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# World Medical Association Officers, Chairpersons and Officials

**Dr. Ketan DESAI**

WMA President  
Indian Medical Association  
Indraprastha Marg  
110 002 New Delhi  
India

**Sir Michael MARMOT**

WMA Immediate Past-President  
British Medical Association  
BMA House, Tavistock Square  
London WC1H 9JP  
United Kingdom

**Dr. Yoshitake YOKOKURA**

WMA President-Elect  
2-28-16 Honkomagome  
113-8621 Bunkyo-ku,  
Tokyo, Japan

**Dr. Ardis D. HOVEN**

WMA Chairperson of Council  
American Medical Association  
AMA Plaza, 330 N. Wabash,  
Suite 39300  
60611-5885 Chicago, Illinois  
United States

**Dr. Donchun SHIN**

WMA Chairperson of the Finance  
and Planning Committee  
Korean Medical Association  
46-gil Ichon-ro  
Yongsan-gu, Seoul 140-721  
Korea

**Dr. Joseph HEYMAN**

WMA Chairperson  
of the Associate Members  
163 Middle Street  
West Newbury, Massachusetts 01985  
United States

**Dr. Heikki PÄLVE**

WMA Chairperson of the Medical  
Ethics Committee  
Finnish Medical Association  
P.O. Box 49  
00501 Helsinki  
Finland

**Dr. Otmar KLOIBER**

Secretary General  
World Medical Association  
13 chemin du Levant  
01212 Ferney-Voltaire  
France

**Prof. Dr. Frank Ulrich  
MONTGOMERY**

WMA Vice-Chairperson of Council  
Bundesärztekammer  
Herbert-Lewin-Platz 1 (Wegelystrasse)  
10623 Berlin  
Germany

**Dr. Andrew DEARDEN**

WMA Treasurer  
British Medical Association  
BMA House, Tavistock Square  
London WC1H 9JP  
United Kingdom

**Dr. Miguel Roberto JORGE**

WMA Chairperson of the Socio-  
Medical Affairs Committee  
Brazilian Medical Association  
Rua-Sao Carlos do Pinhal 324,  
CEP-01333-903 Sao Paulo-SP  
Brazil

[www.wma.net](http://www.wma.net)

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**Editor in Chief**

Dr. Pēteris Apinis, Latvian Medical Association, Skolas iela 3, Riga, Latvia  
Phone +371 67 220 661  
[peteris@arstubiedriba.lv](mailto:peteris@arstubiedriba.lv), [editorin-chief@wma.net](mailto:editorin-chief@wma.net)

**Co-Editor**

Prof. Dr. med. Elmar Doppelfeld, Deutscher Ärzte-Verlag, Dieselstr. 2, D-50859 Köln, Germany

**Assistant Editor**

Maira Sudraba, Velta Pozņaka; [lma@arstubiedriba.lv](mailto:lma@arstubiedriba.lv)

**Journal design and  
cover design by**

Pēteris Gricenko

**Layout and Artwork**

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## Valedictory speech of WMA President Sir Michael Marmot October 2016

This year I have been ever more vigorous in promoting my two key messages on health equity: evidence based policy and the central role of social justice. It seemed ever more urgent given the rise of some rather nasty political movements with scant regard for the truth, which has led to the notion of 'post-fact' politics.

Martin Luther King said it rather better than I: 'I believe that unarmed truth and unconditional love will have the final word in reality'. This is why right, temporarily defeated, is stronger than evil triumphant.

My mission as WMA President, stated clearly from the outset, was to encourage doctors' involvement in social determinants of health and health equity. 'Encouraging doctors' includes individual doctors, National Medical Associations and other bodies, and the World Medical Association.

To support this mission, I set out three aims:

- WMA issue a statement on social determinants of health and health equity; and produce a supporting publication that would answer the question: "what do we do?"
- Support post-graduate education and training.
- Promote regional networking on social determinants of health

The WMA Statement and Publication, The Declaration of Oslo, agreed at the Council



*Sir Michael Marmot*

meeting in Oslo in April 2015, was passed by the General Medical Assembly in Moscow. It sets out the importance of social determinants of health (SDH) and principles of action for WMA, NMAs and individual doctors.

A question commonly put, sometimes even a *cri de coeur*, is of the form: "I am convinced but what do you want me to do?" My colleagues at the UCL Institute of Health Equity have prepared a document, Doctors for Health Equity, which seeks to answer that question. We emphasise five domains of activity:

- Education and training
- Seeing the patient in broader perspective

- The health service as employer and its impact on the local community
- Working in Partnership
- Advocacy

In addition, there is the crucial issue of measurement of health equity and key determinants. The report is as a way of developing communities of action, sharing knowledge and a source of material for budding partnerships at local level. It is an opportunity for the WMA to show by their actions what they are doing. Sharing through the report and the web site are good ways of helping each other in each of our member's countries. We see this publication as continuing to develop with the addition of case studies. We have invited NMA's to contribute examples.

During the year the WMA put out statements consistent with this SDH theme. In particular, following the meeting in Istanbul on War, Migration and Health, the WMA issued a declaration.

