SUMMARY RECORD OF THE SECOND MEETING
(Mandarin Hall, Shanghai International Convention Centre)
Tuesday, 14 September 2004 at 09:00

CHAIRPERSON: Mr GAO Qiang (China)

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1. **ADDRESS BY THE INCOMING CHAIRPERSON**: Item 4 of the Agenda

The CHAIRPERSON addressed the Committee (Annex I).

2. **REPORT OF THE REGIONAL DIRECTOR** (continued)

Dr ABU BAKAR (Brunei Darussalam) thanked the Shanghai Municipal Health Bureau for the excellent arrangements and warm reception. He noted the progress achieved by WHO in prevention and control of noncommunicable diseases, control of malaria and other vectorborne diseases, HIV/AIDS care and prevention, safe motherhood, and management of childhood illnesses. He also cited the successful achievement of goals in tobacco control and tuberculosis treatment. He remarked on the improvements in the work of WHO and Member States in communicable disease control, building healthy communities, and health sector development, particularly strengthening of health systems to respond to emerging threats. He supported the Regional Director’s initiative for increased biregional cooperation with the WHO South-East Asia Region, as SARS had proved that such cooperation was vital. He also supported the proposal for biregional reporting every three to four years.

At the invitation of the CHAIRPERSON, representatives of the International Council for Control of Iodine Deficiency Disorders, the International Pediatric Association, the International Federation of Otorhinolaryngological Societies and the Sasakawa Memorial Health Foundation made statements to the Committee.

The REGIONAL DIRECTOR said that comments from Member States had highlighted five major issues, to which he would respond in turn.

First, regarding communicable diseases, countries were currently better prepared to face new threats such as SARS, having learnt lessons from the previous outbreak, although they should remain vigilant. However, several warning signs indicated the need to be on the alert for a potential influenza pandemic. The H5N1 virus was circulating far more widely than expected in the area. Historical data suggested that an influenza pandemic occurred every 30 years, which meant that one was due. If human-to-human transmission materialized, virtually no one had immunity against the virus. A previous influenza pandemic in 1918–1919 had killed an estimated 40 million people, and since then the movement of people and goods had increased immeasurably. Although the outbreak in January 2004 had occurred in areas of large-scale poultry production, recent cases were being reported on small farms where the poultry population was low. That meant that either surveillance was poor in rural areas and/or, as research suggested, the virus was being carried by other species of fowl, such as ducks, which did not develop the disease. Lastly, research also suggested that the H5N1
strain was gaining virulence. For those reasons, and others, he urged Member States to strengthen the
capacity of both health personnel and systems in order to ensure prompt case detection and to mount a
decisive response if the need arose.

Referring to the two Member States that had eliminated leprosy but had subsequently lost that
status, he said that WHO, in collaboration with the Sasakawa Memorial Health Foundation, would
provide as much support as possible so they could regain elimination status.

WHO would also provide support for the meeting of the Global Alliance to Eliminate
Lymphatic Filariasis, to be held in Fiji in 2006. As had been noted by the Representative of Samoa,
his country had taken the lead in filariasis control in the Pacific, and was the first country in the world
to complete five full rounds of mass drug administration.

Second, he observed that his annual report performed two functions: it provided an account of
WHO’s activities during the year, which was of limited interest outside the health sector, and it
analysed the health situation in the Western Pacific Region, which was also of limited value since it
did not cover Asia as a whole. He therefore proposed that two documents should be issued in future:
the regular report to Member States on progress, produced in a format similar to other documents, and
an in-depth analysis of the health situation with a broader geographical scope, to be published jointly
with the Regional Office for South-East Asia. Although its periodicity remained to be determined, he
hoped the first issue would appear before the Fifty-eighth session of the Regional Committee in 2007.
He assured the small island countries that their special circumstances would be given due attention in
the new publication. He agreed with the representative of Australia on the need to streamline data
collection.

