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Editorial

A low dose of any chemical compound may be virtually harmless, while its higher dose may cause diseases, but the highest dose may turn into a deadly poison (there are exceptions – even the smallest drop of hydrocyanic acid and some other chemicals used in warfare is deadly). And too large a dose of a chemical compound is a global poison for our planet. This idea has already been known since the time of Hippocrates because the Greek word “pharmakon” means either ‘medicine’ or ‘poison’ depending on the context. The father of toxicology, Swiss doctor and alchemist Paracelsus (1493-1541), said, “The dose makes it clear that a thing is not a poison.”

A swallowed tablet is medicine, but exaggerated dosing of medicines means poisoning. Discharge in Asian rivers of substances from chemical plants manufacturing pharmaceutical raw material due to insufficient wastewater treatment means an ocean poisoned with biologically active substances. However, the raw materials of these medicines are manufactured in Asia exactly because of their lower cost and lower environmental standards there. The chemical industry and pharmaceutical industry are often in the hands of one business group. The chemical structure of some consumer chemicals and pesticides is similar to that of synthetic female sex hormones, while part of them – to modern antibiotics. These pesticides are ruthlessly sprinkled on the fields of the globe. In the world, the production of chemicals has doubled since 2000, and man depends on it more than ever before.

It is similar with global warming – a hot day usually means switching on air conditioners on this planet. A heatwave means the deaths of patients with chronic cardiovascular diseases. Global warming means new infectious diseases, injuries caused by catastrophic floods and hurricanes, psychosomatic diseases. Global challenges can only be tackled by reducing environmental poisoning with pesticides, fertilizers and consumer chemicals, greenhouse gas emissions, deforestation, cleaning the ocean of plastic and implementing other planet rescue programmes.
Interview with Miguel Roberto Jorge, President of the World Medical Association by WMJ Editor Peteris Apinis

**Miguel Roberto Jorge**

**Jorge:** Peteris, An initial suggestion: ask someone to review the English language in your questions. I believe they can be improved. And I delete a phrase in your question number 3 not because of the language but because I do not think it was correct.

**Apinis:** You are a physician known worldwide and a leader among psychiatrists. Could you comment on whether doctors in the world are burned out? Are doctors more threatened by anxiety and depression than other people? Is it true that doctors in certain professions (such as anesthesiologists and psychiatrists) are more at risk of suicide than people of other professions? How can we help doctors in the world to feel appreciated and reduce the risk of burnout?

**Jorge:** There are studies indicating a high prevalence of burnout among physicians worldwide even considering that burnout is not equally distributed among them. Providing medical care usually in difficult circumstances exposes physicians to continuous stress at work and burnout is one of the consequences of this kind of situation. On regards of anxiety and depression, some data suggest that physicians do not present more depression than other people but the rate of suicides among physicians is higher than in the general population and, again, the distribution of suicide rates among different medical specialties is not equal. In my personal opinion, the best way for a physician to feel appreciation and reduce the risk of burnout is to dedicate to build a good relation with patients and share with them the power to take decisions on treatment alternatives.

**Apinis:** We see a new trend in world politics – doctors are undervalued. The global trend is growing: doctors’ earnings are declining against average earnings in the country. Politicians and financiers, meanwhile, talk publicly about preparing doctors too expensive, that universal health coverage should be cheaper to have health specialists. How can we build the prestige of our global profession and restore the renumeration?

**Jorge:** I can identify different situations in your question. Nowadays, compared to past times, medical doctors are given less value and I believe the dehumanization of the medical practice has contributed to this situation. Physicians not always have enough time to dedicate themselves to build a good physician-patient relationship that takes the individuality of each patient in consideration. And even when they have that time, they are more prone to pay attention to lab exams than to listen to the person they have in front. I do not know if just earnings of medical doctors are declining but I believe the reasons for that are multiple and linked to profound changes in the work market everywhere in the globe. To prepare good professionals, in any area of work, deserves meaningful investments. And I do not believe that to prepare good primary care physicians will cost less than to train a good specialist. Any system of care, and particularly those under the Universal Health Coverage, requires good primary care physicians as well as good specialists.

**Apinis:** In Thilisi, the WMA accepted a declaration on euthanasia. In this declaration, the WMA condemned euthanasia and assisted suicide. As physicians, they can’t and don’t want to perform euthanasia or assisted suicide. However, surveys show that physicians as patients would like to shorten their lives when they encounter major physical and mental health problems. These are doctors as patients who are most likely to refuse complicated and excessive treatment if it can’t significantly prolong survival and improve the quality of life. How would you comment on a situation where a doctor, as a patient, requires euthanasia or assisted suicide?

**Jorge:** Indeed, the WMA took a very clear position opposing physician assisted suicide and euthanasia. We think that physicians should not involve in such practices. We want our patients to be sure that we value their lives and that we are there to protect and to help them even in very difficult situations. Physicians, when they become patients, are patients like any other person. There is no different ethics for physicians being patients. But the same is also true as for any other person: we should abstain from futile and undesired treatment, we must respect a demand for ending treatment and we have to give comfort and to alleviate pain.

**Apinis:** Every doctor turns into a patient sooner or later. Shouldn’t we find a global approach to assisting sick doctors? As said before, when physicians become a patient, they act as any other patient. So, medical doctors need to treat them as any other patient, with courtesy, empathy, compassion, and respect. There is not other global approach than to treat well every patient we can have, being them physicians or not. But the attending physician needs to consider the possibility of facing colleagues as more difficult patients to treat.

**Jorge:** The World Medical Association counts for many years with an Environmental Caucus that meets yearly when the WMA has its General Assembly. The WMA has been producing a series of policies dealing with themes of interest to the environment with recommendations to be followed by physicians around the globe. So, as the current WMA President, I will continue to develop activities as the leaders who came before me in highlighting the importance of fighting against any situation that can decrease the world health levels.

**Apinis:** World experience today shows that these are doctors who most energetically and honestly speak about the climate crisis and pollution of the planet, protest against burning of forests, against the reduction of biodiversity on the planet. What are you going to do, as President of the World Medical Association, in the fight for the well-being of our planet?

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Interview with Dr. Robert Twycross, DM Oxon, FRCP, FRCR, Emeritus Clinical Reader in Palliative Medicine, Oxford University, Oxford, UK by WMJ Editor Peteris Apinis

**Robert Twycross**

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**Twycross:** I am aware that in countries where euthanasia and/or assisted suicide (EAS) are legal options there are palliative care services that have integrated EAS with palliative care. However, for me, EAS and palliative care are mutually exclusive philosophies. Expecting doctors to switch from one to the other is an expectation too far. Further, palliative care specialists know that almost all patients who begin by asking for EAS change their mind when adequately supported by palliative care. What of those who do not? In my opinion, it is perfectly consistent to argue that, ethically speaking, EAS might be permissible in some extreme cases but that we should refuse to change the law. As at present, it could be better to allow hard cases to be taken care of by various expedients than to introduce new legislation that would inevitably become too permissive as has happened, for example, in both the Netherlands and Belgium.

**Apinis:** Every doctor becomes a patient sooner or later. We know that medical doctors are more open to shorten their lives when severe physical or mental health problems arise. Does a doctor as a palliative patient differ from other palliative patients and how is it to work with a doctor as a palliative patient?

**Twycross:** It is harder caring for medical colleagues – it is too easy to become emotionally over-involved – but, in 30 years, only one doctor-patient unwaveringly wanted to pursue EAS. This was because of existential distress, not for unrepaired physiological symptoms. Indeed, despair is the commonest reason for a consistent desire for EAS. Even in such cases, given adequate
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support (including appropriate palliative psychotherapy), there is often resolution. The question remains: if EAS was permitted, how long would one work for resolution before concluding that the distress is definitely intractable?

Apinis: Three concepts – care, rehabilitation and palliative care – are often mixed up (in the whole world). By care, we understand individual services for people with very poor treatment forecasts and survival. Is there any tendency for these different types of care to overlap? Is there a place for rehabilitation in palliative care? Palliative care, in particular hospice care, should be distinguished as the one provision of which must not be a source of profit for the organisation concerned.

Twycross: All definitions of palliative care have fluffy boundaries. Fifty years ago, it was largely limited to comfort care at the end of life. Since then the scope of palliative care has expanded considerably, and probably best be described as ‘care beyond cure’. It is holistic (addressing physical, psychological, social/family, and spiritual/existential concerns); focused on quality of life; based on need (not limited by diagnosis or prognosis); apportioned equally necessary. For this, centres of excellence must establish and propagate best conceptions that abound around morphine use, and discussion should focus specifically on the adequacy of palliative care provision. Thus, in Georgia, if palliative care was available to all who needed it, the annual necessary consumption of medicinal morphine is estimated to be 45 kg, but the actual amount currently used is only 8 kg. In fact, the proportion of morphine that is used in low and middle income countries is less than 10% of the world’s total (with about 85% of the world’s population), compared with over 90% in high income countries (with about 15% of the world’s population). This is a terrible injustice, and one which the medical profession, actively supported by national and international Medical Associations, must strive to correct.

However, changing overly restrictive laws is only part of the answer. Changing medical and societal cultural attitudes to opioids is equally necessary. For this, centres of excellence must establish and propagate best practice, accepting responsibility for training the medical profession, actively supported by national and international medical associations, must strive to correct.

Apinis: Palliative care is not a priority in many countries of the world, politicians often forget about it. Universal health coverage does not really provide for palliative care. However, the lifespan of people extends and the role of palliative care is increasing. To make world politicians and financiers be aware of the importance of palliative care?

Twycross: At the recent High Level Meet- ing at the United Nations, palliative care was recognized as an essential component of universal health coverage. However, for an established palliative care service and meet some of the many patients who have rehabilitated largely because of morphine.

much we need palliars in palliative treat- ment?

Twycross: Medicinal availability of opi- oids, particularly morphine, has been championed by those for some 40 years by the use of sedative drugs in palliative care. These medicinal products should be administered in accordance with ethical and pharmacological principles – justified by need and administered proportionately. In my opinion, the term ‘palliative sedation’ should be dropped because of ambiguity in its use, and discussion should focus specifi- cally on continuous deep sedation (CDS) until death in dying patients. CDS is clearly ethically challenging because it ends a pa- tient’s biographical (social) life and, if truly deep (no response to noxious stimuli), will shorten biological life because the neg- ative impact on the brain will lead to cardiorespiratory failure. Thus, CDS must be viewed as an extra-ordinary ‘last resort’ measure, and should never be seen as the default position for terminal distress. In ex- treme circumstances, I imagine most doc- tors would accept that it is ethically accept- able to shorten survival by a few hours, or maybe even by a few days. However, when continuous sedation continues beyond this, it is tantamount to ‘low euthanasia’. Regrettably, there is plenty of evidence that the sedation is not always proportionate. Further, in the Netherlands and Belgium for example, CDS is sometimes used as a proxy for EAS because it is more straight- forward in terms of implementation, docu- mentation, and external monitoring. France, CDS is now a legal right for termin- ally ill patients should they request it on the grounds of unbearable suffering, and the activists who campaigned for this regard it as substitute for EAS.

Apinis: What should the WMA and national medical associations do to teach their doctors to improve their respective knowl- edge, and their national politicians and fi- nanciers that they should invest in hospice and palliative care?

Twycross: Fortunately, palliative care does now have greater global visibility than 30– 40 years ago. Every little helps; and hopeful- ly the recent Scientific Session on palliative care at the Annual Assembly of the WMA will lead to several delegates from ‘palliative care poor countries’ returning home deter- mined to move things forward. Guidance is available through such organizations as the International Association for Hospice and Palliative Care and the Worldwide Hospice and Palliative Care Alliance, and regional bodies such as the European Association for Palliative Care.

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Interview with Mari Michinaga, Vice-Chairperson of Council of the World Medical Association by WMJ Editor Peteris Apinis

Mari Michinaga

Apinis: Japan is among the top countries in the world as to low infant mortality rate and the highest average life expectancy. What is the contribution of the Japanese Medical Association in this area?

Michinaga: In Japan, maternal and child health measures that seamlessly offer support from pregnancy to childbirth based on health checkups for expectant and nursing mothers and infants and Maternal and Child Health Notebooks are well established. This background leads to our globally high level of maternal and child health, which further leads to low infant mortality rate.

