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TEETH FOR THE TIGER

STRENGTHENING THE ROLE OF THE WORLD HEALTH ORGANISATION IN GLOBAL HEALTH

CONFERENCE REPORT
OCTOBER 2012

Teeth for the Tiger
Conference Report
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Strengthening the Role of the World Health Organisation in Global Health

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Introduction

The 2012 conference of Action for Global Health (AfGH) was organised by Oxfam Deutschland, terre des hommes, and Deutsche Stiftung Weltbevoelkerung (DSW) as German partners of the European network AfGH, in cooperation with action medeor, Action Against AIDS Germany and Church Development Service (EED).

1.0

THE 2012 CONFERENCE

The conference was a timely event to discuss the current reform process of the World Health Organisation (WHO) as it took place in between the Executive Board meeting of WHO in January 2012 and the World Health Assembly (WHA) in May 2012. The first part of the conference started with a keynote on the history and role of the WHO in the global health architecture, setting the scene for the following workshops. Two parallel workshops offered the opportunity to analyse the roles of WHO and the German Government in addressing the Human Resources for Health (HRH) crisis and Universal Health Coverage (UHC). WHO has claimed its leadership in these topics, in particular with the World Health Reports 2006 and 2010,[1] not only analysing the problematic situations but also identifying possible solutions. German Government development cooperation is actively working on both issues as well. There has been close exchange and mutual support between WHO and the German Government represented by the German Ministry of Health (BMG) to effectively address these two pressing global health issues.

The second part of the conference was devoted to a panel discussion on the role of WHO in the 21st century. The results of the preceding workshops informed the panel discussion.

Danuta Sacher, Chair of the Executive Board of terre des hommes, opened the conference and introduced the central questions of the conference:

* Can and should WHO become a leader within global health again?
* Where should the main emphasis of the reform of WHO be?
* What is the role of WHO in human resources for health and social protection?
* How can Germany best contribute to realising WHO´s goals and to strengthening the organisation?

In two parallel workshops participants worked on recommendations addressed to the German Government and WHO.

Danuta Sacher, terre des hommes

The recommendations include:

* The German Government should acknowledge the crucial role of WHO in the global health field and actively support its reform process. This includes issues like adequate financing and facilitating the representation of other actors, e.g. civil society.
* The German Government needs to address the present and future shortage of health workers in Germany and in developing countries. Coordination between different Government Ministries and participation of civil society are preconditions for the successful implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.
* The German Government should support the efforts towards UHC to ensure adequate and fair financing of health systems. UHC should also be at the heart of Germany's Global Health Strategy that is currently being developed.

The complete list of recommendations can be found in the annex of the conference report.

WHO: A Short Overview

Shortly after the end of World War II, the UN Conference on International Organisations in San Francisco decided to establish WHO as the directing and coordinating authority on international health in the UN system.

2.0

HISTORY

In April 1948, the Constitution of WHO was adopted. The same year, the first World Health Assembly established malaria, tuberculosis, venereal diseases, maternal and child health, sanitary engineering, and nutrition as priorities for the new organisation.[2]

WHO was successful in fighting several infectious diseases, for example yaws and smallpox. After three decades of mostly focusing on infectious disease control and prevention, WHO's working field was broadened by the 1978 International Health Conference on Primary Healthcare (PHC) in Alma Ata. At the conference, a milestone declaration[3] was passed by all WHO member countries that formally adopted PHC as the means for providing comprehensive, universal, equitable and affordable healthcare services in all countries. Access to basic health services was re-affirmed as a fundamental human right.[4] WHO's engagements in the field of UHC and also HRH are both closely linked to the understanding of health as a human right.

In the new millennium, WHO has still been very much involved in controlling epidemic outbreaks. These were for example the new influenza H1N1 and SARS – in the latter context the revised International Health Regulations[5] were developed. It has also increasingly paid attention to the prevention and treatment of non-communicable diseases which cause an increasing disease burden worldwide.[6]

In 2003, WHO negotiated the Framework Convention on Tobacco Control which illustrates well its treaty-making power.[7]

However, with the emergence of new global health initiatives and increased bilateral cooperation in the health sector since the beginning of the new millennium, WHO's role as the leading global health institution has been challenged.

STRUCTURE

One hundred and ninety-four countries form the membership of WHO. The WHO Headquarters are in Geneva. There are six Regional Offices for Europe, Africa, the Americas, Western Pacific, South Asia and the Eastern Mediterranean Region, working somewhat independently from the WHO Headquarters. WHO has almost 150 country offices worldwide that deliver technical assistance to countries.

The World Health Assembly is the highest decision-making body for WHO and meets once a year in Geneva. It is attended by delegations from all 194 Member States, led by their respective Ministers of Health. It decides on the policies and the programme budget of the organisation. The Executive Board is composed of 34 members who are elected for three-year terms. Germany has been represented in the Executive Board for the past three years (2009-2012). The main functions of the Board are to give effect to the decisions and policies of the World Health Assembly, to advise WHO and generally to facilitate its work. The Secretariat of WHO comprises almost 8,000 staff working at WHO Headquarters and Regional and Country Offices. The organisation is headed by the Director-General, who is appointed by the World Health Assembly on the nomination of the Executive Board.[8]

* *See WHO structure diagram overleaf*

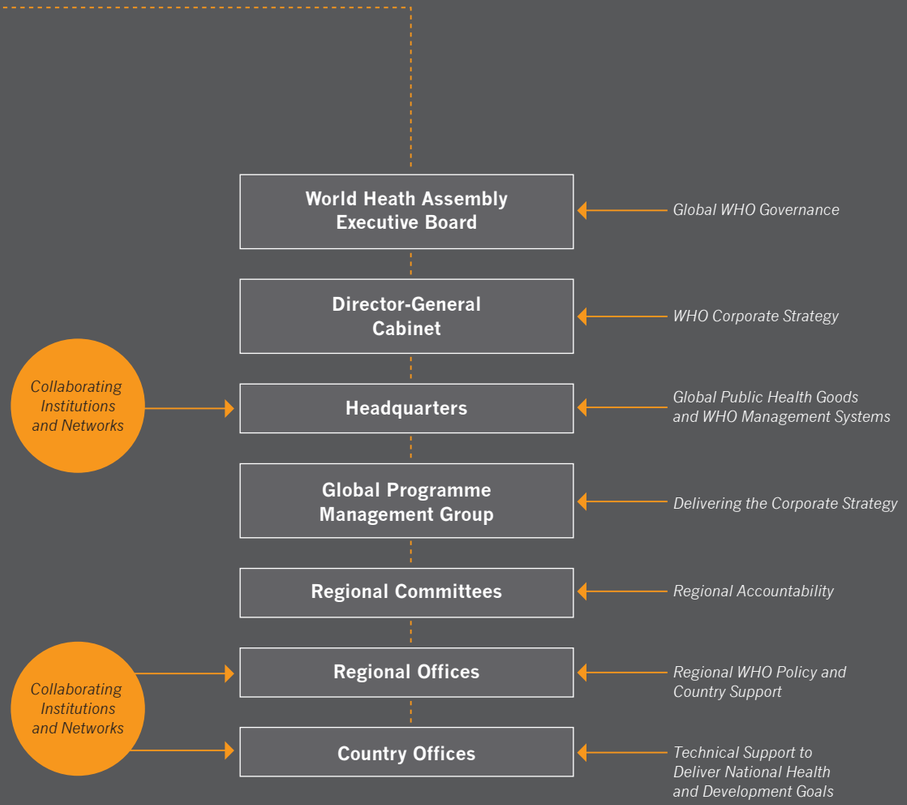
FINANCES

WHO is financed by two sources: the assessed contributions[9] by Member States and voluntary contributions. As of 2012, the largest annual assessed contributions from Member States came from the United States (US$110 million), Japan (US$58 million), Germany (US$37 million), United Kingdom (US$31 million) and France (US$31 million).[10] The majority of the voluntary contributions are also given by Member States followed by foundations (e.g. the Bill and Melinda Gates Foundation) and other UN organisations. The ratio between assessed contributions and voluntary contributions has shifted to the voluntary ones – now covering almost three-quarters of WHO's budget. The combined 2012–2013 budget proposed a total expenditure of US$3,959 million, of which only US$944 million (24%) will come from assessed contributions.