Third, on the subject of biregional cooperation, collaboration on disease control was already
under way with the South-East Asia Region. It could be further extended to such areas as counterfeit
drugs and food safety. In particular, it could cover the response to emerging diseases. In the event of
an outbreak in either region, the two regional offices would then work as one team.

Fourth, Tonga had drawn attention to the need for more resources for control of
noncommunicable diseases. Admittedly, an area such as health promotion tended to be less well
dowered than others, partly because results were visible only over the long term. However, fresh
evidence suggested that strong government commitment to achieving an environment conducive to
health, coupled with public willingness to change behaviour, could produce an effect within a few
years. He expected that more resources would be allocated to the Region in the biennium 2006–2007,
and he would allocate much of that increase to control of noncommunicable diseases.
Fifth, the biomedical approach to health, which had enabled scientists to make quantitative and qualitative assessments in certain areas, had led to remarkable developments in care, such as immunization and gene therapy. Nonetheless, the tendency had been to neglect areas that were less amenable to scientific analysis, being subjective in nature, particularly the health impact of such conditions as depression, anxiety or stress. Ample evidence now confirmed the impact of psychosocial factors on health outcomes and he therefore proposed to draw up a preliminary concept paper on the subject for presentation in 2005, to be followed by a draft policy framework at a subsequent session.

3. ADDRESS BY KEYNOTE SPEAKER: PROFESSOR WILLIAM HSIAO, K.T. LI
PROFESSOR OF ECONOMICS, HARVARD SCHOOL OF PUBLIC HEALTH: Item 7 of the Agenda

The Chairperson invited Professor Hsiao to address the Committee (Annex 2).

Item 9 of the Agenda: (Document WPR/RC55/3)

The REGIONAL DIRECTOR introduced the final report on budget performance for the biennium 2002–2003 (document WPR/RC55/3), which contained details of the financial implementation of the regular budget and “other sources” of funds from 1 January 2002 to 31 December 2003. It also provided details of programme outcomes for the same period and information on the end-of-biennium assessment exercise conducted by all country offices and regional focuses. Additional information on WHO activities in the biennium was to be found in the Regional Director’s reports for 2001–2002, 2002–2003 and 2003–2004. The final report was intended to inform representatives of the outcomes of programme budget implementation since the endorsement of the original budget proposals by the Committee in 2001. It was part of the process for achieving transparency that had been a feature of financial reporting in the Region.

Details of the financial implementation were set out in Annexes 1–3 of the report. Annex 1 showed the changes up to 31 December 2003 in the overall amount of the original budget since its presentation to the Regional Committee in September 2000. Annex 2 showed the status of financial implementation by theme and focus; column 2 consolidated all the changes that had occurred as a result of efficiency savings, changes to absorb cost increases, cost variations and changes due to reprogramming. Annex 3 was a new table that presented the final financial implementation by country and area for regular budget and other sources of funds, consistent with an “integrated” approach to programme budgeting.
The appropriation resolution for the financial period 2002–2003, adopted by the World Health Assembly in May 2001, had encouraged the Director-General to continue to effect efficiency savings in pursuance of resolution WHA52.20, to be applied towards the required adjustments for cost increases and currency fluctuations. In the Western Pacific Region, an additional USS 1.3 million had been transferred to various programme activities, largely from savings in staff-related costs. In addition, funds from savings and unimplemented activities had been shifted to the extensive regional response to the SARS outbreaks.

At 31 December 2003, the full working allocation of US$ 71,975,000, or 100% of the regular budget, had been obligated. Figures for the implementation of “other sources” of funds by focus for regional and country activities appeared in Annex 2, column 6. The total obligation of funds from other sources as at 31 December 2003 had been US$ 58,810,986.

All country offices and focuses had undertaken an end-of-biennium assessment of programme budget implementation. Annex 4 set out programme outcomes from that exercise, as requested by the representatives of several Member States at the fiftieth session of the Regional Committee. The exercise was in line with the results-based budgeting approach introduced in the Region in 2000–2001, which required formulation of programmes and budgets that were driven by expected results articulated at the outset of the budgeting process. The approach was the basis of the managerial process in WHO.