Recognizing the importance of the roles of physicians and medical associations in promoting the establishment of medical, health, and welfare environments for the mother and child and supporting the healthy mental/physical development of children who will lead our next generations, the Japanese Medical Association (JMA) proposed the JMA Declaration on Child Support concerning pregnancy, childbirth, and child care in May 2006.

The Declaration states the following:

- Support those who wish to become pregnant
- Enhance medical environment for safer pregnancy and childbirth
- Ensure social environment for satisfying (fulfilling, comfortable) pregnancy and childbirth
- Enhance medical environment where children can comfortably grow up
- Ensure social environment for childcare
- Enhance school health
- Support children with disabilities/difficulties
- Advocate various measures for children and child support to government officials and others involved

It is worth noting that The Basic Law for Child and Maternal Health and Child Development was enacted in December 2018 because of outreach activities by the JMA and others.

The Basic Law clearly states that the national and local governments and other organizations involved are responsible for implementing necessary measures.

Under the public health insurance program delivering Universal Health Coverage in Japan, community planning is underway wherein kairaitosha physicians play the main role. Its core is the collaboration of medical and long-term care through the Community-based Integrated Care System model, moreover, efforts for prevention and healthy living for local residents are underway.

Apinis: In Japan, the proportion of old people is increasing. There is rising incidence of chronic diseases. The role of preventive medicine is growing in the Japanese health care. Japan focuses on the extension of healthy life expectancy. Please tell us about the performance of the JMA in this area.

Michinaga: The public health check-up program in Japan is well established from infancy to elderly, but the program is not systematized. The JMA is proposing the necessity of the systems as life-long health services. In order to contribute to lifelong health management for each individual citizen, the data obtained from health check-ups should be centralized and managed under a strict privacy protection.

In addition, the Japan Health Conference was launched in 2015, with the JMA President and Head of the Japan Chamber of Commerce and Industry in joint representation roles.

The Conference is a place for leaders of the business community, healthcare organizations, local governments, and others involved to work together to extend healthy life expectancy.

Apinis: You have done a lot to help the victims of the earthquake and nuclear disaster. Could you describe the situation in these areas at present?

Michinaga: In the Great East Japan Earthquake of March 2011, the JMA organized the Japan Medical Association Team (JMAT) – consisting of the members of all prefectural medical associations, excluding the four that suffered major damage – and provided medical assistance in the affected areas.

This experience has been applied further in subsequent medical assistance activities in major natural disasters, such as earthquakes, major typhoons, and torrential rains.

The JMA is also planning various efforts within the Confederation of Medical Associations in Asia and Oceania (CMAAO) region as the World Disaster Medicine Platform plan, and an event to mark the launch of the platform is scheduled for May 2020.

The JMA will be promoting the activity to extend this plan to other WMA regions as well.

Apinis: You have become the WMA Vice-Chairperson of the Council. What are your successes, reflections and conclusions?

Michinaga: In June 2019, the Health Professional Meeting (H20) 2019, co-hosted by the WMA and JMA, was held in Tokyo, Japan. As the vice-chair of the WMA Council, I served as a moderator for the entire meeting and announced the adoption of the Memorandum of Tokyo on Universal Health Coverage and Medical Professions with the Council chair. I also prepared its report and submitted it to the WMJ.

In addition, the JMA and the International College of Person-centered Medicine co-hosted the 7th International Congress of Person-Centered Medicine on the theme “Work-Life Balance: Challenges and Solutions”, featuring physician burnout and work style reforms (November 2019). There, I chaired some sessions in which the WMA president, council members, and immediate past/former presidents participated.

Furthermore, at the CMAAO General Assembly in Goa in September 2019, I gave a report on WMJ meetings and related events to CMAAO, which is positioned as a WMA regional conference with the membership of 19 National Medical Associations in Asia-Oceania and to which I serve as the Secretary General.

Apinis: You are the editor-in-chief of the Japanese Medical Journal. What is discussed and advised by the Journal, and how does it help in the work of Japanese doctors?

Michinaga: I should note that I am the Associate Editor of the JMA Journal, not the Editor-in-Chief. The JMA Journal accepts a wide range of research papers in all fields of medicine including clinical medicine, basic medicine, and public health, as well as the submission on healthcare policy and opinions. Its purpose is to develop global and broad perspectives and grow into a widely shared journal in the international community by collecting excellent study results from around the world. The JMA Journal is intended to serve as a powerful media particularly for Japanese physicians and medical researchers to speak out about their achievements to the international community. Its impact factor needs to be improved to reach these goals.

The publication of this type of comprehensive English medical journal is the first challenge in Japan. The JMA Journal is expected to contribute to the enhancement of medicine and the improvement of healthcare quality on a global scale by being read and cited by many readers.

Apinis: Could you recommend good articles of Japanese authors for the WMJ?

Michinaga: It seems to us that the WMJ would merit to have in every number an article by some Japanese author presenting a global view.

I recommend the following Japanese doctors as authors for the WMJ:
- Dr. Shigeru Suganami, President, AMDA (Association of Medical Doctors of Asia) https://en.amda.or.jp/
- Dr. Masamune Jumba, Professor, Department of Community and Global Health, Graduate School of Medicine, University of Tokyo
- Dr. Osamu Kunii, Head, Strategy, Investment and Impact Division (SHII)
- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- Dr. Kenji Shibuya, Professor and Director, University Institute for Population Health, King’s College London

Apinis: We know that your special interest is medical science. Could you tell us what was essential in medical science in 2019 and what to expect from 2020?

Michinaga: In December 2017, Japan’s Prime Minister Shinzo Abe, with world health leaders, supported the promotion of universal health coverage (UHC) at the UHC Forum 2017. It grew into a global movement and led to the Memorandum of Understanding between the WMA and the WHO in April 2018, establishing their collaboration on UHC. In June 2019, the Health Professional Meeting (H20) 2019 was held as the place to practice their cooperation.

At the G20 Osaka Summit and the Joint Session of Finance and Health Ministers (held at the end of the same month), the importance of strengthening finance in health to promote UHC and the shared understanding for the need of sustainable finance were expressed.

Last September, the United Nations High Level Meeting on UHC was also held for the first time, which raised the interest in UHC promotion and led to concrete efforts for its promotion among nations.

I believe that it was important that these movements of UHC promotion and its acceleration shifted from theory and moved into practice.
The Japan Medical Association

The Health Professional Meeting (H20) 2019 was held in Tokyo on June 13-14. The theme of the meeting, jointly hosted by the Japan Medical Association (JMA) and the World Medical Association (WMA), was the Road to Universal Health Coverage (UHC).

In April 2018, JMA President Dr. Yoshitake Yokokura, also the then President of the WMA, concluded a memorandum of understanding (MOU) with WHO Director-General Dr. Tedros Adhanom Ghebreyesus, the purpose of which was to promote UHC and emergency disaster preparedness. Thus, the H20 meeting was organized as an opportunity to expound the implementation of the MOU, focusing on the roles of physicians and medical associations in promoting UHC. Approximately 220 people from 38 countries, including eight countries from the African region, were in attendance.

Opening ceremony

The opening ceremony took place in the presence of Her Imperial Highness the Crown Princess. At the opening of the H20, Dr. Yoshitake Yokokura emphasized the increasing importance of cross-border unity among physicians worldwide, and expressed the desire to witness further UHC progress under “beautiful harmony,” which is the meaning of the new imperial era Reiwa. The WMA President Dr. Leonid Eidelman (the immediate past President of the Israel Medical Association) stated that UHC promotion is a priority for the achievement of the Sustainable Development Goals, a global political objective, by 2030. He also called on the attendees to use this meeting as an opportunity to debate and discuss viable solutions for the further promotion of UHC by strengthening cooperation among the concerned parties in each country.

Subsequently, Her Imperial Highness the Crown Princess delivered a congratulatory message. She referred to the high rates of tuberculosis incidence and infant mortality until the mid-twentieth century in Japan, and to the fact that the Tuberculosis Control Law was enacted and the Mother and Child Health Handbooks were introduced in order to improve the situation. She appreciated that the realization of Universal Health Insurance in 1961 facilitated great improvements in living conditions in Japan. She also lauded the efforts of health professionals in various organizations, including the JMA, in supporting the health of all Japanese people against the population aging. In closing, she stated, “I wish that your efforts will be fruitful in helping create a world in which all people can enjoy a healthy and happy life.”

Japanese Prime Minister Shinzo Abe stated in his video message that the promotion of UHC is an essential element of our society, and appreciated that this meeting was being held in 2019, the year of the Japanese Presidency of the G20 Osaka Summit. He expressed his hopefulness regarding the continued efforts of the concerned parties toward the achievement of UHC.

Keynote addresses

The first keynote speech, titled Health Inequalities and Social Determinants of Health, was delivered by Sir Michael Marmot, Professor of Epidemiology University College London, Past President of the WMA. He highlighted the fact that health is largely affected by social situations, including wealth gaps and poverty. He also pointed out that it is imperative for health professionals to take action to ensure that the global population has access to better health. Health gaps resulting from country-specific inequities in healthcare constitute a social crisis impacting much of the world. Thus, in addition to the promotion of UHC, the following must be ensured: (1) optimal childhood environment, (2) lifelong learning, (3) adequate employment, (4) minimum income necessary for maintaining an acceptable standard of living, and (5) disease prevention. He called on all governments to act to aid people in leading lives of dignity.

In the second speech, titled Toward UHC – What We Need, Dr. Naoko Yamamoto, Assistant Director-General, Universal Health Coverage/Healthier Populations, the WHO, pointed out that the realization of UHC by 2030 would require the following: (1) strong political leadership, (2) infusion of funds into the field of healthcare, (3) fostering of human resources, (4) primary health care (PHC), and (5) development of communities. Then, she enumerated the following expectations from medical associations: (1) participation in various fields beyond healthcare and advocacy and support of activities placing a high value on human health, (2) finding evidence, as well as effective policy formulation and implementation based on the evidence collected, (3) playing a role in cultivating human resources and career path building, (4) improvement of healthcare quality and promotion of people-centered care, (5) contributing to fields that require further research, education, and practice, (6) taking action to manage emerging infectious diseases and disasters, and (7) cooperating and participating in creating an environment where people have basic knowledge of health and make efforts to develop communities that promote and foster healthy living.

Session 1: Viewpoints on How to Achieve UHC

According to the WHO, half of the world’s population still lacks full coverage of essential health services, with about 100 million people being pushed into extreme poverty by having to pay for healthcare. In this session, presentations were made from the viewpoints of patients, international health authorities, and medical associations.

From the perspective of a patient organization, the International Alliance of Patients’ Organizations (IAPO), equitable and universal access to quality and affordable medications is indispensable. It was assured that the IAPO is ready to work with the WMA and its members to achieve UHC, placing top priority on patient safety.

Medical professionals play a crucial role in UHC. The expansion and transformation of the health workforce is an investment anticipated to pay a triple dividend: improved health outcomes, enhanced global health security, and economic growth through the creation of employment opportunities. It is necessary to ensure adequate public-sector investment for education and employment of health workers. It is anticipated that medical associations will facilitate governmental development and implementation of universal health plans and strategies, and aid in the creation of resilient and sustainable healthcare systems.

From the perspective of medical associations, advancing UHC requires addressing the need for an adequate and well-trained workforce, preventive care and health promotion efforts, sustainable health financing mechanisms, and strategic purchasing using public funds. For example, to achieve UHC, the Indian Medical Association provides inputs into health governance and aids in service delivery, particularly in fragile populations. It further advocated that to improve health service delivery the deployment of highly skilled health workers is crucial.

Session 2: Health Security and UHC

Disasters and disease epidemics are major threats to ongoing efforts to achieve UHC. However, once attained, UHC can provide a strong foundation for overcoming such threats. This session addressed two major issues: (1) the potential for controlling health threats to contribute to achieving UHC, (2) how UHC can be a key to overcoming various devastating health threats.

Trust is important for responding to health threats, such as natural disasters and disease epidemics, as it can build resilient social systems bonding individuals, local communities, and countries. It makes a major contribution to overcoming devastating health threats and, thereby, to achieving UHC.

The international community needs to strengthen efforts to support healthcare systems in preparation for crises. UHC is not possible until the right to healthcare is protected. It is necessary to urge those responsible for conflicting conflict and violence to allow for neutral and impartial treatment of all victims. In addition, amidst the global health narrative of achieving UHC, doctors need to facilitate patient-centered discussions. To promote UHC, healthcare should be delivered safely, and criminalizing medical colleagues must be condemned when they provide care to patients.

