

FIFTH MEETING

Wednesday, 19 January 2005, at 09:05

Chairman: Mr D.Á. Gunnarsson (Iceland)

1. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda (continued)

Social health insurance: Item 4.5 of the Agenda (Document EB115/8)

Dr HUERTA MONTALVO (Ecuador), referring to paragraph 1(1) of the draft resolution, supported the idea of systems that would allow risk pooling, but was concerned that the reference to prepayment might be confused with private prepayment schemes, which differed from a system of income-based contributions to a general fund. It was also important to determine the scope of the so-called social health insurance schemes, which were a traditional system based on payment by the workforce. Broader health insurance schemes were needed that were part of an integrated health plan, a basic reference point for private and public insurers alike, providing universal coverage for individuals and families rather than services such as treatment and care, and prevention and control of environment-related risks. The concept of external funding, whether or not from state funds, also needed to be clarified to ensure that financing models were not established on the basis of external debt, as they would be non-sustainable. The draft resolution might also provide for the participation of citizens, and an oversight mechanism.

Professor FIŠER (Czech Republic) said that, to avoid having conflicting recommendations from two different international organizations, a situation that had occurred three years previously, he proposed the insertion, in paragraph 2(2) of the draft resolution, of the words “in coordination with the World Bank,” after “to provide Member States”.

Dr GAKURUH (Kenya) welcomed the timely attention being given to the topic, which was fundamental to the health sector in the African Region, where grossly inadequate financial resources made health-care reform a struggle. In Kenya, efforts to enact a bill to establish a social health insurance system were proving difficult, not least because of the resistance of the private insurance sector. She therefore fully supported the draft resolution, particularly in view of the need for support to countries from not only the World Bank but all stakeholders, in dealing with one of their biggest problems, that of developing a policy advocacy document.

Dr CAMARA (Guinea) fully supported the draft resolution. In Guinea, many people had difficulty in paying the reasonable rates set by the Government because of the level of poverty, which affected some 40% of the population, and of fluctuations in incomes. During the past five years the authorities had attempted to tackle the situation by means of community-managed mutual funds; but such schemes were not yet well advanced. Efforts were continuing, however, and those systems that had been established showed a potential for broadening access for fund members and ensuring that demand could be met by stabilizing some of the charges of health care establishments. As part of the poverty reduction strategy, the Ministry of Health was trying to expand access beyond the system of mutual funds, which were only available to members. The preferred system would provide universal coverage, involving a financing policy focused on mobilization of resources and the pooling of purchasing power; payment exemption for the poorest to ensure universal access; and an increase in funds for the highly indebted poor countries to provide care for the poorest through contractual agreements with health-care establishments.

Dr STEIGER (United States of America) said that he was disappointed with the deep-seated bias shown in WHO, including the Executive Board, against private enterprise. All proposals embodied a statist approach and reflected a presumption that the private sector's motives were questionable, on subjects such as infant formulas, pharmaceuticals and food. In the "3 by 5" initiative, for instance, there was little mention of the private sector or of the advantage that could be taken of the many non-state providers. The report regrettably reflected that bias. There was no comprehensive description of the full range of public and private options for comprehensive health insurance for all. The Secretariat, and the relevant documentation, ought to make clear the advantages of private providers, such as responsiveness to patients, flexibility, innovation and efficiency. Subsidies to purchase private insurance could achieve equity in a mixed system, and every government needed a reasonable overall regulatory regime. WHO should continue its work on the subject but propose a broader range of schemes and mixes that would expand coverage and minimize problems such as those mentioned by the previous speaker. The range should include the private and public systems, and blends of the two, depending on a country's political and economic realities, while striving for efficiency and sustainability.

He therefore proposed the following amendments to the draft resolution. The fourth preambular paragraph should be amended to read: "Acknowledging that a number of Member States are pursuing health-financing reforms which may involve a mix of public and private approaches (including the introduction of social health insurance);".

In paragraph 1(1), the words "introduce or develop prepayment of financial contributions for the health sector" should be replaced by "include a method for prepayment of financial contributions for health care, ...". In paragraph 1(3), the words "Millennium Development Goals" should be replaced by "internationally agreed development goals, including those contained in the United Nations Millennium Declaration". In paragraph 1(6), the words "health-financing reform" should be replaced by "different methods of health financing", and the words "and private, public and mixed schemes" should be inserted after "social health insurance schemes".

In paragraph 2(2), the proposal by the member for the Czech Republic should be extended by addition of the words "and other relevant partners". In paragraph 2(3), the words "to create an evidence base in order to identify best practices" should be replaced by "to provide technical support in identifying data and methodologies to better measure and analyse the benefits and costs of different practices ...". In paragraph 2(4), the words "to assist Member States, as appropriate," should be added at the beginning.

Dr OÑORBE DE TORRE (alternate to Dr Lamata Cotanda, Spain) appreciated the inclusion of the topic on the agenda and the draft resolution. During the past 100 years universal health insurance cover in Spain had advanced from a limited system in 1900, covering a small group of workers, to compulsory contributory sickness insurance in 1942 and, since 1986, to an almost totally tax-funded national health system based on universal coverage, financing proportional to personal income, equity and access according to need. The accent was on primary care, preventive care and sound training of health professionals, with decentralized regional management. The capacity to improve an entire system would largely depend on a country's available income; but there was no doubt that, at any given level, results could be improved by the way that health services were financed and organized. Universal coverage, solidarity-based viable financing and efficient management were key factors. Spain had collaborated with various countries and with WHO in developing management structures and the training of health professionals, and was ready to collaborate, through WHO, in providing technical assistance.

