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## *The world health report 2000*

### **Health systems: improving performance**

1. In the letter convening the Fifty-third World Health Assembly, Member States were informed of the Director-General's decision to publish *The world health report 2000* after the Health Assembly, in order to allow for its publication in all six official languages. The intention is to launch the report as close as possible to 19 June 2000. This date commemorates the opening of the International Health Conference in New York in 1946. The conference was a historic event which decided that the planned new specialized agency for health within the United Nations system would be known as the World Health Organization, and agreed on WHO's Constitution. The present document provides an overview of the report to assist delegations in their preparations for the Health Assembly.

#### **MESSAGE FROM THE DIRECTOR-GENERAL**

2. What makes for a good health system? What makes a health system fair? How do we know if a health system is performing as well as it could? These questions are the subject of public debate in most countries around the world. Answers will depend, naturally, on where the respondent stands. A minister of health defending the budget in parliament; a minister of finance attempting to balance multiple claims on the public purse; a harassed hospital superintendent under pressure to find more beds; a health centre doctor or nurse who has just run out of antibiotics; a news editor looking for a story; a mother seeking treatment for her sick two-year old; a pressure group lobbying for better services – all will have their views. We in the World Health Organization need to help all involved to reach a balanced judgement.

3. Whatever standard we apply, it is evident that health systems in some countries perform well, while others perform poorly. This is not due just to differences in income or expenditure: performance can vary markedly even in countries with similar levels of health spending. The way health systems are designed, managed and financed affects people's lives and livelihoods. The difference between a well-performing health system and one that is failing can be measured in terms of death, disability, impoverishment, humiliation, and despair.

4. When I became Director-General in 1998, one of my prime concerns was that development of health systems should become increasingly central to the work of WHO. I also took the view that although our work in this area must be consistent with the values of health for all, our recommendations should be based on evidence, rather than ideology. *The world health report 2000* is a product of those concerns; I hope it will be a landmark publication in the field of health systems development.

5. Improving the performance of health systems around the world is the *raison d'être* of this report. Our challenge is to gain a better understanding of the factors that make a difference. It has not

been as easy task. We have debated how a health system should be defined in order to expand our field of concern beyond the provision of public and personal health services to other key areas of public policy that have an impact on people's health. The report suggests that the boundaries of health systems should encompass all actions whose primary intent is to improve health.

6. The report breaks new ground in the way that it helps us to understand the goals of health systems. Clearly, their defining purpose is to improve and protect health – but they have other intrinsic goals. These are concerned with fairness in the way people pay for health care, and with how systems respond to people's expectations about how they will be treated. Where health and responsiveness are concerned, achieving a high average level is not good enough: the goals of a health system must also include reducing inequality in ways that improve the situation of those who are worst off. In the report, performance of health systems is measured against attainment of such goals.

7. If policy-makers are to act on measures of performance, they need a clear understanding of the key functions that health systems have to fulfil. The report defines four key functions: providing services; generating the human and physical resources that make service delivery possible; raising and pooling the resources used to pay for health care; and, most critically, the function of stewardship – setting and enforcing the rules of the game and providing strategic direction for all the different actors involved.

8. Many of the concepts and measures used in the report require further refinement and development. To date, our knowledge about health systems has been hampered by the weakness of routine information systems and insufficient attention to research. A major effort was needed to assemble data, collect new information, and carry out the required analysis and synthesis for the report, which also drew on the views of a large number of respondents, within and outside WHO, concerning the interpretation of data and the relative importance of different goals.

9. Although the report cannot provide definitive answers to every question about the performance of health systems, it does bring together the best evidence available to date. It demonstrates that, despite the complexity of the topic and the limitations of the data, it is possible to obtain a reasonable approximation of the current situation, in a way that provides an exciting agenda for future work. I hope that the report will contribute to work on how to assess and improve health systems. Performance assessment enables policy-makers, health providers and the population at large to see themselves in terms of the social arrangements they have constructed to improve health. It invites reflection on the forces that shape performance and the actions that can improve it.

10. For WHO, *The world health report 2000* is a milestone in a long-term process. The measurement of health system performance will be a regular feature of each report from now on – using improved and updated information and methods as they become available.

