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on Tuesday, 7 July 2009, at 9.30 a.m.

President: Mr. LUCAS (Luxembourg)

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The meeting was called to order at 9.45 a.m.

ANNUAL MINISTERIAL REVIEW: IMPLEMENTING THE INTERNATIONALLY AGREED GOALS AND COMMITMENTS IN REGARD TO GLOBAL PUBLIC HEALTH (item 2 (b) of the provisional agenda) (E/2009/12, E/2009/50, E/2009/73, E/2009/81 and E/2009/101)

Introduction of the report of the Secretary-General on the Annual Ministerial Review (E/2009/81)

The PRESIDENT said that for the discussion of the theme of the Annual Ministerial Review the Council had before it the report of the Secretary-General contained in document E/2009/81.

Mr. SHA (Under-Secretary-General for Economic and Social Affairs), introducing the report of the Secretary-General (E/2009/81) on the theme of the Annual Ministerial Review, said that the Millennium Development Goals were intertwined: ignoring one at the expense of another would have serious consequences, especially during a time of crisis. The Secretary-General's report, which showed that some progress had been made towards achieving the Goals, but that visible gaps remained, yielded six key messages.

First, the global crisis was exacerbating existing gaps and was having a disproportionate impact on the poor and most vulnerable. Livelihoods of the poor were deteriorating rapidly, and government expenditures and social protection systems would be negatively affected. There was a serious threat of a reversal of progress, which would have adverse implications not only for human well-being, development and economic growth, but also for peace and stability.

Second, there had been some success in combating HIV/AIDS, malaria and tuberculosis, but less progress had been seen in controlling non-communicable and neglected tropical diseases. Tragically, the least progress had been made towards MDG 5 on improving maternal health. Maternal health had to be kept high up on the political and financial agenda, implying the training, retaining and deployment of skilled health workers and the provision of necessary infrastructures, medicine and equipment. The Department of Economic and Social Affairs would work with member States and donors to support the efforts of WHO, UNFPA, UNICEF and the World Bank, to accelerate progress in the area of maternal and newborn health and would report

to the Council during the 2010 Coordination Segment on the advances achieved by the United Nations system in collaborating with civil society organizations, health professional associations and academia.

Third, while good health was a prerequisite for advancement towards most of the MDGs, inequities in health outcomes persisted within and among countries. Most of the differences were attributable to the conditions in which people were born, grow, live, work and age - which included underlying problems of gender inequality.

Fourth, aid to the health sector had been increasing but was now threatened by the economic downturn. A decline in aid would be devastating for developing countries and must be prevented; equally, government and their development partners must strive to invest resources wisely.

Fifth, to make the most of the support received would require strengthening health systems in many countries - through better planning, investment and coordination of aid. The issues of human resource development and brain drain also needed to be addressed. Finally, a strong commitment on the part of leaders to the health-related MDGs had yet to be fully converted into urgent, collective and multilateral action. The Council could draw upon its unique convening power to spearhead the response needed to move the global public health agenda forward.

National Voluntary Presentations (E/2009/94 and E/2009/96)

The PRESIDENT said that the National Voluntary Presentations provided the opportunity to link the discussion of policy options to specific country experience. She then invited the Council to hear the presentations of Jamaica and China, having requested Mr. Michael Marmot, Chairman of the Commission on Social Determinants of Health, to moderate the corresponding discussions.

Mr. MARMOT (Moderator) referred to the point made by Mr. Sha regarding the intimate link between health and development. Health was a significant measure of the effectiveness of economic and social policy in improving the well-being of populations. It was important to determine not only how the development process was progressing, but also, crucially, how it was being distributed. Economic development was indeed a health issue,

because the degree to which a country prospered would impact the health of its population. Issues of distribution, population ageing and increasing urban populations were common issues for many countries.

During the 9th meeting, the Director-General of WHO had said that, rather than being a rising tide that lifted all boats, globalization had created waves that lifted the bigger boats but could swamp the smaller ones. How the benefits of an interconnected, globalized world could be distributed more fairly was an important question for the meeting to consider.