In many cases the voluntary contributions are earmarked for certain programmes that are not necessarily aligned to priorities of WHO as decided by the World Health Assembly. Using this mechanism, Member States can influence WHO's working agenda beyond their vote in the World Health Assembly or the Executive Board. The Director-General's report on the 'Future of Financing for WHO' stated that a larger share of the voluntary contributions should be flexible (not earmarked) and that Member States should "give serious consideration to the issue of increasing assessed contributions and, where appropriate, revisiting national policies that restrict their growth."[11]

WHO: A Short Overview

Organisation Structure



WHO's Current Situation and Future Options

Two internationally renowned experts of global health shared their perspectives on WHO's current challenges, its reform agenda and its potential future role. Key issues emerging in both presentations included questions of governance, funding and the politicisation of a once predominantly technical agency.

3.0

3.1

Dr. Devi Sridhar, University Lecturer in Global Health Politics, Department of Public Health, Oxford University

Dr. Devi Sridhar explored in her keynote speech the role of WHO in a changing global health architecture. According to her analysis, WHO is currently challenged in its role as the coordinating body of global health and is becoming less relevant. Due to financial problems, the organisation has been forced to lay off 300 staff. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is also facing problems. However, the Global Fund received a financial injection from the Bill and Melinda Gates Foundation, and it has been actively engaging in management reform.

The governance of WHO is very special compared to other UN organisations as it is based on the principle, 'one country, one vote'. While WHO used to be a rather technical organisation based on the professional expertise of its staff, it has lately become more politicised.

According to Dr. Sridhar, there are two old and two new multilaterals in the field of global health: The old ones being WHO and the World Bank, the new ones, the Global Fund and the GAVI Alliance. Both WHO and the World Bank depend on core funding (also called assessed contributions) and voluntary funding, and both the WHO and World Bank's share of voluntary contributions has increased compared to their assessed contributions.

The old and new multilaterals differ in various aspects. The new ones have multi-stakeholder boards and much narrower mandates, i.e. focusing only on selected aspects of health. They rely entirely on voluntary contributions and have different relations with the recipient of the funds, e.g. they don't have country offices, unlike WHO and the World Bank. The old ones gained their legitimacy as being part of the UN. The new ones gained legitimacy by their degree of delivery and performance, this being an important reason for donors to move to the new multilaterals.

"'Trojan multilateralism' is the new form of global health governance by financial control of a few." (Dr. Devi Sridhar)

The 'de facto' control of a handful of rich donors over the strategic directions of the new multilaterals as currently exemplified in the dramatic reform process of GFATM and increasingly over the old multilaterals is one of the fundamental shifts in global health. Dr. Devi Sridhar coined this new form of global health governance by financial control of a few, 'Trojan multilateralism'. These developments have different effects, for example on the prioritisation of working fields and on the focus on short-term versus long-term interests and results, which ideally should be balanced out – WHO's Framework Convention of Tobacco Control being an excellent example of how this can be handled. Additionally, the new multilaterals neither have the institutional capacity to keep up a global monitoring on health development nor to continue or even start work in areas that are currently not prioritised.

IMPLICATIONS FOR TODAY

Dr. Devi Sridhar summarised some of the functions of the old and new multilaterals as: provide financial support, work on rules and norms and deliver technical assistance. While WHO and the World Bank are primarily agencies of technical assistance with – in the case of WHO – a rather limited funding envelope – GFATM and GAVI are primarily funding agencies with almost no role in countries beyond financial risk management. In addition, WHO is responsible for the development of rules and norms. The example of the 'Global Code of Practice on the International Recruitment of Health Personnel' (CoP) in 2010[12] regarding the health worker crisis clearly illustrates the power of WHO as a normative organisation as it puts the interests of developing countries above the interests of rich countries. And in the case of UHC, the respective World Health Report 2010 puts health over financial interests.

For both cases it is true that no other organisation would have been able to accomplish this task.

Dr. Sridhar concluded by giving suggestions for the reform of WHO:

- Priorities for WHO's work need to be identified by deliberations at the World Health Assembly, and these priorities need to be funded appropriately. For this, the core funding needs to be appropriate, otherwise the institution is going to erode even further.
- The issue of accountability needs to be addressed on the basis of governments' accountability to their people.
- In general, the work of WHO needs to become more transparent (e.g. assigning an observer status to organisations in a less bureaucratic way, putting reports on the internet etc.).
- And lastly, WHO should continue to rely on and to strengthen its technical expertise. Its evidence-based work has been and still is its biggest asset.

3.2

Prof. Ilona Kickbusch, Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva, and Kickbusch Health Consult

In her keynote for the panel discussion, Prof. Ilona Kickbusch focused on WHO and global health in the 21st century. In her opinion, WHO originally had three functions which are not given enough attention in the current reform process:

- WHO's work is value-based as laid down in its Constitution.
- WHO works on health systems rather than health programmes.
- WHO has treaty-making power.

HEALTH IN A CHANGING FIELD

In the past, the global health field was characterised by the division of labour between WHO (norm-setting) and World Bank (financing). In the meantime, a new governance structure has emerged as the world has become multi-polar and poorer countries have gained a stronger voice.

Prof. Kickbusch's definition of global governance[13] stresses the characteristic of conscious acting/deciding/steering to influence the behaviour of autonomous actors. Between the 20th and 21st century, the structure of governance has been changing enormously. The 20th century was characterised by the creation of universal membership organisations (i.e. League of Nations, United Nations) that are based on the principle of 'one state, one vote'. In contrast, the 21st century is characterised by a new multilateralism in general, and more specifically by the creation of multi-stakeholder hybrid organisations and initiatives. The former governance model that was based on the pure cooperation between states is questioned; and organisations that are based on this original principle are faced with the question of how to act in a globalised and multi-polar world.

Health is one of the biggest global markets and at the same time threatens other big markets e.g. the tobacco industry's interests. In the framework of new multilateralism, not only does the huge variety of actors need to be dealt with, but also the question of how to bring these actors together. The goal would be to create 'good global governance', including delivery of results and fairness and addressing the distribution of power, ultimately resulting in more health and more justice.

Good global governance is challenged by a dynamic context of high complexity: the world order has become increasingly multi-polar, and the influence of the West is waning. Emerging economies, e.g. the BRICS[14] countries gain influence and power, and South-South-cooperation has become more important as well. Globalisation needs to be managed, since a new redistribution challenge is caused by the fact that the majority of poor live in the emerging economies (China, India, Thailand, Indonesia). Lastly, there are still the 'bottom billion'[15] and the question of fragile states that may need a totally different form of governance.

