FIFTH MEETING

Friday, 24 May 2013, at 14:40

Chairman: Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)
later: Dr P.K. SINGH (India)
later: Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)

HEALTH SYSTEMS: Item 17 of the Agenda (continued)

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 17.2 of the Agenda (Document A66/23) (continued)

Mr PIPPO (Argentina) said that the main mechanisms generating incentives to promote research and development were based on competitive systems aimed at securing a monopoly income. When the expected value of that income was insufficiently attractive, commercial interest evaporated, leading to gaps in research and a lack of medicines. The draft resolution before the Committee reflected the consensus that had emerged from long and difficult discussions, and represented a useful step forward. Nonetheless, his delegation supported the position expressed on behalf of the Union of South American Nations that consensus was incomplete. Although progress had been made on setting up the observatory and promoting projects, further dialogue was needed in order to find a sustainable solution to the question of financing. He had noted the draft decision proposed by the delegate of the United States of America: if the draft resolution was adopted without amendment, it should be emphasized that the meeting proposed in the draft decision should be regarded as separate from that mentioned in subparagraph 4(7) of the draft resolution.

Ms CHEDEVILLE-MURRAY (France) supported the draft resolution. It provided a suitable framework for tackling the financing and coordination of research, particularly with regard to developing countries, but it did not settle every issue. France had made a commitment to provide support to the Secretariat in order to make progress, in particular in the establishment of the observatory. She also supported the draft decision proposed by the delegate of the United States of America; the suggested process would advance matters. She asked whether the technical experts from external stakeholders referred to could include experts from civil society and nongovernmental organizations and, whether the conclusions of the proposed meeting would then be considered and, if necessary, decided upon by the WHO governing bodies.

Ms VACA GONZALEZ (Colombia) said that her country had been pleased to participate in the discussions that had given rise to the draft resolution under consideration. During that 10-year process, enormous efforts had been made to agree on proposals that would close the gaps in the current model of innovation for health technologies. She recognized that the report of the Consultative Expert Working Group, the draft resolution and the proposal put forward by the United States of America all represented progress in that regard. Member States now had the opportunity to act, so that in the near future research and development incentives and the resulting innovations would respond to the health needs of most of the world's population. Colombia was committed to seeking and implementing specific solutions to the outstanding matters mentioned in the report and the draft resolution. She agreed that there should be discussions by governments and academics before the Sixty-ninth World

Health Assembly in order to clarify the current difficulties in innovation and suggest initiatives for the monitoring, coordination and financing of research and development.

The national development plan in Colombia had established the relevance of science, technology and innovation in the health field, and the Government had earmarked a significant percentage of resources derived from mining fees for health research projects. There was a national commitment to the mandate of the Health Assembly, as it provided an important opportunity to bring about coherence between national and global public policies with a view to taking up the challenge of universal health coverage that all countries had discussed fully during the session. Innovation was part of efforts to secure well-being and prosperity: it led to well-being when it was directed towards solving health problems that were relevant to countries, regardless of income; and it could create prosperity if it also facilitated measurable, simple and high-impact solutions that were consistent with promotion of the rational use of, and equal access to, technologies.

Mr KIM Young-hak (Republic of Korea) asserted that, in order to ensure that research and development met the health needs of developing countries, it was essential to expand international collaboration and joint research, and to build a network linking businesses and research institutes. During the discussions that had led to the draft resolution, agreement had been reached mainly on the monitoring of resources and information-sharing. Member States had differed in their views on the development of a convention on financing and coordination. The Secretariat should conduct a thorough feasibility study and examine implementation strategies before considering a global convention on health research and development.

Mr VON KESSEL (Switzerland) recognized the lack of investment in research and development on diseases that disproportionally affected developing countries, and backed the establishment of a global observatory that would improve the monitoring of resource flows and identify research and development gaps. The process should be implemented in stages, and the draft resolution under discussion was an important step. Development of demonstration projects would provide added value for continuation of the process and enable coordination and financing models to be assessed. Those projects should be used to implement the key principles and approaches described in the report and should build on existing structures to ensure rapid results. Models such as the Drugs for Neglected Diseases initiative and the Medicines for Malaria Venture were good examples that had proved successful and could provide inspiration. In that connection, Switzerland had decided to double its financial support to the Drugs for Neglected Diseases initiative for 2013 and considered that priority should be given to neglected diseases urgently requiring treatments, focusing initially on projects needing additional financial support for the final clinical trial phases, in order to speed up approval. In the longer term, less advanced projects should also receive financial support and be included in the global coordination process. By 2016, the chosen model must be shown to work by attracting donors and advancing selected research projects. Given its large pharmaceuticals industry and world-renowned public health, medical research and medicine approval institutions, it was important for Switzerland to find synergies and establish dialogue among the various players at the national and international levels, in order to guide and support research into solutions for neglected diseases. He was in favour of adopting the draft resolution without amendment.

Mr JONES (Canada) agreed that inadequate monitoring of research and development spending was a barrier to the coordination of efforts among research networks and funders; the global observatory was a robust solution. He supported the draft resolution and agreed with previous speakers that it was important to demonstrate concrete progress. He supported the convening by the WHO Secretariat of an advisory meeting of government representatives and technical experts to identify research projects, methodologies for coordination and ways of promoting advocacy for identified research and development needs as called for in the draft decision proposed by the delegate of the United States of America. Those were areas of critical importance that required further guidance.

Dr JUAN LÓPEZ (Mexico) reiterated her country's interest in all parts of the research and development agenda, particularly the attention to diseases that disproportionally affected the poorest countries. She commended the joint efforts of Member States that had resulted in the draft resolution now before them, which she firmly supported.

Dr SHOHANI (Iraq) said that it was imperative to progress towards new implementation mechanisms. In developing countries there was an urgent need for expansion of research and development, especially with respect to public health.

Ms HARB (Lebanon) urged adoption of the draft resolution because monitoring, financing and coordination of health research development were crucial to universal health coverage with affordable, good-quality medicines and health technologies where most needed. Establishing a global health research and development observatory and capacity-building for research institutions were of particular importance. She endorsed the view expressed by the delegate of China at the previous meeting that there could have been greater progress on the Consultative Expert Working Group's recommendations, but she nonetheless welcomed the draft resolution as part of a stepwise approach.

