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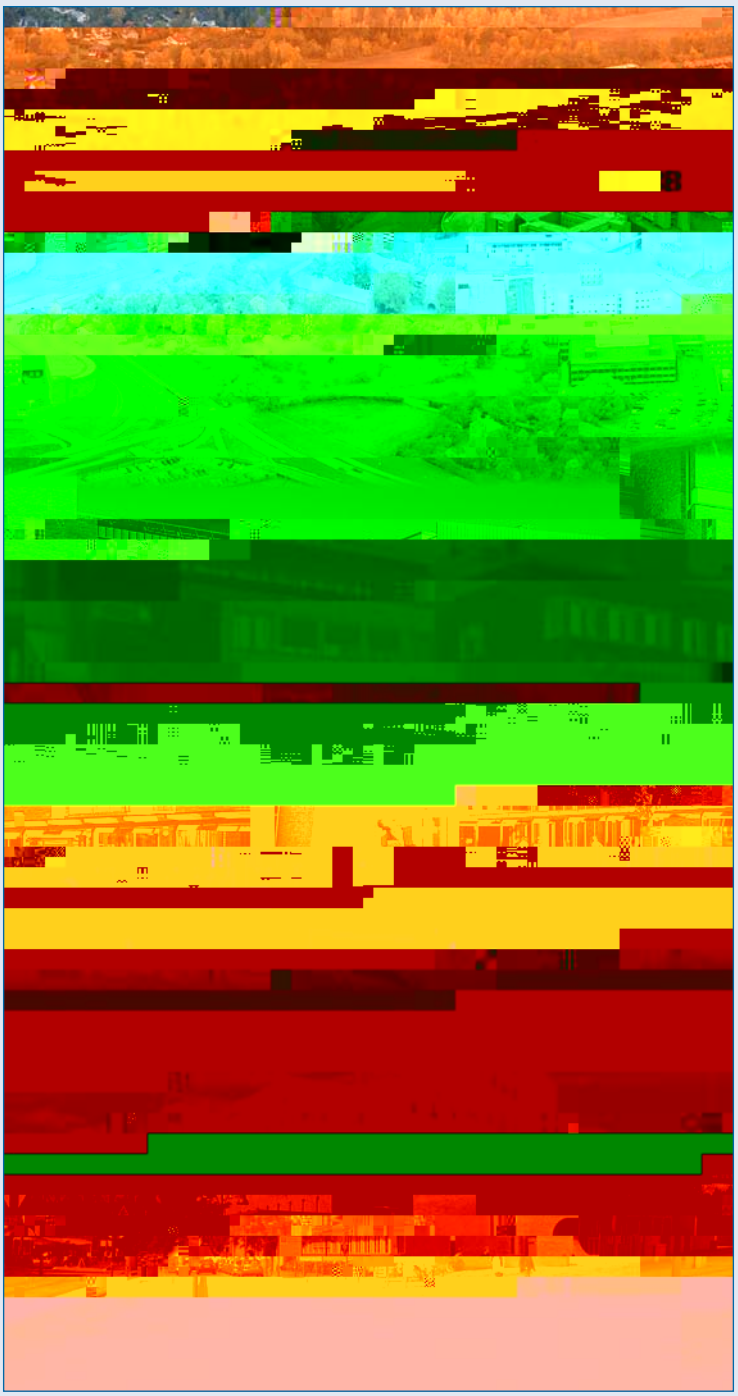

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Editorial

Human health resources and moral responsibilities

Since the beginning of the 21st century there has been increasing concern, both nationally and internationally, about the distribution and shortages of human health resources-doctors, dentists, nurses, pharmacists and all other varieties of paramedical professions. In the '70s. and even in the '80s. physicians were gloomily predicting an excess number of physicians, and there were even calls for the reduction of the number of medical students in some countries. Suddenly all changed, and from a projected excess which had been predicted there was concern about a shortage of doctors and nurses, first at national level and more recently at global level. Over the past five years there have been a number of demographic studies of the distribution and future needs of the various categories of health workers – not least physicians.

