SUMMARY RECORD OF THE SECOND MEETING

Room A of the Kyoto International Conference Hall
Tuesday, 17 September 2002 at 9 a.m.

CHAIRPERSON: Dr Hideo SHINOZAKI (Japan)

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The CHAIRPERSON addressed the Committee (Annex 1).

2. ADDRESS BY THE DIRECTOR-GENERAL: Item 7 of the Agenda

The DIRECTOR-GENERAL addressed the Committee (Annex 2).

Professor HUANG Jiefu (China) noted that in the past few years WHO had undergone many changes, which had given health a more prominent position on the development agenda and increased the volume of extrabudgetary resources. The Director-General had played a remarkable role in changing the Organization, and China regretted that the current session of the Regional Committee was the last she would attend. She had shown considerable interest in the health system in China, which had been much appreciated and would always be remembered.

He drew attention in particular to the important work of the Commission on Macroeconomics and Health. On the basis of comprehensive data, its report illustrated the relationship between investment in health and economic development, which would help to persuade Member States to invest more in health, and international development partners to provide more financial support to low-income countries. The conclusions of the report should be widely disseminated in order to raise the awareness of policy-makers that investment in health had a far-reaching impact on economic development, poverty reduction, and improvement of people's health.

China, with the support of WHO, was organizing a ceremony to launch the report, together with a workshop which would promote it among senior policy-makers and make proposals for implementing its conclusions. It was hoped it would also persuade officials in other sectors of the importance of improvements in health. He thanked the Director-General for her advocacy efforts among senior policy-makers in China, and hoped that either she or senior officials of WHO would attend the launch and the workshop.

Dr TANAKA (Japan) commended the strong leadership of the Director-General, her restructuring of the Organization, and her efforts to place health at the centre of international development. He praised in particular her launching of the proposed framework convention on tobacco control and assessment of health systems' performance. Further, the objective assessment of risks to health and its use in framing policy, as proposed by the Director-General, were essential for the efficient use of scarce resources.

The establishment of partnerships between governments, international organizations, nongovernmental organizations and the private sector, to which the Director-General had given special attention, was important for strengthening interventions on specific health problems, and his Government supported those developments. In particular, establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria was a landmark development in control of those communicable diseases, and he highly commended the contribution of the Director-General in fostering international commitment to the Fund. In collaboration with WHO, Japan would provide maximum support for its management.

Regretting the Director-General's decision not to stand for a second term of office, he expressed his support for continuing reform of WHO, improved efficiency and management, and the redress of imbalance in geographical representation. He also looked forward to enhanced ties between the Organization and Member States to tackle health problems.

Dr SMALLWOOD (Australia) thanked the Director-General for her outstanding achievements, in particular her emphasis on the links between health, poverty and economic development. She had also successfully restructured the Organization, as reflected in the proposed programme budget for 2004-2005, which included the figures for regional offices and was moving to results-based budgeting. As a result of her exceptional work, WHO was clearly a more effective and efficient organization.

The REGIONAL DIRECTOR said that he had had many public and private opportunities to discuss matters with the Director-General, through such mechanisms as the Global Cabinet, from which he could ascertain that she was indeed a leader with a vision, integrity and commitment to public health. She was also a warm-hearted family person.

The Director-General deserved recognition for her excellent leadership and achievements in three areas in particular. First, she had raised the profile of WHO, not only in the health arena, but also in other sectors. Second, she had successfully emphasized the concept that health should be placed at the forefront of socioeconomic development, which had resulted in increased donor support. Third, she had produced extraordinary results in such areas as tobacco control and of essential drugs, especially with regard to accessibility of antiretroviral drugs for HIV/AIDS. Because of her commitment, the price of those drugs had fallen dramatically.

Her decision to leave the Organization was deeply regretted, but her legacy would remain for many years.

The DIRECTOR-GENERAL noted that it was considered unusual for someone in their prime to withdraw voluntarily from office. Even though she could continue working energetically for another few years, the choice was between standing for another full term of five years or working for one more year; there was no midway option. She had decided, on the advice of her family, that to continue working for a total of six more years would have been unwise.

She drew attention to the fact that her election in 1998 had been the first time that a woman had been elected to head a major organization of the United Nations system. Hitherto, women had been selected by the United Nations Secretary-General and appointed to high office. At national level, women had reached senior political positions in a similar fashion until they started to be elected. However, it was no coincidence that WHO had been the first; the participation of women was more extensive in the health sector than in others.

She shared the Regional Director's analysis of the key achievements of the past four years. In particular, the fact that WHO had been able to transcend the sectoral aspect of health was generally acknowledged as an important breakthrough. It had been recognized that health was not merely a humanitarian or human rights issue, or an ideal, but an essential factor in achieving socioeconomic development. That momentum had to be maintained and expanded.

3. PROPOSED PROGRAMME BUDGET 2004-2005: Item 9 of the Agenda

The REGIONAL DIRECTOR presented document WPR/RC53/4 - proposed programme budget for the biennium 2004-2005.