Dr MALECELA (United Republic of Tanzania) said that the draft resolution was the result of a hard-won consensus and a stepwise approach, and, if implemented, in particular with the establishment of a global observatory, would represent real progress. Although further dialogue was needed, a start could be made immediately. In the current focus on process, however, Member States should not forget outcomes, which must include more health products to combat the diseases of developing countries that disproportionally affected the poorest of poor people, through increased investment in health research and development, and improved coordination. Moreover, demonstration projects should be implemented with a view to subsequent scaling up. She supported adoption of the draft resolution without amendment and was willing to consider the draft decision proposed by the United States of America.

Dr MUTAMBU (Zimbabwe) appreciated the three key activities proposed in the draft resolution. However, a number of questions raised in the report of the Consultative Expert Working Group had not been resolved, and she therefore recommended that another open-ended meeting of Member States be held in 2014, rather than in 2016 as proposed.

Ms Jie-Ru TZENG (Chinese Taipei), commending the endeavours of the Consultative Expert Working Group, supported the setting of goals related to the global strategy and plan of action on public health, innovation and intellectual property. Improvements in monitoring, coordination and priority-setting in order to ensure sustainable funding for health research and development on Type I, II, and III diseases in developing countries would contribute to a fairer, healthier and more sustainable global society. Chinese Taipei recognized the need to promote capacity-building and technology transfer, as well as investment in health research and development, for diseases disproportionally affecting developing countries, as set out in the draft resolution. It therefore stood ready to work with the international community to share its health research technologies, achievements and experiences with developing countries, and to provide training and funding. A healthy and sustainable global health system required the participation of all members of the international community, together with the contributions of capable partners.

Mr EDWARDS (Council on Health Research for Development), speaking at the invitation of the CHAIRMAN, endorsed the call for the establishment of a global health observatory. However, such an endeavour could not simply be a supranational process; monitoring capacity must also be built from the bottom up. Countries would require support in mapping national research and development resources to enable them to assess whether those resources accorded with their priorities, and in identifying opportunities for strengthening national research management capacity. Moreover,

Member States would need to provide comprehensive and sustainable financing in order to avoid the risk of failure.

With regard to coordination, the report of the Consultative Expert Working Group had stressed the importance of supporting country-led research agendas. When a priority-setting process was designed at the global level, country agendas must be recognized and incorporated into the process, thereby increasing its legitimacy.

The observatory, the global priority-setting process and the demonstration projects would not materialize without financial commitment by Member States. The demonstration projects should incorporate the principle of de-linking the cost of research from the prices of the products, and should support the other principles outlined in the report, including strengthening the sustainability of research and development through capacity-building. The projects should move forward, rather than delay, the multilateral process. The criteria for judging their success should be their ability to test alternative funding models and incentives. There was no need for low- and middle-income Member States to wait until 2016 to take action on research and development financing. Their governments must continue to invest more in research and innovation, to reach out to like-minded neighbours, to form a consortium, and to create their own development fund for health research and development needs.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the consensus reached at the end of the open-ended meeting showed Member States' long-term commitment to comprehensive action and to delivering tangible results. He welcomed the idea of undertaking a systematic and standardized global review of unmet needs for health research and development related to Type II and Type III diseases, and of resource flows and research capacity. Understanding key research gaps was a precondition to addressing them, and the establishment of an observatory would offer a prime opportunity for achieving that goal. Members of his organization were continuing their engagement. A recent status report showed that research and development projects on the diseases concerned had risen by 40% in 2012 compared with the previous year. Moreover, 85% of those projects had been carried out through collaborative approaches. There was also an opportunity to work through existing initiatives, such as WHO's Special Programme for Research and Training in Tropical Diseases and WIPO's Re:Search initiative, and to learn from positive examples such as the recently established Global Health Innovative Technology Fund. His organization and its members were ready to provide expertise and further assistance in the process.

Mrs FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, commended the efforts made in developing the global strategy and plan of action. The draft resolution gave rise to some concerns, however, in particular with regard to the establishment of an observatory and the implementation of health research and development demonstration projects. The projects should be consistent with the principles outlined in the global strategy and plan of action and in the report of the Consultative Expert Working Group, including those of open innovation and de-linking the costs of innovation from the price of health products. Moreover, the terms of engagement with private for-profit entities should be clarified, so as to avoid replicating the current framework for conducting research, which was based on the principles of intellectual property.

While the actions proposed in the draft resolution represented small steps forward, fundamental changes in the innovative activity concerning health products required more decisive and bolder measures. Systems should favour human lives over patents and profits. A decade after the establishment of the Commission on Intellectual Property Rights, Innovation and Public Health to stimulate new research and development models that would address the unmet needs for new products, real action was still lacking. The global strategy and plan of action had constructed a roadmap to redeem the promise of the Commission's report. At the heart of its recommendations was the call to begin discussions on a global research and development convention. She was disheartened that the

proposed resolution fell far short of expectations by postponing consideration of such a convention, and urged Member States to set an early date for the initiation of discussions thereon.

Ms ATHERSUCH (MSF International), speaking at the invitation of the CHAIRMAN, recalled that her organization had welcomed the analysis and recommendations of the Consultative Expert Working Group, including the central recommendation that Member States should start formal negotiations on a research and development convention, as its field teams bore witness to the fact that the current innovation model was failing. There were still gaps where financial incentives were insufficient to encourage research and development and products were often priced out of reach. Innovation models should accord with health needs and should result in medical innovations that were affordable and accessible to all.

The operative part of the draft resolution appeared to lack ambition and precise definition. Despite the clear recommendations of the Working Group's report, WHO-level discussions on a global research and development convention were not scheduled until 2016, showing a failure to connect with recognition of the scale and urgency of the problem. The draft resolution proposed just three concrete actions. Those elements were important, and it was critical to ensure that they were designed and implemented in a way that built on the Working Group's conclusions. The work should be guided by the principles of innovation with access. Member States should show political will and ensure that technical and financial resources were provided to drive the proposals forward in a meaningful way. The draft resolution before the Committee was simply the starting point. Although the medium-term framework of the global strategy and plan of action was due to end in 2015, much of its ambition remained unfulfilled. Member States should consider the longer-term framework that would be needed to ensure affordable, needs-driven innovation, and meaningful negotiations on financing, coordination and the agreement of global norms should follow. In respect of the proposal from the United States of America, she said that it was important to learn from past mistakes and to institute a Member State-led process for the selection of technical experts, in order to ensure transparency.