Mr. SPENCER (Observer for Jamaica), introducing his country's report to the Annual Ministerial Review and providing information on its innovative National Health Fund, said that the results were mixed in terms of the achievement of the MDGs. Jamaica had met its targets for reductions in absolute poverty and hunger and for universal access to primary education, and it was on track to achieve universal access to reproductive health and to potable water and basic sanitation as well as to halt or reverse the spread of HIV/AIDS, malaria and tuberculosis. Unfortunately, it was lagging behind in the areas of gender equality and empowerment of women, the reduction of biodiversity loss, the reduction of child and maternal mortality, and improvement of the lives of slum dwellers.

Jamaica was confident that it could attain the health-related MDGs with the help of a number of crucial policies. They included: the renewal of primary health care through the upgrading of infrastructure, the reshaping of human resources and improved information systems; and the elimination of user fees at public health facilities, covering diagnostic tests, drugs, admissions and surgeries.

Jamaica's efforts to address the HIV/AIDS pandemic had been a major success. While there was room for improvement in tackling stigma and discrimination, it had succeeded in providing greater access to antiretroviral drugs and thus making a significant reduction in mother-to-child transmission and deaths due to AIDS.

With regard to the prevalence of chronic non-communicable diseases, Jamaica recommended that the Council should propose to the General Assembly the target of halving the incidence of chronic non-communicable diseases by 2015, and a new target pertaining to the

prevalence of such diseases by sex and age. It also advocated that more health-related development assistance be made available to heavily indebted countries that were likely to fail to meet the MDGs, especially in the light of the global recession.

Ms. CAMPBELL FORRESTER (Observer for Jamaica), illustrating her presentation with a number of slides, reported on her country's progress with regard to the public-health-related MDGs. Jamaica was a middle-income small island developing State, ranked third by the World Bank out of the 75 countries subject to two or more natural hazards. It was heavily indebted; and with over half of its budget going to service its debt, few resources were left over for other goods and services.

In terms of the MDGs, Jamaica had already reached the target for reducing absolute poverty, had reduced hunger, had achieved the goal for providing universal access to primary education. However, its poverty reduction gains were fragile owing to the threat posed by the global recession, and Jamaica was faced with major quality and equity issues in early childhood and primary education, including that of rural attendance. It was on track towards providing universal access to reproductive health services, potable water and basic sanitation. It was also on course towards halting and reversing the spread of HIV/AIDS, malaria and tuberculosis. Jamaica was thankful for the Global Fund inputs, which had enabled it to provide antiretroviral drugs at reduced rates and to improve its laboratory and treatment capacity. With respect to malaria, public health interventions had succeeded in reducing its incidence to a small number of cases in 2009 following its reappearance in the country in 2006. With respect to Goal 7, the country had eliminated ozone-depleting substances but was behind in reducing biodiversity loss and carbon dioxide emissions.

The country was also lagging behind in the area of gender equality and the empowerment of women. The situation in that respect was uneven: while unemployment among women was high and their level of political representation low, Jamaica had also to address the underperformance of males at all levels of education. Thus, in addition to the critical need to empower women, it was also necessary to balance and target both gender-related aspects.

Like other countries, Jamaica was far behind in its efforts to reduce child and maternal mortality - although starting from comparatively low child and maternal mortality rates made, the targets were more difficult to attain. Maternal death from direct causes had been halved, but deaths from indirect causes had risen sharply. Slippage in the quality of life of urban slum dwellers was of great concern. Inner city areas were often hotspots for violence, and deterioration in living conditions in those areas could impact on progress towards many of the MDGs.

Jamaica had a well-developed primary health-care system that reached deep into rural areas. Its focus was on equity, access and social justice and on building innovative health teams. A renewed primary health-care strategy was being developed to meet the challenges of sustainability, cost effectiveness and quality. As part of that effort, user fees had been abolished for children and adolescents in 2007 and for the entire population in 2008. The strategy was based on innovative financing, the improvement of infrastructure and information systems, re-engineering of human resources and leader/manager training, public-private partnerships and community empowerment. In addition, ever since the 1970s Jamaica had been working to develop allied health professionals in order to enhance its health service delivery capacity.

A second focus of Jamaica's health package was the provision of universal access to essential drugs. It had established the National Health Fund, which subsidized a range of drugs for chronic illnesses and employed procedures that avoided manipulation by market forces. A timely payment system helped to ensure the participation of over 95 per cent of the country's private pharmacies, and its transaction processing system was being converted into a health record database. All drugs at public pharmacies, clinics and hospitals were free.