By the year 2003 international bodies were beginning to be concerned not only about the shortage, but also with the effects of efforts to recruit doctors and nurses from countries with limited economic resources and which already had serious under supply of health-care professionals. In 2001, the Commonwealth Ministers of Health considered a paper prepared by its secretariat and at a pre-World Health Assembly meeting in 2003, the Ministers adopted a Commonwealth Code of Practice for the International Recruitment of Health Workers. The World Medical Association considered the issue and adopted a Statement on this topic in 2003. At this time the World Health Assembly, noting the Commonwealth Code, requested the Director-General to explore possible ways forward to improve the situation concerning international recruitment (including the possibility of a Code of Practice on international recruitment of health personnel, in particular from developing countries)

The key issues have been concerns that migration of health workers, notably doctors and nurses from undeveloped and developing countries were not only consuming substantial numbers of professionals from these countries, but were diminishing the national workforce in these countries to even more dangerous levels, from their already overstretched and understaffed position. In the columns of this journal we have already drawn attention to this situation *(see Orvil Adams, WMJ50(3)pp 60-64,2004)*.

In the early part of this year the concerns were such that the British Medical Association is-

This expenditure is a complete loss to the poorer economies which are not in any way compensated for this loss either financially or in terms of the professional resources of which they have been deprived.

Migration for higher training is of course essential, especially when it is not available in the home country, and the basic human right to migrate, whether for better working conditions or other reasons, is that of everyone, including physicians. However, while regard must be paid by healthvT*09omies312a67 herea have5vemplete liturmtway

The Committee of Ministers of the Council of Europe (CoE) opened on January 25th, 2005 the Protocol concerning Biomedical Research for signature.

This Protocol, already signed by 14 member states, is the first international legally binding instrument to regulate research on man. This framework defines the legal limitations of research on man which need to be incorporated in law, unlike the Declaration of Helsinki or recommendations of CIOMS (see "Biomedical Research in Europe" WMJ, Vol. 50, 64-66, 2004) etc.

Special attention should be paid to some very important protective provisions which are dealt with in a different manner, often without regulation. These points are

a) research on persons not able to consent and

Dr. Coble also paid particular tribute to Dr. Myllymaki and Dr. Appleyard, his predecessors for all their work and support.

Turning to the change of Secretary General, he outlined the process of change. The Search Committee who considered the numerous applications for the post eventually resulting in the appointment of Dr. Otmar Kloiber, and said that the process of the transition and hand-over had been smooth and successful In the course of this, earlier in the year both Dr. Human and Dr. Kloiber had met with him on a number of occasions, notably on two of them to consider the responses of NMAs on governance and their co-ordination into a single document. During these periods there had also been the opportunity to attend the Executive meeting of WHO which received Dr. Nabarro's initial report on the tsunami, and to meet Dr. Nabarro on a further occasion which promised fruitful Opportunities for further collaboration.

Turning to the "Caring Physicians" project he gave some details of the project and its progress. This was a project responding to the NMAs indication that there was a need for greater transparency to be given to the "caring role" of physicians which was not as widely known as it should be. Hence the project asked individual NMAs to identify examples of physicians whose work demonstrated these qualities, with the intention of publicising this in book form which he felt would go some way to emphasise these values. He had approached the Pfizer Humanities Division, which felt this to be this worthy of support and a committee representative of the six regions was appointed to advise on the project. NMAs from 55 countries made a very good response on a very tight time scale, to an approach to identify physicians from their own countries who illustrated these qualities. Following a meeting of the judges in London, appropriate candidates were identified and this publication would be released at the General Assembly in Santiago.

Referring to the regions, he reported that he had had contact with the Council of the

(CPME) on Patient Safety and on their identification of key problems in common with WHO Regional Scientific Session. In this connection, systems to identify or report hazards in patients safety net need to be set up; a safety culture has to be built up that departs from the blame and shame approach and provides a blame-free procedure to handle mistakes, accidents and “close calls”. The use of telematics (e-health) should be promoted. It will allow health care to be made safer, as demonstrated in the field of drug prescription. Senior officials including the Mr Markos Kyprianou, European Commissioner for Health, the current Chair of the Council Health Ministers, and the Director of Public health of the European Commission, all committed themselves to EU support for research and development in the field of patient safety.