Ms RASMUSSEN (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that the health needs of neglected populations could not be met unless Member States embraced a new research and development paradigm, in which the cost of drug development and product price were no longer linked. A commitment to innovative research and development models that yielded global public goods would benefit all countries, low-, middle- and high-income alike. A robust global health research and development observatory was needed with real monitoring, priority-setting and coordination capacities. She called for leadership from the WHO Secretariat and strong engagement and financing from Member States, to ensure that the observatory was not understaffed or underfunded, and that it genuinely advanced global understanding of critical research and development needs. Demonstration projects should be substantial and well financed. Open-source collaboration could spur more expansive and efficient research and development; the resulting innovations should be openly licensed for competitive, affordable production as global public goods. With regard to the proposed advisory meeting, Member States should reserve the right to propose and select advisers, who should represent a wide range of innovative thinkers and civil society actors. The advisory group should not be limited to establishment stakeholders that might have financial or political conflicts of interest regarding the maintenance of flawed elements of current innovation models.

Ms MELLEMA (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, recalled that the report of the Consultative Expert Working Group had expressed the urgent need to repair a broken research and development system with a comprehensive solution in the form of a global framework. However, the draft resolution did not provide a clear agenda towards that goal, and suffered from lack of ambition, clarity and concrete commitments. It did, however, contain some valuable elements that could be used as stepping stones. She welcomed the commitment to a

health research and development observatory and the demonstration projects. Nonetheless, she was concerned that the core principles and norms that should govern public health research and development were being lost sight of. Projects should advance work on those principles and norms, otherwise the subsequent process would risk being reduced to a weak coordination mechanism that put little money into an existing system that was failing. The demonstration projects should be used to harness the "push and pull" mechanisms that, according to the Working Group, best incorporated the principles of de-linkage and knowledge sharing. The proposed observatory should identify and provide guidance on the priority areas of needs-driven research and development, and data should, as far as possible and appropriate, be publicly accessible. The observatory should collect economic, legal scientific and health impact data on research and development spending by both State and non-State actors, but it could even be more ambitious and also collect actual research data. Given the urgency of the situation, she called on Member States to begin discussions on a framework for coordination, norm-setting and financing for health research and development in 2014. With regard to the proposal by the delegate of the United States of America, she said that it was important to avoid repeating mistakes, and any advisory group should be either consultative with governments or intergovernmental. When other stakeholders were involved, they should include civil society.

Dr KIENY (Assistant Director-General) thanked delegates and civil society representatives for their helpful and positive comments and assured the Committee that preliminary work was already under way.

The CHAIRMAN observed that during the discussion there had been significant consensus around support for the draft resolution without amendment, but the United States of America had tabled a draft decision, which had been circulated, and a number of delegates had referred to it in their interventions. She suggested that the Committee should examine the draft decision to clarify the text before proceeding to formal consideration of the draft resolution and subsequently the draft decision.

It was so agreed.

Dr ONDARI (Secretary) read out the text of the proposed draft decision, which read:

> Member States direct the WHO Secretariat to convene an advisory meeting including government representatives as well as, at the discretion of the Secretariat, technical experts from external stakeholders and the private sector, at the earliest possible date, in order to take forward action in relation to monitoring, coordination and financing for health R&D, in accordance with the terms of Resolution A66/XX. Such a meeting should particularly include members of the biomedical research community at a technical level and those currently involved in managing funds for research and development, with a mandate to (1) assist in the identification of translational research projects and the methodologies for coordinating research for the demonstration projects, in ways that emphasize the de-linkage of cost of R&D from product price; and (2) identify ways to promote advocacy for identified R&D needs, and seek voluntary financing for the demonstration projects.

Mr MAMACOS (United States of America) said that he had had further discussions with some delegates and that those of Ecuador and Argentina had proposed minor amendments to the text that did not change the substance significantly. Concerning the two points in the draft decision on which France had asked for clarification, he said that the technical experts from external stakeholders referred to should indeed include experts from civil society, and that the conclusions of the meeting would be reviewed by WHO's governing bodies. The word "advisory" had been intended to imply exactly that, and the meeting would not have any decision-making powers. The question of how "outside experts" should be defined was tricky, however. The idea was that it would be a technical meeting and therefore should be small.

The CHAIRMAN asked the delegate of the United States of America for details of the proposed amendments to the draft decision. He had said they did not affect the substance, but the Committee needed to see them in order to decide.

Miss PATCHAREEWAN PHUNGNIL (Thailand) welcomed the draft decision submitted by the delegate of the United States of America but proposed two amendments: deleting from the first sentence the words "as well as at the discretion of the Secretariat" and, in the second sentence, in point (1) after "translational research projects" adding the words "with high potential of success", and in point (2) replacing the word "identified" with the word "priority".

Mr ROSALES LOZADA (Plurinational State of Bolivia) thanked the delegate of the United States of America for seeking to build bridges between the various positions. He welcomed the suggestion of holding a meeting led by Member States but also attended by other interested groups, including researchers and people involved in biomedical research, and supported the proposed timing. The Union of South American Nations had problems with some of the language, however, a concern shared by most of the other Member States with which he had discussed the matter. In particular, he believed the reference to membership of the meeting being at the discretion of the Secretariat needed rewording. Furthermore, he proposed that the text should be amended by inserting the words "and sustainable" after the word "voluntary" in point (2).

Dr AL KALBANI (Oman) suggested displaying the text of the draft decision on an overhead projection to make it easier to see and discuss.

Ms HAGERTY (Ireland), speaking on behalf of the European Union, thanked the delegate of the United States of America for the proposed wording. She suggested that consideration should be given to deleting the word "translational" in point (1) of the proposed mandate, so that the proposed meeting could consider all appropriate potential projects.

Ms MATSOSO (South Africa) welcomed efforts to make progress, in particular the draft decision. The text of the draft decision required further refinement, however, to consolidate references to each of the three components: membership, projects, and subsequent action on identified projects. She agreed with other speakers that the wording concerning projects was too restrictive and proposed that the word "translational" should be deleted. She questioned the use of the word "advocacy" in point (2): in earlier discussions, the talk had been of setting priorities, and she considered that "advocacy" represented a watering down of that approach.

Mr PIPPO (Argentina) endorsed the observations made by the delegate of the Plurinational State of Bolivia. He proposed that the draft decision should be amended to refer to conflicts of interest in relation to the participation of other interested groups, and supported the proposed deletion of the word "translational" in point (1).

Ms HARB (Lebanon) expressed concern that the current wording of point (2) might jeopardize financing and proposed that the text be amended by replacing the words "voluntary" with the words "sustainable financing, including voluntary".

