Statement by

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Only ten years are left to achieve the Millennium Development Goals. These goals have underlined the importance of improving health, and particularly the health of mothers and children, as an integral part of poverty reduction. Mothers, babies and children represent the well-being of society and its potential for the future. Their health needs cannot be left unmet without harming the whole of society. Yet this year, almost 11 million children under five years of age will die, 4 million of them within 28 days of birth. In the same one-year period, almost half a million women will die in pregnancy or childbirth or soon after.

How can it be that this situation continues when the causes of these deaths are largely avoidable? Although an increasing number of countries have succeeded in improving the health and well-being of mothers, newborn babies and children in recent years, the countries that started off with the highest burdens of mortality and ill-health are the ones that made least progress during the 1990s. In some countries the situation has actually got worse, and worrying reversals in newborn, child and maternal mortality have taken place. Progress has slowed down and is increasingly uneven, leaving large disparities between countries as well as between the poor and the rich within countries. Slow progress, stagnation and reversals are related to poverty, to humanitarian crises, and particularly in sub-Saharan Africa, to the effects of HIV/AIDS. These operate, at least in part, by increasing or maintaining exclusion from care. Unless efforts are stepped up radically, there is little hope of eliminating avoidable maternal and child mortality in all countries.

The technical knowledge exists to respond to many, if not most, of the health problems and hazards that affect the health and survival of mothers, the newborn and children. The strategies for putting these technical solutions into practice for all, in the right places, in the right ways and at the right time, are also becoming increasingly clear. Maternal and child health services are the bedrock of health systems, especially for the poor, in most countries, and the demand for these services is high. Much more can be done to realize their potential. It includes emphasizing effective interventions and using them as a platform for other health programmes such as HIV/AIDS and the prevention and treatment of sexually transmitted infections, tuberculosis and malaria initiatives, and family planning. Making the right technical and strategic choices is a critical step in correcting the course of our efforts to reach the Millennium Development Goals.

Even if the right technical choices are made, however, maternal, newborn and child health programmes will only be effective if they work together, and with households and communities, to establish a continuum of care, from pregnancy through childbirth into childhood, instead of the often fragmented services available at present. It makes no sense to provide care for a child while ignoring the mother's health, or to assist a mother giving birth
but not the newborn child. Providing families with access to such a continuum of care requires invigorated health systems that maintain maternal, newborn and child care at the core of their development strategies. This need is driving programmes and stakeholders with different histories, interests and constituencies to join forces. The common project that can unite their different agendas is universal access to care. This puts the health of mothers, the newborn and children within the broader political project of responding to society’s demand for the protection of the health of its citizens and for access to care - a demand that is increasingly recognized as legitimate. The magnitude of the effort needed to scale up services towards universal access, however, should not be underestimated.

To ensure that all families have access to care, governments must accelerate the expansion and strengthening of health systems. A critical challenge is to put in place the required workforce. In many countries, this workforce has been destabilized and undermined by economic hardship and financial crises. There is an urgent need to prevent further escalation of the crisis - which has to include measures to prevent the distortions that may result from well-intentioned but disruptive global initiatives. There is also a need for planning the expansion of the workforce, and at the same time, for urgent, immediate corrective measures to bring productivity and dedication back to the level the population expects and to which most health workers aspire. Sustainable approaches have to be devised to offer competitive remuneration and incentive packages that can attract, motivate and retain competent and productive health workers. In many of the countries where progress towards the MDGs is disappointing, substantial increases in the remuneration of health personnel are urgently needed. Such measures would have political and macroeconomic implications and require a considerable effort, involving not only governments but international solidarity as well.

Universal access, however, is more than deploying an effective workforce to supply services. For health services to be taken up, financial barriers to access have to be removed, and users have to be given predictable protection against the cost of seeking care, and particularly against the catastrophic payments that push households into poverty. Such catastrophic payments occur wherever user charges are significant, households have limited ability to pay, and pooling and prepayment are not generalized. To attain the financial protection that has to go with universal access, countries throughout the world have to move away from user charges, and generalize prepayment and pooling schemes. Financial protection can be organized on the basis of tax-generated funds, through social insurance, or through a mix of schemes. The objective must be health systems that can respond to critical health needs, eliminate financial barriers to care, and protect people from the poverty that is both a cause and an effect of ill-health.

Full coverage with a set of essential interventions would enable countries to attain and exceed the MDGs. This will not be possible without a substantial increase of expenditure on child health. In the 75 countries that account for most of child mortality, reaching full coverage would cost an additional US$ 2.2 billion in 2006, increasing, as coverage expands, to US$ 7.8 billion in 2015: a total of US$ 52.4 billion over 10 years, of which US$ 25 billion represents additional costs for human resources. This US$ 52.4 billion corresponds to an increase as of now of 6% of current median public expenditure on health in these countries,
rising to 18% by 2015. This is equivalent to an extra outlay of US$ 0.47 per inhabitant of those countries per year initially, increasing to US$ 1.48 in 2015.

For maternal and newborn care, universal access is further away. In the same 75 countries, realistic estimates predict that coverage will increase from 43% at present (with a limited package of care) to around 73% (with a full package of care) in 2015. This would cost an additional US$ 1 billion in 2006, increasing, as coverage expands, to US$ 6 billion in 2015: a total of US$ 39 billion over ten years, in addition to present expenditure on maternal and newborn health. This is equivalent to an extra outlay of US$ 0.22 per inhabitant per year initially, increasing to US$ 1.18 in 2015.

In most countries, financial sustainability for maternal, newborn and child health can best be achieved in the short and middle term by looking at all sources of funding: external and domestic, public and private. Channelling increased funding towards generalized insurance schemes offers the best prospects for sustainable financing of core services and the health systems on which they depend. This strategy could protect the funding of the workforce both in public sector and health sector reform policies and in the forums where macroeconomic and poverty reduction policies are decided. It offers the possibility of tackling the problem of the remuneration and working conditions of health workers in a way that gives them credible long-term prospects. Traditional budgeting and the stop-gap measures of project funding do not usually offer such prospects.

While the financing effort seems to be within reasonable reach in some countries, in many it will go beyond what can be borne by governments alone. Both countries and the international community will need to show a sustained political commitment to mobilizing and redirecting the considerable resources that are required, and to building the institutional capacity to manage them. At the same time, placing maternal, newborn and child health at the core of the drive for universal access provides a platform for building sustainable health systems where existing structures are weak or fragile. Regardless of what can be achieved by 2015, moving towards universal access has the potential to transform the lives of millions for decades to come.

The Millennium Development Goals place the health of mothers and children at the centre of the struggle against poverty and inequality, as a matter of human rights. The next ten years can be a time of accelerating the move towards universal coverage, with access for all and financial protection. Only by moving in this direction can we make sure that every mother, newborn baby and child in need of care can obtain it, and no-one is driven into poverty by the cost of that care. In this way we can work not only towards the Millennium Development Goals but far beyond them.