

## **TENTH MEETING**

**Saturday, 24 January 2009, at 09:05**

**Chairman:** Mr N.S. DE SILVA (Sri Lanka)

### **TECHNICAL AND HEALTH MATTERS:** Item 4 of the Agenda (continued)

#### **Human organ and tissue transplantation:** Item 4.12 of the Agenda (Document EB124/15) (continued)

Dr CHAUHAN (India)<sup>1</sup> welcomed the updated WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. His Government was amending its domestic transplantation legislation in line with those principles. Nevertheless, WHO needed to be more proactive in creating capacity for the equitable and transparent distribution of organs, to include networks based on information technology. National and subregional networks, surveillance systems and registries were required to monitor transplant activities. He urged the Secretariat to provide the support for establishing affordable infrastructure, technical guidance, and the capacity-building needed by Member States. A global system for tracing transplantable material would be welcomed.

Mgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, acknowledged the urgency of the matter under discussion. WHO estimated that some 10% of kidney transplants performed in 2007 had resulted from the illicit purchase and sale of kidneys; trafficking across borders; or removal of kidneys from involuntary donors in vulnerable population groups. Pope Benedict XVI had expressed grave concern about such abuses when receiving participants at an international conference on the topic in November 2008, and had appealed to the scientific and medical community to unite in rejecting such unacceptable practices. The determination of the Director-General to continue examining ethical, clinical and epidemiological issues related to human organ transplantation was greatly appreciated.

He emphasized the need to promote voluntary donation of organs, a noble act of solidarity. However, he reiterated the Holy See's view that care must be exercised in relation to organs from non-heartbeating donors, mentioned in paragraph 11 of the report. In all such cases it must be ensured that the cessation of vital functions was truly irreversible and certified by valid criteria. Respect for the life of the donor must always prevail. Additional research, including paediatric research, and interdisciplinary reflection were needed in order to truthfully inform the general public of the anthropological, social, ethical and legal implications of transplantation. Clinical research had demonstrated the therapeutic benefits of interventions using adult stem cells rather than embryonic cells, a direction that guaranteed respect for human dignity, even at the embryonic stage.

Professor CHAPMAN (The Transplantation Society), speaking at the invitation of the CHAIRMAN, said that in addition to transforming the health and well-being of people with end-stage organ failure, successful transplantation was also of economic benefit, especially in kidney failure, since it was less expensive and provided longer and higher quality of life than dialysis. However, the desperation of patients awaiting suitable organs had led to exploitation and trafficking of organs from

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

the most defenceless members of society. Donors became vendors in return for some illusory release from poverty; and purchasers suffered poor transplant outcomes and high mortality rates. The Transplantation Society applauded the objectives of the revised Guiding Principles. He agreed with the previous speaker, in relation to the transplantation of organs from non-heartbeating donors, that it was essential to ensure that the cessation of vital functions was truly irreversible and certified by valid criteria.

Donation of kidneys by live donors entailed risks. Even with rigorous donor assessment in the best conditions, the donor death rate was around 1 in 3000. The Transplantation Society had developed a professional consensus on the assessment and care of living organ donors. However, specific government oversight was needed to ensure their protection. The Declaration of Istanbul on Organ Trafficking and Transplant Tourism (Istanbul, April 2008) set out definitions of organ trafficking, transplant tourism and transplant commercialism and affirmed ethical solutions and practices. The Declaration should support Member States in combating the targeted sourcing of organs from poor people. Action by the medical profession was complementary to the WHO Guiding Principles, implementation of which should provide the global transparency and vigilance needed to ensure safety and improved outcomes. The challenge to Member States would be to entrench transparency in all programmes. He urged the Board to approve the revised Guiding Principles and recommend their adoption at the Sixty-second World Health Assembly.

Dr ETIENNE (Assistant Director-General) noted the broad consensus on the issue and the amendments proposed to the text, which the Secretariat would endeavour to effect. She re-emphasized the importance of monitoring, surveillance and registries. Traceability of cell tissue and organs for transplantation was a key component of safety and could be very important in combating trade. The global coding system had already been established and the Secretariat would work with Member States to ensure broad participation. She noted the requests for improved technical guidance, support and capacity-building within Member States. The Secretariat would seek to carry out their wishes.

The CHAIRMAN suggested that, as informal consultations on the draft resolution introduced during the ninth meeting were still ongoing, discussion should be continued at a subsequent meeting.

**It was so agreed.**

(For adoption of the resolution, see summary record of the twelfth meeting, section 2.)

**WHO's role and responsibilities in health research:** Item 4.9 of the Agenda (Documents EB124/12, EB124/12 Add.1 and EB124/12 Add.2) (continued from the eighth meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution on WHO's role and responsibilities in health research incorporating amendments proposed by several members, which read:

The Executive Board,  
Having considered the draft of the WHO strategy on research for health,<sup>1</sup>

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

---

<sup>1</sup> Document EB124/12.

The Sixty-second World Health Assembly,

Recalling resolution WHA58.34 on the Ministerial Summit on Health Research and resolution WHA60.15 on WHO's role and responsibilities in health research;

Recognizing the contribution of research to the development of solutions to health problems and the advancement of health worldwide;

Aware that, in a rapidly changing world facing significant environmental, demographic, social and economic challenges, research will be increasingly essential for clarifying the nature and scope of health problems, and for identifying effective life-saving interventions and strategies;

Realizing the increasingly multidisciplinary and intersectoral nature of research for health improvement;

**Affirming the roles and responsibilities of WHO, as a leading global health organization, in health research; [Indonesia]**

**Recognizing the need to strengthen the capacity of public sectors in health research; [Indonesia]**

Acknowledging that research activities in the private and public sectors can be mutually supportive and complementary in improving health globally;

Conscious of the need to strengthen the conduct, management and coordination of WHO's activities in health research;

Cognizant of the need to better communicate WHO's research activities and results, especially to its Member States and partners;

**Noting Welcoming [USA]** the references to research for health in resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property and relevant conclusions and recommendations of the WHO Commission on Social Determinants for Health;

Taking into account the outcomes of the Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008),

1. ENDORSES the WHO strategy on research for health **annexed hereto [USA]**;
2. URGES Member States:
  - (1) to recognize the importance of research for improving health and health equity and to adopt and implement policies for research for health that are aligned with national health plans, that include the participation of all relevant sectors, public and private, that align external support around mutual priorities, and that strengthen key national institutions;
  - ~~(2) to support the implementation of the research for health strategy according to their own national circumstances and contexts, and as part of their overall policies on health and health research; [USA]~~
  - (32) to strengthen national health research systems by improving leadership and management of research for health, by focusing on national needs, by establishing effective institutional mechanisms for research, by using evidence in health policy development, and by harmonizing and coordinating national and external support (including that of WHO);
  - (43) to establish, as necessary **and appropriate, [USA]** governance mechanisms for research for health, to ensure rigorous application of good research norms and standards, **including protections for human subjects involved in research, [USA]** and to promote an open dialogue between policy-makers and researchers on national health needs, capacities and constraints;

