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POLICY

## WHO for the 21st Century

NEXT YEAR, 2015, WILL BE PIVOTAL FOR GLOBAL HEALTH. THE DEADLINE FOR REACHING the United Nations Millennium Development Goals (MDGs) expires, and the MDGs will be succeeded by a new framework that focuses on poverty reduction and sustainable development (1). In the lead-up to 2015, the spotlight is already on the achievements and disappointments of the MDG era. Among the successes, 2 billion people have gained access to improved sanitation since 1990. Yet, there are still 2.5 billion people worldwide who do not have day-to-day use of functioning toilets. The death rate of children under 5 years has been cut by about one-half, and the rates of decline in child mortality in some African countries, notably Senegal and Rwanda, are among the fastest ever recorded. Nevertheless, between 6 million and 7 million children died in 2012, nearly half of whom died in the first month of life (2). The great majority of these deaths could have been prevented. During this period of reflection on the MDGs, we are also looking to the future. Our attention at the World Health Organization (WHO) is focused on ways to build on the global health successes of the past 25 years, on how to fill in the gaps, and on how we can continue to improve health in the post-2015 era.

Any allusion to our current place in the 21st century brings to mind events that take place over decades. Such events include the long-running epidemiological transition from communicable to noncommunicable diseases in our aging populations, now mostly located in cities, and the long-term health impacts of climate change and environmental degradation. But we must also contend with major events that take place on shorter time scales. The MDG era has coincided with, and is partly a product of, the huge increase in development (financial) assistance for health. This is reflected in the proliferation of health donors, global funds and partnerships, nongovernmental and civil society organizations, philanthropists, and commercial investors. The MDG era has also coincided with the growing wealth and more assertive voices of formerly low-income countries, symbolized by the BRIC nations (Brazil, Russia, India, China), and other countries such as Indonesia, Nigeria, and Thailand that have moved from low to middle income. As these events have unfolded, the reach of health has extended far beyond clinical practice and epidemiology. In the midst of debates about the changing role of international aid—and with the emergence of SARS, pandemic influenza, and most recently the Ebola virus—global health has become central to foreign policy and international relations.

In this time of transition, I will highlight some of the challenges we face in putting health at the heart of sustainable development. In confronting these challenges, we can draw on 66 years of WHO experience, but we are also prepared to work in new ways (3). As the post-2015 agenda is being crafted through international debate, our most important message is that good health is a valuable goal in its own right, and indispensable to poverty reduction and sustainable development. This is a global message with a human face: People want assurance that they have access to the health services they need and at a price they can afford. This is the essence and the promise of universal health coverage (4).

WHO is often referred to as a technical agency. We are certainly that—in our use of science and technology to underpin health policy. But WHO has a bigger role, in showing how technical approaches to health promotion and disease control are part of a larger vision for health and well-being, one in which good health for everyone is integral to social cohesion and stability.

The first of our challenges is to help reach, and surpass, the health targets set in the MDG era. One urgent task is to tackle the persistent causes of maternal and neonatal mortality. From a technical standpoint, we know how to do this, but we must find the right approach in each and every setting. Most maternal and child deaths can be prevented with high-quality care during pregnancy, delivery of babies by skilled birth attendants, breastfeeding, and through guaranteed access to appropriate antibiotics and immunization. Another well-defined task is to expand the coverage of antiretroviral therapy for HIV-positive people and to ensure prompt diagnosis and treatment for people with malaria, tuberculosis, and hepatitis. During the MDG era, disease control programs rightly emphasized the provision of good health services. But there are some extra steps to be taken—for example, to ensure that

people who live under the threat of communicable diseases are adequately protected from financial risk, a vital ingredient of universal health coverage. Furthermore, our commitments to communicable disease control include elimination and eradication of, for example, malaria from selected countries, including Mexico, Malaysia, and South Africa, and polio and guinea worm disease from all countries.

The growing importance of noncommunicable diseases such as heart disease, diabetes, and cancer is, in part, the inevitable consequence of successfully controlling infections. In 2012, the average life expectancy at birth worldwide had increased to 70 years. This astonishing fact means that a large number of people now live long enough to suffer and eventually die from chronic illnesses—mainly cardiovascular disease and cancer. Clearly, we must all die of something, but many deaths from noncommunicable diseases are premature and preventable. Having examined the underlying causes and possible remedies, WHO's World Health Assembly set a target of reducing premature mortality due to cardiovascular disease, cancer, diabetes, or chronic respiratory disease by 25% between 2010 and 2025.

