

THIRD MEETING

Thursday, 23 May 2013, at 14:30

Chairman: Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)

1. MANAGEMENT AND LEGAL MATTERS: Item 24 of the Agenda (continued)

Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization: Item 24.1 of the Agenda (Documents A66/41 and EB132/2013/REC/1, resolution EB132.R14)

Ms CHEDEVILLE-MURRAY (France), speaking on behalf of the Member States of the European Region, expressed firm support for the draft resolution recommended by the Executive Board for adoption by the Health Assembly in resolution EB132.R14. The draft resolution was the outcome of a lengthy and complex process and would ensure a more robust procedure for the election of future directors-general. In that regard, she welcomed the institution of a code of conduct and of a candidates' forum through which candidates could present themselves to Member States on a fair and equitable basis. The introduction of a standard curriculum vitae form would ensure that compliance with the criteria as revised by the Executive Board, and the proposed amendments to the Rules of Procedure of the Executive Board and of the World Health Assembly, were satisfactory. The request for the Secretariat to explore options for the use of electronic voting for the appointment of the Director-General, including the financial implications thereof, and to report thereon to the Sixty-seventh World Health Assembly was also welcome, on the understanding that the Board and the Health Assembly would continue to come to decisions by secret ballot, in accordance with Rule 52 of the Rules of Procedure of the Executive Board and Rule 108 of those of the Health Assembly. Similarly welcome was the principle of consolidating in a single reference document the description of the overall process for the election of the Director-General.

Mr OSEI (Ghana), speaking on behalf of the Member States of the African Region, said that one of the greatest strengths of WHO was the rich diversity of its membership, which must be given full expression in the appointment of its staff and management, including at the highest level of the Organization. Bearing in mind the issues identified by the Working Group on the Election of the Director-General as being critical to reform of the election and appointment process, he welcomed the introduction of a candidates' forum in that it would give all Member States the opportunity to assess and interact meaningfully with candidates. The adoption of a code of conduct would also help to ensure a level playing field, thereby safeguarding the integrity of the electoral process. Noting the voluntary nature of the application of the code of conduct, the Member States in his Region would keenly follow the willingness of candidates to comply with the code as a marker of their integrity, which was an important factor from the perspective of those Member States. The revision of the Rules of Procedure of the Executive Board and the World Health Assembly to allow for the nomination of more than one candidate by the Board for consideration by the Health Assembly represented a fundamental enrichment of the election process, underscoring the collective will of Member States to infuse greater transparency, fairness and inclusiveness into that process. Due regard must nonetheless be paid to the principle of equitable geographical representation, not forgetting that candidates appointed to the post of Director-General had thus far hailed from three of the six WHO regions. The process should continue to be guided, however, by the paramount consideration of the highest standard

of efficiency, competency and integrity. He endorsed the draft resolution and looked forward to its effective implementation.

Mr KIM Young-hak (Republic of Korea), expressing full support for the draft resolution, said that the code of conduct would serve as a model for all international organizations. As a representative of the directing and coordinating authority for health within the United Nations, the Director-General of WHO should possess the requisite qualifications, demonstrate a balanced perspective on global health issues and have the courage and confidence to make bold decisions in emergency situations. In order to ensure that WHO continued to be led by an individual with strong commitment and qualifications, concerted efforts must be made at all levels to ensure implementation of the resolution. In particular, the page of the WHO web site dedicated to information disclosed by candidates, referred to in Annex 2 to the draft resolution, should be fully utilized in the interest of informed decision-making by Member States concerning the selection of a candidate qualified to oversee the Organization's programmes for improved global health.

Dr SHOHANI (Iraq) said that, in order to guarantee the principle of fairness, equality and equal opportunity, the post of Director-General should be rotated among the different WHO regions, provided that the candidates had the necessary competence and expertise, qualifications that were not lacking in any of the regions. Regions and Member States should also be invited to submit proposals for mechanisms designed to ensure that the election process was conducted in a professional, transparent and fair manner.

The CHAIRMAN said she took it that the Committee wished to approve the draft resolution.

The draft resolution was approved.¹

Real estate: Item 24.2 of the Agenda (Documents A66/42 and A66/62)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on the item, which was contained in document A66/62. The Committee, on behalf of the Executive Board, had recommended that the Health Assembly adopt the draft resolution contained in that document, which concerned the construction of the new WHO sub-office in Garowe, Puntland, Somalia.

Dr DIAKHABY (Guinea), speaking on behalf of the Member States of the African Region and referring to the project options for achieving a site-wide, comprehensive refurbishment strategy for WHO headquarters, said that option 1 was preferable to the other three options for the reasons set out in the Secretariat's report (document A66/42). Of those reasons, she highlighted: the cost advantages offered by the possibility of disposing of the three annex buildings L1, L2 and M, which would be made redundant by the construction of a new low-maintenance, low-energy building; the access to Host State loans for new construction; the most flexible use of space; easier compliance with local legislation; and less disruption during the works. She called on the Health Assembly to take note of the Secretariat's report, to provide guidance concerning the updated refurbishment strategy and to approve the construction of the new WHO sub-office in Garowe, Puntland, Somalia.

Ms HERNÁNDEZ NARVÁEZ (Mexico) acknowledged the need to adopt a longer-term strategy for the management of WHO's real estate and therefore welcomed the proposals aimed at establishing an integrated strategy that took account of building conditions. The strategy should also

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.18.

take account of the need to reduce operational costs in the long term; additional information on the possible savings would therefore be useful. She noted that the financing mechanism presented would have no additional financial implications for the Member States in the coming biennial budgets. In view of the renovation projects being carried out at the headquarters of other multilateral organizations and their serious financial implications for the Member States, she gratefully acknowledged the Director-General's commitment to absorb project costs within the financing mechanism presented. She supported the draft resolution.

Ms BULLINGER (Switzerland) said that the Secretariat's report provided a solid basis for further discussion and decision-making concerning the Organization's long-term real estate strategy. Project option 1 appeared to offer significant long-term cost and sustainability advantages, but it should be noted that the Host State's agreement to a loan for new construction would be subject to approval by the Swiss Parliament. Switzerland would continue to work in close collaboration with WHO for the best possible solution.

