SUMMARY RECORD OF THE EIGHTH MEETING

Room A of the Kyoto International Conference Hall
Friday, 20 September 2002 at 9 a.m.

CHAIRPERSON: Dr Hideo SHINOZAKI (Japan)

CONTENTS

1. ESSENTIAL PUBLIC HEALTH FUNCTIONS: THE ROLE OF MINISTRIES OF HEALTH (Document WPR/RC53/10) (continued)

Responding to questions that had been raised during the previous meeting, the REGIONAL DIRECTOR said that it would be impossible to define a standard role for ministries of health in public health activities, in view of differences in political systems, culture and history. All did, however, have responsibility for supervision, stewardship, oversight and coordination of public health activities, and a number of core functions could be identified. For example, the coordination, monitoring and evaluation of essential services should not be left to others, such as the private sector. Likewise, ministries of health should ensure the safety and quality of services and enhance equity and equality. They should also ensure that resources were allocated fairly and vulnerable groups were protected. Another important function was the maintenance of balance between incentives and control of the private sector. As a further example, he noted that all ministries of health had to coordinate the control of outbreaks of communicable diseases.

A number of countries had commented that the nine essential functions that had been identified should not be considered a prescriptive or inflexible list. He agreed and explained that the Regional Office would begin wide consultations to refine and improve the quality of the definitions.

THE REGIONAL ADVISER IN HEALTH SYSTEMS DEVELOPMENT, also responding to the questions that had been raised, illustrated the framework that had been used in defining essential public health functions with a series of slides. The objective had been to define public health in concrete terms. In the past, the core business of public health had been variously defined as disease control, injury prevention, health protection, healthy public policy, promoting health and equitable health gain and combating threats to public health. It had also been defined in terms of the essential outcomes, which were to raise health status and quality of life, reduce health inequalities, increase safeguards for the public's health and reduce the burden of acute and chronic disease. However, those approaches did not ensure that a comprehensive range of services was provided. One possibility would be to focus on the wide range of services provided, which could be categorized into population-based public health services, such as health education; personal preventive services, such as immunization; and personal treatment services of public health significance, such as DOTS for tuberculosis. However, improving services would not permit identification of gaps or improvement of coordination or organization of those services. Therefore, it was necessary to identify activities that covered all services: a set of fundamental activities that addressed the

determinants of health, protected the health of populations and treated disease. Next, it was necessary to identify the practices required to accomplish each key task. Those practices could be defined as the collective processes through which public health inputs (such as the workforce and information) were applied to fulfil the functions and deliver the outputs (programmes and services) intended to improve health status. Fourteen such practices had been identified: assess, investigate, analyse, advocate, negotiate, integrate, set priorities, plan, implement, evaluate, communicate, collect and use evidence, ensure compliance with regulations and manage (resources and patients). All of those practices could be linked to competences. Thus, a series of tasks was associated with fulfilling each of the essential public health functions, and each task was associated with a specific set of practices. The three important aspects of essential public health functions were: governance and stewardship, which included leadership, strategic goals, building partnerships, incentives and generation of information to evaluate how effectively public health was delivered; their multi-dimensional character, in that not all functions, tasks and practices were required at all levels of the health service; and critical links and relationships within sectors, across sectors and across countries.

The framework had been tested in three countries, Fiji, Malaysia and Viet Nam, and he thanked them for their cooperation.

In response to the comment of the representative of New Zealand that 'diagnostic and clinical services' should be considered key functions, he said that the list was flexible and could be altered for each country.

With respect to the comments of the representatives of Japan and New Zealand regarding financing mechanisms, it was necessary to set reasonable boundaries for the responsibilities of public health. A decision had been taken not to include financing mechanisms per se in the list of essential public health functions, as they were often not within the purview of the ministry of health. Nevertheless, giving advice on the priorities of publicly funded health services and the public health impact of tax policies was the responsibility of ministries of health. Furthermore, some ministries of health might find themselves responsible for administering social health insurance systems. More consideration would be given to including aspects of financing in the framework.

