WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD
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Governing body matters

Report by the Chairman of the Executive Board

1. This report provides a summary of matters discussed at the retreat for members of the Executive Board (Hertenstein, Switzerland, 12 to 14 November 2000).

2. The retreat was made possible by the generous support of the Government of Switzerland. It was attended by 26 Executive Board members (Bangladesh, Belgium, Brazil, Cape Verde, Chad, Chile, China, Côte d'Ivoire, Equatorial Guinea, France, Guatemala, India, Iran, Italy, Japan, Jordan, Lao People's Democratic Republic, Lebanon, Lithuania, Qatar, Sweden, Switzerland, United States of America, Vanuatu, Venezuela and Yemen) and two alternate Board members (Democratic People's Republic of Korea and Russian Federation). The environment in Hertenstein was warm and friendly, encouraging open and cooperative interaction among participants.

3. The main issues discussed were:

- expectations of members on the role and functions of the Executive Board;
- *The world health report*, public health and its impact on civil society;
- scaling up action against diseases of poverty (massive effort);
- links between clinical medicine and public health.

FUNCTIONS OF THE EXECUTIVE BOARD

4. The Chairman presented a note on the functioning of the Board, with proposals for increasing the participation of members, namely

- establishment of a discussion forum on the WHO Internet site for communication between Board members (a virtual Executive Board);
- earlier involvement of members in the topics of the Board's agenda;
- establishment of a Director-General's question time during sessions of the Board;
- formalized process of initial guidance for new members.

5. Members broadly supported these proposals. They also felt that there should be more connection between the Board and the regional committees, and that the Board should exercise more fully its function of ensuring follow-up to resolutions and decisions of the Health Assembly. The period between January and May should be used to inform delegations to the Health Assembly about the matters considered by the Board and to assess any issues that might give rise to difficulties in the Assembly's deliberations.

6. Other reflections and ideas on future directions for the Executive Board were:

- the need to explore mechanisms for greater involvement of the Board in providing strategic directions and orientation for the work of WHO;
- the need to make the Executive Board more proactive rather than reactive;
- prioritizing of the Board's agenda so that adequate time is allowed to deal with sensitive or conflictive subjects;
- the need to assure that Health Assembly resolutions are action-oriented and able to be implemented;
- preparation of a handbook for new members, including case studies that clarify methods of work and ways of dealing with different issues.

ASSESSMENT OF HEALTH SYSTEMS PERFORMANCE

7. The approach to *The world health report 2000* was discussed at length. The consensus was that the report had helped to raise awareness of health systems worldwide; there was a call for the further involvement of Member States in data collection and in peer review of the methodology. Views were expressed on the frequency of assessment, either annually or every two to four years, and on using a band approach rather than numerical ranking.

8. It appeared that there is a conflict with countries that are not satisfied with the concepts used and methodology applied on account of insufficient data or quality of information. Some ministries were pursuing further clarifications and eventual modifications of the exercise. The case of Brazil, and the backing of ministries in the Region of the Americas seemed to be the most important of these.

9. Several additional points were made in the discussion:

- existence, quality and reliability of the information should be discussed and shared with countries and within regions;
- a formula for the index to express performance assessment should be accepted and shared by countries as an acceptable way to undertake evaluation;
- rankings are a conflictive way to assess performance; other options to reflect performance should be considered, such as bands, or groupings;
- pilot projects to apply the methodology in countries that provide all the necessary information should be considered;

- self-assessment by countries should be a way to evaluate performance, with a common and accepted methodology.

MASSIVE EFFORT AGAINST DISEASES OF POVERTY

10. Members of the Board were interested in more information about the genesis and evolution of the massive effort against diseases of poverty – a contribution to improving the health of poor people and promoting prosperity. The Director-General explained that the concept "massive effort" had been introduced in response to the increasing understanding that good health must be at the centre of economic development. Political will was high among the Group of 77 and other countries where the problems were greatest; political commitment for increased and sustained funding was growing in the Group of 8, the European Union and new "mega-foundations".

11. The main goals of this effort are:

- to reduce the impact, within poor communities, of high-mortality diseases linked to poverty – acute respiratory infections, AIDS, diarrhoeal diseases, malaria, measles, parasitic diseases, and tuberculosis – together with unsafe pregnancy;

- to make wider (and wiser) use of the vaccines, drugs and commodities available now;

- to provide incentives for delivery of health care to poor communities, rewarding good work;

- to stimulate research and development for better use of existing tools and development of new technologies.

It is intended to implement the effort, with government stewardship, through diversified health services (mix of government facilities, nongovernmental organizations, religious-based groups, private providers, employers, communities, and other proven means). Members considered this initiative very favourably and asked to be kept informed of developments and progress.

LINKS BETWEEN CLINICAL MEDICINE AND PUBLIC HEALTH

12. A paper on clinical medicine and public health prepared by the Chairman was discussed in one of the small groups. Members suggested that the paper should be annexed to the Chairman's report to the Board (see Annex to the present document). It was generally recognized that further work would be required to define the form and configuration of the proposed initiative. Some members suggested that a resolution should be prepared for implementation of an action plan.

ANNEX

CLINICAL MEDICINE AND PUBLIC HEALTH: IN SEARCH OF A RE-ENCOUNTER

1. In the past two centuries, the exercise of medicine and the practice of public health have evolved into two different facets of the same discipline. They have become independent professions – sometimes in competition. This document outlines a proposal for cooperative re-encounter.

2. Politicians and experts have, for long, promoted public health solutions for diseases related to poverty, arising, for instance from polluted environments, bad food, overcrowding and poor working conditions. The prime movers of conscience and solutions for these problems were clinicians, who, after learning about these correlates of disease through their patients, pressured governments and parliaments to enact laws, impose regulations and find resources for interventions.