The proposed programme budget for the Western Pacific Region amounted to US$ 71 305 000. That was a reduction of US$ 1 957 000 or 2.67% from the 2002 2003 approved budget of US$ 73 262 000. That reduction was a result of the application of resolution WHA51.31 on regular budget allocations to regions. Of the total regional budget, US$ 39 574 000, or 55.50%, had been allocated for country activities and US$ 31 731 000, or 44.50%, for intercountry and regional activities.

The presentation of the proposed programme budget for 2004-2005 was similar to that for 2002-2003. Part 1 was the global proposed programme budget 2004-2005 and was common to all WHO regions (Annex 1), while Part 2, which was a strategic overview of the proposed programme budget 2004-2005, was specific to the Western Pacific Region (Annex 2). Taken together, the two budget documents reflected a more integrated and strategic approach to planning and budgeting. The documents established clear

Organization-wide priorities and objectives, and outlined what WHO as an Organization planned to achieve during the period 2004-2005. Annex 3 contained indicative country planning figures for 2004-2005 for the countries and areas in the Region. These had been prepared using the methodology requested by the Regional Committee in resolution WPR/RC50.R1, and adjusted according to guidance from the Director-General.

The regional overview of the proposed programme budget 2004-2005 had been prepared according to the results-based management approach. The application of that approach to management and budgeting was an essential part of the reforms being carried out throughout the Organization. Preparation of the proposed programme budget 2004-2005 also took into consideration feedback on the programme budget 2002-2003 from the Executive Board, the World Health Assembly and the regional committees, as well as lessons that had been learned from the last budgeting exercise.

Part 1 of the proposed programme budget (Annex 1) had been developed through a process of close consultation between WHO Headquarters and the six regions, paying due regard to the Organization-wide priorities that had been set out in the General Programme of Work for 2002-2005. As for the previous biennium, Part 1 was organized around 35 areas of work. Two areas of work, "Director-General's and Regional Directors' Offices" and "Director-General's and Regional Directors' development programme and initiatives", had been merged and a new area of work "WHO's presence in countries", had been added.

For each area of work, the issues and challenges were identified and the goal towards which WHO, its Member States and other partners would work was defined. The WHO objectives reflected the objectives that WHO – Organization-wide – was committed to. The expected results were the results for which the WHO secretariat was directly responsible. The strategic approaches would be used by WHO to address the issues and challenges.

Part 2, the regional overview of the proposed programme budget 2004-2005 (Annex 2) was organized according to the regional themes and focuses. For each focus, the most important issues and challenges that faced the Region were identified and the regional goals and WHO regional objectives were defined. The strategic approaches WHO proposed to employ during the biennium were then described. The financial information shown by theme and focus was related to the regional and intercountry level activities. Country level activities would be prepared later and the Regional Director would present a more comprehensive regional budget, which would include the country programme budgets, at next year's session of the Regional Committee.

Part 3 of the proposed programme budget 2004-2005 (Annex 3) contained the indicative country planning figures for each country. They had been determined according to resolution WPR/RC50.R1, which had been adopted by the Regional Committee at its fiftieth session. That resolution had requested the Regional Director to determine country allocations in accordance with the model recommended by resolution WHA51.31. Adjustment had been made following guidance from the Director-General to carry out a 10% shift from country activities to WHO's presence in countries, which was further explained in Annex 3.

Of greater significance had been the effect of resolution WHA51.31 on country planning figures. Over the three bienniums, the regional allocation for the Western Pacific had been reduced by US$ 9 million, and country activities by US$ 4.9 million. The negative effect of the implementation of that resolution had been substantial, both for country activities and for regional programmes.

The indicative planning figures presented in Part 3 would be the basis for detailed country plans, which would be prepared later.

Professor NYMADAWA (Mongolia) asked what percentages of the global and regional budgets for 2004-2005 were allocated to global priorities.

Dr TUKUITONGA (New Zealand) noted the financial pressures on the Regional Office, and sought reassurance on the matter of vaccine supply in emergency situations. In assessing the work programme, he asked whether the right work was being done in the right way, whether preparations were being made to counteract future threats to health, and whether the balance was right. There was a proposed reduction of some 10% in the immunization programme – though perhaps more would be made available through the Global Alliance for Vaccines and Immunization (GAVI). He noted that immunization was one of the most cost-effective actions known, and he encouraged continued support for adequate immunization coverage.

Several Member States had spoken of the immense burden of noncommunicable diseases, especially obesity and its consequences, which, according to the Report, caused 8 out of 10 deaths in the Region; yet a 6% reduction in funding for noncommunicable diseases was proposed. While acknowledging that that reduction might be offset by increases in country programmes, he advocated considerable strengthening of the noncommunicable disease programme. Lessons learned from tobacco control could be used to establish a more comprehensive framework for noncommunicable disease control. Few interventions in that area had been shown to be effective, which was a matter for concern. If such a framework

were established, several questions would have to be asked: could legislation and regulation support nutrition and physical activity programmes? Could the food industry be encouraged to pay more attention to the health effects of its products? Was it ethical to advertise inappropriate food products to children? How could the health sector work with other sectors to reduce the burden of noncommunicable diseases?