Jamaica's third focus was on combating HIV/AIDS, which was recognized to be a development concern as well as a health issue. The Ministry of Health had implemented a multifaceted response based on increased access to antiretrovirals, health system strengthening, building partnerships and creating a supportive environment, community outreach and public education.

Jamaica's fourth public health focus was on addressing challenges to the health and well-being of children. The five-year National Strategic Plan for the Jamaican Child, launched

in 2008, provided closer monitoring of growth, nutrition and development as well as risk screening in primary health-care clinics; under the Plan, a child health passport was being developed to ensure continuity of care. As part of its response to MDG 4 (reducing child mortality), the Ministry of Health, in cooperation with UNICEF, had run, from 2004 to 2008, an experimental child abuse mitigation project in a hospital setting, which had been recognized as a best practice and which, when funding became available, would be restarted and enlarged. One of the country's most active NGOs was "Children First at a Glance", which had begun in 1989 as a welfare project for street children and had assumed the status of a non-governmental organization in 1997. "Children First" ran various programmes in such areas as vocational and entrepreneurial skills training, career development, reproductive health services and parenting education. Among its most noteworthy activities were a project designed to provide support, skills training and employment opportunities to young people at risk of becoming involved in illicit activities; a remedial education project targeting young people who had dropped out of or never enrolled in school; and a project aimed at changing the behaviour and attitudes of young men from poor communities.

As part of its campaign to combat HIV/AIDS, Jamaica had launched the Bashy Bus Project, a "mobile clinic" that provided a "wholesome" environment where young people could get information about youth issues, obtain basic sexual and reproductive health services, and get free HIV counselling and testing. Baseline research and follow-up studies had also been conducted under the project, which had won international recognition for both its research and clinical activities.

Through its various holistic programmes, the Ministry of Health had contributed to Jamaica's progress in achieving the Millennium Development Goals. It had set new targets, one of which was to halve by 2015 the incidence of chronic non-communicable diseases. In that connection, her country suggested that the Council recommend to the United Nations General Assembly that it convene a special session on non-communicable diseases, given the toll such diseases took on the world's population. Jamaica's greatest long-term challenge to achieving the MDGs was its debt burden, which consumed 57 per cent of its budget. The added pressure of the global recession made it inevitable that there would be some deterioration in Jamaica's progress towards the MDGs. To offset that trend, her country needed more

development aid as well as debt forgiveness, debt swaps and affordable concessionary financing for health-related activities. It was time for the international community to work together to ensure that the health of the world's people was protected.

Mr. MARMOT (Moderator) thanked the Minister of Health and the Environment and the Chief Medical Officer of Jamaica for their clear presentations and said that the challenges issued to the international community and to the Council would have to be met.

Ms. FARANI AZEVEDO (Brazil) said that Jamaica had made remarkable progress in a number of key areas, including the reduction of poverty, malnutrition and hunger, the achievement of universal primary education and the provision of safe drinking water and sanitation. The additional efforts needed in areas such as child and maternal mortality and environmental sustainability would require, in Jamaica as elsewhere, substantial additional financial and human resources. Jamaica's focus on public health was well-founded since adequate primary health care was the key to ensuring quality, low-cost basic health services.

It was clear that Jamaica had recognized the importance of giving greater coherence to sustainable development policies. In that connection, Brazil supported Jamaica's plan to promote sustainable energy by blending locally-produced ethanol with gasoline, which would stimulate rural development, reduce the country's carbon dioxide emissions and decrease its dependence on foreign oil.

The national report had rightly emphasized the need to address Jamaica's escalating violence, which was undermining the well-being of the population, hampering social development and causing skilled labourers to move abroad. According to the World Bank, a reduction of one-third in the crime rate could more than double the country's per capita growth rate. Jamaica's focus on early childhood education was part of its long-term response to the problem of violence.

The reduction of inequality remained an important challenge. The recently established social safety net and conditional cash transfer programmes would not only help to address immediate concerns but would also serve to prepare children for employment opportunities in the future. Based on Brazil's experience, she was optimistic about Jamaica's initiatives in that regard.

It was vital that the international community maintain its commitment to Jamaica and help it to meet its development challenges. In view of the severity of the global economic and financial crisis, international support was essential if Jamaica was to enjoy sustained progress over the next critical five-year phase.