3. Together with the important developments in science, and microbiology in particular, these links became firmly grounded on knowledge, forming a coherent basis of public health policy worldwide at the beginning of the twentieth century. After the Second World War, clinical medicine and public health began to follow independent paths; often, their activities were competitive if not conflictual. In academia, too, public health split off and became an independent subject. Its practitioners' reputations fared poorly, faced with the popular image of successful clinicians saving lives with modern technologies. Public health became the domain of bureaucrats and technocrats entrenched in ministries and international agencies. Ministries of public health, established in most countries in the early part of the twentieth century, have suffered low profiles and exerted little influence within most governments.

4. **Clinical medicine**, on the other hand, has increasingly embraced biology – cellular and molecular – and genetics. Recent biomedical and scientific advances have enabled clinicians to achieve breakthroughs, for example, with new drugs and high-tech surgical interventions such as transplants and gene therapy. Clinicians, secure in their hospitals with their focus on the outcome of individual cases, became isolated. Their very successes provoked a parallel increase in both costs and the public's expectations. Such prospects were not met for everybody, only for those who could pay, creating a frustration popularly expressed as "doing better and feeling worse".

5. In several countries, medical costs, having reached 10% to 14% of GNP, have become a macroeconomic problem. Initiatives to contain costs and allocate resources have started to be implemented everywhere, with financial caps, new methods of budgeting, and managed care, for example, becoming standard or forced solutions. Clinical medicine became entrapped in its own success; physicians' utopias began to crumble under these pressures.

THE PRIMARY CARE REVOLUTION AND THE WIDENING GAP

6. During the 1970s, WHO started its own revolution: primary health care was framed in the Global Strategy for Health for All by the 2000 and the Alma-Ata Declaration, which together expressed a democratization of health care. Barefoot doctors, traditional healers, and ancillary staff that worked with and within the communities were the actors in this new effort that was taking place in the poor and underserved populations. Yet the gap between public health and clinical medicine

became wide and deep; in many countries, public health, including primary care for the poor and basic sanitation, received no more than 20% of health expenditure – clinical medicine spent the lion's share.

7. High-level policy makers, beginning to react to this schism between public health and clinical medicine, proposed ways to bridge the gap. An example of a response aiming to give clinical researchers a broader view of health care in the developing world is the International Clinical Epidemiology Network, supported by the Rockefeller Foundation for more than 20 years. Another initiative is the Cochrane Collaboration for evidence-based medicine, started by Oxford University (United Kingdom) and McGill University (Canada). Defined as the "conscientious, explicit, and judicious use of current best evidence in making decisions about care of individual patients",[1] evidence-based medicine has been progressively establishing itself as a tool for rationalizing the use of resources which will lead to lower costs and an improvement in the ethical standards in this domain. Ethics, always fundamental to the exercise of the medical profession, has had and will have a crucial role in clinical advances, but also in public health, most particularly for resource allocation.

8. Quality assurance has also been a response to excesses in clinical practice and their negative consequences, with certain countries having established agencies devoted to its promotion. Other initiatives, such as "clinical governance", lead to improvement in quality, rational use of resources and medical excellence. Quality assurance is a valuable and interesting approach.

IN SEARCH OF A RE-ENCOUNTER

9. All this change in cultural behaviour is leading to a better understanding and collaboration between clinicians and public health officials. Both share the same goals and are being constrained by the same external conditions of scarcity and competition for resources. WHO's concern with the problems and diseases affecting the largest part of populations in the world means putting the emphasis on the majorities – the poor, the ill and the underserved. The priorities defined by WHO, including poverty-related diseases, control of tobacco use and the capacity and performance of health systems, signify a commitment to all, including those who live in high-income countries and are affected by common epidemics such as those of tobacco-related diseases, which cause a third of all deaths in the world today. So it may be argued that medicine and public health, reconciled, should advance together, sharing common methods and facing common problems. The challenge for the future is how to join forces to improve the efficacy of common efforts. Public health professionals must convince clinicians to join together in this undertaking and prove to the rest of the society that the two professions can work together for the good of all.

PROPOSAL

10. A project is proposed to promote the re-encounter of public health and clinical medicine, based on the following principles:

- clinicians should use epidemiological evidence and population-based health information in order to recognize the relevance of broader issues than individual well-being and apportion their efforts accordingly;

[1] D.L. Sackett et al. Evidence based medicine: what it is and what it isn't. *British Medical Journal* 1996, 312 (January 13), 71-72.

- priorities in clinical practice should be established on the basis of population-level information, and interventions should be designed and implemented according to their effectiveness and efficiency; and

- clinicians should clearly appreciate the economic implications of their decisions and be conscious of the managerial aspects of their performance.

11. *The world health report 2000 – Health systems: improving performance* has been important, with its proposals for a new paradigm for the analysis of health systems, taking into account users as well as providers, and making distinctions between personal and non-personal services, and the generation of resources, including physical and human resources, together with research and knowledge. This step forward will contribute greatly to the rapprochement of clinical medicine and public health.

12. The proposed project should aim:

- to make explicit to clinicians and the public health community the above principles and their interdependence;

- identify key actors and evaluate their knowledge of the issues and their willingness to participate in the project;

- propose activities that bring clinicians and public health professionals together at all levels; and

- elaborate operational guidelines for the project.

13. The outcomes should include:

- meetings for analysis and discussion;

- documents setting out goals, objectives and areas for collaboration;

- analyses of methods and tools needed to bring about the re-encounter between the two professions, such as quality assurance, clinical governance and evidence-based medicine; and

- higher levels of mutual appreciation and understanding.

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