Mr NAKAZAWA (Japan) welcomed the successful implementation of the programme budget for 2002–2003, in particular, the 100% obligation of the regular budget allocation. The Regional Director had shown excellent leadership in determining the allocations to programmes, which had been in accordance with the needs of the Region and were fully acceptable. He asked whether any difficulties had been encountered during implementation.

Dr HE (China) expressed satisfaction at the 100% regular budget implementation rate and at the effective use of funds from other sources. The Regional Director and his staff were to be congratulated on those achievements, especially in view of the difficulties encountered, including the SARS outbreaks in 2003. The Region’s programmes had focused on 17 key areas, in accordance with the priorities set. However, the reduction in allocations in comparison with the previous biennium had affected implementation of the expanded programme on immunization and leprosy elimination activities, which had failed to reach expected goals. He therefore hoped that allocations to the Region could be increased. He welcomed the inclusion in the report of information on financial implementation by country, and on achievements according to expected goals. It would be useful if
future reports could also provide an analysis of the current situation, together with proposals for improvement.

Mr KIRATA (Kiribati) thanked the Regional Director for his report and requested further information on how the implementation rates for Kiribati had been calculated.

Mrs BLACKWOOD (United States of America) commended the Regional Director on achieving a 100% implementation rate for the regular budget allocation and on the efforts made to increase efficiency and effect cost savings of USS 1.3 million, which had enabled a shift in resources to high-priority areas.

Dr SONG (Vanuatu) commended the report, which took into account the important budget process changes approved at the Fifty-Fourth World Health Assembly. He also expressed satisfaction at the financial implementation rate for Vanuatu, indicated in Annex 3, which had been achieved thanks to the support and flexibility extended by local WHO staff. He endorsed the final implementation figures and programme outcomes.

The REGIONAL DIRECTOR, replying to the representative of Japan, said that two major obstacles to the implementation of the 2002-2003 programme budget had been encountered. First, the SARS outbreaks had required a shift of resources to emergency response amounting to around USS 5 million, which had delayed the implementation of some other activities. Second, following adoption of resolution WHA51.31 there had been a reduction in allocation to the Region of USS 2.6 million in comparison with the previous biennium. That change had necessitated a reduction in posts at the Regional Office in the areas of the expanded programme on immunization, environmental health and health promotion, which had affected activities in those areas. Like the representative of China, he hoped that an increase in resources for the 2006-2007 biennium would redress the balance.

In reply to the representative of Kiribati, he explained that an implementation rate of 94.85% had been achieved for the regular budget country allocation for Kiribati, as shown in the column headed "% of working allocation" in Annex 3. Financial implementation in Kiribati accounted for 0.53% of the total implementation in the Region, as shown in the last column of the annex.


The REGIONAL DIRECTOR presented document WPR/RC55/4, which contained the proposed programme budget for the biennium 2006-2007, a proposed regional strategic programme
budget and a process and outline for preparation of the eleventh general programme of work, 2006–2015.

The proposed programme budget for 2006–2007 was presented in the first three annexes of the document. Annex 1 showed the global proposed programme budget 2006–2007, common to all WHO regions. Accompanying budgetary information was presented in Annex 2. Annex 3 showed the proposed regional strategic programme budget 2006–2007, which was specific to the Western Pacific Region. The budget documents reflected an integrated, strategic approach to planning and budgeting; they established clear Organization-wide priorities and objectives and outlined what WHO planned to achieve during the period. A draft outline and a proposed preparation process for development of the eleventh general programme of work, 2006–2015 were attached as Annex 4. An information document had also been distributed, which contained indicative planning figures for the countries and areas in the Region.

He explained that the global proposed programme budget had been developed through a process of results-based budgeting. It would form the basis of the programme budgets at all levels of the Organization. Table 1 of Annex 2 showed the amount determined for each region and for WHO Headquarters to allow them to achieve the expected results in each area of work. Regional allocations and estimates of voluntary contributions were presented in Annex 2. The Director of the Planning, Resource Coordination and Performance Monitoring Department of WHO Headquarters had been invited to present more information on the global proposed programme budget.

