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Making a Difference

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MESSAGE FROM THE DIRECTOR-GENERAL

In May of this year, health ministers and leaders from around the world will gather in Geneva for the final World Health Assembly of the century. This year's *World health report – Making a difference* reviews the accomplishments and challenges in world health and highlights their implications for WHO's approach, priorities and work in the years to come.

The world enters the 21st century with hope but also with uncertainty. Remarkable gains in health, rapid economic growth and unprecedented scientific advance – all legacies of the 20th century – could lead us to a new era of human progress. But darker legacies bring uncertainty to this vision – and demand redoubled commitment. Regional conflicts have replaced the global wars of the first half of the 20th century as a source of continued misery. Deep poverty remains all too prevalent. The sustainability of a healthy environment is still unproved. The Universal Declaration of Human Rights – now half a century old – is only a tantalizing promise for far too many of our fellow humans. The HIV/AIDS epidemic continues unchecked in much of the world, and it warns us against complacency about other, still unknown, microbial threats.

We can make a difference. Those of us who commit our lives to improving health can help to make sure that hope will predominate over uncertainty in the century to come. Human health – and its influence on every aspect of life – is central to the larger picture.

With vision, commitment and successful leadership, this report argues, the world could end the first decade of the 21st century with notable accomplishments. Many of the world's poor people would no longer suffer today's burden of premature death and excessive disability, and poverty itself would thereby be much reduced. Healthy life expectancy would increase for all. Smoking and other risks to health would fade in significance. The financial burdens of medical needs would be more fairly shared, leaving no household without access to care or exposed to economic ruin as a result of health expenditure. And health systems would respond with greater compassion, quality and efficiency to the increasingly diverse demands they face. Progress in the 20th century points to the real opportunity for reaching these goals.



Dr Gro Harlem Brundtland

Opportunity entails responsibility. Working together we have the opportunity to transform lives now debilitated by disease and fear of economic ruin into lives filled with realistic hopes. I have pledged to place health at the core of the global development agenda. That is where it belongs. Wise investments in health can prove to be the most successful strategies to lead people out of poverty.

This report argues that improvements in health have contributed to spur human and economic development in the past – and that this will also prove true in the future.

I have always believed that you cannot make real changes in society unless the economic dimension of the issue is fully understood. I firmly believe that this is what took “the environment” from being a cause for the committed few to becoming a societal issue for the attention of major players. The scientific facts were gathered. The true costs of environmental degradation were analysed and enumerated in figures. Then, gradually, governments and parliaments started to vote incentives to change behavioural patterns among industry and consumers. There is still far to go in the field of environment and sustainable development, but the trend has been started.

A new trend may be set in motion as we see and understand the broader implications of poverty. For the World Health Organization this means real inspiration. We intend to collect, analyse and spread the evidence that investing in health is one major avenue towards poverty alleviation.

We must be realistic: there will be setbacks and difficulties. A greater collective effort will generate more demands on each of us individually and on the institutions we represent – national and international, public and private. Compressing the time required to accomplish major and tangible results is the task for leadership in the 21st century. This leadership must be technical. It must be political. And it must be moral.

PROGRESS AND CHALLENGES

An historic conference in Alma-Ata in 1978 established the goal of Health for All by the year 2000. It defined this goal as “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”. This report describes how the past few decades – the period following the Declaration of Alma-Ata – have witnessed revolutionary gains in life expectancy. These gains build on progress that began for some countries in the late 19th century. Among today's high income countries, life expectancy increased by 30 to 40 years in this century. Most of today's low and middle income countries have experienced even more dramatic gains, although remaining inequalities needlessly burden disadvantaged populations and prolong their poverty. Under WHO's leadership the world eradicated smallpox, one of the most devastating diseases of history, and today a substantial majority of the world's population faces relatively low risk from infectious diseases of any sort.