Session 3: Political Dimension of UHC/PHC and Role of Medical Professionals

UHC/PHC is more than simply a technical challenge; its progress also depends on the cooperation of governments, international organizations, and civil society. In Thailand, UHC was successfully implemented nationwide during the 2001–2003 period. This achievement is attributable to the resilience of the health system, which fostered the resilience of other essential systems. The dynamics and interactions of various groups and institutions within and outside the health sector also reportedly contributed to the marked effectiveness of UHC and the resilience of the health system.

In closing, the Japanese Prime Minister Shinzo Abe stated that UHC promotion is a priority for the achievement of the Sustainable Development Goals, a global political objective, by 2030. He also called on the attendees to use this meeting as an opportunity to debate and discuss viable solutions for the further promotion of UHC by strengthening cooperation among the concerned parties in each country.
Session 4: Shared Responsibilities and Individual Obligations toward UHC

In this session, Dr. Yoshitake Yokokura made a speech on the steps necessary for achieving UHC in Japan. In Japan, the provision of health insurance as an essential part of UHC, in which all citizens are covered by insurance, was achieved in 1961. Dr. Yokokura explained that until this achievement, there had been extensive discussions among physicians, medical associations, and governments about the medical practices of physicians and healthcare expenditures, as well as many other relevant factors. Given that Japan is currently facing the challenge of population aging, the national health insurance program must be firmly maintained as the cornerstone of UHC. The JMA expresses its views to the government based on two criteria: does any policy contribute to safe healthcare for the public and does such a policy allow for UHC to be maintained through public health insurance? He concluded by stating that with this in mind, it is important for the JMA to continue making proposals aimed at promoting and maintaining the most appropriate healthcare system in which medical practitioners and patients can provide optimal level of care.

In the subsequent panel discussions among representatives of the government, JMA, WHO, and international organizations, sharing the ongoing global UHC initiatives and approaches, challenges and opportunities for achieving UHC, and a proposal of solutions and actions for promoting UHC were discussed, and various issues impeding the achievement of UHC were highlighted. These issues include shortage of human resources in healthcare, regional issues such as Ebola hemorrhagic fever, differences in healthcare systems across countries, and relationships with patients. In particular, the shortage of human resources was shown to be related to the global shortage of human resources involved in primary care, concentration of human resources in urban areas that are advantageous in terms of pay and education, and the trend of medical students from developing countries sent to developed countries for educational purposes not returning home. Thus, the problem is not only of absolute numbers but also uneven distribution of resources. Further, the importance of trusting relationships between healthcare providers and receivers was highlighted. Continuing efforts in each country and unity among physicians across countries were identified as essential for solving a variety of problems and ultimately achieving the aim of providing UHC.

Adoption of Memorandum of Tokyo on UHC and the Medical Profession

The H2O adopted the Memorandum of Tokyo on UHC and the Medical Profession that prescribed mainly (1) strengthening the understanding and involvement of UHC and primary care, (2) designing long-term national policies aimed at achieving UHC, and (3) defining the roles of physicians and the medical associations and formulating proposals relevant to governmental policies and to all aspects of society.

This memorandum calls on physicians and their medical associations worldwide to play a profound role in the advocacy for and achievement of UHC. In addition, it expresses hope that the G20 Summit will focus on pursuing sustainable investments in the healthcare systems of not only the G20 countries but also other economies where healthcare system investments are still insufficient.

• Raising tobacco taxes
• Enforcing bans on tobacco advertising, promotion, and sponsorship
• Raising tobacco taxes

The FCTC has contributed to an overall decrease in smoking prevalence [6]. Notably, countries that have higher MPOWER composite scores see a greater decrease in current tobacco smoking [19].

Using the FCTC as a guiding document, many countries, such as Spain and Kenya, have created national coordination strategies that adopt a multi-sectoral approach to control tobacco [6; 9]. There has been substantial progress in FCTC articles that address the packaging of tobacco products, protection from exposure to tobacco smoke, public awareness and education, and the reporting and exchange of information [6; 9]. There has been some progress in articles that address regulations on taxes, advertising, sponsorship, illicit trade, and research [6; 9]. While not as significant, there has also been progress in articles that address environmental protection, liability, and economically viable alternatives for farmers who grow tobacco [6; 9].

Successful implementation of the FCTC is supported by a variety of factors. A crucial element is a stable, effective political system with a national tobacco control plan and the capabilities to successfully enforce tobacco control policies [9; 15; 16]. Other beneficial factors include having accountability across stakeholders, including NGOs, and having higher levels of FCTC implementation, such as having mandated graphic warning labels (GWLs) on tobacco packaging [10; 12].

There are also many factors that impede FCTC adoption and implementation. The global tobacco industry is a hugely important obstructing factor, as will be discussed later. Other factors include smoking-accepting cultures [23], ineffective implementation of existing guidelines [9; 13], illicit trade [18], lack of stakeholder involvement [6; 9; 11], lack of a multi-sectoral approach [6; 17; 22], and lack of sufficient resources, capacity, and support, especially for LMICs [6; 9; 14; 17]. In addition, not enough special action has been made for vulnerable and disadvantaged groups, such as youth, which the tobacco industry targets [6].

Moller’s Memo

On June 28, 2019, Michael Møller, the outgoing director of the UN Office at Geneva, raised skepticism against the tobacco-industry ban imposed by the FCTC by writing a memo directed to UN Secretary General Antonio Guterres. In this memo, he proposes that engaging the tobacco industry in discussions may help better achieve the 2030 SDGs for a “more nuanced approach”, since “businesses which are legitimate enough to pay taxes to governments should also be legitimate enough to participate in discussions concerning joint efforts to minimize health risks and address other problems of a common nature” (memo).

While this memo is worthy of consideration as a “think piece” (foreign policy article), its purpose as suggested by Møller’s chief of staff, David Chikvaidze, is clear – the UN should not engage the tobacco industry in matters relating to tobacco control.

Evidence of TII

A substantial reason is the evident history of persistent tobacco industry interference (TII), which has been recognized as the most important barrier against FCTC implementation [2; 6]. Investigative reports into TII have shown that the industry views the WHO as an enemy and has paid consultants to discredit key individuals and the WHO, with a key strategy to “contain,” political processes unique to the context of each country and healthcare system. Medical professionals have a crucial role to play in health policy. In this session, discussions focused on the presentations of distinguished speakers from different angles such as the national government, global health academia, and national and world medical associations.

In the case of Lebanon, it was shown that the active involvement of medical professionals contributed to conversion to people-centered healthcare in the PHC network. World health systems are challenged by populating age groups, chronic diseases, an explosion of health technologies, and globalization. System transformation is required to ensure that no one is left behind.

In the US, whether to continue with or repeal the Affordable Care Act (ACA, widely referred to as “Obamacare”) is the major subject in current debates on healthcare reform. The new administration is eager to repeal the ACA, which has led to concerns regarding the erosion of patient protection. The American Medical Association forms a broad alliance that aims to take the necessary actions to protect the interests of patients and their families. An appeal was made for medical associations to engage more actively in the ongoing debate on how to deliver PHC.

To strengthen PHC, which is an essential component of UHC, it is important to achieve sustainable healthcare systems, invest in efficient PHC, implement performance evaluation and data collection relevant to PHC, and strengthen partnerships among international health institutions. It was also pointed out that the establishment of healthcare systems is the most important element of social common capital, ultimately serving as the foundation of an affluent society.

The world of medical professionals is shaped by complex processes that shape how medical professionals are involved in primary care, concentration of human resources in urban areas that are advantageous in terms of pay and education, and the trend of medical students from developing countries sent to developed countries for educational purposes not returning home. Thus, the problem is not only of absolute numbers but also uneven distribution of resources. Further, the importance of trusting relationships between healthcare providers and receivers was highlighted. Continuing efforts in each country and unity among physicians across countries were identified as essential for solving a variety of problems and ultimately achieving the aim of providing UHC.

Ruth T. Lee
neutralize, and reprioritize WHO” as quoted in 10 away from tobacco control and other NCDs.

The tobacco “big five” – Philip Morris International, British American Tobacco, Imperial Brands, Japan Tobacco International, and China National Tobacco Company – has substantive economic power, with revenues of one of these companies itself matching the GDPs of countries like Morocco and Ecuador [10]. Their economic leverage and financial interests have caused them to interfere with tobacco control by lobbying governments and advocating for regulations concerning tobacco advertising restrictions, voluntary warning labels, and lower taxes under a guise of “social responsibility” for the public interest [6, 12]. This is apparent in the issue of illicit tobacco trade, which has been used by tobacco industry – even though research has shown that the major multinational tobacco companies themselves have been involved in tobacco smuggling – to prevent governments without adequate financial capacity to pass stronger tobacco control policies [18]. The industry has been found to fund surveys of dubious methodology that show associations between tobacco control and large increases to health [44].

A significant portion of TI is directed towards warning labels on cigarette packaging. A result, for example, is that between 1992 and 2012, sixteen countries made voluntary agreements with the tobacco industry to put weak, text-only health warning labels (HWLs) on cigarette packages [12]. Philip Morris in 1992 put English-language HWLs on the sides of packages being sold in 49 small, mostly African countries whose native languages are not English [12]. In 2008 in Vietnam, test-only health warnings of “Smoking can cause lung cancer” and “Smoking can cause COPD” covering 30% of the cigarette package became the minimum requirement after successful TI, conducted against the MOH’s effort to push stronger warning labels on cigarette packaging – to prevent governments without adequate financial capacity to pass stronger tobacco control policies [18]. The industry has been found to fund surveys of dubious methodology that show associations between tobacco control and large increases to health [44].

A one-secret document of British American Tobacco revealed that the industry tries to foster government relations and community involvement programs to maintain loose regulations, especially in marketing, with results like a proposed ad ban in Sta...
Materials and methods

On the occasion of International Noise Awareness Day 2019, Indian Medical Association’s National Initiative for Safe Sound (NISS) carried out a study to assess hearing in traffic police personnel. The study was conducted in 8 cities across India using pure tone audiometry. The severity of NIHL was based on the WHO grading.

### Table 1: Grades of hearing according to WHO

<table>
<thead>
<tr>
<th>Grade of hearing</th>
<th>Degree of hearing loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal hearing</td>
<td>0-25 dB or loss (better ear)</td>
</tr>
<tr>
<td>Mild impairment</td>
<td>26–40 dB (better ear)</td>
</tr>
<tr>
<td>Moderate impairment</td>
<td>41-60 dB (better ear)</td>
</tr>
<tr>
<td>Severe impairment</td>
<td>61-80 dB (better ear)</td>
</tr>
<tr>
<td>Profound impairment</td>
<td>&gt;80 dB (better ear)</td>
</tr>
</tbody>
</table>

The subjects have never used any form of protective equipment to insulate their ears from high traffic noise levels. Police personnel with pre-existing ear disease were excluded from the study.

### Results

A total of 588 traffic police personnel were screened across 8 cities in India using pure tone audiometry 266 (45.23%) had normal hearing while 320 (54.42%) had some form of sensorineural hearing loss. 2 (0.34%) personnel had conductive hearing loss. Out of the 320 police personnel who had hearing loss, 175 (54.60%) had mild hearing loss, 91(28.43%) had moderate, 25 (7.81%) had severe to profound 29(9.06%) had high frequency dip at 4000 Hz.

### Discussion

Noise pollution has several detrimental effects on the human body, the most important being hearing impairment. Noise-induced hearing loss (NIHL) is the second most common cause of sensorineural hearing loss after age related hearing loss or presbysysis. Sustained exposure to loud noise is associated with damage to outer hair cells of the cochlea in the inner ear. These hair cells are responsible for conversion of sound energy to electrical signals transmitted to the brain. The damage is irreversible. In general, the amount of noise required to cause permanent damage from chronic exposure is equivalent to 10 years or more at a level of 85 dB for more than 8 hours a day [4,5]. The maximum hearing loss due to noise exposure is 40 dB at low frequency and 75 dB at high frequency but when the effects of presbycusis are added, the thresholds may become greater [6,7]. Noise related hearing changes can be categorized into three groups: noise-induced temporary threshold shift (NITTS), noise-induced permanent threshold shift (NIPTS) and acoustic trauma. Initial exposure to excessive sound level causes temporary fullness of hearing (temporary threshold shift) which usually recovers within 24 h of exposure [8]. If there is repeated sustained exposure, the threshold shift becomes permanent (permanent threshold shift) due to nerve fiber degeneration. Acute traumatic hearing loss is defined as sudden exposure to a loud sound like an explosion which can result in permanent hearing loss.