He noted that, despite the proposed overall reduction in the budget available to the Region, there was a proposed increase of 6.6% in costs of administration and a 14% increase in the personnel department.

While New Zealand shared global concerns about the potential use of biological and chemical agents to cause harm, it was equally aware of natural threats, such as a possible influenza pandemic, for which there would not be an adequate supply of vaccines for all countries. The subject of fair and equitable distribution of vaccines in the case of a pandemic should be considered for inclusion in the agenda of the World Health Assembly.

Dr CHOI (Republic of Korea) acknowledged that the budgetary allocation to his country had had to be reduced. Annexes 1 to 11 showed close connections between areas of work in terms of issues, objectives, strategic approaches, expected results and indicators of programmes. He suggested that WHO should distribute its limited resources more effectively, using overall coordination to implement the budget.

He advocated a further increase in the allocation for resource mobilization, external cooperation and partnerships. Noting that the proposed programme budget for human resources development had increased by more than 50%, he hoped that, as his country had long recommended, more support would be accorded to underrepresented countries. He noted further that the budget for WHO presence in countries was to increase by 10%, but he found the expected results and indicators for this somewhat abstract. The evaluation system for country office implementation should be strengthened.

Mr LIU Peilong (China) observed that the document before the Committee was the second proposed programme budget presented in the new style. The first – the proposed programme budget for 2002-03 – had had clear priorities and structure, and a results-based approach. It had included regular and extrabudgetary funding and was a very good document. However, since it was the product of a complete reform, there had still been room for improvement. The 2004-2005 budget document should retain the merits and overcome the shortcomings of the previous one. In the interests of brevity, he focused not on the merits but

on the weak points of the document in hand, in terms of budget level and allocation, structure, and formulation of country budgets.

The 2004-2005 budget was still based on the assumption of zero nominal growth, while it was predicted that extrabudgetary resources would increase by 37% over the previous biennium. While the whole budget for 2002-2003 had increased by 8% over the budget for the previous biennium, the corresponding figure for 2004-2005 was 23%. That was very encouraging, but actual resources received by the Western Pacific Region were not so promising. It appeared that actual extrabudgetary resources received by the Region in 2000-2001 accounted for only 3% of WHO extrabudgetary resources – the least received by any of the six regions. That figure obviously was not in line with the population size or needs of the Western Pacific Region. The projected figure for 2002-2003 for extrabudgetary resources had been reduced by a further 9% from the figure for 2000-2001. As regards extrabudgetary resources for 2004-2005, it was still not clear how much the Western Pacific Region would obtain as the proposed programme budget 2004-2005 did not show the level of extrabudgetary resources each region would receive. Attracting extrabudgetary resources had been one of the major tasks listed in the document WHO in the Western Pacific Region: a framework for action. Since it was very important to attract extrabudgetary resources to make up for the shortfall in the regular budget, he requested the Regional Director to work with WHO Headquarters to increase the allocation of extrabudgetary resources to the Region and hoped that WHO would formulate clear criteria for allocation of extrabudgetary resources to the regions.

The unfavourable allocation of extrabudgetary resources to the Region had coincided with a decline in regular budgetary provisions. Following the adoption of resolution WHA51.31, the allocation for the Western Pacific Region would be reduced by approximately US$ 9 million over 3 bienniums. He maintained that the decline in the regional allocation resulting from resolution WHA51.31 should not continue after the end of 2005, otherwise country and intercountry programmes would be severely affected.

It was proposed that global priority areas should receive 38% of the regional regular budget. However, the annex to part 1 indicated that some areas would receive no allocation. Did that mean that no activities would be carried out in those areas? As indicated by the representative of New Zealand, administration and finance would receive a substantial increase in funding; given the views expressed at WHO Headquarters concerning the need to reduce administrative costs, he suggested that this be reconsidered.

Annex 3 to document WPR/RC53/4 indicated that the allocation to finance WHO's presence in countries had been substantially increased, largely by reallocating 10% of the funds for country activities. While he supported the strengthening of WHO country offices, which would benefit national capacity-building, it should not be achieved at the cost of country activities. Indicative country figures for China suggested a reduction of 13% in the allocation for the 2004-2005 biennium compared with 2002-2003. Such a substantial reduction over a short period would surely affect country activities.

The proposed programme budget had been structured by area of work, different levels of organization, and sources of funding and it was difficult to see how budget allocations were related to disease burden, which was frequently used in analysis of the global situation. China had commented on that point during the formulation the 2002-2003 proposed programme budget and had expressed the hope that future proposed programme budgets would permit such comparison. He asked why the earlier practice of providing a breakdown by major disease had been discontinued.