### Training

We run a Summer School at UCL in London on social determinants of health. In addition, we are planning one or more workshops with the International Association of Academies of Medical Science (IAMP). The first was in Trieste. We conducted a regional workshop at the University of Brasilia in Brazil. With BMJ

Publishing we have developed a MOOC, Mass Online Open Course on Social Determinants of Health. It was launched in October 2016, and is running at the same time as the WMA General Medical Assembly.

## Networking

My agenda for the year was clear, involving doctors in social determinants of health and health equity. It is part of my broader, longer term mission promoting the importance of social determinants of health in research, training, policy and practice. Accordingly, my choice for the year, was to attend those meetings that had the prospect of advancing that agenda. And proudly wearing the WMA hat while doing so. The networking has taken three forms.

1. Country visits. These visits have included: BMA House London; Livingston Zambia; Helsinki; Alpbach Austria; USA, various cities; Suriname; Taipei; Sweden – Commissions++; Kolkata; Bangkok; Istanbul; Tashkent, Uzbekistan; Montevideo; Buenos Aires; Ghent and Brussels; Trinidad and Tobago; Panama; Canada various cities; German MA, Hamburg; Geneva; Tel Aviv; Tokyo; Australia; Malta; Sri Lanka. I single out Sweden from this list to make the point that action on social determinants of health and health equity can be at city level as well as at country level. Sweden has now set up a national commission on social determinants of health. But prior to that it had several city commissions to plan city level action. Similarly in the UK, we have had action at city

level which is very encouraging. We did a report for the government of Taiwan on health inequalities. We recommended cross government action on the social determinants of health.

2. Networking with groups. My general strategy has been to probe gently to see where interest is to be found. I have spoken at meetings of CONFEMEL, the confederation of Latin American Medical Societies, CMAAO, confederation of medical associations of Asia and Oceania, the Commonwealth Medical Association, and the World Health Professionals Alliance. I spoke at the EFMA meeting in Uzbekistan, which involved doctors from the Eastern part of the WHO European Region. We have a partnership which includes the constituent countries of the UK – England, Scotland, Wales and Northern Ireland – as well as the Republic of Ireland. We held a side event with the International Committee of the Red Cross at the World Health Assembly. We will now be working with them to bring a social determinants of health framework to their work.
3. Commission on Equity and Health Inequalities in the Americas. I have been asked by the Pan American Health Organisation, PAHO, to lead a review of social justice and health in the Americas. It will focus on social determinants of health putting equity and human rights, gender and ethnic differences, at the heart of social action to improve health. I will seek to engage the active cooperation of medical societies. We have now had our second meeting of Commissioners. We are due to report

in Spring 2018. Fourteen countries will become active partners in this PAHO Commission.

While in Washington DC, I came across this quotation from President FD Roosevelt: In these days of difficulties, we Americans must and shall choose the path of social justice...the path of faith, the path of hope, and the path of love toward our fellow man. Inspiring words for our Commission on Equity.

## Fantasy Land?

I was in Australia giving lectures for the ABC. On a Television programme I described extreme inequalities in income. I used the example that the top 25 hedge fund managers in New York, with a combined annual income of \$25 billion, had the same combined income as the 48 million people of Tanzania. When I mused about what a fairer distribution of income could achieve, I was told I was in Fantasy Land. In my lecture I responded. When Martin Luther King rose in Washington to declare: "I have a dream that on the red hills of Georgia, the sons of former slaves and the sons of former slave owners will be able to sit down together at the table of brotherhood", what if he had said: "I've been told I'm in Fantasy Land. We should accept the status quo", there would have been no civil rights act.

Let me invite you to join me in my Fantasy Land and let us seek a fairer world and more socially just societies.

## Inaugural speech of WMA President 2016–2017 Dr. Ketan Desai

Respected Chairperson of the Council, Sir Michael Marmot, learned dignitaries, ladies and gentlemen. It is a great honour and privilege for me to be here in Taipei to assume the prestigious Presidency of the World Medical Association. For me it has been a humble journey, which began with WMA as a representative of Indian Medical Association, way back in the year 2000. Ultimately this journey has shaped itself one step at a time, bringing me to the ascendancy of assuming charge as President of this august body of great intellectuals/ medical scientists – the World Medical Association.

I offer my humble salutations to our Past President, Sir Michael Marmot. His great and incessant work over the past years in the field of redefining social determinants of health, has enormously contributed towards brightening the image of the WMA across the Globe, in an enviable manner.

### Starting an online course on social determination on health

I sincerely appreciate the efforts of WMA for starting an online course on Social Determination on Health, prepared by the Institute of Health Equity at the University College of London – under the stewardship of Sir Michael Marmot. Coupled with the efforts of our beloved Vivienne Nathanson, this online course will go a long way to fulfil many objectives of WMA in the times to come. Yet more needs to be done in continuation with such deserving efforts.

### Increasing the membership of WMA

It is an undeniable fact that as of now out of 197 countries, WMA has only 111 countries



*Ketan Desai*

as members in its fold. This reality brings to the fore that the representation of the Gulf countries needs to be increased. The 'representative character' of the WMA must be such, that it should be recognized as representing the true and genuine voice of the entire Globe. This can be achieved only by our committed and collective efforts towards increasing WMAs membership strength.