- (54) to improve the collection of reliable health information and data and to maximize, **where appropriate, [USA]** their free and unrestricted availability in the public domain;
- (65) to promote intersectoral collaboration and high-quality research in order to produce the evidence necessary for ensuring that policies adopted in all sectors contribute to improving health and health equity;
- (76) to initiate or strengthen intercountry collaboration with the aim of obtaining efficiencies of scale in research through the sharing of experiences, best practices and resources, the pooling of training and procurement mechanisms, and the use of common, standardized evaluation methods for research;
- (87) to consider, where appropriate, establishment of regional collaborating mechanisms, such as centres of excellence, in order to facilitate access by Member States to the necessary research and expertise to meet health challenges;
3. ~~INVITES CALLS UPON~~ **[USA]** the health research community, international organizations, supporters of research, the private sector, civil society and other concerned stakeholders:
- (1) to provide support to the Secretariat ~~and Member States~~ **[USA]** in implementing the research for health strategy and in monitoring and evaluating its effectiveness;
- (2) to collaborate with the Secretariat ~~and Member States~~ **[USA]**, within the framework of the strategy, in identifying ~~global~~ **[USA]** priorities for research for health, ~~in agreeing norms and standards relating to research for health, [USA]~~ and in the collection of health information and data;
- (3) to assist the Secretariat and WHO's research partners in mobilizing enhanced resources for the identified global priorities for research for health;
- (4) to pay particular attention to the research needs of low-income countries, notably in areas such as technology transfer, research workforce, and infrastructure development **and other determinants of health [Indonesia]** particularly where this will contribute to the achievement of the Millennium Development Goals, health equity and better health for all **and to collaborate with the Secretariat and Member States to better align, coordinate and harmonize the global health research architecture and its governance through the rationalization of existing organizations, to improve coherence and impact, and to increase efficiencies and equity; [UK]**
- (5) to support, where appropriate, technical cooperation among developing countries in research for health;
4. REQUESTS the Director-General:
- (1) **to provide leadership in identifying global priorities for research for health; [Netherlands seconded by UK]**
- (2) to implement the strategy within the Organization at all levels and with partners, **and in coordination with the Global strategy and plan of action on public health, innovation and intellectual property [UK];**
- (3) to improve the quality of research within the Organization ~~and strengthen WHO's leadership in research for health; [Netherlands seconded by UK]~~
- (4) to provide adequate core resources in proposed programme budgets for the implementation of the research for health strategy;
- (5) to ensure that the highest norms and standards of good research are upheld within WHO, including technical, ethical and methodological aspects and the translation into practice, use and dissemination of results **and to review and**

**streamline the architecture and governance of the Organization's research activities and partnerships; [UK]**

~~(5) to provide support to Member States, upon request and as resources permit, in implementing the strategy in order to strengthen national health research systems and intersectoral collaboration; [USA]~~

~~(6) to align better the work of WHO collaborating centres involved in research with the goals of the research for health strategy;~~ **to strengthen the role of WHO collaborating centres as a well-established, effective mechanism for cooperation between the Organization and countries in the field of research for health; [Russian Federation]**

(7) to report to the Sixty-fifth World Health Assembly on the implementation of this resolution, through the Executive Board, in 2012.

Mr HOHMAN (alternate to Dr Wright, United States of America) requested time for informal consultations on the revised draft resolution with a view to reaching consensus, as he had further amendments to propose.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) suggested that the words "review and streamline" in subparagraph 4(5) should be altered to avoid any implication of budget cuts.

The CHAIRMAN suggested that the item should be left open pending the results of informal consultations on the draft resolution.

**It was so agreed.**

(For resumption of the discussion, see below.)

**Public health, innovation and intellectual property: global strategy and plan of action:** Item 4.13 of the Agenda (Documents EB124/16, EB124/16 Add.1 and EB124/16 Add.2)

Ms KRISTENSEN (alternate to Mr Fisker, Denmark) commended the Secretariat's development of the global strategy and plan of action by the Intergovernmental Working Group, and work on the Quick Start Programme. The medium-term framework for research and development relevant to diseases that disproportionately affected developing countries would contribute much to achieving the Millennium Development Goals. The establishment of the expert group would enhance the strategy and plan of action. Denmark expected that, through continuing consultations, Member States would resolve their remaining differences concerning the text of the plan of action with a view to adoption at the Sixty-second World Health Assembly.

Dr ZARAMBA (Uganda), speaking on behalf of the Member States of the African Region, commended the development by the Intergovernmental Working Group and the Secretariat of the draft global strategy and plan of action, parts of which had been adopted at the Sixty-first World Health Assembly. He welcomed the proposed progress indicators set out in the report.

At its fifty-eighth session, the Regional Committee for Africa had suggested the need to take account of: a range of Health Assembly resolutions; progress reports from Member States; and synergies with the 2008 Algiers Declaration, arising from the Ministerial Conference on Research for Health in the African Region, and the 2008 African Union Pharmaceutical Manufacturing Plan for Africa. It had also recommended that the subject should be discussed in subsequent sessions.

The proposed indicators would form the basis for regular reporting to the Health Assembly on performance and overall progress. However, Member States must actively implement the global

strategy. He urged the Director-General to focus technical and financial support on African Member States, which would continue working on the text of the plan of action and looked forward to its finalization at the Sixty-second World Health Assembly.

Professor ALI (alternate to Professor Haque, Bangladesh) also commended the work achieved. He noted the innovative genetic mapping of indigenous resources, such as herbs and medicinal plants in developing countries, through the application of biotechnology. However, those activities were commercially driven and would lead to a takeover of resources by the multinational companies. The strategy should protect the right of countries to own their indigenous resources. WHO should enhance the capacity of developing countries to acquire the competence and technical know-how for exploiting the newer technologies and expanding their research in those areas. Bangladesh had developed a strategy to promote and prioritize research, to develop traditional medicine and to encourage technology transfer.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that, given the difficulty of developing appropriate progress indicators, he welcomed the Secretariat's approach in seeking just a few for each element of the global strategy and plan of action. However, he was unsure of the action requested of the Board in respect of the proposed progress indicators set out in document EB124/16 Add.1. Further work was needed as some of the indicators would be hard to measure and some were not clearly aligned with the plan of action. The costs projected in document EB124/16 Add.2 were staggering, and it would be difficult for Member States to mobilize such sums. He welcomed the continuing work on the text of the plan of action and looked forward to its finalization at the forthcoming Health Assembly.

Mr VIEGAS (alternate to Dr Buss, Brazil) said that Brazil had participated in the work on developing the global strategy and plan of action regionally and internationally. Implementation would significantly improve access to innovations that responded to the health needs of developing countries. Brazil was committed to applying the recommendations contained in resolution WHA61.21. The Regional Committee for the Americas/PAHO Directing Council had adopted resolution CD48.R15, which inter alia called on Member States to collaborate with PAHO in promoting regional action. Together with other Member States of the Region of the Americas and in collaboration with PAHO, Brazil had hosted in November 2008 a first meeting on high-cost medicines which had emphasized: mapping regional specificities; challenges relating to access to essential medicines; and implementing the global strategy. Brazil was also promoting access to essential medicines through its universal free health system. He welcomed the establishment by WHO of a group of experts on financing mechanisms for research and development. Brazil requested the Secretariat to prepare a report on the activities conducted under the Quick Start Programme.

The proposed progress indicators were largely quantitative, which would not fairly assess the implementation of the global strategy and Member States were urged to adopt qualitative indicators. His Government was providing financial support for implementation of the global strategy, in line with paragraph 15 of the strategy.

Dr VARGAS (Bolivarian Republic of Venezuela)<sup>1</sup> welcomed the contribution of the Secretariat to guaranteeing universal access to medicines. He enquired about the composition of the expert working group referred to in paragraph 6 of the report, the criteria used for selecting members, and whether the group had already been formally established.