He welcomed the more consistent structure and titles of the various areas of work and focuses in parts 1 and 2, respectively. However the strategic approaches in the two parts were handled differently. The information given in part 1 was too general compared with that in part 2; the provision of further details would provide more specific guidance to Member States on the attainment of WHO objectives. He asked why, in part 2, the title of the box setting out expected outcomes for each focus had been changed from "Expected results and indicators" in the previous biennium to "Indicators" in 2004-2005. Although several indicators were shown for each focus, only a single figure was given for the budget allocation. As a consequence it was not possible to determine the specific allocations within each focus. For example, how much would be allocated to traditional medicine, which came within the allocation for health technology and pharmaceuticals. He asked whether it would be feasible to provide a breakdown of each allocation by expected result.

He understood that, once the Director-General had approved the indicative country planning figures, the Regional Office would work with Member States to develop country programmes. Member States, including China, had encountered problems in 2002-2003, the first time the procedure had been implemented, and interpretations of the guidelines provided by the Regional Office had varied. He hoped that the guidelines would be improved for 2004-2005, that relevant training would be given to Regional Office and country staff, and that more time could be allowed for the formulation of country programmes. Further information on the proposed time-frame for the procedure would be welcome.

Ms BLACKWOOD (United States of America) reiterated the commitment of her country to the mission of the WHO Western Pacific Regional Office and its support for goals to improve health in the Region. She congratulated the Regional Office on having prepared a results-based budget, as had been done at WHO Headquarters. WHO should focus on the identified priorities of its Member States, and the allocations in areas of lower priority should be decreased; other ways should be found to finance those areas.

She noted that a significant 37% increase in extrabudgetary resources was projected for WHO in part 1 of the proposed programme budget for 2004-2005; however, no details were provided. She concurred with the representative of China in requesting an indication of the proportion of those funds that would be available for the Western Pacific Region for 2002-2003. Part 2 of the proposed budget also made little mention of extrabudgetary resources, the only reference being to the availability of US$ 2 million for external cooperation and partnerships.

She was pleased to note the link that had been made between communicable disease surveillance and global and national security, in view of the attacks on her country in the preceding year. She remarked that the decision to reduce the budget allocation for healthy settings and environment by nearly 15% must have been a difficult one, given the priorities of the Region. She proposed that, in addition to collaborating with the Healthy Cities initiative, the Regional Office might like to note the example of her country's Healthy People 2010 initiative.

She expressed concern regarding the figures given in the section on reproductive health for unwanted pregnancies, for which no reference was cited. The statement in part 2 that unsafe abortion was the major cause of maternal death in most developing countries contradicted the report of the Secretary-General of the United Nations, *We the children*, which stated that the vast majority of maternal deaths were due to complications arising during pregnancy, the single most common cause being postpartum haemorrhage. Part 2 of the proposed programme budget 2004-2005 did not mention those other important causes of maternal death.

She was pleased to note that, although the budgetary allocation for noncommunicable diseases had decreased, the emphasis on incorporation of mental health into general health services remained strong, and indicators of noncommunicable diseases were included in evidence-based medicine. Furthermore, the WHO Western Pacific Region was more than doubling its allocation to the Tobacco Free Initiative.

She trusted that the considerable reduction in the budgetary allocation for health systems development was due to successful use of the tools that had been developed for that purpose, and not a sign of decreased priority for that area. In view of the benefits of specifying and monitoring the results sought in each programme area, she noted with satisfaction the budgetary increase for programme planning, monitoring and evaluation.

She agreed with the representative of China regarding the usefulness of a chart showing the distribution of expenditure within each area of work and comparisons with the previous biennium.

Mr MANUOHALALO (France) noted the decrease in the regular budget for the Region for 2004-2005 as compared with the preceding biennium, in accordance with resolution WHA51.31. That decrease affected programmes that his country considered as priorities, such as Stop TB and the Expanded Programme on Immunization, and he asked what criteria had been used in making those difficult decisions. The 4% decrease in resources for the Stop TB programme appeared to contradict the position of the Regional Office, as one of the actions proposed in document WPR/RC53/7 was to "bridge the resource gap that currently affects further DOTS expansion." Similar comments could be made with regard to the Expanded Programme on Immunization, in view of its important preventive role.

Dr OTTO (Palau) reiterated his satisfaction with the progress that had been achieved in the area of mental health, both worldwide and within the Region; his query regarding capacity-building for care givers of patients with mental illness had been addressed satisfactorily. Nevertheless, part 1 of the proposed programme budget stated that the portion of the global burden of disease attributable to mental and neurological disorders and substance abuse was expected to be 15% by 2020. Part 1 indicated that the burden of disease attributable to major depression could be halved if all affected persons were treated. It also reported that, of the countries with specific budgets for mental health, 36% allocated less than 1% of their health budget to that aspect. One of the indicators for achieving the goal "To reduce the burden associated with mental and neurological disorders and substance abuse and to promote good mental health worldwide" was the "number of countries that had increased their budget for mental health". He was therefore concerned that the proposed increase in the budget for mental health and substance abuse was less than 1%. If the Organization did not increase its allocation by a greater amount, Member States could not be expected to do so. He therefore asked that the budgetary allocation be increased by at least 2.5%.