Responding to the comment by the representative of Palau that the framework was too limited and should encompass economic development and environmental politics, he said that the functions were in fact broad enough to include those considerations. The representative of the Republic of Korea had raised the issue of coordination. The nine functions that had been

defined were intended to be as broad as possible and not just to reflect the responsibility of the health sector. However, ministries of health had a coordinating role and were also responsible for evaluating or commenting on the public health effects of the policies of other ministries.

It was clear that further work would have to be done, on the functions themselves and also to formulate guidelines, tools, a glossary and indicators, so that the concept would evolve. The framework would be enriched by continuing input from all Member States of the Region.

2. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following resolutions.

2.1 Malaria, filariasis and other parasitic diseases (Document WPR/RC53/Conf.Paper No. 4)

Decision: The draft resolution, as presented, was adopted (see resolution WPR/RC53.R4).

2.2 Antimicrobial resistance (Document WPR/RC53/Conf.Paper No. 5)

The CHAIRPERSON said that an amendment to operative paragraph 1(2) had been proposed by the representative of Japan, to read as follows: "(2) to adopt and enforce laws and regulations to ensure that antimicrobials be made available only on prescription;".

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC53.R5).

2.3 Ethical issues related to new developments in the health sector (Document WPR/RC53/Conf.Paper No. 6)

Dr CHING (Hong Kong, China) proposed that in the fourth preambular paragraph, the words ", patient safety" be added after "care of chronic conditions".

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC53.R6).

3. COORDINATION OF THE WORK OF THE WORLD HEALTH ASSEMBLY, THE EXECUTIVE BOARD AND THE REGIONAL COMMITTEE: Item 17 of the Agenda (Documents WPR/RC53/11 and WPR/RC53/INF.DOC./2)

The DIRECTOR, PROGRAMME MANAGEMENT said that document WPR/RC53/11 referred to resolutions adopted by the Fifty-fifth World Health Assembly that were of particular significance for the Western Pacific Region. The resolutions themselves were attached to the document. Resolutions adopted by the Fifty-fifth World Health Assembly that related directly to other items on the agenda had been annexed to the documents covering those items. He drew the attention of the Committee to the operative paragraphs, which related to activities that Member States could undertake in the Region to implement the resolutions.

Those who had attended the previous session in Brunei Darussalam would remember that the Committee had endorsed a regional strategy for mental health, and a stimulating ministerial round table on mental health held during that session raised many thought-provoking issues. The considerable attention that had been paid to that topic by WHO and Member States in 2001 had been successful in moving mental health up the health agenda, reducing the stigma of mental illness and outlining a strategy for the future. It was essential to build on that excellent work.

He drew the Committee's attention to operative paragraph (1) of resolution WHA55.10, which urged all Member States to support the global action programme on mental health, which complemented the regional strategy. Taken together, those two initiatives offered Member States a framework for ensuring that more attention was paid to mental health and that people suffering from mental illness were treated with dignity and received appropriate care.

Ensuring access to essential medicines was one of the most fundamental elements of public health and one in which WHO had a critical role to play. WHO had worked with Member States to improve access to good-quality essential medicines and to ensure their appropriate use. It supported the formulation and effective implementation of national medicine policies. However, many people in the Western Pacific Region still did not have regular access to the medicines they needed. The prices of medicines, especially new ones, were high. Finances were limited, especially in the public system, and scarce resources were often wasted in purchasing nonessential medicines or on medicines that were not used appropriately.

Resolution WHA55.14 reaffirmed the key actions that WHO and Member States should take in order to ensure access to essential medicines. The operational paragraphs urged Member States to implement effective national medicines policies and to establish lists of essential medicines based on evidence. They also called for actions to promote access to medicines and to assure their quality and rational use within national health systems. WHO's work to improve access to medicines was guided by the WHO Medicines Strategy.

Many Member States would be aware of the "Declaration on the TRIPS Agreement and Public Health" that had been adopted at the Fourth World Trade Organization Ministerial Conference in Doha in November 2001, which had been referred to by the Director-General and by several representatives during the current session. The Declaration supported the rights of countries to protect public health by promoting access to medicines for all through affordable pricing. The Declaration and other recent international developments had opened up significant opportunities for Member States to improve access to essential medicines. He urged all Member States to implement the actions proposed in operative paragraph 1 of the resolution.