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The proposed progress indicators should not be based on disease classification alone. There should be clear instruments to measure management progress; and the indicators themselves should be analysed and reviewed on a regular basis.

The documents under discussion were a valuable starting point but further regional and subregional examination was required, notably on the development and application of the proposed indicators and how they would affect research at national level.

Dr BABB-SCHAFER (Barbados)<sup>1</sup> asked whether the expert group set up by the Director-General would in due course examine proposals on a prize-fund model.

Mr ROSALES LOZADA (Bolivia)<sup>1</sup> drew attention to the need for more thorough debate on the relationship between innovation, intellectual property and health, and specifically the multilateral intellectual property standards that allowed the patenting of living materials. Bolivia's new Constitution, if approved in the following day's referendum, would ban such patenting; it would establish clearly that negotiating, adhering to and ratifying international treaties should be governed by the principles of harmony with nature, defending biodiversity and prohibiting forms of private ownership that led to the exclusive use and exploitation of living materials. Bolivia was pursuing initiatives in various forums with a view to amending or clarifying international standards in order to prohibit, first, the patenting of all forms of living materials and, secondly, biological processes for the production of living organisms, as in the case of some provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which was usually taken as a point of reference in relations between innovation and intellectual property.

Bolivia opposed the patenting of living materials because it contradicted the morals and culture of most of the world's peoples. There were insufficient technical and scientific grounds for patenting such materials and their associated processes that existed in nature. Those were not inventions. International law, including the TRIPS agreement, recognized the monopoly rights of private parties without recognizing the collective ownership by indigenous peoples of their traditional knowledge and genetic resources. Thus international intellectual property standards were out of step with various international agreements, in particular the 2007 United Nations Declaration on the Rights of Indigenous Peoples.

The above principles should be taken into account in the future decision-making activities of the Intergovernmental Working Group and related bodies. He echoed the request made by the member for Barbados regarding the status of proposals submitted in April 2008, and asked when they would be published in all official languages on the WHO web site.

Mr SILBERSCHMIDT (Switzerland)<sup>1</sup> said that the technical nature of work on progress indicators should be carried out by the Secretariat alone rather than through formal negotiations. Funding requirements should be met by all stakeholders, including the private sector and not just by Member States. He asked the Secretariat to clarify the process for integrating the outstanding components of the plan of action and whether there would be a decision at the Sixty-second World Health Assembly to incorporate them in resolution WHA61.21.

His country was committed to the implementation of the global strategy and plan of action. He encouraged countries, nongovernmental organizations and industry to do as his country had done, by developing their own implementation plan.

Ms WISEMAN (Canada)<sup>1</sup> commended the Secretariat's work and prioritization of the areas requiring further action. She was pleased to note the establishment of the expert working group. Her

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Government was considering further collaboration in the fields of traditional medicine, humanitarian licensing, transfer of research technology and strengthening of regulatory capacity.

Mr RAJALA (European Commission) said that the European Commission would actively implement the global strategy and plan of action. He highlighted the need for additional research, and for further collaboration between the Secretariat and Member States in regard to bilateral agreements affecting developing countries. He asked for clarification of the single-figure million US dollar amounts given in document EB124/16 Add.2; certain points of that document might require clarification at a later date.

Mr CHAN (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that he supported the fundamental objectives of the global strategy. Challenges lay ahead in ensuring health equity while creating incentives to develop innovative therapies. Drawing attention to Element 6 of document EB124/16 Add.1 on improving delivery and access, policies were needed to increase professional training and provide incentives for retaining health personnel. In that regard, his Federation had been working closely with the Global Health Workforce Alliance and the WHO Secretariat. He urged both the Secretariat and Member States to focus on strengthening the pharmaceutical workforce, which was crucial to successful implementation of the global strategy.

Mr BALASUBRAMANIAM (Churches' Action for Health), speaking at the invitation of the CHAIRMAN, supported the implementation of the global strategy and plan of action and welcomed the creation of an expert working group. He urged WHO and all its partners to initiate action as set out in paragraph 5.3(a) of the plan of action. In that regard, he noted the proposals put forward by the representatives for Barbados and Bolivia to create a prize fund for a low-cost diagnostic test for tuberculosis, and another for developing new treatments for Chagas disease.

He asked WHO to provide further guidance on intellectual property issues, particularly on use of the flexibilities in the TRIPS agreement. Referring to action 2.3(c), he favoured the creation of a treaty on health, biomedical research and development.

Ms CHILDS (Médecins Sans Frontières (MSF) International), speaking at the invitation of the CHAIRMAN, said that her organization was cosponsoring a new initiative to conduct clinical trials for multidrug-resistant tuberculosis. She placed high expectations on the expert working group to identify new sources of funding and propose alternative financing mechanisms. The views of all stakeholders should be represented in the expert working group. She asked for clarification of how the Secretariat would build on the discussions of the expert working group, and when further meetings would be held.

Mr BOŠTJAN (alternate to Dr Voljč, Slovenia) thanked the Secretariat for its work and supported the adoption of the global strategy and plan of action. He commended the expert working group and looked forward to finalizing the outstanding components of the plan of action at the Sixty-second World Health Assembly.

Dr KEAN (Executive Director, Office of the Director-General) thanked Board members and other speakers for their constructive comments. On behalf of the Director-General, he also thanked Member States and other bodies for their support of the Secretariat's work on the global strategy and plan of action, including their assistance with the progress indicators, their financial support and, in some instances, through the secondment of their staff. The item had been included on the agenda as a means of indicating progress made, before submission of the full report to the Sixty-second World Health Assembly. He acknowledged the work, and progress made, on the text in brackets.

The expert working group would consider the proposals made by the members for Barbados and Bolivia at its next meeting. He had noted comments made by previous speakers concerning areas that required additional work.



A decision adding to resolution WHA61.21, based on the supplementary information provided by the Director-General and Member States, would be proposed to the Sixty-second World Health Assembly. There would be further consultation on the way in which that decision would be presented.

Dr RENGANATHAN (Executive Secretary, WHO Secretariat on Public Health, Innovation and Intellectual Property) said that, with regard to the progress indicators, the Secretariat had followed the guidance given by the Intergovernmental Working Group, namely to devise a manageable set of indicators covering 107 specific actions. The comments provided by the members for the United States of America and Brazil, the representatives of Venezuela (Bolivarian Republic of) and Switzerland, and others were appreciated, and he looked forward to receiving further comments on how to refine the progress indicators further.

With regard to costing, in reply to the question from the European Commission regarding the single-digit million US dollar figure given in document EB124/16 Add.2, he said that an “ingredients approach” had been taken, similar to that adopted in different global strategies. The work had been led by the health systems financing team with support from a number of different departments. Document EB124/16 Add.2 provided further insight into how the estimates had been made; paragraph 8 of the costing document explained the context of the global total of research and development spending.

The expert working group had met for the first time in January 2009 and would meet again in June and in November 2009. Innovative proposals for financing would be reviewed at the second meeting, and the experts had requested the Secretariat to give Member States and stakeholders the opportunity to provide input in that regard.