"WHO is now in the process of clarifying its mandate for the 21st century." (Prof. Ilona Kikbush)

Health is also increasingly perceived as part of foreign policy which is very clearly demonstrated by the Oslo Ministerial Declaration on global health in 2007.[16] In this declaration, the Foreign Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand affirm that they will focus on the impact of health in foreign policy.

THE CONCEPT OF GLOBAL HEALTH GOVERNANCE

Based on the global governance definition mentioned above, Prof. Kickbusch introduced her analogue definition of 'global health governance' that reads: "Global health governance is the conscious creating, shaping, steering, strengthening and using of international and transnational institutions and regimes of principles, norms, rules and decision-making procedures to advance the promotion and protection of health on a global scale through a wide range of autonomous actors."

In comparison, the term 'global governance for health' has to be understood in a much broader sense that goes beyond the health sector and includes other sectors as well (e.g. when addressing the social determinants of health). The term 'governance for global health' is the multi-level governance at the national and regional level, i.e. decisions by parliamentarians and governments in regard to global health issues.

WHO'S ROLE IN THE 21ST CENTURY

WHO has been undergoing constant changes in the six decades of its existence and is now in the process of clarifying its mandate for the 21st century. According to Prof. Kickbusch, this mandate would include: WHO's leadership as an agent of change in a multi-polar world; upholding of values, and the understanding that health is a global public good. This way, WHO would manage globalisation in the health field by setting norms and standards. Furthermore, it would act as a broker for health in other sectors and would stronger focus on policy issues.

At the same time, WHO is facing numerous health challenges in this decade, such as issues of inequality and social determinants of health, universal access to health systems, environmental issues, and non-communicable diseases. The crucial question regarding WHO's future mandate is whether the community of states is actually prepared to actively steer global health, especially after WHO has been weakened in recent neo-liberal decades.

Besides, a new transparency is needed between Member States and other stakeholders. It remains one of the open questions, how representation can be broadened and other actors can participate in a meaningful way. More transparency and accountability need to be ensured, and at the same time the financing of WHO needs to be put on a more stable basis to enable WHO to fulfil its normative function.

GUIDING PRINCIPLES FOR WHO'S REFORM PROCESS

Prof. Kickbusch concluded by highlighting three domains that should guide the WHO reform process:

- Values as spelled out in the WHO Constitution: the Constitution is very much value-based and refers to the right to enjoy the highest attainable standard of health as one of the fundamental rights of every human being. It clearly assigns governments the responsibility for the health of their people. This soft law[17] should not be under-estimated and should be used to bring health issues into other sectors.
- It will be important for WHO to move away from programmes and instead focus more on value-based policies and on systems (UHC being a very good example).
- WHO's role as directing and coordinating authority in international health work: The global health field is characterised by a multitude of actors. WHO needs to go beyond states and also address and involve other UN agencies, companies, NGOs, religious groups, faith-based organisations, sub-state units etc. to build strong coalitions for health.[18] WHO could become an agent of global change and thus it would be re-legitimised as intermediary between states, civil society and markets.
- WHO's treaty-making power: WHO can propose conventions, agreements and regulations, best illustrated by the International Health Regulations, the Tobacco Framework or the Global Code of Practice on the International Recruitment of Health Personnel that was adopted by WHA in 2010.

RECOMMENDATIONS TO MEMBER STATES

Lastly, she gave some recommendations to Member States including:

- Make use of the constitutional powers of WHO for advancing not only national but also global health. This could be done by a stronger focus on systems and polices, instead of projects.
- Take global health diplomacy seriously and develop national positions in a participatory way with stakeholders from other sectors and civil society (e.g. development of a national global health strategy).
- Ensure policy coherence and the creation of synergies at national and regional levels.

Workshops and Discussions

The two workshops and discussions are summarised here along with the presentations given by the key resource persons in each workshop.

4.0

4.1 Workshop I

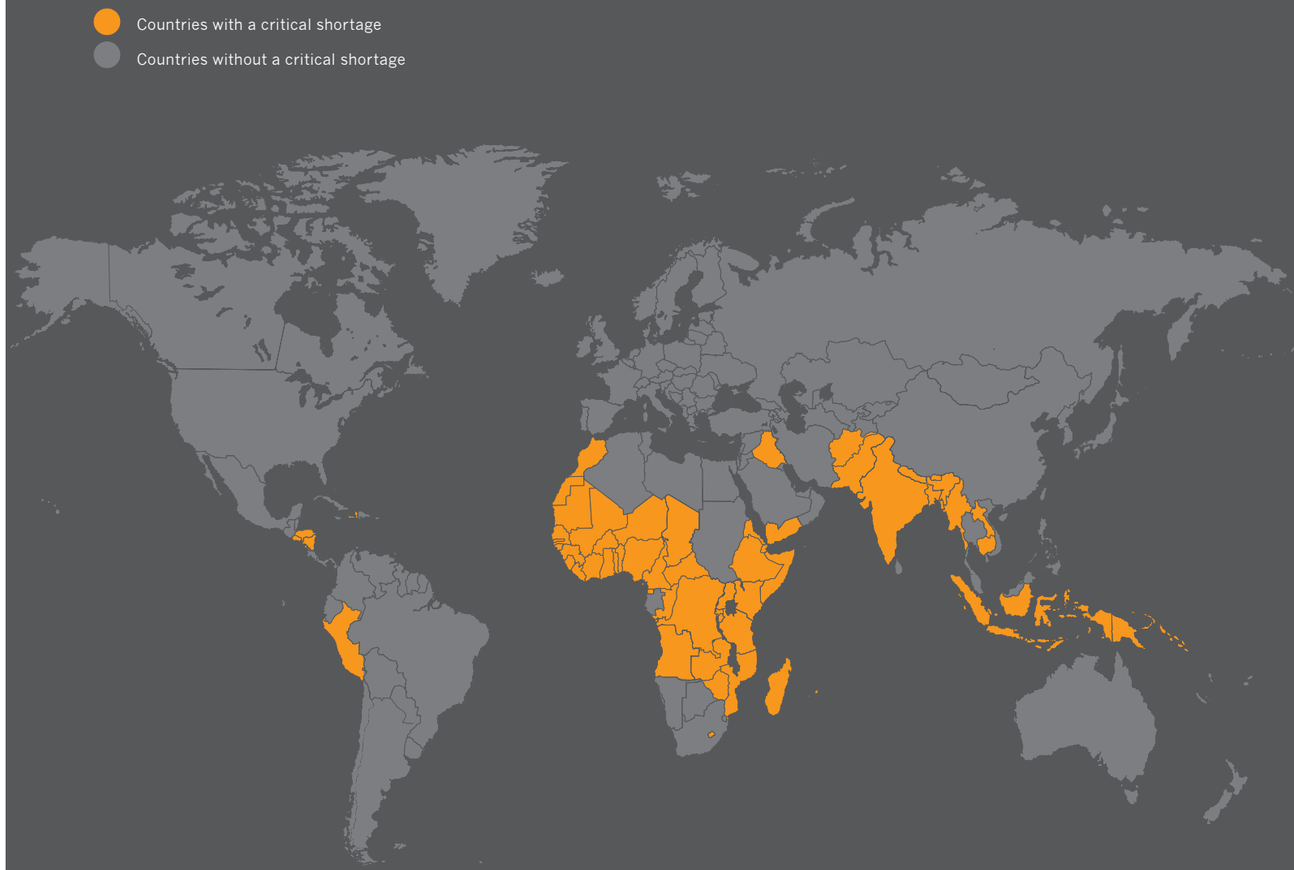
Human Resources for Health (HRH) The Role of WHO and the German Government in Addressing the Crises

DR. ANGELIC SOUSA
(Technical Officer, Human Resources for Health, WHO)

Dr. Sousa stated that HRH is a central issue for WHO as the world is facing a global shortage of health workers as highlighted by the World Health Report 2006. The shortage is especially critical in 57 countries, 36 of which are located in Africa. It is widely recognised that the health workforce crisis is the bottleneck for the implementation of health programmes and the improvement of health outcomes. The HRH shortage will also slow down progress towards achieving the health-related Millennium Development Goals (MDGs).