Mr BERTONI (Italy), referring to the whole-life cost of options set out in Table 6 of the Secretariat's report, asked whether the amount of US\$ 82.5 million anticipated from the sale of the three annex buildings under option 1 was based on expert evaluations.

Mr ESPINOSA SALAS (Ecuador) said that any plan to renovate WHO's real estate must take account of the need to provide adequate facilities for people with disabilities, in line with the draft resolution currently before the Health Assembly under item 13.5, Disability.

Mr PRESTON (Operational Support and Services), responding to comments, said that disability access had thus far been facilitated only in areas that were not to be replaced through renovation, but that such access was treated as a matter of paramount importance in all new renovation projects, new constructions and total refurbishments, especially in the main building. With respect to access to a loan from the Host State, it was hoped that an agreement on the way forward could be reached in principle during the session of the current Health Assembly in order to formalize the informal negotiations that had taken place on that score over the previous few months. He expressed appreciation to the Government of Switzerland for its collaboration with WHO in developing the refurbishment strategy. The amount indicated under option 1 for the sale of the three annex buildings was indeed based on expert advice provided by a local firm of architects. Additional studies were being undertaken, however, in order to qualify that initial evaluation.

He added that the refurbishment proposals considered in 2010 had covered only seven floors of the main building, whereas the strategy now before the Health Assembly covered the entire WHO compound on the basis of the expected 40-year life span of the buildings. It was therefore a comprehensive long-term strategy that had taken considerable time to prepare, albeit on a less formal basis than desired. Full and detailed plans would be submitted to the Organization's governing bodies in 2014. Every effort had been made to validate the content of the strategy, and he expressed confidence that WHO could implement it without unduly affecting the financing mechanism approved in 2010.

The CHAIRMAN said she took it that the Committee wished to note the Secretariat's report and to approve the draft resolution contained in document A66/62.

The Committee noted the report.

The draft resolution was approved.¹

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.19.

Agreements with intergovernmental organizations: Item 24.3 of the Agenda (Document A66/46)

The CHAIRMAN drew attention to the draft resolution on the proposed agreement between WHO and the South Centre contained in document A66/46.

Dr LIU Peilong (China) said that the South Centre had facilitated collaboration among developing countries and played a major role in promoting United Nations activities and South–South cooperation. Striving as it did to promote the Centre’s activities, China was in favour of the proposed agreement between WHO and the Centre; it would formalize the relationship between the two and further their long-term collaboration. He therefore supported the draft resolution.

Mrs GOONERATNE (Sri Lanka) remarked that developing countries, including her own, needed to collaborate and work doubly hard in order to achieve their objectives. They therefore welcomed constructive support, such as that crucially provided over the years by the South Centre, on multilateral policies in a variety of areas including health. The South Centre was well known and its personnel were experienced, skilled and extremely competent in health and development issues. She likewise supported the proposed agreement and the draft resolution.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that the South Centre was an intergovernmental organization whose support and cooperation as an adviser, source of publications and centre for debate on health and other multilateral matters was highly appreciated by his country. He therefore endorsed the establishment of a relationship between WHO and the South Centre and supported the draft resolution.

Dr RANJAN (India) welcomed the proposed agreement between WHO and the South Centre, which played an important role in WHO’s work on multilateral health and development policies. He too expressed support for the draft resolution.

Mr ESPINOSA SALAS (Ecuador) said that his country had benefited in the past from fruitful cooperation with the South Centre on various matters including health. He endorsed the views of previous speakers on the value of the constructive advice, which was sometimes critical, offered by the South Centre to WHO, and expressed support for the draft resolution.

Mr AMRI BUKHAIRI BAKHTIAR (Malaysia) said that Malaysia had from the outset benefited from the work done by the South Centre in providing analytical assessments in such areas as health, intellectual property, trade and development, and environment. Together with other inputs by the Centre, such assessments had supported developing countries in formulating strategic and concrete positions on key issues at international meetings and conferences. A formal relationship with WHO would benefit both organizations. The international multilateral system was complex, and the South Centre played an increasingly significant role as a think tank and an instrument for facilitating and further promoting South–South cooperation. It remained the only institute in a position to provide intellectual support to developing countries in multilateral negotiations and international dialogue. He therefore supported the draft resolution.

Ms BLACKWOOD (United States of America), appreciative of the strong support expressed for the South Centre and of the excellence of its work for South–South cooperation, commented on the need to ensure protection for WHO, as an evidence-based organization, from vested interests of any kind. She nevertheless supported the proposed agreement.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) expressed support for the proposed agreement; engagement by all non-Member State actors in the work of providing capacity-building and intellectual and policy support to developing countries was decidedly important. For

WHO, the primary interest lay in promoting global health and supporting the poor and vulnerable. All partners, Member States and non-Member States must therefore work together in a positive and constructive manner to achieve the Organization's global health objectives.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that the South Centre championed intellectual capacity-building, in particular in order to help developing countries to deal with the impact of international trade and intellectual property regimes, as well as to protect the interests of poor people. The proposed agreement between WHO and the South Centre would further develop the latter's role in that context and he therefore strongly supported the draft resolution.

The draft resolution was approved.¹

2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 25 of the Agenda (Document A66/44)

The CHAIRMAN pointed out that in paragraph 16 of the Secretariat's report (document A66/44), the figure at the end of the first sentence should read US\$ 134 million and not US\$ 34 million.

Ms CALDER (Switzerland), speaking on behalf of Australia, Denmark, Finland, France, Netherlands, Norway, Switzerland and the United Kingdom of Great Britain and Northern Ireland, and supported by Dr CARTIER (Belgium), said that a strong commitment to a more efficient, effective and coherent United Nations system was essential for achieving maximum development results. Effective coordination among organizations of the United Nations system and other relevant actors was a key element of those efforts, which were of growing importance in a global landscape of multiple new stakeholders. The recently adopted United Nations General Assembly resolution 67/226 on the quadrennial comprehensive policy review of operational activities for development of the United Nations system demonstrated the strong international consensus on the issue; the Resident Coordinator System and the "delivering as one" approach provided for in that resolution were central to the efforts to enhance coherence. The organizations of the United Nations system had moreover reached welcome agreement on sharing the costs of coordination that served the entire United Nations system, including WHO's programmatic activity.