**The Board noted the report.**

**Chagas disease: control and elimination:** Item 4.14 of the Agenda (Document EB124/17)

The CHAIRMAN drew attention to a proposed draft resolution on Chagas disease: control and elimination proposed by El Salvador on behalf of the Latin American and Caribbean Group, which read:

The Executive Board,

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

Having considered the report of the Secretariat on Chagas disease: control and elimination,

Expressing its satisfaction at the considerable progress achieved by countries towards the goal of eliminating Chagas disease by 2010, as recommended in resolution WHA51.14 of the Fifty-first World Health Assembly;

Underlining that 2009 will mark the 100th anniversary of the description of this disease by Dr Carlos Chagas;

Acknowledging the progress made with vector-control strategies;

Recognizing the success achieved through the intergovernmental initiatives in Latin America;

Taking into account the need for the harmonization of diagnostic and treatment procedures;

Recognizing the need for the provision of adequate care for late complications of the disease;

Underlining the need for more effective, safe and adequate drugs, including paediatric formulations, and for better coverage and distribution of those currently available;

Recognizing that the risk of transmission through blood transfusion, organ transplantation and congenital transmission is increasing;

Acknowledging the significant collaboration and support among Member States and the support of other partners and appreciating their continuous assistance,

1. URGES Member States:

- (1) to reinforce efforts to strengthen and consolidate national control programmes and to establish them where there are none;
- (2) to establish mechanisms to ensure broad coverage of adequate control measures, including the promotion of decent and healthy living conditions, prevention and the integration of specific actions within health services based on primary care;
- (3) to harmonize systems and strengthen capacities for surveillance, data collection and analysis and dissemination of information;
- (4) to promote and encourage operational research on control of Chagas diseases in order to:
  - (a) interrupt transmission by domestic insect vectors;
  - (b) develop more suitable, safer and more affordable drugs;
  - (c) reduce the risk of late complications of the infection;
  - (d) establish systems of early detection, in particular for the detection of new infections, of congenital infections in newborns and the reactivation of the disease in immunocompromised patients;
  - (e) harmonize blood-screening procedures;
- (5) to develop public health measures in non-endemic countries for the prevention of transmission through blood transfusion and organ transplantation, early diagnosis of congenital transmission and management of cases;

2. REQUESTS the Director-General:

- (1) to draw attention to the burden of Chagas disease and to the need to provide equitable access to medical services for the management and prevention of the disease;
- (2) to strengthen implementation of vector-control activities in order to achieve interruption of transmission and to promote research to improve or develop new prevention strategies;
- (3) to support the countries of the Americas in order to strengthen intergovernmental initiatives and the technical secretariat of PAHO/WHO as a successful form of technical cooperation among countries;
- (4) to collaborate in order that countries and intergovernmental initiatives set objectives and new goals for the elimination of the transmission of the disease;
- (5) to support the mobilization of national and international, public and private financial and human resources to ensure achievement of the goals;
- (6) to promote research on elimination of Chagas disease;
- (7) to support efforts at collaboration among multisectoral actors, networking among organizations and other interested parties to support the development and implementation of Chagas disease control programmes;
- (8) to report on progress in the elimination of Chagas disease to future World Health Assemblies.

The financial and administrative implications for the Secretariat were:

<b>1. Resolution</b> Chagas disease: control and elimination	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
1. To reduce the health, social and economic burden of communicable diseases.	1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.
<b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b>	
The resolution aims to strengthen activities linked with the following:	
<ul style="list-style-type: none"> <li>the information and surveillance system on the epidemiological distribution of Chagas disease</li> <li>an enhanced and renewed strategy towards the elimination of Chagas disease.</li> </ul>	
<b>3. Financial implications</b>	
<b>(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</b>	
A maximum of US\$ 2 million per year including:	
<ul style="list-style-type: none"> <li>one staff member in the professional category for five years (at US\$ 188 000 per year)</li> <li>distribution of medicines for five years (at US\$ 300 000 per year)</li> <li>documentation costs, including guidelines and dissemination for five years (at US\$ 100 000 per year)</li> <li>technical support to regions and countries for five years (at US\$ 1.4 million per year).</li> </ul>	
<b>(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)</b>	
<ul style="list-style-type: none"> <li>Distribution of medicines (US\$ 350 000)</li> <li>Documentation costs including guidelines and dissemination (US\$ 150 000)</li> <li>Technical support to regions and countries (US\$ 500 000)</li> </ul>	
<b>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?</b>	
This is a new initiative, the planned activities for which were not budgeted in the original workplan.	
<b>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</b>	
Through an agreement with a pharmaceutical company (expected to be finalized in due course).	

**4. Administrative implications****(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Headquarters in collaboration with regional and country offices.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

No additional staff required beyond those planned for the biennium 2008–2009.

**(c) Time frames (indicate broad time frames for implementation)**

About 60 months.

Dr SERPAS MONTOYA (alternate to Dr Larios López, El Salvador) said that the Group of Latin American and Caribbean countries had studied the report, the achievements reached and new challenges. An estimated 16 to 18 million people worldwide were infected with the disease, 50 000 of whom died each year. The disease was prevalent in 19 countries in Latin America, and the number of cases identified in Europe and the United States of America was increasing as a result of migration. El Salvador had been implementing an integrated plan involving surveillance, education, prevention and control aimed to identify acute cases. Between 100 and 110 new cases were identified each year, mainly in children under 15 years of age, all of whom were treated.

The countries of the Latin American and Caribbean Group had submitted the draft resolution recognizing that the considerable progress made by countries was not sufficient to achieve the goal of eliminating Chagas disease by 2010, as recommended by the Health Assembly in resolution WHA51.14. Its adoption would provide for continued support and would strengthen prevention and control, and research into the disease.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, expressed support for the draft resolution. Chagas disease, like its sister disease human African trypanosomiasis, was a neglected tropical disease, and the African group welcomed WHO's efforts to combat such diseases. He thanked the Drugs for Neglected Diseases Initiative for its efforts to encourage pharmaceutical companies to develop more effective, non-toxic and affordable medicines. He highlighted their work on diseases which, because they affected poor populations who could not afford medicines, suffered from a lack of research and were neglected by manufacturers.

Mr ABDOO (alternate to Dr Wright, United States of America) said that his country attached priority to combating neglected tropical diseases. It welcomed WHO's efforts to combat Chagas disease and encouraged continued technical assistance to countries attempting to control its spread. His Government supported the screening of blood for *Trypanosoma cruzi* in both non-endemic and endemic countries in order to prevent transmission through blood transfusion, organ transplantation and pregnancy. Accordingly, he suggested that the text of subparagraph 1(4)(e) of the draft resolution be replaced with: "optimize blood transfusion safety in endemic and non-endemic areas". The words "endemic and" should also be inserted in subparagraph 1(5) after "health measures in".

Dr DAHL-REGIS (Bahamas), commending WHO's efforts to combat Chagas disease, said that her country wished to sponsor the draft resolution.

Mr VIEGAS (alternate to Dr Buss, Brazil) said that neglected diseases such as Chagas disease were directly related to poverty and relevant to the social determinants of health, access to medicines, safe blood donation, primary care, and the strengthening of health systems. The report did not give a

balanced representation of the achievements of the Region of the Americas in their efforts to eliminate transmission of Chagas disease by 2010.

Brazil had been certified as a country free of vector-borne transmission. All donated blood was screened for the causative parasites. Brazil provided free treatment for all citizens and, in partnership with the Drugs for Neglected Diseases Initiative, it would be producing paediatric formulation of benznidazole. He was pleased that the item had been placed on the Board's agenda, particularly in the centenary year of the discovery of the disease by the Brazilian, Dr Chagas, and noted that an exhibition on Dr Chagas would be taking place at the Palais des Nations during the Sixty-second World Health Assembly.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that, although Member States in the South-East Asia Region did not suffer from Chagas disease, they had to deal with other neglected tropical diseases including leprosy, lymphatic filariasis and yaws. Indonesia supported the draft resolution. Greater priority should be given to tackling neglected tropical diseases around the world.