As the Regional Director had mentioned in his opening address, a number of important recent global developments affected the role of health in development. One of the most significant had been the establishment of millennium development goals by the United Nations General Assembly in September 2000. The World Health Assembly in 2002 had discussed the contribution that WHO could make to achievement of those goals. Resolution WHA55.19 contained a number of important operative paragraphs. Operative paragraph 1 urged Member States to take a number of actions to achieve the development goals, while operative paragraphs 2 to 4 set the goals in a more general development framework and encouraged developed countries to increase their level of development assistance, in particular for the health sector, taking into account the recommendations of the Commission on Macroeconomics and Health. The goals themselves were listed in Annex 2 to document WPR/RC53/11.

One of the millennium development goals was to reduce childhood mortality by two-thirds by the end of 2015, from 1990 levels. The task was huge, but it could be done if resources were focused and used where they could make the most difference. One way in which child health could be improved was by promoting appropriate infant and young child nutrition and, in particular, the global strategy for infant and young-child feeding. Resolution WHA55.25 endorsed the global strategy and, in operative paragraph 2, identified a number of actions that Member States might take to implement it. The representative of Cambodia had

stated earlier in the week that his country had already conducted a national workshop on that subject. Many people in the Region had been closely involved in preparing the global strategy, and they could take some satisfaction from the fact that it had now been finalized and endorsed by the World Health Assembly. It was important to carry the work forward through national plans of action on infant and young-child feeding. WHO, in cooperation with UNICEF and our other partners, would work with Member States to develop such plans. WHO was finalizing an organization-wide strategy on child and adolescent health and development. The global strategy for infant and young-child feeding and the forthcoming strategy on child and adolescent health and development would help WHO to make a major contribution to child health in the Western Pacific Region.

There being no comments from representatives of Member States, the CHAIRPERSON invited the representative of the Association of South East Asian Nations (ASEAN) to make a statement to the Committee (Annex). He then invited the representatives of the International Federation of Pharmaceutical Manufacturers Associations and the International College of Surgeons to make statements to the Committee.

Responding to comments by the representative of ASEAN, the DIRECTOR, PROGRAMME MANAGEMENT acknowledged the importance of the partnership between ASEAN and WHO. While it was always possible to do more, the two regions of WHO covering Asian countries – the South-East Asia Region and the Western Pacific Region – had made great efforts to improve coordination and collaboration in recent years; several initiatives had been mentioned during the session. Steps had been taken to identify priority areas for collaboration in the control of communicable diseases (e.g. tuberculosis, poliomyelitis, HIV/AIDS, malaria and disease surveillance) and in environmental health, tobacco control and health system development (e.g. essential medicines and development of national health accounts). Numerous biregional meetings had been held on subjects such as HIV/AIDS and disease surveillance, and collaboration was ongoing in the implementation of joint programmes such as Roll Back Malaria in the Mekong countries. Efforts were also made to present health information for the Asian region as a whole, rather than for the two separate groups of countries, for example the 2001 report on HIV/AIDS. WHO was also endeavouring to coordinate collaboration with other organizations that were common to both Regions, such as ASEAN, the United Nations Economic and Social Commission for Asia and the Pacific, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. For example, two biregional meetings had been held recently, in Bangkok and Beijing, to help Member States prepare proposals for submission to the Global Fund. WHO would continue to strive for better coordination of its activities in the two regions.

4. SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION: MEMBERSHIP OF THE POLICY AND COORDINATION COMMITTEE Item 19 of the Agenda (Document WPR/RC53/13)

The DIRECTOR, PROGRAMME MANAGEMENT explained that the Policy and Coordination Committee (PCC), which was the governing body of the Special Programme of Research, Development and Research Training in Human Reproduction, was composed of four categories of members and had a total of 32 members. Category 2 comprised 14 Member States elected by the WHO Regional Committees for three-year terms, three of which were to be selected by the Western Pacific Region. At present, the three Member States from the Western Pacific Region were Cambodia, Papua New Guinea and Viet Nam.

