World Health Organization

EXECUTIVE BOARD **EBSS/2/INF.DOC./10**
Special session on WHO reform **1 November 2011**
Agenda item 3.2

Programmatic priorities

Introductory remarks by the Director-General

Mr Chairman,

You have asked that Board members structure their discussion around the three chapters of the reform paper.

I would like to open the debate with a few comments about the first chapter you will discuss, on WHO programmes and priority setting. In my view, this is the hardest part of the reform process. This is the area where we need your guidance most.

As you are aware, your guidance on the five core areas of work will feed into preparation of the next General Programme of Work.

As you have made extremely clear, priority setting should be the force that drives all reforms. Reforms follow priority functions. Money follows agreed priorities.

The document proposes some flagship priorities which we believe reflect today's major health challenges. These are issues that need full WHO engagement.

These are issues where our reputation stands or falls depending on how nimble and capable we are in addressing these challenges or paving the path for others to do so.

In a nimble and responsive organization, flagship priorities shift with events and change over time. These are overarching priorities, and they are most definitely not exclusive.

We have included noncommunicable diseases in the list of suggested flagship priorities, as these diseases are now the biggest killers and causes of disability the world over. But these are by no means the only killers. WHO made much of its reputation fighting infectious diseases, bringing many to their knees.

Rest assured: we will never let down our guard. We know how quickly infectious diseases, even when apparently close to control, can take advantage of any opportunity to resurge with a vengeance.

The document[1] further develops the five core areas of work identified during the Health Assembly in May 2011. These areas designate broad WHO functions; broad areas where WHO is uniquely well-positioned to have an impact.

They are not specific priorities, but they do provide a framework for thinking about priorities and making wise decisions.

Here is the important point, the hard job. Within each broad area of work, WHO has unique strengths that make it fit to do some specific jobs, to take on some specific priorities. Other priorities are best left to others, whose strengths are complementary but demonstrate a clear comparative advantage.

In my view, when establishing priorities, we need to ask two questions. First, is WHO best positioned, properly mandated, to address a specific problem? And second, is WHO best qualified and best equipped to have a measurable impact on the problem?

As I said, this is not an easy job. The ability of WHO to take on a priority is strongly influenced by the way the Organization is financed and how it is governed and managed.

I agree with you entirely. Priorities must be driven by burning unmet health needs, and not by resources. Money follows priorities, and not the other way around.

Let me give an example. Think, for a minute, about the truly remarkable fact that nearly 7 million people in the developing world are now seeing their lives prolonged by antiretroviral therapy for HIV/AIDS. In late 2002, the figure was fewer than 200 000 people.

WHO does not purchase or distribute the medicines. This is not our job. But we definitely set the aspiration and established the priority, because it was the only right and moral option.

We produced the technical guidelines that made therapy in resource-constrained settings entirely feasible. We constantly revised and simplified these guidelines as challenges emerged and evidence evolved.

Together with others, we fought for affordable prices, which is part of the very definition of equitable access. The price of treatment regimens dropped from more than US$ 10 000 per year per patient to less than US$ 200 for the first-line regimen recommended by WHO in 2010.

This example illustrates how WHO exercises its convening power, its capacity to generate evidence, and the impact of its advice for health development. This is leadership.

And priority setting is a hard job for other reasons. Let me give another example, that of strengthening health systems.

As we have learned in pursuit of the Millennium Development Goals, abundant cash and ample commodities mean nothing in the absence of health services and human capacities within countries that can reach the poor.

[1] Document EBSS/2/2.

At the same time, development partners are impatient for measurable results. Capacity building takes time and is notoriously difficult to measure.

Many Member States have been succinct and straightforward in their advice on priorities. WHO priorities should match the pressing health needs of countries. But again we face a problem.

At present, some 85 countries, representing 65% of the world's population, do not have reliable cause-of-death statistics. This means that causes of death are neither known nor recorded, and investments in health programmes are left to base their strategies on crude and imprecise estimates.

These two examples illustrate why strengthening health systems and institutions must be a top core function for WHO.

Any thinking about WHO programmes and priorities needs to be grounded in the context of today's unique health challenges, recognizing the diversity of countries and regions.

The first decade of the 21st century delivered a series of commitments, opportunities, innovations, successes, setbacks, surprises, and new realities unprecedented in the recent history of public health.

Equally unprecedented was the vulnerability of health to new threats arising from the radically increased interdependence of nations and policy spheres.

In work on development, the Millennium Development Goals demonstrated the value of concentrating international efforts on a limited number of time-bound goals. That commitment stimulated a host of innovations, from new global health initiatives, funding mechanisms, and financial instruments to strategic public-private partnerships set up to develop new medicines, vaccines and diagnostics for diseases of the poor.

WHO and its Member States contributed to these innovations, including through the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.

These collective actions strengthened the value system of public health and added new principles of operational efficiency. Every child, regardless of its place of birth or the income status of its parents, deserves the best vaccines that science can offer.

Access to life-saving interventions should not be denied for any reason, including an inability to pay. People should not die for want of market incentives to develop new products for diseases of the poor.

Effective aid honours national priorities and capacities and aims for self-reliance. Health initiatives should be purpose-driven. Funding should be results-based. Improvements in health outcomes, especially for the poor, should be the greatest measure of success.

The rise of transnational threats to health sparked other forms of international health cooperation. In the second half of the decade, two legal instruments came into force. The WHO Framework Convention on Tobacco Control entered into force in 2005, followed two years later by entry into force of the revised International Health Regulations (2005).

Both instruments demonstrate the role of WHO in providing collective security against shared threats.

The 2011 report of the IHR Review Committee, set up to examine the functioning of the International Health Regulations, with particular reference to the 2009 influenza pandemic, makes yet another contribution to collective security against public health emergencies of international concern.

As the decade continued, progress towards the Millennium Development Goals, though somewhat slower than hoped, was readily apparent, leading many to conclude that increased investment in health development works.

Others were more sceptical. As global health initiatives proliferated and activities and demands intensified, some concluded that work on health development was losing much-needed coherence, focus, and integrity. Others wondered how well the increasingly crowded landscape of public health matched the genuine health priorities and capacity needs of developing countries.

Nearly everyone agreed that cash and commodities alone would not improve health outcomes in the absence of strong health care systems for service delivery, better information, adequate numbers of qualified staff, and strong regulatory capacity.

The forces that shaped the previous decade are powerful, nearly universal, and difficult to reverse.

The sweeping changes and challenges of the past ten years are almost certain to be the new reality that defines international health cooperation and its prospects for success.

It is within the context of these complex challenges that we seek your guidance on WHO programmes and priorities. Priority setting is our collective responsibility.

= = =