Dr NAKATANI (Assistant Director-General) thanked the Board for its guidance and support concerning neglected tropical diseases in general. Remarkable progress had been made in controlling Chagas disease in Latin America in the 100 years since its discovery, as a result of efforts by the countries themselves, which deserved congratulation, with technical support from PAHO/WHO Regional Office for the Americas. However, the disease had not yet been eliminated and cases were being reported from a wider geographical area. Noting the broad implications of the disease, he said that it was timely in the centennial year of its discovery to reaffirm commitment to addressing old and new challenges. The Secretariat was committed to working harder with Member States in order to transform the Board's guidance into broad action, and confident of achieving further progress.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela),<sup>1</sup> having endorsed the draft resolution, said that more emphasis should be given to education and active community participation in research and control of the disease. In his country the disease was not confined to rural communities; the vector had been identified in heavily populated and sometimes affluent urban communities. The expansion of the disease meant that it must be tackled at the international level and with the close involvement of local communities.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution, as amended.

Dr SERPAS MONTOYA (alternate to Dr Maza Brizuela, El Salvador) said that the countries of the Latin American and Caribbean Group wished to consider the amendments further. Mr VIEGAS (alternate to Dr Buss, Brazil) endorsed that position.

Dr DAHL-REGIS (Bahamas) said that she supported the minor amendments made by the member for the United States and wished to adopt the draft resolution.

Dr GIMENÉZ CABALLERO (Paraguay) said that he wanted to consider the proposed amendments further.

**The meeting was suspended briefly for informal discussions on the proposed wording of the draft resolution.**

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr KEAN (Executive Director, Office of the Director-General) said that, following the informal consultations, it was proposed that in subparagraph 1(4)(e) “harmonize blood screening procedures” should be replaced by “optimize blood transfusion safety and screening procedures in endemic and non-endemic countries, with special focus on endemic areas”. It was further proposed that the beginning of subparagraph 1(5) should be amended to read: “to develop public health measures in endemic and non-endemic countries, with special focus on endemic areas”, with the paragraph then continuing unchanged from “for the prevention of transmission ...”.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)<sup>1</sup> said that, although his Government supported the draft resolution as amended, he wished to stress the importance of community participation. He also emphasized that financing might be public or private.

**The resolution, as amended, was adopted.<sup>2</sup>**

**WHO’s role and responsibilities in health research:** Item 4.9 of the Agenda (Documents EB124/12, EB124/12 Add.1 and EB124/12 Add.2) (resumed)

Mr HOHMAN (alternate to Dr Wright, United States of America) said that, following informal consultations, a change had been agreed in paragraph 63 of the strategy, which might perhaps be read out at a later time. In the draft resolution, it was proposed that the latter part of subparagraph 3(4) of the draft resolution should read: “... and to collaborate with WHO Member States and the WHO Secretariat to better align and coordinate the global health research architecture and its governance through the rationalization of existing global health research partnerships, to improve coherence and impact, and to increase efficiencies and equity”.

It was also proposed that the latter part of subparagraph 4(2) should read: “and in coordination with the references to research for health in the ...”, with the paragraph then continuing unchanged from “Global strategy ...”. It was further proposed to incorporate the amendment submitted by the member for the United Kingdom, replacing the word “streamline” with “align” in subparagraph 4(5).

The rationale for his Government’s proposal to delete “Member States” from subparagraphs 3(1) and 3(2) was that the research strategy was an internal strategy of the Secretariat, not a negotiated strategy for Member States, which made it inappropriate to refer to Member States implementing that strategy.

Ms ROCHE (New Zealand) suggested that in the fifth preambular paragraph “WHO, as a leading global health organization” should be changed to “WHO, as the leading global health organization”.

Dr LUKITO (alternate to Dr Supari, Indonesia) requested that time be allowed for additional informal consultations on the draft resolution.

The CHAIRMAN took it that the Board wished to postpone further consideration of the draft resolution.

**It was so agreed.**

(For continuation of the discussion, see summary record of the eleventh meeting, section 1.)

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

<sup>2</sup> Resolution EB124.R7.

**Capacity-building to constructively engage the private sector in providing essential health-care services:** Item 4.15 of the Agenda (Document EB124/18)

The CHAIRMAN drew attention to a draft resolution entitled “Capacity building to constructively engage the private sector in providing essential health-care services” proposed by Bangladesh, China, Oman, Republic of Korea, Sri Lanka and Thailand, together with its financial and administrative implications for the Secretariat, which read:

The Executive Board,

Having considered the report on capacity building to constructively engage the private sector in providing essential health care-services,<sup>1</sup>

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

Recalling resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance which calls for the collaboration between public and private providers and health financing organizations to achieve universal coverage;

Recognizing the significant health expenditure in and services provided by private health sectors;

Recognizing that in Africa as a whole the private health-care sector is expected to grow by more than 100% between 2005 and 2016, compared with an increase of about two thirds in the public health sector, which underscores the potential role of private health sector in achieving the national health systems goals;

Noting the wide range of private sector providers, including formal and informal providers, and that the cost and quality of care may vary considerably;

Concerned that in the context of emerging and re-emerging diseases where substantial cases of notification diseases were managed by private health sector and this information is not covered by the national surveillance systems;

Noting the limitation of health information systems in particular developing countries, in relation to the private health sector which hampers appropriate policy interventions;

Noting in particular developing countries, the poorly resourced and lack of staff in accreditation agencies, the limited size of social health insurance agencies hamper the opportunity to engage private health sector to achieve the health systems goals;

Recognizing the fact that where there is government institutional capacity to govern the private health sector and where relations between public and private are well-managed, private providers can play a significant role in providing essential health services;

Concerning over the international agencies advocate the role of private providers in expanding access to care, but limited attention has invested in enhancing the role and capacity of government in providing policy guidance, exercising oversight, defining and enforcing the mix of incentives and regulation needed;

Aware that trust and constructive policy dialogues between public and private health sector results in improved human resources planning;

---

<sup>1</sup> Document EB124/18.

Concerned that the information, administrative and political constraints impede the capacity and stewardship function of the government in relation to private sector role;

Noting the WHO's ongoing work on the renewal of primary health care can contribute to consolidate experience, document best practice and plan the way ahead, particularly regarding the role of private providers,

1. URGES Member States:

- (1) to assess the relationship between the public and private health sector in order to achieve the national health systems goals effectively;
- (2) to assess, build up and strengthen the capacity of the public sector, professional councils where appropriate, through adequate funding and staffing; strengthen the insurance agencies to involve private health sector through their role of purchasing, price setting and providing information to consumers;
- (3) to strengthen and support the role of governmental and nongovernmental health-consumer protection agencies including patient groups;
- (4) to establish policy forum to facilitate continued dialogues between public and private sector to enhance trust building, joint infrastructure and human resources planning in order to synergize the role of public and private health sectors;
- (5) to develop and strengthen disease surveillance and information sharing networks between the public and private health sector to achieve an effective disease prevention and control;
- (6) to accelerate the expansion of public health insurance and its roles in re-orienting public and private providers towards a proper mix of personal care and public health interventions through purchasing and contractual arrangements;

2. REQUESTS the Director-General:

- (1) to convene technical consultations on health systems and policy research agenda in relation to public-private partnership;
- (2) to compile, synthesize and disseminate lessons and good practices from developed and developing countries on the role of private health sector in providing essential health services and achieving national health systems goals;
- (3) to provide technical assistance to Member States, upon request, in their efforts to strengthen the capacity of the ministries of health and other regulatory and financing agencies in order to improve the capacity of the private health sector;
- (4) to collaborate with and support development partners, nongovernmental organizations, private foundations, private health institutions and other global and regional partnerships, in their support for strengthening the capacity of the government and other relevant agencies in Member States to work constructively with the private health sector.