The CHAIRMAN suggested the establishment of an informal group of interested Member States, chaired by Ms Matsoso (South Africa), to refine the text of the draft decision further, and took it that the Committee would wish to adjourn the discussion of item 17.2 until the group had concluded its work.

It was so agreed.

(For continuation of the discussion and approval of the draft resolution and the draft decision, see the summary record of the sixth meeting, section 2.)

The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs: Item 17.4 of the Agenda (Document A66/25)

Mr ABDALLAH QASEM (Jordan) said that in the light of the shortcomings revealed in document A66/25 concerning the response to requirements under the WHO Global Code of Practice on the International Recruitment of Health Personnel, it would be necessary either to review the mechanisms for implementation of the Code or to investigate the reasons for those shortcomings, in order to clarify matters. Commitment to the Global Code should be reaffirmed in view of the tremendous impact it had on public health, particularly in developing countries.

Mr KOUYATE (Burkina Faso), speaking on behalf of the Member States of the African Region, said that the review of the implementation of three resolutions (WHA63.16, WHA64.6 and WHA64.7) relating to the health workforce had shown that little progress had been made. The advance towards universal health coverage would require the integration of health workforce planning, policy development and overall strengthening of health systems. The roadmap for scaling up the health workforce, adopted by the Regional Committee for Africa at its sixty-second session, encouraged collaboration between Member States, the African Union, the Global Health Workforce Alliance and development partners in drawing up and implementing detailed health personnel plans that focused on reducing the effects of migration, increasing production and devising mechanisms for retaining health personnel. All Member States should implement the three resolutions mentioned in the report, and the Director-General should support them in doing so.

Professor SUCHITTRA LUANGAMORNLERT (Thailand) noted that the WHO Global Code of Practice, despite being voluntary, had been implemented by a number of Member States, particularly in the European Region. There was nonetheless a great deal of room for improvement, notably in designating national focal points and increasing the number of reporting countries. Although international migration of the health workforce was not a major problem for Thailand, the country complied fully with the Code. The recruitment of foreign nurses and midwives from countries with a critical shortage of health personnel was strongly discouraged. As a response to a significant increase in demand for health services, Thailand had increased the numbers of health personnel trained and had implemented several effective retention strategies, including financial and non-financial incentives. Thailand gave support to neighbouring countries by training nurse educators, who then returned to their countries. Much could be learned from the European Union's experience of regional cooperation: it would be useful to replicate European practices in the Asia-Pacific region and ASEAN. Collaboration among key stakeholders within countries was also essential. Working together across sectors and professions as a team with patient-centred education and services would ensure holistic education and health systems. Education systems for human resources for health should be revised accordingly. A global movement on reforming health workforce education was under way and the Health Assembly was considering a draft resolution on the subject. She looked forward to seeing greater commitment to the WHO Global Code of Practice through effective implementation and reporting on its impact over the three years ahead.

Dr SWANN (Bahamas) said that the member countries of the Caribbean Community had generally incorporated the WHO Global Code of Practice into their recruitment and retention policies. Faced with the challenge of health workers migrating from the Caribbean region to more developed areas, those countries needed to build health sector capacity; plan and train for attrition; mitigate "push" factors, such as by increasing job satisfaction; and train sufficient people to meet national needs. Adequate health workforce numbers and competencies were prerequisites for the successful implementation of universal health coverage. Health ministries in countries throughout the Caribbean

were therefore working with stakeholders, tertiary education institutions and regulatory bodies to develop and implement appropriate health workforce strategies. He urged the larger international bodies to be mindful of the detrimental effect that recruitment practices could have on human resources for health in the Caribbean region.

Ms HAGERTY (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 and Armenia aligned themselves with her statement. A well-trained health workforce was one of the main pillars of a sustainable health system capable of achieving universal health coverage: the lack of health personnel represented the principal constraint on quality and coverage in low-income countries. The European Commission had therefore approved an action plan covering skills required, recruitment and workforce planning. A European Union joint action plan on workforce planning and forecasting had been launched in April 2013, which brought together some 50 partners from health ministries, public health institutes and professional organizations, many of which were connected to institutions in low-income countries.

The economic crisis had exacerbated the strain on health systems, and health workforce shortages had prompted an increase in the cross-border recruitment of health professionals. National policies, intersectoral structures and measures that included health workforce planning, distribution, retention and training were the key to providing sustainable health workforces. Steps should be taken to avoid overloading scarce human resources by duplication of tasks, poor integration of services, underuse of the skilled health workforce and diversion of highly specialized resources away from their specific skill sets. In the European Region, 80% of Member States had designated a national authority in accordance with the WHO Global Code of Practice; other Member States should endeavour to do the same. As the health workforce crisis was global and multidimensional, more efforts should be made to implement the Code. Reporting was of crucial importance for following up implementation, and the Secretariat was therefore requested to give Member States guidance and support with the necessary monitoring.

Dr WIDIYARTI (Indonesia) said that the key to success was to strengthen commitment and collaboration among stakeholders, including international agencies and professional organizations, in order to mobilize resources together and to implement a comprehensive health workforce plan in accordance with the role and function of each stakeholder. Indonesia had drawn up a human resources for health development plan for the period 2011–2025 using the country coordination and facilitation approach. The plan was expected to mobilize support from all stakeholders in relation to information systems, assessment of requirements, recruitment, distribution, incentive schemes to improve rural retention, pre-service and in-service training, continuing medical education, migration and quality control.

Indonesia was trying to speed up attainment of the Millennium Development Goals and was looking beyond them, but those efforts would require adequate support by a qualified health workforce. Nurses and midwives played critical roles as front-line personnel, working closely with the community at village level, and additional training of such persons in remote areas where there were no physicians available would help to save more lives. More than 30 000 new nurses were trained each year and there was a limit to the extent to which they could be absorbed into the Indonesian market. As a "sending country", Indonesia planned to adopt the WHO Global Code of Practice into national legislation as a means of controlling internal and external migration. The country had already designated a national authority responsible for implementation of the Code; sent its first monitoring report to WHO; and translated the Code into Indonesia's national language and distributed it to key stakeholders for further implementation. She suggested that all "destination countries" should also commit themselves to adopting the Code.

Mr TEGENE (Ethiopia) said that his country was implementing programmes to train large numbers of health professionals but such programmes required integrated support from the

Government, development partners, civil society and professional associations. He called on the Secretariat to facilitate collaboration between teaching institutions in different Member States. Countries that received health professionals who had migrated from developing countries had a moral obligation to support those in which they had been trained.