These health gains have transformed quality of life and created conditions favouring sustained fertility reductions and consequent demographic change. In many developing countries, for example, the total fertility rate – the expected number of children a woman will bear over her lifetime – declined from over six in the late 1950s to about three at present. These health and demographic changes have contributed directly to the global diffusion of rapid economic growth that, like the health revolution, constitutes an extraordinary accomplishment of the century now closing.

In an important sense, then, the world has made great progress towards better Health for All. Inspiration and guidance from Alma-Ata, with its major emphasis on the critical

role of primary health care, contributed in no small measure to the health revolution. Continued improvement in living standards has also played a role. More important, though, has probably been the generation and application of new knowledge about diseases and their control. These factors have yielded substantial success by any measure, but problems and challenges remain.

Some problems emerge from the reduction in mortality from infectious disease and accompanying declines in fertility: the very successes of the past few decades will, inexorably, generate a “demographic transition” from traditional societies where almost everyone is young to societies with rapidly increasing numbers of the middle-aged and elderly. With this transition a new set of diseases rises to prominence: cancers, heart disease, stroke and mental illness figure prominently among them. Available interventions against these diseases, including preventive ones, yield less decisive results than we have achieved for most infectious diseases. And their costs can be very high indeed.

Furthermore, as this report documents, over a billion people will enter the 21st century without having benefited from the health revolution: their lives remain short and scarred by disease. Many countries must deal with these disease problems of the poor while simultaneously responding to rapid growth in noncommunicable diseases: they face a double burden. Large numbers of other individuals, while not poor, fail to realize their full potential for better health because health systems allocate resources to interventions of low quality or of low efficacy related to cost. Increasing numbers of people forego or defer essential care or suffer huge financial burdens resulting from an unexpected need for expensive services. The continuing challenges to health ministries and to countries thus remain enormous. New problems constantly arise: witness the emergence of the HIV epidemic, the threat of resurgent malaria or the unexpected magnitude and consequences of the tobacco epidemic. Achieving better health for all is an ever-changing task. Success will make a major difference in the quality of life worldwide. And the difference for the poor will be not only in improving their quality of life but also, through increasing their productivity, in addressing one of the root causes of poverty.

Global leadership and advocacy for health remain critical missing ingredients in the formula for making a difference and conveying evidence to the highest level of government. We need to remind prime ministers and finance ministers that they are health ministers themselves and that investments in the health of the poor can enhance growth and reduce poverty. Leadership must motivate and guide the technical community to bring today’s powerful tools to bear on the challenges before us.

Let us review the challenges to be addressed in order to improve the world’s health.

- First and foremost, *there is a need to reduce greatly the burden of excess mortality and morbidity suffered by the poor.* The OECD’s Development Assistance Committee has established the target of halving the number of people living in absolute poverty by the year 2015. This goal is attainable, but it will require major shifts in the way that governments all over the world use their resources. It will mean focusing more on interventions that we know can achieve the greatest health gain possible within prevailing resource limits. It will mean giving renewed attention to diseases like tuberculosis, which disproportionately affect poor people, as well as malaria and HIV/AIDS, which we now recognize as major constraints to economic growth.

Women and children suffer poverty more than men: there is therefore a need for greater investment in reducing maternal mortality – and finding ways of improving maternal and childhood nutrition. Reducing the burden of excess mortality and mor-

bidity also means revitalizing and extending the coverage of immunization programmes – still one of the most powerful and cost-effective technologies at our disposal. The elimination of poliomyelitis in the Americas in the past decade, and great progress in control elsewhere, hold out the promise that polio will join smallpox as a disease known only to history.

The new focus on reducing the burden of disease suffered by poor people is not just a call to governments alone. To make real inroads into absolute poverty will mean harnessing the energies and resources of the private sector and civil society as well. We need to be clear about what the world should be aiming to achieve and the resources needed to achieve global goals. We believe there is a good case for negotiating realistic national and international targets as a means of mobilizing resources, concentrating international attention on the most important problems, and ensuring proper monitoring of progress and achievement.

