World Health Organization

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Your Excellency, Madam Chair, honourable ministers, distinguished delegates, Dr Danzon, our Regional Director, ladies and gentlemen,

First and foremost, I would like to join previous speakers in offering my condolences to those who lost family members or suffered in recent events. Let me thank the government of Georgia for its hospitality in hosting the Regional Committee. As is true for several countries in the European region, the health care system in Georgia is in transition, with many obstacles to overcome.

Let me congratulate the Ministry of Labour, Health and Social Affairs for its plans to reform the health sector. You are grappling with a fragile economic situation, and with catastrophic health expenditures that deepen poverty.

You are seeking to improve the health of the people of Georgia by guaranteeing universal access to a package of public health services and basic health care. You have made primary health care a priority area for investment. These are laudable aims, but the challenges are great. Rest assured of continuing support from WHO.

The Regional Director's report for 2006–2007 refers to the good collaboration between the regions, and between headquarters and regions. I fully agree with his comments. I am grateful to the Regional Directors and staff throughout the Organization for their cooperation. We all realize the importance of working together to support our member states in a seamless manner.

In his report, the Regional Director identifies the development of health systems as the most important area of work for the regional office.

Recent work in this area, and most especially the Tallinn Charter and supporting documents, serves health here in Georgia, throughout Europe, and indeed worldwide.

Ladies and gentlemen,

During this session, you will be tackling two of the most complex, tenacious, and elusive issues in public health.

You are looking at ways to improve the performance of health systems, and this means better fairness as well as greater efficiency. And you are looking at ways to change human behaviours, again with an emphasis on health systems.

In all of public health, there is probably nothing harder than changing human behaviours. When a programme brings success, the results often cannot be replicated in another setting. Or they cannot be brought to scale, Or, most often, they cannot be sustained.

We are like Sisyphus, the mythical king from ancient Greece, who is condemned to role a huge boulder up a hill, only to watch it roll right back down again.

Efforts to improve the performance of health systems also have a long history, and likewise with patchy success. This is a history of decades of experiments, shifting policy advice, huge and costly errors and an almost incomprehensible failure to learn from successes and mistakes.

I applaud your courage in tackling these problems. Though difficult, they represent two of the most important barriers to health development facing every country in the world.

The European Ministerial Conference on Health Systems sent a clear message to the rest of the world. The way that health systems are organized, financed and managed is important. Improved performance is critical, even in countries with some of the best life expectancies, and the best health systems in the world.

Improved performance aims not just for greater efficiency, but also for better fairness. And it does so in ways that influence or coordinate actions in other sectors, so that health impacts are taken into account in all policies.

The achievements behind the Tallinn Charter take the international debate on health development a step forward. This time around, we have a better chance to get things right. The problem is recognized, and the motivation and momentum for change are stronger than ever before.

Ladies and gentlemen,

Stalled progress towards the health-related Millennium Development Goals, notably in sexual and reproductive health, has forced a hard look at the consequences of decades of failure to invest in basic health infrastructures, services, and staff.

As we have seen, powerful interventions and the money to purchase them will not buy better health outcomes in the absence of efficient systems for delivery.

Last month, the International AIDS Conference in Mexico gave major emphasis to the importance of strengthening health systems. The successful drive to reach 3 million people with antiretroviral therapy has revealed the critical barriers caused by weak systems for drug procurement and delivery, weak laboratory support, and inadequate numbers of staff.

That conference also stressed prevention as the only way to catch up with the HIV/AIDS epidemic and get ahead. It showed, in a vivid way, the great difficulty of behaviour change. In the Americas, as in parts of Europe, the AIDS epidemic has resurged in men who have sex with men.

This is exactly the group that initially pioneered behaviour change for prevention, and had such good success. Once again, we have rolled a huge bolder up a hill, only to watch it roll down again.

In June, a Global Leadership Forum looked at the need to integrate the response to the closely related epidemics of AIDS and TB. This is yet another expression of the drive for more efficient service delivery.