Mr DEANE (Barbados) asked what reasons lay behind the worryingly low number of reports submitted by Member States. He noted the lack of harmonization between the demand and supply of health professionals in the private and public sectors, a situation that did not facilitate workforce planning and projection of trends. Most countries already had systems for registering the health workforce, and so arguably something more substantial was required. In view of the role played by human resources in delivering health care, and given the drive towards universal health coverage, he urged the Secretariat to provide more guidance on the establishment of human resource observatories, workforce planning and research mechanisms.

Ms GIBB (United States of America) said that her country supported the goals of the WHO Global Code of Practice and had submitted its report in 2012. However, few other countries had designated a national authority to implement the Code and even fewer had submitted a national report. The Secretariat should investigate the barriers that Member States had faced and then provide technical guidance on improving data collection strategies. In addition, the national reporting instrument should be more refined; in its current form it was too broad and general to monitor migratory trends.

In the United States of America, medical and nursing school enrolment had been increased and health workforce programmes were being carried out to reduce the "pull" factors for health worker migration; they had already led to a drop in the migration of physicians and nurses. Similarly, a national centre for health workforce analysis had been set up to assess current and future health workforce supply and demand and to inform the public and private sectors of the country's recruitment needs.

Internationally, the President's Emergency Plan for AIDS Relief, the Peace Corps and other health-related development assistance continued to increase the pool of trained professionals and support training opportunities worldwide, especially in Africa. Moreover, in the first few days of the current Health Assembly, the United States of America had sponsored a side event with African colleagues on the Plan's Medical and Nursing Education Partnership Initiatives, which were dedicated to increasing educational capacity for training health care workers in sub-Saharan Africa.

Ms JAMEEL (Maldives), noting the importance of the WHO Global Code of Practice, said that there was a critical need for long-term health workforce plans and for more data on the health workforce at the national and international levels. More than 80% of health system personnel in Maldives were expatriates, but the turnover rate of expatriate physicians was so high that it was difficult to train and orient them towards national health needs. The resulting frequent service disruptions and negative impact on quality of care hampered efforts to achieve universal health coverage. Health workforce regulatory systems should be improved, with greater collaboration between governments and regulatory authorities. Nurses and community health workers played crucial roles in health promotion and disease prevention, especially in remote areas; it was important to strengthen those categories of personnel, to reduce dependence on expatriates, sustain services and progress towards universal health coverage. Given its lack of medical colleges and limited capacity for training health care workers, Maldives called on the Secretariat to continue supporting efforts to build national capacity and seek innovative solutions to the health workforce crisis.

Ms SORDAT (Switzerland) said that the WHO Global Code of Practice, a major success story of the Sixty-third World Health Assembly, was one of the Organization's most important instruments. Switzerland had submitted its first annual report in 2012 and, in cooperation with Germany and Austria, had translated the Code into German. The news that only approximately 50 countries had

submitted reports was somewhat worrying, especially considering that 36 of them were from the European Region, and also that one of the Code's main strengths was the monitoring mechanism designed to ensure its implementation. In preparation for the next round of national reports due in 2015, it would be sensible to consider the reasons for the low response, as the delegate of the United States of America had suggested, and to contemplate possible amendments, particularly regarding the questionnaire format and the involvement of civil society in the exercise.

Since the adoption of the Code, attention to health workforce migration seemed to have declined at WHO headquarters, and the responsible unit had been restructured and reduced in size. She wondered how the Code could be effectively monitored in those conditions, without losing the benefit of many years of experience. In her view, the Secretariat had not taken full advantage of the national reports submitted. How did it plan to use the data that it had received? What would be done to encourage the exchange of information based on those initial reports? If there was a lack of coordinated and comprehensive data, she suggested that WHO should continue to work closely with OECD to monitor trends in workforce migration. She reiterated the hope expressed by her delegation at the Board's 132nd session and at the recent meeting of its Programme, Budget and Administration Committee that work on the WHO Global Code of Practice would be adequately reflected in the Programme budget 2014–2015.

Mr COTTERELL (Australia) said that his country was working hard towards self-sufficiency of its health workforce and had invested more than 1.5 billion Australian dollars in health workforce reform, increasing training places for physicians, nurses and allied health professions. He urged the Secretariat to continue to work closely with OECD on data collection and workforce planning. OECD had considerable experience in monitoring workforce shortages and migration, and was also examining the impact of the global financial crisis on the health workforce. Many health workforce challenges were closely linked to those of universal health coverage, strengthening of health systems and whole-of-government approaches to health priorities, and Australia therefore encouraged the Secretariat to continue to work in those three areas.

Mr KLEIMAN (Brazil) said that health workforce shortages and migration were common across the world and required a coordinated response from international organizations, Member States, and stakeholders from different sectors that took into account the specific characteristics of each setting. Despite establishing a government department to formulate policies and taking various initiatives to increase the number of medical schools and improve the distribution of health personnel, Brazil was struggling to cope with shortages of health professionals in rural areas. Perhaps the action plan being developed by WHO and the European Union could be shared with countries outside Europe, to help them improve their ability to tackle common problems? He invited all Member States to discuss the matter further at the Third Global Forum on Human Resources for Health, to be held in Brazil in November 2013.

Dr SINGH (India) said that the availability of human resources remained a key constraint to the expansion of health service delivery: merely building infrastructure would serve no purpose unless more health care workers were available. There was a need to increase the number of nursing and medical schools, and to ensure that they were distributed in a geographically more equitable way. India was therefore striving to expand training in areas that were currently underserved and also the training of paramedical and community-level health workers. More attention should be paid to the collection of data on the current health workforce, especially outside the public sector. A national human resources observatory would address such a need. In addition, given the increasing burden of noncommunicable diseases, ageing populations and the high costs of health care, prevention and promotion must be balanced with curative services. Nurses and midwives could play a cost-effective role in boosting health promotion, disease prevention and self-care. India was committed to promoting the deployment of community nurses and midwives in both urban and rural areas, as a means of increasing access to health care and contributing to universal health coverage.