- Second, *there is a need to counter potential threats to health* resulting from economic crises, unhealthy environments or risky behaviour. Tobacco addiction is one of the single most important threats. It is not just an issue for the north: over 80% of all smokers today live in developing countries. A global commitment to tobacco control can potentially avert scores of millions of premature deaths in the next half century, and its success can point the way for effective control of other threats.

Preparing effective responses to emerging infections and countering the spread of resistance to antimicrobials will help insure against the prospect of a significantly increased infectious disease threat. Beyond countering specific threats, promotion of healthy lifestyles underpins a proactive strategy for risk reduction: cleaner air and water, adequate sanitation, healthy diets and safer transportation – all are important. And all are facilitated by stable economic growth and by ensuring that females as well as males have opportunities to increase their educational attainment.

- Third, *there is a need to develop more effective health systems*. In many parts of the world, health systems are ill-equipped to cope with present demands, let alone those they will face in the future. The institutional problems which limit health sector performance are often common to all public services in a country. But, despite their importance, they have been relatively neglected by governments and development agencies alike.

We now recognize that dealing with issues such as pay and incentives in the public sector, priority setting and rationing, and unregulated growth in the private sector constitute some of the most challenging items on the international health agenda.

The report's chapter on health systems development points to change taking place in all parts of the world – change that responds to different problems in different ways. The pressure for change provides the opportunity for reform. But reform requires a sense of direction. In my view, the broad goal of better health for all should guide reform. Beyond this, however, there is a need to be clear about the desirable characteristics of health systems. The goal must be to create health systems that can:

- improve health status;
- reduce health inequalities;
- enhance responsiveness to legitimate expectations;
- increase efficiency;
- protect individuals, families and communities from financial loss;
- enhance fairness in the financing and delivery of health care.

Limits exist on what governments can finance and on their capacity to deliver services and to regulate the private sector. Hence the need for public policies that recognize these limits. Governments should retain responsibility for setting broad policy directions, for creating an appropriate regulatory environment, and for finance. At the same time they should seek both to diversify the sources of service provision and to select interventions that, for the resources each country chooses to commit, will provide the maximum gains in health levels and their most equitable distribution. At an international level we need, collectively, to improve our capacity for humanitarian assistance and for responding to complex emergencies, when national health systems cannot cope.

- Finally, *there is a need to invest in expanding the knowledge base* that made the 20th century revolution in health possible, and that will provide the tools for continued gains in the 21st century. Governments of high income countries and large, research-oriented pharmaceutical companies now invest – and will continue to invest – massive resources in research and development oriented to the needs of the more affluent.

Much of this investment benefits all humanity, but at least two critical gaps remain. One concerns research and development relevant to the infectious diseases that overwhelmingly afflict the poor. The other concerns the systematic generation of an information base that countries can use in shaping the future of their own health systems.

A CORPORATE STRATEGY FOR WHO

The challenges outlined above constitute an agenda for the world community as a whole: for governments and development agencies alike. Even as the lead agency in health, we have to recognize that the agenda is too broad for WHO alone. We therefore have to be realistic, and start to define how WHO can contribute most effectively to this agenda in coming years.

We intend that four interconnected strategic themes should guide the work of the whole Organization. The first two concern *where* we focus our efforts. The second two concern *how* we work. These are the themes that must guide our work:

- we need to be more focused in improving health outcomes;
- we need to be more effective in supporting health systems development;
- we need to be more impact-oriented in our work with countries;
- we need to be more innovative in creating influential partnerships.

IMPROVING HEALTH OUTCOMES

This theme runs through everything we do. Our first priority must be to reduce – then eliminate – the debilitating excess burden of disease among the poor. I am particularly concerned that we focus on health interventions that will help lead populations out of poverty. Let me highlight some key priorities as they are defined in the *Proposed Budget 2000-2001*.

