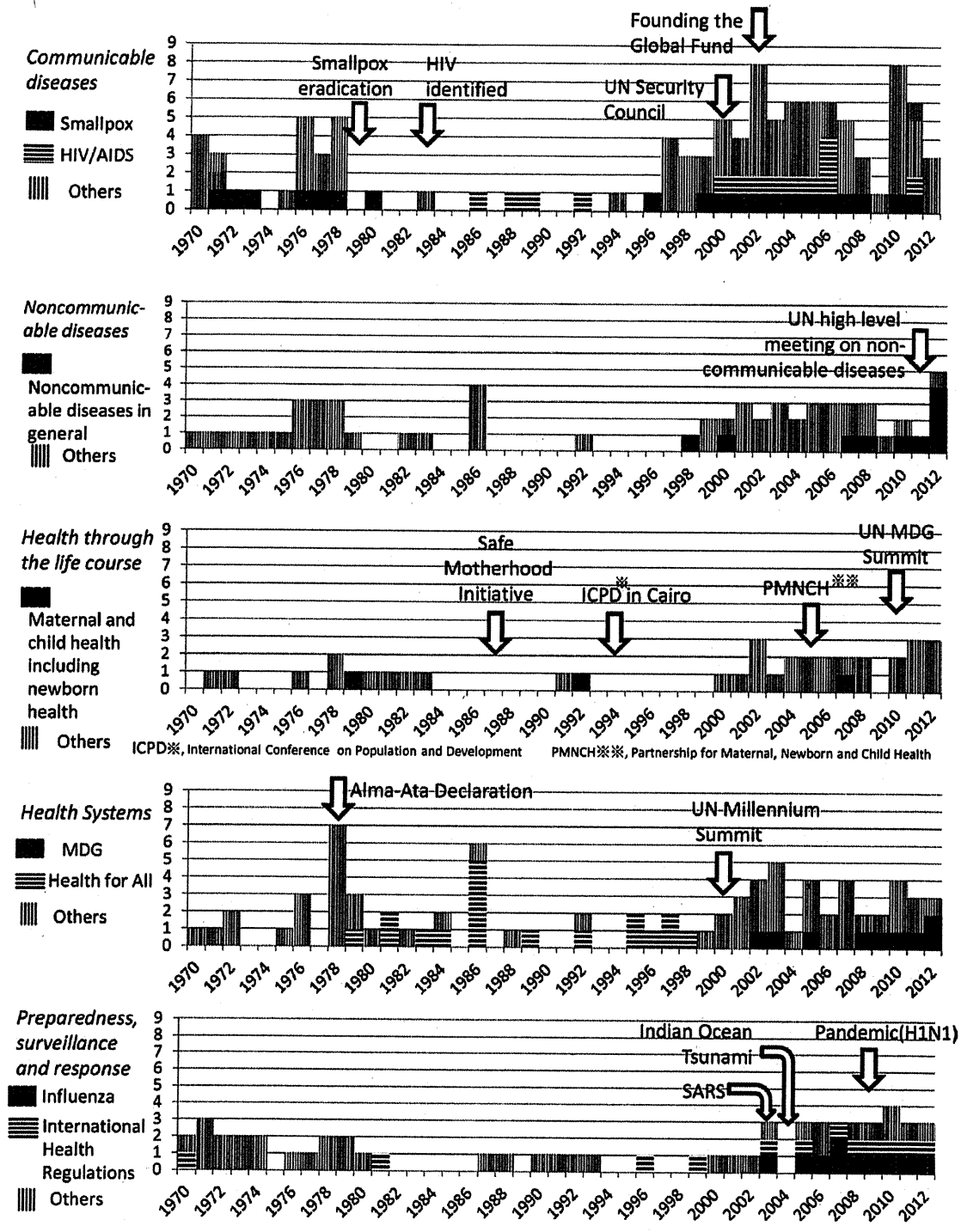

Fig. 2. The relationship between the health issue milestones and the trend of related sub-categories of the WHA agenda items.