In electing members, due consideration was to be given to a Member State's financial or technical support to the Special Programme and its interest in the field of human reproduction, as reflected in its national policies and programmes.

The term of Cambodia would expire on 31 December 2002. The Regional Committee was now requested to elect one Member State, whose three-year term would start on 1 January 2003, to succeed Cambodia. The Regional Committee might choose to elect Fiji.

It was so decided (see decision WPR/RC53(2)).

5. TIME AND PLACE OF THE FIFTY-FOURTH AND FIFTY-FIFTH SESSIONS OF THE REGIONAL COMMITTEE: Item 20 of the Agenda

The REGIONAL DIRECTOR recalled that, at its fifty-second session the previous year, the Committee had decided to hold its fifty-fourth session in Manila. It only remained for him to propose the dates of the session. WHO tried to coordinate the dates of all six regional committees, first, to enable the Director-General to attend at least part of the sessions; and second, to allow enough time for the discussions of all the regional committees to be reflected in the documentation for the Executive Board meeting in January. He therefore proposed 8 to 12 September 2003 as the dates of the fifty-fourth session.

It was so agreed.

Regarding the venue of the fifty-fifth session, the REGIONAL DIRECTOR suggested that the floor be open to any Member State wishing to extend an invitation to host the fifty-fifth session of the Regional Committee.

Mr LIU PEILONG (China) said that, in order to express support for the work of WHO in the Western Pacific and to demonstrate the hospitality of the Chinese people, on behalf of the Chinese Government, he extended an invitation to host the fifty-fifth session of the Regional Committee in 2004. This would afford representatives of other Member States an opportunity to see the progress of China's reforms and experience its ancient culture. He hoped the fifty-fifth session in China would, like the current session, leave the representatives with good memories.

The CHAIRPERSON thanked the representative of China and requested the Rapporteurs to prepare an appropriate draft resolution, and to include the Committee's acceptance of the kind invitation of the Government of China to host the fifty-fifth session.

6. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolutions:

6.1 Essential public health functions: (Document WPR/RC53/Conf. Paper No. 7)

The RAPPORTEUR for the English language said that the representative of China had proposed that in the fourth preambular paragraph, the word "State's" should be deleted, and the phrase "of the State, particularly the ministry of health," should be inserted after the word "responsibility". In operative paragraph 2, subparagraph 3, a comma should be inserted after the word "managers", the following word "and" should be deleted, the words "and government institutions" should be inserted after the word "policy-makers". Finally, the representative of China had suggested that the phrase ", and the strengthening of the central role of the ministry of health;" be inserted at the end of the subparagraph.

Dr OTTO (Palau) proposed that a new subparagraph should be added at the end of operative paragraph 1, to read "(4) to monitor and evaluate the impact of policies of other sectors on public health and to respond in an appropriate and timely manner in order to ensure protection of public health;".

He further proposed that in operative paragraph 2, subparagraph 2, the words "and responsibilities" should be added after "infrastructures".

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC53.R7).

6.2 Time and place of the fifty-fourth and fifty-fifth sessions of the Regional Committee (Document WPR/RC53/Conf. Paper No. 8)

Decision: The draft resolution, as presented, was adopted (see resolution WPR/RC53.R8).

7. RESOLUTION OF APPRECIATION

Professor NYMADAWA (Mongolia) proposed a resolution expressing the Regional Committee's appreciation of the Government of Japan, the office bearers and presenters, Rotary International District 2650 and the representatives of the Joint United Nations Programme of AIDS and the intergovernmental and nongovernmental organizations for their statements.

Mr PITA FITI SUNIA (United States of America) said that he was proud to second the resolution, proposed by the representative of Mongolia, thanking the Government of Japan for its generous hospitality and excellent support for the fifty-third session of the Regional Committee, and all those who had contributed to the success of the session.

Decision: The resolution was adopted (see resolution WPR/RC53.R9).