- We are committed to reducing the burden of sickness and suffering resulting from communicable diseases. Roll Back Malaria is central to this approach. But we will also contribute as effectively as possible to combating the global epidemics of HIV/AIDS and tuberculosis, and to completing the eradication of poliomyelitis.
- We need to step up our ability to deal with the rising toll of noncommunicable diseases. Special attention will be given to cancer and cardiovascular diseases. The Tobacco Free

Initiative is supporting and leading this approach.

- We will pay more attention to the delivery of high quality health care for children, adolescents and women.
- WHO is committed to making progress on the issues of population and reproductive health – with a special focus on maternal mortality and adolescent sexual and reproductive health.
- We will put the spotlight back on immunization as one of the most cost-effective health interventions.
- We need to intensify our efforts to reduce the enormous burden of malnutrition, especially in children.
- We will continue to support countries in their quest for access to affordable and high quality essential drugs.
- We will work to see that mental health – and particularly the neglected scourge of depression – is given the attention it deserves.
- We need to be better at responding to increasingly diverse kinds of emergencies and humanitarian crises.
- We will develop our capacity within WHO – and in collaboration with others – to give advice on crucial health care financing issues.
- And we need to be able to deal more effectively with intersectoral issues – particularly the threats to health that result from environmental causes.

Let me focus on two of our key initiatives: Roll Back Malaria and the Tobacco Free Initiative. *The world health report 1999* devotes a chapter to each of these.

Malaria and underdevelopment are closely intertwined. Over 40% of the world's population live where there is a risk of malaria. The disease causes widespread premature death and suffering, imposes financial hardship on poor households, and holds back economic growth and improvements in living standards. Malaria flourishes in situations of social and environmental crisis, weak health systems and disadvantaged communities.

Its ability to develop resistance makes malaria a formidable adversary. Available and effective interventions – such as insecticide-treated bednets – fail to reach the people with the greatest burden of malaria. Capacity for malaria control is inadequate in endemic countries, where health systems are often weak. Better implementation of current knowledge, and new products and technologies are all needed to break down the barrier to human progress which malaria poses. Overcoming these problems is a challenge for leadership, a challenge to be met by the Roll Back Malaria project.

Successful malaria control involves strengthening health systems. Weak health systems and uninvolved communities are part of the malaria problem. Because malaria is an acute condition with a rapid natural history, easy access to health care of good quality is vital in its management. Externally driven initiatives, by-passing local and national health systems, are neither sustainable nor supportive of malaria control and health development. Many countries have begun the process of reforming their health system to improve performance. Malaria control, like the better management of all illnesses, needs to build on and support these changes. Through strengthened health systems, total malaria deaths could be halved – 500 000 deaths could be averted annually – for about US\$1 billion per year of additional spending.

A new willingness to collaborate has been demonstrated. The Organization of African Unity, the World Bank and WHO's African Region have already planned a major African Initiative on Malaria which is expected to spearhead Roll Back Malaria in Africa. Roll Back

Malaria differs from previous efforts to fight malaria. It will work to create new tools for controlling malaria, and by strengthening health systems for sustainable health improvement. Roll Back Malaria will also act as a pathfinder, helping to set the direction and strategy for more integrated action in other priority areas, such as tuberculosis control and safe motherhood. Greater reliance on partnerships in fighting malaria will inform WHO's approach to other major health challenges and to the development of effective coordinated multipartner action.

Momentum for action against malaria has been increasing fast. Strong political support has come from the Organization of African Unity and the G8 group of the most industrialized countries. Four international agencies with major concerns about malaria and its effects on health and the economy – UNICEF, the United Nations Development Programme, the World Bank and the World Health Organization – agreed, at a meeting of agency heads in October 1998, jointly to support Roll Back Malaria with WHO leadership.