The first signs of NIHL can be observed in the typical 4000 Hz “notch” observed on audiograms, indicating a loss of hearing ability in the middle of the frequency range of human voices [9].

Occupational noise is a widespread risk factor, with strong evidence base linking it to an important health outcome (hearing loss) [3]. An assessment of the burden of disease associated with occupational noise can help guide policy and focus research on this problem. This is particularly important in light of the fact that policy and practical measures can be used to reduce exposure to occupational noise [10].

### Table 2: Results of screening showing percentage of personnel with hearing loss

<table>
<thead>
<tr>
<th>Total no. of police personnel screened</th>
<th>Total no. of personnel with normal hearing</th>
<th>Total no. of personnel with sensorineural hearing loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>588</td>
<td>266</td>
<td>322</td>
</tr>
</tbody>
</table>

### Table 3: Data from individual cities

<table>
<thead>
<tr>
<th>Sr.No.</th>
<th>Centre</th>
<th>Doctor in charge</th>
<th>Total no. of personnel screened</th>
<th>Total no. of personnel with normal hearing</th>
<th>Total no. of personnel with sensorineural hearing loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Gurgaon</td>
<td>Dr. Sanjiv Verma</td>
<td>124</td>
<td>87 (54.03%)</td>
<td>37 (45.97%)</td>
</tr>
<tr>
<td>2</td>
<td>Noida</td>
<td>Dr. Haninder Pal Singh</td>
<td>3</td>
<td>24 (83.33%)</td>
<td>4 (6.67%)</td>
</tr>
<tr>
<td>3</td>
<td>Gwalior</td>
<td>Dr. Swagata Khanna</td>
<td>27</td>
<td>9 (33.33%)</td>
<td>18 (66.67%)</td>
</tr>
<tr>
<td>4</td>
<td>Dibrugarh</td>
<td>Dr. Swagata Khanna</td>
<td>43</td>
<td>17 (39.53%)</td>
<td>25 (58.38%)</td>
</tr>
<tr>
<td>5</td>
<td>Una</td>
<td>Dr. Rajiv Pachauri</td>
<td>11</td>
<td>5 (45.45%)</td>
<td>6 (54.55%)</td>
</tr>
<tr>
<td>6</td>
<td>Rewari</td>
<td>Dr. Archana Saini</td>
<td>52</td>
<td>48 (92.31%)</td>
<td>4 (7.69%)</td>
</tr>
<tr>
<td>7</td>
<td>Panipat</td>
<td>Dr. Pratik Anu</td>
<td>169</td>
<td>77 (45.36%)</td>
<td>92 (54.64%)</td>
</tr>
<tr>
<td>8</td>
<td>Karnal</td>
<td>Dr. Sanjay Khanna</td>
<td>138</td>
<td>52 (35.30%)</td>
<td>86 (64.70%)</td>
</tr>
</tbody>
</table>

The strength of the present study is the data size as well as the study being conducted in different parts of India and hence it gives a larger picture of the noise effect of induced hearing loss among police personnel. All the police personnel are actively working and medically fit and hence it also provides an insight into the burden hearing loss in our country, which by and large, remains undiagnosed or untreated. Since the study was only one time screening for hearing evaluation, we were not able to measure the exact level of noise exposure. Also age related hearing loss was not taken into account.

According to WHO recommendations:

- For average noise exposure, the Guideline Development Group (GDG) strongly recommends reducing noise levels produced by road traffic below 53 decibels (dB), as road traffic noise above this level is associated with adverse health effects.
- For night noise exposure, the GDG strongly recommends reducing noise levels produced by road traffic during night time below 45 dB, as night-time road traffic noise above this level is associated with adverse effects on sleep.
- To reduce health effects, the GDG strongly recommends that policymakers implement measures to reduce noise pollution from road traffic in the population exposed to levels above the guideline values for average and night noise exposure. For specific interventions, the GDG recommends reducing noise both at the source and on the route between the source and the affected population by changes in infrastructure.

NIHL is a major avoidable cause of permanent hearing impairment. Some effective ways to prevent NIHL in traffic police personnel:

- **Strive Implementation of the existing Noise Rules 2000 including fine for unnecessary honking on Indian roads, Implementation of Silent Zones in Towns and Cities and removal of loudspeakers from all places of worship.**
• Health authorities and NGOs must use hearing protective devices such as those mandated in traffic police personnel. KG Venkatappa, Shankar V, Annamalai N. Assessment of knowledge, attitude and practices of traffic police personnel regarding the auditory effects of noise. Indian J Pharmacol 2012; 44(5):306-310.


• Prevention of occupational noise induced hearing loss among traffic police personnel of Kathmandu Metropolitan City. Shrestha I, Shrestha BL, Pokharel M. [12]


• Prevalence of noise induced hearing loss among traffic police personnel. Thoothukudi (Tamil Nadu) 2018. 50 Total number with hearing loss — 94%

• Prevalence of noise induced hearing loss among traffic police personnel. M. Dhinakaran N, Karthikeyan B. M. [14]

• Prevalence of noise induced hearing loss among traffic police personnel in Madurai city. Madurai (Tamil Nadu) 2017. 241 Total number with hearing loss — 153 (63.48%)

• Prevalence of noise induced hearing loss among traffic police personnel in Madurai city. Jammu city (Jammu and Kashmir) 2015. 150 Total number with hearing loss — 33 (22%)


• Effect of road traffic noise on auditory threshold of traffic police personnel KG Venkatappa, S V Shankar, Dr. Sparshadeep. [16]

• A Study on noise-induced hearing loss of police constable M Senthil Kanitha, C Balasubramanian, Heber Anandan. [15]

• Use of hearing protective devices such as ear muffs, ear plugs and ear canal caps.

• Periodic health check-ups and hearing assessment of police personnel.

• Duty scheduling or duty rotation for exposure limitation.

• Health authorities and NGOs must create awareness among traffic police personnel about the auditory and non auditory effects of noise by implementing education and training programmes for traffic police personnel about the auditory and non-auditory effects of noise.

• At policy level, the government should take adequate steps to reduce the level of the horn from present levels of 90-112 dB to 50-65 dB. Efforts should also be made to reduce the engine noise of vehicles towards lowering levels of traffic noise.

• Noise Mapping of India should be undertaken with urgency to document the existing noise levels and then address the problem of ambient noise higher than the permissible limits as recommended by the WHO.

• School text books should educate children about good driving habits including driving without using the horn except in life threatening situations. The habits of several decades can only be changed through educating the next generation.

Conclusion

As can be seen from this preliminary screening of 588 traffic police personnel, continuous exposure to loud and chronic noise causes sensorineural hearing loss in the long run. 54.42% of those screened had hearing loss. Considering that India has the highest number of SNHL people above the age of 65 years, it is time to put WHO and European Guidelines 2018 into practice along with enforcing Noise Rules 2000. Immediate and urgent steps must be taken to prevent Noise Induced Hearing Loss (NIHL) develop into a serious health issue in India.

Achieving Universal Health Coverage and Sustainable Development Goals: The Global Fund’s contribution and my expectation for medical professionals, national medical associations and World Medical Association

The Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) was invited to H2O Meeting co-hosted by World Medical Association (WMA) and Japanese Medical Association (JMA) on June 13 and 14 in Tokyo to present the Global Fund’s contribution towards achieving universal health coverage (UHC) and Sustainable Development Goal 3 (SDG 3) “Ensure healthy lives and promote wellbeing for all at all ages”.

Based on this presentation, this article describes the role, achievement and challenge of the Global Fund towards UHC and SDG 3, a country’s good practice of tremendous progress, and shares my personal expectations for medical professionals, national medical associations, and WMA to achieve global common goals of UHC and SDG 3.

Role of the Global Fund to achieve UHC

Since its inception in 2002, the Global Fund has mobilized financial resources from all over the world and has been supporting more than 140 countries by dispersing more than US$41 billion [1], making it one of the largest financiers or channels of assistance for global health [2].

The Global Fund is called the 21st century partnership organization because relevant key partners such as donor and implement-
Ending Epidemics

Since the 1950s, global efforts to end major epidemics have been facilitated by cross-cutting interventions and innovations, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). The GFATM was established in 2001 with the goal of supporting countries in the fight against these diseases, which are among the leading causes of death and disability globally. The GFATM has provided funding and technical support to countries to strengthen health systems, increase access to treatment and care, and promote equity in service delivery.

Tuberculosis is still a major public health challenge, with an estimated 10 million new cases and 1.5 million deaths in 2018. The Central Asia region, including Afghanistan, Pakistan, and the South Pacific, remains one of the most affected regions, with a high burden of multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB).

The GFATM has supported countries in implementing evidence-based strategies to control and end TB, including improved diagnosis, treatment, and case detection. The Global Plan to End TB, launched in 2015, sets ambitious targets to reduce TB incidence by 2035 and eliminate the epidemic by 2050. The Plan focuses on accelerating and scaling up comprehensive national TB control programs, improving access to quality-assured services, and involving affected communities in decision-making and service delivery.

The GFATM has been instrumental in supporting countries to sustain and further accelerate progress towards the global TB targets. The Global Fund's support has enabled countries to scale up TB control programs, improve diagnostic strategies, and reduce the incidence of TB. The GFATM has also been critical in supporting research and development to develop new and more effective TB interventions.

In conclusion, the GFATM's support has been crucial in promoting health equity and addressing TB in low-income countries. The Fund's contributions have helped countries to strengthen health systems, improve access to care, and reduce TB mortality and morbidity. The Global Fund's commitment to end TB remains critical, and continued support will be needed to achieve the ambitious targets set by the Global Plan to End TB.
3. Nsanzimana S, Prabhu K, McDermott H, Kar-
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which begins with the health of a single person (citizen). Health policy itself may include various directions and fields, such as healthcare, insurance, vaccination, mental health, pharmaceutical, healthy life styles and environmental health policies, including anti-smoking, anti-obesity, reproductive policies, etc. Being complex in nature, it also concerns issues of financing, improving legislation, ensuring social justice and implementing many targeted programs to solve various problems in this area. Health policy is multilevel and comprehensive, since decisions made at the state level are passed for execution to separate bodies such as the Ministry of Health and municipalities. The importance in this regard is given to solving the most urgent problems in the country. So, for example, the problem of obesity is not as acute as the problem of hemophilia / hemophilia in Azerbaijan. In this regard, the Cabinet of Ministers of the AR approved the Resolution on the State Program on Hereditary Blood Diseases of Hemophilia and Thalassemia [5] adopted in 2006.

Today, the development concept – Azerbaijan 2020: A Look into the Future – approved by the Decree of the President of Azerbaijan Ilham Aliyev in 2012, defines the main objectives in the field of development of the state budget, as well as in other areas. Paragraph 7 of the Concept gives priority to “the development of human capital and creation of an effective social security system” [6]. This paragraph defines the goals and objectives in the healthcare system, seeks to ensure a dignified and comfortable life, improving education, modern development, educating youth and sports potential, ensuring gender equality and family development.

One of the main tasks in modern healthcare policy is increasing government allocations for the development and modernization in the field of medicine. The public health system in Azerbaijan is financed from the state budget. The Ministry of Health is the central authority in the field of healthcare [7] coordinating relevant issues. In 2014 the Ministry adopted the Decree on Approval of the Strategic Plan of the Ministry of Health of the Republic of Azerbaijan for 2014–2020 [8], which outlined the social orientation of its activities. The Ministry of Finance develops and determines the budget of the Ministry of Health, which is approved by the Milli Majlis (Parliament). In 2017, more than 775 million manats were allocated to healthcare; expenditures on science, education, healthcare, social protection and other related categories accounted for 32.5% of the total state budget, of which 4.7% was allocated for healthcare [9]. By Decree of November 30, 2018, President of Azerbaijan Ilham Aliyev approved the country’s budget for 2019 [10], in which more than 1 billion manats were allocated to the healthcare sector. As an increase in the amount of budgetary funds for health careunderlinesthe priority of this sphere in the domestic political course and indicates increased attention to this sphere from the top leadership of Azerbaijan. The key task of modern healthcare reformation is the introduction of the compulsory medical insurance system. Although, the use of insurance in healthcare was laid down in 1999, by the adoption of the Law “On Compulsory Health Insurance” [11], the text of the law is still being edited, and its updated version will come into force only in 2020. In 2007, by the Decree of the AR President, the State Agency for Compulsory Health Insurance was established [12] under the Cabinet of Ministers. Formation of a uniform compulsory health insurance is one of the Agency’s main tasks.