He regretted the decision of the Director-General to retire, as the developing Pacific island countries would be losing a strong advocate.

Mr UNA (Solomon Islands) commended the structure and layout of the proposed programme budget for 2004-2005, which reflected the areas of priority identified in the report of the Regional Director. The onus was now on countries to identify pressing health issues that fell within the major areas of work covered by the proposed budget. He hoped that the resources would be distributed fairly.

Mrs LE THI THUI HA (Viet Nam) said that she supported the proposal by the representative of China that the reduction in regular budget allocations to regions following adoption of resolution WHA51.31 should expire by the end of 2005. The indicative country planning figures in the proposed programme budget for 2004-2005 showed a significant decline in the regional allocation as a whole and in country allocations in particular, and Annex 3 to the document showed a reduction of 9% in the proposed allocation to her country. Nevertheless, owing to the strengthened role of the WHO country office during the past three years, substantial additional resources had been mobilized for activities including HIV/AIDS prevention and control, health care financing, food safety, safe motherhood and control of lymphatic filariasis, and she thanked WHO for its support.

Dr TANAKA (Japan) commended the efforts made to formulate a budget with appropriate focus on priority areas at a difficult time of reduced budgetary allocation to the Region. He asked, however, for clear statements of 'expected outcomes', as had been done in the budgets for 2000-2001 and 2002-2003. The Director-General had remarked on the negative impact of resolution WHA51.31 on the Western Pacific Region. Although the countries of the Region had acceded to the terms of that resolution, a limited time-frame had been included. He supported the proposal of the representative of China that the validity of the resolution should expire at the end of 2005, at which time regular budget allocations to regions should be renegotiated.

The meeting rose at 11:45 a.m.

ANNEX 1

ADDRESS BY THE INCOMING CHAIRPERSON

It is with deep pride and a humble spirit that I have accepted your nomination to be the Chairperson of the fifty-third Session of the Regional Committee for the Western Pacific. Pride, at having been given a major role to play in this very important meeting; and a humble spirit at the thought of steering the deliberations of such highly respected and distinguished colleagues. However, I am confident that with your kind support and that of my fellow office bearers I shall be able to justify the heavy responsibility that has been placed on my shoulders.

Some years ago, I worked in the WHO Regional Office in Manila where I had my first experience of international work, as Regional Adviser for Mental Health. At that time, I was impressed not only by the warm and friendly atmosphere pervading in the Region but also by the dedication with which people performed their work. Now that I am representing a Member State, I am delighted that this Region, despite its great diversity, is still bound by that same spirit of solidarity and unity of purpose.

Distinguished Representatives, the Government of Japan is privileged to host this fifty-third session of the Regional Committee. This will be the fourth time that Japan has played host to the Committee. The fourth session in 1953 and the twenty-eighth session in 1977 were held in Tokyo, while the forty-second session in 1991 was held in Omiya, Saitama Prefecture. The fifty-third session this year is being held in the ancient and historic City of Kyoto. It was also here in Kyoto that the Regional Certification Commission declared the Western Pacific Region to be polio-free in October 2000, an extremely important milestone in our efforts to achieve the goal of health for all.

Considerable changes have occurred in the world and in this Region since the Committee first met in Japan in 1953. First of all, the membership of the Committee has increased from fourteen in 1953 to its current total of thirty-three. There has also been a significant growth in the Region's total population, which now accounts for about one fourth of the global population. Great efforts have gone into building and strengthening basic health infrastructures throughout the Region. Countries are now experiencing economic progress and improvements in the health and quality of life of their peoples. So successful have countries been that the Region's population is ageing very quickly, with important health, social and economic implications.

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The Region also faces challenges to health from rapid urbanization, degradation of the environment and the need to ensure that health services are available in remote areas and for vulnerable groups. Despite moves towards globalization, the world remains divided, with gaps between the rich and poor remaining, and even increasing in some countries. As a Region, we have to strike a balance between the positive and the undesirable effects of economic development. The Director-General, in her address at the just concluded World Summit for Sustainable Development held in Johannesburg, South Africa, posed the question of how the world can meet the needs of a growing population in the present and in the future, stressing that people are at the centre of sustainable development, and their health is therefore central to the future.

Honourable Representatives, the challenge is even greater since we have to address these issues under conditions of budgetary constraint. The Regional Director has made difficult and painful decisions in managing the affairs of the Region and we thank him for his leadership in this. I would also like to thank the Director-General, Dr Brundtland, for her consistent and determined efforts to position health high in the development agenda. The world is now beginning to realize the close relationship between economic growth and health development. This has led to an increase in various forms of partnerships and alliances for health, something that gives us hope during these challenging times.