[20–22], the WHA in 1995 stressed the continued validity of health for all as a timeless aspirational goal and agreed that a new global health policy should be elaborated [23]. Thus, the Alma-Ata Declaration provided the revolutionary principles of health throughout the world in 1978 [24], and WHA adopted the *Global Strategy for Health for All by the year 2000* in 1981 [25], which seemed to affect the number of WHA agenda items from the 1980s to mid-1990s. In short, the period from 1980 to the early 1990s can be summarized as a period of concentration on PHC.

A characteristic from the late 1990s to the early 2000s was the increasing number of Health Matters. This corresponded to Nakajima's second term of office and Brundtland's term of office. WHO published the World Health Report targeted on infectious diseases in 1996 [26]

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Table 2
Number of Health Matters and progress reports in each Director-General's terms of office between 1973 and 2012.

Names of Director-General	Term of office	Years of WHA[a]	No. of WHA	Total no. of Health Matters	Total no. of progress reports	Average no. of Health Matters per WHA	Average no. of progress reports per WHA
Mahler	1973–1988	1974–1988	15	106	22	7.1	1.5
1st term			5	61	5	12.2	1
2nd term			5	25	9	5	1.8
3rd term			5	20	8	4	1.6
Nakajima	1988–1998	1989–1998	10	34	73	3.4	7.3
1st term			5	16	21	3.2	4.2
2nd term			5	18	52	3.6	10.4
Brundtland	1998–2003	1999–2003	5	76	0	15.2	0
Lee	2003–2006	2004–2006	3	58	21	19.3	7
Chan	2006–	2007–2012	6	104	66	17.3	11
Total			39	378	182	9.7	4.7

[a] The WHA of the year of appointment of each Director-General was excluded.

and the number of agenda items for *Communicable diseases* started to increase from that year, as shown in Table 1. After 2000, strengthening health systems and MDGs were frequently discussed in the WHA, as shown in Table 1 and Fig. 2. These results indicate that the period between the late 1990s to the early 2000s was a turning point in terms of *Communicable diseases* and *Health systems*.

Both the total number and type of agenda have been expanding remarkably since the late 1990s. Since the first function of the WHA is to determine the policies of the WHO, it is critically important for the WHO and Member States to properly prioritize and effectively discuss the agenda items in the limited time given to the Assembly so that the WHO might be able to revitalize its ability in setting its own priorities although the 75% of its budget comes from voluntary contribution [27]: funds that donor countries often earmark for their own pet projects.

Health Matters in the WHA may not have covered all the major important health issues in the world. It is notable that the number of agenda items in the category of '*Health through the life course*' accounted for only 36 (8.5%) of the total of 423 Health Matters between 1970 and 2012. In this sub-category, the WHO has mainly focused on the breast milk issue, which led to the International Code on Marketing of Breast Milk Substitute (hereafter referred to as the Code) adopted in 1981. The objective of the Code was to restrict advertising of formula milk aiming to eliminate the negative impact on babies of formula milk, especially in the developing world. Within three years of its adoption, 130 countries had taken action by passing legislation or formulating policies to restrict advertising [28]. However, the formula milk industry continued to undermine the Code [29–31]. As Forsyth pointed out, it was not uncommon that a formula-milk company located in one country may violate the Code regulations in another country [32]. This must be a challenge for future WHA resolutions. Although MCH including newborn health is tremendously important [33,34], there were only three Health Matters related to MCH, including newborn health, in 1979, 1992 and 2007. It seems to be imbalanced agenda setting compared with the burdens of mortality and illness of infectious diseases and noncommunicable diseases [35–37].