<b>1. Resolution</b> Capacity building to constructively engage the private sector in providing essential health care services	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
10.To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, effective governance and leadership, institutional capacity building for policy analysis, greater transparency and accountability for



performance, and more effective intersectoral collaboration.

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

The resolution is fully consistent with both the expected result and the indicators associated with it. Implementation of the strategy is expected to contribute to meeting the target set for the expected result. The relevant baselines will remain largely the same.

**3. Financial implications**

**(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

In line with previous practice with regard to draft resolutions, the estimated cost only relates to the convening of the technical consultations; the cost of the other activities that the Organization is requested to perform – knowledge dissemination, technical assistance and collaboration with partners – is not included. The cost of technical consultations, if held in all regions, will be US\$ 900 000.

**(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)**

US\$ 450 000, incurred in the regional offices and at headquarters.

**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?**

None

**(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Voluntary funds will need to be mobilized.

**4. Administrative implications**

**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Headquarters and regional offices

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

None

**(c) Time frames (indicate broad time frames for implementation)**

For the technical consultations, implementation would take place during 2009 and 2010. Activities related to the other elements of the resolution are part of the continuing work of the Secretariat.

Mr JAYANTHA (alternate to Mr de Silva, Sri Lanka) observed that the private health sector existed in all countries and the quality of the health services that were provided ranged from very good to poor. The intention of the draft resolution was to build the capacity of Member States to steer the private sector in a proper manner, not to expand the role of the sector. Sri Lanka had set up a special

council to guide the private sector in providing affordable high-quality care to supplement government services. He urged adoption of the draft resolution.

Dr JAKSONS (Latvia) said that the recommendations in the report could be broader, and could be important for countries in transition and for those reforming their health-care systems, particularly in the current economic crisis. Some issues remained unresolved with regard to the engagement of the private sector including how best to use public money in strengthening health-care systems; how to purchase cost-effective and quality services by the use of benchmarking; and which services should be offered exclusively by the public sector.

The draft resolution acknowledged the advantages offered by private health-care providers and emphasized the role of purchasing as a regulating mechanism. It made recommendations on the role of the public sector, government bodies and nongovernmental organizations in providing quality of care and consumer protection. He supported it but suggested that the title should be expanded to include “in low- and middle-income countries”. He also suggested that subparagraph 2(1) should call for an evaluation of best practices in public–private cooperation leading to recommendations or principles for making effective use of public money.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, recognized that the private sector could have an important role in health service provision and welcomed the draft resolution. However, some countries considered that the estimated costs for implementation were too high, particularly those for the technical consultations that the Director-General was asked to convene. Speaking as the member for Hungary, he endorsed the comments made by the member for Latvia.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) acknowledged the important role of the private sector in the delivery of health care, but suggested that in some parts of the draft resolution the emphasis was misplaced. For example, the third preambular paragraph referred to the “potential role of the private health sector in achieving national health systems goals”. He was not aware of any evidence for such a role. The draft resolution seemed to emphasize the limitations of health information systems, whereas in his view the principal limitation of the private sector had to do with its impact on equity of access to health services. The resolution should include some reference to that potential for inequity.

The draft resolution seemed to emphasize all the positives of the private sector, rather than suggest the use of resources to strengthen health services in publicly run systems. The draft resolution had not been intended to offer an uncritical promotion of the role of the private sector, but that was inadvertently suggested by some of its language. He looked forward to a more balanced revised draft.

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, said that almost half the total expenditure on health in the African Region (and 58% in Malawi) was spent on private providers. Perceptions of greater respect and confidentiality, and greater availability of medicines favoured private providers. In some countries the trend towards greater involvement in health care by the private sector had been associated with the start of the AIDS epidemic. A country such as Malawi, with an HIV prevalence of 12% and a weak health system, could not have afforded to treat the entire population in need of antiretroviral therapy through its public health services and had therefore designed its antiretroviral programme to include all health-care providers as part of a single national system. It had improved access to safe, affordable, quality services. Government control enhanced relations of trust with the private sector and improved accountability and transparency.

Following the International Conference on Primary Health Care and Health Systems in Africa (Ouagadougou, 28-30 April 2008), at which Member States had been urged to promote public–private partnerships, many international agencies had focused on private providers, but without sufficient attention to equity, cost and affordability. The countries of the African Region called upon the

Director-General to help governments to enhance their ability to provide policy guidance, exercise oversight and apply the mix of incentives and regulations needed in order to protect people from the harm they might suffer as a result of seeking medical services from unregulated private providers. Malawi wished to become a sponsor of the draft resolution.

Professor ALI (alternate to Professor Haque, Bangladesh) said that efficient operation of public services was a great challenge to developing countries. The private sector might, in special conditions, be involved in providing such services, although the government's intentions regarding the outsourcing of health services might be misinterpreted. Patients might have to cover the cost of certain medicines or medical tests because the government lacked the money. Such fees could be invested in the improved quality and maintenance of services. Active community involvement could help to improve the behaviour of providers, the supply of medicines and the quality of services.

The involvement of the private sector, as a partner of the public sector in the provision of high standards of essential health-care, should be pursued. The revitalization of primary health care would require the direct engagement of the private sector and of all development partners. He called on the Secretariat to support countries in establishing harmonious relations between the public and private sectors in a mutually beneficial environment.

Mr TSESHKOVSKIY (alternate to Dr Starodubov, Russian Federation) said that the market for fee-paying medical services was growing in the Russian Federation. Heavy maintenance expenditures on the health-care infrastructure had necessitated private fees for certain services in State institutions in order to preserve the public nature of the health-care system. However, that had adversely affected the moral climate in such institutions and had blurred the distinction between the services provided by the State free of charge and paid medical services. That had led to the growth of under-the-counter payments, reduced access to care and had adversely affected the medical profession.

The issue of public-private partnerships within the health-care field was of increasing concern both to the public and to medical professionals in his and other countries. In many countries the transition from a State health-care system to a mixed public-private system was creating challenges, such as the privatization of jobs in the health sector and the threat of privatization in the social sector. He welcomed the Board's discussion of the matter, which would encourage sharing of experiences, identify best practices and planning for future work.

The report allowed for different ideological interpretations. The Secretariat had not taken any position with regard to managing public-private partnerships or the privatization of certain medical services, nor had it prioritized particular strategies for enhancing the role of the public sector in such partnerships. The report gave the impression that the Secretariat's activities were geared towards analysing and encouraging the participation of the private sector in primary health care. However, the experience of the Russian Federation and other countries had showed that the privatization of medical services had reduced the access to, and quality of, medical services and had undermined the effectiveness of health-care systems. The Secretariat should focus on identifying the optimal balance between the public and private sectors in the delivery of health services.

Dr BIN SHAKAR (United Arab Emirates) said that in his country the private sector was a crucial partner not only in the provision of health services but also in education, training and research. Nevertheless, the provision of health-care services in the private sector should be closely monitored in order to protect public health. Unregulated and unlicensed private providers, to which the report made reference, might provide counterfeit medicines, a problem which had occurred in his country. WHO should support the establishment and strengthening of international information networks in that area.