Let me remind you of the alarming rise of multi-drug resistant TB in Europe. This region has by far the world's highest percentage of multi-drug resistant TB among newly diagnosed cases. In fact, one in every five new cases is resistant to multiple drugs, right from the start.

The implications for health systems and budgets are huge, as this form of TB is much more difficult and around 100 times more expensive to treat. In this region, Estonia and Latvia have shown that, when basic health system capacity is improved, high rates of multi-drug resistant TB can be contained and even reversed.

The rise of chronic diseases has uncovered further problems. It has demonstrated the burden of long-term care on health systems and budgets. It has revealed the catastrophic costs that drive households below the poverty line.

It has shown us the bitter irony of promoting health as a poverty-reduction strategy at a time when the costs of health care can themselves be a cause of poverty.

Prevention is by far the better option, and this requires behaviour change and coherence of government policies. At the same time, the main risk factors for chronic diseases lie beyond the direct control of the health sector.

In other words, the response to chronic diseases and many other health problems requires efficiency, fairness, and multisectoral action.

Ladies and gentlemen,

Thirty years ago, the Declaration of Alma-Ata articulated primary health care as a set of guiding values for health development, a set of principles for the organization of health services, and a range of approaches for addressing priority health needs and the fundamental determinants of health.

Fairness in access to care and efficiency in service delivery were overarching goals. Above all, primary health care offered a way to organize the full range of health care, from households to hospitals, with prevention equally as important as cure, and with resources invested rationally in the different levels of care.

The values of equity, social justice, and universal coverage are solidly present in the Tallinn Charter. As the document before this Committee notes, these common values play a central role in health decision-making all across Europe.

The principle of a holistic approach to health, which includes attention to prevention and addresses the fundamental determinants of health, is equally present.

The approaches of community participation, particularly involving women as agents of change, multisectoral action, and technology choices aligned with priority needs have likewise shown their enduring value.

As stated in the Regional Director's Report, developing high-quality services based on primary health care is the key to improving health system performance in both the eastern and western countries of Europe.

The primary health care approach, as articulated in 1978, was almost immediately misunderstood. It was a radical attack on the medical establishment. It was utopian. It was confused with an exclusive focus on first-level care. For some proponents of development, it looked cheap: poor care for poor people, a second-rate solution for developing countries.

After 30 years, primary health care is no longer so deeply misunderstood. The ministerial conference has helped return primary health care to its original meaning. This is a rational approach to fair and efficient, good quality care. And its values, principles and approaches have relevance in rich and poor countries alike.

The Tallinn Charter drew on work that followed the Commission on Macroeconomics and Health. This work showed that health is not a drain on resources. Instead, it is a producer of economic gain.

You have extended this thinking to health systems. A health system is not just a burdensome and expensive duty of government. It is not a system, say, like a municipal water supply that is expected to pump out some basic services, and let market forces take care of the rest. If people want fancy bottled water, let them buy it.

If health services in the public sector provide poor quality care, if health services in the public sector are overcrowded and poorly staffed, it is not an acceptable solution to rely on private health services to make up for these inadequacies.

To do so is to invite inefficiencies and encourage inequity. We have abundant evidence that proves this point. Good stewardship means oversight for health care in all its dimensions.

People should not become poor because of ill health. As the health plan for Georgia notes, a single episode of illness can drive an entire household into poverty.

Health systems will not automatically gravitate towards greater fairness and efficiency. Deliberate policy decisions are required.

This, I believe, is the most significant achievement of the Tallinn Charter and all the preparatory work that supported its development. You have recast the significance of health systems.

A health system is not a burdensome money-guzzling duty. It is a strategic opportunity. A health system provides a strategic opportunity to manage health in a foresighted, proactive way. And it provides a strategic opportunity to manage the dynamic two-way relationship between a nation's health and its wealth.

Let me use just one example, taken from documentation prepared for the ministerial conference on health systems. Demographic ageing is now a global trend. Increased life expectancy is driving the rise of chronic diseases.

The costs of caring for the elderly are considered a major reason for increased government expenditures on health. The burden of caring for growing numbers of the elderly is one reason for the shortage of health care workers.