Jamaica was particularly vulnerable to variations in global market conditions because of its budget deficit and high debt burden, which were hampering its efforts to gain access to international capital markets and borrow money under acceptable terms. In addition to its financial problems, Jamaica was highly vulnerable to natural disasters, which had largely accounted for the sharp fall in the country's gross domestic product in 2006 and 2007.

The international community would need to be responsive to countries in special situations such as Jamaica, and the present dialogue could play a key role in raising awareness of the challenges ahead and providing policy guidelines and suggestions on how to meet them.

Mr. OLDHAM (Canada) said that his country valued its close relationship with Jamaica, supported the priorities outlined in its national report and was committed to working with Jamaica to address its critical development needs. He congratulated the Government of Jamaica on the results attained to date, particularly in the areas of poverty reduction and access to primary education, but continued and concerted efforts would be required to sustain progress in the context of the global economic downturn. In that regard, Jamaica was to be commended on its efforts to identify obstacles to progress, gaps remaining and lessons learned, particularly in areas in which the objectives were particularly challenging, such as child and maternal morality targets.

Jamaica's National Report reflected the seriousness with which it had embraced the Millennium Development Goals as a framework for advancing its human and social development, with particular reference to early childhood care and development and gender inequalities. He welcomed Jamaica's use of national planning exercises - such as the inclusive Vision 2030 long-term development plan - to stimulate development and contribute to a more secure and prosperous future. He supported Jamaica's efforts to address the problems of crime and violence, which were a major obstacle to economic development, affecting progress in all

spheres of human development. He wondered, finally, how Jamaica's disaster risk management capacities could be improved so that natural disasters would be less of a threat to its development efforts.

His country looked forward to strengthening its partnership with Jamaica as it addressed the development challenges identified in its national report.

Mr. KAMWI (Namibia) congratulated Jamaica on the great strides it had made towards attaining the Millennium Development Goals, 50 per cent of whose targets had been met. Particularly noteworthy was the progress towards universal access to HIV/AIDS treatment, care and support. However, owing to a lack of human, institutional and financial resources, Jamaica was still having difficulty meeting certain MDG targets, in particular those relating to child and maternal mortality.

Jamaica was particularly vulnerable for three reasons: the impact of climate change and natural disasters had the potential to wipe out hard-won achievements; the global economic downturn had caused an increase in unemployment, negatively affected tourism and reduced remittances and government revenue, thereby limiting the Government's capacity to invest in health services; finally, Jamaica's status as a middle-income country had turned into a liability by making it ineligible for the financial aid or concessional loans needed for social investment.

The international community had a responsibility to help Jamaica remain on course in its efforts to meet internationally agreed development goals. It should also take a fresh look at the situation of the middle-income companies, in which 40 per cent of the poorest of the poor actually lived. He hoped that countries such as Jamaica and Namibia would not be left out of the mechanisms envisaged by the Task Force on Innovative International Financing for Health Systems to mobilize additional resources to be spent on health in low-income countries.

Mr. HACHETT (Barbados) said that, while as middle-income country it failed to qualify for certain sources of financial aid, Jamaica remained in need of additional financial resources to help it to achieve MDGs 4 and 5, especially given its heavy debt burden. Its ability to sustain its poverty reduction programmes was in jeopardy owing to the global economic downturn and its domestic circumstances of high inflation, rising unemployment and increasing migration.

Small Island Developing States such as Jamaica were particularly vulnerable to the effects of climate change and natural disasters. While disaster mitigation was certainly important, countries must also focus their efforts on adaptation to climate change - a topic that he hoped would receive due attention at the United Nations Climate Change Conference in Copenhagen in December 2009.

Jamaica needed more substantial donor aid and greater partnership cooperation to halt the spread of HIV/AIDS. Another challenge was gender inequality, which had health implications for both men and women. While focusing on women, programmes should identify specific needs of men in their supportive role for women.

He urged the international community and, in particular, international financial institutions to provide additional resources to middle-income countries, which were experiencing serious difficulties owing to the global economic crisis.

Mr. MARMOT (Moderator) observed that Jamaica was affected by the current economic crisis as well as by climate change, factors over which it had no control. The fact that it had become a middle-income country likewise meant that it was entitled to less foreign assistance. It had to deal with increasing violence, a significant informal sector, which affected official employment figures, and an increase in the urban population, including the number of slum-dwellers. That situation might make one pessimistic about Jamaica’s ability to continue developing yet there was also cause for optimism given the many wonderful initiatives that had been described in the presentation.