He reported his attendance at several Assemblies of National Medical Associations. Dr. Kloiber detailed the objectives for the future incorporated in the Strategic Plan 2003-2007 namely, to increase visibility of the WMA at all levels, to increase both membership and associate membership by 20%, to focus on agreed objectives and not pursuing all possible opportunities, and create a stable financial position. He detailed the main activities needed in

- the improvement of medical care and health in general;
- medical ethics
- human rights

Adv. Malke Borrow introduced the proposed statement on Genetics and Medicine on which NMA comments had been received. The draft produced considerable discussion, in particular in relation to the use of the word "regulated" in relation to developments in the field of Gene therapy and genetic research. It was finally decided hat this word was not appropriate and the relevant sentence introducing guidelines should read "However, with the continuing development of this field (Gene therapy and genetic research) it should proceed, according to the following guidelines…". A number of other texts and amendments were introduced and the text **adopted** as amended Organ donation and transplant. The working group would continue its work.

The proposed statement on HIV/AIDS was **referred to NMAs**; as was a document on Telematics, and the Venice Declaration on Terminal illness.

Although the Statement on Human Organ and Tissue Donation and Transplant was a relatively new one, the Danish Medical Association had proposed an addition in January 2005. Having received comments on this from NMAs, it was **agreed that this should undergo general review**.

Of the pre- 1995 documents, it was agreed that the Declaration of Sydney (determination of Death), the Statements on Freedom to attend medical meetings (Singapore), the

aoni".

posed policy changes designated in Tokyo as requiring minor revision.

The committee recommended **approval** of the revision to the Boxing Statement and the Statement on female Genital Mutilation and the Declaration on the Abuse of the Elderly (Hong Kong).

However, it recommended that the Statement on Adolescent Suicide undergo major revision.

Concerning those policies requiring major revision, the committee next considered reports on the progress, which had been made.

Dr. Calloc'h reported that in relation to the Statement on the Role of Physicians in Environmental and Demographic issues, the French Medical Association felt that a major issue needed to be addressed, namely the need for WMA to adopt policy on achieving a balance between informing the public and avoiding public alarm on environmental and preventive issues, citing Pollution and Asthma as an example. At the Chairman's suggestion the FMA would prepare an appropriate document.

Dr. Letlape reported that the South African Medical Association had decided to delay revision of the Statement on Access to Health Care until after the General Assembly discussion of this issue later in the year.

Following considerable discussion and some amendment, the proposed **Statement on Drugs Substitution** was recommended **for approval and forwarding to the General Assembly for adoption,** and that the Statement on Generic Drug Substitution and the resolution on Therapeutic Substitution be **rescinded and archived**.

A proposed WMA Statement on Medical Education as amended was recommended to be forwarded for NMA comment.

Turning to a proposed statement on Medical Liability Reform, Dr. Palmisano stressed the seriousness of the situation in the USA where, in the previous week, awards of 20 and 30 million US$ had sent a chill through the profession. The Swedish delegation stated that the document as written was unacceptable to them as they had a " no-fault system", and there was a contribution from Spain which pointed out that both criminal and civil courts may consider liability cases where appropriate. "There was however a need to fight against the criminalisation of liability." Following a discussion on these issues a suitable form of words was agreed and the proposed **WMA Statement on Medical Liability Reform as amended was recommended for approval and transmission to the General assembly for Adoption**.

Turning to six policies which had not been classified; the following decisions were made:

Recommendations concerning Medical care in Rural Areas - be **rescinded and archived**

The Statement on Use and Misuse of Psychotrophic Drugs to **undergo major revision**

The Statement on Persistent Vegetative State **be rescinded and archived**

The Statement on traffic Injury **undergo major revision**

The Statement on Noise Pollution, to **undergo major revision**.

The Statement on Alcohol and Road Safety to **undergo major revision** (also to include consideration of drugs and road safety).

Concerning 1995 Socio-medical policies, the committee recommended the following

The Statement on the Prescription of Substitute drugs in the Outpatient Treatment of Addicts to Opiate Drugs to **undergo major revision**

The Statement on Health Promotion to **undergo major revision**

The Resolution on Testing of Nuclear Weapons **to be rescinded and archived**.

Various NMAs accepted responsibility for revision of some of these policies and the secretariat for two others.

The Irish delegation reported on the progress of the workgroup on a Statement on Obesity. Dr. Calloc'h reported that the CPME were also working on this topic and he called for something from WMA on Lipids, carbohydrates etc.

The Secretariat reported on the development of an *On-line Course on the Treatment of Drug- Resistant TB*, and the South African Medical Association gave a report on their progress in co-operation with WHO on this issue.