The proposed regional strategic programme budget for the Western Pacific Region, to be financed from assessed contributions and miscellaneous income, was US$ 81 044 000, which was 12.5% greater than the budget for the 2004–2005 biennium. Of the total proposed regional budget, US$ 45 267 000, or 55.85%, had been allocated for country activities and US$ 35 777 000, or 44.15%, for intercountry and regional activities. The proportions were similar to those for the current biennium, with a slight increase in the percentage for country activities. The estimated regional budget from voluntary contributions was US$ 151 817 000, which represented a 25% increase over that in the current biennium.

The regional strategic programme budget would be further refined during close consultation with Member States, WHO country offices, the Regional Office and WHO Headquarters, in accordance with the principles of results-based management. That budget would be further discussed by the Regional Committee at its fifty-sixth session.

The distribution of the regional allocation, covered in Annex 3, Appendix 2, and in document WPR/RC55/INF-DOC.1, was similar to that in previous bienniums. The information document
contained indicative planning figures for each country and area. WHO had been unable to include the planning figures with the main document, as the regional allocations had been finalized only in July 2004, almost six months later than in previous bienniums. The delay had resulted from the requirement in resolution WHA51.31 that the Director-General should present an evaluation of the model for distribution of regional allocations to the Fifty-seventh World Health Assembly in May 2004. The indicative planning figures presented would be the basis for detailed country plans, to be prepared later in the year.

It was important to note that the final amount of the assessed contributions and miscellaneous income and its distribution would be determined by the Fifty-eighth World Health Assembly in May 2005. He stressed that there might be some changes to the indicative country figures once the regional allocation had been finalized.

The eleventh general programme of work would be a unique document in several respects. For the first time, it would cover a 10-year period, thus providing a long-term strategic look at the place of health in the world. It would be presented to the Fifty-ninth World Health Assembly in May 2006 for approval. The views of the Committee would be forwarded to the Director-General and would be taken into account in finalizing the document.

The DIRECTOR, PLANNING, RESOURCE COORDINATION AND PERFORMANCE MONITORING, WHO HEADQUARTERS reiterated that the proposed integrated programme budget for Member States, the regions and Headquarters had been formulated in accordance with the results-based budgeting approach. WHO as a whole was committed to achieving the expected results laid out in the budget document. The aim was to obtain resources that were related to the expected results. The 36 areas of work represented both continuity with previous bienniums and some minor changes. She noted that there was significant synergy among the different areas of work. When the budget was presented to the Executive Board at its next session, a small table would accompany each of the 36 topics, showing the expected results in related areas of work. Much had been learnt from the four previous exercises in results-based budgeting. An important principle in drawing up the budget had been that of decentralization: thus, all the proposed increases in allocations had been for the regions and countries. The allocation for Headquarters had been decreased by 1.2%.

The four strategic directions represented in the budget were: improving health outcomes at country level, with continued focus on major communicable diseases and increased focus on epidemic alerts and reducing maternal and child mortality; improving health systems and access to products; addressing health determinants, such as the environment, chronic diseases, tobacco control and food safety; and improving the efficiency and accountability of the Organization.
The proposed increase of 12.8% in the budget was a direct response to the increased demands and expectations of Member States and partners. The importance of achieving the Millennium Development Goals was recognized throughout the world, as was the role of health in poverty reduction strategies. Global investments were being made in health, and the importance of health as a global security issue had become evident, especially in the Western Pacific Region. The proposed increase was the outcome of results-based budgeting in close consultation with the regions. It was an indication of the robustness of the planning process that the increase was found to be consistent with the growth of the budget over the past six biennia. The required increase of 6.5% per annum was also broadly consistent with the growth in official development assistance for health and average national expenditure on health.