Mrs GILDERS (alternate to Dr Shugart, Canada) said that access to health services must be universal and based on need, not ability to pay. Canada continued to reform the health system in order to increase its efficiency and long-term sustainability. It supported the draft resolution, recognizing that the choice of financing mechanisms would reflect the situation in each country. Much could be learnt through the exchange of ideas in forums such as WHO; ultimately, however, a government's

decision on the way to modify its existing health financing system should reflect what was most likely to lead to universal coverage, in the light of the country's situation and objectives.

Mrs LE THI THU HA (Viet Nam) said that Viet Nam's social health insurance system currently covered 20% of the population. Optimal pooling had been achieved through the established framework, and the most vulnerable groups, namely the poor and the elderly, were covered. Many problems, such as the limited benefit package, financial stability, management capacity and interministerial cooperation persisted. The Government had recently reviewed the 1989 decree on health insurance, and was receiving support from WHO in drawing up a master plan for social health insurance. For low-income countries such as her own, a parallel approach was recommended, comprising compulsory health insurance and a social security framework for workers in the public and private sector and their dependants; development of legislation involving a suitable tripartite administrative structure; a voluntary, community-based health insurance system for the self-employed and the informal sector in rural areas, for a limited period of three years from implementation of the plan; and social assistance through Government funds to purchase health insurance for the economically non-active and the poor. The master plan envisaged a comprehensive range of benefits, including primary health care, in-hospital and outpatient care, and the entitlement of all categories to the same benefits. The Government's commitment to achieving universal coverage had been reflected in a resolution adopted by Congress in 2001; its full effect would, of course, take many years to achieve, and much remained to be done. WHO's continued technical support was therefore needed; for that reason Viet Nam supported the draft resolution.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that the report set out important principles of health-system funding and showed that, although no single financing mechanism could be recommended as the optimum method in all situations, pooling resources could improve the supply and use of services, since poverty-related factors were an obstacle to universal health insurance coverage. In most of the countries where 60% of the population was living on less than US\$ 2 a day, sustained external funding would be essential from the outset, as would strengthening the capacity of administrative and oversight staff. He supported the draft resolution as amended by the previous speakers.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) said that health insurance was of great relevance to the quality of the services offered. In Kuwait, primary and specialized health care was provided free of charge. People suffering from incurable diseases were sent abroad for treatment at the expense of the State, notwithstanding the high costs involved. A social health system had been introduced for foreign workers, who were asked to pay a small contribution, the remaining charges being borne by the State.

Dr ACHARYA (Nepal) said that the report highlighted the fact that universal coverage could be realized only through a mix of financing systems, that Government stewardship was needed and that funds had to be collected efficiently and then pooled. Hence tax-funded health financing and social health insurance were both viable mechanisms. The debates on health-care financing which had been held in many high-level forums in south-east Asia had identified regional issues that influenced the technical feasibility of social health insurance, including the structure of the labour and financial markets, the existence of other types of insurance schemes, the need for regular contributions, and health and management infrastructures. Lack of consensus and trust, inadequate health care, insufficient human and social capital, political instability and the absence of policy debates were preventing the expansion of social health insurance in most countries of the South-East Asia Region. It was to be hoped that the holistic approach of WHO and its support would make it possible to address those concerns in the future. It was vital for countries like Nepal, whose health insurance scheme was in its infancy, to make progress in that area. He therefore supported the draft resolution with the proposed amendments.

Dr WANCHAI SATTAYAWUTHIPONG (adviser to Dr Suwit Wibulpolprasert, Thailand) noted that the sizeable increase in budgetary appropriations for social health insurance activities was evidence of significant commitment to that subject. Thailand had launched health insurance for the poor in 1975, but, after 25 years, had found that less than half the target group was actually benefiting from the scheme and therefore that a substantial number of households were suffering from catastrophic illnesses. The subject had consequently become a priority issue in the 2001 general election and the new Government had decided to implement a scheme that provided universal coverage at a cost of 30 baht per patient per visit to a public or private health facility for treatment ranging from minor complaints to major surgery and cancer treatment; the poor, the elderly, children and other underprivileged sections of the population were exempt from payment. The introduction of the co-payment component had made it possible to abolish direct insurance contributions, and had led to the establishment of a financial mechanism based on a per capita fee, with the result that each facility tried to enrol large numbers of patients as a means of increasing its budget for salaries and operating expenses. All those mechanisms had greatly enhanced poor people's awareness of their rights.

The programme had proved to be extremely popular, had scored successes in fund-raising, pooling of resources and procurement, and had strengthened the health infrastructure and human health resources. Nevertheless it had to be borne in mind that the country had adequate resources for health, including human resources, in the area of care, drugs and technology, owing to its climate of peace and economic growth. It also had a proper management system. If those conditions had not obtained, the abolition of the financial qualifying condition would have led to low-quality services.

He supported the amendments to the draft resolution proposed by the members for the Czech Republic, Kenya and the United States of America and proposed the addition of two subparagraphs. The first, in paragraph 1, would read: "to ensure adequate and equitable distribution of good-quality health-care infrastructures and human resources for health to ensure that the insurees will receive equitable and good-quality health services according to the benefit package". The second, in paragraph 2, would read: "to create sustainable and continuous mechanisms, including regular international conferences, to facilitate countries in the continuous sharing of experiences and lessons learnt on social health insurance".

Dr MOLDOVAN (alternate to Professor Cinteza, Romania) said that in her country health care, health promotion and preventive medicine were chiefly funded by the national social health insurance fund which was financed from employees' and employers' compulsory contributions, State budget subsidies, donations and sponsorship. Although the Romanian health system faced difficulties in respect of access to health services, equity in financing and the quality of the services provided, she believed that by developing the social health insurance system it would be possible to ensure universal access for all citizens to basic health services, to enhance quality of life by improving the quality and safety of medical treatment and to introduce tax-deductible private health insurance as a means of reducing informal payments. WHO's recommendations would help countries with economies in transition to devise strategies for developing schemes of that kind.