The Regional Director's report that we discussed yesterday referred to significant progress that we have made in the control of infectious diseases, although some still remain as major problems. Our discussions over the next four days will cover such persistent health problems as: tuberculosis; sexually transmitted infections including HIV and AIDS, and malaria, filariasis and other parasitic diseases.

Later in the week we shall also take the a broader look at the health sector, when we discuss the agenda items on essential public health functions and ethical issues related to new developments in the health sector. These discussions will allow us to take a step back from our concern with immediate and urgent problems and to examine future directions for the health sector.

Cancer, diabetes, cardiovascular and cerebrovascular diseases are major public health problems in practically all countries of the Region. Oral health remains an issue in many countries. Yet, despite evidence that good diet, physical activity, not smoking and moderate alcohol consumption make a major contribution to good health, in most countries health

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promotion is still low on the list of government priorities. Although it will always be difficult to promote healthy lifestyles because of the need to involve partners from outside the health sector, we need to explore fresh approaches that will make healthy lifestyles exciting and socially desirable and strategies that encourage and reinforce positive, healthier behaviour. For this reason, I am very much looking forward to our ministerial round table on diet, physical activity and health on Wednesday afternoon. I am sure this will produce many excellent ideas that we can apply after the session.

As we review the proposed programme budget for 2004-2005 later today, let us be reminded that this will be the basis for our own country planning in the coming months. Let us focus sharply on the implications of this in terms of setting strategic directions and priorities.

Distinguished Representatives, we will have much to occupy our minds in the next four days. However I believe that we shall come out of this meeting with renewed vigour to push the agenda of health forward and improve the lives of the people of the Western Pacific Region.

Although it will be a busy week, I would urge you to take some time to discover and enjoy Kyoto. Kyoto is a special place. Kyoto was the capital of Japan for over a thousand years, and for us Japanese, it is the centre of our culture and spirit. Yesterday, our Minister of Health, Labour and Welfare welcomed you to Kyoto and to Japan. Let me convey to you again our Government's and our people's warm welcome to you all. I hope you will find the session and your stay here a truly memorable and productive one.

Again thank you for electing me to be your chairman. I shall do my best to live up to your expectations and to be worthy of the trust you have placed in me.

ANNEX 2

ADDRESS BY THE DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

At the World Summit on Sustainable Development in Johannesburg earlier this month, there was clear recognition that investment in people's health is an essential element of sustainable development.

Ten years on from Rio, the world accepts that health is a key element in securing our common future.

Now we must act: to do better at addressing ill health, and to succeed. This means focusing on the issues that matter the most, and better ways of working.

First - the focus.

Two years ago, world leaders agreed on development goals for the millennium - the Millennium Development Goals or MDGs. Many of them are concerned with health. Since then we have worked together to define indicators and analyse the costs of achieving them. The MDGs help us to unify our actions - both internationally and at country level. At the same time, we need to focus on the needs of countries which are well on the path to social and economic development, and the health problems that reflect this "post-transition" agenda.

Last year the Report of the Commission on Macroeconomics and Health was launched. The Commissioners showed that the annual minimum cost of essential health care is around $40 per person. For millions of people the spend is much less. In this region we see real progress though there is still the challenge of ensuring that all can access the health care they need.

Through the "MacroHealth" project WHO is now communicating the key messages of the Commission's report. Several countries within this region are engaged with us in the vigorous effort to plan - and then programme - substantial increases in health investments .

Increases will include resources that are becoming available through new partnerships - like the Global Alliance for Vaccines and Immunisation, the Global Fund to fight AIDS, TB and Malaria and now the Global Alliance to Improve Nutrition.

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We have interventions that work. We can show what will be achieved with extra resources, because we know the price of success. And we see that development assistance for health is on the increase.

That is why health has been so prominent in recent international conferences - particularly in Financing for Development in Monterrey, Mexico, the start of the new Trade Round in Doha and the Sustainable Development Summit in Johannesburg.

I said that we need better ways of working. The most important requirement is that we work well together. Only then can we break down the barriers which prevent poor people accessing effective health systems and essential medicines.

New international agreements can help. Three years ago, we began to negotiate the Framework Convention on Tobacco Control. I hope that the Health Assembly next year adopts a strong Convention: when it comes into force we must implement it with all speed.

But on most occasions we will need to establish and sustain more informal partnerships. The challenge is for Governments, civil society and private entities to respond, within this spirit. WHO is helping, and - as we heard yesterday - there are many good examples within this Region.

For example, we are working together to help the Global Fund to fight AIDS, Malaria and TB to be a technical and administrative success. I have shared some of our perspectives with the Fund's Executive Director. We will do our best to help countries in this Region to prepare sound proposals and implement them successfully. Above all, we need to ensure that the Global Fund has enough resources to function properly.