Five areas in which Member States had requested increased activity had been identified from World Health Assembly resolutions: enhancing global health security; accelerating progress towards the Millennium Development Goals; responding to the increasing burden of noncommunicable disease; and promoting equity in health.

The terms used to describe the different sources of the WHO budget had been changed to increase transparency. Thus, instead of referring to the 'regular budget' and 'extrabudgetary sources', the three sources would be known as 'assessed contributions', 'miscellaneous income' and 'voluntary contributions'.

WHO would be asking for a 9% increase in assessed contributions, which was a reasonable request in view of the increasing demands on the Organization. If zero nominal growth were maintained, the regular budget would constitute only 17% of the overall budget by 2015. Although voluntary sources of funding were the mainstay of the budget, reliance on such sources was difficult for a number of reasons. The timing of such contributions often did not coincide with budgetary allocations, and voluntary contributions to specific programmes meant that other expected results might not receive funding.

The meeting rose at noon.
ADDRESS BY THE INCOMING CHAIRPERSON AT THE FIFTY-FIFTH SESSION OF THE WHO REGIONAL COMMITTEE FOR THE WESTERN PACIFIC, SHANGHAI, CHINA

It is a distinct honour and privilege for me to have been elected Chairperson of the fifty-fifth session of the WHO Regional Committee for the Western Pacific. I thank you, dear representatives, for your trust and confidence. I will try my best to make this session fruitful and live up to your expectations. Sessions of the Regional Committee for the Western Pacific have a well-earned reputation for having provided critical policy guidance and strategic directions, and most important, of facilitating consensus and strengthening cooperation among the countries and areas of the Region. Currently we are still faced with difficult tasks and there is a lot of work to be done. Governments and people from our Member States and our partners expect that this session will feature in-depth discussions of important health issues and regional actions to address them. With your kind support and cooperation and with the strong technical guidance of the WHO Secretariat, I am confident that we shall have a very productive and successful meeting.

Colleagues, our Vice Premier H.E. Madame Wu Yi welcomed you to Shanghai on behalf of the Chinese Government at the opening ceremony yesterday. Today, I would like to add to this welcome by emphasizing to the Regional Committee that the Chinese Ministry of Health is deeply honoured to host this session. Only a few of you attended the thirty-eighth session of the Regional Committee, which was hosted in China 17 years ago. That session was held in Beijing, the capital city of China, in September 1987, 15 years after the People’s Republic of China resumed its rightful place in WHO. Professor Chen Minzhang, then Minister of Health of China and Chairman of the Regional Committee, spoke of the three Ds that characterize work of our Region: diversity, dynamism and development. These three Ds still ring true today. I would like to use the following additional four words to outline the current health development and future prospects in our Region: exploration, innovation, cooperation and improvement.

As you look around, you will appreciate the great advances that have been made in economy and in technology, and you will see great changes taking place all the time. The majority of countries in the Region are undergoing very rapid industrialization and modernization, and are playing a more and more active role in the international community. China, like many other countries in the Region, is confronting a series of challenges brought about by globalization and development, including how our health service system can provide health protection and satisfy the mounting health care demands of our people. It is therefore very significant that the Committee wisely chose to meet this year here in
Shanghai, which, in terms of economic and social development, is one of the fastest growing areas in China, to discuss health issues that concern us all.

Dr Omi, in his report yesterday, spoke of the great measures that have been adopted to improve the health of people in the West Pacific Region by the Regional Committee and the Member States of the Region. At the same time, he also cautioned us to pay attention to new and re-emerging diseases, including HIV/AIDS, SARS, avian influenza and tuberculosis. These diseases have had huge negative economic and social impacts on Member States. They challenged the capacity of the health systems to respond to emergencies and threatened the national security of Member States.