Ms Chun-Ying HUANG (Chinese Taipei) said that to avoid imbalances in the supply and demand of health professionals, Chinese Taipei's training and employment strategy involved conducting regular surveys to measure supply and demand, and subsequently adjusting health workforce development as required. As the critical care sector and remote areas currently faced a shortage of health professionals and severe work overload, steps were being taken to improve working conditions and to provide incentives to health professionals in those areas. Chinese Taipei hoped to establish long-term cooperative exchanges in the area of human resources for health.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the progress achieved in the reporting of health workforce shortages and migration, although its own surveys had shown that there was little documentation on the migration of pharmacists. The growing number of essential medicines and increased evidence of a lack of responsible use underlined the need for comprehensive planning and for education and training of pharmacists and their support workforce. His organization had welcomed the opportunity to work with WHO on the global survey on human resources for the pharmaceutical sector and was committed to hosting a global pharmacy observatory, to ensure that national and regional data on pharmaceutical human resources were continually updated and made available at the global level. In addition, it would soon be publishing its first global technical report on pharmacy education, prepared in collaboration with WHO, with data analysis covering more than 100 countries, and a qualitative analysis of the drivers affecting pharmacy education in 12 countries.

Ms DE PONTE (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, observed that Member States were responsible for implementing the Code and requested to report on progress, and WHO was mandated to ensure the collection of comparable and reliable data for monitoring and analysis. However, the country information gathered through the national reporting instrument was not accessible to organizations such as hers. Transparency of the contents of national reports was an essential requirement for increasing Member States' accountability and the involvement of civil society.

She expressed concern at the lack of sufficient dedicated capacities and financial resources within the WHO Secretariat and at the fact that regional offices sometimes had insufficient resources to liaise with Member States. Such shortages could adversely affect monitoring and reporting on implementation of the Code and on Member States' involvement in the process.

Implementation of the Code and of the necessary monitoring demanded commitment, leadership and a spirit of ownership of the Code at all levels. That spirit needed to be further developed, as the Code was one of the few regulatory instruments adopted by WHO, and its implementation would be seen as a case study of the ability of the Secretariat and its Member States to set global standards and regulations. The technical issue of implementation of the Code was therefore linked to the broader issue of WHO reform and the Organization's overall role in global health governance.

Ms ECCLES (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, welcomed the work done under resolution WHA64.6 to strengthen the health workforce and emphasized the need to include pharmacists as unique practitioners. Health care was increasingly focused on universal health coverage, and the theoretical and practical role of the pharmacist was changing accordingly, as observed in the 2012 Student Declaration on the Future of Pharmacists. There were many areas referred to by the Director-General in her opening address where tasks could be safely and effectively shifted to pharmacists. Additionally, giving priority to payment for pharmacy services rather than for the cost of drug products dispensed had been shown to save costs and incentivize workers by allowing them to perform additional roles. Pharmacists were among the most accessible of health care providers, and much greater use could therefore be made of their skills. She therefore called on Member States and their partners to promote opportunities and incentives for pharmacist-provided services when engaging in workforce planning, and to ensure that the professional education of pharmacy students was geared towards the future. Pharmacy students had

the strong sense of shared purpose referred to by the Director-General and were prepared to contribute to the skills mix required for optimum patient care.

Dr GUINTO (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, warned that the health workforce crisis, one of the main barriers to achieving universal health coverage, was in danger of becoming neglected, and should be included in United Nations discussions on health in the post-2015 development agenda.

Although data collection was difficult, accurate information on the nature and scale of migration, and its impact on health personnel planning, was crucial. Member States should develop robust monitoring systems, with the WHO Secretariat taking the lead and providing guidance. Human resources for health planning was essential in order to maintain quality while increasing quantity. Training health professionals required time, commitment, support and investment. Data-driven planning should inform national policies, in accordance with the WHO Global Code of Practice. The Global Health Workforce Alliance, a collaborative effort between different stakeholders, was currently underused and underfunded. Likewise, there was insufficient engagement of health profession students in making the national and global policy decisions on the health workforce that would govern their working lives. He called for a standardized reporting instrument and a framework to ensure timely reporting, identify gaps and inform policy responses; greater involvement of the Global Health Workforce Alliance in the coordination of national health workforce policy development and implementation; active engagement of health profession students; and, most importantly, long-term and comprehensive human resources for health planning by all Member States.

Dr KIENY (Assistant Director-General), thanking speakers for their contributions, acknowledged that although some progress had been made with implementing the WHO Global Code of Practice over the previous three years, greater efforts were needed. The Secretariat would continue to work with Member States and other partners to enhance support for and monitoring of implementation of the Code, to promote the establishment of designated national authorities and to improve country reporting. The Secretariat recognized the role of civil society in supporting the implementation of the Code; State and non-State actors should step up collaboration to reinforce the Code's relevance. The Secretariat had increased its collaboration with OECD to improve data collection in over 60 countries; the necessary strengthening of information systems on human resources for health would remain a priority for WHO's support to countries. It was also increasing collaboration with the Global Health Workforce Alliance to strengthen all relevant activities. The Secretariat had taken note of the request for a review of the current data collection instrument, with a view to collecting more detailed information on health workforce migration trends, and for the sharing of country reports.

The Committee noted the report.

eHealth and health Internet domain names: Item 17.5 of the Agenda (Documents A66/26 and EB132/2013/REC/1, resolution EB132.R8)

Dr MOHAMED (Maldives, representative of the Executive Board) said that, at its 132nd session, the Board had considered a report by the Secretariat that outlined progress on eHealth, the need for eHealth standardization and interoperability at all levels of the health system, and matters related to health Internet domain names. The Board had also commented on a draft decision on health Internet domain names submitted on behalf of the European Union and its member states. The Board had requested the Director-General to continue working with relevant bodies to protect the names of intergovernmental organizations and to emphasize that the allocation and use of Internet domain names should not compromise public health objectives. The Board had considered two draft resolutions, one on eHealth, the other on health Internet domain names, and had decided to combine

them into a single resolution, EB132.R8, which contained a draft resolution for consideration by the Health Assembly.

Professor AZAD (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, said that the establishment of a good health information system in the Region, with adherence to standardization and interoperability, would benefit many people and generate evidence that the rest of the world could learn from. The Region had already adopted a 10-point regional strategy on strengthening health information systems. Some countries had forged ahead with their plans for eHealth: for example, his own country had been recognized with an award by the United Nations in 2011 for digital health. To ensure their interoperability and durability, standards were needed on various aspects of emerging eHealth services.

He welcomed the National eHealth Strategy Toolkit, developed by ITU and WHO to promote standardization and interoperability, and hoped that such support would be continued and extended. The draft resolution contained in resolution EB132.R8 should be adopted as soon as possible, so that countries could design eHealth systems without wasting resources through duplication, faulty design and a lack of interoperability. However, eHealth and health Internet domain names were two completely separate matters and therefore warranted consideration in two separate resolutions.