WHO's commitment to improving the United Nations system in support of better development results and its factoring of the necessary coordination costs into the proposed programme budget 2014–2015 were also welcome. In that light, however, the implication in parts of the report that the Secretariat harboured doubts as to the usefulness of the United Nations development system and of United Nations coordination was therefore somewhat surprising. It would be interesting to hear the Secretariat's views on the matter and gratifying to receive reassurance of its continuing full commitment to an efficient and effective United Nations coordination system. Member States must hold themselves accountable for demonstrating coherence in United Nations forums and should accordingly feel under an obligation to discuss and underline the importance of coherence.

Mr HOLM (Sweden), endorsing the statement made by the delegate of Switzerland, expressed support for the Development Operations Coordination Office and for its work to secure the resources and staff required for coordination efforts at country level. While there could be some merit both in WHO's focus on the implications of the quadrennial comprehensive policy review resolution as it pertained to the funding of United Nations coordination and in its questioning of the concept of coordination as currently implemented, he underlined the fact that the United Nations Development

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.20.

Group had decided only a few weeks earlier on a cost-sharing agreement. He noted with appreciation that the amount included for coordination in the WHO proposed programme budget 2014–2015 was as stated in that agreement. Until such time as the current practices for coordinating United Nations activities at country level had been revised, all participating organizations must pay their fair share of costs. WHO should continue its commitment in that regard.

Dr SHOHANI (Iraq) said that cooperation within the United Nations system and with other international organizations led to optimum use of resources and prevented the duplication of programmes and activities. In Iraq, the United Nations Development Assistance Framework had promoted an effective partnership between ministries and relevant stakeholders, paving the way for partnership with other supporting bodies and organizations. In that context, a technical advisory group, formed as part of a primary health care project supported by the United States Agency for International Development, convened regular meetings, attended by staff from organizations of the United Nations system, to ensure integrated planning and follow-up and to promote the concept of primary health care throughout the country. The Government of Iraq had also strengthened that approach by sharing in the costs, with a view to obtaining the support needed for joint financial planning to improve primary health care activities and thereby attain Millennium Development Goal 8 (Develop a global partnership for development).

Dr TROEDSSON (Executive Director, Office of the Director-General) expressed appreciation for all the comments made on the subject during the consultations held at the global, regional and country levels and at the present meeting. He wished to make it abundantly clear that WHO was fully committed to United Nations coordination and collaboration at all levels. Any misinterpretations to which the report may have given rise were inadvertent; there had never been any question of not working together, “delivering as one”, cooperating or collaborating. The intention of the report had been to reflect not the WHO position, which had been explained by the Director-General on numerous occasions, but rather some of the negotiations that had taken place within the United Nations Development Group and among organizations of the United Nations system. As described in the report, those negotiations had focused on how fairly to divide among the United Nations Development Group organizations the additional costs for the Resident Coordinator System following the withdrawal of donor support. WHO’s share, which it would honour, had been estimated at US\$ 5.2 million per biennium. It should be noted, however, that not all WHO activities at country level were included in the United Nations Development Assistance Framework or in the One United Nations programme, in so far as legitimate requests for support might be received from Member States concerning highly specific public health issues that fell outside the United Nations mandate. In conclusion, he reiterated the WHO commitment to working actively in coordination with other organizations at the country level and to taking on all the responsibilities of a technical agency.

The Committee noted the report.

3. HEALTH SYSTEMS: Item 17 of the Agenda

Universal health coverage: Item 17.3 of the Agenda (Document A66/24)

Professor PISAKE LUMBIGANON (Thailand), speaking on behalf of the Member States of the South-East Asia Region, recalled that the United Nations General Assembly had committed to universal health coverage in December 2012 with the adoption of resolution 67/81 on Global Health and Foreign Policy. At the subsequent High-level Dialogue on Health in the Post-2015 Development Agenda, held in Botswana, and the meeting of the High-level Panel on the Post-2015 Development Agenda held in Bali, Indonesia, universal health coverage had been identified as one of the

overarching health goals for the post-2015 development agenda. Adequate numbers of competent health workers were the key to achieving successful outcomes in that regard, and preparing such workforces required effective and appropriate health workforce education systems. Such systems had been gradually transformed in the past 100 years and were no longer predicated on experience but rather on science and technology. Health care systems had been improved as a result, and life expectancy extended, but science-based health workforce education systems had gradually led to fragmentation, were technology-driven and entailed high costs. In December 2010, a Lancet Commission report, *Health professionals for a new century: transforming education to strengthen health systems in an interdependent world*, had served to kick-start a global process to reform health workforce education. A number of initiatives had since been tested and had proved the potential for positive results. The health workforce, its education and its training were among the most neglected of areas. In that context, 21 Member States from all six WHO regions (Bangladesh, Bhutan, China, Democratic People's Republic of Korea, India, Indonesia, Israel, Japan, Malaysia, Maldives, Myanmar, Nepal, Norway, Pakistan, Philippines, South Africa, Sri Lanka, Thailand, Timor-Leste, United States of America and Viet Nam) had submitted a draft resolution, which read:

The Sixty-sixth World Health Assembly,

PP1 Recalling resolution WHA59.23 urging Member States to scale up health workforce production in response to the shortages of health workers which hamper the achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

PP2 Recognizing that a functioning health system with adequate number of committed and competent health workers at the primary health care level is fundamental to equitable access to health services as an important objective of universal health coverage, and highlighted in the World Health Report 2006;¹

PP3 Recognizing also the need to provide adequate, reliable financial and non-financial incentives and an enabling and a safe working environment for the retention of health workers in areas where they are most needed, especially in remote, hard to reach areas and urban slums as recommended by WHO Global Guide;²