Mr. SPENCER (Observer for Jamaica) said that Jamaica had inadequate resources to achieve its development goals. He pointed out however that in spite of budget cuts overall his Government had increased spending in the health sector. He wondered how Jamaica, which had succeeded in becoming a middle-income country, could be penalized for doing so well and expressed the hope that international agencies would review their policies and find some way to increase assistance. It was all very well to recognize the progress made by individual countries but they could only go so far on their own; there came a time when increased international assistance must be made available.

Mr. MARMOT (Moderator) said that the growth of the informal economy was a factor in economic growth but expressed concern that since women were more likely than men to be employed in the informal sector they might be more affected by the lack of labour standards in the informal economy.

Mr. SPENCER (Observer for Jamaica) said that the informal economy was especially significant in the Small Island Developing States, where the population had few resources to work with. His Government's approach was to try to formalize what were currently informal sector activities.

Ms. FARANI AZEVÊDO (Brazil) wondered whether Jamaica had discussed with international agencies and institutions the possibility of freeing up additional resources for primary health care in the context of realization of the Millennium Development Goals through such mechanisms as debt forgiveness or equity swaps.

Mr. MARMOT (Moderator) noted that given the size of Jamaica's annual debt payments, even a small reduction in that amount would free up significant additional resources to complement current official development assistance (ODA).

Mr. SPENCER (Observer for Jamaica) said that the national health fund was contributing greatly to the development of health infrastructure and reiterated his concern at the current attitude of international financial institutions towards the middle-income countries, which still required significant international assistance.

Ms. CAMPBELL FORRESTER (Observer for Jamaica) said that little accommodation had been possible to date with the World Bank and the International Monetary Fund although some assistance had been received for improvements to the health system, in particular with regard to HIV/AIDS. She wondered whether international institutions should re-evaluate the rating system they used as a basis for allocating assistance. In Jamaica a stress on community-level intervention had proven successful and, although more funding was needed, her Government had learned to do a lot with little and provide good health care at low cost. The most pressing problem currently was how to ensure the sustainability of that level of health care with scarce resources.

Mr. FAUTUA (New Zealand) noted the progress made by Jamaica in strengthening all three levels of education. In the Pacific region countries faced the problem of the so-called brain drain, where educated and skilled workers moved away after completing their training. He wondered if Jamaica was encountering the same problem and how it was addressing that situation.

Ms. CAMPBELL FORRESTER (Observer for Jamaica) said the brain drain phenomenon was a problem and Jamaica, in partnership with the Government of Canada, was undertaking a study and establishing an observatory to monitor the situation. The departure of skilled staff posed a problem for quality health-care delivery and the realization of the Millennium Development Goals. There was no short-term solution for the recruitment and retention of health workers, who were lured away by the much higher salaries in for example North America, where trained health-care workers were likewise needed. She urged the World Health Organization (WHO) to finalize its draft code of practice on the international recruitment of health personnel and said that States should then take the code seriously.

Mr. SPENCER (Observer for Jamaica) said that Jamaica trained many health-care professionals. It trained for example over 700 nurses a year but more than a third emigrated to take employment, leaving Jamaica in a situation where it was always playing catch-up to meet its own needs.

Mr. HACHETT (Barbados) said the Small Island Developing States faced a particular challenge in meeting the Millennium Development Goals. They very much needed support from the international financial institutions but if they were classed as middle-income countries by those institutions they were in fact entitled to less assistance.

Mr. MARMOT (Moderator) said that the current discussion had highlighted the problems faced by middle-income countries, in particular the Small Island Developing States, and their vulnerability to climate change and the economic crisis. It had also underscored the problem of the high debt burden faced by countries in relation to levels of official development assistance (ODA).

The PRESIDENT informed delegates that the ministerial declaration on the high-level segment would contain references to the WHO draft code of practice on the international recruitment of health personnel, the problem posed by the brain drain phenomenon, and the need to review the specific challenges faced by the middle-income countries.

Mr. MARMOT (Moderator) said that it was important to keep some perspective when citing statistics. While statistics might show that the number of individuals living in poverty worldwide had decreased, one could not extrapolate and say that the situation in specific countries or regions must likewise be improving. The specific situation of each country must be taken into account. While the population of Jamaica was statistically insignificant relative to the population of the world, their concerns and needs were real and must be addressed. He looked forward to hearing the presentation from China, a country very different from Jamaica, facing different challenges. The situations of both countries however were of great interest and could offer lessons of crucial importance.