Let me now turn to the Tobacco Free Initiative. The tobacco epidemic claims a large and rapidly growing number of premature deaths every year. Our estimates suggest that in 1998 the world suffered about 4 million tobacco-related deaths; to put this slightly differently, about one in twelve adult deaths in 1990 resulted from tobacco use and, by 2020, tobacco will cause as many as one in seven. Perhaps 70% of these will be in the developing world. Millions more suffer from disabling lung or heart disease, impotence or impaired pregnancies.

This tobacco toll is now growing most rapidly in developing countries. Can the momentum of the epidemic be slowed? Have government policies been able to counter the marketing strength of the industry and the addictive powers of nicotine? The record here is clear: effective control strategies exist and governments that have adopted them have succeeded in reducing tobacco use. The challenge is to transform ongoing successes into far more comprehensive global efforts.

At the same time that it is saving lives, tobacco control will also save money. Resources committed to tobacco production will be freed, but as this is at best a gradual process today's producers will suffer few transition costs. Consumer "benefits" from tobacco use accrue substantially to addiction – addiction acquired for most smokers while they were children or young teenagers. A recent and comprehensive World Bank review concludes unequivocally that tobacco control results in net economic as well as health benefits.

What lessons have we learned concerning the design of effective anti-tobacco strategies? This report concludes that effective action rests on four principles of control:

- providing public health information through media and schools, and banning tobacco advertising and promotion;
- using taxes and regulations to reduce consumption;
- encouraging cessation of tobacco use in part by encouraging less harmful and less expensive ways of delivering controlled and diminishing quantities of nicotine;
- building anti-tobacco coalitions and defusing opposition to control measures.

These measures cost relatively little and, through tobacco taxes, can more than finance themselves. Each contributes to the control agenda, and typically each would be included in national control strategies.

Yet how best to design the implementation of these measures in a national or local context is still a puzzle; how to counter the opposition of the multinational tobacco industry remains a constant challenge; and how to tap the global moral, intellectual and political commitment to tobacco control for advancing a national agenda is often an unanswered

question. No central point has existed for accumulating the experience of what does and does not work – or for mobilizing political, legal and financial resources to assist governments or elements of civil society that are committed to tobacco control. It was to fill these gaps – to provide the requisite leadership – that we launched the global Tobacco Free Initiative on 21 July 1998. A major milestone for the initiative will be the adoption of a “Framework Convention on Tobacco Control” by 2003, and initial efforts towards this are well under way.

SUPPORTING HEALTH SECTOR DEVELOPMENT

WHO has always been strong at responding to specific requests. The Organization is good at fielding highly qualified technical experts. But often individual experts tend to see the world through their own expert lenses. WHO has, however, been less good at helping senior decision-makers deal with the big picture.

We know that senior policy-makers in ministries of health do not have the luxury of focusing on single issues. Health is one of the most politically and institutionally difficult sectors in any country. If WHO is to earn a leadership role in health, we cannot deny the responsibility of helping our colleagues to deal with complexity.

In many countries, national governments have tended to look to other agencies for advice on issues that affect the sector as a whole. WHO has to be a more reliable and effective supporter of countries as they reform and restructure their health sectors. We also have to be clear that reform is not an end in itself. It is a way of making sure that people – particularly poor people – get a better deal from their health system.

Many determinants of better health lie outside the health system altogether: they lie in better education (and in ensuring that girls have the same educational opportunities as boys). They lie in cleaner environments, and in sustained reductions in poverty. We must understand these linkages. One path to better health for all is for those of us within the health sector to serve as active and informed advocates of health-friendly policies outside the sector.

The second path is through reform of health systems themselves. Reform today, in much of the world, will take place in a context of increased reliance on the market forces which have increased productivity in many sectors of the world economy. But markets have failed to achieve similar success in health services or health insurance. At the same time, many of the new products critical to improving health originate in the private sector. Active government involvement in providing universal health care has contributed to the great gains of recent years – but many governments have overextended themselves. Efforts to provide all services to all people have led to arbitrary rationing, inequities, nonresponsiveness and inadequate finance for essential services.