### Raising the status of WMA

Is it not a hard fact that when any Government talks about formulation of health policy in its wide and varied manifestations, they invariably ask for inputs from WHO or any other concerned UN organization. Efforts need to be made to take the credibility of WMA to that very level, whereby inputs from WMA are considered as inevitable imperatives by each and every Government when they seek to crystallize and formulate health policies.

### About myself

In the fitness of things, I deem it appropriate to apprise this distinguished gathering,

in nutshell, about my passion and profession. I am a Urologist by profession but a committed educational reformist by passion. When I took over, in my home country India, as the Head of the regulator Medical Council of India way back in 1996, I realized that my country had needed tough yet enforceable regulations in the context of evoking desired doctors-pharma relationships, introduction of soft skills in medical curriculum and transparency in 'Undergraduate' and 'Post Graduate' medical entrance examination and imparting of quality based medical education. It is a matter of record that my tenure was instrumental in placing various 'regulations' in place bringing pharma-doctors Code of Ethics, introduction of Common Medical Entrance Examination and introduction of Soft Skills and Mental Health in the medical education curriculum. These have resulted in inducing desired quality centricity towards fulfilment of the set out objectives, in a measurable manner.

### Internationally significant issues

In this context I would like to flag some of the international issues of urgent importance and of significant consequence as well. Global health, which is defined as "the area of study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide" needs to be incorporated in the medical education curriculum across the world as an inclusion of unavoidable need.

The next pertinent issue is a material reality to the effect that health care is in danger: Physicians are under constant threat all over the world. Realistically speaking they risk their lives while treating their patients in a committed manner. They legitimately need protection from violence while at work, whether in war or civil conflict situations. While on one hand in some parts of the



world hospitals are bombarded, ambulances hijacked, nurses and doctors kidnapped or killed and physicians are pressured, threatened and tortured, on the other hand in other parts of the world especially Asian Countries, doctors are assaulted and medical establishments attacked and damaged. The Geneva Convention is practiced more in 'breach' than 'observance', invariably ending up in flagrant violation of the inviolate human rights. It is the core commitment of 'Physicians' as a part of their basic duty to help patients by their professional knowledge without any distinction or discrimination of any type and magnitude. To a physician a patient is neither a 'friend' nor an 'enemy' but an opportunity rendered to him by the Almighty God to cater to a humane cause in the most diligent and devoted professional manner. They legitimately need protection from violence while at work, whether in war or civil conflict situations.

Yet another arena of vital concern turns out to be 'Professional Autonomy'. In many countries like Turkey, India, United Kingdom and others, there are continued political attempts to undo or marginalize autonomy and self-governance of the medical profession including mauling and trampling upon the trinity of 'Professional autonomy, Clinical independence and Self-governance'. This is an imperative, sine-qua-non, for the pink health of the profession. Frankly speaking, professional autonomy is not limited to asking for the privilege to do what we want to do. It is less about physicians and more about patient's rights. It is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence of any type from any quarter how so powerful and mighty they be. Regulation of clinical practice, framing evidence based standard treatment guidelines, defining and checking professional malpractice and medical education all need vital professional independence and a democratic system based on meaningful participative decision making.

The WMA has been, is and must continue to be against the Government attempts to usurp the professional independence through bureaucrats and politicians and making the same 'subservient', as a part of their calculated nefarious designs. In a democratic society, self-governance is an element of horizontal power sharing and an important pillar of civil society and democracy itself. Doing away with the vital concept of self-governance will not only amount to subverting a valuable element of democracy but end up in devouring the very soul of it. Borne out from the various 'international charters' generally and vide the constitutional mandate, 'Right to Health' should be a humane priority not open to any 'concession, compromise or condonation' of any type. This must be espoused by WMA and all NMAs should put in all their might at their disposal to see that the same is wholesomely reflected in the laws enacted by the respective Governments in their health policies.

We need to recognize the criticality of diligence in the present era of living in a 'digital world'. The medical profession has to be concerned about the protection of our patients' personal and health data with the introduction of 'e-health and m-health'.

Good quality education is essential and vital for generating 'Competent, Confident, Concerned and Compassionate' trained health manpower. The same needs to be promoted.

It is imperative that the desired goals need to be achieved by ensuring that timely efforts are made at the WMA level to shift the focus of health care from 'Disease' to 'Wellness' and from 'Human Health' to 'One Health' towards achieving the real essence of unitary unification.

The unchecked malady of the unqualified people indulging in professional medical practice has caused and continues to cause endless harm to society. Keeping in mind the cardinal scientific reality that modern scientific medicine is not without ill effects, it can-

not be bestowed in the hands of unqualified and unregulated people. This is in the interest of men, mankind and for upholding the 'ethos and morality' of the profession.

It has to be our collective uppermost concern that 'equality, justice and equity' are fundamental bioethic principles that need to be upheld at all costs and consequences.

There is no denying the fact that sexual violence against children and women is a serious concern in most countries. Sexual violence against children, whether evident or suspect, is a common, preventable and punishable acute medico-legal emergency. Educators are duty bound to address sexual violence against children, which needs to be addressed with 'timely, appropriate and effective' intervention.