Mr. CHEN Zhu (China), accompanying his statement with a computerized slide presentation, said that his Government had made the achievement of the Millennium Development Goals an integral part of its overall social development programmes. The Millennium Development Goals should be achieved ahead of schedule; significant progress had been made in such areas as reducing poverty, illiteracy and maternal and under-five mortality, eliminating hunger and combating such diseases as malaria, tuberculosis and HIV/AIDS. In the 30 years since 1978, average annual economic growth had been 9.8 per cent; per capita GDP had increased from 379 to 22,600 yuan; and China's human development index had increased from 0.53 to 0.78, ranking it 81st in the world.

The number of people living in poverty had decreased from 94 million, or 10.2 per cent of the population in 2000, to 40 million, or 4.2 per cent of the population, in 2008, more than achieving Millennium Development Goal 4 of halving by 2015 the number of people living on less than $1 a day. He noted that a study of the causes of poverty had shown that the burden caused by disease was a major factor in poverty. Improved health care therefore played an essential role in reducing poverty. Furthermore, the rise in GDP improved nutrition levels and likewise had a positive effect on the health of the population. His Government had steadily improved health infrastructure and technology and health insurance coverage in both urban and

rural areas. Infectious and endemic diseases had been brought under effective control. The overall health of the urban and rural populations continued to improve and life expectancy had increased from 67.8 in 1981 to 73 in 2005.

China's experiences in achieving the health-related MDGs were based on the principle that the needs of the people must come first. It had had considerable success, given that the infant and under-five mortality rate had fallen by 70.3 per cent, from 61 per 1,000 in 1991 to 18.1 per 1,000 in 2007. The maternal mortality rate had also been reduced by 63.4 per cent, from 94.7 per 100,000 in 1990 to 34.7 per cent in 2008. HIV/AIDS prevalence was low, with high rates only in specific groups and areas. Wide coverage had been achieved for the DOTS strategy, and the recovery rate for tuberculosis patients, who now received free treatment, had risen to 85 per cent since 1994. Since 1995 the incidence of malaria had remained below 5 per 100,000. Since the severe acute respiratory syndrome (SARS) outbreak in 2003, the capacity of the health system to respond to emergencies had been greatly improved through enhanced information systems, international and interregional exchanges and better legislation and regulation. As of 6 July 2009, there were currently only 1,114 confirmed cases of infection from the A (H1N1) influenza, and no deaths, and the rate of spread of the epidemic had slowed.

It was the Government's duty to improve the health of the people, since public health was central to sustaining socio-economic development. Universal access to health services was a necessity for achieving a prosperous and harmonious society. Given the country's size and the significant differences between regions, it was important to help those in real need. The medical insurance system must cover both urban and rural populations, and must focus on primary care and prevention. As for preventive health in practice, from the four vaccines previously used to protect against six infectious diseases, the Chinese system had progressed to 14 vaccines for 15 diseases. Preventive care was being extended to other chronic diseases and to occupational diseases and birth defects. A family planning policy was also in effect.

There were three basic medical insurance schemes, covering in total 1.13 billion people, or 85 per cent of the population, including almost the whole of the rural population. China had learned and borrowed a great deal from international cooperation and experience, and was grateful to the international community for its help in achieving the MDGs for health.

Turning to the challenges facing the Chinese health sector, he explained that there was still a long way to go in redressing the disparities in health-care provision between regions and between the urban and rural areas. On the eastern seaboard and in cities, the indicators for infant and child mortality were close to those in developed countries, but in communities in the western and central parts of China they lagged far behind. Large numbers of rural to urban migrants and an ageing population also placed extra burdens on the health system. New challenges were posed by changing disease patterns and the need to deal with HIV/AIDS and tuberculosis, combat the causes of non-communicable diseases and ensure food safety. The 114 million migrant workers newly resident in the cities posed an enormous challenge for the health system, as well as for education and employment.