To achieve this goal, WHO, as an intergovernmental organization, is using all available instruments at its disposal. The 2005 Framework Convention on Tobacco Control was the first global health treaty negotiated under the auspices of WHO. In 2013, with 178 signatories, an estimated 2.3 billion people were protected by at least one measure reducing tobacco demand that had been fully implemented by governments worldwide. The entire campaign against noncommunicable diseases was given a huge boost by the 2011 United Nations General Assembly, which recognized chronic diseases to be a major challenge, not merely for health but also for development in the 21st century.

The task of controlling communicable and noncommunicable diseases inevitably focuses on specific causes or risk factors. These are aided and abetted by insidious, systemic causes of ill health in populations, among which social inequality is a prime example. Despite some arguments to the contrary, we still inhabit a very unequal world. The richest 1% of people own ~40% of the world's assets, and less than 1% of all assets are owned by the poorest 50% of people. The result is that 1.2 billion people still live in extreme poverty. And there are some disturbing trends. Over the past two decades, income inequality has been growing on average within and among countries—a trend that drives health inequalities, too. Social inequality is a structural problem that requires many kinds of remedy, but universal health coverage can make a powerful contribution. The first point about universal health coverage is that it must be precisely that: universal. However, universal health coverage is not merely the quest to reach an arithmetic target, but also has the goal of demanding equal rights to health and social protection for all, even those in the smallest minority.

The 1978 Alma Ata Declaration was one of the 20th century's landmarks in public health. It emphasized the role of the state in providing adequate health and social measures. In the 21st century, states still have this responsibility of course, but now, health depends on many more actors. Recognizing that no intergovernmental organization can achieve its goals by operating from within the public sector alone, WHO now works with a multiplicity of nonstate actors—including nongovernmental organizations, philanthropic organizations, and academic institutions—to create and protect global public goods, such as standards of medical practice and the quality control of health products. WHO also works with nonstate actors to draw on private expertise, knowledge, commodities, personnel, and finances for the benefit of health and to encourage nonstate actors to improve their own activities to protect and promote health.

Last, nearly 30 years after the publication of a seminal report from the Rockefeller Foundation, we do still place a high premium on Good Health at Low Cost (5). Besides supporting research into better ways of sharing financial risks, and in addition to providing technical guidance for major funding initiatives (the Global Fund, the GAVI Alliance, and others), WHO is also promoting market mechanisms to lower the prices of high-quality commodities, including vaccines and essential medicines. Among the most successful efforts so far is “prequalification,” a mechanism that guarantees the quality of vaccines, drugs, and diagnostics for purchasing agencies, including the GAVI Alliance, and opens up the market to new manufacturers. In 2013, for example, prequalification of a Japanese encephalitis vaccine made in China cut the cost of each dose to US\$0.30, well below the price of other Japanese encephalitis vaccines then on the market. This decision followed WHO approval, in 2011, of the China Food and Drug Administration as a functional regulatory authority for vaccines, a milestone on China's road to becoming a global vaccine supplier.

In ventures of this kind, United Nations agencies often work best together, rather than alone. The 2013 report on Promoting Access to Medical Technologies and Innovation, prepared jointly by WHO, the World Intellectual Property Organization (WIPO), and the World Trade Organization (WTO), is a comprehensive guide to the interface between health, trade, and intellectual property. Likewise, the Pharmaceutical Manufacturing Plan for Africa, a proposal of the African Union Commission, is jointly supported by WHO, the Joint United Nations Programme on HIV and AIDS (UNAIDS), and the United Nations Industrial Development Organization (UNIDO).

As WHO moves into the post-2015 era of development, we shall remain true to our roots. We shall covetously guard our reputation for impartiality and sound science. We shall continue to serve as an honest broker, acting in the best interests of our Member States. We shall monitor health trends and track progress toward universal health coverage. We shall draw on our global perspective to help shape the agenda for health research. From guidelines to treaties, we shall use all of the instruments available to us in the cause of better health.

But, we are also open to new ways of doing business, by putting disease control programs in the context of universal health coverage, by actively seeking alliances beyond the public sector, and by promoting health, not only through health institutions, but also through agriculture, the economy, education, and the environment.

Everyone has a stake in health, and WHO has always worked to guard the health of everyone. But the professional business of health has changed profoundly since the turn of the millennium. WHO's role, more than ever, is to provide leadership by building consensus around a shared responsibility for health, and by responding with agility to the unexpected challenges and new opportunities of the 21st century.

– Margaret Chan

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