Where, then, do the values of WHO lead when combined with the available evidence? *They cannot lead to a form of public intervention that has governments attempting to provide and finance everything for everybody.* This “classical” universalism, although seldom advanced in extreme form, shaped the formation of many well-established health systems. It achieved important successes. But the old universalism fails to recognize both resource limits and the limits of government.

Our values cannot support market-oriented approaches that ration health services to those with the ability to pay. Not only do market-oriented approaches lead to intolerable inequity with respect to a fundamental human right, but growing bodies of theory and evidence indicate markets in health to be inefficient as well. Market mechanisms have enormous utility in many sectors and have underpinned rapid economic growth for over a century in

Europe and elsewhere. But the very countries that have relied heavily on market mechanisms to achieve the high incomes they enjoy today are the same countries that rely most heavily on governments to finance health services.

With the exception of only the United States, the high income market-oriented democracies mandate universal coverage. Their health outcomes are very high. They have contained expenditures to a much smaller fraction of GDP than has the USA (7–10% versus 14%). In the one country where it was studied – Canada – introduction of National Health Insurance resulted in increased wages, reduced unemployment and improved health outcomes. Therein lies a lesson.

This report advocates a “new universalism” that recognizes governments’ limits but retains government responsibility for leadership, regulation and finance of health systems. The new universalism welcomes diversity and, subject to appropriate guidelines, competition in the provision of services. At the same time it recognizes that if services are to be provided for all then not all services can be provided. The most cost-effective services should be provided first. The new universalism welcomes private sector involvement in supplying service providers with drugs and equipment, and encourages increased public and private investment in generating the new drugs, equipment and vaccines that will underpin long-term improvements in health. But it entrusts the public sector with the fundamental responsibility of ensuring solidarity in financing health care for all. It further calls for a strategic reorientation of ministries of health towards stewardship of the entire system through participatory, fair and efficient regulation.

Countries approach WHO with concerns about health finance broadly defined, more than on any other question. Our thinking in this area generally reflects this new universalism. We are rapidly building internal capacity to learn about health finance and to respond more effectively to questions concerning it.

Regaining our place at the centre of the health sector development agenda is a challenge for the whole of WHO; it is one reason why I have launched a project under the title of Partnerships for Health Sector Development. The project will be working to advance our strategic agenda on several fronts. It will work throughout the Organization to establish a health sector development perspective in all aspects of our work. It will also be concerned to help to develop a more strategic approach to work with countries. In addition, the project will have a role in establishing more influential partnerships.

A MORE STRATEGIC APPROACH TO OUR WORK IN AND WITH COUNTRIES

The financial resources for health lie overwhelmingly *within* countries. Responsibility for success (or failure) thus lies ultimately with governments. Only a tiny fraction of resources for health in low and middle income countries originates in the international system – development banks, bilateral development assistance agencies, international nongovernmental organizations, foundations and WHO. Health spending in low and middle income countries in 1994 totalled about \$250 billion, of which only \$2 or 3 billion was from development assistance. We also need to recognize that WHO is not a donor agency. Its prime resources are knowledge and people. In thinking about our relationships with Member States, we need to think not just about what we spend but about what we *do*.

We work for countries in two ways. We work *in* countries by establishing a direct presence to respond to national developmental needs. In this regard, it is essential that our in-country presence is adequate for the tasks we need to undertake. We also work *with* the entire community of countries, collectively or in groups, helping them to mobilize their collective wisdom, knowledge and efforts in the production of norms and standards, sound evidence and surveillance data. These are all international public goods which benefit all.

In allocating our resources to country-specific work, concentrating technical assistance on countries with a shared strategic vision will enhance impact. We have a clear mandate adopted by our Member States – and the World Health Assembly regularly votes recommendations and policies which we are pursuing – so we should support related projects and policies to which governments are committed, rather than attempting to impose an outsider's perspective.