11. Even though we are at an early stage in understanding a complex set of interactions, some important conclusions emerge:

- Ultimate responsibility for the performance of a country's health system lies with government. The careful and responsible management of the well-being of the population – stewardship – is the very essence of good government. The health of people must always be a national priority; government responsibility for it is continuous and permanent.
- In terms of dollar for dollar spent on health, many countries are falling short of their performance potential. The result is a large number of preventable deaths and lives stunted by disability. The impact of this failure is borne disproportionately by the poor.

- Health systems are not just concerned with improving people's health, but also with protecting them against the financial costs of illness. The challenge facing governments in low-income countries is to reduce the regressive burden of out-of-pocket payment for health by expanding prepayment schemes, which spread financial risk and reduce the spectre of catastrophic health care expenditure.
- Within governments, many ministries of health focus on the public sector, often disregarding the – frequently much larger – private financing and provision of care. A growing challenge for governments is to harness the energies of the private and voluntary sectors to achieve better levels of health system performance, while overcoming the failures of private markets.
- Stewardship is ultimately concerned with oversight of the entire system, avoiding the short-term view, tunnel vision, or neglect of a system's failings. The report is meant to make that task easier by bringing new evidence into sharp focus.

12. I hope the report will help policy-makers to make wise choices. If they do so, substantial gains will be possible for all countries, and the poor will be the principal beneficiaries.

## OVERVIEW

13. Today and every day, the lives of vast numbers of people lie in the hands of health systems. From the safe delivery of a healthy baby to the care with dignity of the frail elderly, health systems have a vital and continuing responsibility to people throughout the life span. They are crucial to the healthy development of individuals, families and societies everywhere.

14. Although improving health is clearly the main objective of a health system, it is not the only one. *The world health report 2000*, devoted entirely to health systems, goes beyond its traditional professional interest in people's physical and mental well-being and takes a much wider view. To an unprecedented degree, it takes account of the roles people have as providers and consumers of health services, as financial contributors to health systems, as workers within them, and as citizens engaged in the responsible management, or stewardship, of them. It also looks at how well or how badly systems address inequalities, how they respond to people's expectations, and how much or how little they respect people's dignity, rights and freedoms.

15. The report also breaks new ground in presenting for the first time an index of national health system performance in trying to achieve three overall goals: **health improvement, responsiveness to the legitimate expectations of the population, and fairness of financial contribution**. Both the level and the distribution of these goals are important. Progress towards them depends crucially on how well systems carry out four vital functions: **service provision, resource generation, financing and stewardship**. The report devotes a chapter to each function, and reaches conclusions and makes policy recommendations on each. It lays special emphasis on stewardship, which has a profound influence on the other three.

16. Until now, many of the questions asked about health system performance have had no clear or simple answers – largely because there have been few reliable methods to measure performance. Building on a valuable body of previous work, the report introduces WHO's framework for the assessment of health system performance. This comprises a set of powerful new tools to help Member States measure their performance, understand the factors that contribute to it, improve it, and thereby respond better to the health requirements and expectations of the people they serve and represent. The

framework makes it possible to analyse and synthesize a wealth of information on health systems. It is summarized by a performance index which will trigger a great amount of exciting new work. The index will be a regular feature of forthcoming world health reports, and will be expanded, improved and updated every year.

17. The framework is of such potentially great value because policy-makers need to know why health systems perform in certain ways and what they can do to improve the situation. All health systems carry out certain functions – providing or delivering personal and nonpersonal health services; generating the necessary human and physical resources to make that possible; raising and pooling the revenues used to purchase services; and acting as the overall stewards of the resources, powers and expectations entrusted to them.

18. Comparing the way these functions are actually carried out provides a basis for understanding performance variations over time and among countries. Undoubtedly, many of the concepts and measures used in the report will require refinement; more and better data need to be generated on goal attainment and on health system functions. Yet much can be learned from existing information. The report presents the best available evidence to date. In doing so, it seeks to push forward national and global development of the skills and information required to build a solid body of evidence on the level and determinants of performance, as a basis for improving the way in which systems work.