China was proposing five key reforms of the health sector over the period 2008-2010: improving the grass-roots medical and health service systems; ensuring equal access to primary health care; expediting the construction of a basic medical insurance system; establishing a national system of essential medicines; and promoting pilot reform projects in public hospitals. In the framework of those reforms, primary health-care services and access to them would both be improved, especially for poor rural people and those in the central and western provinces. There would be a programme for building 2,000 county-level hospitals to a guaranteed standard, with at least one in each county, and 5,000 hospitals in urban locations would be renovated or expanded. The Government would support the construction of village clinics in the more remote areas, and especially in the central and western provinces, so that every village would have its own clinic within three years. There would be free access to primary health-care services in both urban and rural areas. National immunization plans would be extended to ensure vaccination against HIV/AIDS for all those aged between 8 and 15. Sanitation in rural areas would be improved through the construction of public toilets. Within three years, 1 million poor people would be able to have cataract operations. Breast and cervical cancer screening would be provided for 1 million rural women aged between 25 and 64. Mental health services would be improved. The existing health insurance schemes would be extended to cover all urban and rural residents, working, non-working or retired, and former employees of bankrupt enterprises or those which had gone out of business would be brought within the schemes. A national system of essential medicines would be set up, in order to reduce costs and increase the efficiency of dispensing and drug use. All Government-run health facilities would be equipped with the

essential drugs, which would also be available for purchase from retail pharmacies. Guidelines for a national list and formulary of essential drugs would be drawn up. The management of hospitals would be improved by reforming their governing structures, and rules would be introduced for the running of medical services.

In conclusion, he pointed out that China was still a developing country with a large percentage of poor people and a low per capita gross domestic product. However, the Government was committed to the pursuit of equality and to balanced economic growth and social development. It would accordingly be investing more in the central and western provinces where the most disadvantaged groups lived. It would continue to promote the achievement of the MDGs for health, and would support health developments in other developing countries.

Mr. BADR (Observer for Egypt), commenting on the presentation by the representative of China, noted that China had transformed its population burden into an asset, making remarkable progress in raising the standard of living and quality of life for its entire population over the past three decades. The numbers living in absolute poverty had been reduced from 250 million to 15 million. China had successfully introduced a rural cooperative medical care system covering 800 million citizens, the largest such system the world had ever known. It had also decided to invest a further 850 billion yuan into its public health system, as a stimulus package for the entire economy. From the viewpoint of the international community, there were lessons to be learned from China's success in combating both the current A (H1N1) influenza pandemic and the severe acute respiratory syndrome (SARS) a few years previously. As for its medicines strategy, China had consistently supported the development of traditional remedies alongside Western medicines, drawing attention to the importance of the latter in enabling developing countries to diversify their policies on medicines within public health systems.

Mr. KHAN (Pakistan) said that the presentation had shown how a clear political vision based on the principles of equity and social justice could bring about a fundamental transformation in society. By consistently maintaining a growth rate of 9.8 per cent a year since 1978, China had become the third largest economy in the world. It had increased its per capita GDP from 379 yuan and had met all the MDG targets. Of particular interest were the five health reform measures being implemented by China in 2008-2010, and the advances made in its rural cooperative health-care system. Other strengths of the Chinese health system were its

emphasis on traditional medicine, its work on disease prevention and its promotion of health literacy. Pakistan would be striving to replicate Chinese best practices through active bilateral cooperation.

He asked how developing countries could best learn from China's experience in handling pandemics, and how China planned to integrate traditional medicine into its existing health system. What was China's approach to dealing with non-communicable diseases, and how did it propose to tackle the increasing burden of contagious diseases, including HIV/AIDS and tuberculosis?

Ms. ADNIN (Malaysia) noted China's commitment, in spite of the huge size of its population, to providing universal access to basic medical and health-care services. The programmes introduced in China, including the scaling-up of medical infrastructure, the accelerated establishment of a basic medical insurance system and the introduction of a national system for essential drugs, could be models for other developing countries to follow. She welcomed the holistic and comprehensive approach taken by the Chinese Government towards public health, which included paying attention to poverty eradication, education, hygiene and sanitation.

Mr. DENISOV (Russian Federation) congratulated the Government of China on its success in achieving the MDGs for health, and especially on reducing infant, child and maternal mortality and combating the spread of infectious diseases. His country and Pakistan were both working with China on containing infectious diseases. He welcomed the priorities for health reform mentioned by the representative of China, and noted with interest its work on combining traditional and Western medical treatments.