Concentrating resources on poor countries or vulnerable groups without alternative sources of finance will also amplify our impact. A recent World Bank review of what works in development assistance – and of what fails – found strong support for these conclusions. When development assistance was used to support governments with sound policies it contributed significantly to economic growth and poverty reduction, particularly in poorer countries. But when external actors pushed against the grain of weak national policies they failed. The review further concluded that far too much development assistance has indeed been wasted for just this reason.

If WHO is to make a difference the implication is clear: concentrate country-specific technical assistance for health on countries whose policies reflect a shared vision of reaching the poor and of efficiency in health systems development. But as a technical agency committed to improve the health of the poor, we also need to focus on vulnerable populations and do what we can to help to improve their health status.

The second modality for focusing our country efforts involves working with the entire community of countries. The international community should avoid using its resources for what individual countries can do for themselves. International resources should, instead, concentrate on functions that require international collective action. These tasks include:

- global leadership and advocacy for health;
- generating and disseminating an evidence and information base for all countries to use;
- catalyzing effective global disease surveillance (as is currently done with influenza, to take one important example);
- setting norms and standards;
- targeting specific global or regional health problems where the concerted action of countries is required (for example, eradication of poliomyelitis);
- helping to provide a voice for those whose health is neglected within their own country or who are stateless;
- ensuring that critical research and development for the poor receives finance.

Each of these tasks involves working with the community of nations.

I wish to see a shift in the way WHO thinks and acts in its work with countries. Let us reflect for a moment on what it will take for our Organization to enhance its contribution.

- WHO needs to be seen by governments and other agencies to have a sound understanding of sectoral needs and the political and institutional contexts in which they have to be addressed.
- WHO needs to be a reliable source of high quality advice, and to act as a facilitator with

a technically authoritative voice.

- WHO needs to possess up-to-date and relevant evidence, set relevant norms and standards, and be responsive to the needs of Member States.
- WHO should be able to serve as a broker and negotiator for better health – helping to reconcile concerns and needs of Member States and external agencies that support the health sector.
- WHO should be able to help to shape the rules of engagement between governments and external agencies, as well as being able to use its own limited financial resources as strategically as possible.
- WHO should be instrumental not only in raising international resources for health, but also in placing health at the heart of the development agenda.

This is a tall order. But it is a clear and consistent message, one that comes from all our international partners, and is a sound reminder for the renewal process.

FORGING MORE INFLUENTIAL PARTNERSHIPS

In approaching partnerships, we need to shift our strategic direction substantially. We need to move from our traditional approach – which too often has favoured our own small-scale projects – to one which gives more emphasis to strategic alliances. Alliances will allow us both to learn from and to influence the thinking and spending of other international actors; and they will allow us to shape what we do into a broader picture.

WHO is the lead agency in health. But we can lead more effectively when we link up with others and agree on a division of labour and on ground rules for conducting our relationships. In this way we can create real partnerships for the attainment of tangible health outcomes.

WHO is in an ideal position to play a pivotal role in sector-wide approaches – and in several countries it is already doing so. Agencies, development banks and Member States are coming to realize the disadvantages of traditional development projects. They recognize, as we do, that sectoral approaches offer a way of supporting health development that strengthens national ownership and helps to build sustainable national systems.

Our thinking on sector-wide approaches is at an early stage. There are no blueprints to show how they should be organized. But we will actively promote cooperation and joint efforts with a number of our partners – in the United Nations family, civil society and the private sector. We will do so among agencies and in our country work. Here are some of the partnerships we have been working to strengthen:

- We have worked energetically during our year as chair of the cosponsors of UNAIDS, supporting the work of achieving more common programme and budget planning.
- We have initiated a closer working relationship with the World Bank – not only on the Roll Back Malaria project and the Tobacco Free Initiative, but also by engaging in a deeper dialogue on policy issues, including in the follow-up of the Comprehensive Development Framework put forward by the President of the Bank. We are likewise beginning to intensify our efforts with the regional development banks.
- We have initiated common analyses with the International Monetary Fund. We will share with the IMF our knowledge of the health sector, working with them in seeking to avoid the harm that can occur to the social sectors during economic adjustments to financial crises.
- We have developed working relations with the World Trade Organization. In addition to contacts between our experts, I will be meeting the Director-General of WTO twice a

year on a prepared agenda. We need to interact better with WTO to make sure that the health dimension of trade and globalization is considered before and during – and not only after – complex negotiations.