8. CLOSURE OF THE SESSION: Item 21 of the Agenda

The REGIONAL DIRECTOR expressed his gratitude to all participants, including the observers and nongovernmental organizations, for their positive and constructive suggestions, and for the collegial atmosphere they had created. He assured the Committee that all their recommendations and suggestions would be thoroughly examined in order to improve the performance of the Secretariat at regional and country levels and to make it more relevant to the needs of all the Member States in the Western Pacific Region.

He conveyed his special thanks to the Government of Japan for its unflagging support to ensure the smooth running of the session, and to all the office bearers for their hard work.

Praising the CHAIRPERSON for his capable leadership, which had brought the session to a satisfactory conclusion, he presented him with the ceremonial gavel.

The CHAIRPERSON thanked the office bearers for their support and all the staff of the Secretariat who had worked hard to make the session a success.

The CHAIRPERSON declared the fifty-third session of the Regional Committee closed.

The meeting rose at 11.15 am.

ANNEX

STATEMENT BY THE ASSISTANT DIRECTOR OF THE BUREAU OF FUNCTIONAL COOPERATION, ASEAN SECRETARIAT

Let me thank the WHO Western Pacific Regional Office for inviting the Association of Southeast Asian Nations (ASEAN) to this meeting and for the opportunity to deliver this statement. WHO is an important strategic partner for ASEAN and our cooperation dates back to 1986 with the commencement of a project on pharmaceuticals. Cooperation between WHO and ASEAN has been put on a firmer institutional foundation with the signing of a five-year Memorandum of Understanding (MOU) involving both the South-East Asia Regional Office (SEARO) and the Western Pacific Regional Office (WPRO). The MOU was recently extended for another five years. ASEAN highly values collaboration with the WHO, under which many significant initiatives have been developed, including plans of action on HIV/AIDS disease surveillance, tuberculosis and healthy lifestyles.

Health cooperation is one of eight areas of cooperation in social development. The others are labour, education, social welfare, poverty, disasters, women, youth. Though ASEAN cooperation on health has been previously hampered by an inadequate funding, four development which have significantly moved forward regional cooperation on health issues, especially after the reactivating of the ASEAN Health Ministers Meeting (AHMM) in April 2000 in Indonesia and the convening of the 7th ASEAN Summit on HIV/AIDS in November 2002.

Firstly, health cooperation has enjoyed greater visibility in the overall scheme of regional cooperation. In November 2002, the ASEAN heads of government convened a summit session to discuss HIV/AIDS. This has given HIV/AIDS cooperation a new visibility and attracted additional resources to respond to the epidemic. The summit adopted a declaration and four-year work programme, both of which were prepared with the participation NGOs and organizations representing people living with HIV/AIDS.

The reconvening of the ASEAN Health Ministers Meeting after a decade long hiatus has re-invigorated health cooperation with the adoption of plans on addressing the health impact of globalization and to strengthen cooperation to promote healthy lifestyles. The 5th ASEAN Health Ministers Meeting adopted in 2000 a vision of "Health ASEAN 2020" which stated that by 2020, "health shall be at the centre of development". The ministers also adopted an action programme to address the health impact of globalization, prevent tobacco use, strengthen health policy reform and mainstream health in national development, for

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example. In March 2002, the 6th ASEAN Health Ministers Meeting, in an effort to realize the vision of a healthy ASEAN by 2020, adopted a regional action plan on health lifestyles to address the following priorities among others: accident and injury prevention; healthy ageing; mental health; noncommunicable disease prevention; promotion of physical activity; and tobacco control. The Ministers have emphasized that health should be mainstreamed into national development plans, and that issues concerning the interface between macroeconomics and health will be given due attention. In this connection, I would like to express our sincere thanks to WPRO for the excellent support provided for the preparation of the comprehensive regional action plan.