Dr BUSS (Brazil) expressed support for the draft resolution. Brazil had a free, universal, public health system financed by general taxation, which was designed to meet the needs of the population. Services were offered by a mix of public and private providers, the latter being contracted by the public sector. Private practices and private financing systems were regulated by the State through an agency which had been established for that purpose. In order to put in place systems that met universal health needs, WHO should draw on and analyse individual countries' experiences and promote an exchange of information on innovations introduced into national health systems for the benefit of other countries. Its role in managing such information was vital for the improvement of health systems. Close attention should be paid, therefore, to paragraph 2(3) of the draft resolution, referring to the creation of an evidence base.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that, although his country was experiencing rapid socioeconomic development, urban and rural economies were growing at different paces and the income gap between various sectors of urban society was widening. When establishing social health insurance it was essential to protect people's rights and to promote the sustained development of society. In 1998, China had launched a basic medical insurance system that had gradually been introduced throughout the country and subsequently improved; for example it had been extended to the private sector, the self-employed and to rural areas, with a view to covering the entire rural population by 2010. Developing countries were bound to encounter many challenges and difficulties in promoting universal health insurance coverage. For example, they would have to reduce disparities in health facilities between urban and rural areas and provide health care for all residents, finance insurance in a way that struck a balance between revenue and expenditure, regulate the quality and pricing of social medical services, improve skills, increase the accessibility of medical services and strengthen the management of the social health insurance system. The Secretariat could provide Member States with suggestions and support, with particular emphasis on the exchange of technologies and experience. China endorsed the draft resolution.

Dr ANTEZANA ARANÍBAR (Bolivia) said that the key to achieving the goal of health for all lay in finding a mechanism that would enable the whole population in every country to have equitable access to an acceptable standard of care at a cost which that country could finance. In a country like Bolivia, the fact that a substantial percentage of the population had no access to health services and that social security coverage was poor was indicative of certain problems. The Spanish model offered equity, quality and universal access. The systems that developing countries were adopting should therefore provide options designed to do likewise.

Unfortunately the focus was on curative treatment and little interest was being shown in the equally important prevention of disease. For that reason, the document should have referred to health promotion and the prevention of disease. Account should also have been taken of the changing epidemiological profile, particularly of developing countries, the additional burden placed on social security mechanisms by increased life expectancy and the loss of revenue caused by job losses. Rising unemployment meant that more imaginative financing solutions would have to be sought. Paragraph 12 of the report made it clear that no one system constituted a panacea, because conditions and possibilities varied from country to country. There was no such thing as a free health system; somebody had to pay. He favoured a mixed system of tax-funded financing combined with the participation of the private sector. He agreed with the Thai amendments, but requested clarification of paragraph 2(2), which was complex and somewhat controversial.

Dr AHMED (Ghana) outlined the many changes made to the financing of the health system in his country. Immediately after independence a free health service had been funded through direct taxation. Out-of-pocket payments, to cover about 20% of the cost of drugs, had been introduced in the 1980s. A law establishing social health insurance had been passed in 2003, to provide access to health care services and to underpin those services with a reliable source of financing. The scheme was based on district mutual health systems. For-profit and non-profit private schemes existed alongside the Government-sponsored district mutual schemes. The latter were run by district committees and were funded by contributions from all the people in the district: everyone had to belong to a private or public scheme. Indirect taxes in the form of a national health insurance levy on some goods and services were also paid into the central fund.

Social insurance covered the cost of about 90% of basic health services, with the Government supplying the remaining 10%. The Government therefore had sufficient funds to focus on health promotion and the prevention of disease. Some problems had been met in implementing the mutual schemes in more than 130 districts throughout the country, but an attempt was being made to solve them. All persons over the age of 70 and all pensioners and their families received free health care.

He supported the draft resolution as it stood.

Dr TANGI (Tonga) said that, in his country, health care had always been funded by the State. Infant and maternal mortality rates were low, and immunization coverage stood at 98%. However, the Government's current expenditure on health care, totalling up to 11.5% of the budget, was unsustainable in the long term. It was not yet clear which system of health-care financing would be adopted, but it was essential to ensure that people with chronic illnesses were not disadvantaged by the new arrangements. A research project on health-care coverage was under way, with the support of the World Bank. The results of a survey of more than 1000 households conducted in 2004 to determine their out-of-pocket expenditure on health care were being analysed. A health foundation was being set up, partly financed from taxes on tobacco, to conduct health promotion activities, particularly for noncommunicable diseases – an area in which he had also requested WHO support.

He supported the draft resolution, with the proposed amendments.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) welcomed in particular the emphasis on Member States' freedom to choose their own system of health-care financing and on the provision of technical information by WHO to Member States. He suggested two amendments to the draft resolution: the sixth preambular paragraph should be amended to read: "recognizing the leading role of State legislative and executive stewardship in ...", and paragraph 1(3) should be amended to read: "... to contribute to meeting the population's need for health care and improving its quality ...".

Dr PHOOKO (Lesotho) said that social health insurance would make health interventions possible even in poor countries such as his own. It should be developed and administered in consultation with stakeholders, including health professionals, the finance sector, and the private sector. WHO should support Member States in developing tools and methodologies for evaluating the impact of insurance on health services; more information on best practices in health insurance would be useful. He supported the draft resolution with the proposed amendments.