19. “Improving performance” are therefore the key words and the *raison d’être* of the report. The overall mission of WHO is the attainment by all people of the highest possible level of health, with special emphasis on closing the gaps within and among countries. The Organization’s ability to fulfil this mission depends greatly on the effectiveness of Member States’ health systems. Strengthening those systems is one of WHO’s four strategic directions, interlinked with the other three: reducing the excess mortality of poor and marginalized populations; dealing effectively with the leading risk factors; and placing health at the centre of the broader development agenda.

20. Fighting against disease epidemics, striving to reduce infant mortality, and defending safer pregnancy are all WHO priorities. But the Organization will have little impact on these and other combats unless it is equally concerned to strengthen health systems through which life-saving and life-enhancing interventions are delivered to the front line.

21. The report asserts that the differing degrees of efficiency with which health systems organize and finance themselves, and react to the needs of their populations, explain much of the widening gap in death rates between the rich and poor, in countries and between countries, around the world. Even among countries with similar income levels, variations in health outcomes persist. In short, how health systems – and the estimated 35 million people they employ worldwide – perform makes a profound difference to the quality and value, as well as the length, of the lives of the billions of people they serve.

### **How health systems have evolved**

22. The report’s review of the evolution of modern health systems, and their various stages of reform, leaves little doubt that in general they have already contributed enormously to better health for most of the global population during the twentieth century. Today, health systems in all countries, rich and poor, play a bigger and more influential role in people’s lives than ever before. Health systems of some sort have existed for as long as people have tried to protect their health and treat diseases. Traditional practices, often integrated with spiritual counselling and providing both preventive and curative care, have existed for thousands of years and often coexist now with modern medicine.

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23. But 100 years ago, organized health systems in the modern sense barely existed. Few people alive then would ever visit a hospital. Most were born into large families and faced an infancy and childhood threatened by a host of potentially fatal diseases – measles, smallpox, malaria and poliomyelitis among them. Infant and child mortality rates were very high, as were maternal mortality rates. Life expectancy was short – even half a century ago it was a mere 48 years at birth. Birth itself invariably occurred at home, rarely with a physician present.

24. As a brief illustration of the contemporary role of health systems, one particular birth receives special attention in this report. Last year, United Nations experts calculated that the global population would reach six billion on 13 October 1999. On that day, in a maternity clinic in Sarajevo, a baby boy was designated as the sixth billionth person on the planet. He entered the world with a life expectancy of 73 years, the current Bosnian average. He was born in a big city hospital, staffed by well-trained midwives, nurses, doctors and technicians. They were supported by high-technology equipment, drugs and medicines. The hospital is part of a sophisticated health service, connected in turn to a wide network of people and actions that in one way or another are concerned with measuring, maintaining and improving his health for the rest of his life – as for the rest of the population. Together, all these interested parties, whether they provide services, finance them or set policies to administer them, make up a health system.

25. In the report, health systems are defined as comprising all the organizations, institutions and resources devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health.

26. Health systems have undergone overlapping generations of reforms in the past 100 years, including the founding of national health care systems and the extension of social insurance schemes. Later came the promotion of primary health care as a route to achieving affordable universal coverage – the goal of health for all. Despite its many virtues, a criticism of this route has been that it gave too little attention to people's **demand** for health care, and instead concentrated almost exclusively on their perceived **needs**. Systems have foundered when these two concepts did not match, because the supply of services offered could not be aligned with both.

27. In the past decade or so there has been a gradual shift of vision towards what WHO calls the "new universalism". Rather than all possible care for everyone, or only the simplest and most basic care for the poor, this means delivery to all of high-quality essential care, defined mostly by criteria of effectiveness, cost and social acceptability. It implies explicit choice of priorities among interventions, respecting the ethical principle that it may be necessary and efficient to ration services, but that it is inadmissible to exclude whole groups of the population. This shift has been due in part to the profound political and economic changes of the last 20 years or so, including the transformation from centrally planned to market-oriented economies, reduced State intervention in national economies, fewer government controls, and more decentralization.

28. Ideologically, this has meant greater emphasis on individual choice and responsibility. Politically, it has meant limiting promises and expectations about what governments should do. But at the same time people's expectations of health systems are greater than ever before. Almost every day another new drug or treatment, or a further advance in medicine and health technology, is announced. This pace of progress is matched only by the rate at which the population seeks its share of the benefits. The result is increasing demands and pressures on health systems – both their public and private sectors – in all countries, rich or poor. Clearly, limits exist on what governments can finance and on what services they can deliver. The report intends to stimulate public policies that acknowledge

these limits – recognizing that if services are to be provided for all, then not all services can be provided.