She explained that one of the main reasons for these shortages is that the majority of the countries are not training enough health workers to meet their needs. However several other factors aggravate the shortage of health workers within countries such as migration, unequal distribution of health workers within countries, low productivity, and imbalances in skill mix composition. She stressed that these problems are not exclusive to developing countries; many developed countries are likely to face severe shortages of health workers as a consequence of the financial crisis. Wealthy countries are experiencing budget cuts for social services, including health. In addition, emerging issues such as aging populations and chronic conditions will be an additional pressure and mean a higher demand of health services in developed countries

In order to tackle the HRH crises, other sectors need to be addressed at country level (e. g. education and labour sectors), and migration needs to be better monitored and managed on a national and global level.



57

countries with a critical shortage of health service providers

(doctors, nurses and midwives)

Data source: World Health Organisation (WHO)

"As Zimbabwe does not have enough funds to pay for its health workers, medical staff are going abroad." (Mr. Itai Rusike)

Dr. Sousa stressed that WHO is placing a strategic focus on HRH by:

- Providing evidence and information for policy and knowledge-sharing (including examples and approaches to address the crisis from countries) to guide policy development.
- Developing methods and measurement tools for evidence-informed decision-making (e.g. on the analysis of health workforce inequalities and health labour markets).
- Building capacity and supporting countries.
- Monitoring and assessing progress of HRH through improved and updated global and regional health workforce databases.[19]
- Linking UHC and HRH to reduce inequalities.
- Producing guidelines and policy options (e.g. guidelines on transformative education to scale up the production of health workers – being finalised in September 2012).
- Convening with partners including academic institutions to address HRH issues.

She outlined the steps that WHO is planning to take in order to move the HRH agenda forward:

- The review of current assets, strengths and weaknesses at global and regional levels and define HRH lines of work and priorities.
- The assessment of consequences of the identified WHO agenda on resources and staff.
- The identification of best approaches to influence other partners' agendas and actions in a way that they can contribute to a better HRH situation.
- The increase of financial resources available for the development of the health workforce.

Currently, WHO is in the process of organising the first reporting for CoP with the national authorities, including the German Federal Ministry of Health.

Discussions in the HRH workshop

MR. ITAI RUSIKE
Executive Director, Community Working Group on Health (CWGH), Zimbabwe

Mr. Rusike explained that after independence, Zimbabwe built a good health system which was weakened by the World Bank and the International Monetary Fund (IMF) structural adjustment programmes in the late 1990s. User fees are the biggest obstacle to access to healthcare. In 2011, Zimbabwe together with UNICEF and other international donors launched the Health Transition Fund to revitalise Zimbabwe's ailing health system and to improve maternal and child health.[20]

As the national health system does not have enough funds to pay for its health workers, medical staff are going abroad, for example, to Australia, Botswana, Canada, Malawi, South Africa, UK, US and Zambia. It is worrying that even primary care nurses, who only received two years of training, are recruited by the UK to work in care homes. The situation almost becomes absurd as health professionals from other countries come to Zimbabwe in the framework of bilateral agreements and work under better conditions than local staff (e.g. from Cuba, China, the Democratic Republic of the Congo and South Korea).

The migration of health workers is caused by push and pull factors. The push factors include mainly economic reasons such as poor living conditions, unemployment and very low wages. The pull factors include the needs of other labour markets and attractive migration policies in the countries of destination. UK and Australia still have – in spite of the Global Code of Practice – recruiting agencies (mainly targeting Registered General Nurses) in Zimbabwe. According to Mr. Rusike, most health professionals migrate for professional reasons, namely lacking resources, under-staffed and under-equipped facilities, heavy workloads and insufficient opportunities for career development. Moreover, people are dissatisfied with the almost non-existent (financial) benefits offered by the public sector.

He explained that there is almost no interaction at all between local NGOs in Zimbabwe and the Country Office or Regional Office of WHO. The only relationship that exists is via the People's Health Movement at the World Health Assembly and WHO Headquarters.[21] This causes a very limited flow of information between WHO and Zimbabwean civil society. Local NGOs only get their information with the help of Northern NGOs on whose solidarity they rely. The Zimbabwean Ministry of Health, on the contrary, engages a lot with local NGOs. The whole situation is made more difficult by the fact that WHO (like other international organisations) recruits staff from the national Ministry of Health and local NGOs. This hampers good cooperation between all actors as local people working for WHO at times don't feel free to act on the basis of their expertise, but may still feel underlying obligations.

Mr. Rusike closed his presentation by explicitly asking WHO to create a formalised platform to enable Zimbabwean civil society to participate and engage meaningfully in addressing the pressing health issues and to guarantee a flow of information.

In Germany, only 6.5% of health workers are from abroad and mainly from other European countries.

MR. BJÖRN KÜMMEL (Unit Z34, Multilateral Cooperation in the field of Health, Federal Ministry of Health, Germany)

Mr. Björn Kümmel stated that the reform of WHO has been one of the key issues of the German Ministry of Health (BMG) and its respective unit. The Ministry of Health led the negotiations on the 'Global Code of Practice on the International Recruitment of Health Personnel' (CoP). The unit Multilateral Cooperation (Z34) was designated as national authority for the implementation of CoP and the national reporting process.[22] Due to the fact that CoP was based on the concept of centralised health systems which actively recruit health personnel from overseas, he foresaw challenges in the reporting process for federal states with decentralised health systems and self-administered healthcare management. There are also various German institutions involved in the implementation of the CoP like the Ministry of Labour and Social Affairs, the Ministry of the Interior, the Ministry for Economic Cooperation and Development (BMZ) and the Federal Office for Migration and Refugees which could make reporting even more challenging.

In Germany, only 6.5 % of health workers are from abroad and mainly from other European countries. Germany is not a major recipient country for health workers because of language barriers and immigration regulations. Existing German legislation ensures the management of international recruitment from other source countries.

In the field of German development cooperation, the issues of health system strengthening and health workforce are priorities. BMZ is directly involved in health sector reform processes in 16 countries, and both BMZ and BMG are supporting the Global Health Workforce Alliance. To ensure better coordination between the different government agencies, an informal working group on HRH comprising BMZ, BMG, the German Agency for International Cooperation (GIZ), and representatives of civil society was established.

Mr. Kümmel acknowledged the need to explore the bilateral agreements with Albania and Croatia on the recruitment of health personnel in more detail. There is also the necessity to pay more attention to health workers from Eastern European countries, who increasingly work in the informal sector, i.e. taking care of elderly persons in private households.

