Round Table

Translating words into actions: are governments acting on the advice of the *World health report*?

David C McCoy[a]

Abstract Every year, WHO produces the *World health report*: the 2005 report concentrated on maternal, neonatal and child health. But what is the value of these reports? Are they ritualistic publications designed to promote WHO, or are they worthy of proper discussion and debate? One would think that given the current crises in global health, the annual report of the UN's primary agency for health would be important. However, unless there is evidence that these reports are taken seriously, discussed and debated, and shown to have an effect, a conclusion might be drawn that they are largely insignificant. And that would consign WHO to a level of insignificance that it does not warrant. In this discussion of the 2005 report, I aim to provoke a response from both WHO and the international health community to demonstrate that the annual *World health reports* are meaningful. Furthermore, I suggest here that WHO shows its commitment to the recommendations of the 2005 report by monitoring how well recommendations have been taken forward.

Keywords Maternal welfare; Child welfare; Maternal health services; Child health services; Socioeconomic factors; Health economics; World Health Organization (*source: MeSH, NLM*).

Mots clés Protection maternelle; Protection enfance; Service santé maternelle; Service santé infantile; Facteur socioéconomique; Economie de la santé; Organisation mondiale de la Santé (*source: MeSH, INSERM*).

Palabras clave Bienestar materno; Bienestar del niño; Servicios de salud materna; Servicios de salud infantil; Economía de la salud; Organización Mundial de la Salud (*fuente: DeCS, BIREME*).

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Voir page 330 le résumé en français. En la página 330 figura un resumen en español.

يمكن الاطلاع على الملخص بالعربية في صفحة 330.

Introduction

The *World health report 2005 — Make every mother and child count*, draws attention to the continued neglect of children and pregnant women.[1] Although the aggregate mortality rate in children under 5 years old decreased from 146 to 79 per 1000 live births between 1970 and 2003, 40 000 children still die every day. In addition, there are 9000 stillbirths and 2740 cases of birth asphyxia daily. In Africa, one in six babies born alive will die before they reach the age of 5 years. 1500 women die from a pregnancy-related cause every day, and in several countries there has been deterioration in maternal health status over the past decade or so. These child and maternal deaths are largely avoidable and mostly the result of a continued failure to implement simple interventions and technologies.

Here, I discuss two aspects of the *World health report 2005*. The first relates to the importance of following up on the analysis and recommendations of the report, and ensuring the translation of these recommendations into meaningful changes. Such translation would require the adoption of recommendations by national governments, actors such as the World Bank, UNICEF and the multitude of new global public–private partnerships, and WHO itself. WHO has already derived a set of policy briefs from the 2005 report, but questions remain: can more be done to ensure the adoption of the analysis and recommendations of the report? How can WHO avoid its annual report becoming just another ritualistic publication? Does the report underpin WHO's role as the world's leading multilateral health agency?

The second aspect of my discussion here relates to the requirement for WHO reports to be taken seriously and be the subject of critical debate. Without scrutiny and discussion, gaps in the report may not be brought to light and barriers to successful implementation of recommendations would remain unchallenged.

Key issues

Exclusion and resources

A major focus of the 2005 report is the exclusion from care of hundreds of millions of people through the non-availability of health services; financial barriers to accessing care; demotivated and demoralized staff; gaps in health-care workers' skills and competence; and abusive behaviour towards patients. Properly trained health professionals are

[a] Global Health Watch, care of: Health Policy Unit, University College London, 29–31 Tavistock Square, London WC1 9QU, England (email: d.mccoy@ucl.ac.uk).
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identified as the primary building block of a health-care system, and the key importance of comprehensive rehabilitation of the health workforce is highlighted — health workers must not only be adequately remunerated, but they must also be provided with a secure and rewarding work environment (p. 137).[1]

Underlying the exclusion from health care is household poverty and poorly funded health-care systems. An estimate of the cost of scaling-up coverage of maternal, neonatal and child health services over the next 10 years in 75 countries (covering 75% of the world's population, 90% of all births and 95% of all maternal, neonatal and child deaths) amounted to an additional US$ 91.4 billion of expenditure: an increase from US$ 3.2 billion in 2006 to US$ 13.8 billion in 2015.