PP4 Recalling resolution WHA64.9 urging Member States to further invest in and strengthen the health delivery systems, in particular primary health care, and adequate human resources for health in order to ensure that all citizens have equitable access to health care and services;

PP5 Concerned that in many countries, notably those in sub-Saharan Africa, there is inadequate capacity to train sufficient health workers for adequate coverage of services to the population;

PP6 Recognizing specific challenges of some Member States which have limited economy of scales in local health workforce education and training, their special needs, the potential partnerships and collaborations with other Member States;

PP7 Recognizing also the needs for intersectoral collaboration among Ministry of Health, Ministry of Education, public and private training institutions, health professional organizations in strengthening health workforce education and training system in producing competent health workforces to support universal health coverage;

PP8 Concerned also that many countries lack the financial means, facilities and sufficient educators to train adequate health workforces; and that there is a need to improve the health workforce education and training system in response to country's health needs;

¹ The world health report 2006: working together for health. Geneva: World Health Organization; 2006.

² Increasing access to health workers in remote and rural areas through improved retention, <http://www.who.int/hrh/retention/home/en/index.html>.

PP9 Mindful of the need for a comprehensive national policy and plan on human resources for health, where health workforce education is one of its elements;

PP10 Recalling resolution WHA63.16 WHO on Global Code of Practice on the International Recruitment of Health Personnel, which urged Member States to create a sustainable health workforce system through effective health planning, education and training and retention strategies;

PP11 Recognizing the Dhaka Declaration on Strengthening Country Health Workforce in the Countries of South-East Asia Region and the Southeast Asia Regional Committee resolution SEA/RC65/R7 on Strengthening Health Workforce Education and Training in the Region, which urged Member States to assess the health workforce education and training system as a basis for regional strategies to improve health workforce production in response to country's health needs;

PP12 Recognizing also the recommendations contained in the Global Independent Commission report on "Health professionals for a new century: transforming education to strengthen health systems in an interdependent world";

PP13 Appreciating the ongoing initiatives to strengthen health workforce education and training in various regions, including the Medical and Nursing Education Partnership Initiative, in-service training of health workers in sub-Saharan Africa supported by Japan in line with the Toyako G8 Summit commitment and the Asia Pacific Network on Health Professional Education Reform,

1. URGES Member States:¹

- (1) To further strengthen national health policies, strategies and plans through intersectoral policy dialogue among ministries of education, health and finance to ensure that the health workforce education and training contribute to achieving universal health coverage;
- (2) To conduct comprehensive assessments of the current situation of health workforce education with the application of standard protocol and tool to be developed by WHO;
- (3) To formulate and implement evidence-based national policies and strategies, based on findings from the assessment in the previous paragraph, to strengthen and transform the health workforce education and training, including through the promotion of inter-professionals, community-based and health systems-based education, linkages of pre-service education to continuous professional development, and the accreditation system to ensure quality of training institutes and competency of health workforces; with a view to better respond to the health needs of people and the needs of the health systems, take into account the special needs of some Member States which have limited economy of scales in local training;
- (4) To provide adequate resources and political support to implement national strategies for the strengthening and transformation of health workforce education;

2. REQUEST the Director-General and the Regional Directors:

- (1) To develop a standard protocol and tool for assessment, and to support Member States in conducting comprehensive assessments of the current situation of health workforce education with the application of the protocol which may be adapted to the country contexts;
- (2) To convene regional technical consultations to review the findings of country assessments and to formulate regional and global strategies on transforming health workforce education in support of the universal health coverage;

¹ And, where applicable, regional economic integration organizations.

- (3) To provide technical support to Member States in implementing national, regional, and global strategies on transforming health workforce education in support of the universal health coverage;
- (4) To submit a progress report on the implementation of this resolution to the Sixty-ninth World Health Assembly through the Executive Board.

The financial and administrative implications for the Secretariat of the resolution's adoption were as follows:

1. Resolution Transforming health workforce education in support of universal health coverage	
2. Linkage to programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)	
Strategic objective(s): 10 (Category 4 in Programme budget 2014–2015)	Organization-wide expected result(s): 10.9 (Outcome 4.2, Output 4.2.2 for Programme budget 2014–2015)
How would this resolution contribute to the achievement of the Organization-wide expected result(s)?	
The resolution should lead to an increase in the number of countries that have an investment plan for scaling up and/or improving training and education of health workers in accordance with national health needs. This will involve an assessment of current practices, guidance and collaboration in order to transform education systems in support of a better response to people’s health needs.	
Does the Programme budget already include the products or services requested in this resolution? (Yes/no)	
Yes.	
3. Estimated cost and staffing implications in relation to the Programme budget	
(a) Total cost	
Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).	
(i) Three years (covering the period 2013–2015)	
(ii) Total: US\$ 5.5 million (staff: US\$ 3.5 million; activities: US\$ 2.0 million)	
(b) Cost for the biennium 2012–2013	
Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).	
Total: US\$ 1 million (staff: US\$ 600 000; activities: US\$ 400 000)	
Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.	
Headquarters and the six regional offices.	
Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)	
Yes.	
If “no”, indicate how much is not included.	
(c) Staffing implications	
Could the resolution be implemented by existing staff? (Yes/no).	
No. Additional staff would be needed at headquarters and in the regional offices to implement the following activities:	
adapting and field testing the assessment tool and guidelines;	

providing technical support to Member States;
organizing regional training and monitoring meetings;
developing guidance for the transformative education of health professionals.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

One additional full-time equivalent staff member would be required at the global level to develop tools and guidance, and to coordinate and monitor regional activities. In addition, six full-time equivalent staff members would be required, one in each regional office, with skills in health professional education and health systems.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)
No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 1.0 million; source(s) of funds: external, international donors.

He proposed that a drafting committee be established to consider the draft resolution.