Instead of accepting this burden as inevitable, you have shown how health systems can offer a better option. You have shown how a health system that makes prevention and health promotion a priority can reduce disabilities in the elderly, reduce the costs of care, and also improve the quality of life.

This is the superior, far-sighted approach that emerges when health systems are treated as a strategic opportunity.

This view makes tremendous good sense in the interest of efficiency, fairness, and the ultimate goal of health development: better health outcomes. This view also has some solid support.

Ladies and gentlemen,

At the end of August, the Commission on Social Determinants of Health issued its final report. The striking gaps in health outcomes are its main concern, and greater equity is the objective.

The report challenges the assumption that economic growth alone will reduce poverty and improve health. On present trends, increased economic prosperity tends to benefit populations that are already well-off, leaving others further and further behind. This trend is readily apparent in parts of Europe.

As the report notes, the most important determinants of health arise from the social conditions in which people are born, live, work, and age. And these conditions are shaped by government policies.

Economic growth will improve the health of the poor only when policies are in place that explicitly address these underlying social conditions. In the absence of such policies, the majority of the world's population will not achieve the level of health and economic productivity that is biologically possible.

Gaps in health outcomes are not a matter of fate. They are markers of policy failure.

The report places the responsibility for reducing health inequities squarely on the shoulders of policy-makers. And it does so in sectors well beyond health.

The report recognizes that nearly all the social determinants of health fall outside the direct control of the health sector. Work done in this region fully substantiates this finding, especially for chronic diseases. The report calls for a whole-of-government approach that makes health a part of all governments policies, in all sectors. In other words, health in all policies.

The Commission's findings hold true at the international level. The forces that fuel inequities in health operate within countries under the authority of governments. But increasingly, these forces operate among countries under the influence of globalization.

As just one example, the industrialization of the food supply and its globalized marketing and distribution are one reason why diet-related diseases are now found the world over.

Let me remind you: the health sector had no say in policies that have made climate change inevitable. We had no say in policies responsible for the crisis of soaring food prices.

When we think about the Commission's findings, we must also think about a fundamental paradox. At the international level, health has risen to a high place on the development agenda. Yet within most governments, the health ministry usually has less clout and negotiating power than other members of cabinet.

Ladies and gentlemen,

Let us be frank. In most countries, an appeal to the value of health equity will not be sufficient to gain high-level political commitment. It will not be enough to persuade other sectors to take health impacts into account in all policies.

This is why I believe the work being done in this region is so important. You have elaborated a range of policy tools, incentive schemes, and legal and regulatory instruments for improving the performance of health systems.

You have done so based on solid evidence. And you have used some powerful – and persuasive – economic arguments.

Primary health care is quality health care. This is health care that requires resources. This is an approach that must be supported by powerful arguments and persuasive evidence. And this is an approach that requires enormous political courage.

Ladies and gentlemen,

As I have said, this world will not become a fair place for health all by itself.

Economic growth within a country will not automatically alleviate poverty or reduce the present great gaps in health outcomes. Health systems will not automatically gravitate towards greater fairness and efficiency. These changes require deliberate policy decisions.

It is not easy to make a value, such as fair access to medicines, count at the international policy level. But it can be done.

The May resolution on Public Health, Innovation and Intellectual Property was a triumph. It showed that the rules that govern the international trade system can indeed be shaped in ways that favour greater equity in health.

It is not easy to make health equity a guiding principle for health systems, especially when market forces make health care a commodity and encourage inefficient consumption. But it can be done.

In October, the World Health Report on primary health care will be issued to commemorate the anniversary of Alma-Ata. The report offers practical and technical guidance for reforms that can equip health systems to respond to health challenges of unprecedented complexity.

The report asks political leaders to pay close attention to rising social expectations for health care. As mounting evidence shows, people want care that is fair as well as efficient. People want health care that incorporates many of the values, principles and approaches articulated at Alma-Ata 30 years ago.

Political leaders would be wise to heed these rising social expectations. This, too, may add to your arsenal of arguments as you strive to make health a whole-of-government concern, with health in all policies.

Thank you.