Dr REN Minghui (China) said that private providers were important to his country's national health system. China encouraged and supported private funding of health-care services and promoted complementarity between the private and public sectors in order to meet the nation's health needs.

Private-sector engagement in essential health-care services should be encouraged, and guidance and supervision strengthened. The private sector must be required to respect regulations and standards and to put into practice quality control schemes in order to improve services and safety. He looked forward to working with other members in order to improve the draft resolution.

Dr GIMENÉZ CABALLERO (Paraguay) expressed support for the report. Although he agreed with the intent of the draft resolution, he could not approve it as currently drafted. The penultimate preambular paragraph referred to the constraints impeding the stewardship function of the government in relation to the private sector. The resolution should emphasize the stewardship role of health ministries and the leadership that they should exercise within the system.

Subparagraph 1(2), regarding the private sector, referred exclusively and restrictively to insurance companies. As mentioned in the report, the private sector comprised both for-profit and non-profit-making entities, and there were different categories within those groups, not only insurance companies. The same was true in subparagraphs (4) and (6). Subparagraph 1(6) contained a proposal relating to the various types of entities that constituted the private sector.

In Paraguay, the private sector accounted for only 7% of health-care services. The Government wished to expand its public sector coverage, as 38% of the population had been excluded from health services owing to social and economic inequities. Subparagraph 1(4) should emphasize stewardship and leadership. Subparagraph 2(3), which referred to improving the capacity of the private health sector, again seemed to limit the role of health ministries.

The draft resolution should also provide opportunities to focus on important areas mentioned in the report, such as the primary health care strategy which should be given special emphasis.

The draft resolution should deal with the issue of shared risk. Privately insured patients with limited insurance coverage often incurred high treatment costs. Thus the economic burden again fell on the public sector, and there was no mechanism for offsetting costs between the public and private sectors. With regard to HIV, not all insurance companies and private insurance models covered all aspects of HIV prevention and treatment, such as treatment of opportunistic infections. The same was true for other catastrophic illnesses.

Although he shared the strategic view of the item and believed that public-private and public-public linkages would help to strengthen health systems, the draft resolution did not cover all the issues that had been mentioned, even those in the report. For that reason he recommended that a working group should be established to continue enriching the document.

Dr MOHAMED (Oman) said that, in the Eastern Mediterranean Region, the private sector played a major role in delivery of health services. In some countries, the public sector purchased health services from the private sector. Certain other countries depended almost entirely on the public sector. As noted in the draft resolution, the spread of health services in such a manner could at some point fail to fulfil the health-care requirements.

Many countries in the Region had implemented policies whereby the health ministries performed essential public health functions and turned to the private sector for secondary or tertiary services, or even for primary health care. That had been true 10 years earlier, when the trend had been towards privatization. Genuine partnership was needed between the sectors so that the private sector could play a constructive role, rather than simply harnessing profits. In many countries the private sector did not deal with communicable diseases; in Oman, for example, tuberculosis was considered to be within the purview of the public sector. For that reason, Oman had joined other Member States in submitting the draft resolution, which aimed to encourage the private sector to assume more responsibility. He welcomed the suggestion by the United Kingdom and China that a working document should be prepared that would meet the requirements of other partners.

Dr DAHL-REGIS (Bahamas) said that most governments were engaged in some form of private health-care delivery. She welcomed the statement by the member for Latvia and the experience which

he had shared in that regard. She observed that capacity-building to constructively engage the private sector in providing health-care services appeared to focus on low- and middle-income countries. She expressed concern that many of the countries that needed such support would be excluded, particularly in the Caribbean region.

Her Government had submitted a number of proposed amendments to the draft resolution. The draft resolution referred exclusively to insurance agencies, and there was no recognition of the inequities that resulted from private arrangements. The document should distinguish arrangements were for-profit from those that were non-profit-making, which were beneficial and which were exploitative, and highlight the best practices. It should also recognize that policy must be established by governments and not by private services. She acknowledged the importance of the draft resolution and looked forward to participating in its redrafting.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that the private sector was one element, albeit a crucial one, that complemented the public and nongovernmental sectors in providing health services around the world. He supported efforts to build constructive relationships between public sector and private providers. In view of the mixed public-private nature of health-care delivery in his country, the building of trust between the two sectors was needed, as reflected in the report. He supported the general thrust of the draft resolution but wished to take part in further discussions to improve the text.

Ms TOELUPE (Samoa) said that the private health-care sector was in its infancy in many small Pacific island States. Samoa would require technical assistance from WHO in the areas of national policy guidance; the ability to exercise oversight; and in defining and enforcing the mix of incentives and regulations that were needed. She looked forward to the revised version of the draft resolution.

Ms ROCHE (New Zealand) said that the private sector could play an important role in financing and delivering health care. However, there were also potential negative effects from its involvement, as the member for the United Kingdom had stated.

The draft resolution should clearly establish that any private-sector involvement in providing essential health care aimed to improve health outcomes among the population; and that that involvement should not contribute to health inequities. The private sector should be subject to similarly appropriate regulation and monitoring as that of the public sector, in order to ensure that safe and effective care was delivered.

She had several amendments to propose to the draft resolution and looked forward to working with other members in order to achieve consensus.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)<sup>1</sup> said that he did not concur with the report, and supported the member for Paraguay in his rejection of the draft resolution. In his country, private insurance existed but the Constitution required, and his Government strove to ensure, that public insurance and social security had the widest coverage. Since most WHO documents gave due weight to the private sector, he questioned the need for a resolution aiming to strengthen or stimulate the private sector. The private sector always had a profit motive, and thus had always been excluded from health care. His Government believed that the public sector should exercise stewardship, and that any role of the private sector should be regulated. If a draft resolution implied the need to regulate the private sector, his Government was prepared to support it, otherwise, it would reject it. He proposed that the title of the resolution should be changed to “Strengthening the State’s regulatory capacity in order to constructively engage the private sector in providing essential health-care services”.

---

<sup>1</sup> Participating by virtue for Rule 3 of the Rules of Procedure of the Executive Board.

Dr MUÑOZ (Chile)<sup>1</sup> said that it was essential to strengthen the regulatory capacity of governments in order to make proper use of public and private health resources. In many countries, the for-profit and non-profit-making private sector met the health needs of a large share of the population. The difficulty of defining the private sector, which could encompass a private general practice, a nongovernmental organization, large clinics or a health insurance industry, sometimes prevented focus on the main points of the draft resolution.

He recalled recent debates concerning the impact of health services on efforts to achieve the Millennium Development Goals. Clearly, proper coordination between both public and private services would contribute to the achievement of those goals.

Private health care often lacked coordination and regulation by the health authorities, with resulting difficulties in complying with plans for rational management of health services. He also believed that the unregulated use of fees for health services contributed to a disproportionate increase in the cost of medical care. It was vital, therefore, to promote efficient public health services.

Chile supported the draft resolution's basic concept of engaging the private sector and would participate in its further drafting. He suggested that the development of health services should be coordinated with the work of other agencies, such as the work carried out by the ILO on community health insurance.

Dr BABB-SCHAEFER (Barbados)<sup>1</sup> said that the private health-care sector in small island developing States faced particular challenges, such as the high cost of labour and the lack of economies of scale. Accordingly, in the interest of equity, particular assistance in capacity-building to engage the private sector should be given not only to low- and middle-income countries, but also to small high-income countries such as Barbados and others in the subregion. She supported the statement by the member for Bahamas.