We need to take note of the stark reality that professional honesty and integrity is at stake in many countries. The profession should be practiced transparently. All referrals and prescriptions should be transparent. Referral by physicians to health care facilities, where they do not engage in professional activities but in which they have a pecuniary interest is called 'self-referral'. This practice can influence clinical decision-making and is not in sync with the desired ethicality and morality. Kickbacks (or fee splitting) occur when a physician receives financial consideration for referring a patient to a specific center or for a specific service for which a fee is charged. This obviously is inconsistent with a desired value system of the profession. As such, the physician should not receive any financial or other consideration for referring a patient to labs, pharmacies or opticians etc.

One needs to decipher clearly that the interests of the 'clinician' and the 'researcher' may not be the same. If the same individual is assuming both the roles, the potential conflict should be addressed by ensuring that appropriate steps are put in place to protect the patient, including disclosure of the potential 'conflict of interest' to the patient and all concerned.

Cross Boarder Terrorism anywhere and everywhere needs to be stopped at all costs. Be it the 9/11 terrorist attack in the USA (twin towers), Mumbai terror attack, traumatized Brussels, victimized Paris, school children massacred in Pakistan, bruised Uri or any other attack globally disrupts the tranquility and harmony of the society in an irreparable manner. Terrorism by any name and for any reason is terrorism and terrorism alone. There is nothing like “good” or “bad” terrorism. It is a slur on civilization of mankind and hence needs to be dealt with an iron hand and commensurate political will by all the countries in the world.

Along with the problem of malnutrition, ‘lack of safe drinking water and poor sanitation’ are among the major causes of child illnesses and deaths. The incidence of diarrhoea can be reduced by nearly a quarter and the number of deaths by close to two-thirds through improvements in safe water supply with sanitation and hygiene.

Non communicable diseases are on the rise globally. The focus must change from ‘sickness’ to ‘wellness’ and on common country specific life style protocols. The same needs to be advocated strongly.

As per WHO projections, there’s a global shortage of 7.2 million doctors, nurses and midwives. As we begin the first full year of our new Sustainable Development Goals, more countries will be working towards ‘Universal health coverage’ and to meet their health-related targets through stronger, more equitably distributed health workforces that include ‘community health workers, widespread access to technology and a health team’ approach for bringing care to those in need.

The relevant statistics brings out that around 3 in 10 deaths globally are caused by cardiovascular diseases. At least 80% of premature deaths from cardiovascular diseases could be prevented through a healthy diet, regular physical activity and avoiding the use of tobacco, but then why the same remains wanting?

In the backdrop of deafening slogans of gender equality, every day about 830 women die due to complications of pregnancy and childbirth. Maternal mortality is a health indicator that shows very wide gaps between rich and poor, both between countries and within them. Should the pregnant mothers be left to die or should it not be realistic human touch to reach them in a ‘handy, accessible, timely and affordable’ manner, which would be in the interest of mother, the child and resultantly all humanity.

Mental health disorders such as depression are among the 20 leading causes of disability worldwide. Depression affects around 300 million people worldwide and this number is projected to increase. This needs to be addressed on priority.

Almost 10% of the world’s adult population have diabetes. People with diabetes have increased risk of heart disease and stroke. It is imperative that timely action plans are evolved for dealing with the problem in the context of its magnitude, so that it does not gain proportions that would turn out to be difficult to tackle in times to come.

Around 70% of all HIV/AIDS deaths in 2012 occurred in sub-Saharan Africa. Globally, the number of people dying from AIDS-related causes is steadily decreasing from a peak of 2.3 million deaths in 2005 to an estimated 1.6 million in 2012. As such timely policy interventions need to be evoked.

More extreme weather and rising sea levels, temperatures, and carbon dioxide levels are ushering a wide array of human health effects, from asthma to chikungunya to mental illness. Concern on these aspects should not remain a matter of ‘lip sympathy’, that is ‘cosmetic’ in nature.

## Yoga and meditation

Today, more than ever, the need for preventive systems of medicine is being widely realized. Sophisticated diagnostic tools, prescriptive drugs that come in complicated

combinations and a high level of specialization are making medical care expensive. Illnesses are on the rise.

This is where Yoga comes in. Meditation is an integral part of Yoga. The mind is the root of most physical problems, is brought out and guidelines for healthy living are given. Shri Narendra Bhai Modi, the Hon’ble Prime Minister of India and a Global leader has also emphasized the need for connecting more and more people not only in India but all over the world – with Yoga and its adoption for the complete health of the mankind. United Nations from 2015 has also adopted 21<sup>st</sup> June of every year as the International Yoga Day.

As such, the core thought that WMA has to evolve so as to gain credibility, whereby its inputs are availed by all the Governments all over in formulation of their policies. Perhaps the time has come to seriously think about the need to create a “World Health Keeping Force” on the lines of “World Peace Keeping Force”. By virtue of the fact that National Medical Associations that have substantial membership of health professionals with them together can jointly go in for creation of such an ‘international health keeping force’ under the aegis of the WMA. This requires diligent application of mind and evolving necessary ‘blue print’ and a resultant ‘action plan’.