The Committee proposed that a statement on reducing the Global Impact of Alcohol on Health and Society be forwarded for NMA's for comment.

In the discussion of a proposed Council Resolution on *the Healthcare Skills Drain*, The UK reported on the conclusions of a successful Conference recently held at the BMA which included amongst those attending, various Commonwealth countries as well as others including Africa, WHO, the Commonwealth Secretariat, Nurses and other interested bodies.

The Canadian Medical Association commended WHO for taking a leadership role in facing the global challenges of Human Health Resources. It concluded by stressing the major ethical implications for health care, the problem of the northern countries "siphoning off" resources, and stressed that in the discussions the financial cost of medical studies should not be overlooked. There was an impassioned plea from South Africa that doctor substitution was not the only answer, but it was vital to produce doctors to meet needs (see page 56).

The Committee was informed that an invitation had been received from WHO to contribute to the WHO Annual report for next

Governance Committee. Dr. Coble, in introducing the report commented that the working group had representation from all regions and there had been very good input into the report. They had divided the issues into three groups, namely (a) those for which the was general agreement on, (b) those on which there appears to be no answer and (c) those which were rejected by consensus There was also the need to look at the Bye- laws and other standing documents which needed to be consolidated. Finally he referred to Council reports which had not been put into policy.

In the opening discussions the need for the governance review was expressed forcibly by several members, in particular stressing the need for a clear structure setting out where authority lies and likewise where responsibility lies. The Secretary General pointed out that there was a clear understanding that governance was being worked on urgently. Other speakers urged that the work go forward and the committee then engaged in a detailed debate on the report before them, as a result of which the following Recommendations were made and ***later adopted by Council:***

That an Executive Committee with an advisory role, be established, comprising the Chair and Vice-Chair of Council and the Chairs of the three Standing committees, the Secretary General being a non- voting member. This committee would also undertake the Chief Executive Officer review process.

The Chair of Council to establish an "ad hoc" committee to review, consolidate and update WMA bye-laws, rules of procedures and operating policies.

One committee should make a trial of the use of a "consent calendar".

A proposal for the possible consolidation of the positions of Treasurer and Chair of Finance and Planning Committee be circulated to NMAs for comment.

A proposal for the timing of leadership transition be circulated to NMAs

That approval be given for a proposal to restrict the term of office of all Chairs of Council and Standing Committees and Treasurer to three two year terms (6 years "in toto") for each position.

Council later endorsed all the recommendations of the Finance and Planning Committee.

Council, in addition to endorsing the reports listed above from the committee **agreed** that a proposed statement on reducing the Global impact of Alcohol on Health and Society be referred to NMAs for comment. Council, also discussed possible dates and venues for future meetings of the General Assembly and Council, and other many other internal issues. It received reports on the forthcoming

Criticism of the current situation

Due to the fixed contribution rate per notified member physician of the constituent organisation, smaller and poorer nations have less voting power in the General Assembly and fewer seats to occupy in the Council. While the first reflects the general idea of a representational democracy, the latter is indeed challenging the democratic understanding of the institution.

A more transparent system with a higher degree of fairness should allow the financially less potent medical associations the same chance of representing their physicians as the richer ones.

Furthermore, the potential unfairness of the dues structure in relation to poorer associations and the fact that Council membership is determined only every two years, has led to disappointments and concern, as some constituent organisations pay a higher share in the year the Council seats are determined, reducing it significantly in the following year, thereby remaining in the Council without contributing the proper dues.

Previous attempts at change

During the last fifteen years, major changes in the dues structure were attempted twice. They aimed both to increase the dues income and to improve the fairness of the dues structure and representation. (The free-rider effect mentioned above was not addressed.) A first task force in the late 80s delivered a moderate change, when the number of votes in the General Assembly was changed from one vote per 5,000 notified members to one vote per 10,000 noti-

AIDS

GTZ, WHO and sex workers networks share information and lessons learned.

Berlin/Geneva – The German technical cooperation (GTZ) and the World Health Organization, in collaboration with sex work networks around the world, are launching the first ever online tool kit aimed at helping sex workers to protect themselves and their clients from infection with HIV and other sexually transmitted infections. The tool kit is intended for use by people working with female, male and transgender sex workers including programme managers, field workers and peer educators. This is the first time this expertise has been formally documented and made widely accessible.