Ms MATSAU (South Africa)<sup>1</sup> said that South Africa had a long history of public-private partnerships. She emphasized effective regulatory frameworks, as well as complementarity between sectors and health-care services, in order to ensure the correct balance. The government must be able to identify strategic areas where the private sector would achieve optimum results.

She shared the views expressed by the member for Paraguay. The draft resolution asserted in the third preambular paragraph that in Africa the private health-care sector was expected to grow by more than 100% between 2005 and 2016. That was extremely unlikely to happen, in South Africa at least, because of poverty and lack of access to services. Since it was recognized that about 80% of the population of developing countries depended on the public health-care system, she questioned why WHO was putting forward a resolution which appeared to support the growth of the private sector. The drafting of a resolution should seek to enhance the capacity of the public sector to exercise its leadership and stewardship role. She supported the proposal to establish a working group in which South Africa would wish to participate.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)<sup>1</sup> said that, in searching the Health Assembly resolutions in WHO's electronic database, he had found only one that dealt with the role of the private sector. The other resolutions supported the role of governments in health-care services. However, the private sector was engaged to one degree or another in nearly all countries, and its existence must be acknowledged. It was necessary to work constructively with the private sector to achieve health goals.

There appeared to be some misunderstanding with regard to subparagraph 1(6) of the draft resolution, which read "to accelerate the expansion of public health insurance". Although he could not

---

<sup>1</sup> Participating by virtue for Rule 3 of the Rules of Procedure of the Executive Board.

read Spanish, he doubted that, in the Spanish version of the draft resolution, “public health insurance” was translated as “insurance companies”. If so, that was a factual error. Otherwise, there was a misunderstanding on the part of a member of the Board or a Member State that the draft resolution proposed the accelerated expansion of private insurance companies, which was not the case. The draft resolution proposed to expand public health insurance, or social health insurance, in accordance with resolution WHA58.33. The role of social health insurance was to engage both the public and the private sector in achieving health-system goals through contracting arrangements, purchasing functions and methods of payment by providers, thereby expanding efficient and equitable health-care services. He welcomed further consideration of the draft resolution by a drafting group with a view to achieving consensus.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) explained that, despite his constructive criticisms of the draft resolution, he strongly favoured the emergence of a resolution from the working group. In the United Kingdom, the National Health Service used Government funding to purchase care from private providers for its patients, while also providing public services. His Government regarded that as good practice; the private sector brought skills, modernization and a challenge to the system. However, the population was universally covered, whether people were treated in a public or a private hospital. The Government did not tell its citizens that they should find insurance coverage or draw on their funds, and he could not foresee that happening.

The population of every country was divided into, first, those who had access to safe, high-quality health services and, secondly, those who did not, either because no care was available or because of their social or economic circumstances. The main purpose of the draft resolution was to increase numbers in that first category and reduce those in the second.

Dr ETIENNE (Assistant Director-General) requested clarification on the balance that should be brought to the report. It had been suggested that the report should be entitled “Strengthening the leadership role of the government to engage with the private sector”, thus placing more emphasis on supporting the government in that role. Millions of people depended on private health services, even for their primary care. Good leadership and governance were also essential. Governments must respond to the reality that the private sector existed, and must do so as part of their efforts to increase access to, and equity of, health care. The scaling up of primary health care with a view to achieving the Millennium Development Goals clearly required Member States to take all providers into account; and to ensure that all care was provided in an ethical, safe and high-quality manner. Moreover, it should be affordable.

There was an issue with regard to evidence. The Secretariat needed more time to conduct a literature review in order to identify and analyse the available evidence and any gaps, and bring it to the Board in a more effective form. Government bodies responsible for engagement with the private sector should strengthen their oversight and regulatory capacity. The Secretariat would work with Member States to support and improve their stewardship and leadership role. Support must also be provided for monitoring, evaluation, guidance and the creation of a policy environment for stronger public-private engagement.

The DIRECTOR-GENERAL said that the representative of Thailand had articulated the importance for the Board of deliberating the role of the private sector. The private sector participated in the health-care system of every country, depending on the government’s policy and the country’s socioeconomic, cultural or historical circumstances. An unregulated private sector was a major concern for many Member States. An important issue for the Board to consider was how governments could engage constructively with the private sector, while exercising stewardship functions. She asked whether Member States were prepared to take on that challenge in a way that ensured that fewer people would be denied access to health care, irrespective of how the care was provided. It could be

provided by the public sector, by the profit-making private sector, or by the non-profit-making private sector. The term “private sector” should not be seen as unacceptable. One member had asked whether WHO was being used to promote the private sector. That was a decision for the Board to make. The Secretariat had no hidden agenda. The Secretariat encouraged the Board to have a robust discussion on the subject, and stood ready to assist the Board in its further deliberations on the draft resolution.

Professor ALI (alternate to Professor Haque, Bangladesh) suggested that an open-ended working group should be convened to discuss improvements to the draft resolution.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that, in listening to the discussion, he had not heard overwhelming support for a resolution on the subject. The subject was complex and controversial. The Director-General and the Assistant Director-General had said that the Secretariat needed further guidance. Even if an informal working group were to be convened, as proposed by the member for Bangladesh, there were only two days left for it to work. He suggested that, rather than rushing to adopt a resolution at the current session, the Board should postpone its discussion of the issue pending further work.

Dr JAKSONS (Latvia), replying to the points raised by the member for the United Kingdom, said that there was a danger that the draft resolution would try to cover too much ground, from the relationship between private and public providers and financing mechanisms to governance, equality and transparency. He also understood from the debate that many African countries needed to know how they could ensure patient safety in situations where private health-care providers had entered the field because no other health care existed. It might be possible to formulate some narrow provisions on how to regulate that process as a first step. Otherwise, he agreed with the statement by the member for the United States of America.

Dr KÖKÉNY (Hungary) supported the statements by the members for Latvia and the United States. The private sector played a significant role in many countries, as emphasized by the Director-General’s statement in that regard. The Board should take note of its debate up to that point and ask the Secretariat to undertake further analysis with a view to considering a draft resolution at a later stage.

Dr REN Minghui (China) supported the proposal by the member for Bangladesh. Informal consultations should be held during the following week. That would at least provide guidance for the Secretariat in preparing a revised report and draft resolution.

The DIRECTOR-GENERAL requested that, if an informal working group were to be convened, as proposed by the members for Bangladesh and China, it should give guidance to the Secretariat on the elements to be included in the next version of a document, to be submitted to the Sixty-second World Health Assembly. On the basis of such guidance, the Secretariat could determine whether there was a need for a draft resolution and, if so, what its focus should be, given the complexity of the issue and the urgency of supporting the capacity of Member States to regulate the private sector.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)<sup>1</sup> said that the Secretariat should make available more evidence on the strengths and weaknesses of both public and private health-care services. Thus, Member States would be better informed when they discussed any new draft resolution on the subject at the Health Assembly.

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.



Mr HOHMAN (alternate to Dr Wright, United States of America), replying to the Director-General, said that the new report to be prepared by the Secretariat for the Health Assembly should include a draft resolution.

The CHAIRMAN said that, in the absence of any objections, he would take it that the Board wanted informal intersessional consultations on the subject to be held.

**It was so agreed.**

**The meeting rose at 12:55.**