Dr DAULAIRE (United States of America) said that the expansion of health care coverage, which was fundamentally about all people having equal access to care, was presently at the forefront of his country’s domestic agenda. The Affordable Care Act sought dramatically to expand access to health care services. It contained numerous provisions to keep costs low and promote prevention, and would ultimately extend coverage to 30 million Americans who were currently uninsured. Realizing universal health coverage was primarily the responsibility of national governments; WHO could serve as a powerful advocate and provide needed technical support, but national governments must assume ownership of that goal. Universal health coverage was a strong unifying element in the discussion of the post-2015 development agenda, but it was not an outcome in itself and must be accompanied by clear health targets and supported by evidence-based interventions. Such targets should focus on continuing achievement of the current health-related Millennium Development Goals. He expressed support for the addition of noncommunicable diseases to the discussion, with prevention as the cornerstone of sustainable universal health coverage.

Mr ÁLVAREZ LUCAS (Mexico), referring to United Nations General Assembly resolution 67/81 on Global health and foreign policy and the discussion about including universal health coverage on the post-2015 development agenda, commended the Secretariat’s efforts to formulate indicators that would help measure the progress made by each country towards ensuring access to health services independently of its specific characteristics and problems. Efforts would need to be intensified to meet the challenge of guaranteeing effective, high-quality access to health services for all.

Dr MAKUBALO (South Africa), speaking on behalf of the Member States of the African Region, welcomed the completion of the plan of action, which would help many countries in the African Region move towards universal health coverage despite the challenges many of them faced. *The world health report 2010* and the report of the WHO/World Bank ministerial-level meeting held in February 2013 clearly indicated that a successful transition required the spread of financial risks through prepayment and pooling, a reduction in out-of-pocket payments, additional funds for health where necessary, and an emphasis on primary health care and broader health system development. She was nevertheless concerned to note that the plan of action focused on health financing at the expense of elements such as increasing the quality and availability of health services. Greater emphasis should

be placed on improving the availability, accessibility, acceptability and quality of primary health care services. Full implementation of the various declarations on primary health care and health systems would ensure that services reached poor and marginalized communities, especially in low- and middle-income countries, and had the greatest potential to make affordable improvements in population coverage. It was also important to strengthen facility and district health management systems, enabling them to be more responsive to the needs of communities and to the incentives created through active purchasing. Steps in that direction should be accompanied by mechanisms and processes that supported accountability, community participation and ownership.

People's survival and health were among the most fundamental of development outcomes. The goals, policies, programmes and resource flows from national and international players should therefore address unfair and avoidable inequalities in those outcomes.

Ms JACOB (Ireland), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. Universal health coverage was an important means of achieving healthier lives for people and was also a goal in itself. It contributed to the realization of health equity and enjoyment of the right to health. A minimum set of services was not sufficient. Effective universal health coverage required a health system with sufficient human, technical and financial capacities to provide good-quality services that were accessible to and answered the needs of all. It should comprise targeted efforts for poor, vulnerable and marginalized segments of the population that were particularly at risk of financial hardship from excessive out-of-pocket payments. To address the broader determinants of health, and given that all aspects of health should be covered, from promotion to rehabilitation, effective universal health coverage required a health system with broad public health measures. It also required a multisectoral "health in all policies" approach conducted in collaboration with, and with support from, ministries such as finance, trade, labour and social affairs, as well as civil society and the private sector. In order to address the demands from countries about how to elaborate a system of universal health coverage, development partners should align their efforts and coordinate their inputs for capacity development, preferably through existing partnerships such as Providing for Health and the International Health Partnership. The European Union firmly believed that universal health coverage had a key role to play in the post-2015 development agenda since it could make a significant contribution to sustainable development and help contain new and existing health threats.

Mr S. DIOUF (Senegal) said that his country, which was a member of the United Nations Foreign Policy and Global Health Initiative and in which access to health care remained a problem for many people, commended the importance attached to universal health coverage. However, document A66/24 should have allowed for better definition of strategic approaches to achieving universal health coverage and should have attached crucial importance to strategies for providing medical treatment to the poorest and most vulnerable sectors of the population. For example, the health maps for each country, mentioned in paragraph 15, should be updated to take account of the goal of universal health coverage and thereby prompt an effort to narrow the gap between health care supply and demand. There was also a need to understand the limits to the development of mechanisms offering protection against financial risks, so that appropriate reforms could be introduced in order to move towards universal health insurance; and to take action against preventable diseases through a stronger commitment to a multisectoral approach to dealing with the social determinants of health, so as to ease the morbidity burden and thus make more efficient use of health-sector resources.

Ms BOTERO HERNANDEZ (Colombia) said that, as stated in the report, universal health coverage was contingent on the availability of health services at an affordable price, a critical aspect of which was equitable access to medicines. In recent years, however, different parts of the world had suffered shortages of essential medicines, and they had been displaced by therapeutic alternatives which, while relevant and effective, were more costly and therefore had an impact on the financial

sustainability of health systems. Her country had recently embarked on a process of consultation with other countries and regions to analyse the problem and tackle it from three angles: gaining a clearer understanding of what caused the shortages, in order to prevent and mitigate the resulting problems; conducting a worldwide evaluation of the extent and nature of the shortages; and developing strategies to manage shortages and strengthen the concept of essential medicines as part of the process leading to universal health coverage. The aim was to make tackling the shortages a WHO priority, so as to obtain the Organization's support. Colombia supported the inclusion of universal health coverage on the post-2015 development agenda.

Mr AL-SHEHABI (Bahrain) said that, in common with other countries, Bahrain faced challenges that threatened the sustained delivery of good-quality health services in the current economic climate, not least the high costs of health care, compounded by such factors as an ageing population, an increase in chronic diseases and wasted spending. The demand for high-quality health care also stepped up pressure on politicians to develop financing options for moving towards universal health coverage. Bahrain was currently working to build national capacities for providing such coverage, and consultations were under way with the legislature on the best way forward to achieving that aim, which was perhaps a goal to be included on the post-2015 development agenda. It was essential to evaluate and monitor progress towards universal health coverage in order to appraise successes and work on ways of overcoming any obstacles that might arise.