The 'Global Health Strategy' that is currently developed in Germany will pay adequate attention to WHO and its role in global health.

MR. REMCO VAN DE PAS (Senior Health Policy Advocate, WEMOS Foundation, the Netherlands)

Mr. Remco van de Pas gave an overview on WHO and its role in the 'Global Code of Practice on the International Recruitment of Health Personnel' (CoP).

He shared three statements, the first one being:

* "CoP is a successful tool of modern global health diplomacy and demonstrates how health governance with a network and diverse range of actors can be conducted under coordination by WHO."

CoP is not a legally binding treaty like the WHO Framework Convention on Tobacco Control, but a non-binding code. However, it sends very important signals to all global players in health. Its development was coordinated by the WHO HRH unit and with active support by Kenya, Norway, the Philippines and South Africa. Input was given by civil society and professional and scientific institutions and the Code was negotiated and agreed upon during the World Health Assembly in 2010.

His second statement was:

* "The Global Code of Practice considers (global) health workforce development and health systems, but fails to include other crucial determinants that have an impact on migration and the development of health systems in both source and destination countries."

He explained that only 15% of the health worker shortage in Sub-Saharan Africa is related to external migration (South-South and South-North), while 85% of the shortage is caused by migration from rural to urban areas, from the public to the private sector and from primary to secondary healthcare.

There is an estimated gap of 4.5 million health workers to reach the MDGs. In many countries, the reasons include the lack of education opportunities or low salaries for health workers. For the time being, the EU still prevents the health sector of its Member States from recruiting health workers from outside the European Union as it fears a flood of cheap labour into its labour markets.[23] Migration is mostly taking place between European countries and it involves to a large extent auxiliary and chronic care health workers. However, if the European demography of an aging population with low-fertility rates is taken into account, it is quite obvious that in the future health workers from abroad will be required to work in care and cure sectors. Europe has to address this issue urgently, but with a focus on sustainability and human rights.

His third statement was:

* "The ongoing WHO reform demonstrates how important global health has become, and that Member States position themselves in what the future role of the organisation should be."

Healthcare has become an issue of global importance and is more and more dealt with as a key issue for global stability, economic growth, security and the realisation of human rights. Health as a global issue needs to be addressed by many actors and stakeholders, but WHO should have the coordinating role. Unfortunately, several Member States do contest the role of WHO and prefer instead to work bilaterally or via the G8, G20 and the global health initiatives.

Remco van de Pas, WEMOS Foundation, the Netherlands discussing with Sonja Weinreich, EED

Civil society is much-needed to advocate for UHC at global and also at national and local level. (Mr. Jean-Olivier Schmidt)

4.2 Workshop 2

Universal Health Coverage (UHC) The Role of WHO in Health Systems Financing and Social Protection

DR. DAVID EVANS
Director of the Department of Health Systems Financing, WHO, Geneva

Dr. David Evans identified the World Health Assembly (WHA) resolution on sustainable health financing which was initiated by Germany as a starting point for revisiting health financing.[24] The 'old' idea of universal coverage with health services was complemented by the 'new' idea of coverage with risk protection. This is based on the rather new understanding of the potential role of health financing systems to assure access to health services.

In 2010, the World Health Report on Health Systems Financing was published and in 2011, another WHA resolution urged WHO to develop an action plan to help countries implement the recommendations from the report.[25] Since the publication of the World Health Report, more than 60 countries have expressed their interest in receiving WHO support to evaluate where they are in terms of UHC and to review their health financing systems.

Dr. Evans put these developments in the context of general WHO reform. He stated that UHC is at present, and very probably will be in the future, a priority of WHO's work as it is part of health systems strengthening. Nevertheless, the work in UHC is not financed and staffed adequately. To at least partly satisfy the demands of technical support, the department has been trying to raise additional funds (at the cost of staff time). Until now, only the UK and France provide funding in support of WHO's technical support for countries. Other countries like Germany support the Providing for Health-Initiative (P4H) that also offers technical assistance in the field of UHC.[26]

There is only limited WHO staff capacity available to provide technical support to countries. Three staff members in the Geneva office plus staff from regional offices cannot satisfy the demand of 60 countries for technical support in the field of UHC. Under these circumstances, partnerships become very important, e.g. with civil society who advocate on country level for UHC reforms or with other initiatives like P4H.

Dr. Evans concluded by pointing out that lately a new rhetoric has started to dominate the discussion on global health. Rather than more money being provided, the same amount is to be used more effectively. In his opinion, the fact that low-income countries simply don't have enough money to provide health services to all who need them is neglected by key actors. This makes it very important to get UHC (and both aspects of it, namely services and financial risk protection) on the post-MDG agenda as part of sustainable development goals. This can only be done with the support of civil society and Member States.

MR. JEAN-OLIVIER SCHMIDT
Project Coordinator, Sector Project 'Providing for Health (P4H) Social Health Protection Initiative', GIZ

Mr. Schmidt explained that Germany has been playing a very active part internationally in the field of UHC in the past years through a whole series of activities: it started with convening a Ministerial Conference in Berlin in 2005 and supporting a report on sustainable health financing and universal coverage,[27] which received quite a lot of attention and resulted in subsequent regional meetings on more specific aspects of social health protection (e.g. follow-up conferences in Manila and Rwanda). Germany was also one of the promoters, together with France, of P4H which, launched in the context of the G8 Summit in Heiligendamm in 2007, aimed to increase social health protection. In 2010, the World Health Report on UHC and health financing was officially launched in Berlin, and Germany supported the resolution WHA 64.9 on Universal Health Coverage in 2011. At country level, Germany is also engaged through a whole range of programmes in the topic of social health protection.

In the meantime the P4H-Social Health Protection Initiative has been joined by WHO, the International Labour Organisation (ILO), the World Bank, the African Development Bank, Spain and Switzerland. Technical support at country level is delivered through this network of organisations and, in many cases, particularly closely with WHO. Mr. Schmidt stated that the demand by countries has been growing increasingly as UHC is more and more understood as a core element of overall development and also as a reaction to international resolutions such as WHA 64.9.

However, UHC still remains at times an elusive concept that needs to be operationalised to be fully grasped. He shared the example of Malawi to raise the awareness of the limitations of UHC and the obligations of donors and the Government of Malawi to translate a vision into reality. In Malawi, as per constitution and law, there is UHC as theoretically every citizen has a right to access an essential package of health in public facilities free of charge. But Malawi does spend only US$22 per year per person on health, resulting in limited services often not within geographical reach of the needy population. Malawi is already almost reaching the Abuja target of 15% of its national budget allocations going to Ministry of Health. But in order to realise the right to health, Malawi is going to need support from external sources for years to come. In the current situation, internal resources are simply not sufficient to finance an adequate health service package.

Despite financial obstacles, there have been some very promising approaches in the field of UHC, such as China, India and Indonesia. In the case of India, the Government opted for a pragmatic solution and provided as a very first step an insurance scheme for the poor called RSBY[28] under the Ministry of Labour, reaching out within a few years' time to 120 million people.