As we all know, over the past year or so, we have experienced some extraordinary events. Last year, Asia and the rest of the world were hit by SARS. Since the beginning of this year, avian influenza outbreaks have occurred periodically. We have learned many lessons. Our initial response to SARS was insufficient because of our lack of understanding of the new disease, inadequate preparedness for public health emergencies, slow communication of information and inadequate systems for infectious disease prevention and control. Facing the prevailing challenge of SARS, the Chinese Government gave people’s safety and health the top priority. Led by President Hu Jintao and Premier Wen Jiabao and with Vice Premier Wu Yi at the helm, a National SARS Committee was established. The Committee mobilized all possible resources in an effort to strengthen health work and epidemic prevention, to undertake rigorous epidemic surveillance and infection control, to isolate infected patients and treat them properly, and to institute strict infection control to prevent the spread of the disease, especially to rural areas. It is a tribute to our legal system, to science and technology, to our people, to the strong support of the international community and to the fighting spirit and national pride that permeated all segments of the population that we finally overcame the ferocious epidemic of SARS.

The Chinese Government subsequently allocated significant financial resources to strengthening its public health system. In this year’s efforts against avian influenza and the re-emergence of SARS, these recently improved public health surveillance and emergency response systems were fully used and epidemics were contained. The frequency of the outbreaks, coupled with the fact that diseases respect no borders, means we have continuously to improve international communication and strengthen international collaboration. We learnt a lot from those experiences – lessons that should serve us well in the future. There will be a round table discussion on “International cooperation in the face of public health emergencies” tomorrow afternoon. I believe there is surely much we will learn from each other.
Distinguished representatives, we have a full agenda ahead of us. Allow me to say just a few words on some of the issues. Under the agenda item on outbreak response, I am sure you will have a lot to share on recent developments on SARS and avian flu. In addition, we shall also discuss how to improve preparedness for such events through measures embodied in the revised International Health Regulations. We may even wander outside of the traditional realm of health when we start to discuss the safety of food, especially the strengthening of regulatory frameworks and their enforcement in relation to the marketing of live birds and animals for food. The recent occurrence of avian influenza will make this very pertinent discussion.

We attach great importance to the issue of HIV/AIDS. We are fortunate that the Region continues to control the spread of HIV/AIDS through improved surveillance, effective sexually transmitted infections (STI) education and counselling, and promoting national STI programmes. However, we should also now set our sights on providing care and treatment to those afflicted by the disease and look at better ways to target and increase coverage of interventions. We will also review the progress of our efforts to control tuberculosis. It has been five years since we declared a tuberculosis crisis in the Region. We need to exert more effort if we are to reach the targets that we have set for the Region by the end of 2005, namely, 100% coverage by directly observed treatment, short-course (DOTS), an 85% cure rate and a 70% case detection rate. As the report of the Secretariat shows, we still face significant challenges, including TB/HIV co-infection, multidrug resistant TB, and limited access to TB treatment due to poverty. It is our responsibility to solve these problems.

Distinguished representatives, Dr Omi, in his report yesterday, took pride in the fact that the Western Pacific Region is the only WHO Region where all Member States had signed the WHO Framework Convention on Tobacco Control when it closed for signature on 29 June 2004. However, we still have a long way to go from signing to implementing the Convention. We should not be complacent. On the contrary, we should remain steadfast and continue to take action in our countries in accordance with our national situations. Our discussion on this subject will definitely set us in the right direction.

Dear colleagues, we meet at a time when we are facing critical changes and challenges. The political, economic and social environments in which we work are changing rapidly. These changes come from profound global transformations and developments in our own countries. We face increasing demands for health care. However, in many countries, resources available for health services are very limited. The most effective approach is development, which is the fundamental solution to all difficulties. During the meeting, we shall review the final report on final
implementation of the programme budget for 2002–2003. We shall also have the opportunity to consider the proposed budget for 2006–2007 and the eleventh general programme of work 2006–2015. Guided by the Global Strategy for Health for All and the Millennium Development Goals, governments of the Member States will develop effective routes towards better health. Let’s work together to utilize our limited resources as effectively as we can to realize our common aspirations.

In the early years of the 21st century, exploration, innovation, cooperation and improvement will be the basic characteristics of our Region and should provide directions for our Region’s health efforts. Let us learn from our rich experience, work more closely together and take advantage of technological advancement and economic development to ensure equity in health for all people of this Region.