The Concept of Reforming the Health Financing System and the Application of Compulsory Health Insurance was adopted in 2008 [13], its implementation requires a complete reorganization of the financing system, a new healthcare restructuring, etc. According to the Concept, the reform of healthcare financing is aimed at creating new economic principles, improving access to medical services, increasing the efficiency of using budget funds; the state provides free budget-funded medical services, however, publicly guaranteed health care is not universal, and some services must be paid by citizens [14]. The reform implies creation of an integrated electronic healthcare system, i.e. combining a universal type of public health insurance system (financed from the state budget) and a private system partially funded by citizens, which is a lengthy process. So, since 2016, two cities of Azerbaijan – Mingachevir and Tovkul with their districts have been selected as pilot territories for testing a new type of health insurance [15]. In December 2017, by a decree of the President, the Agdash district [16] was also included in the pilot program.

The Center for Public Health and Reforms (CPhHR) under the Ministry of Health was established in 2006 is financed from the state budget and implements the state health policy in the direction of its reformation. According to the Regulation on the CPhHR, it participates in the development and implementation of health policy; ensures the organization of healthcare, develops proposals for reforms in this area, implements reforms in primary health care, etc. The Center has already implemented many projects, such as Creating Schools for Diabetics, Developing a National Tobacco Control Strategy [17].

The Health Informationization Center under the Ministry of Health, established in 2010, [18] operates as an online resource that provides numerous services, such as request of appointments for specialists, online consultation, electronic insurance cards, e-prescriptions, electronic social services or electronic registration to visit a doctor. However, the electronic system is still under development and has a limited number of services. In addition, the use of electronic services is not popular among citizens living away from the capital.

Preventive measures to improve the health of the population, as one of the priorities of the health policy, include many programs to help patients with infectious and non-infectious (social) diseases. The preventive policy on infectious diseases is based on legal norms formulated in the medical laws of the Republic of Azerbaijan, such as On the Immunoprophylaxis of Infectious Diseases [19] and On Fight Against Tuberculosis [20], adopted in 2000. Both of these laws indicate state support for their implementation.

Non-communicable diseases, such as cardiovascular, oncological, diabetes, etc., and risk factors like smoking, drug addiction, obesity, alcohol abuse, constitute a significant threat to public health, especially to young people. For example, smoking harms not only smokers, but also people around them (second-hand smoke) and, no less important, the environment. So, in 2015, by Decree of the President of the Republic of Azerbaijan, the Strategy to Combat Non-communicable Diseases in the Republic of Azerbaijan for 2015–2020 [21] was approved. The adoption of such a strategy has two important aspects. Firstly, it is a striking example of the tasks of domestic health policy corresponding with international trends and responding to modern challenges. Secondly, the adoption of the program in the framework of cooperation with the UN and WHO speaks of a policy of harmonization of internal health goals with global goals, i.e., the adoption of the Strategy of 2015 was a direct result of the close cooperation of the Republic of Azerbaijan with the UN and WHO. Namely, the UN adopted the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases in 2011, which gave impetus to the further development of the WHO Global Action Plan on Noncommunicable Diseases 2013–2020 [22]. Since non-communicable diseases cause concern of the world community, the Azerbaijani leadership also responds to the need to solve the problem of non-communicable diseases in modern legislation, adopting relevant decrees and regulatory documents aimed at eliminating them.

Moreover, the State Program for Improving Maternal and Child Health for 2014–2020 [23] was adopted in 2014. Because of the importance of the problem, the prevalence of non-communicable diseases and demographic indicators have increased and, according to data for 2015 over the past 10 years, infant mortality per 1000 live births decreased from 11.9 to 11.1, and maternal mortality decreased from 30.2 to 14.4 [24].

The political course of the country is closely connected with legislation, since it is the legal norms that govern the implementation of decisions taken at the political level. Legislation in turn is based on international principles and norms, such as universal bio-ethical principles. The basis of state policy related to the protection of public health lies in the country’s main law – the Constitution, which declares that each decent standard of living of a citizen “is the supreme goal of the state” [25]. Article 41 (The right to health care) declares the right to medical care and a state role in the development of all types of healthcare, which operates on the basis of various types of property and various forms of health insurance [25]. The Article is consistent with the provisions of the Universal Declaration of Bioethics and Human Rights that emphasizes “role of the state” [26] in the implementation of bioethical principles.

Medical law in Azerbaijan is somewhat fragmented due to the lack of systematic approach of national health authorities to this matter, lack of understanding of informed consent doctrine and equality of rights of medical professionals and patients concerning the treatments, etc. However, patient’s rights are protected by different legal documents and represent part of the Law on Protection of Public Health of 1997 [27]. The Law defines state obligations in the field of public health protection, such as determining state policy and developing programs, financing in the field of healthcare and environment, as well as the rules for organizing and functioning of the healthcare system. The Law encompasses also numerous bioethical principles, such as protection of environment, biophere and biodiversity, social responsibility and health. The universal bioethical principles of justice and equal rights are also reflected in Article 10 (Chapter III) of the Law, which indicates equality in health issues between citizens and non-citizens, and Article 12, which protects the right to receive not only medical, but also social assistance in case of disability [27, etc.

Health of the people in research and clini- cal experimentation is protected by Decree of the AR Cabinet of Ministers of 2010 on the Rules for the Conduct of Scientific Research of Drugs, Preclinical Research and Testing. Despite the fact that this Decision is not directly related to the protection of public health, its importance for the development of the field of medicine in the country is obvious. It refers to a field of research that underlies the development of new drugs – an integral element that ensures the development of medicine. So, Clause 4.4 of the Decree states “The safety and health of the person in whom the tests are conducted are of paramount importance, and they must be above public and scientific interests.” [28] This norm corresponds to the bioethical principle “human dignity and human rights”, which proclaims the inviolability of an individual as an individual over the interests of science or society. Moreover, the resolution indicates the obligation to obtain informed consent (written or oral, with the participation of two witnesses, if the person cannot write), which directly corresponds to the bioeth- ical principle of “consent” (implied or informed) and “persons without the legal capacity to give consent”.

The principle of “consent” is also widely reflected in the Law on Psychiatric Care [29]. The Law obliges medical institutions to provide appropriate assistance (with the exception of involuntary hospitalization), to attract (with the right to refuse at any time) patients to research as an object, as well as their use in the educational process only after receiving consent.

Information from National Medical Associations

Information from National Medical Associations
It must be emphasized that the issue of health is in progress. As said, the 1997 main health law covers the main provisions, including the patients' rights [27], and confirms the right of all citizens to medical care. Inequalities in the level of medical services for various social groups of the population are prevented by access to state medical institutions, such as clinics, free of charge. Moreover, according to numerous legal acts, vulnerable segments of the population, especially those who are chronically ill, receive medicines and medical assistance from the state. Thus, the Law on State Assistance to Patients with Disabilities [34] was adopted in 2003, which defines free diagnosis and treatment of this group of patients. Similar legislation was adopted concerning oncology patients as well. In 2013, the Law on Compulsory Medical Examination of Children [35] approved state fundings for implementation of comprehensive measures of medical examination. The mentioned provisions reflect the essence of universal bioethical principles, such as equality, justice and equality, protection of future generations. Today, the introduction of bioethical principles and the harmonization of medical law in post-Soviet countries [38], the holding of such a congress for the first time during its 52-year history in this part of Eastern Europe and Near Asia confirms the development of this field in the Republic.

Thus, based on the analysis of the state's policies and legislative acts of Azerbaijan in the field of healthcare, the following points are evident:

1. The field is actively developing, and although the bioethical principles are widely reflected in legislation, yet there is much to be done. Given the close relationship between policy and law, it is obvious that the norms reflected in legislation, including bioethical principles, are a determining vector in the formation of healthcare policy.

2. Azerbaijan implements many activities in order to harmonize medical legislation with international standards and its reformation is in progress.

References

1. National Committee on Bioethics and Multiculturalism under the President of the National Academy of Sciences of Azerbaijan monitors bioethical issues, their scientific research, educational and counseling activities [36]. However, unfortunately, this body does not have the legal ability to regulate bioethical issues in healthcare.

The Azerbaijan Unit of the UNESCO Chair in Bioethics has translated into Azerbaijani the UNESCO Basic Program on Bioethics. Moreover, the Unit initiated the Training of Teachers on Ethical Education of UNESCO which was held in Baku in 2012, introduction of the subject Bioethics and Medical Law as a scientific discipline in the educational program of students of the law school of Baku State University and inclusion of articles in the code of scientific specialists [37]. The 18th session of the UNESCO International Commission on Bioethics, the 23rd World Medical Law Congress (WAML – the 50th Anniversary Congress – under the title Medical Law, Bioethics and Multiculturalism were held in the capital of Azerbaijan in 2011 and 2017 respectively. Since the WAML has an important role in shaping medical law in post-Soviet countries [38], the holding of such a congress for the first time during its 52-year history in this part of Eastern Europe and Near Asia confirms the development of this field in the Republic.

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"Medicine is an art whose magic and creative power have long been recognized as residing in the inter-personal aspect of patient-physician relationship" [1]. It is based on trust and mutual respect and it is a well known fact that clinical outcomes are determined by the confidence a patient has in his treating healthcare professional.

Today, effective doctor-patient relationship is one of the central clinical elements, as it contributes to more patient-centered healthcare delivery. Alongside creating a good interpersonal relationship, the exchange of information, it also constitutes including patients in the decision-making, regarding their condition and treatments via a wide range of health benefits and quality of life [2, 3]. Thus, shared decision-making requires close and continuous communication between patients and doctors – at inter-personal level for improved individual care, as well as between their associated communities, in order to influence policies for better access to and quality of healthcare at wider population scale.

Our founders aspired that we should centre healthcare worldwide on the value of healthcare and to help build patient-controlled healthcare decision-makers. This transformation of the global healthcare and healthcare delivery. Firstly, creating an enabling environment, globally and within a patient organisation, that encouraged and gave a greater number of patient organisations the opportunity to have their representative serve on international boards, committees and policy-making bodies. Secondly, through carefully designed leadership training, capacity building programmes and attendance at WHO and World Bank forums expose more patient representatives to the global healthcare institutional, legal, policy, and practice and standards framework and develop their skills and confidence to undertake national or regional patient advocacy. Thirdly, by focusing on cross cutting issues of safety and quality, research & innovation and disruptive technologies, every member organisation could have the opportunity to participate in IAPCO programs and projects thus improving the quality of patient advocacy skills in our networks and lastly, using this diverse global Governance Board to develop innovative programmes, projects and tools for our members that has a high reach and impact on healthcare. Today, IAPCO movement has matured and has come of age. Where in the past we were excluded from the healthcare institutional, legal, policy, practice and standards framework, today we are fitted to join them. We are valued because we bring special insight and experience of healthcare and have developed a considerable voice to reach out to the key healthcare decision-makers. This transformation of an exclusory healthcare infrastructure into a positive patient-centric one has permeated all levels and institutions in many healthcare settings and systems.

Many WHO Member States are now waking up to the idea that they need the patients’ perspective and experience to make their healthcare policy and services effective and efficient. This realisation has also drip-fed to the recognition which want patient insights and perspectives on market authorisation of innovative medicines and devices. The pharmaceutical industry has long benefited from patient participation and including them in the drug discovery and development. They are now looking at co-creation and co-designing to maximise patient value and efficiency in their industry. Most countries now aspire to have universal health coverage by 2030. IAPCO strives to ensure that patients have a high quality of patient advocacy in place so that we can ensure that they have a sufficient quantity of accessible, acceptable and affordable preventative, therapeutic, curative, rehabilitative and palliative healthcare by 2030. But much more than this, we must ensure this healthcare is delivered in a safe and compassionate manner, to WHO standards.

One of your colleagues has rightfully said, “the patient will never care how much you know, until they know how much you care” [4]. Thus, IAPCO wishes to call upon all medical and health professional associations to closely work together and collaborate with patient organizations in their respective countries. It is only through the involvement of patients and patient-doctor synergies that we can have a comprehensive holistic health service delivery to all.

References
Unfortunately, Somaliland has not yet op- erationalized health sector regulation to address these gaps; Somaliland’s health system is young, it requires providing equitable, efficient and affordable quality priority health services as close to the communities and families as pos- sible based on primary health care approach.