Dr DIALLO (Mauritania), speaking on behalf of the Member States of the African Region, said that the agenda item under consideration was of particular significance to the African Region, the Internet playing a crucial role in health security, education and training of health personnel, research, and health networks. National health bodies should harness the full potential of health-related information and communication technologies, for exchanging accurate and up-to-date data in line with the International Health Regulations (2005). All African countries had implemented strategies that made use of innovative technologies for public health purposes, but even though the digital divide had been included in the Millennium Development Goals, African countries lacked the legal framework to develop national eHealth programmes and were beset by various other problems. The lack of an international legal framework hindered efforts to respond effectively to fraud, identity theft and the illegal promotion or sale of medicines. As standardization and interoperability of eHealth were other important factors for the development of eHealth across the world, the African Region expressed its support for the adoption of the draft resolution. Every effort should be made to develop, disseminate and implement interoperability standards with support from the Secretariat and Member States, although African countries would require regular funding, especially to procure and maintain the relevant equipment. It was unacceptable for management of the "*.health*" Internet domain to be entrusted to private entities; WHO should manage health-related domain names and work closely with the African Union and the Internet Corporation for Assigned Names and Numbers (ICANN) to draw up appropriate policies to protect the names and acronyms of intergovernmental organizations on the Internet.

Ms CHEDEVILLE-MURRAY (France) hoped that the follow-up measures to the draft resolution referred to by the delegate of Mauritania would keep Member States informed of the latest developments in the area of health-related Internet domain names and protection of the WHO name and acronym. Care should be taken to ensure that the resolution could still be fully applied within the new Internet "architecture" that was being introduced. Her delegation would be prepared to discuss the delegate of Bangladesh's proposal to split the resolution in two.

Mr SHI Guang (China) commended WHO on its promotion of eHealth as a cost-effective technological solution and the use of data standardization to improve the health outcomes of patients. Information and communication technologies had advanced so rapidly that many developing countries, including China, were struggling to keep their systems updated. Re-engineering of existing health information systems that were out-of-date was expensive and required considerable human resources. For that reason, China appreciated the words "as appropriate" in paragraph 1 of the draft

resolution, which implied that each country should evaluate the cost-effectiveness of health data standardization in its own specific circumstances.

The Secretariat should continue to collaborate with ICANN to ensure that public health interests were protected during the approval of new domain names. Given its technical, staff and management constraints, WHO should look to cooperate with other non-profit organizations to apply jointly for the "*.health*" domain name. At the same time, China supported WHO in its cooperation with ICANN and other organizations to ensure that the name and acronym of WHO were fully and permanently protected against inappropriate registration by third parties.

Dr Singh took the Chair.

Dr TSECHKOVSKY (Russian Federation) drew the Committee's attention to the importance of cooperating on national eHealth strategies under the aegis of WHO, as otherwise Member States might apply general measures without considering interoperability. He appreciated the Secretariat's work on Internet domain names and recommended that Cyrillic domain names should also be offered. The Russian delegation endorsed the draft resolution in its current form.

Mr VEGA MOLINA (Spain) said that his country was unwavering in its support for eHealth, as shown by its participation in the European eHealth project, epSOS. Although it was encouraging that WHO was setting eHealth as a priority and that the standards were sufficient to establish the technical infrastructure of eHealth, clinical health professionals must be more aware of them in order to apply them. He urged WHO to lead the way in guiding Member States to apply the standards correctly.

Reducing health inequalities was an ongoing task that entailed, among other things, increasing access to eHealth services. Countries and regions should be able to tailor eHealth to their prevention needs, and public and private incentives should be offered to guarantee interoperability. It would be beneficial to expand electronic databases containing patient records to create health registers that would be more reliable and easier to manage. Standardization was the key to making the information useful for teleconsultation between professionals in remote regions, and for research and assessment of public health. Similarly, scientific studies should be promoted on the efficiency, effectiveness, usefulness, benefits and cost–effectiveness of new technological solutions appearing on the market.

Mrs Tyson resumed the Chair.

Dr RANJAN (India) supported the draft resolution. The promotion of information and communication technologies would help to strengthen health systems. He welcomed the WHO/ITU National eHealth Strategy Toolkit and the development by WHO of a handbook on health data standardization and interoperability. The Secretariat should support Member States in integrating the application of health data standards and interoperability in their national eHealth strategies.

Ms JAMEEL (Maldives) supported the draft resolution and expressed appreciation for the WHO/ITU National eHealth Strategy Toolkit and the leadership role of WHO in the promotion and development of eHealth. In 2012, Maldives had approved its national eHealth strategy and was starting to apply the latest technologies in health care delivery, as shown by the introduction of telemedicine kiosks on 39 of the country's islands. A new integrated health information system was being developed with real-time data on health indicators to enable stakeholders and policy-makers to take evidence-based health care decisions and strengthen monitoring and surveillance. The online system would also include electronic patient records and permit patient access to information, which was particularly important for ensuring continuity of care in a geographically fragmented country like Maldives. It was difficult to guarantee specialized health services to the entire population in her country, so she urged WHO to continue its support for the development of eHealth systems and, in particular, telemedicine.

Ms ROOVÄLI (Estonia) said that eHealth was one of the cornerstones of an open society and that Estonia aimed to promote equal and transparent online access to all public services. In that spirit, Estonia had recently hosted regional consultations as part of the WHO efforts to develop the comprehensive handbook on eHealth standardization and interoperability. In 2012, a European Union health taskforce chaired by the President of Estonia had made a number of recommendations to the European Commission, including the following: to establish a legal framework for managing large quantities of health-related data and thus enhance integration of official and user-generated data; to support health literacy by ensuring that health data were available in a form that patients could easily understand; and to ensure that eHealth applications earned users' trust, since only then would users provide information for feedback on preventive care and for benchmarking and monitoring the performance of health systems. The foundation of each of those recommendations was standardization and interoperability of information. She therefore commended WHO's leadership in the area of eHealth and supported the draft resolution.

Mr PRIMADI (Indonesia) said that standardization and interoperability of health data strengthened health systems and were particularly important for collaboration between administrative levels and in the event of public health emergencies. Later in 2013, Indonesia would host a national workshop to incorporate standards into the national comprehensive health data dictionary. Indonesia stood ready to cooperate with the international community to provide training and technical assistance at the subnational level, particularly given that the country's local government offices had been given authority to develop area-specific strategies. eHealth was included in the country's national health strategic plan 2010–2014, and full implementation of eHealth services, including telemedicine and teleradiology, was considered essential, especially in the challenging remote provinces. He supported the draft resolution in its current form.