Dr HORI (Japan) said that Japan's national health insurance scheme, introduced 50 years earlier, ensured that all citizens had access to essential health care services whenever necessary. The scheme constituted a solid base from which to boost public health and had provided a strong backbone for subsequent socioeconomic development. Although universal health coverage was an important common goal for the global health community, the many factors to be considered complicated its promotion and achievement. Working towards universal health coverage required ongoing national efforts to improve the availability and quality of health care services, and to establish and manage mechanisms for protecting the population from financial risk. Japan and the World Bank had started a joint research project on universal health coverage in 2012. On the basis of the findings, Japan planned to organize an international training course later in the year for high-level officials from developing countries. In its recently announced strategy for global health diplomacy, Japan explained how it intended to use its knowledge to expand international cooperation for global health. The strategy's ultimate goal was universal health coverage. Japan would continue to share its experiences and contribute to health system strengthening through bilateral and regional cooperation.

Ms CALDER (Switzerland), expressing satisfaction at the considerable progress made towards universal health coverage worldwide, said that such coverage provided a framework for meeting the challenges facing the global effort to strengthen equitable, efficient and sustainable health systems. Major inequalities remained in terms of health coverage and financial risk, not only between but also within countries, and urgent action was needed to ensure more equitable access to health services and information and to take into account the social determinants of health. A multisectoral approach, bringing together health players and those from other sectors, was crucially important to allow for consideration of the social, economic and environmental determinants that had a direct impact on the reduction of inequality and enabled sustainable development. The concept of universal health coverage was a pertinent and useful means of measuring progress towards sustainable development. A social health protection system providing universal health coverage was therefore a key instrument for attaining the global health objective. In the light of discussion of the post-2015 development agenda, WHO should strengthen its role of coordinating and supporting country efforts to implement universal health coverage; efforts should include continuing development of the Providing for Health initiative.

Mr SANNE (Norway) said that Norway had sponsored the draft resolution in recognition of the importance of health personnel to the achievement of universal health coverage. He expressed support for the establishment of the drafting group chaired by Thailand.

Mr ARKO HANANTO BUDIADI (Indonesia) said that Indonesia, a sponsor of the draft resolution, considered that, through universal health coverage, countries would strengthen their people's health and in turn obtain a development dividend. Indonesia was working to expand health coverage and services to all Indonesians by 2019. In cooperation with the Non-aligned Movement Centre for South-South Technical Cooperation, it had been conducting global health diplomacy for health professionals and related personnel in the South-East Asia Region for some years.

Dr LUCO (Chile), recalling that her country had been working for 50 years towards universal health coverage, said that Chilean legislation incorporated a system of universal access with explicit guarantees for a group of diseases, known as Plan Auge. Under the plan, her country was implementing strategies that took account of the need for universal health coverage, in particular for vulnerable groups and for diseases meeting priority criteria, and included preventive activities. The plan currently covered about 60% of the disease burden and ensured access, timely treatment, financial protection and a recently incorporated quality guarantee for the population. Per capita health expenditure varied widely depending on whether the people concerned were covered by the private or public components of the Chilean health system. In addition, many people insured under the public health system were treated by private service providers covered by the public insurance. The out-of-pocket component, which in Chile was estimated at 40% but again varied widely, was an even more complex aspect of spending. In view of those conditions, her country supported the call for progress towards universal health coverage, integral care, solidarity and income redistribution.

Dr ROZITA HALINA TUN HUSSEIN (Malaysia) expressed strong support for multisectoral involvement to achieve universal health coverage. Malaysia, which was a sponsor of the draft resolution, suggested that WHO should strengthen the modalities for enhancing understanding among non-health government sectors and others of the importance of strong support and funding for health. WHO should develop an effective manual and training package for stakeholder engagement and strategic communication. In order to engage with non-health agencies, particularly financial and economic authorities, it would be useful to have summary indicators and "dashboard-type" user-interface modalities providing information on universal health coverage, health financing and equity status. Countries would need technical support to learn how to use such tools, draw the right conclusions and establish policy directions.

She commended efforts to foster sharing of experiences between countries and practitioners and suggested that WHO might wish to strengthen cooperation with networks such as the Joint Learning Network for Universal Health Coverage, which involved nine practitioner countries from the African, South-East Asia and Western Pacific regions. Budget constraints had made WHO less inclined to foster such forums, yet it was international agencies that had the capacity and opportunity to bring numerous countries together on common agendas. She also expressed support for WHO's efforts to develop other building blocks beyond health care financing, as they were important for achieving quality health care services and universal health care. WHO could go further by making tools readily available in the public domain, for example in the form of computer software for patient management systems and for monitoring and evaluation of efforts to achieve universal health coverage, and by helping Member States to establish legal and regulatory frameworks to enable good governance, enforcement, monitoring and evaluation of services in the private and the public sectors, patient safety and quality of care.

Mr KIM Young-hak (Republic of Korea) commended WHO for giving priority to universal health coverage and welcomed its collaboration with the World Bank to that end. The key to universal health coverage, as previous speakers had said, was financing strategies; Member States needed

support to develop appropriate financing mechanisms to ensure that people were not impoverished by the excessive cost of health care.

The Republic of Korea had introduced a financing mechanism for universal health coverage 25 years earlier but was still working to expand coverage. Universal health coverage was an ongoing undertaking; expansion must always be weighed against financial sustainability, and striking a balance between the two was a strenuous job that required public understanding and social consensus. Universal health coverage was an important means of achieving better health outcomes and should be one of the post-2015 health goals.

The Republic of Korea was willing to share its expertise and experience to help Member States develop their universal health coverage financing facilities, bilaterally and multilaterally. In that connection, it would make a voluntary financial contribution of US\$ 1 million annually for the next five years to WHO activities to that end.

The CHAIRMAN thanked the Republic of Korea for that contribution.