There are opportunities to address these gaps; Somaliland’s health system is young, it requires providing equitable, efficient and affordable quality priority health services as close to the communities and families as possible based on primary health care approach.

The policy makers’ involvement is crucial to have a willing leadership to improve the quality of health care and increase the patient safety standards; this is to develop standard operating procedures for the qual- ity of care that includes checklists and rou- tine/regular monitoring and training.

Improving infrastructure and equipment, surgical training, residency specialization and anesththesia, health workforce plan adap- tion and regulation are essential.

Mariam Abdullahi Dahir
MBBS, MPH
Health systems specialist in Somaliland Medical Association

I would argue that the modern Ugandan Doctor, a practicing doctor in three aspects: First, report for duty, in time and actually attend to patients as our first consideration due to Hippocratic Oath. A doctor’s presence guarantees quality of care to Ugandans in immediate need, including children with severe malaria and mothers in obstructed labour.

Secondly, take leadership and have operat- ing theatres in our Health Centres IV. Many doctors have shed away from our health system due to its weakness. Yet, strengthen- ing the health system is in our interest by promoting the practice of medicine as well as securing our lives as potential patients or victims of road traffic accidents.

Third, let us speak-up for our patients to ad- vises and call to action our decision makers at various levels from health facility to Local Governments, Parliament and the Executive. This is in line with the utilitarian principle (greatest good for the greatest majority) and Hippocratic Oath that “…the health of my patient shall be my first consideration…”.

With this three-pronged approach, Ugan- dan doctors will make a meaningful contri- bution towards the Universal Health Cov- erage of 2030.

The Right to Health: What is the Role of the Doctor in Uganda?

Health is wealth, and any nation worth its salt will upgrade for a healthy popula- tion for sustained economic productivity. The right to health is enshrined in vari- ous international and Ugandan laws and is a basic right of every Ugandan. However, beyond dry ink on paper what is our role as Doctors in guaranteeing the common Ugandan citizen the right to health?

Doctors are the natural leaders in medi- cal teams and principals in guiding society about healthy living. To support this claim, one of our forefathers Dr. Carl Ludwig Vir- chow (1821–1902), who wrote about the Virchow’s triad of functioning health sys- tem was the establishment of Amoud Uni- versity Medical Faculty in October 2000 and later Hargeisa University Medical Fac- ulty in 2004. The establishment of the Edna Adan Nursing School and the opening of Nursing & Midwifery Training Institutions such as Hargeisa Institute of Health Sci- ences, Bureau Institute of Health Sciences and Amoud Nursing School. The first group of locally trained doctors graduated in Au- gust 2007 from Amoud Medical School.

Patient safety is not sufficiently taken into account, theoretical understanding about quality is good but the application is not widely practiced. The existence of guidelines is limited and not readily available, reducing the accessibility to knowledge about the ex- pected standards of care. Supervision from the hospital management and leadership is limited, requiring capacity development and investment in their workforce.

The right of Ugandan doctors to be rec- ognized by the accreditation agencies or un- accredited institutions means that the coun- try continues to produce “graduates” whose qualifications are currently unrecognized by the government of Somaliland.

There are opportunities to address these gaps; Somaliland’s health system is young, it requires providing equitable, efficient and affordable quality priority health services as close to the communities and families as possible based on primary health care approach.

Only a national health insurance scheme could come close to bridging this health- financing gap and empowering the citizen to fight corruption in the health sector. This mechanism permits for solidarity that the rich pay for the poor, the employed pay for those not working (retired and children) and those who fall sick often are catered for by contributions from those who are healthy. By directly contributing to a national scheme Ugandans will be empowered to demand for quality of health care, less so in the current “free health care” regime (tokenism).

Somaliland has not yet Uhuru! Why not Uhuru in Uganda?

Ugandan doctors have been engaged with making the state highlight the key policy con- cerns: plaguing the health sector, with a par- ticular focus on human capital. More recently, this culminated into the 3-week countrywide doctors industrial action during November 2017. Indeed, the government of Uganda responded positively by increasing the health sector budget in the subsequent fiscal years 2018/19 and 2019/2020, specifically target- ing medicines and essential supplies via the National Medical Stores by Uganda shillings 138 billion (+60%), Uganda Blood Transfu- sion Services supervisory over 21 billion (100%) and salary enhancement for all health workers by 30% to nearly 100% depend- ing on the cadre. Consequently, it is obvious even to the blindfold that the government has heavily invested in physical infrastructure and equipment, such as the numerous hospi- tals renovated or newly constructed: Kirem- du, Naguru, Kawempe, Karamoja, Muhende, Mityana, Masaka, Entebbe and the Mulago complex with the new Cancer Institute and specialized one for Women in Mulago.

Overall, Uganda has come a long way and made significant achievements in key health outcomes. The life expectancy at birth is now at 60 years and above from below 45 years due to the wrath of HIV/AIDS; maternal deaths have dropped from above 500 to less than 350 per 100,000 live births, which is still very high; tremendous reduc- tions in child mortality with simultaneous reduction of malaria in the recent past.

Health Sector Reforms in Uganda, not yet Uhuru!

British Medical Association was formed. Between 1918 and 1921, the BMA secured major salary improvements to attract and re- tain its members to practice in East Africa. Soon after, between 1930 and 1950 the doc- tors’ Association concerned itself with hos- pital conditions and public health. Around the time Uganda gained independence, the struggle was for African doctors to be rec- ognized as such and not Medical Assistants. The late Prof. Akil Mwa Odonga, in his book The First Fifty Years of Makerere Medical School and the Foundation of Scientific Medical Education in East Africa, recalls how African doctors would travel to the United Kingdom to sit for examinations and return even be- fore the results were released as a sign of pa- triection. Indeed, Makers used to be a breeding ground for African doctors continent-wide.

President Obu and Uhuru

President Uhuru Kenyatta declaresUhuru Kenyatta declares health a fundamental rightElectronic Health RecordsElectronic Health Records

However, is it yet Uhuru for the health ser- vices Ugandans are subjected to? Uhuru in Swahili means freedom from poverty of self-determination. How many Ugandans are increasingly impoverished by enormous costs for their medical care (catastrophic health expenditure)? In the next paragraphs, I describe that there are three game chang- ers the government could build on to realize the Universal Health Coverage especially to the poor and very poor Ugandans.

First, the most effective intervention for Uganda is to increase the money available for health services through the long awaited national health insurance scheme. This in- surance scheme idea has stagnated for over 3 decades, appearing in over 3 presidential manifestos, since the time Uganda’s health sector budget share was 3%. The budget of the health sector has not been responsive, stagnating between 7% and 9% for the past decade, while that for roads has tripled to about 20% share of the national cake. The ideology of a national health scheme is that of solidarity in the sense that the rich pay for the poor, the working class pays for the indigent, retired and children; whilst the healthy population pays for the sick. Most of all, every citizen shares this collective

Unfortunately, Somaliland has not yet op- erationalized health sector regulation to include functions like the registration, li- censing and accreditation of health pro- fessionals and institutions and programs to properly protect the patients’ right to get quality health care. The unregulated nature of the health sector and the short- age of health professionals have created a health system where an unknown number of persons work as unqualified “health pro- fessionals” and proliferation of unregulated healthcare facilities such as clinics, pharma- cies and medical laboratories and education program for healthcare workers. This situa- tion has raised public safety concerns, and is a barrier to improving the quality of health services. Furthermore, the emergence of the so-called training program provided by un- accredited institutions means that the coun- try continues to produce “graduates” whose qualifications are currently unrecognized by the government of Somaliland.

I would argue that the modern Ugandan Doctor, a practicing doctor in three aspects: First, report for duty, in time and actually attend to patients as our first consideration due to Hippocratic Oath. A doctor’s presence guarantees quality of care to Ugandans in immediate need, including children with severe malaria and mothers in obstructed labour.

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responsibility further entrenching patrio-
tism whose curriculum would hardly be
 taught in formal classes. A prepay-
ment scheme of this kind is inherently dem-
cratic as it improves the demand for quality
services and acceptability by the tax-paying
citizenry. Indeed, it is such a scheme that
would subsidize the service costs at the
newly commissioned Women Hospital in
Mulago that has generated uproar from the
population.

The second game changer is Mr. Museveni’s
focus on health promotion and disease pre-
vention. In September 2017, our 2nd Grande
Doctors Conference was held, the theme was “promoting healthy lives”. The cost sav-
ings for disease prevention programmes are unprecedented for low-income countries
like Uganda whose investment in health
mismatched the burden of diseases. Indeed,
after the mass distribution of insecticide
treated mosquito nets, malariologists have
discovered that in some areas in Uganda,
such as Kampaala, malaria has disappeared. Gone are the days that every fever would likely be malaria. Certainly, Mr. Museveni’s response to the epidemic of non-communicable diseases is a game
changer akin to the “ABC strategy” of the late 1980s and early 1990s when, in the
absence of antiretroviral therapy, Uganda’s
homegrown solution dealt a major blow
to the HIV/AIDS scourge. Ugandan doc-
tors have hardly been spared by the cancer
epidemic to which we lost over 5 doctors in
the past year alone including our icon Dr.
Margaret Mungureza who passed away on
Consequently, the Uganda Medical As-
sociation initiated the Physician Wellness
Programme for screening all medical doc-
tors for cancer and other diseases of life-
style, as we lead by example. We are pleased
that the government has purchased several
radiotherapy machines that will be installed
as soon as the bunkers at Mulago are com-
pleted.

Third, solutions for human capital weak-
nesses in Uganda’s health system should be
in sync with the progressive global stratet-
gies on human resources for health recom-
mented by the World Health Organization
and Global Health Workforces Alliance. The
recent increase in salaries will definitely at-
tract health workers to report early, report
in hard to reach areas and remain productive at
the health facility. This move may comple-
ment the proposed biometric surveillance
machines. However, where health worker
staffing is chronically low or with perennial
shortage of medicines and limited access to
medical technologies, Ugandans cannot be
guaranteed quality services. These data from
5,600 absentee health workers suggest that
the sheer scarcity of a robust health work-
force is a bigger underlying problem for
which we should invest as a country. With
the new competitive salaries, Moroto Re-

Clean Indoor Air is Key to Asthma Prevention

In most homes, the air inside is dirtier than
the air outside, contributing to asthma and
other pulmonary complaints. This month,
the WMA’s My Green Doctor program has
a short guide to help your patients improve
indoor air quality. "Go Green at Home to
Prevent Asthma and Breathing Problems". You
might print copies to share with your
office colleagues and for the waiting room.
https://www.mygreendoctor.org/go-green-at-
home-to-prevent-asthma-breathing-problem

There’s also a link to a free waiting room
poster.

My Green Doctor is a free membership
benefit from the World Medical Associa-
tion that is saving members money as their
offices adopt wise environmental practices
and share these ideas with their patients.
Hundreds of healthcare offices and clinics
of WMA members use My Green Doc-
tor. It adds just five minutes to each regular
office organizational meeting. My Green
Doctor explains what to say and do at each
meeting and says that there is nothing for the
office manager to study. Your patients will be
impressed! Ask your clinic manager to regis-
ter: https://www.mygreendoctor.org

If you are a leader in your national medi-
cal association, please add this message to
your organization’s newsletter so that your
members can enjoy this free membership
benefit. To receive this e-newsletter an-
ouncement in a language other than Eng-
lish, simply contact My Green Doctor’s
Editor: todd@nppa.com

Interview - Survival: One Health, One Planet, One Future –
Routledge, 1st edition, 2019, by Daniele Dionisio
PEAH – Policies for Equitable Access to Health

Re-published with permission from Dr. Daniele Dionisio, Member, European Parliament Working Group on Innovation, Access to
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Initiative as well as the international One
Health for One Planet Education Initiative
(1 HOPE). He has published widely on educa-
tional transformation, innovation and leader-
ship and been invited as a plenary speaker
to different corners of the world.

Lueddeke: The book tries to make sense of
the uncertain and tense (“turbulent”) times
we are experiencing and asserts that the One
Health & Well-Being concept (OHWB) –
that recognizes the interdependencies among
humans, animals, plants and their shared en-
vironment – is critical to safeguarding our
future while also providing a “unity among
a common purpose” that seems to be miss-
ing globally. I prefer the term One Health &
Well-Being (vs just ‘One Health’) as it
emphasizes not only the crucial importance
of human physical and mental well-being
but also the need to strive toward meeting
socioeconomic, geopolitical and ecological
conditions to ensure the sustainability of all
living species and the planet.