We are best able to secure extra funds if we can achieve good results with available resources. That is why we have all worked hard for reductions in the price of essential health commodities, including medicines. After intense efforts over the last four years, differential pricing is now commonly used to widen poor people's access to medicines. Prices of some antiretrovirals dropped by 80-90% and TB medicine prices reduced by a third. Nevirapine is available free of charge for preventing mother-to-child transmission of HIV, as is multidrug therapy for leprosy .

There is more. At Doha, safeguards in the TRIPS agreement were strengthened with respect to essential medicines. In parallel, several new partnerships have been established to develop new medicines for neglected diseases.

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Governments, NGOs, researchers, companies, the media, and the UN should all join up with WHO and take credit for these achievements. They placed the issue of access to medicines on the global agenda. They insisted that people's health must take precedence over trade. They broke the mould, developing new rules on medicine pricing.

But so much remains to be done.

For example, we now see a welcome openness on AIDS issues. This has implications for prevention programmes. In addition, the six million people living with AIDS need effective care, including antiretrovirals (ARVs). Many ask why - when they have struggled for lower prices - they still see so many people suffering for lack of medicines.

The reality is that low medicine prices are essential but other factors are also crucial to improving access to care. These include rational selection and use of essential drugs; quality control; and health systems capable of providing treatment and care with compassion and efficiency for years.

This year, countries will take forward discussions, which started in Doha on trade and public health. WHO's position is that no clause in any trade agreement should work in a way that denies access to life-saving medicines to those who need them for common diseases - wherever they live and whatever their ability to pay. I would add that we will be taking up the theme of traditional medicines, and the new WHO strategy document, at the forthcoming Executive Board Session.

How do Health Ministers develop effective, fair and responsive health systems when budgets are tight and not enough skilled people are available?

As we saw yesterday, we need to know what is happening in each of our countries and share evidence on what works. How can lessons learned be adapted to different settings and conditions? Within WHO we are developing systems to gather and share such information.

Through the World Health Survey we are helping countries to analyse the performance of their health systems. Countries can use survey data to generate information that helps improve the performance of health systems in addressing underserved populations.

Health systems depend on skilled professionals for managing the delivery of health services. WHO will continue working with governments to help establish and implement

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human resource policies for the health sector. WHO is also working with governments on the issues of health worker migration, salaries and salary supplements, and the potential impact of the General Agreement on Trade in Services.

In partnership with health professional bodies, academic institutions and the World Bank we will give priority to facilitating an increase in the numbers of experienced health system professionals both in countries and regions.

What are the most important risks to health in today's world? This year's World Health Report, to be issued in October, provides some of the answers. They include some familiar risks associated with underdevelopment, such as unsafe water, poor sanitation and hygiene, unsafe sex (particularly related to HIV/AIDS), iron and other nutrient deficiency, and indoor smoke from solid fuels.

Other enemies of health are more associated with unhealthy consumption patterns such as unhealthy diets and obesity, high blood pressure and blood cholesterol, tobacco use, excessive alcohol consumption, and physical inactivity. These risks, and the diseases they cause, are dominant in all lower-middle and high-income countries. They now dominate the epidemiological profile of countries from China to Palau; from Australia to Singapore.

Throughout the world, unhealthy consumption patterns are replacing healthier ways of eating and moving: these changes are now starting to affect the health of all - young and old, rich and poor.

Our work helps with the selection of cost-effective ways to reduce such risks. Consider tobacco.

Why else have we fought so hard to regulate a product that kills half of its regular users? For decades we have known how to prevent each of the four million annual deaths caused by tobacco consumption. It's not difficult: tax increases, advertising bans and regulations to keep indoor air clean.

In 1998 I was convinced that we must act. So we examined Article 19 of WHO's Constitution. Member States can use this to negotiate global standards. That is why we chose to use the Organization's treaty-making power to prevent tobacco-related diseases. By setting in motion the Framework Convention on Tobacco Control negotiations, we were making history.

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The FCTC negotiations have reminded us about the critical role of the State in public health, - particularly in setting norms and standards, and ensuring that others adhere to them.

Such efforts do encounter opposition. In all regions we find tobacco companies continuing to act solely in their own interests – safeguarding market share and profits, luring ever-younger women and men into the smoking habit. How? With flawed science and false propaganda, often disguised as corporate citizenship.

The first draft of the FCTC is now ready for the next round of negotiations in October. It spells out possible agreements on tobacco advertising, promotion, sponsorship, illicit trade in tobacco products, taxes, and international cooperation.

If countries want it badly enough, FCTC can become real. But this means political determination in the final, crucial stages to determine the strength of WHO's first international treaty.

My target date for finishing is the World Health Assembly in May 2003. The FCTC will then come into force. It will bring benefits to countries and to their people. It will help safeguard important public health policies, in a way that is tailored to national needs.

I know that you are better prepared then ever before. Many Island States met recently to prepare for October, other countries will be meeting soon. I know you are committed to make the FCTC a treaty in the service of public health.