This would be my endeavour of priority. With reverence, committing myself to the path by my illustrious predecessors who have left their marks on the sands of time as ‘milestones’ to guide me, I sincerely commit myself to the ‘Vedic’ ethos to the effect – Om Sarve Bhavantu Sukhinah Sarve Santu Nir-Aamayaah | Sarve Bhadraanni Pashyantu Maa Kashcid-Duhkha-Bhaag-Bhavet

The English version of the same means – “May all be prosperous, joyous and happy May all be sickness free, all their way May all gain spiritual ascendency May no one suffer, in any way” Thank you one and all Jai Hind.

## WMA 2016 General Assembly Report

Taipei City, Taiwan, October 19–22

### Wednesday October 19

At the invitation of the Taiwan Medical Society, delegates from more than 40 National Medical Associations met at the Grand Hyatt Taipei Hotel from October 19–22 for the WMA's 2016 General Assembly. It was the first time the WMA had met in Taiwan and the number of policy documents submitted for the meeting was the most ever recorded.

### Council

Dr. Ardis Hoven, Chair of the WMA, opened the 204<sup>th</sup> Council session, by welcoming the delegates and thanking the

Taiwan Medical Association for its hospitality and great leadership. In particular, she thanked Dr. Yung-Tung Wu, chairperson of the Taipei organizing committee, as a mentor and great friend of the WMA.

### Apologies

The Secretary General, Dr. Otmar Kloiber, reported that apologies for absence had been received from several Council members – Dr. Mark Porter from the British Medical Association, Dr. Jorge Janez of Argentina, who had been replaced by Dr. Ruben Tucci, and Dr. Mzukisi Grootboom from South Africa who had been replaced by Dr. Mark Sonderup. There were new members of Council, Dr Michael Gannon from Aus-

tralia, Dr. Mari Michinaga from Japan and Dr. David Barbe from the American Medical Association.

### Treasurer

In an election for Treasurer of the WMA, Dr. Andrew Dearden, Treasurer of the British Medical Association, was elected unopposed. He succeeds Dr. Masami Ishii who had left the leadership team of the Japan Medical Association.

### China

Dr. Kloiber responded to a question he had been asked at the last Council meeting about the use of organs from executed prisoners in China. He had written to the Chinese Medical Association to ask them if the procedure was still going on. He had received a reply from the Secretary General of the Chinese Medical Association that read as follows: 'In 2007 the State Council of







*Nigel Duncan*

China promulgated the Human Transplant Regulation. In March 2013, the National Health and Family Planning Commission and the Red Cross Society of China jointly formed the National Organ Donation and Transplantation Committee (NODTC). Under the leadership of the State Council this committee is the highest policy making body and accountable organisation for organ donation and transplantation in China. The Hangzhou Resolution fully showed the determination of further improvement of organ donation and transplantation system. The NODTC made a public announcement that China will fully cease the use of the death penalty prisoners' organ for transplantation, with effective from January 2015. The community-based organ donation has become the only legitimate source of transplantable organ in China since then. The organ procurement from 'Falun Gong practitioners and members of other religious and ethnic minority groups' never happened in China. We strongly protest those who have ulterior motives assaulting organ transplantation course in China, just like the auscultation of politics and culture in China. We sincerely hope that the organ transplantation could benefit more patients through efforts from different parties. And

we also hope our international peers could learn about the reality in China and positively face the advances in China's organ transplantation. Therefore we firmly oppose including this item into business item of WMA session and abolish the 2006 policy regarding organ procurement in China'.

## *Syria*

A proposed emergency Resolution on the protection of health care facilities and personnel in Syria was submitted by the Finnish Medical Association and it was agreed that this should be considered by the Socio-Medical Affairs Committee.

## *Legal Adviser*

The meeting approved the appointment of a new legal adviser, Ms. Marie Colegrave-Juge from France, who succeeds Ms. An-nabel Seebohm. Ms. Seebohm had left to become CEO of the Standing Committee of European Doctors.

## **Finance and Planning Committee**

Prof. Dong Chun Shin, Chair of the Committee, took the chair.

The Committee approved the report of the previous meeting held in Buenos Aires.

## *Financial Statement*

The newly elected Treasurer, Dr. Dearden, gave a brief report on the healthy and stable state of the Association's finances for 2015.

The Committee agreed that the audited financial statement for 2015 be approved by the Council and be forwarded to the General Assembly for approval and adoption.

## *Membership Dues*

The Committee received a report on membership dues payments for 2016 and on

dues categories for 2017 and agreed to forward these to the General Assembly for information.

## *Budget*

The Committee considered the proposed Budget for 2017 and agreed that it be approved by the Council and forwarded to the General Assembly for approval and adoption.

## *Royal Dutch Medical Association*

Dr. Kloiber reported that a request had been received from the Royal Dutch Medical Association to abstain from voting in the Council elections at the end of 2016 and to obtain a council seat by increasing their declared membership to 50,000 physicians. Prof. Rutger J. van der Gaag from RDMA said that the RDMA wished to have stronger engagement with the WMA and suggested this method in order to achieve this goal.

The Committee agreed to the request and recommended that the Council approve the arrangement.

## *Auditor*

The Treasurer recommended the reappointment of KPMG as auditor for the 2016 WMA Financial Statement. The Committee agreed to this and recommended the Council to approve the decision.