Once again, I welcome all of you to China. We will try our best to make the meeting successful and to make every representative and guest feel at home. I hope very much that you will all find the time to enjoy the rich Chinese culture and history and the past, present and future of Shanghai during your stay here.

Thank you.
FINANCING AND PROVISION OF PUBLIC HEALTH SERVICES

by Professor William Hsiao, K.T. Li Professor of Economics, Harvard School of Public Health

It is a great honour to be invited to speak before you today and I am particularly pleased to meet a number of friends I have not seen for a few years. I am an economist, and economics is known as a dismal science. Recently, there was an interdisciplinary conference held in Vienna. The topic turned to which profession was the oldest in the world. And you know how aggressive surgeons are and they right away said: "Of course, it is surgery, because God took a rib out of Adam and created Eve." The engineer was not going to be left behind and said: "No, no, no, no. God created order out of chaos, so engineering is the oldest profession." The economist leaned over to the engineer and asked, "Who do you think created chaos?"

I appear before you today not to make more chaos; I would like to play the role of an engineer today. I have been asked to shorten my speech because of your heavy schedule today. In the next twenty minutes, I would like to stimulate and provoke you to think about the national health systems for the rural populations of the Western Pacific nations. There are 2 billion people today who are living in the rural areas of low and middle-income countries. In the Western Pacific Region, I estimate that there are at least 700 million people who are living in the rural areas of low and middle-income countries. China, of course, is the biggest one. You know very well that these people do not have adequate preventive and primary care. This has been known for decades, but we have not found a solution for them. This is a failure of academics, of governments, and of the people who specialize in public health. Today, I would like to suggest one possible solution.

It helps to begin with some facts. The major problems facing the farmers of the low and middle-income countries are well known to you. I just want to highlight one aspect. People want basic health care and disease prevention in their villages. They cannot and do not want to walk three to four hours to the towns where there are sub-district health centres. Consequently, you will observe in the field most peasants or farmers actually self-medicate or go to indigenous doctors who are located in the villages, and the medical care you offer does not necessarily reach them. The major problem facing the supply side is that there is inadequate funding for disease prevention and basic health care. That is already well known to you and that is something you face on a daily basis. But I also know many countries have tried to set up primary care at village level through government efforts and most of them have not worked. One exception is Sri Lanka, where I did a field study. Viet Nam and China tried while they were socialist economies, but those efforts have been abandoned or abolished since then.
With regard to inadequate funding, spending levels vary tremendously between nations. To make the appropriate comparison, we have to convert currencies to a purchasing power parity basis. Given a similar basis, countries can vary their spending. This is just for low- and middle-income countries. I am not considering high-income countries like the Republic of Korea, Australia or Malaysia. In most countries, the funding for health care comes from directly out of people’s pockets. It does not come from the Government. Meanwhile, the Government usually only focuses on its own spending and does not look at the whole picture.

In recent years, we all know that the world has been affected by new communicable diseases, such as HIV/AIDS and avian influenza, as you discussed this morning. Through the UN agencies and the leadership of WHO, you have mobilized the world and new funds, like the Global Fund, are being generated to address three communicable diseases: one new communicable disease - HIV/AIDS - and two old ones - tuberculosis and malaria. These are what we economists call vertical programmes, and they are very important. I applaud you for giving such attention to these three diseases. But, if we look at the data from China on the burden of just three common diseases, respiratory infections, perinatal diseases and diarrhoea, their burden of disease is more than three times that of HIV, tuberculosis and malaria, and that is true in most countries in this Region. So these efforts, which have captured the world’s attention today, do not necessarily, in my view, really deal with the health of the people.

In the past decade, we have documented that medical expenses have impoverished many households. WHO’s finding is that 2% to 7% of the population in low- and middle-income countries is driven into poverty every year because of medical expenses. So your national health system or your health policy also has to address this issue.