Countries that try to achieve UHC need unbiased technical advice on how to proceed and, in some cases, also financial support from outside. WHO and its P4H partners can play a crucial role in giving exactly that. However, civil society is much-needed to advocate for UHC at global and also national and local level. Efforts need to be made to ensure the integration of UHC into the Rio +20 Agenda and the post-MDG framework, as UHC is a vital part of the three pillars of sustainability.[29]

DR. ANDREAS WULF
Health Coordinator, Medico International

Dr. Andreas Wulf stated that WHO was the most legitimate place to engage for 'health for all' in general and UHC in particular due to its mandate (stemming from its constitution) and its broad membership. WHO resolutions have repeatedly referred to the right to 'health for all'. But to bring resolutions into reality, they need to go hand in hand with political commitment and sustainable funding. It is essential for governments to engage in serious efforts to redistribute resources and shape public services to make them accessible, affordable, user-friendly and non-discriminatory for all citizens.

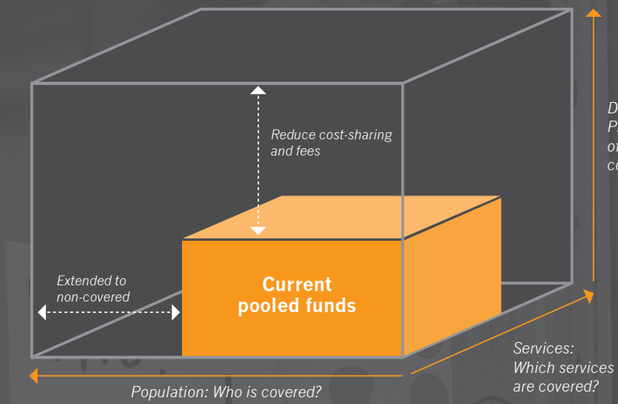
UHC goes beyond the rather narrow basic packages approach that was pursued by the Commission for Macroeconomics and Health, and it brings health rights back into the centre of the discussion on health systems financing. These discussions have long been dominated by economic 'sustainability' arguments and thus 'de facto' pushed the burden of health costs onto users with catastrophic consequences for the poorest.

UHC should be understood in relation to its three dimensions: coverage of people, coverage with services and reduction of direct payments. It goes beyond the social protection floor agenda that limits itself to setting minimum standards of social protection and leaves it to the individual to secure more protection by formal work contracts, private insurances etc. Instead, the mechanism of 'progressive expansion' of coverage that is suggested by the UHC model is based on the equity principle and thus contributes to the realisation of the right to health.

THREE DIMENSIONS OF UNIVERSAL HEALTH COVERAGE

Any discussion on health systems financing also needs to take into account the key factor of the service provider. If only the public funding for healthcare is increased while at the same time the profit-oriented and competitive model on the provider side is maintained, the risks of over-consumption of healthcare and of a one-sided focus on clinical care (and not on prevention and health promotion) increases. Good value-for-money going into healthcare must be assured (in WHO terms, 'More health for the money.')[30]

In the context of UHC, the WHO reform process has shown contradictory developments. The most apparent one is the fact that the demand of Member States for technical assistance for UHC cannot be satisfied, although UHC is defined as a priority. Universal coverage should not become an academic discussion or an economic exercise. In its report, WHO already included concepts on how to raise money nationally and also expand and secure UHC with the help of global solidarity mechanisms. Dr. Andreas Wulf recommended to Germany – as the leading country in the UHC debate – to continue its work on budget support in order to find sustainable funding options for the least developed countries.



3D

three dimensions to consider when moving towards Universal Health Coverage (UHC)

Panel Discussion on the Role of WHO in the 21st Century

The panel discussion opened the conference to a broader audience. The panel comprised Mr. Udo Scholten, Mr. Uwe Kekeritz, Mr. Itai Rusike and Prof. Ilona Kickbusch. It was facilitated by Mr. Tobias Luppe, Oxfam Deutschland and Action for Global Health.

5.0

IMPORTANCE OF WHO

Mr. Rusike reaffirmed the importance of WHO for civil society at the national level. Technical assistance by WHO was of crucial importance to developing countries and needed to be funded adequately. Other actors like the Bill and Melinda Gates Foundation and the World Bank also play dominant roles in global health. However, WHO should have the leadership in this arena as it is the only organisation that can lay down norms and values to which others are accountable. To reach this goal, WHO's dependence on donors' earmarked funds needs to be reduced as donors end up influencing WHO's agenda beyond its priorities agreed by all Member States. But, WHO also needs to acknowledge the need to involve civil society more and ensure coherence between its Headquarters, Regional and Country Offices.

FUTURE VISIONS

Mr. Scholten shared his vision of WHO in ten years' time. It is possible for WHO to sit in the driving seat for global health again if it undergoes a full reform process. It has to be acknowledged that WHO has been over-stretched and cannot react to all challenges. It must become more transparent, its priorities need to be defined by the Member States, and the responsibilities for the global, regional and national levels need to be spelled out more clearly. Germany has been supporting the WHO reform process actively.

Mr. Kekeritz agreed in principle with the reform ideas. However, he asked the German Government to acknowledge and address the problematic financial situation of WHO, stemming from neo-liberal ideologies that weakened multilateral organisations from the 1980s onwards. He expressed his hope that WHO will have reclaimed its central role by the year 2022 and will be able to fulfil its mandate to set norms and standards, to provide health-related data, and to intervene in crisis situations. In order to reach this goal, corruption and the growing dependence on private foundations need to be addressed.

Udo Scholten

Head of the Sub-Department for European and International Health Policy, Federal Ministry of Health

"WHO is not under-financed per se; it needs to undergo a reform process and focus on its main areas of work to keep its central role in global health."

Uwe Kekeritz

Member of the German Parliament, Alliance 90/The Greens Party, Chair of Parliamentary Sub-Committee on Health in Developing Countries

"The global health problems have increased. To effectively tackle them, entire health systems need to be strengthened. Investing in social systems including health means investing in future stability and peace."

FINANCIAL

Prof. Kickbusch explained that the assessed contributions have 'de facto' been stagnating over the years, resulting in an increased reliance on voluntary contributions. Voluntary contributions are attractive to Member States, as they don't require a long-term commitment and offer the possibility to influence WHO's working agenda by earmarking money for certain areas. This leads to the contradictory situation that Member States define working priorities in the WHO budget process but in a parallel process they might finance different priorities altogether.[31] A few countries already started playing a more positive role by having a long-term commitment and by providing voluntary contributions that are either not earmarked or that go intentionally into the working priorities of WHO.

MIGRATION OF HEALTH WORKERS

In regard to chain migration, Mr Scholten stated that the German Government was not actively recruiting health workers from other countries. There is only one bilateral agreement on health workers and that is with Croatia.[32] Seventy-five percent of non-German health workers come from other European countries and only 25% from outside Europe (many from Iran). He acknowledged that chain migration might be an issue. He referred to Poland as an example, as it is a source country for Germany and satisfies its own demand of health workers from Ukraine.

Mr. Rusike shared an experience from Zimbabwe concerning recently trained primary care nurses (basic training). While it was hoped that due to their very basic training they would not be attractive for rich country markets, they still migrate to the UK to work in homes for the care of the elderly. The salaries for doctors and nurses in Zimbabwe are below the poverty line which causes them to look for work abroad and to migrate to richer countries. Paradoxically, it is possible to offer the external doctors from Cuba and the Democratic Republic of the Congo much better packages to attract them to work in Zimbabwe.