"Thanks to this innovative project, people working on HIV/AIDS prevention for sex workers can now learn what does and does not work from Poland to Papua New Guinea. Targeted HIV/AIDS prevention and care programmes are urgently needed for sex workers, injecting drug users and other vulnerable groups and we welcome GTZ's leadership and support in this often under funded area," said Dr Jim Yong Kim, WHO's Director of HIV/AIDS.

Included in the online sex work tool kit are practical "how to do it" documents like "*Hustling for Health*" and "*Making Sex Work Safe*", written by experienced sex worker groups to support programme managers in setting up and maintaining projects. "*Of Veshyas, vamps, whores and women*" for example, is based on experiences from an Indian NGO and gives practical advice on how to build up a network of peer educators in brothels and deal with the brothel owners, how to set up condom distribution networks and how to structure payment incentives for peer educators.

Despite proof that prevention programmes are useful in sex work settings, currently only 16% of sex workers have access to these services. Around the world, poor services generally mean higher HIV prevalence.

"Sex workers know better than anyone about the problems they face, the kind of language and programs that are effective. Only by involving them can both male and female sex workers and clients be motivated to make use of condoms and health clinics," said Friederike Strack from Hydra — one of the sex worker organizations collaborating on the tool kit.

The tool kit also includes valuable data and analysis which can be shared across regions and used to design better HIV/AIDS prevention programmes for sex workers, for example "*Police and Sex Workers in Papua New Guinea*". A report on "*Meeting the sexual health needs of men who have sex with men in Senegal*" gives valuable insight into dealing with the cultural sensitivity surrounding male homosexuals in West Africa, how their lives are characterized by violence and rejection and that many find it easier to get help and treatment from clinics than traditional healers.

WHO and GTZ worked closely with sex work networks and organizations to produce an online collection of more than 130 easily-accessible documents, manuals, reports, and research studies. The aim of the tool kit is to make vital information about sex work interventions more accessible to a wider audience and to share lessons learnt to contribute to global efforts which will develop and increase effective HIV prevention and care interventions among sex workers.

"Targeted programmes make a difference — in Germany we have shown over the last 15 years that these kinds of interventions can really work. It's important to share knowledge across borders and within communities to help save lives within one of the oldest professions in the world. We are pleased to support this initiative," said Thomas Kirsch-Woik, Senior Consultant HIV/AIDS, GTZ.

In many countries, sex workers are frequently exposed to HIV and other sexually transmitted infections (STIs). Where sex workers have poor access to HIV prevention, HIV prevalence can be as high as 60-90%. Evidence shows that targeted prevention interventions in sex work settings can turn the epidemic around.

In Thailand and Cambodia for example, condom use rose to over 80% and HIV and STIs declined dramatically thanks to large scale programmes targeting sex workers and clients. In Nairobi, Kenya, strengthened interventions with sex workers – including peer support, condom promotion and STI services – led to falls in HIV incidence, from 25-50 % to 4 % in Nairobi sex workers.

"To really have an impact on the epidemic, it is important for services and policies to be made more user-friendly and to be adapted to the reality of the sex work as well as to regional differences. Injecting drug use and sex work are closely linked in Eastern Europe and it is essential to integrate the services", said Monica Ciupagea from the Open Society Institute Hungary which also collaborated on the tool kit development.

The HIV/AIDS Sex work tool kit brings together over a decade's worth of research and practical experience on what does and not work to change behaviour and protect sex work and clients from HIV/AIDS. Now online, it will also be available as CD-ROM and hard copy in early 2005.The kit is a living document and will continue to be updated as new resources are released.

The Sex Work tool kit is one of a series of online tool kits produced by WHO and GTZ and can be found at www.who.int/hiv/toolkit/sw. The Antiretrovrial (ARV) Tool kit: A public health approach for scaling up ARV treatment (www.who.int/hiv/toolkit/arv) and the Tool kit for scaling up HIV Testing and Counselling services (www.who.int/hiv/ toolkit/ tc) are also available online.

tice. The condition of the world continued to change and our institutions continue to adapt themselves. The agenda of the 58th WHA reflected the changes and bore witness to the continuing importance of the fight against sickness and the improvement of health essential for a viable world.