Dr ABDUL WAHAB (Bahrain) expressed support for the draft resolution with the proposed amendments. In his country, health services had always been provided free of charge for all residents and even temporary visitors. However, the burden of health expenditure on the State budget could no longer be sustained, and a more appropriate policy was needed that would safeguard the health of the population, particularly the large numbers of foreign workers. The Government had introduced fees for secondary and tertiary health care, but had taken care to maintain free emergency care for expatriate workers.

The Government was studying the various types of health insurance schemes introduced in the Middle East and elsewhere, but had not yet found a model that would provide appropriate and affordable coverage for everyone in Bahrain. In the light of those developments he asked WHO to prepare a working paper describing the various types of schemes used in different countries, so that countries such as his own could study the different options and decide which one would suit them best.

Dr YOOSUF (Maldives) said that his country was trying to develop a system of health financing that would alleviate poverty and reduce the need for out-of-pocket payments for health care, a task that was difficult in a country with a small, widely-dispersed population, where the costs of providing health care and transport were high. The burden of disease was shifting from communicable to chronic diseases, which were expensive to diagnose and treat and required expensive medical technology, and the population's expectations were increasing. He agreed with the member for the United States of America that the private sector had a valuable role to play in the provision of health care. However, capacity in the public sector should also be increased, so that the Government could regulate the system appropriately whether provision was publicly or privately funded.

He proposed that paragraph 2(1) of the draft resolution should be amended to read: "... universal coverage, including the special needs of small island countries and other countries with small populations ...".

Professor DAB (France) expressed support for the draft resolution with the proposed amendments. Access to care was one of the factors that determined the health status of a population. Care should not be separated from prevention. There was no universal solution which would bring health expenditure under control at a stroke: the issue must be approached with humility and pragmatism. The relative importance of the public and private sectors in health care should be determined by scientific and practical, rather than ideological, factors. Epidemiological and economic research had shown that State-run systems were inadequate in quality and performance, while for-profit systems were not necessarily more efficient or less costly and indeed restricted patients' access to care, as shown by the data on health status from various countries. It was important to remember that health care brought benefits as well as expense – a fact which was often not emphasized enough.

Dr AGARWAL (India)¹ welcomed the draft resolution. Social health insurance had received considerable attention in recent years as the most promising option for extending health-care coverage to the majority of a country's population. The health insurance system adopted had to be appropriate to the country concerned and involve various methods of risk pooling, such as community-based financing and subsidies for the poor. The health policy adopted in India in 2002 encouraged the creation of private health insurance packages to increase insurance coverage in the secondary and tertiary health sectors. About 75 million people were covered by some form of health insurance, including the central government health scheme, the employers' state insurance scheme and separate schemes run by different ministries. Social health insurance systems should pay particular attention to population coverage, methods of financing, level of fragmentation, composition of risk pools, benefits packages, provider payment mechanisms and administrative efficiency.

Mr KRECH (Germany)¹ welcomed the draft resolution. Social health insurance and tax-funded health systems should be seen in the wider context of universal coverage and health financing. Germany helped its partner countries to develop solidarity-based systems with prepayment of financial contributions in order to distribute the risks more evenly among the population. Currently, more than 100 million people each year were forced into poverty by having to make out-of-pocket payments for health care. The financing mechanism which should be adopted depended on the cultural, historical and political context of the country concerned. To reflect that wider context, therefore, the Board might wish to consider changing the title of the report and the draft resolution to "Health financing, universal coverage and social health insurance".

If a country decided to develop a social health insurance system, it should receive the best possible technical assistance. Germany's development assistance agency had reorganized the way it worked with WHO and ILO. The three agencies had improved coordination of their efforts at country level in the African, South-East Asia and Western Pacific Regions. He expressed the hope that WHO would meet the increasing demand from Member States for technical assistance in the field of social health insurance and invited Member States to attend a joint conference being organized by the three agencies to review experiences in social health insurance, which would take place in Berlin in November 2005.

Following an explanation of procedure by the CHAIRMAN, Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the European Union and its Member States, formally seconded Germany's proposal to amend the title of the report and the draft resolution.

Ms LAMBO (The Save the Children Fund), speaking at the invitation of the CHAIRMAN and also on behalf of the International Alliance of Women, said that, if developing countries were to achieve sustainable universal coverage, they would need to explore new mechanisms of health financing with pro-poor redistributive taxation, as had been done in Sri Lanka. Her organization

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

supported the abolition of user fees and the increase in the resources allocated to health, as called for in the report published by the United Nations Millennium Project.¹ Essential health care must be free at the point of access. Her organization urged donors and national governments to ensure that adequate long-term resources were allocated to ensuring provision of essential health services free of charge for everyone, and called on WHO to include a statement on user fees and cost-sharing mechanisms in its report.

Her organization was finalizing a report on user fees that highlighted their failure as an effective health-financing mechanism in low-income settings: user fees discriminated against poor, marginalized and sick people, were complex to manage, incurred high transaction costs, reduced health-service coverage and raised only between 5% and 10% of recurrent costs, while failing to spread the financial risk over time or among households. WHO should provide developing countries with the tools and technical support they needed to decide on the most effective mechanism for their own situation. The proposed monitoring tool, the so-called “primary health care lens”, could help countries to explore the potential impact of policies on the poorest people before adopting them.

Countries making changes in their health-financing systems would require long-term, predictable resources and transitional support. Save the Children’s recent research on the cost of coping with illness in eastern and central Africa showed that paying for health care had led the poorest people into further poverty, but a recent report² showed how one poor country had succeeded in concentrating public funds on ensuring equitable access to inpatient care for the poor, while expanding the private sector to serve people able to pay. WHO and donors should support operational research in developing countries on pro-poor health-financing mechanisms, in order to increase equity and contribute to the health-related Millennium Development Goals.