To assess the possible imbalanced agenda setting, we apply the disability-adjusted life year (DALY) to the WHA agenda items, where appropriate, since DALY is a known metric to qualify the burden of disease, injuries and risk factors [38,39]. HIV/AIDS (DALY 3.8), tuberculosis (DALY 2.2), and malaria (DALY 2.2) are discussed 14 times, 7 times, and 9 times, respectively, in the WHA, which seems to be associated with DALY. On the other hand, maternal conditions (DALY 2.6), perinatal conditions (DALY 8.3), neuropsychiatric disorders (DALY 13.1), and road safety (DALY 2.7) have high burdens of disease and injuries, but were not frequently discussed at the WHA. Meanwhile, there are many agenda items which do not have DALY. The WHA also should not overlook other important health issues such as potable water, climate change, healthy ageing, occupational health, which are not frequently discussed, while appropriate measures are not available to assess the burdens of their risks.

On the other hand, the WHA brought important health issues to the global health arena such as noncommunicable diseases and the IHR. After the year 2007, the number of "noncommunicable diseases in general" as sub-category has increased mainly due to the agenda item named "Prevention and control of noncommunicable diseases". This ties up with the recent attentions on the diseases and leads to the United Nations High Level Meeting on the Prevention and Control of Noncommunicable Diseases [40]. It indicates that the WHA discussed the important agenda item which has great disease burden before any other major health organization may decide to do so. Regarding the IHR, WHA had frequently discussed and revised it as IHR (2005), which could respond timely the pandemic (H1N1) 2009 and health risks and emergencies [41,42].

The agenda items of WHA are mostly decided by the Executive Board in January, held four months before the WHA. In the process of agenda setting, not only does the Director-General draw up a draft of the provisional agenda, but Member States or Associate Members of the WHO are also allowed to propose a provisional agenda item [1]. In this sense, the agenda setting of the WHA is not confined. Therefore, Member States and Associate Members of the WHO are responsible for agenda setting to facilitate the attainment by all peoples the highest possible level of health.

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This article has several limitations. First, we considered the quantity rather than the quality of the WHA agenda items. Recognizing that the numbers of the agenda items do not directly reflect the weight of health issues, we selected a simple and clear way to compare the number of the agenda items in this analysis. Second, we did not focus on the resolutions, but on the agenda items of the WHA. Since a resolution was not always adopted from each agenda item, we decided to use the agenda items to analyse the trends and characteristics of international health issues. Third, we did not analyse WHO budgetary allocations relating to the WHA agenda items in this study. Stuckler et al. [43] noted that WHO biennial budget allocations from 1994–1995 to 2008–2009 were heavily skewed towards infectious diseases. Our data indicated that the WHA agenda items for the *Communicable diseases* from 1994 to 2009 accounted for 61 out of 196 Health Matters (31.1%). Further studies about the resolutions and budgetary allocations would be our future challenge. Finally, we utilized the five categories from the WHO reform in the 65th WHA. Since the new categories are created for the WHO's priority setting and programmes, each category in our study includes a limited number of health issues based on that priority [11]. Thus, 82 agenda items were classified into *others* in our analysis. However, we believe that our analysis will help to consider the WHO reform and which agenda items should be discussed in the future WHA.

5. Conclusions

In this article, we found a number of trends and characteristics of international health issues among agenda items through the WHA for 43 years. Among the five categories of the WHO reform, *communicable diseases* was the most discussed, followed by *health systems*, but *health through the life course* was relatively small compared with the other categories. Among the sub-categories, HIV/AIDS, noncommunicable diseases in general, health for all, MDGs, influenza, and IHR discussed frequently and appeared associated with the public health milestones. The fact that the number of noncommunicable diseases in general as subcategory increased after 2007 deserves attention. However, the agenda items of the WHA do not always reflect international health issues in terms of burdens of mortality and illness, such as MCH including newborn health. Most of the WHA agenda items are decided by the Executive Board meeting every January. Therefore, reflecting from the number and the trend of the WHA agenda items, Member States and Associate Members of WHO should take more respective and responsive roles in setting agenda items to attain the highest possible level of health for all.

Conflict of interest statement

None declared.

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