While the Millenium Goals placed Health at their centre,, the translation of them into reality was very far from completion and progress towards them was not reassuring. „Unless we succeed in bringing about the major changes we are working for in the near future, the targets for reducing child mortality will not be achieved by 2015“. In some areas death rates have actually risen as a result of extreme poverty and epidemics. While the necessary technical and practical know-how existsM 7tFnow-how g.

the computer age, computers were very large and costly, which limited the number of people who could use them. The continuous process of discovering new designs helped make the technology smaller and cheaper so that someone like me could declare the goal of a computer in every home and on every desk. Millions more people can get the benefits of new discoveries if you make delivery a priority, and if delivery shapes the design."

"Priority number 4. To find new discoveries and deliver them, we need to make political and market forces work better for the world's poorest people."

Political systems in rich countries work well to fuel research and fund health care delivery, but only for their own citizens. The market works well in driving the private sector to conduct research and deliver interventions, but only for people who can pay.

Unfortunately, these political and market conditions that drive high quality health care in the developed world are almost entirely absent in the rest of the world. We have to make these forces work better for the world's poorest people.

There is a model in the Global Alliance for Vaccines and Immunization – an effort we launched in 2000 to address the tragedy of millions of children dying every year from vaccine-preventable diseases. When the project began, vaccines were sitting on the shelf as kids were dying from those very diseases. Other necessary vaccines were not being manufactured at all. The market wan't working to bring people what they needed because there wasn't enough money to create a demand and guarantee a supply.

Since 2000, eleven governments have provided hundreds of millions of dollars for vaccine purchase and distribution. This has given companies a market incentive to manufacture these vaccines. As a result, in five short years, four million additional children have been immunized with basic vaccines, 42 million with hepatitis B, five million with haemophilus influenzae type B, and over three million with yellow fever – saving more than 700,000 lives.

"We hope even more funding will be made available through the proposed International Financing Facility for Immunizations proposed by the United Kingdom; with support pledged by France, Germany, Sweden, and Italy, this initiative would provide developing countries with the reliable funding they need, year after year, to buy vaccines, which gives the private sector the market incentive to make them and deliver them." He believes that if we act on these four priorities, we can build a world where all people, no matter where they're born, can have the preventive care, vaccines, and treatments they need to live a healthy life.

Governments in developed countries should match their financial commitments to the scale of the crisis – and make sure their efforts get results.

Governments in developing countries should make health a priority by dramatically increasing the percentage of their budgets they commit to health – particularly in their efforts to build health systems that can adopt and deliver low-cost interventions.

Citizens around the world should petition their governments to put up money to make market forces work better for the world's poorest people.

"It's one thing to define the goals and design the tasks, it's quite another to get them done. An important duty falls to the health ministers in this room."

He appealed to Health Ministers present. They occupied a crucial position between the people who make funding decisions and the people suffering from disease. They can make an immense difference by urging the world to make eye contact with the people who are suffering and can also show the world that there are solutions that work. One key to this is the new Health Metrics Network, which will be announced tomorrow and which the foundation are proud to support. This network will work to strengthen health information systems in countries so that health efforts are based on evidence, not speculation.

"There is no bigger test for humanity than the crisis of global health. Solving it will require the full commitment of our hearts and minds. We need both. Without compassion, we won't do anything. Without science, we can't do anything. So far, we have

helping countries improve their ability to gather this vital health information. Accurate data is critical to identifying problems and implementing effective solutions for people's health."

HMN brings together health and statistical constituencies to build capacity and expertise for strengthening health information systems so that local, regional and global decision-makers have quality data on which to base decisions to improve health.

"Health information is not simply an end in itself but provides the basis for better decision-making," said Dr. Richard Klausner, Executive Director, Global Health, the Bill & Melinda Gates Foundation. "Good data, quality reporting and tracking, thoughtful analysis and consistent health information systems will enable decision-makers to make informed and therefore better decisions on disease control and human development."

HMN responds to a need for evidence-based policy-making that can enable countries to make more efficient use of health budgets. In addition, other global initiatives including the Millennium Development Goals, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines & Immunization (GAVI) and the President's Emergency Plan for AIDS

Science Can Do More – Research To Bridge The "Know-Do" Gap

Geneva – Health Systems Research has the potential to produce dramatic improvements in health worldwide and to meet some of the major development challenges in the new millenium. Effective research could prevent half of the world's deaths with simple and cost-effective interventions, the World Health Organization says in a new world report on global health research.