Ms BUHAT (Philippines) said that national authorities should address the emerging role of information and communication technologies in the delivery of health services and be aware of their benefits. Her country therefore strongly supported the draft resolution and was committed to developing its own national eHealth strategy, with the support of WHO and other international partners.

Ms BLACKWOOD (United States of America), expressing support for the draft resolution, said that health information technology could help to improve efficiency within the health care system and expand access to high-quality and affordable services for all. She welcomed efforts by regions and Member States to integrate eHealth into national programmes but noted that patients' privacy and interests must be central to all such strategies.

She agreed that the Internet domain names of intergovernmental organizations like WHO needed to be protected from third-party registration through the ICANN process. She therefore encouraged WHO to participate further in meetings of the ICANN Governmental Advisory Committee, which was the appropriate platform for the discussion of domain names by governments and intergovernmental organizations. At its most recent meeting in April 2013, the Committee had issued general advice on safeguards in a number of areas, including consumer protection.

Mr ABDALLAH QASEM (Jordan) suggested that with an increasing number of people looking online for health advice, global governance and internationally agreed criteria on the registration of health-related Internet domain names could inspire trust among users, prevent the further expansion of illicit markets for medicines, medical devices and inappropriate health products, and ensure that the online health environment was transparent, lawful and of high quality. WHO should continue working with appropriate entities such as ICANN, its advisory committees and United Nations organizations to protect the "*.health*" domain name.

Ms BELL (Canada) said that her country had participated in the surveys of the WHO Global Observatory for eHealth and the WHO compendiums on innovative health technologies and eHealth solutions, and it intended to continue contributing to such valuable initiatives in the future. It was important to understand the impact of investment in information and communication technologies on health care systems and health outcomes. Sharing best practices internationally would certainly strengthen the evidence base for eHealth.

With regard to Internet naming conventions, a balance should be found between harnessing the potential of the Internet and protecting users; even before the current process of allocating top-level names had been launched, concerns had been expressed that the initiative might open opportunities for fraud and that the Internet might be beyond the scope of national jurisdictions. Although it was too early to know to the extent to which ICANN would impose measures to protect the public, Canada agreed that WHO should have an influence on the governance of the "*.health*" domain name if it was allocated to one of the four applicants.

Dr SWANN (Bahamas) said that his country was taking steps to implement PAHO Directing Council resolution CD51.R5 on strategy and plan of action on eHealth. Over the previous 15 years the Bahamas had invested in the creation of an effective data network infrastructure, and 26 island groups would be on the network by the end of 2013. In the Caribbean region, it was a challenge to find suitable information and communication technologies for data collection and universal access to health care. Although private software packages met Health Level Seven International standards, they did not meet all regional health needs or facilitate interoperability. He therefore applauded the development of a WHO handbook on health data standardization and interoperability.

An integral component of the Bahamas' continuing education strategy for health care workers was eLearning, which had good potential for disseminating education and training materials and would be further bolstered once the data network for the public health sector had been completed.

He looked forward to the outcome of the work that WHO was pursuing with regard to health-related Internet domain names and protection of the names and acronyms of intergovernmental organizations and therefore supported the draft resolution.

Ms HARB (Lebanon) said that her Ministry of Health had established a national eHealth programme and had recently launched a mobile application with the aim of improving both access to health services and transparency. A mobile births and deaths reporting system and a mobile disease notification system were also planned in an effort to enhance vital statistics and disease surveillance, and an eLearning tool would be introduced to train physicians to record causes of death properly and to select appropriate ICD-10 codes. Given the importance of eHealth she called on WHO to continue to support her country in developing its health information system and to continue activities in the application of eHealth. She supported the draft resolution.

Ms CHEDEVILLE-MURRAY (France) proposed that the draft resolution should be amended by adding a paragraph after paragraph 2 along the following lines: "to continue working with the appropriate entities, including the Internet Corporation for Assigned Names and Numbers and its stakeholders, to ensure that decisions by those responsible for health-related Internet domain names take account of public health objectives and protect the name and acronym of WHO".

Dr DIALLO (Mauritania) said that, although he had no objections to the wording proposed by the delegate of France, it was important to make sure that the resolution formed a coherent whole. Was it wise to make additions to a text that had already been approved by the Executive Board? Speaking on behalf of the Member States of the African Region, he said that he would need to consult further on the matter with other Member States of the African Region.

Ms BLACKWOOD (United States of America) said that her delegation was also open to the delegate of France's proposal. However, at such a late stage of the Health Assembly it might be better to work within the context of the draft resolution proposed by the Board.

Mr Chin-Shui SHIH (Chinese Taipei) said that Chinese Taipei welcomed the draft resolution. Its universal health insurance programme demonstrated the progress it had already made in developing its eHealth system. Chinese Taipei fully understood the importance of using health information to strengthen the overall health care system, enhance health care quality, increase administrative efficiency and prevent insurance fraud. Chinese Taipei stood ready to share its experience in developing eHealth services.

Mrs BERGER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the Internet was an essential tool through which to access health information, and in countries with limited resources, it was sometimes the only way of accessing such information. Health information online should therefore be evidence-based, quality-controlled and trusted. However, none of the four applicants for the "*.health*" domain name belonged to the health community: all were commercial entities and intended to sell use of the name on a "first-come, first-served" basis. Awarding the management of the domain name to them would be tantamount to placing private interests ahead of the public interest. Supporting the objections against the "*.health*" applications by the ICANN At-Large Advisory Committee and the ICANN Independent Objector, she questioned whether the general safeguards proposed by the ICANN Governmental Advisory Committee would be properly enforced. Unless strong public health criteria could be applied, people's health would be placed at risk, especially in developing countries.

WHO's Member States and the public health community still had limited awareness of the potential harm of the ICANN process. It was urgent for them to understand the need to set up appropriate mechanisms to govern "*.health*" in the public interest, and to call for the global public health community to be given a central role. Member States and the Secretariat should act immediately in the Governmental Advisory Committee and other relevant forums to postpone the attribution of "*.health*", until the domain could be run in the interest of global public health.

Dr KIENY (Assistant Director-General) thanked Member States' delegates and civil society representatives for their contributions. She assured them that the Secretariat would address their concerns, especially in relation to health data standardization and interoperability, health Internet domain names, and the protection of the WHO name and acronym.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the sixth meeting, section 2.)

The meeting rose at 17:40.