### **The potential to improve**

29. Within all systems there are countless highly skilled, dedicated people working at all levels to improve the health of their communities. As the new century begins, health systems have the power and the potential to achieve further extraordinary improvements. Unfortunately, health systems can also misuse their power and squander their potential. Poorly structured, badly managed, inefficiently organized and inadequately funded health systems can do more harm than good.

30. The report finds that many countries are falling far short of their potential, and that most of their efforts in terms of responsiveness and fairness of financial contribution are inadequate. There are serious shortcomings in the performance of one or more functions in virtually all countries.

31. These failings result in very large numbers of preventable deaths and disabilities in each country; in unnecessary suffering; in injustice, inequality and denial of basic rights of individuals. The impact is most severe on the poor, who are driven deeper into poverty by lack of financial protection against ill-health. In trying to buy health from their own pockets, they succeed sometimes only in lining those of others.

32. The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society in its stewardship. The careful and responsible management of the well-being of the population – stewardship – is the very essence of good government. For every country it means establishing the best and fairest health system possible. The health of people is always a national priority, and government responsibility for it is continuous and permanent. Ministries of health must therefore take on a large part of the stewardship of health systems.

33. Health policy and strategies need to cover the private provision of services and private financing, as well as State funding and activities. Only in this way can health systems as a whole be oriented towards achieving goals that are in the public interest. Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. At international level, stewardship means mobilizing the collective action of countries to generate global public goods such as research, while fostering a shared vision towards more equitable development across and within countries. It also means providing an evidence base that contributes to countries' efforts to improve the performance of their health systems.

34. The report finds, however, that some countries appear to have issued no national health policy statement in the past decade; in others, policy exists in the form of documents which gather dust and are never translated into action. Too often, health policy and strategic planning have envisaged unrealistic expansion of the publicly funded health care system, sometimes well in excess of national economic growth. Eventually, the policy and planning document is seen as unfeasible and is ignored.

35. A policy framework should recognize all three health system goals and identify strategies to improve the attainment of each. But not all countries have explicit policies on the overall beneficence and fairness of the health system. Public statements about the desired balance among health outcomes, system responsiveness and fairness in financial contribution are yet to be made in many countries. Policy should address the way in which the system's key functions are to be improved.

36. The report finds that, within governments, many health ministries are seriously short-sighted, focusing on the public sector and often disregarding the – frequently much larger – private provision of care. At worst, governments are capable of turning a blind eye to a “black market” in health, where widespread corruption, bribery, “moonlighting” and other illegal practices have flourished for years and are difficult to tackle successfully. Their vision does not extend far enough to help construct a healthier future. Moreover, some health ministries are prone to losing sight completely of their most important target: the population at large. Patients and consumers may only come into view when rising public dissatisfaction forces them to the ministry’s attention.

37. Many health ministries condone the evasion of regulations that they themselves have created or are supposed to implement in the public interest. Rules rarely enforced are invitations to abuse. A widespread example is the condoning of public employees charging illicit fees from patients and pocketing the proceeds, a practice known euphemistically as “informal charging”. Such corruption deters poor people from using services they need, making health financing even more unfair, and it distorts overall health priorities.

### **Providing better services**

38. Too many governments know far too little about what is happening in the provision of services to their people. In many countries, some, if not most, physicians work simultaneously for the government and in private practice. When public providers illegally use public facilities to provide special care to private patients, the public sector ends up subsidizing unofficial private practice. Health professionals are aware of practice-related laws but know that enforcement is weak or non-existent. Professional associations, nominally responsible for self-regulation, are too often ineffective.

39. Oversight and regulation of private sector providers and insurers must be placed high on national policy agendas. At the same time it is crucial to adopt incentives that are sensitive to performance. Good policy needs to differentiate between providers (public or private) who contribute to health goals and those who are detrimental, and to encourage or sanction appropriately. Policies to change the balance between providers’ autonomy and accountability need to be monitored closely in terms of their effect on health, responsiveness and distribution of the financing burden.

