Health Challenges & Opportunities in a Rapidly Changing World

WHO's Evolving Role

Dr Henk Bekedam
Director Health Sector Development
WHO/WPRO
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Outline

• Rapidly changing world
• Diseases and its threats
  – Emerging diseases, MDR and NCDs
• Health systems challenges
  – Poverty, health sector reforms, and health workforce
• International response
  – Development Aid and Aid effectiveness
  – International Health Partnership
• WHO and UN role
• Universities
• Universal health coverage
A rapidly changing world

- **Industrialization:**
  - Driving economic growth, but also threatening health
- **Globalization and urbanization:**
  - Introducing unhealthy & sedentary lifestyles, and fast food
  - Increasing access to **goodies** (fresh fruit year long, knowledge, drugs & vaccines) and **bad-ies** (cigarettes, alcohol, unhealthy food)
  - Increasing connectivity and spread of emerging diseases (SARS and AI)
- **Demographic and epidemiological changes:**
  - Ageing with low fertility rates in many countries (Rep of Korea – 1.22)
  - Getting healthier and sicker (increasing NCDs and decreasing mortality from infectious diseases)
- **Powers are shifting**
  - Economic crisis and upcoming of BRICS countries and Asia

Threats of infectious diseases

**Lessons Learning**

- An infectious disease in one country is a threat to others
- Effective response requires political commitment
- The best chance to eradicate or contain a new or a re-emerging disease is when it surfaces. Key to timely response:
  - Early detection & response, reporting, information & samples sharing within countries and with the international community
  - Treating information, samples and products (vaccines, diagnostics, drug sensitivities) as a **global public good** throughout the process
- Market failures in public health: SARS a global wake-up call
  - Governments needs to invest in safety and security
1. **Current & emerging and re-emerging diseases**
   - Global challenges: AIDS, tuberculosis, malaria, rabies, Avian influenza, etc.
   - One new human disease per year, of which 75% is of animal origin: zoonosis
   - Diseases can re-emerge after containment if reservoir of the virus still exists:
     - Ebola re-emerged after five years; SARS likely still reservoir in wild animals

2. **Bio-terrorism**
   - Anthrax in 2001 in the US reminded us that infectious diseases can also deliberately be introduced into society

3. **Bio-safety lapses**
   - 11 out of 15 SARS cases after 2003 major outbreak were linked to bio-safety lapses in 3 separate laboratories
   - In 2004 bio-safety lapses occurred with Ebola and inadequately inactivated anthrax in different countries with some deadly consequences
   - In 2005, live influenza A (H2N2), a strain that killed 4 million people in 1957, was mailed to 5,000 labs in 18 countries showed vulnerability current global practices
   - (2011 → H5N1 research .... bio-safety fear)

4. **Antimicrobial Resistance (AMR)**
Penicillin increased survival of patients with pneumonia and bacteria in blood from 10% to 90%

Adapted from Austrian et al. Ann. Int. Med 1964; 60, 759

Now facing a global public health crisis

Increasing resistance to antimicrobial medicines among many pathogens
- bacteria
- viruses
- parasites

Few new antimicrobial medicines in pipeline

Unavoidable reality: more we use antimicrobial drugs, the faster resistance develops
Many other factors contributing to development of resistance

- **Unrestricted sale & misuse of antimicrobial drugs in many settings**
  - Clinical medicine, communities, agriculture
- **Widely used in in food animals**
  - Food considered most important vector for spread of resistance
  - Globalized distribution of food - requires international cooperation
- **Inadequate systems for ensuring quality medicines**
- **Insufficient information on scope & key trends**
  - Surveillance systems weak or absent
- **Few countries have national plans to limit use**
  - No clear accountability within countries

It has taken long, but noncommunicable diseases (NCDs) are now on the agenda!

14.2 million people die every year from an NCD between the ages 30 and 69:
Most of these premature deaths could have been prevented

- Communicable, maternal, perinatal and nutritional conditions
- Noncommunicable diseases
- Injuries
More than 12 million people who die every year from an NCD between the ages 30 and 69 live in a developing country

86% of people who die from NCDs between the ages of 30 and 69 live in a developing country

Huge disparities exist across countries in relation to the probability of death from an NCD between the ages of 30-69
Health system challenges access and poverty

- Sickness causes poverty and poverty raises prospect of poor health
- High medical charges to patients (out-of-pocket payments - OOP):
  - Low utilization of healthcare
  - Financial hardship and impoverishment of households