Mr. CHEN Zhu (China) said that while China had made progress on public health, a great many challenges remained, which were exacerbated by the sheer size of its population. State investment of 850 billion yuan in health reforms despite the global financial crisis was evidence of a people-centred approach to governance which viewed public health expenditure not as a burden, but as investment in the country's economic development.

With regard to the influenza A (H1N1) virus outbreak, China was on high alert, since it had a large high-risk group that included 15 million newborn babies and more than 10 million pregnant women. Some 1,014 cases had been confirmed to date, but the Government was confident that the pandemic could be controlled with an integral strategy combining containment and mitigation. A cross-sectoral government body had been established to deal with the pandemic, with a focus on community-level prevention. Vaccine production had been intensified; following the severe acute respiratory syndrome (SARS) outbreak some years previously, a centralized disease reporting system had been established; and there were plans to strengthen disease monitoring.

Another speaker had raised the issue of Chinese traditional medicine, which benefited from preferential policies. Some 25 per cent of hospital patients were treated with traditional remedies and that figure was even higher in rural areas. China was currently compiling a directory of essential drugs, 40 per cent of which were traditional. Scientific controls were being stepped up to ensure drug safety and quality, and centres of excellence had been established to conduct clinical research and determine the applicability of traditional medicine for major cases.

Government efforts to curb the spread of chronic and non-communicable diseases emphasized prevention, service capacity, training and local health knowledge. A health file was planned for every citizen.

China provided official development assistance to more than 40 countries, including in the area of maternal health.

Mr. PINO ÁLVAREZ (Observer for Cuba) said that China was a model of equity and social justice. It had made remarkable progress on the MDGs thanks to the efforts of its socialist Government and people. China now had a comprehensive system for disease prevention. Thanks to increases also in its health budget, it had achieved impressive results with regard to life expectancy, maternal morbidity and infant mortality and provision of free treatment for AIDS and tuberculosis, inter alia. He would appreciate more details of the national health-care reform strategy and its likely impact on the nation’s health. China offered a positive example of what could be achieved when a country’s leaders were committed to strengthening the right to health and development at the national and international levels.

Mr. SYED HASSIM (Observer for Singapore) said that as a regional neighbour, Singapore wished to acknowledge the giant steps China had made towards the MDGs. Its achievement was particularly remarkable in view of the size and rural nature of much of its population. China accounted for a very large proportion of the region's population and its health efforts thus had a wider regional impact. China should share its experience in providing assistance to other countries with the MDGs.

Mr. KAHENDELIYANAGE (Observer for Sri Lanka) agreed that much could be learned from China's experience. With minimum resources, it had succeeded in reducing under-five mortality and maternal morbidity and tackling AIDS. He would appreciate further details of China's new health insurance scheme.

Mr. DHARMAPUTRA (Indonesia) encouraged Mr. Chen Zhu to elaborate further on lessons learned with respect to institution-building for disease prevention and control.

Mr. ALVIAREZ (Bolivarian Republic of Venezuela) said that China's report revealed major and remarkably speedy developments in people-centred public health provision. The entire world, in particular developing countries, could draw valuable lessons from the progress it had achieved towards the MDGs. He would appreciate more information on the human resource situation in the health sector and on the training of health personnel in both Western and traditional medicine. Both China and Cuba were examples to the world in the field of health and social security.

Mr. MOSCA (Observer for the International Organization for Migration) asked how successful China had been in providing health-care access to its large migrant population and whether a specific migrants' unit had been established within the Ministry of Health.

Mr. CHEN Zhu (China), responding to the second round of questions and comments, said that China still had a long way to go compared to some other advanced developing countries. It still lagged five years behind Cuba with regard to life expectancy. Within China, there was also more than 10 years' disparity in life expectancy between the western and eastern provinces, hence the importance of increasing access to primary health. A new cooperative health insurance system now covered more than 90 per cent of farmers, with the State providing for 80 per cent of costs. Health was the responsibility of individuals as well as Governments.

Human resource development was another priority for the health sector, with more than a million new medical and technical personnel needed in rural areas. Another challenge was how to persuade medical personnel to work in more remote rural areas. The development of Chinese traditional medicine was currently in crisis owing to the economic situation. A special policy was needed to establish three types of medical team, focusing respectively on traditional, Western and combined medicine. Other ministries shared the responsibility for further developing health services in China.

The meeting rose at 12.45 p.m.