I also argue that the OHWB approach
ought to drive/enter the 17 UN 2030 Sus-
tainable Development Goals (SDGs) that
were agreed by all 193 Member States of
The main aim of the UN Global Goals is to
create a ‘more just, sustainable and peace-
ful world’. The OHWB perspective needs to
inform and encourage decision-makers at
every level – especially Civil Society – to
get behind the UN global initiative regard-
less of ideological persuasion or divisions.
The challenge is how to get government,
business and civil society behind OHWB

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PEAH: Dr. Lueddeke, the internation-
al One Health for One Planet Education
(1 HOPE) initiative was created to address
perhaps the most important social problem
of our time: ‘How to change the way hu-
mans relate to the planet and each other to
ensure a more sustainable future to all life’. On this wavelength, what about the main
purpose of Surviv-
al: One Health, One
Planet, One Future?

George R. Lueddeke: ‘Survival: One
Health, One Planet’ was designed to
steer the UN 2030 Sustainable Development
Goals (SDGs) and Global Health Workforce
Alliance. The

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World Medical Journal
and the SDGs across all nations – those that are economically developed and those that are developing and of course those that are in disarray – many for reasons that defy logic. Concentrating on local needs guided by national priorities that are in keeping with sustainability values and practices is without a doubt the best way forward.

There are about 7.7 billion people on the planet, and it is estimated that there will be over 9.8 billion by 2050 and 11.2 bilion in 2100. Climate change, urbanisation, pandemics, conflicts (globally we spend over US $7 billion on war and only 3% on peace – $6 billion!) and food security are main issues we need to tackle now and feature in the book along with health care – perhaps prompting reconsideration of the term “Public Health” and widening its remit to the more inclusive “Global Health and Well-Being” as the focus must shift to ecocentrism.

Changing the way we think and behave should no longer be a question of why but how – although our main concerns continue to be political and economic rather than sustaining the planet. Populism, nationalism and isolationism are antithesis of the paths toward which we ought to be striving. The root causes of these movements need to be investigated and solutions found that ensure global equity, peace and sustainability. It may be important to re-group global decision-makers that if we fail to save the planet none of the other human activities will matter. Shelley’s poem Ozymandias (1818) comes to mind. I am also reminded of a quote by economist and author John Kenneth Galbraith – A nuclear war does not defend a country and it does not defend a system … not even the most accomplished ideologue will be able to tell the difference between the ashes of capitalism and the ashes of communism.

PEAH: The book highlights two of our greatest social problems: changing the way we relate to the planet and to one another and confronting how we use technology for the benefit of both humankind and the planet. How to translate theory into practice?

Lueddeke: Several years ago, Marco Lambertini, executive director at WWF, made clear why there has to be a major societal transformation. As one example, he observed that “in less than two human generations, population sizes of vertebrate species have dropped by half!” Further, he reminded us: “These are the living forms that constitute the fabric of the ecosystems which sustain life on earth and the barometer of what we are doing to our planet, our only home.” He also warned that “We ignore their decline at our peril.” Echoing the book’s main theme, he also emphasised the need for “unity around a common cause,” collaboration, and leadership “to start thinking globally and to stop behaving as if we have a limitless world.”

In the intervening five years since the WWF report was published, too few leaders – G7 (France, United States, United Kingdom, Germany, Japan, Italy, Canada, Russia suspended) and G7 (emerging – China, India, Brazil, Mexico, Russia, Indonesia, and Turkey) have listened. Given the available evidence today (e.g., the UN biodiversity report published in May 2019), there is now, unquestionably, a pressing need to re-orient society towards a sustainable future. The challenge is to shift our perspective from two-dimensional to three-dimensional, “bird” thinking, as NASA International Space Station astronaut Col Ron Garan contends – “bringing to the forefront the long-term and global effects of every decision.”

PEAH: Relevantly, you maintain in the book that two fundamental changes are necessary if we – and all other species – are to survive in the coming decades. Tell us more, please, around these changes.

Lueddeke: In terms of sustainability we are challenged to make a fundamental mind-shift – adopt a new worldview – to ensure our needs and human beings are compatible with the needs of our outer world – our ecosystem. Education is key in this regard as it is global/national/local policies and strategies that underpin OHWB and the SDGs.

Secondly, we must ensure that technology/AI is used only for peaceful purposes and in support of the health and well-being of all species and the planet. The dangers of techno warfare and genetically engineered viruses are all too real and we must learn from history. The late physicist, Stephen Hawking, said it best: “We are all different. We all share the human spirit but ‘unless crucial societal transformations occur, including the prevention of nuclear war, global warming and genetically engineered viruses – the shelf life of Homo sapiens could be extremely short.’

“The battle between technology and human- ity may yet become our greatest threat. As we head further into a techno-driven society – age of quantum computers (where computations can be done in minutes vs 10,000 years on today’s supercomputers), there is a real danger that we become increasingly dehumanized rather than as Klaus Schwab, executive chairman of the World Economic Forum, aspirated, that we refocus on becoming ‘better humans.’

PEAH: Summarised in “Ten Propositions for Global Sustainability” (Ch. 12), the volume calls for the One Health and Well-Being concept to become the cornerstone of our educational systems and societal structure at large and that OHWB principles and approach should underpin the UN 2030 Sustainable Development Goals.

Lueddeke: Well, the UNSC was formed after WWII (1944) consisting of 5 permanent members (US, China, Russia, UK, France), while in 2019, the most densely populated regions with the greatest pov- erty and conflicts (Africa (c. 1.2 bill), India (c.1.3 bill), SE Asia (c. 600 mill), Middle East (c. 400 mill) – c. 50 % [3.5 bill out of c. 7.7 bill] – are NOT permanently repre- sented. shifting to regional (6) representa- tion (vs countries) would clearly be in the best interest of the world given the need for global accountability and sustainability. UNSC members should also be held globally accountable by key stakeholders; governments, business, civil society – for their role in maintaining world peace and security – based on a genuine commitment to shared values and population health. The ques- tion is how can we achieve these ends when forces are pushing the world in the opposite direction. Surely, these decision-makers also have children and grandchildren and would like to see them thrive in a better world where hopes and dreams can be realised.

PEAH: As for the range of key topics cov- ered in the book?

Lueddeke: This is my third book this decade and in a way represents a personal journey of discovery trying to understand the world and healthcare – from a more narrow human- centric medical education perspective (Medi- cal Education for the 21st Century), moving to the wider public health horizon and rec- ognizing the limitations of my assumptions (Global Population Health & Well-Being in the 21st Century) to pulling various strands together in Survival: One Health, One Plan- et, One Future. I don’t think I could have written the latter without the former. The new publication is really a building block of personal knowledge acquisition tinged with personal and professional experience in Can- ada and the UK plus other countries.

PEAH: As reported ‘...The sub-discipline that has perhaps come closest to integrating other disciplines, including medicine and environmental science, is public health. ‘Survival: One Health, One Planet, One Fu- ture’, George R. Lueddeke, the chair of the One Health Education Task Force, shows how public health can be incorporated into a wide range of fields to address individual, population, and ecosystem health...’With respect to this, kindly let us know more.

Lueddeke: This quote appears in one of the on-line book reviews and comes from a World Economic Forum / Political Indicate on-line article, “Economics can no longer ignore the earth’s natural boundar- ies,” written by Erik Bengt of the London School of Economics. Three key messages are that 1) economists have treated inequal- ity too narrowly and that income dispari- ties within countries are caused by global financial forces rather than local labor-market conditions; 2) policies are required to make society more sustainable; and 3) a new field of planetary social science is needed to bring together ‘different per- spectives, conceptual frameworks, and ana- lytical tools.’ He affirms that public health is closest to integrating other disciplines and refers to Survival: One Health, One Planet, One Future, and ‘how public health can be incorporated into a wide range of fields to address individual, population, and ecosys- tem health.’

Survival concludes with a discussion on the leadership role that Generation Z – those the ‘fiers’ born in the mid 90s – need to play in the decades that lie ahead. They are becoming the face of the planet and are much more tolerant of others and thrive on collaboration. Recalling the eloquent words of civil rights leader Martin Luther King Jr, Gen Z are certainly far from silent ‘about things that matter.’ Their voices must be heard across the globe as their future de- pends on decisions we make today!

PEAH: Your insightful answers best en- hance the book. So compounded, the vol- ume is of great interest to policy-makers,
multi-professional practitioners, academics, students across all disciplines and concerned members of the general public – especially the younger generation – in both developed and developing nations. For many reviewers to date, your book is indeed a wake-up call which needs to be heard "loud and clear" globally.

Just echoing a recent endorsement by Tracey Collins, founder at The Island Retreat, County Cork, Ireland… When we accept that human kind is part of something bigger, then the world would be a better place. Our natural world is not there to provide us with unlimited resources… it really is time to start learning to respect it. "Thank you Garry R. Lucocke for being a voice of reason in a world of chaos!"

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Digital Transformation Initiatives

Digital Transformation Initiatives in South African Context

Digital transformation is growing at a slow rate in medical schemes, and may only accelerate when compared with other industries such as banking and insurance. The healthcare sector needs to embrace the digital transformation and adopt and optimize the use of technology. Otherwise, the sector will be left behind. Other sectors have taken advantage of technology, typically, in the retail sector, nowadays consumers shop online, bank, and do travel bookings online. The logistics business has also embraced digital transformation in that most activities are now done through devices using the convenience of one’s office or home.

The recent HPCSA1 conference included topics such as Telemedicine’s where several digital transformations and innovations in the health sector were presented. What was evident in the discussions was that progress in accelerating digital transformation is hampered by the slow pace of regulation and other relevant guidelines. The topics discussed clearly revealed that the health sector is still far behind, compared with other countries. For example, there is a gap in the adoption of digitally enabled tools for diagnosing, providing treatment, and better management of chronic and other conditions. Electronic medical records are still not a part of routine care, both from the supply and the funders side, except for a handful of players.

On the funders’ side, you do find several medical schemes who invest in technological innovation. For example, there are schemes that are already implementing digital application forms for smooth onboarding of new members. This is with the aim of going digital and reduce paper application forms. Similarly, the submission of claims of which more than ninety-eight (98%) are submitted in electronic form has transformed claims significantly. Strategies such as digital marketing are typically used to reach the target market and to communicate more effectively with members. Several schemes have invested a lot in product development, such as mobile apps, and by developing communication channels through online and social media platforms. Social media platforms provide an opportunity for brand repositioning. They also provide an opportunity to reach a new target market and gain access to a larger pool potential client base. Social media platforms could also be used as a tool to improve services to clients, create convenience and provide instant interaction with clients. However, very few medical schemes optimize on these platforms, particularly small to medium schemes. There is still a need to measure the value added of digital transformation to members, chiefly where the quality of care is concerned.

A recent study was conducted by Wilje, which was an unstructured survey on the use of medical scheme mobile apps by members [7]. The survey revealed that more than seventy-five percent (75%) of the respondents did not have the app installed.

Some of the reasons given for not using the app were:
• Lack of awareness about the app;
• The app is complex;
• No reason to use the app;
• Does not meet my needs.

Digital disruption has great potential in healthcare. The main areas of investments are certainly Big Data analytics and AI (Artificial Intelligence). Some of the Big Data analytics tools are useful for improving efficiencies, where some of the tools can be automated. This could potentially yield better utilization of human resources and could potentially create huge cost savings. In the main, Big Data and AI tools are used to profile clients, medical service providers and to look at healthcare utilization patterns and trends. Some of the techniques such as predictive analytics are important; in that they can be used, not only to profile members but also to create a strategy to combat attrition. Insights from the data could be used for data-driven decision-making processes that could potentially save huge downstream costs for medical schemes. There is also great potential in investing in digital marketing and in the optimal use of mobile apps.