- We are strengthening our work with the Organization of African Unity by upgrading our presence in Addis Ababa.
- We are updating and expanding our working relations with the European Union, an increasingly important partner in health, not only in Europe but beyond.
- We need to work with our United Nations partners to help refine the purpose of the UN Development Assistance Framework process, and develop a clear vision of how closer coordination will be expressed in individual countries. Ideally, this will mean moving towards the development of common policy positions on key sectoral issues, and drawing other development partners into the process.
- In addition to governmental and intergovernmental partners, we are making progress in building partnerships with nongovernmental organizations and the private sector. We have had a number of round table meetings with industry. We are working closely with the Global Forum on Health Research in their efforts to catalyze greater public and private sector involvement in developing new products of relevance to the poor. The initial focus is on a public/private partnership to produce a new generation of anti-malarial drugs.

REPOSITIONING WHO FOR THE 21ST CENTURY

Helping to meet the health challenges facing the world through effectively implementing our strategic themes requires changes in WHO. Much of my work in the past ten months, and that of my colleagues, has attempted to reposition WHO internally to respond better to external needs and demands. The key objectives we identified for structural change at headquarters have either been reached or we are very close to reaching them.

The structure is flatter, and staff report to a competent and clearly mandated senior management with clear priorities. There is more transparency through more open decision-making in a new Cabinet form of governance, where heads of the nine clusters of departments meet on a weekly basis. We are moving with determination towards gender parity. We have initiated a process of staff rotation and mobility. There is a new dialogue with staff.

Some reforms need time. We wish to see the number of senior positions come down – and they will. But in getting there we are fully respecting contracts and previous commitments. We have reduced administrative costs. And we will go further. It is my ambition to see to it that our administrative and programme reviews identify further scope for redirection of funds from administrative to technical activities.

Having spent ten months at WHO I feel I can say this: staff serving the United Nations are hard-working people, often accepting workloads that many national civil servants would turn down. These staff constitute our ultimate resource. Providing them with the tools, skills and mandates to work effectively is the objective of our personnel policies, and I believe we are beginning to see results.

Our work in this initial phase is about WHO renewal, and I wish to see this penetrate everything we do: safeguarding what works, drawing on experience and knowledge, but looking ahead to serve a world in dramatic change. The challenge now is to work better and focus our efforts on where the return in health gains is greatest. In this we intend to draw more heavily on the wisdom and experience of the WHO Executive Board and to create a

shared vision and sense of direction with our country representatives. In February, for the first time ever, we brought together all our country representatives to introduce them to the change process and to learn from their experiences.

With structural changes at headquarters behind us, we are now engaging closely with the regions. The regional offices are a major strength of WHO. Many United Nations agencies are struggling to decentralize. WHO has already done it. Now the task is to make the whole Organization pull together, pursuing a shared corporate strategy. Our target is “One WHO” – aiming to make our contribution to better health outcomes for the populations we are here to serve, through our own work and through our work in partnerships with others.

The purpose of our work is to improve people’s lives, reduce the burdens of disease and poverty, and provide access to responsive health care for all. We must never lose this vision. Thanks to the support of our Member States and the commitment of our staff, we are beginning to see results on the ground. In my next message I look forward to reporting on how we have made a difference and on the measurable improvements that have been achieved as we move into a new century.

A handwritten signature in blue ink, reading "Gro H. Brundtland". The signature is fluid and cursive, with the first name "Gro" and the last name "Brundtland" clearly legible.

Gro Harlem Brundtland
Geneva
May 1999