In several African countries, the estimated additional expenditure required solely for child health would correspond to a 46% growth in public expenditure over 10 years. In the 20 countries with the weakest health-care systems, plugging the gap in maternal health-care resources would require a 30% increase in expenditure. Furthermore, the cost projections are underestimates of need since they do not include, for example, the cost of providing antiretroviral treatment to children. Most tellingly, however, these cost estimates do not include salary increases and other benefits for health-care workers. This exclusion is despite the statement in the report that "there is no getting around the fact that low salaries and poor working conditions remain a major disincentive to the public sector workforce" (p. 136) and the note that nurses in Mozambique have seen the purchasing power of their salaries eroded by 85–90% over the past 15 years (p. 134).

Organization of maternal and child health services

The report also stresses the importance of a tiered organization of services with functional referral systems and a continuum of care in child health that extends from primary facilities towards a point of upward referral, as well as towards households and the community. The limitations of vertical programmes that target specific diseases or that focus on a narrow selection of interventions are also highlighted. The report calls for health-care systems to be more than a conduit for the delivery of medical technologies and to go beyond the provision of health education so as to facilitate actual community empowerment (p. 110). The District Health System model is promoted as the means of organizing maternal, neonatal and child health services; providing a platform for the integration of vertical programmes; and involving communities in health improvement.

Health-care systems

The report raises several general issues about health-care systems. One is "the rampant commercialization of the health sector" that fuels exclusion (p. 35) and erodes the implicit psychological and social contracts that underlie the public service values of well functioning public organizations (p. 134). The report also mentions the "frequently forgotten issue" of supply-driven over-medicalized care for reasons of financial gain, which causes harm and unnecessary expenditure to households (p. 48).

The relationship between public and private health-care services is described, including how higher salaries in the private sector result in an "internal brain drain". International nongovernmental organizations and donor-funded projects also contribute to the loss of skilled workers from the public sector, compounding the problem of emigration and the effect of HIV/AIDS on the health workforce. The report recognizes the central role of the public and quasi-public sector, and challenges the unfair labelling of public-sector health workers as unproductive, inefficient or corrupt.

The report also calls for the abolition of user fees (p. 138) and for health-care financing to be based on forms of pre-payments which are pooled to allow financial protection, risk sharing and cross-subsidization. Countries are encouraged to maximize the potential of tax-based financing and social health-insurance and to take steps towards the pooling of fragmented health-insurance schemes.

Another issue highlighted is the lack of coordination between donors and international agencies, the resemblance of health-care systems to a patchwork of projects, and the "shifting agendas" that undermine ministries of health and the coherent, long-term development of health-care systems (p. 43). By contrast, the report highlights how the development of health-care systems requires vision, time and sustained action (p. 130).

Finally, the report stresses the role of civil society in contributing to a system of checks and balances on the functioning of health services; helping citizens to take up their entitlements; and preventing financial exploitation and over-medicalization. Because civil society organizations have weak institutional capacity in many countries, the report argues for a greater investment in such organizations and for governments and donors to give these groups access to decision-making processes. This recommendation complements the rights-based approach promoted in the report, and the use of "specific legal and regulatory measures" to improve the protection of patients and to make audits of maternal and perinatal deaths mandatory.

The national and global context

The report highlights poverty, HIV/AIDS, conflict and gender imbalances as important contextual and underlying determinants of maternal and child health. It notes macroeconomic and political stability as preconditions for mobilization of institutional, human and financial resources to strengthen health-care systems and also highlights the importance of Poverty Reduction Strategy Papers, hinting at the need for ministries of health to ensure that these strategy papers promote macroeconomic and public-sector policies that will have a positive effect on the organization and financing of health-care systems.

Discussion

Much of what I have described in this report is to be welcomed. But what are the next steps for this analysis and set of recommendations? What would these steps mean for actors involved in promoting maternal, neonatal and child health? And what might be missing from the report?

How can WHO build on the report's methodical calculations of the resource gap in maternal, neonatal and child health? The establishment of the Commission on the Social Determinants of Health (CSDH), launched in May 2005, offers the hope that WHO will play a more assertive part in assessing and advocating for the need to reshape the structure and rules of the global political economy in favour of poor countries and communities. However, other commissions, such as the World Commission on

the Social Dimension of Globalization (WCSDG),[2] have already pointed clearly to a range of structural problems with the global political economy.

According to the WCSDG, for example, "there are deep-seated and persistent imbalances in the current workings of the global economy, which are ethically unacceptable". It goes on to explain that the "rules of world trade today often favour the rich and powerful, and can work against the poor and the weak, whether these are countries, companies or communities"; that "the global financial market is heavily dominated by financial interests in the industrialized countries"; and that "none of the existing global institutions provide adequate democratic oversight of global markets, or redress basic inequalities between countries".