## *Strategic Plan*

Dr. Kloiber reported on the WorkGroup's progress and indicated that a report would be made next year.

## *Business Development Group*

Dr. Dearden, Chair of the WorkGroup, presented a written report and gave an oral report on three items – the issue of subscriptions, possible forms of foundation support

and potential sponsorship and the development of a web-based platform for educational materials as a way of offering a new service to members and as a possible additional source of income to the Association.

The Committee agreed to the WorkGroup's proposals.

## *WMA Meetings*

The Committee considered planning and arrangements for future WMA meetings.

It was reported that the Chinese Medical Association had invited the WMA to hold a meeting in Beijing for either the Council session in 2020 or for the General Assembly in 2021. The Chair said that the invitation would be considered at the next meeting along with any new invitations.

Dr. Jón Snædal (Iceland) informed the Committee on the progress made for the General Assembly in Reykjavik in 2018. The UNESCO Chairs of Bioethics Conference planned to have a three-day conference, and the WMA Scientific Session would be replaced by the third day of the bioethics conference.

The Chair reminded the committee that the meetings in 2017 would be held in Living-

stone, Zambia (Council) and Chicago (Assembly), and in 2018 in Riga (Council) and Reykjavik (Assembly).

Dr. Kloiber reported on the first WVA-WMA Global Conference on One Health and said that the second conference would be held in Fukuoka, Japan in November. He also reported on the 12<sup>th</sup> UNESCO World Conference on Bioethics, Medical Ethics and Health Law to be held in Limassol, Cyprus, in March (21–23) 2017.

It was proposed to hold two sessions, one on databases and biobanks and a second discussion on the Declaration of Geneva.

## *Governance Review*

Prof. Dr Rutger J. van der Gaag, Chair of the WorkGroup, reported on the four sub groups that had been set up to consider involvement, inclusiveness and representation; consistency, efficiency and quality; transparency; and the value of associate membership. Their work would be concluded next year.

He said the WorkGroup was considering how to involve the 80 countries worldwide who were not members of the WMA or not involved in the Association's activities.

A survey was being planned for early next year on the issue of prioritizing goals and increasing members' involvement. The results would be reported to the Council meeting in Livingstone, Zambia. The committee accepted the report and agreed to the survey.

## *Associate Members*

The Committee received a written report on the activities of the Associate Members.

## *Past Presidents' and Chairs' Network*

The Committee received a report from Dr. Kloiber of the Past Presidents and Chairs of Council Network. Dr. Kloiber thanked Drs Cecil Wilson, Yank Coble, Yoram Blachar, Wonchat Subhachaturas and Jón Snædal for their contributions.

## *Junior Doctors Network*

The Committee received a report of the Junior Doctors Network from Dr. Ahmet Murt, and he thanked the NMAs and WMA for the support provided to the JDN.

## *International Committee of Military Medicine*

The Committee considered the Memorandum of Understanding with the Inter-



national Committee of Military Medicine (ICMM). Dr. Kloiber explained the long-standing relationship with the International Committee and the ICMM's proposal to have a formal memorandum.

It was agreed that the Memorandum be approved by the Council and be forwarded to the General Assembly for approval.

## Socio-Medical Affairs Committee

Dr. Miguel Roberto Jorge, Chair of the Committee, took the chair.

The Committee approved the report of the previous meeting held in Buenos Aires, Argentina.

### *Doctors for Health Equity*

The President, Sir Michael Marmot, reported that this issue had been a key theme of his Presidency for the year. He said that he had been hugely encouraged by national medical associations in all regions expressing enthusiasm for taking action on health equity. He was hopeful that something tangible would come out of this.

### *Health Care in Danger*

Prof. Vivienne Nathanson (British Medical Association) reported on the activities

of the WorkGroup, which had met the day before. The Group discussed its role in the framework of the HClD initiative, led by the International Committee of the Red Cross, which has been in progress for several years. The initiative was now evolving from a project to a community of concerns with continuous active involvement of various partners, including the WMA. She called for an intense letter writing campaign whenever attacks took place on hospitals, patients and health care personnel, particularly physicians, and she urged NMAs, when they write to their governments about such attacks, to send copies of their letters to the WMA.

The Group had agreed to conclude its activities and disband.

### *Physicians' Right to Information*

The Committee considered a proposed Declaration submitted by the Russian Medical Society on Physicians' Right to Information about the WMA and its Policies. The Russian delegate informed the Committee that it wished to withdraw the document. This was agreed by the Committee.

Role of Physicians in Preventing the Trafficking with Minors and Illegal Adoptions

The Committee considered the proposed Statement on the Role of Physicians in Preventing Trafficking with Minors and Illegal Adoptions which sets out guidelines for increasing physicians' awareness of the possible criminal activities related to trafficking of children. During a brief debate, some opposition was voiced about the way the issue had been addressed in the document, and it was suggested that further consideration was needed.

The committee recommended that the document be sent back to the WorkGroup for further consideration and that a revised version be circulated among members for comment.