Mr LI Mingzhu (China) thanked the Secretariat for the help it had given Member States to realize universal health coverage. Thanks to the joint efforts of the Secretariat and Member States, great progress had been made towards universal health coverage worldwide in that regard. In China, basic health coverage had increased in the previous decade from less than 30% to more than 95%; it had also broadened in scope and covered more items.

WHO should clarify what was meant by universal health coverage, that is, what were the key components, what percentage of the population was covered, what percentage individuals would be required to pay, what the service package comprised, and what was an acceptable reimbursement ratio. The Secretariat should continue to support Member States in developing strategies for the introduction of universal health coverage that were based on national specifics, set a timetable and defined a road map for step-by-step progress. Legislation and regulations provided crucial institutional safeguards for the implementation of universal health coverage. Document A66/24 should therefore have recommended the adoption of legislation on universal health coverage so as to facilitate policy implementation. Finally, the Director-General should take steps to convey the importance of universal health coverage to nongovernmental organizations so as to encourage them to shift their investment focus to developing countries that required help in achieving that goal.

Mr JONES (Canada) said that universal access to health care was a fundamental principle of the Canadian health care system. He supported the efforts of the international community to extend universal coverage but recognized that countries could use different approaches to implement it. He commended the countries that had taken concrete steps to achieve universal health coverage and reduce inequalities. In the context of the post-2015 development agenda, Canada encouraged the emphasis that universal health coverage placed on strengthening the capacities of health systems as opposed to vertical approaches.

Mr HO (Singapore) endorsed Malaysia's view that the Secretariat had a unique role to play in bringing together Member States on the universal health coverage agenda. As underscored in the Secretariat's report, the achievement of universal health coverage had gained traction with the international community, and the push to include it on the post-2015 development agenda was a further demonstration of its close links with sustainable development and the ultimate goal of poverty eradication. The process of achieving universal health coverage was nonetheless complex, and every Member State should adopt the solution best suited to its unique circumstances. As mentioned by previous speakers, universal health coverage must be affordable and sustainable, it must ensure that nobody was denied good-quality health care because of the inability to pay, and it must encourage patients and doctors to choose effective health care that was appropriate to their needs. Each country must also design its own system for financing, whether through taxation, social insurance or a medical

savings fund, adopting the features that worked and refining them in the light of the changing environment.

Dr AL WAHAIBI (Oman), applauding in particular the plan of action to support Member States in developing financing strategies for moving towards universal health coverage, said that despite the critical shortage of health workers and the difficulty of retaining such workers in underserved areas, Oman was working hard to develop national human resources in various fields, in line with development plans. He echoed the comments made by the delegate of Bahrain concerning the challenges to health service delivery and affirmed the importance of sound management and an appropriate level of health spending.

Dr SHOHANI (Iraq) said that universal health coverage in Iraq was monitored through the national health account and other activities related to health economics, as had been recommended by a conference on development of the country's health system. Emphasis was placed on the need to balance economic feasibility and cost with the impact on primary health care services and their integration with secondary and tertiary services. The aim was to achieve universal coverage while keeping costs down through the application of quality-related components.

Ms ALI (Maldives) thanked the Secretariat for its leadership and support in helping Member States to move towards universal health coverage. The regional strategy for universal health care, approved by the Regional Committee for South-East Asia at its sixty-fifth session, would steer efforts to achieve evidence-based, equitable and efficient health systems focused on primary health care. During the Regional Committee session, Member States had emphasized the importance of public funding in ensuring social protection; expenditure on pharmaceuticals was one of the largest contributors to out-of-pocket payments in the Region, especially in small countries like hers, which were totally dependent on imported drugs, made extensive use of costly brand-name medicines, required low volumes and faced additional costs because of their geography. In Maldives, medicines accounted for 17% of total health expenditure, prompting the country to explore ways of reducing costs, for example by expanding the use of generic medicines and making bulk purchases. She expressed appreciation for WHO's support in that regard and urged the Secretariat to continue helping small Member States work on supply-chain management and bulk purchases of medicines of assured quality. Maldives had launched a universal health insurance scheme in 2012 to ensure the availability of a basic health care package for all citizens. It had also introduced telemedicine services in 39 islands across the country. However, the fragmented and dispersed nature of the country's islands and the high dependency on expatriate health care workers made providing access to quality health services extremely difficult. She supported the inclusion of universal health coverage in the post-2015 development agenda.

Mr KLEIMAN (Brazil) said that a universal, public, integral and equitable health system was a prerequisite for attainment of the Millennium Development Goals by 2015. In Brazil, where health was a right enshrined in the Constitution and a State obligation, the system had been improved in order to guarantee universal coverage. Simple measures had been taken in recent years to reduce costs and enhance efficiency, including strengthening management and assistance capacity, regulating private health plans and establishing a health industrial complex. Civil society participation in federal, provincial and municipal health councils had lent transparency to and broadened participation in the public policy process. In May 2013, the health ministers of Brazil, the Russian Federation, India, China and South Africa (the BRICS countries) had agreed to identify national institutions that would work with WHO to develop a monitoring framework to help countries track their progress towards achieving universal health coverage, which was a key means of promoting equity and a rights-based approach to sustainable development.

Mr ABDALLAH QASEM (Jordan), expressing support for the goal of universal health coverage, said that his country had made progress in that direction. The provision of appropriate, affordable and accessible health coverage for all was an economic challenge and an ongoing process. The question of sustainability required further consideration if success was to be guaranteed.

Dr DE ROSAS VALERA (Philippines) thanked the Secretariat for the support it provided to the Philippines and to other countries with regard to universal health coverage, which constituted her Government's strategy to improve access to affordable and quality health care and provide financial risk protection to all Filipinos, especially those who were poor. Key aspects of universal health coverage in the Philippines were the expansion of national health insurance coverage through a national Government-sponsored programme; the scaling up of preventive programmes and health promotion; and investment in infrastructure and the health workforce to improve clinical and management processes and regulate the quality of care. Providing coverage for neglected populations, including indigenous peoples, street families, orphans and people with disabilities, was a major challenge. Progress towards universal health coverage meant extending coverage not only of health services but also of the types of intervention that qualified for benefits. The payment mechanism required serious study, and interventions must be well developed and supported by a robust information system providing timely evidence for sounder decisions. The Secretariat was requested to support the promotion and use of health technology assessments and the strengthening of capacity to monitor financial risk and manage hospitals.