Rather than repeat these findings, the CSDH and WHO must discuss the manner in which health agencies can intervene to reshape the global political and economic causes of impoverished health-care systems. In suggesting that ministries of health engage with Poverty Reduction Strategy Papers, the *World health report* is also implicitly calling on WHO and other health actors to engage with the political and economic determinants of health at the national level.

One starting point might be to repudiate (rather than echo) the "conventional wisdom" that income poverty (as defined by a US$ 1 per day threshold) is "on its way out". Although the report notes that income has declined in Africa, World Bank measurements of income poverty are based on methods that systematically undercount the depth and breadth of poverty.[3] Furthermore, the number of people living in poverty has actually risen according to World Bank figures[4] when the more appropriate US$ 2 per day poverty threshold is used.

WHO could also intervene by, for example, protecting and promoting public-health interests in the various fora that determine global trade and financial agreements. For example, it could create teams of experts to provide public-health advice to developing-country delegations at world trade talks as well as during regional and bilateral trade negotiations. Such support would raise the profile and status of health considerations relative to the narrow economic, commercial and corporate considerations that dominate trade discussions and economic policy.

But it is insufficient to merely rely on WHO to fix the injustices and faults of the global political economy. WHO must also be lobbied and supported to do so. The health ministries of developing countries must strengthen their resolve to capacitate WHO with the mandate and resources to protect and promote human rights and public-health interests. Likewise, health and development agencies in donor countries must place pressure on their own governments to give WHO the opportunity to be the "health conscience" of the world as envisioned by former WHO Director-General, Halfdan Mahler in the 1970s. In turn, civil society and nongovernmental organizations must lobby and watch to see if both WHO and the CSDH will be brave enough to confront and challenge the vested interests that lie in the way of fair reform and redistribution of resources.

Although familiar calls to increase the quantity and quality of aid as well as for the cancellation of unfair and unjustified debt repayments are still relevant, other options to raise resources remain inadequately discussed let alone advocated for. For example, a huge amount of wealth is now effectively exempt from tax as a result of decreasing tax rates, financial deregulation, transfer pricing and other opportunities for tax avoidance.[5] The diversion of both personal and corporate wealth to tax havens has cost public institutions hundreds of billions of dollars every year at both the national and global level. The recapture of this lost public revenue is surely a more appropriate and sustainable way forward than the current over-reliance on corporate donations and "public–private partnerships". Alternative sources of revenue include a currency transaction tax, an arms trade tax and an airline tax. Other sections of the UN system have mooted the idea of an international tax authority — why has WHO been silent on this issue?

And what of the problems of vertical programmes and the lack of coordination between donors and international health agencies? How will coherence in the approach to maternal and child health be achieved between WHO and UNICEF? Not to mention the need for the Global Fund, the Global Alliance for Vaccines and Immunization (GAVI), Roll Back Malaria, the [US] President's Emergency Plan for AIDS Relief (PEPFAR), United States Agency for International Development (USAID), UK Department for International Development (DFID) and the Gates Foundation to all work together without overlap. The Child Survival Partnership launched in December last year may be a step in the direction of improved coordination between different agencies, but it appears at the same time to be reinforcing a vertical and selective approach to health care, and setting itself up to compete with other global initiatives. How will the proliferation of competing global health initiatives and the pressure to roll out certain selective interventions be squared with the 2005 *World health report*'s view that development of health systems requires careful and sustained action over longer time frames?

WHO alone can not solve the problem of a lack of coordination between agencies, but it can develop and push for all donor and international agencies to operate by a code of conduct that places the institutional development of ministries of health at the centre of their programmes, and to acknowledge that countries need time, national leadership and clarity of vision to achieve health-systems development goals. Research could also be encouraged with the aim of holding a mirror to donors, international health agencies and global health initiatives. Action Aid, for example, recently estimated that the 700 or so international consultants working in Cambodia cost more than the combined salaries of all of Cambodia's 160 000 civil servants, and questioned whether these consultants achieve enough to justify their wages.[6]

But to improve the international community's assistance towards better health, more needs to be done to flesh out the principles of health-care systems development, such as clearly stating the implications of the promotion of the District Health System model. As with concerns about selective interventions, debates about this model have had a long history both within and outside WHO. It is therefore notable that the report advocates a shift towards the "de-verticalization" of health interventions and the rationale behind the District Health Systems model. But where do we go from here in the face of failed attempts to establish effective District Health Systems models, the damage done to many health-care systems by structural adjustment programmes and what appears to be a resurgence of "selective primary health care"? These are questions that must now be answered.