### *Armed Conflicts*

The Committee considered the proposal for a Statement on Armed Conflicts which reminds governments of the human consequence of warfare. The Chair of the WorkGroup, Dr. Shin, suggested that discussion on this document be postponed until the next meeting to allow further consideration

The Committee recommended that the proposed Statement be sent back to the WorkGroup for further consideration and that a revised version be circulated among members for comment.





## *Occupational Health*

The Committee considered the proposal for a Resolution on Occupational and Environmental and Safety as well as Gender Aspects, setting out a package of measures to strengthen the role of physicians in preventing, diagnosing, treating and reporting work accidents and occupational diseases.

The Committee recommended that the proposed Resolution be approved by the Council and forwarded to the General Assembly for adoption.

## *Boxing*

The Committee considered a proposed revision of the 2005 Statement on Boxing, submitted by the South African Medical Association. This suggests hardening the WMA's opposition to boxing.

After a brief debate about the proposal that boxing should be regulated before it was banned, the Committee agreed that the proposed revision be revised by the South Africans and then be re-circulated among members for comment.

## *Obesity in Children*

The Committee considered the proposed Statement on Obesity in Children submitted by the Israel Medical Association. This set out a comprehensive programme to prevent childhood obesity, including consideration of a tax on non-nutritious foods and sugary drinks. A brief debate followed, when the committee agreed that there should be a specific WMA policy document on childhood obesity. It was agreed that the proposed document should be amended to include a sentence about the crucial role that parents have in fostering physical activity in their children.

The Committee recommended that the document, as amended, be approved by the

Council and forwarded to the General Assembly for adoption.

## *Fossil Fuel Divestment*

The Committee considered the proposed Statement on Divestment in Fossil Fuels urging national medical associations and other health organisations around the world to transfer their investments from energy companies relying on fossil fuels to those generating energy from renewable sources.

The Committee recommended that the proposed Statement be approved by the Council and forwarded to the General Assembly for adoption.

## *Cyber Attacks on Health and Other Critical Infrastructures*

The Committee considered the proposed Statement on Cyber-Attacks on Health and Other Critical Infrastructures submitted by the German Medical Association. The document warns that the spread of electronic medical records and billing systems has made the healthcare sector vulnerable to cyber-attacks. It says the sector is now a prime soft target for cyber criminals. The meeting heard that this was a very big problem for health care, and hospitals had been threatened and blackmailed by cyber-attacks. The meeting amended the document to refer specifically to the risk of medical records being altered as a result of cyber-attacks.

The Committee recommended that the proposed Statement, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

## *Medical Tourism*

The Committee considered a proposed Statement on Medical Tourism submitted by the Israel Medical Association, which sets out protocols to protect the right of

foreign patients who receive medical treatment abroad. In the debate that followed, several delegates criticised the document, and it was suggested that the WMA should not approve policy that might be seen as legitimising medical tourism. However, it was argued that there were ethical issues involved and it would be wrong to ignore the topic. Medical tourism should be regulated because medicine has been commercialised whether they liked it not. Many people were making profits out of medical tourism and the WMA had a responsibility to the profession and to the population to have a policy.

After changes to the document, the Committee recommended that the proposed Statement, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

## *Medical Cannabis*

The South African Medical Association Committee submitted a proposed Statement on Medical Cannabis saying that laws governing the use of cannabis in research should be modified to allow unhindered scientific research. However, some delegates argued that the document did not properly separate the issues of medical and recreational use of cannabis.

The Committee recommended that the Statement be revised by the South African Medical Association and then re-circulated among members for comment.

The Committee then considered documents that had been revised as part of the annual policy review process.

It recommended that the following policies with minor revisions be approved by the Council and forwarded to the General Assembly for adoption.

- Statement on Traffic Injury
- Statement on Adolescent Suicide
- Statement on Alcohol and Road Safety



- Statement on the Physician's Role in Obesity
- Statement on Physicians and Public Health
- Statement on the Responsibilities of Physicians in Preventing and Treating Opiate and Psychotropic Drug Abuse
- Statement on Injury Control

The revised policy on adolescent suicide was approved only after a lengthy debate on whether or not to it should refer to specific adolescent groups, such as first peoples in some developed countries. The Committee decided to amend the document to include the sentence 'The incidence of adolescent suicide is observed to be greater in the "first peoples" of some nations'.

The Committee also recommended that the following policies that had undergone major revision should be circulated among members for comment.

- Resolution on Medical Assistance in Air Travel
- Resolution on Tuberculosis
- Statement on Access to Health Care
- Professional Autonomy of Physicians
- Medical Education
- General policy on alcohol

The Committee recommended that three new items that had been submitted should also be circulated among members for comment. These are

- Proposed Statement on Water and Health
- Proposed Statement on Cooperation of National Medical Associations during or in the Aftermath of Conflicts
- Proposed Statement on Epidemics/Pandemics

### *Sustainable Development*

The Portuguese Medical Association proposed that a WorkGroup be set up to develop a WMA policy on sustainable development and to define a proposed strategy for sustainable development at international and national level.

The proposal was agreed by the Committee and it was decided to recommend this to the Council.

### *Advocacy*

Dr. André Bernard (Canadian Medical Association), Chair of the Advocacy Advisory Group, reported on the activities of the Group. He said they had discussed their remit and the need to focus on advocacy and communication. It was suggested that the Group should report directly to the Council and that new terms of reference should be developed. He also reported that as this was his last meeting at the WMA, Dr. Steven Stack (American Medical Association) would serve as chair *ad interim* until the next meeting when a decision on the new chair would be made.