Millions miss out on needed health services

Coverage of births attended by skilled health personnel and diphtheria–tetanus–pertussis (DTP3) vaccination by country, latest available year

- Births attended by skilled health personnel (%)
- 3 doses of DTP3 among 1 year old (%)
Health sector reform and improving delivery of services

Many countries has included Universal Coverage central to their health reforms to:

- Increase government investment (>3-4% GDP) and reduce OOP
- Increase access to improved quality health services
- Control overall cost

All health systems elements (finance, information, drugs, utilities, etc) have to come together to deliver services

Health workforce slow to respond to changes and often major bottle neck in improving services

- Getting things done takes time as many stakeholders are involved and training health workforce takes time

Many stakeholders involved in HR policies

- Ministry of Finance
- Ministry of Health
- Ministry of Labour
- Ministry of Personnel
- Civil Service Commission
- Ministry of Transport
- Professional associations
- Populations/communities

Challenges:
- Numbers
- Distribution
- Skill-mix
- Quality

ENTRY:
- Preparing the workforce
- Planning
- Education
- Recruitment

WORKFORCE:
- Enhancing worker performance
- Supervision
- Compensation
- Systems support
- Lifelong learning

EXIT:
- Managing attrition
- Migration
- Career choice
- Health and safety
- Retirement

Health workers
Health has never been given such attention in history

- Health aid increased fourfold from 1990 to 2010 with main focus on three diseases (MDG 6) and immunization

Gap between between aid goal and current level

- Total development assistance 0.25% GNI in 2003 far short of 0.7% Monterrey (2002)
- Total aid has yet to reach relative levels of the 1990s
- Few European countries still committed to 0.7% GNI, but economic crisis rethink
Health partnerships and Global Health Initiatives

Increased Health aid led to

- Scale up of cost-effective health interventions, esp for AIDS, TB, malaria and immunization
- Proliferation of Health Partners causing coordination challenges globally and for countries

Funds

- Global Fund for AIDS, Tuberculosis and Malaria (GF)
- Global Alliance for Vaccines and Immunisation (GAVI)

Private Foundation

- Bill & Melinda Gates Foundation
- Clinton Foundation

Many other Health Partnerships over 100, including 3by5

3 by 5 initiative of JW Lee

- Lifelong treatment strategy for 3 million people living with HIV/AIDS in poor countries by 2005
- Raising the need and urgency for equitable and universal access to prevention and treatment also for resource constraint settings
- WHO’s 3 by 5 team established and refined the framework in intensive consultation with partners
  - Invest more in order to reduce costs by expanding the market
  - Speed up production and get the drugs out to the people
- Clinton foundation, PEPFAR, UNAIDS
Paris declaration on Aid Effectiveness: principles

- **Development Results**
  - Result based aid and financing

1. **Ownership** (Partner countries)
   - Countries set the agenda

2. **Alignment** (Donors - Partner)
   - Aligning with country's agenda
   - Using country systems

3. **Harmonisation** (Donors - Donors)
   - Establishing common arrangements
   - Simplifying procedures
   - Sharing information

4. **Managing for Results**
5. **Mutual Accountability**
WHO’s core functions

• **leadership** on matters critical to health and engaging in partnerships where joint action is needed;

• shaping the **research** agenda and stimulating the generation, translation and dissemination of valuable knowledge;

• setting **norms and standards** and promoting and monitoring their implementation;

• articulating ethical and **evidence-based policy** options;

• providing **technical support**, catalysing change, and building sustainable institutional capacity; and

• **monitoring** the health situation and assessing health trends.

WHO’s roles in global Health

• **Raising awareness** and getting public health and equity on the **agenda** by various means, including World Health Day (AMR), World Health Reports, etc.

• **Facilitating agreement on milestones, indicators and targets**
  – What gets measured, gets done!

• **Bringing Health partners together** (convensing)

• **Sharing information** - like in disasters re- and emerging diseases (AI, HFMD)

• **Country focus** in providing guidance and building capacity in developing countries through guidelines, technical support, etc.