Perhaps an even more urgent action stemming from the 2005 *World health report* is the need to develop a strategy to

help countries decommercialize and decommodify health care, to counter policies and forces that promote segmented, nonuniversal health-care systems and constrain the enlargement of corporate and commercial health-care providers. This effort should include advocating for practical steps to be taken to abolish user fees and to pool fragmented health-care financing systems. Although the 2000 *World health report* was criticized for its treatment of equity and the methodology to rank health systems performance, it did, however, have the sound intention of monitoring health-financing indicators against benchmarks of equity. Here is an example of work done in one *World health report* that has not been adequately followed up. Principles and indicators of sound and equitable health financing have been developed — now let us start to use them more proactively. Once again, action from civil society actors will need to ensure that governments, health providers and other agencies are held accountable against these principles and indicators.

I have raised only a few suggestions and questions about the 2005 *World health report* here, but hopefully they will contribute to a more meaningful use of not only the 2005 report, but also future *World health reports*. ■

Competing interests: none declared.

Résumé

De la théorie à la pratique : les gouvernements appliquent-ils les recommandations du *Rapport sur la santé dans le monde* ?

Chaque Année, l'OMS publie le *Rapport sur la santé dans le monde* et la version de 2005 est axée sur la santé de la mère, du nouveau-né et de l'enfant. Mais quel est l'intérêt de ces rapports ? Leur publication correspond-elle à une opération rituelle de promotion de l'OMS ou est-elle à même de susciter des discussions et des débats pertinents ? Compte tenu de la crise sanitaire qui touche le monde actuellement, on pourrait penser que le rapport annuel de la principale agence des Nations Unies pour la santé devrait être important. Néanmoins, si rien n'indique que ces rapports sont pris au sérieux, font l'objet de discussions et de débats et ont un effet démontré, on peut en déduire que leur impact est dans une large mesure insignifiant. La faiblesse de cet impact risque de conduire à une sous-évaluation imméritée du rôle de l'OMS. La discussion de ce rapport 2005 s'efforce de susciter une réaction de la part de l'OMS, comme de la communauté sanitaire internationale, pour faire valoir l'intérêt des rapports annuels sur la santé dans le monde Entre outre, il est proposé que l'OMS démontre son engagement à l'égard des recommandations du rapport 2005 en exerçant un suivi de l'application de ces recommandations.

Resumen

De la teoría a la práctica: ¿siguen los gobiernos las recomendaciones del *Informe sobre la salud en el mundo*?

Cada año la OMS elabora su *Informe sobre la salud en el mundo*. El informe de 2005 se centró en la salud de la madre, del recién nacido y del niño. Ahora bien, ¿qué valor tienen estos informes? ¿Se trata de una publicación ritual concebida para promocionar a la OMS, o merece ser examinada y debatida cabalmente? Cabe pensar, considerando las crisis por las que atraviesa actualmente la salud mundial, que el informe anual del principal organismo de las Naciones Unidas para la salud ha de ser una obra importante. Sin embargo, si no se demuestra que esos informes son acogidos, examinados y debatidos con interés y que tienen impacto, podríamos llegar a la conclusión de que son prácticamente irrelevantes; y eso rebajaría inmerecidamente la relevancia de la OMS. En este análisis sobre el informe de 2005, mi propósito es provocar una respuesta por parte de la OMS y de la comunidad sanitaria internacional para que demuestren que esos informes anuales sobre la salud en el mundo tienen razón de ser. Además, propongo aquí que la OMS muestre su compromiso con las recomendaciones del informe de 2005, vigilando en qué medida se ponen en práctica.