Dr TONG THI SONG HUONG (Viet Nam) said that in order to achieve universal health care in her country, the budget allocation for health would have to be increased to at least 10% of the total national budget, with priority being given to poor and near-poor populations, children under six years of age, ethnic minorities and social welfare recipients. Efforts would also have to be made to improve the network of health facilities, especially at the district and community level, to expand the benefit package and to improve financial protection for the insured. Universal health coverage was not about achieving a fixed minimum package, it was a process that needed to make progress on several fronts: the range of services available, the proportion of costs covered, and the proportion of the population covered. It should be included as a health-related development goal on the post-2015 development agenda.

Dr JAIN (India) said that India's health care system consisted of a mix of public and private health care providers, with service availability and quality varying considerably in both sectors. The availability of tertiary care in particular was a serious problem for many people, and out-of-pocket expenditure on health was very high. India's current five-year plan (2012–2017) set out a strategy for the gradual introduction of universal health coverage whereby total public funding for core health services would increase threefold compared with the previous five-year plan. Primary health care services would be strengthened, and the primary, secondary and tertiary sectors would be integrated. India remained committed to advancing its universal health care agenda.

Ms HARB (Lebanon) agreed that equitable access to good-quality, affordable health care services should be a cornerstone of the post-2015 development agenda, and stressed the importance of well-defined indicators for monitoring the progress of Member States towards universal health coverage. Lebanon had managed to lower out-of-pocket spending by adopting targeted policies and strengthening primary health care services. It could do still more in that direction, notwithstanding the limited public funding available. It called on WHO for support in finding the best ways of coordinating health service financing, given the presence of various financing mechanisms, multiple public funds and a strong private sector. Strengthening the health care system at all levels, on the basis of social protection and of health as a human right, required political commitment at the highest level.

Dr RODRÍGUEZ (El Salvador) remarked on the timeliness of the discussion, given that universal health coverage was a challenge in most countries during the current period of economic crisis and changing disease burdens. In El Salvador, health care reform was aimed at universal coverage, and great efforts were being made to increase the number of births attended by qualified personnel, to lower maternal mortality rates, to raise immunization coverage, to provide free health services and to lower out-of-pocket expenses. The reform process had tackled three problems: economic barriers, by providing free health care; geographical barriers, by bringing health services closer to the neediest to improve access; and the quality barrier, by improving the quality of care. International solidarity had been a key aspect of efforts to achieve universal health coverage. PAHO, for example, was currently supporting the establishment of a centre of excellence for integrated health service delivery networks in the Ministry of Health of El Salvador, in order to offer internships to people from countries in the Region that were working towards universal coverage, the aim being to compare and study the functioning of universal health care models.

Ms CHERQAOU (Morocco) expressed the hope that the Secretariat's report would serve as a basis for garnering more support for universal health coverage during the forthcoming discussions on the post-2015 development agenda, and would help to influence political decision-makers in Member States concerning the need to achieve that objective. The two challenges to be overcome were those of facilitating access to health services for all, without discrimination, particularly for people with limited incomes, and removing the obstacles to an equitable financing mechanism for all social groups. The health needs resulting from the demographic and epidemiological changes in some countries had prevented timely achievement of the goal of universal health coverage. WHO and other development partners should provide those countries with technical and financial support as part of a joint action plan for moving towards the goal. The current situation must therefore be examined further and health financing policies and strategies must be developed.

Mr ELIAS (Ethiopia) said that Ethiopia had made good progress with regard to primary health care coverage in the past decade through strong political commitment and efforts centred on community mobilization. Universal health coverage should be one of the main items on the post-2015 development agenda, and should be given high priority by the WHO Secretariat, development partners and Member States. Sustained support for the health system was needed to ensure that the population continued to have equitable access to primary health care. It was also important to have a long-term vision of how to transform the existing primary health care coverage in the light of the anticipated epidemiological and demographic changes. International organizations and Member States should work in harmony to establish sustainable health care financing systems in developing countries that ensured access, particularly for poor and marginalized communities, and equity in the face of economic fluctuations.

Mr PALOPOLI (Argentina) said that securing the right to health required bringing about improvements in the conditions in which people lived, grew and died, and hence in health determinants, as well ensuring an effective health system. Universal health coverage was an essential means of responding to and preventing disease. It should not refer only to health care services, however. It must be part of a broader framework comprising a renewed primary health care strategy and action on the social determinants of health. Making progress towards universal health coverage, understood as access by all people without discrimination to a minimum package of basic preventive, curative and rehabilitative medical services, and palliative care, implied improving the overall health of the population and protecting people from the financial risk associated with the payment of medical goods and services.

National health systems financed by general tax revenues and provision of services without payment at the point of care, when properly implemented, had been effective in reducing out-of-pocket costs and had proven to be sustainable and responsive in the face of adverse economic circumstances and the growing emergence of high-cost services. In Argentina, everyone (whether

nationals or foreigners) had health coverage, either through compulsory or voluntary medical insurance systems or by receiving care from completely free public establishments funded out of the public purse. Nonetheless, greater efforts were needed to ensure that all people had access to quality health services in accordance with their requirements. Document A66/24 stated that many families were impoverished by out-of-pocket medical expenses. Argentina's experience showed that public programmes financed with tax revenues facilitated access to health care by the most vulnerable, promoted health and indirectly redistributed income even more effectively than social security programmes. Countries would have to overcome many difficulties before they had fair and equitable health systems. That would require intense efforts that involved the commitment of all Member States and the support of the Organization and its regional offices.

The CHAIRMAN took it that the Committee supported the proposal to establish an informal drafting group in order to consider the draft resolution.

It was so agreed.

(For continuation of the discussion, see the summary record of the fourth meeting, section 2.)

The meeting rose at 17:15.