Digital Transformation Initiatives in the Public Sector – In South African Healthcare

There are several innovations that must take place in the public sector in South Africa as far as digital transformation is concerned. Chiefly, these are still at beta phases and their overall impact and outcomes are still to be realized. Furthermore, there are pockets of digital innovations in the public sector dating back to 2014. Some are initiatives employed at provincial level, while others

Box 1: Digital developments in the public sector

<table>
<thead>
<tr>
<th>Year</th>
<th>Digital developments</th>
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</thead>
<tbody>
<tr>
<td>2014</td>
<td>• Aviro launched their innovative eHealth app.</td>
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<tr>
<td></td>
<td>• North West department of health outlines eHealth plans (RHIS).</td>
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<tr>
<td>2015</td>
<td>• Tier.Net, the software application that monitors patients on HIV and TB treatment.</td>
</tr>
<tr>
<td></td>
<td>• The NDoH has issued a tender for a service provider to conduct an evaluation of the use of the Tier.Net software.</td>
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<tr>
<td></td>
<td>• NDoH sets out eHealth standards evaluation process.</td>
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<tr>
<td>2016</td>
<td>• The Mpumalanga DoH issues eHealth tender.</td>
</tr>
<tr>
<td></td>
<td>• Health cohort high on Gauteng’s agenda.</td>
</tr>
<tr>
<td>2017</td>
<td>• NDoH is working with the CSIR to develop an eHealth system to accompany the rollout of NHI.</td>
</tr>
<tr>
<td>2018</td>
<td>• WHO and ITU to use eHealth to strengthen health services in Africa.</td>
</tr>
<tr>
<td></td>
<td>• South Africa adopts WHO’s HIV ‘Test and Treat’ guidelines.</td>
</tr>
<tr>
<td></td>
<td>• mHealth aiding in the diagnoses of burn injuries.</td>
</tr>
<tr>
<td></td>
<td>• Generic and Biosimilar Medicine of Southern Africa has asked the South African government to accelerate the evaluation and the registration of more affordable biosimilar medicines in South Africa.</td>
</tr>
<tr>
<td></td>
<td>• A subsidiary of CompuGroup Medical SE has developed an e-scripting solution that is helping over 1,000 South African doctors to ensure medication adherence among their patients.</td>
</tr>
</tbody>
</table>

Digital Transformation Initiatives

Digital Transformation Initiatives

The National Department of Health (NDoH) has identified IT and health information systems (HIS). The South African Medical Research Council (SAMRC) has partnered with Jenshi Health Systems NPC. Philips and UTJ renew MoU to empower healthcare professionals. Digital Health Cape Town have announced the commencement of their second accelerator programme.

A new mobile app, called ViaOpta Health, has been unveiled, to help hundreds of thousands of South African living with blindness and severe visual impairment.

A subsidy of CompuGroup Medical SE has developed an e-scripting solution that is helping over 1,000 South African doctors to ensure medication adherence among their patients. Aviro Health launches whipstitch channel to support HIV self-testing.
Recent years. According to Learning (ML) and Big Data analytics are Artificial Intelligence (AI), Machine eHealth developments and implementation pact in the sector. Box 1 below depicts the integrated holistic approach at the national level. An in-

The Use of Artificial Intelligence in Healthcare

Artificial Intelligence (AI), Machine Learning (ML) and Big Data analytics are some of the most talked-about technologies in recent years. According to Bali, Garg, and Bali, AI aims to mimic human cognitive functions, such as the ability to reason, discover meaning, generalize, or learn from experience [9].

Popular AI techniques include machine learning methods for structured data, such as the classical support vector machine and neural network, and the modern deep learning; as well as natural language processing for unstructured data [10]. Machine learning is the foundation of modern AI and it is essentially an algorithm that allows computers to learn independently without following any explicit programming [6].

The use of AI is already at advanced stages in other industries. Its adoption in healthcare is growing at a steady rate; however, there is no doubt that AI is certainly going to change the face of healthcare delivery. AI is being employed in numerous settings; for example, funders, as well as administrators, use it to adjudicate and to process claims and hospital facilities for assessing bed occupancy.

AI is also used to analyse unstructured data such as images, videos, and physicians’ notes to enable clinical decision-making and information sharing. Other commentators such as argued that AI is more prevent in the area of medical diagnosis. AI systems can analyse far more data far faster than humans, which may make them more adept at identifying medical diagnoses than doctors.

Neurology

Neurological healthcare deals with nervous systems disorders such as Parkinson’s disease, Alzheimer’s disease, epilepsy, stroke, and multiple sclerosis. AI can also predict strokes and monitor seizure frequency.

Pathology Images

Most diagnoses depend on a pathology result, so a pathology report’s accuracy can make the difference between diagnosis and misdiagnosis.

Radiology Tools

Various forms of radiology, such as CT scans, MRIs and X-rays provide healthcare providers with an inside view of a patient’s body. However, different radiology experts and doctors tend to interpret such images differently.

Smart Devices

Hospitals are big purchasers of smart devices. The devices, which take the form of tablets and hospital equipment, exist in intensive care units (ICUs), emergency rooms, surgeries and regular hospital rooms.

Box 2: Applications of AI—select list

Medical Diagnosis

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These improvements can improve efficiencies in identifying medical diagnoses better than doctors. It should be noted that AI cannot completely replace the medical profession, but it could be used as a tool to optimize current processes, reach medical conclusions and aid with decision-making factors, thus saving costs and improving quality of life.

Applications of Artificial Intelligence

Artificial Intelligence has the potential to change the healthcare industry in South Africa for the better. This is subject to its optimality in both the supply and demand side of the health care ecosystem. AI is delivering high value, including the following areas:

Waste and inefficiencies occur at every level in a health care system; waste also includes unnecessary procedures done on patients. Other examples include instances where repeat tests on the same patients are done by several providers but billed separately.

According to Albejadi and Nair, failures of care co-ordination typically occur when patients experience care that is fragmented [4]. Other examples include poorly managed care co-ordination which may result in a patient being referred from one health care setting to another.

This could be avoided if the various medical providers in the value chain could access the same patient records for clinical decision-making. Thus, there is value in investing in a healthcare delivery model that is not fragmented and encourages care co-ordination.

The C-section rate in South Africa is higher than the WHO’s recommendation at about twenty-six percent (26%) [1]. In the private sector, the C-section rate is three (3) times higher when compared to the national rate at more than seventy-seven percent (77%), which is significantly higher than the recommended rate [2]. The recommended rate of C-sections is around ten to fifteen percent (10% - 15%) of all births. A study by Manyeh argued that the increase in the C-section rate in developing countries has not been clinically justified and that these increasing trends have become a major health issue, due to potential maternal and perinatal risks, inequality of access and the costs involved [5].

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According to Albejadi and Nair, failures of care co-ordination typically occur when patients experience care that is fragmented [4]. Other examples include poorly managed care co-ordination which may result in a patient being referred from one health care setting to another. Figure 2 below depicts various categories of waste, as defined by Albejadi and Nair [4].

One of the highlighted categories which are frequently prevalent in an uncoordinated health system is typically where patients’ records are not stored in a central secure data repository. As a result, duplication of services, tests and procedures are done more frequently than is clinically necessary.

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The Sustainable Development Goals (SDGs), established by the United Nation (UN), aim to address global challenges worldwide to achieve a better and sustainable future for all [1]. Goal 3, “Good health and well-being,” aims to ensure healthy lives and promote well-being at all ages [2]. It also aims to achieve universal health coverage (UHC), and provide access to safe and effective medicines and vaccines for all. UHC aims to leave no one behind and ensure that health services are available, accessible, acceptable and served in high quality for everyone across countries [3].

The active engagement of young people is imperative to achieve Sustainable Development Goals (SDGs). In 2019, more than 3.8 billion people (49% of the world population) are under the age of 24 years, and 2.4 billion (32%) are between the ages of 10–24 [4]. The distribution of this youth bulge is especially important, with nine out of ten young people live in low and middle income countries [5]. While a youth bulge is often seen as a challenge, it also creates an opportunity for a demographic dividend, a relative surplus of working-age people which could lead to higher productivity, positive impact on economic growth, political stability and social and sustainable development. However, the ability of countries to harness a demographic dividend depends on their investment in the workforce, particularly in youth. Investing in quality education, decent employment opportunities and health and wellbeing of young people, will enable them to develop skills and values that positively contribute to economic growth and sustainable development of their community [6].

The Global Health Workforce Network (GHWN) Youth Hub, established in 2017, aims to promote youth engagement in the health workforce agenda, strengthens data and evidence on education and youth employment issues in health and social care and facilitate inter-professional collaboration to address these. The Youth Hub was created by the World Health Organization (WHO), as an intersectoral, inter-professional community of practice to drive youth-inclusive policy locally, nationally, regionally and globally.

Findings from the Youth Hub paper

This paper describes findings from the rapid review [7] conducted by the Youth Hub on youth and decent work in the health and social care sector. The review was designed to give a rapid assessment on existing research, and focused specifically on decent work including equal opportunities and treatment in employment, safe work environments and social security/adequate earnings. In addition, gender equality was included as a cross-cutting theme [8].

There were a number of pertinent findings from the review, shedding new light on youth employment in the health workforce. In terms of equal opportunities and treatment, a number of barriers were identified that influenced youth occupational decisions, including issues of work-life balance, inadequate mentorship and occupational segregation. Experiences of gender (and other) stereotyping, bias, discrimination and violence in the health and social care work force begin in training programmes and are experienced with stagnation prevalence by young and newly qualified workers. Findings on safe work environments revealed higher rates of burnout for young health workers and students, and alarmingly high rates of violence including verbal, psychological, physical and sexual violence. Social security and adequate earnings emerged as an important determinant of youth wellbeing. In some countries, particularly, organizational or system-level interventions or programmes.

Proposed Solutions

The challenges facing youth in the health workforce are significant. Closing the predicted 18 million health worker gap [9] by 2030 will require significant and strategic youth-responsive investments at the national, regional, and local levels. Firstly, ensuring decent conditions for work is an imperative to recruit and retain youth into the health and social care sectors. This includes addressing financial hardships as a significant factor for early attrition and migration of young health workers. Secondly, interventions, employment strategies and policies for young workers must use gender-transformative and intersectoral approaches to ensure equitable impact and reach. This includes widening the youth health workforce research agenda to highlight the issues in low- and middle-income countries where shortage of health workers, higher disease burden, higher youth unemployment, educational debt and new graduates across professions often carrying large debts from their training.

The review also revealed significant research gaps in the topic of youth in the health workforce. The literature identified was not evenly diverse to give an assessment of the challenges faced globally. Existing literature is focused on high-income countries, and largely on health disciplines such as nursing and medicine as opposed to social work and other health workers, and other social care occupations. The vast majority of the literature retrieved described, analysed and explored the challenges present for youth and decent work in the context of the health and social care sector; there was less focus on solutions, interventions and best practices – in particular, organizational or system-level interventions or programmes.

Conclusions

Meaningful youth engagement is required to achieve Sustainable Development Goals (SDGs). Ensuring decent working conditions is essential to recruit and retain youth into the health and social care sector. Barriers to retention and factors that lead to mi-
Health Care in Developing Countries

The findings from the rapid review will be used to advance youth-responsive work-force action and support the substantive work of the Youth Hub. Effective and strategic youth-inclusive policies will have sustainable effects on Sustainable Development targets. Not only will these policies support the challenges facing global health today, but they will also yield impact far into the future for youth and for the health of populations.

References


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Memorandum of Tokyo on Universal Health Coverage and the Medical Profession

Health Professional Meeting (H20), June 14th, 2019, Tokyo

At the Health Professional Meeting (H20) 2019 in Tokyo, the World Medical Association and the Japan Medical Association welcome the efforts by the World Health Organization, national governments, intergovernmental and United Nations agencies as well as other organizations to foster the development of healthcare systems providing Universal Health Coverage (UHC).

We notice that UHC means “that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.” (WHO definition of UHC)

UHC is a tool to overcome inequities in the health systems themselves.

UHC is for people, but also by people.

Human resources for healthcare in many countries are scarce. We urge all in responsible positions to invest in the education and retention of health professionals to make UHC possible.

This must include quality education, opportunities for continuing professional development and most important safe, dignifying and attractive working and living conditions for those who provide healthcare to their communities and patients.

The WMA encourages physicians and their associations in all parts of this world to play a profound role in the advocacy for and the realization of UHC.

From the side of the medical profession, there should be no hesi-tancy in embracing the concept of UHC, including a strong engage-ment for the development of quality primary care as the core part of a comprehensive health system.

We welcome the recent attention that G20 Finance Ministers give to the development of UHC as a contribution “to human capital development, sustainable and inclusive growth and development, and prevention, detection and response to health emergencies, such as pandemics and anti-microbial resistance, in developing coun-tries.”

We express our expectation to the G20 Summit that this inspires the way to improved and sustainable investments in healthcare sys-tem not only in G20 countries but also and most importantly in other economies, which still invest insufficiently in their healthcare systems, irrespective of the reasons for such shortfalls.

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