ملخص

تحويل الكلمات إلى أفعال: هل تعمل الحكوما بنصائح التقرير الخاص بالصحة في العالم؟

تصدر منظمة الصحة العالمية كل عام التقرير الخاص بالصحة في العالم، وفي عام 2005 تركز اهتمام التقرير على صحة الأمهات والأطفال والولدان. ولكن أين تكمن أهمية هذه التقارير؟ وهل هي مجرد مطبوعات اعتيادية تصمم لتعزيز مكانة منظمة الصحة العالمية أم أنها جديرة بالمناقشة والتحاور البنّاء؟ و يمكننا أن نتبين ما للتقرير السنوي لأكثر وكالات منظومة الأمم المتحدة في المجال الصحي أهمية إذا أخذنا بالحسبان الأزمات الصحية التي يعاني منها العالم. ومع ذلك، فإن غياب البينات على أخذ هذه التقارير على محمل الجد، ومناقشتها والتحاور حولها، وتبيين ما لها من تأثيرات مفيدة، سيجعلها تبدو عديمة الأهمية، وسيوقع بمنظمة الصحة العالمية في مهاوي الإهمال، وهو أمر لا تستحقه. وفي مناقشتي للتقرير الخاص بالصحة في العالم 2005 كان هدفي الاستحصال على استجابة كل من منظمة الصحة العالمية والمجتمع الصحي الدولي لإيضاح أن هذا التقرير كان مفيداً. وأقترح هنا أن تبدي منظمة الصحة العالمية التزامها بتوصيات هذا التقرير برصد كيفية العمل بهذه التوصيات في المستقبل.

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Round Table Discussion

Collaboration and coordination: progress on implementation of recommendations from the *World health report 2005*

Elizabeth Mason[a]

In his discussion of the *World health report 2005 — Make every mother and child count*, David McCoy challenges the global community and WHO to maintain follow-up on the policy recommendations made in the report and to ensure their translation into meaningful changes. We applaud Dr McCoy's challenge to WHO and its development partners to take a more prominent role in shaping the global political economy with the view to protecting health, in particular that in the most deprived populations. We also welcome his proposal for concrete recommendations for immediate action. Here, I describe how WHO is already taking forward relevant actions.

WHO has been proactive in follow-up of the recommendations from the report's policy briefs. In May 2005, Member States adopted the resolution *Working towards universal coverage of maternal, newborn and child health interventions* at the 58th World Health Assembly (WHA58.31). The resolution calls on WHO to strengthen coordination, collaboration and synergies of WHO programmes, including those for health systems development.

The Organization at all levels is now strengthening mechanisms to provide coordinated support to countries. The country cooperation initiative ensures that WHO technical support to countries is coordinated and in line with national priorities. In the European and American Regions, WHO is promoting the functional collaboration between relevant technical units and work areas, resulting in joint work-plans and planning missions to countries. Following the 2005 Regional Committee meeting in Maputo, Mozambique, a process has been started in the African Region to develop a coherent institutional strategy across all levels of WHO will promote universal coverage and access to essential health interventions. The initiative is starting in 13 countries, and has maternal, neonatal and child health central to the agenda.

We share Dr McCoy's concern about the limitations of vertical programmes. Application of the continuum-of-care concept as promoted in the *World health report 2005* will fundamentally change the way in which programmes should be planned, implemented and supported. The recommendation moves us away from vertical programmes that are focused on an intervention, a population group or a condition. It also forces us to consider the interlinked functions of different levels of the health system, revolving from communities through primary-care services to emergency and referral care.

Promotion of the continuum of care calls for vision, long-term planning, and investment in solutions that are sustainable within the framework of national health systems in which public–private partnership are taking root and developing. This approach requires focus, not only on the interventions and their delivery, but also (and perhaps most strongly) on the development of the systems in which the provision of quality services can be institutionalized.

We also share Dr McCoy's concern about coordination between partners. As he correctly highlights, investments in human resources, financial protection mechanisms, district health management and infrastructure, are urgently needed to increase access to health services and to achieve universal coverage of essential maternal, neonatal and child health services in countries. Without such investments, sustainable delivery will remain a challenge and short-term gains will erode when priorities shift or sources of funding dry up. Thus, WHO is taking costing of maternal, neonatal and child health services to country level, so as to better quantify the gap between current provision and needs.

To help secure coordination, and to strengthen the long-term commitment of different actors, the new global Partnership for Maternal, Newborn and Child Health (http://www.pmnch.org), of which WHO is a founding member, seeks to improve partner coordination, advocate globally for more resources, and monitor progress towards achieving the Millennium Development Goals for maternal and child mortality reduction. WHO is also fully committed to the global Child Survival Countdown effort (http://www.childsurvivalcountdown.com), which seeks to track progress in the reduction of child mortality, highlight inequity, and promote greater accountability. These partnerships are resulting in new dialogues, including talks with well established global health partnerships such as the Global Alliance for Vaccines and Immunization and the Global Fund to fight Tuberculosis, AIDS and Malaria, which like WHO have also been challenged to strengthen health systems to scale-up the most effective interventions.