Let us quickly just look at international efforts in health. You are leading these efforts and I will argue that they have made some difference. However, as a member of the Commission on Macroeconomics and Health, I know we have given you very visionary solutions, not practical and realistic solutions, because we know that international donors are not going to come up with US$ 27 billion in new funds to help the developing countries to provide preventive and basic health care. So funding is a major problem, but I would argue it is more than funding.

You have to mobilize more funds for prevention and public health, and the Government needs to shoulder that responsibility. On the other hand, how do you organize the delivery service to be more effective and efficient? How do you make the services and preventive measures reach the people living in the villages? This is another key issue you have to address.
As an applied economist, I like to raise these issues, but I also feel it is also my responsibility to at least offer one possible realistic solution. One innovative solution today is what I call mutual health care. It has two key features and tries to join together public and private initiatives and partner them in financing. The Government has the primary responsibility to fund prevention and public health and basic health care. But the people who are spending a great deal of money out of their own pockets also prepay some funds, so the health care system can be organized. The second partnership is that between the public and private sectors at the village level. Where governments have not demonstrated their capability to organize and manage basic health care for their people, you should turn the job over to the community themselves. Using a catchy, fashionable word, turn to the NGOs - community-based NGOs. Let the farmers manage their health post. Farmers are not that well educated, but in order to survive they have gained a tremendous amount of practical knowledge to manage the meagre funds they have in order to survive. They can manage a health post right there in their village. But most countries have not been willing to turn over that responsibility or that power to the communities. So I am suggesting that the way out is a new partnership between the public and private sectors both in financing and in organization and management of basic health care delivery.

As an economist, I have examined the budgets of more than 70 developing countries. With few exceptions, no country has the tax revenue to fully fund preventive and basic health care for its people. At the same time, people are spending tremendous amounts of their own money on medicine, indigenous medical care and so forth. So the new scheme tries to draw on both sources. In this rural mutual health care, which is just a label I am giving it, there are four essential elements. First, the Government subsidizes the demand side. Governments are very accustomed to always subsidizing the supply side, the providers, the government clinics. Second, you want to empower the people. You want to give them financial assistance and empower them. Third, the basic preventive services need to be in the village. Fourth, as we have learned from the Bamako Initiative, countries should organize a bulk purchasing and distribution system for essential drugs. You can save tremendous amounts of money through this kind of bulk purchasing and distribution as well as eliminate the counterfeit drugs.

This idea is not totally new. It has been tried by different nations, but has never gained international attention. Of course, the one which did gain international attention was China's cooperative medical system, but that collapsed after China shifted from a socialist to a market economy. Other examples include Thailand's rural health card, Indonesia's Dana Sehat and other models which have proved to be successful today in African nations, including Tanzania. They are experimenting with the community health fund based on a similar concept, and have shown some
positive results. China is also conducting social experiments. Madam Wu Yi and Minister Gao mentioned that China is conducting nationwide experiments. I for one, as an applied economist, have two in the Western provinces of China, but I will not take up time by giving you the details.

In innovative schemes, it is extremely important to carry out a scientific evaluation. Otherwise, you as policy-makers do not have the evidence-based information to make sound policy. I want to tell you what we found in China after 10 months of experimentation, covering 60,000 people. Seventy per cent of farmers were willing to join the scheme if we gave them a subsidy of US$ 2.50. Those who did not join tended to be healthy people, who did not feel they could benefit and stayed out of it because they did not think they would get sick and also the near-poor people, who did not have the money to join. In the first 10 months, we were able to make a 30% efficiency gain through purchasing of drugs, removing the counterfeit drugs in circulation, and standardizing treatment of eight common diseases at the village level.

In conclusion, I would like to argue for the Western Pacific Region, that you may want to consider walking with two legs. You want to consider health systems policy where you combine public and private financing. I want to emphasize that it is the responsibility of governments to finance public goods, such as prevention and public health. Another part of the two legs is organizing health care: you establish a horizontal system down to the village level as the platform so you can plug in the vertical programmes to which you are giving so much attention to today.

Thank you very much.