There was no blueprint for success in health financing, but WHO should publicize the good practice of countries such as Madagascar, Sri Lanka and Uganda, where free access to health services had increased use by the poorest people.

It should be made clear in the draft resolution that user fees had a negative impact on health outcomes, especially for the poorest women and children. The Board might also wish to include a reference in paragraph 1(6) to the sharing of experiences gained from ineffective as well as effective health-financing mechanisms and, in paragraph 2(3), to WHO’s support for countries in exploring the most effective health-financing mechanisms to ensure universal access to health care.

Dr EVANS (Assistant Director-General) welcomed the comments and expressions of support. In many of WHO’s 192 Member States, the current financing situation was not merely unsatisfactory, but positively injurious to the citizen. Evidence from more than 70 countries suggested that about 100 million households globally were impoverished every year because of their expenditure on health care. The situation should be monitored, and more should be done to develop financing systems that did not require patients to pay out of their own pockets at the point of service. The idea of moving towards financing systems that promoted universal coverage had been strongly supported, but it was clear that there was not “one size to fit all”. The report and the draft resolution recognized multiple options for the financing of health systems that included both the public and private sectors.

The way in which global financing mechanisms related to the financing objectives of national health systems was still not well understood. External funds for specific health programmes should be managed and organized to support the development of national financing systems. In some areas of the world, most notably Africa, the inflow of funds from external sources was calling into question the relationship between the size of the health sector and the size of the public sector relative to the size of the overall economy, and threatening to upset a delicate balance. The issue required careful

¹ United Nations Millennium Project. *Investing in development: a practical plan to achieve the Millennium Development Goals*, Sachs J ed. New York, 2005.

² *Bucking the trend: how Sri Lanka has achieved good health at low cost – challenges and policy lessons for the 21st century*. McNay K, Keith R and Penrose A (Eds). London, Save the Children, 2004.

consideration, particularly at a time when, although potential opportunities existed for the expansion of health systems in some countries, difficulties were being encountered by others because of fears of macroeconomic instability. WHO would be working with the World Bank and IMF in that regard.

Every effort would be made to respond to the numerous requests for technical assistance and for the development of a paper on options and best practices in collaboration with the regional offices.

Mr AITKEN (Director, Office of the Director-General) read out the proposed amendments and assured members that a revised text containing all the amendments made during the discussion would be circulated in due course. He recalled that the representative of Germany, supported by the member for Luxembourg, had suggested that the title of the draft resolution should read: "Health financing, universal coverage and social health insurance".

Dr BUSS (Brazil), supported by Dr OÑORBE DE TORRE (alternate to Dr Lamata Cotanda, Spain) and Dr HANSEN-KOENIG (Luxembourg) affirmed that it would be preferable if all the amendments proposed were circulated in writing before a decision was taken on the draft resolution.

Dr HUERTA MONTALVO (Ecuador) pointed out that, if the draft resolution were to attempt to reflect all the points of view expressed, there was a danger that it would be inconsistent. Universal coverage was not merely the responsibility of the state, but of all sectors, and unless that was made clear, the role of organizations like WHO would be diminished. Health for all, a long-standing objective in the Americas, could not be attained using methods that left certain sectors out of account.

He himself would welcome the involvement of the World Bank in the matter. While economic considerations should be taken into account, they should not take precedence over health considerations. He questioned whether, in his country, budgetary allocations should be earmarked for servicing external debt rather than for health. The whole discussion had a substantial ideological component which could not be dealt with simply by trying to include all shades of opinion.

The CHAIRMAN suggested that further consideration of the item should be deferred until a new text had been made available.

It was so agreed.

(For adoption of the resolution, see summary record of the twelfth meeting, section 1.)

Blood safety: proposal to establish World Blood Donor Day: Item 4.6 of the Agenda (Document EB115/9)

Mr JUNOR (Jamaica) endorsed the proposal to establish a World Blood Donor Day, but expressed concern over certain aspects of the draft resolution contained in document EB115/9. The HIV/AIDS epidemic and the related stigmatization and discrimination compounded the difficulty in persuading people to donate blood voluntarily, in the Caribbean countries and elsewhere. Jamaica had introduced a system that encouraged families whose members were undergoing surgical procedures or giving birth to donate blood in case it might be needed; donors were credited with the amount of blood they had given, and could decide how their contribution would be used. Jamaica fully supported the prohibition of paid blood donation but wanted the phrase "and family or family replacement" deleted from paragraph 2(3) of the draft resolution which sought to eliminate both types of blood donation. He was aware that the United States of America intended to propose amendments that included the wording "family or family replacement blood donation" in that subparagraph, which he would be unable to accept.

Dr STEIGER (United States of America) said that HIV/AIDS and other factors had made blood safety even more urgent than it had been in 1975, necessitating action in addition to that undertaken in

connection with resolution WHA28.72. He supported the idea of an international World Blood Donor Day, but the draft resolution should not be confined to the Day itself and should refer to policies endorsed as good practice by WHO expert meetings and committees.