[a] Child and Adolescent Health and Development, World Health Organization, 1211 Geneva 27, Switzerland (email: masone@who.int).

The *World health report 2005* provides an in depth and systematic analysis of the issues that affect the scale-up of effective interventions and the achievement of universal coverage of maternal, newborn and child health interventions. As the first *World health report* to share a theme with and be launched on World Health Day, the 2005 report has greatly expanded the audience of its messages. Also, being the first report to be followed by a set of policy briefs, the 2005 report has been complemented by a clear set of tangible actions. I thank Dr McCoy for adding to the report's call on us all to take up the challenge to build stronger and more equitable health systems. Systems that can then be the conduit for the delivery of high quality services with universal coverage that will make an important difference to the lives of mothers and children. ■

Competing interests: none declared.

Challenges in producing the *World health report*

Thomson Prentice[a]

David McCoy raises many interesting points about the *World health report 2005*. I would like to respond to two aspects which interest him — and me — most: namely, the need for this report to be taken seriously, and the importance of following up on recommendations made in the document.

As managing editor of the 2005 report, I have often shared McCoy's worry that it may be perceived as yet "another ritualistic publication". Keeping the *World health report* fresh, relevant and challenging year after year is not easy in a global marketplace that is already crowded with reports from many other UN agencies and similar organizations. Luckily, the responsibility for excellence is widely accepted and shared within WHO.

WHO has an obligation to all its constituents — principally its 192 Member States — to provide a yearly report that will simultaneously fulfil a number of tasks. The report must provide expert analyses and interpretations of the latest and best information and data, it should engage in wide consultation and discussion on content with the Member States and many other partners, as well as draw conclusions and make recommendations.

But the role of the report does not end there. In many ways the *World health report* is the official voice of WHO, and its most powerful advocacy tool. Developing an advocacy strategy and ensuring follow-up are essential elements of producing the report. Unless the key messages of the report are carefully shaped, skilfully delivered, widely disseminated and regularly reinforced, there is indeed the other risk that McCoy identifies: namely, that the report will fail in its job of strengthening WHO's role as the leading international health agency.

In fact, the *World health report 2005* has done rather better than merely avoid failure. Its voice carries further today than at any time since it was launched in 1995, and with greater influence. The report, and its growing armoury of advocacy materials, now reaches a far wider audience than ever before. These improvements in access are mostly, but not only, attributable to the Internet. For example, the number of languages the report has been translated into has increased every year since its first appearance in English and French in 1995. WHO's voice is now being heard in all six of its official languages: Arabic, Chinese, English, French, Russian and Spanish. The 2005 report was the first to be produced in Portuguese, and we get many requests for permission to translate it into other languages. Although perhaps "demands" is a more appropriate descriptor than "requests", since WHO has come under intense pressure in the past couple of years from many of its Member States to produce the report in their languages, and to publish those versions simultaneously with the English original (an almost impossible task).

Furthermore, the decision in 2005 to launch the report on World Health Day every year — WHO's biggest public event of the year — and to have it share the same theme, has ensured that the general and professional audiences for its key advocacy messages have greatly expanded. The results of this coordination are evident in a greater level of media coverage for the report, as measured by our communications staff and by monitoring visits to our web site (www.who.int/whr).

Many more countries are now asking for advocacy materials, including the policy briefs introduced with the 2005 report, and other support in order to stage individual country launches. Very gratifying is the rise in demand for the report and these materials, both in print and in electronic formats. Happily, the demand does not stop there and then. Long after World Health Day is over, we continue to receive many requests for follow-up discussions, meetings and information exchanges. The report features frequently on the agendas of health conferences worldwide; 400 copies of the summary version of 2005 report were requested for a child survival meeting in London in December 2005, eight months after publication.

Without doubt, however, the *World health report* could be a more powerful instrument and it could be used more effectively. We could use more forward planning to allow more time for the preparation of the report and its advocacy and media strategies. We would benefit from more consideration of how to take those messages forward and stimulate greater debate. We could always use more constructive criticism.

However, I believe that it is unrealistic to expect the *World health report* to have much of a visible effect on national or international policy-makers in the short term. The real and lasting gains in global health are going to be achieved through long-term commitment, investment and cooperation, which the report consistently advocates. I believe this approach will be readily evident once more in the *World health report 2006*, which will be on the subject of human resources in health, and which has as its working title (no pun intended) *Working together for health*. ■

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[a] Managing Editor, *World health report*, World Health Organization, 1211 Geneva 27, Switzerland (email: prenticet@who.int).