40. Where particular practices and procedures are known to be harmful, the health ministry has a clear responsibility to combat them with public information and legal measures. Pharmaceutical sales by unregistered sellers, and the dangers of excessive antibiotic prescription or noncompliance with recommended dosages, for example, should be objects of public stewardship, with active support from information campaigns targeted at patients, the providers in question and local health authorities.

41. Contrary to common misconceptions, the share of private health financing tends to be larger in countries where income levels are lower. But poorer countries seldom have clear lines of policy towards the private sector. They thus have major steps to take in recognizing and communicating with the different groups of private providers, the better to influence and regulate them. The private sector has the potential to play a positive role in improving the performance of the health system. But for this to happen, governments must fulfil the core public function of stewardship. Proper incentives and adequate information are two powerful tools to improve performance.

42. To move towards higher quality care, more and better information is commonly required on existing provision, on the interventions offered and on major constraints on service implementation. Local and national risk factors need to be understood. Information on numbers and types of providers is a basic – and often incompletely fulfilled – requirement. An understanding of provider market

structure and utilization patterns is also needed, so that policy-makers know why this array of provision exists, and where it is growing.

43. An explicit, public process of priority setting should be undertaken to identify the contents of a benefit package which should be available to all, and which should reflect local disease priorities and cost effectiveness, among other criteria. Supporting mechanisms – clinical protocols, registration, training, licensing and accreditation processes – need to be brought up to date and used. There is a need for a regulatory strategy which distinguishes between the components of the private sector and includes the promotion of self-regulation.

44. Consumers need to be better informed about what is good and bad for their health, why not all their expectations can be met, and what their rights are, which all providers should respect. Aligning organizational structures and incentives with the overall objectives of policy is a task for stewardship, not just for service providers.

45. Monitoring is needed to assess behavioural change associated with decentralizing authority over resources and services, and the effects of different types of contractual relationships with public and private providers. Striking a balance between tight control and the independence needed to motivate providers is a delicate task, for which local solutions must be found. Experimentation and adaptation will be necessary in most settings. A supporting process for exchanging information will be necessary to create a “virtual network” from a large set of semiautonomous providers.

### **Finding a better balance**

46. According to the report, serious imbalances exist in many countries in terms of human and physical resources, technology and pharmaceuticals. Many countries have too few qualified health personnel, others have too many. Health staff in many low-income nations are inadequately trained, poorly paid and work in obsolete facilities with chronic shortages of equipment. One result is a “brain drain” of talented, but demoralized professionals, who either go abroad or move into private practice. Here again, the poor are most affected.

47. Overall, governments have too little information on financial flows and the generation of human and material resources. To rectify this, national health accounts should be much more widely calculated and used. They provide the essential information needed to monitor the ratio of capital to recurrent expenditure, or of any one input to the total, and to observe trends. The accounts capture both foreign and domestic, public and private inputs, and usefully assemble data on physical quantities – such as the numbers of nurses, medical equipment, district hospitals – and their costs. The accounts in some form now exist in most countries, but they are often rudimentary and are not yet widely used as tools of stewardship. Data from the accounts allow the ministry of health to think critically about input purchases by all fundholders in the health system.

48. The concept of strategic purchasing, discussed in the report, applies not only to the purchase of health care services, but also to the purchase of health system inputs. Where inputs such as trained personnel, diagnostic equipment and vehicles are purchased with public funds, the ministry of health has a direct responsibility to ensure that value for money is obtained – not only in terms of good prices, but also in effective use of the items purchased.

49. Where health system inputs are purchased by other agencies (such as private insurers, providers, households or other public agencies) the ministry’s stewardship role consists of using its regulatory and persuasive influence to ensure that these purchases improve, rather than worsen, the efficiency of the input mix. The central ministry may have to decide on major capital decisions, such as tertiary



hospitals or medical schools. But regional and district health authorities should be entrusted with the larger number of lower-level purchasing decisions, using guidelines, criteria and procedures promoted by central government.

50. Ensuring a healthy balance between capital and recurrent spending in the health system requires analysis of trends in both public and private spending and a consideration of both domestic and foreign funds. A clear policy framework, incentives, regulation and public information need to be brought to bear on important capital decisions in the entire system to counter ad hoc decisions and political influence.