And there is more for us to do. We know that health conditions like diabetes, cardiovascular diseases and cancer can often be prevented. This means changing diets and increased exercise. WHO is responding to a World Health Assembly resolution of last May with a global strategy on diet, physical activity and health. Member States will discuss this at six regional consultations in the next year. I know from what I heard yesterday that countries in this Region will be playing their part.

Just think about it: in 2000, 1.6 million people died as a result of violence. Half were suicides, one-third were homicides, and one-fifth were affected by war. Millions more are scarred for life by violence that they have suffered: for many the scars are locked away. And many of those affected are women. That is why I am going to Brussels early next month to launch the first World Report on Violence and Health. We need to break the silence and confront violence - now.

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Think again: too many children are made ill by their surroundings - where they live, work and play. In 2000, nearly 5 million child deaths resulted from unhealthy environments. Most commonly the children developed acute respiratory infections and diarrhoea.

We know how unsafe environments make children sick. Human waste finds its way into water, into food. Water is further contaminated with germs and chemicals. Air is polluted with smoke from indoor cooking or tobacco use. Other toxins get into air and soil. Insects that carry diseases bite children. Children are injured at home or on the road.

Two weeks ago, in Johannesburg, we started to build an alliance - to promote healthier environments for children. We are working together to tackle environmental health risks - with cost-effective interventions, agreed strategies and precise indicators. We know that by working together we will make more of a difference - to the benefit of our children.

As many of you know, these will be the last Regional Committees I shall be attending as Director-General. WHO's regional structure gives it a unique place in the United Nations system. I want to pay tribute to our dedicated staff in the Regional Offices. I want to thank the governments who host these offices so generously. I also want to express my appreciation to the staff of our country offices.

I am most encouraged by the way in which experience shared among countries has resulted in regional solidarity and solutions.

At present, the Regional Directors and I are looking especially at improving our country operations. WHO is present in 147 countries around the world. At this year's World Health Assembly, I announced a Country Focus Initiative. I want WHO to focus better on the needs of countries, supporting effective health action through both standard-setting and technical cooperation.

Our Initiative draws on the work now being undertaken to establish strategies for cooperation between countries and WHO. It involves the Organization as a whole in responding to a strategic agenda for health for each country. It will improve the core competencies of country teams so that they are better able to pursue the agreed strategy. It will enhance the way in which regional and Geneva-based WHO programmes support country action. It will transform WHO's administrative systems to permit more effective operation of WHO country offices.

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And it will increase the ability of WHO country offices to work with the UN system, World Bank and other development partners.

We are consulting with Member States and development partners to establish options for taking this Initiative forward. We will present the key elements to the next Executive Board.

The outline of our proposed programme budget for 2004-2005 is on the agenda of all Regional Committees this year. Following the debate on priority setting in the Executive Board, health and the environment is now proposed as an additional priority. And two existing priorities have been expanded: health systems will include work on essential medicines, and I am suggesting that children's health be added to the priority of making pregnancy safer.

The new budget has expected results and indicators that integrate activities at all levels of WHO, and it relates to all sources of funds. In response to requests from many Member States, the budget proposals also show, for the first time, how much of our extra-budgetary resources we estimate will be spent in countries and at the regional level.

I have made proposals for investing in strengthening WHO's presence in countries. This is vital if we are to reach the goals of the Country Focus Initiative. It is needed if we are to administer effectively what we expect to be a growing role for country offices in dealing with extra-budgetary resources and with donors. It is also necessary if we are to build up expertise on health systems in our country offices. We also need to collect and collate relevant health information, in conjunction with national health authorities.

The forthcoming biennium will be the third in which we have had to consider the question of the reallocation of the regular budget between regions, in accordance with the decision of the Health Assembly in 1998. As you know, that Resolution set a maximum of 3 per cent per year for the reduction in the regular budget in any region. WPRO is amongst the regions where the formula called for a reduction. In the first biennium, the full 3 per cent was applied. For this current biennium, I decided to limit the reduction to 2 per cent per year, and I am proposing 1.5 per cent per year for 2004-2005. However, given that there are some Least Developed Countries in this Region, the reduction in fact amounts to about 1.3% per year. You will recall, of course, that a review of the Resolution is scheduled for 2004.

When I started my term in 1998, I committed WHO to making a difference.

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Our analysis of the Global Burden of Disease encouraged us to set clear priorities, and we have done so.

We now have a focused approach to world-wide improvements in health that reflects our corporate strategy. We work with partners at all times. Together -

- We are scaling up action to address the health conditions that drive and are driven by poverty.
- We are making sure that the health sector plays a central role in curbing the pandemic of HIV/AIDS.
- We are helping to establish health systems that are effective, fair and responsive to people's needs.
- We are confronting risks that contribute to ill health worldwide.
- And, to underpin all these efforts, we are doing everything we can to put health at the very core and centre of political attention.

It is a challenging agenda; and one which we can only tackle if we continue this focused effort - together.

Thank you very much.