In the light of further broad consultations with Member States and the Secretariat, therefore, he proposed the following amendments. The preambular paragraph should be amended to read "Having considered the report on blood safety and the meeting report of the WHO Forum on Good Policy Process for Blood Safety and Availability," with a footnote giving the full title and date of that meeting. In the fourth preambular paragraph, the words "and blood product" should be added after "unsafe blood", because the transfer of plasma had also caused a problem with HIV transmission in some Member States. In paragraph 2(3), he supported the amendment proposed by the member for Jamaica, and proposed that the words "none exists" should be replaced by "needed". The paragraph should be further amended by adding at the end: "except in limited circumstances of medical necessity and, in such cases, to require informed consent of the transfusion recipient;". In the light of the recommendations of the meeting report of the WHO Forum on Good Policy Process for Blood Safety and Availability, he proposed the addition of four new paragraphs after paragraph 2(4), that would read:

- (5) "to support the full implementation of well-organized, nationally coordinated and sustainable blood programmes with appropriate regulatory systems, in particular through the following:
 - (a) government commitment and support for a national blood programme with quality systems, through a legal framework, national blood policy and plan, and adequate resources,
 - (b) organization, management and infrastructure to permit a sustainable blood transfusion service,
 - (c) equitable access to blood and blood products,
 - (d) voluntary, nonremunerated blood donors from low-risk populations,
 - (e) appropriate testing and processing of all donated blood and blood products,
 - (f) appropriate clinical use of blood and blood products;
- (6) to establish a quality process for policy- and decision-making for blood safety and availability, based on ethical considerations, transparency, assessment of national needs, scientific evidence and risk/benefit;
- (7) to share information nationally and internationally to make clear the scientific, economic and social basis of national policy decisions related to blood safety and availability; and
- (8) to strengthen partnerships at all levels to accomplish these recommended actions."

In the United States, blood safety was a major pillar of the President's Emergency Plan for AIDS Relief, and extensive resources had been devoted to help countries in Africa, Asia and the Caribbean to ensure safe blood supplies with a view to reducing the transmission of HIV. The United States was also working on blood safety issues with WHO, for example, contracting to perform direct blood safety advisory and implementation services in Ethiopia, Haïti and Namibia as part of the Emergency Plan.

Mrs GILDERS (alternate to Mr Shugart, Canada) endorsed the draft resolution and the amendments proposed by the previous speaker which would strengthen it and reflect the work of the Expert Committees. Canada would continue to promote and support the annual designated World Blood Donor Day and was committed to enhancing current systems for the recruitment and retention of voluntary, nonremunerated blood donors and strengthening implementation of stringent criteria for donor selection. Since 1999, Canada's health department had spent a total of Can \$9.5 million on establishing a national blood safety surveillance programme, and its health products and food branch had invested Can \$25 million annually since 1998 to maintain a strong regulatory framework. The Canadian Government would continue to support multisectoral collaboration to promote voluntary, nonremunerated blood donation.

Dr HANSEN-KOENIG (Luxembourg) expressed support for the draft resolution and the amendments proposed by the member for the United States of America, and endorsed the proposal to establish an annual World Blood Donor Day, which would provide encouragement to both new and existing donors. More than 30 years had elapsed since the Twenty-eighth World Health Assembly had called for voluntary, nonremunerated blood transfusion services to be set up. As her country believed that blood safety depended on the voluntary nature of donations, it had been disquieting to learn that in 2000-2001 only 39 Member States had operated a completely voluntary and nonremunerated system. For that reason Luxembourg was providing development assistance to several countries that were attempting to introduce high-quality voluntary, nonremunerated blood transfusion services.

Dr HUERTA MONTALVO (Ecuador) recalled an unfortunate situation in Ecuador when blood contaminated with HIV had been used in renal dialysis. It therefore accorded the highest importance to the issue and welcomed the report and draft resolution, as well as the proposed amendments.

Professor DAB (France) also expressed support for the draft resolution and the amendments proposed by the member for the United States of America. In order to ensure blood safety, his Government had set up an agency to define and enforce standards, and another to organize the collection and distribution of blood products. It would ensure that both agencies cooperated fully in the organization of World Blood Donor Day.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) pointed out that the importance of blood safety was increasing in line with demand for donated blood. The situation became acute in the wake of an emergency, whether in the form of a natural disaster, terrorist attack or armed conflict. He supported the principle and practice of voluntary donation, but the safety aspect was a cause for concern since adequate testing facilities did not exist in his country. More effort needed to be put into increasing the number of voluntary donors.

The introduction of legislation that would encourage voluntary blood donation, as reflected in paragraph 2(3) of the draft resolution, was a positive development. On 1 January 2005 an amendment to his country's federal law on blood donation, clearly distinguishing between paid and voluntary donation, had come into effect, and the voluntary blood donation service had expanded as a result.

He expressed support for the draft resolution, with the proposed amendments, and for the proposal to establish a World Blood Donor Day.

Mr KHAN (Pakistan) said that safe blood transfusion was an essential part of health-care services worldwide. Blood safety was an integral part of the prevention of transmission of HIV and other blood-borne pathogens and in controlling epidemics of hepatitis B and C in most developing countries. The collection of blood exclusively from voluntary, nonremunerated blood donors from low-risk populations was crucial in ensuring the safety, quality, availability and accessibility of blood transfusion. The brunt of the ill effects of blood shortages was borne by women with pregnancy complications, children with severe life-threatening anaemia and trauma victims.

In 2004, his Government and the Pakistan Red Crescent Society had organized a World Blood Donor Day in Islamabad as part of worldwide events to thank millions of voluntary blood donors. He supported holding the event annually on 14 June.

He endorsed the draft resolution as amended by the member for the United States of America, but warned that developing countries might face technical and economic difficulties in implementing it. Many regions of the world, including the Eastern Mediterranean Region, were undergoing major upheavals that had devastated local infrastructures, including health infrastructures.

Dr PHOOKO (Lesotho) commended the report and the proposal to establish World Blood Donor Day, and agreed that blood should be collected only from voluntary, nonremunerated donors to ensure the safety, quality, availability and accessibility of transfusion. Lesotho was among those countries with the highest prevalence of HIV infection and had been trying to interest the families of

people with HIV/AIDS in undergoing a test for a small remuneration. He had been heartened to hear the views of the member for the United States of America in that regard and supported his proposed amendments to the draft resolution.