51. In terms of human resources, similar combinations of strategy have had some success in tackling the geographical imbalances common within countries. In general, the content of training needs to be reassessed in relation to workers' actual job content, and overall supply often needs to be adjusted to meet employment opportunities.

52. In some countries where the social return to medical training is negative, educational institutions are being considered for privatization or closure. Certainly, public subsidies for training institutions often need to be reconsidered in the light of strategic purchasing. Rebalancing the intake levels of different training facilities is often possible without closure, and might free resources which could be used to retrain in scarcer skills those health workers who are clearly surplus to requirements.

53. Major equipment purchases are an easy way for the health system to waste resources, when they are underused, yield little health gain, and use up staff time and recurrent budget. They are also difficult to control. All countries need access to information on technology assessment, though they do not necessarily need to produce it themselves. The stewardship role lies in ensuring that criteria for technology purchase in the public sector (which all countries need) are adhered to, and that the private sector does not receive incentives or public subsidies for its technology purchases unless these further the aim of national policy.

54. Providers frequently mobilize public support or subscriptions for technology purchase, and stewardship has to ensure that consumers understand why technology purchases have to be rationed like other services. Identifying the opportunity cost of additional technology in terms of other needed services may help the public case.

### **Protecting the poor**

55. In the world's poorest countries, most people, particularly the poor, have to pay for health care from their own pockets at the very time they are sick and most in need of it. They are less likely to be members of job-based prepayment schemes, and have less access than wealthier groups to subsidized services. The report presents convincing evidence that prepayment is the best form of revenue collection, whereas out-of-pocket payment for care tends to produce suboptimal performance. Evidence from many health systems shows that prepayment through insurance schemes leads to greater financing fairness. The main challenge in revenue collection is to expand prepayment, via a central role for public financing or mandatory insurance. In the case of revenue pooling, creating as wide a pool as possible is crucial to spreading financial risk for health care, thus reducing individual risk and the spectre of impoverishment from health expenditures.

56. Insurance systems entail combining of resources from individual contributors or sources in order to pool and to share risks across the population. Achieving greater fairness in financing is only achievable through risk pooling – that is, those who are healthy subsidize the care of those who are

sick, and those who are rich, the care of those who are poor. Strategies need to be designed for expansion of risk pooling so that progress can be made in such subsidies.

57. Raising the level of public finance for health is the most obvious route to increased prepayment. But the poorest countries raise less, in public revenue, as a percentage of national income than middle- and upper-income countries. Where there is no feasible organizational arrangement to boost prepayment levels, both donors and governments should explore ways of building enabling mechanisms for the development or consolidation of very large risk pools. Insurance schemes designed to expand membership among the poor would, moreover, be an attractive way to channel external assistance in health, alongside government revenue.

58. Many countries have employment-based insurance schemes which increase benefits for their privileged membership – mainly employees in the formal sector of the economy – rather than widen them for a larger pool. Low-income countries could encourage different forms of prepayment – job-based, community-based, or provider-based – as part of a preparatory process of consolidating small risk pools into larger ones. Governments need to promote community rating (i.e. each member of the community pays the same premium), a common benefit package and portability of benefits among insurance schemes. Public funds should pay for the inclusion of poor people in such schemes.

59. In middle-income countries the policy route to fair prepaid systems lies in strengthening the often substantial mandatory, income- and risk-based insurance schemes, again ensuring increased public funding to include the poor. Although most industrialized countries already have high levels of prepayment, some of these strategies are also relevant to them.

60. To ensure that prepaid finance obtains the best possible value for money, strategic purchasing needs to replace much of the traditional machinery linking budget holders to service providers. Budget holders will no longer be passive financial intermediaries. Strategic purchasing means ensuring a coherent set of incentives for providers, whether public or private, to encourage them to offer priority interventions efficiently. Selective contracting and the use of several payment mechanisms are needed to set incentives for better responsiveness and improved health outcomes.

61. In conclusion, the report sheds new light on what makes health systems behave in certain ways, and offers them directions to follow in pursuit of their goals. It should help policy-makers to weigh the many complex issues involved, examine their options, and make wise choices. If they do so, substantial gains will be possible for all countries; and the poor will be the principal beneficiaries.

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