Mr. Scholten was asked what Germany was doing to generate data on nursing staff and midwives to make sure that no active recruitment takes place in these fields. He explained that for nursing staff no data was available yet as they were not registered with a professional body. However, the Ministry of Health was trying to generate data with the help of the Federal Statistical Office.

only

25%

of Germany's non-German health workers come from outside Europe

Itai Rusike

Executive Director of Community Working Croup on Health (CWGH), Zimbabwe

"The countries of the South depend on the Northern countries' compliance with the Code of Conduct – otherwise the continuous loss of health workers will not come to a halt."

Prof. Ilona Kickbusch

Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva, and Kickbusch Health Consult

"A group of countries should tackle the problematic budget issue in a coordinated and systematic way."

Annexes 6.0

Based on the discussions and ideas generated during the conference, the organisers of the conference summarised the following recommendations.

RECOMMENDATIONS TO THE GERMAN GOVERNMENT

These recommendations were sent to the Parliamentary State Secretary of the Federal Ministry of Health, Ms. Annette Widmann-Mauz and to the Parliamentary State Secretary of the Ministry for Economic Cooperation and Development, Ms. Gudrun Kopp. The letter with the recommendations was supported by the Directors of the Church Development Service (EED), terre des hommes , Oxfam Deutschland, Deutsche Stiftung Weltbevoelkerung (DSW), Action Against AIDS, action medeor, medico international, medicus mundi, WEMOS Foundation, the Netherlands, Save the Children, World Vision Germany, and PLAN Germany. The letters were sent before the World Health Assembly May 2012.

RECOMMENDATIONS FOR THE STRENGTHENING OF WHO IN GLOBAL HEALTH

- Germany's 'Global Health Strategy' should assign a central role to WHO in global health. The systematic involvement of Civil Society Organisations (CSOs) in the further drafting process of this 'Global Health Strategy' is essential.
- Strengthening WHO requires increased commitment by its Members States. Germany should play a leading role politically and in terms of financial support in promoting WHO's important role as a genuinely multilateral institution in global health.
- Germany should continue actively supporting WHO reform. A principal outcome of the current reform should be increased transparency in decision-making structures and processes, actively involving civil society. Financial contributions and lobbying need to be made transparent while clearly naming potential conflicts of interest, e.g. induced by funding from private sources. More transparency would also go a long way to increasing credibility of WHO and its health-related expertise.
- An important outcome of WHO reform is the enhanced and systematic involvement of non-profit civil society in the organisation's structure and its decision-making processes. This accounts to both WHO Headquarters in Geneva and its regional and country structures. Other actors of global health, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, have developed models which can be drawn upon for reference.
- WHO's funding needs to be put on a more solid basis. It is absolutely essential that WHO's priorities – as set by the organisation – are sufficiently funded by regular contributions. Therefore Germany should spearhead the international discussion about a significant increase in core-assessed contributions for Member States. In the meantime, Germany should increase its non-earmarked voluntary contributions.
- The WHO reform process should support the organisation's leading role in overcoming the human resources for health crisis and improving equitable health financing. Massive increases of funding are needed for these areas of work in particular.

RECOMMENDATIONS FOR OVERCOMING THE GLOBAL CRISIS IN HUMAN RESOURCES FOR HEALTH

- Germany – like any other industrialised nation – should address its own lack of health professionals primarily by national investments rather than by recruiting foreign personnel.
- Bilateral agreements on the recruitment of health professionals need to be critically analysed with a view on their direct impact on local health systems and their potential to cause chain migration. The migration of health personnel is a global challenge and its impacts cannot be adequately assessed by looking at the migration between two countries only.
- The issue of circular migration needs to be critically assessed and its assumed positive effects on health systems in countries of origin and recipient countries need to be proven before the concept can be further promoted.
- In implementing the WHO 'Global Code of Practice on the International Recruitment of Health Personnel' (CoP), inter-ministerial and federal cooperation in Germany need to be strengthened. This is particularly necessary when negotiating bi- and multilateral trade agreements with potential impact on social sectors and when generating and analysing data on the recruitment of foreign health professionals in Germany.
- As clearly stated in CoP, civil society should be systematically involved in the German discussion and the country's reporting under CoP.
- A very high – and growing – number of non-registered foreign health professionals currently work in Germany, primarily in private care and nursing. Although not explicitly requested in its reporting obligations under CoP, the role of health workers in the informal sector should be reflected in Germany's report to WHO.

RECOMMENDATION ON HEALTHCARE FINANCING AND UNIVERSAL HEALTH COVERAGE

- With the publication of the World Health Report 2010, 'Health Systems Financing: the Path to Universal Coverage', WHO presented a comprehensive analysis including recommendations for the fair financing of health systems. These recommendations should be decisively supported by the German Government and be the basis for Germany's action domestically and abroad.
- Universal Health Coverage should become a cornerstone of Germany's 'Global Health Strategy'. Paying tribute to political coherence, UHC should guide all decision-making in relevant ministries and implementing organisations.
- (Financial) risk protection in case of sickness is a pre-condition for sustainable development. Germany should use the current discussions about the global development frameworks post-2015 to promote the key relevance of the health sector including strong indicators to measure UHC.
- To achieve UHC, many developing countries need reliable technical and financial support. It is therefore essential for Germany to encourage and apply stronger harmonisation of development partners when supporting national health strategies.
- Official Development Assistance (ODA) – including for health – should be increased massively with the aim to achieve the 0.7% target. Commitments should be longer term and disbursements more predictable.

Annexes 6.1

List of Abbreviations

BMG	German Federal Ministry of Health
BMZ	German Federal Ministry of Economic Cooperation and Development
CoP	Global Code of Practice on the International Recruitment of Health Personnel
DSW	Deutsche Stiftung Weltbevoelkerung
EED	Church Development Service
GAVI	Global Alliance for (tdh) Vaccines and Immunisations
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	The German Agency for International Cooperation
HRH	Human Resources for Health
IMF	International Monetary Fund
MDG	Millennium Development Goal
NGO	Non-Governmental Organisation
PHC	Primary Healthcare
P4H	Providing for Health
UHC	Universal Health Coverage
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organisation

6.2

List of Participants

Surname	First Name	Company/Organisation
Abendschein-Angerstein	Tanja	Wissenschaftszentrum Berlin für Sozialforschung
Aleman	Evelyn	Freelancer
Al-Sahhoum	Rania	Church Development Service (EED)
Angenendt	Steffen, Dr.	Stiftung für Wissenschaft und Politik (SWP)
Backhaus	Johannes	World Vision Deutschland e.V.
Barber	Corey	Ärzte ohne Grenzen
Becker	Charlotte	Berlin School of Public Health, Charité
Bischofberger	Dieter, Dr.	Zahnärztliche Entwicklungshilfe in Ländern der 3. Welt
Bitzer	Jochen	Difäm
Braeseke	Grit	IEGUS Institut
Brandt	Lisa	Sachverständigenrat für Integration und Migration
Buttmann	Nina	
Cohrs	Tanja	Ärzte ohne Grenzen
Dahlman	Anna	Deutsche Stiftung Weltbevölkerung (DSW)
Daudin	Mickaël	Ärzte ohne Grenzen
Diefenbacher	Albert, Prof. Dr. med.	Evangelisches Krankenhaus Königin Elisabeth Herzberge
Dombo	Eva	Büro Harald Leibrecht
Dreezens-Fuhrke	Joyce	Consultant, HIV/AIDS and Disability
Dworack	Sandra	Oxfam Deutschland
Engelking	Julia	Freelancer
Erlingsen	Katrin	Seek Development
Ernst	Reinhild-Renée, Dr.	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
Esser	Rika	Christoffel Blindenmission
Evans	David, Dr.	World Health Organisation (WHO)
Fatth	Waleed	Berlin School of Public Health, Charité
Fernando	Milena	Büro Harald Leibrecht
Frisch	Philipp	Ärzte ohne Grenzen
Funkenberg	Tanja	terre des hommes/Action for Global Health
Fürst	Barbara	Save the Children
Gäbler	Tina	terre des hommes/Action for Global Health
Gomes	Marco	Centre for Health Policy and Innovation
Görgen	Helmut	
Gotthardt	Frank	Merck KGaA