Dr QI Qingdong (alternate to Dr Yin Li, China) welcomed the proposal to establish World Blood Donor Day. As a result of a sustained effort over several years, nonremunerated blood donation in China had increased from 22% in 1998 to 85% in 2003. Referring to paragraph 8 of the report, he asked for more detailed information on the channels used for collecting the discarded blood, the standards donors had to meet, and the countries involved. He supported the proposed amendments regarding family and family replacement donation.

To mitigate China's concern in regard to appropriate clinical use of blood and blood products, he suggested the insertion of an additional subparagraph in paragraph 2 of the draft resolution that would read: "to introduce stringent requirements for ensuring that clinical blood transfusions are carried out in an appropriate manner, thus avoiding unnecessary waste that might lead to a blood shortage and encourage paid donations".

Dr SAM (Gambia) said that it would be difficult for countries to attain the Millennium Development Goals if they did not have accessible, safe and adequate blood supplies. Some resolutions had been adopted by past Health Assemblies mentioning the need for national policies on blood transfusion, but some developing countries in Africa either did not yet have such policies or were not yet in a position to implement them. At the very least, the draft resolution should ensure that that situation was remedied.

He welcomed the proposal to establish World Blood Donor Day. However, a more pressing concern was to encourage developing countries to ensure long-term availability by introducing regular, nonremunerated donation programmes within national blood transfusion services.

In the interests of clarity, it would be helpful if the amendments proposed by the member for the United States of America could be circulated in writing.

Dr YOOSUF (Maldives) expressed support for the draft resolution and the amendments proposed. A large percentage of the population of Maldives suffered from thalassaemia and required frequent blood transfusions. He would like to see an increase in voluntary donations and the expansion and strengthening of blood bank services by means of awareness-raising and education programmes.

Dr MOLDOVAN (alternate to Professor Cinteza, Romania) recalled that Romania had repeatedly expressed concern over blood and blood components, and supported the views expressed by the member for Luxembourg. In 2004, Romania had conducted a national campaign to promote voluntary blood donation. She welcomed the establishment of an annual World Blood Donor Day on 14 June.

Dr WANCHAI SATTAYAWUTHIPONG (adviser to Dr Suwit Wibulpolprasert, Thailand) said that the report clearly showed that there was a shortage of blood supplies in the developing world. Blood safety was also a matter of concern: unsafe blood transfusion had been responsible for 10% of HIV infections in the 1980s and 1990s.

He welcomed the proposal to establish World Blood Donor Day, which would serve to create awareness of the importance of ensuring the safety and adequacy of blood donation and supply. He endorsed the draft resolution, but believed it would be strengthened by the addition of a new subparagraph in paragraph 2 reading: "to provide adequate financing for quality blood donation services and extension of services to meet patients' needs", and of a new subparagraph in paragraph 5 reading: "to work with concerned organizations to assist Member States in strengthening their capacity to screen all donated blood against major infectious diseases".

He shared the concerns regarding blood donation by family members and therefore supported the amendments proposed by the member for the United States of America.

Mrs LE THI THU HA (Viet Nam) said that her country attached great importance to blood safety and to the promotion of voluntary and nonremunerated blood donation. Its experience gained from promoting blood donation on humanitarian grounds had shown that special attention should be given to public advocacy and information, education and communication about voluntary and nonremunerated blood donation, and to the recognition of voluntary blood donors and their right to blood in case of need.

A national voluntary blood donation day had been celebrated in her country on 1 June each year from 1994 to 2000. Viet Nam had responded actively to World Blood Donor Day on 14 June 2004 with various mass-media information, education and communication activities. She supported the draft resolution and endorsed the amendments proposed by the members for Jamaica, Thailand and the United States of America, which she requested be submitted in writing.

Dr OÑORBE DE TORRE (alternate to Dr Lamata Cotanda, Spain) said that nonremunerated, safe and well organized blood donation was an essential part of health systems, and should therefore be promoted by all governments, in a way that was appropriate to specific social and cultural conditions and took into account the needs of different areas and population groups. Spain had a national blood donation system and a safe blood transfusion system. Its blood donation system had made considerable progress, since the annual number of donations had reached almost 40 per 1000 population. Blood transfusion services needed to be improved to guarantee the quality and safety of transfusions and to secure a stable number of donors to meet ongoing blood transfusion needs, not merely those in crises. Once blood had been collected and stored in safe banks, the appropriate and effective clinical use of blood and blood products needed to be ensured. Training programmes for health workers should be developed as a means of preventing unnecessary or unsuitable transfusions.

He supported the draft resolution, with the amendments proposed by the members for Jamaica and the United States of America.

Dr ACHARYA (Nepal) welcomed the draft resolution. The issue of blood safety was important in the context of blood-borne diseases, including HIV/AIDS. Since family and family replacement blood donation was normal practice in Nepal, he supported the deletion of the phrase “and family or family replacement” in paragraph 2(3), as proposed by the member for Jamaica. Although the celebration of more than one blood donor day in a year might lead to confusion, the importance of the issue led him to support the proposal to establish a World Blood Donor Day on 14 June.

Dr CAMARA (Guinea) commended the initiative of drafting the resolution on blood safety, which was an essential aspect of the fight against HIV/AIDS. Equitable access to blood transfusion was vital, since thousands of people, particularly pregnant women and children, died as a result of anaemia and lack of access to blood transfusions. In view of the risks inherent in blood transfusion and the danger that the benefits of blood donation would be negated if safe procedures were not established in developing countries, he requested that assistance be given to such countries to ensure that the blood collected on blood donor days was devoid of any pathogen, particularly HIV. In the hope that such assistance would be provided, he supported the draft resolution, together with the amendments proposed by the members for Jamaica and the United States of America.