Secondly, projects are increasingly focused on regional or transboundary issues. A good example is the ASEAN Work Programme on HIV/AIDS adopted by the ASEAN Summit in November 2001. This Work Programme is divided into two main sections, with high priority given to projects which require joint action or are transboundary, such as joint negotiations to increase access to antiretroviral drugs or reducing the HIV vulnerability of mobile populations such as migrant workers. Under this category are proposals for a regional study on the socioeconomic impact of HIV/AIDS and a concerted effort to "mainstream" HIV/AIDS into the national developments plans of Member Countries. The second section are regional projects in support of national programs such as condom promotion, lifeskills training for youth and prevention of mother-to-child HIV transmission, for example.

Other priority regional projects include the setting up a regional disease surveillance network (which is implemented in collaboration with Indonesia and the US Naval Medical Research Unit), strengthening food and drug safety in the context of trade liberalization in the Region, and articulating common positions on a variety of issues such as the Framework Convention on Tobacco Control (coordinated by Thailand and Malaysia).

Thirdly, increasing numbers of our activities are implemented on the basis of "cost-sharing" through which a country hosting an activity will defray organizing costs while participating countries pay for the cost of airfare and living expenses of their participants. In this way important activities get implemented without reliance on external resources. To facilitate cost-sharing arrangements, Member Countries identify activities which are relevant to an existing ASEAN plan of action and then open these activities participation by other Member Countries. Planned or recently implemented workshops have included promotion of healthy lifestyles, studying the impact of the General Agreement on Trade in Services

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(GATS) on health care, strengthening community care for the elderly, and exchanging information on healthy cities.

Finally, the concept of cost-sharing can also be extended to partnerships with donor countries and international agencies such as the WHO and UNAIDS. Such agencies and donor countries already have extensive inventories of activities, at country or regional level. If participation is open to other ASEAN countries, the ASEAN Secretariat could coordinate with focal points in Member Countries to nominate participants. Such a strategy ensures that we do not reinvent the wheel.

In line with the restructuring taking place in ASEAN health cooperation, WHO could assist ASEAN in addressing many of the new issues given prominent attention by the Ministers, such as globalization and healthy lifestyles. While WHO has assisted in the formulation of plans and declarations, the further operationalization of these plans into concrete activities remains a challenge.

To move forward the further implementation of these plans and to strengthen collaboration with WHO, the following three recommendations of the ASEAN health ministers and senior health officials could be considered.

- The ASEAN Secretariat and WHO could attend each other's yearly meetings on health as observers to facilitate coordination and to avoid duplication.
- The WHO regional offices (SEARO and WPRO) could inform the ASEAN Secretariat of their activities in the region, so that projects addressing mutual priorities could be identified for participation by all Member Countries (WPRO activities could also be opened to other ASEAN Members in SEARO, where appropriate).
- WHO and the ASEAN Secretariat could explore the possibility of utilizing the WHO intercountry programmes for joint regional activities.

The fact that ASEAN is split into two WHO regions creates unique challenges for project formulation and implementation. Any attempt to review the effectiveness of ASEAN-WHO cooperation would have to address this issue. Although proposals to redraw the constituencies of the South East Asia and Western Pacific Regions may be considered impractical, few would argue against the need for greater coordination and collaboration

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between SEARO and WPRO, especially for cross border issues which involve countries in both regions, including the use of their respective intercountry programme budgets.

Activities which involve geographically contiguous countries straddling across two regions could be developed jointly by the two regional offices. For example, SEARO has included in its Supplementary Inter-country Programmes (ICP II) for 2002-2003 a project addressing multidisease surveillance, including health hazards and risk behaviour surveillance. Since communicable disease control in border areas is a priority area under the ASEAN-WHO MOU, both regions could explore how such a project could be jointly developed.

Finally, with a new five-year extension of the ASEAN-WHO MOU through to 2007, it may be opportune for us to conduct a more systematic review of the ASEAN-WHO MOU. The ASEAN Senior Health Officials had suggested that this be done within the first year of the extension (that is, by mid April 2003). The review could also look into identifying regional or cross border issues which require joint programming by the two regional offices as well as mechanisms to facilitate linkage and coordination.

We look forward very much to build on the foundations we have established for cooperation and to revitalize our collaboration through managing our existing resources even more creatively.