Annexes

6.2

List of Participants

Surname	First Name	Company/Organisation
Gurinova	Alexandra	Deutsche AIDS-Hilfe
Haas	Christiane, Dr.	Deutsches Rotes Kreuz (DRK)
Haase	Mareike	terre des hommes/Action for Global Health (Chair)
Höfer	Nadja	Berlin School of Public Health, Charité
Holtz	Verena	
Jahn	Albrecht, Prof.	Institute of Public Health, Universität Heidelberg
Jeantet	Annick	Global Health Advocates, Action for Global Health (Chair)
Kassid	Samia	Plan International e.V.
Kekeritz	Uwe	Deutscher Bundestag (Speaker)
Kickbusch	Ilona, Prof.	Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva, and Kickbusch Health Consult (Speaker)
Kinnicutt	Eleonora	Berlin School of Public Health, Charité
Kirsch-Woik	Thomas, Dr.	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
Kirthi	Ramesh	
Klieme	Paul	Universities Allied for Essential Medicines (UAEM)
Köhler	Carsten, Dr.	Eberhard Karls Universität Tübingen/Institut für Tropenmedizin
Kreischer	Stephan	Welthungerhilfe
Kümmel	Björn	Bundesministerium für Gesundheit (Speaker)
Le Mentec	Rozenn	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
Lohner	Alexander, Prof.	Misereor
Luppe	Tobias	Oxfam Deutschland/Action for Global Health (Chair)
Menzel	Celina	Bundestagsbüro Dr. Marlies Volkmer
Möller-Frentzen	Frederike	action medeor
Nien-tzu	Ting	Berlin School of Public Health, Charité
Owsianowski	Sophia	Humboldt-Universität Berlin
Ramme-Fülle	Beate	Aktionsbündnis gegen Aids (AgA)
Reitenbach	Dagmar	Bundesministerium für Gesundheit
Rüppel	Joachim	Missionsärztliches Institut Würzburg
Rusike	Itai	Community Working Group on Health (GWGH) (Speaker)
Sacher	Danuta	terre des hommes (Speaker)
Scheffler	Katharina	Stiftung Weltbevölkerung (DSW)
Schliebs	Maike	Stiftung Weltbevölkerung (DSW)
Schmidt	Jean-Olivier	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) (Speaker)
Schmitz	Susanne	action medeor
Scholten	Udo	Bundesministerium für Gesundheit (BMG) (Speaker)
Schwienhorst	Eva-Maria, Dr.	Missio Würzburg (IPPNW)
Seifert	Susann	PlaNet Finance Deutschland e.V.
Smith	Alan	Interact Worldwide/Action for Global Health
Sousa	Angelica, Dr.	World Health Organisation (WHO) (Speaker)
Sridhar	Devi, Dr.	University of Oxford (Speaker)
Stelter	Romina	Gesellschaft für Internationale Zusammenarbeit (GIZ)
Stiefler	Susanne	FU Berlin
Thiemann-Huguet	Nathalie	World Vision Deutschland e. V.
Tung Chan	Yan	Ärzte ohne Grenzen
Uellendahl	Fiona	World Vision Deutschland e. V.
Urwantzoff	Nina, Dr.	Misereor
van de Pas	Remco	WEMOS Foundation, the Netherlands (Speaker)
Volkmer	Marlies, Dr.	MdB SPD
von Borries	Bodo	Verband Entwicklungspolitik deutscher Nichtregierungsorganisationen e.V. (VENRO)
Waldherr-Ifada	Ruth, Dr.	Berlin School of Public Health, Charité
Wallraff	Lena	Bundesministerium für Wirtschaftliche Zusammenarbeit und Entwicklung
Weinreich	Sonja, Dr.	Church Development Service (EED) (Chair)
Weisser	Evamaria	Büro MdB Uwe Kekeritz
Wendling	Birgit	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ)
Whitehouse	Katie	Berlin School of Public Health, Charité
Winkelmann	Christine, Dr.	Consultant
Winter	Clara-Sophia	Internationale Ärzte für die Verhütung des Atomkrieges
Wulf	Andreas, Dr.	medico international (Speaker)

Endnotes 7.0

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7 http://www.who.int/bulletin/volumes/88/2/10-075895/en/.

8 WHO homepage on governance: http://www.who.int/governance/en/index.html.

9 The core funding of specialised agencies is through assessed contributions which is normally based on the UN rating system and calculated on the basis of countries' national income. The calculation also takes into account other factors including maximum and minimum ceilings.

10 http://www.who.int/about/resources_planning/2012_2013_AC_summary.pdf.

11 http://apps.who.int/gb/ebwha/pdf_files/EB128/B128_21-en.pdf.

12 http://www.who.int/hrh/migration/code/code_en.pdf.

13 Krasner 1983, quotation based on: Cooper, A.; Kirton, J.; Stevenson, M. (2009): Critical Cases in Global Health Innovation. In: Cooper, A, Kirton, J. (eds.): Innovation in Global Health Governance, p.11.

14 Brazil, Russia, India, China, and South Africa.

15 The term is taken from the book: Paul Collier (2007): The bottom billion.

16 http://www.who.int/trade/events/Oslo_Ministerial_Declaration.pdf.

17 Soft law refers to rules that are not strictly binding but have normative content. In the context of international law, soft law refers to guidelines, policy declarations or codes of conducts.

18 This is called Mega diplomacy by Parag Khanna 2011, cf.: http://www.globalhealtheurope.org/index.php?option=com_content&view=article&id=408:parag-khanna-on-mega-diplomacy&catid=87:other-media&Itemid=146

19 Global Atlas of the Health Workforce: http://apps.who.int/globalatlas/default.asp.

20 http://www.unicef.org/infobycountry/zimbabwe_60380.html.

21 http://www.phmovement.org/.

22 To facilitate the process a new email address was set up: whocode@bmg.bund.de.

23 In the past (2000-2008), a lot of health workers from Africa were recruited by the UK but currently EU states are quite hesitant to allow new health workers and migrants from outside the EU due to higher domestic unemployment rates. Nevertheless, there is still temporary migration.

24 WHA Resolution 5833 (2005): Sustainable Health Financing, universal coverage and social health insurance. (http://www.who.int/health_financing/documents/cov-wharesolution5833/en/index.html).

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26 P4H was initiated by Germany and France 2007 in the context of the G8 meeting in Heiligendamm.

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29 The three pillars are: social, economic, and environmental.

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The goal of AfGH is increased support from European decision-makers of full funding of health, of strengthening health systems and ensuring fair access to healthcare, accountable and responsive to the needs of vulnerable and poor people.

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