Dr AHMED (Ghana) said that the report was especially timely for countries such as his own that were developing blood transfusion policies. Blood transfusion had considerably increased in Ghana, especially for trauma victims and in obstetrics.

Referring to paragraph 2(3), he pointed out that introducing legislation to ban the use of paid donors would disadvantage countries that had insufficient numbers of voluntary donors. He therefore endorsed the draft resolution as amended by the member for the United States of America, especially its proposal to amend the wording of paragraph 2(3) to the effect that legislation should be introduced “where needed”.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) commended the report. Safe blood transfusion was an important issue to which governments should pay constant attention. Kuwait had been monitoring the issue carefully and encouraged voluntary blood donation.

Dr TANGI (Tonga) supported the draft resolution and the proposed amendments. As the member for Pakistan had pointed out, blood was one of the few health products that society was requested to donate voluntarily, yet it underpinned the entire health system. He therefore fully supported the establishment of a World Blood Donor Day.

Dr SAM (Gambia), referring to family and family replacement blood donations, said that, in the absence of routine national blood donor recruitment and of a system of voluntary, nonremunerated blood donation, families were compelled to donate blood because of the unavailability of blood banks. Emphasis should therefore be placed in the draft resolution on the need to develop and implement donor-recruitment programmes. He endorsed the amendments proposed by the member for the United States of America to paragraph 2(3), but suggested that the word “discourage” rather than “eliminate” be used.

He supported the establishment of an annual World Blood Donor Day which should serve as an educational and donor recruitment tool, and proposed the addition of a new paragraph 2, reading: “The annual World Blood Donor Day should be an integral part of the national blood recruitment programme”.

Dr ABDUL WAHAB (Bahrain) also endorsed the draft resolution. The elimination of family blood donation might not be in the best interests of countries in his area of the world, where a large proportion of the population was affected by some form of haemoglobinopathy, particularly sickle-cell disease and thalassaemia, which demanded regular and repeated transfusions. There was also an escalating demand for transfusions in trauma cases and for pregnant women. In the absence of a system of regular voluntary donation, those countries relied on family blood donation in emergency situations, in order to increase blood reserves and blood bank availability. He therefore suggested that paragraph 2(3) should be amended to read: “to ensure the safety of family or family replacement blood donation through the implementation of stringent criteria for donor selection and to require the informed consent of the transfusion recipient”. The closing words incorporated the amendment proposed by the member for the United States of America. Thus, family donation would not be prohibited but would have to be performed under stringent regulations.

Dr STEIGER (United States of America), said that he was prepared to accept the amendment proposed by the member for Bahrain to paragraph 2(3), but wished any amended wording to reflect that paid blood donation should be discouraged with a view to being eliminated.

Dr ABDULLA (Sudan) supported the draft resolution, but pointed out that in Africa and in most developing countries, the belief in taboos discouraged or prevented people from donating blood. In developing voluntary donor recruitment systems, cultural issues needed to be taken into account and an attempt made to change cultural attitudes. In paragraph 2(2) he therefore proposed the insertion of the words “culture-sensitive” between “strengthen” and “systems”.

Dr AGARWAL (India)¹ endorsed the spirit of the draft resolution. India’s annual voluntary blood donation day had long and successfully been celebrated on 1 October. While he supported the proposal to establish a World Blood Donor Day, he suggested that the observance date of 14 June be reconsidered because in India, college and university students, which formed its largest target group, were on holiday during the month of June.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Voluntary, nonremunerated blood donation had increased in India, where activities had been undertaken to promote public awareness of the need for safe and voluntary blood donation. While blood was collected mainly from voluntary and family replacement donors, his Government was taking steps to phase out family replacement donation. Promotion of public awareness should precede the enactment of legislation to eliminate family replacement donation.

The CHAIRMAN, speaking as the member for Iceland, welcomed the report. In view of the current knowledge of the possible and preventable transmission of different pathogens during blood transfusion, any unsafe handling and donation of blood should be regarded as unacceptable. The various risks and ways of eliminating them were well described in the report. The establishment of a World Blood Donor Day would highlight the important contribution made by blood donors worldwide. Iceland therefore fully supported the draft resolution and the amendments proposed.

Speaking as CHAIRMAN, he said that the amendments tabled would be submitted in written form at a later stage.

Dr LEPAKHIN (Assistant Director-General) said that the establishment of a World Blood Donor Day had been proposed because of the successful celebration of the Day in 2004, in which 73 countries had participated and during which millions of units of blood had been donated voluntarily.

He expressed his appreciation of the amendments to the draft resolution proposed by the member for the United States of America. While the text under consideration was similar to the texts of previous Executive Board resolutions on blood safety, it was right that the attention of governments should again be drawn to that important issue.

Turning to family member donation, he said that the word “eliminate” had been used as there was a risk of transmission of disease from one family member to another. However, its replacement by “discourage” could be discussed further. With regard to the question raised by the member for China, most of the 2.5 million units of discarded blood had been collected in countries where paid donations took place, which proved that paid donation was unsafe. In reply to the concern raised by the representative of India, he said that countries that already celebrated their own national blood donor days should make every effort to keep them. However, a world day would promote global solidarity. The date of 14 June had been suggested because it would mark the birthday of Karl Landsteiner, the discoverer of human blood groups.

Mr JUNOR (Jamaica), referring to paragraph 2(3), noted that the prevailing view of Board members appeared to be that family donations should be specifically allowed, not discouraged. All countries had a duty to ensure that all blood collected was safe, and family donation was therefore not an issue.

(For adoption of the resolution, see summary record of the twelfth meeting, section 1.)

The meeting rose at 12:50.