• **Building the evidence with partners**, including Universities – **Asia Pacific Observatory for Health Systems and Policies**
WHO’s role in global Health

Tools

• Binding treaties within Health:
  – Framework Convention of Tobacco Control (FCTC)
  – International Health Regulation

• Indicator frameworks and targets

• Within United Nations to get global commitment at high political level, esp for multi-sectoral responses
  – AIDS
  – MDGs
  – Avian Influenza
  – NCDs

WHO Framework Convention on Tobacco Control (WHO FCTC)

WHO FCTC

• First global health treaty negotiated by WHO
  ➢ establishes tobacco control as a priority on public health agenda
  ➢ provides an evidence-based tool for adoption of sound tobacco control measures
  ➢ introduces a mechanism for firm country commitment and accountability

• 176 parties
• Entry into force 27 Feb 2005
International Health Regulations

- Need for increased global capacity and political commitment as “The system is as strong as the weakest link in the chain”
- Legally-binding global framework for preventing, protecting against, controlling and providing a public health response to the international spread of disease
- Sets out new obligations and agreed procedures for notification, verification, sharing of information, assessment of events and response to significant public health risks and emergencies

UN High-level Meeting on NCDs
(New York, 19-20 September 2011)

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<thead>
<tr>
<th>High-level Meeting</th>
<th>Political Declaration</th>
<th>What WHO is doing</th>
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<tr>
<td>113 Member States</td>
<td>Establish multisectoral national plans by 2013</td>
<td>Develop a global monitoring framework and targets</td>
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<td>34 Presidents and Prime-Ministers</td>
<td>Integrate NCDs into health-planning processes and the national development agenda</td>
<td>Develop a global implementation plan 2013-2020</td>
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<td>3 Vice-Presidents and Deputy Prime-Ministers</td>
<td>Promote multisectoral action through health-in-all policies and whole-of-government approaches</td>
<td>Provide technical support to developing countries</td>
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<td>51 Ministers of Foreign Affairs and Health</td>
<td>Build national capacity</td>
<td>Identify options for partnerships</td>
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<td>11 Heads of UN Agencies</td>
<td>Increase domestic resources</td>
<td>Coordinate work with other UN Agencies</td>
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<td>100s of NGOs</td>
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<td>Measure results</td>
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World Health Assembly in May 2012:
Decided to adopt a global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025
Realizing the commitments included in the UN Political Declaration on NCDs: Developing a global monitoring framework and targets for NCDs

11 voluntary global targets presented in the revised WHO Discussion Paper

- Premature mortality from NCDs: 25% reduction
- Raised blood pressure: 25%
- Tobacco smoking: 30%
- Salt/sodium intake: 30%
- Physical inactivity: 10%
- Obesity: 0%
- Fat intake: 15%
- Alcohol: 10%
- Raised cholesterol: 20%
- Generic medicines and technologies: 80%
- Drug therapy and counselling: 50%

Target adopted by the World Health Assembly
Targets with wide support
Targets with support for further development
Universities important role in Health

1. Create relevant evidence that can lead to policy development
   - Build evidence to promote science in the policy debate
   - Work with WHO and NGO’s – incl Asia Pacific Observatory

2. Reach out to policy makers and people
   - University as a neutral broker and mediator

3. Invest in research of measuring inequity and neglected areas
   - Focus on what is needed for the most in need, incl neglected diseases

4. Help to define future agenda
   - Support thinking about the future
   - Inspire society about new thinking and create atmosphere for open debate

5. Society to invest in Universities
   - Review incentive system of Universities  → not just writing articles

Now focus on: Universal Health Coverage

- Everyone has access to needed high quality interventions
- No one should be exposed to financial hardship because of paying for these services

1. Population Coverage
2. Benefit package, like outpatient services etc.
3. Reimbursement levels

Towards universal coverage
What are the Obstacles to Universal Coverage?

There are many obstacles, including:

1. **Exclusion linked to factors outside the health system** – inequalities in income, education and social exclusion associated with e.g. ethnicity, gender and migrant status

2. **Weak health systems**: Insufficient health workers, medicines and health technologies. Ineffective service delivery. Poor information systems and weak government leadership

3. **Health financing systems that do not function**. This is critical because the other parts of the health system cannot function if the financing system is weak

The Vision of global health development

Universal Health Coverage

“Universal health coverage is the best way to cement the gains made during the previous decade. It is the ultimate expression of fairness. This is the anchor for the work of WHO as we move forward,” said Dr. Chan.

‘I believe in universal health coverage. I also believe that if we all join together we can save lives.’ BAN Ki-moon, UN SG

“The impact of universal coverage goes beyond health. It is a vehicle to reduce poverty and to build social solidarity, national pride and trust in the Government.” in a speech made by Dr SHIN Young-soo
Thank you!

Contributors:
Rodel Nodora
Xu Ke
Cherian Varghese
Kidong Park
Manju Rani
K Fukuda