Dr. Jorge thanked Dr. Bernard for his committed work in successfully leading the Group.

### *Protection of Health Care Facilities and Personnel in Syria*

The Committee considered the proposed emergency Resolution from the Finnish Medical Association on the bombing that had taken place in Syria and in particular in Aleppo. The meeting heard that there had been repeated and targeted bombings of hospitals, healthcare facilities and people working there, as well as patients being treated. This was something totally new. In past decades both sides agreed not to attack hospitals and places where patients were being treated. The new situation was something the WMA should be especially worried about.

The Committee approved the proposed Resolution and recommended that it be sent to the Council and be forwarded to the General Assembly for adoption.

## **Medical Ethics Committee**

Dr. Heikki Pälve (Finland Medical Association) took the chair.

The Committee approved the report of the previous meeting held in Buenos Aires, Argentina.

### *Euthanasia and Physician Assisted Dying*

The Committee received an oral report from the Secretary General. He said the Executive Committee planned to initiate regional debates about this topic, particularly with those medical associations they had not heard from. Dr. Kloiber reported that the first initiative has been taken by the Brazilian Medical Association, which had offered to host a workshop bringing together the Latin-American medical associations to discuss end-of-life issues, including euthanasia and physician-assisted suicide.

He expressed the hope of the Executive Committee that medical associations from Africa and Asia would also organize regional debates and workshops.

### *Person Centered Medicine*

Dr. Andrew Dearden, Chair of the Work-Group, gave an oral report, saying that the group would not be able to pursue this issue at this time because members had other commitments. He suggested that the group should be disbanded and that subsequent work on person centered medicine should be left to individual member associations. He stressed that this did not mean the topic should not be pursued, but that a work group was unnecessary. At any time, any NMA was welcome to continue working on this topic again, using the existing definition paper and the draft policy.

The Committee approved the oral report, and recommended to the Council that the

WorkGroup be disbanded for the time being.

## *Health Databases*

The Committee received the newly proposed Declaration on Ethical Considerations regarding Health Databases and Biobanks, which sets out ethical guidelines for physicians involved in the collection and use of identifiable health data and biological material in health databases and biobanks. Dr Jon Snædal, Chair of the WorkGroup, gave an oral report on the extensive work that had been undertaken to produce the document. He proposed several amendments to the document concerning the compatibility between the proposed guidelines and national laws. This led to a lengthy debate.

The Committee considered the revised Statement and recommended that, as amended, it be approved by Council and forwarded to the General Assembly for adoption.

It was also recommended that the Statement be called the Declaration of Taipei if adopted by the Assembly.

## *Pre-natal Gender Selection*

An oral report was received about a proposed Resolution from the Swiss Medical Association on the Participation of Physicians in Pre-natal Gender Selection, which stated that national medical associations should recommend their governments to adopt laws to prohibit the use of pre-natal sex selection for reasons of gender prevalence. However, the document did not gain widespread support. It was argued that rather than approve a new policy, delegates should be revising existing WMA policy documents.

The Committee recommended that the proposed Statement not be accepted.

## *Quality Assurance in Medical Education*

The American Medical Association Committee submitted a Proposed Declaration on Quality Assurance in Medical Education.

The Committee recommended that the document be circulated to members for comment.

## *Declaration of Geneva*

The Committee received oral reports from Dr. Ramin Parsa-Parsi, Chair of the WorkGroup on revising the Declaration of Geneva, and from the ethics expert on the Group, Prof. Urban Wiesing. The meeting was updated on the work of the group, including a survey of NMAs on the use of the Declaration. There was some discussion of possible amendments to the Declaration and information about holding a possible session to present a new draft policy at the 12<sup>th</sup> UNESCO World Conference on Bioethics in March 2017, if accepted by the conference organizer.

The Committee recommended to the Council that the WorkGroup continue with its work.

The Committee recommended that the following agenda items be referred to the Council.

Policies with minor revisions:

- Declaration of Sydney on the Determination of Death and the Recovery of Organs
- Declaration of Therapeutic Abortion
- Declaration of Tokyo with guidelines for Medical Doctors concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment
- Statement on Child Abuse and Neglect
- Statement on Medical Ethics in the Event of Disasters

- Statement on Weapons of Warfare and Their Relation to Life and Health

Policies with major revisions:

- Declaration of Venice on Terminal Illness
- Declaration of Malta on Hunger Strikers
- Statement on Assisted Reproductive Technologies
- Statement on HIV/AIDS and the Medical Profession

New items:

- Proposed Resolution on Forced Anal Examinations
- Proposed Statement on Bullying and Harassment within the Profession

## **Thursday October 20**

### **Associates Members**

Dr. Joseph Heyman, Chair of the Associated Members, took the chair.

The minutes of the previous Associate Members Meeting, held in Moscow in October 2015 were approved.

### *Junior Doctors Network*

The meeting received an oral report from Dr. Caline Mattar (Lebanon), Junior Doctors Network Chair-Elect, who presented the JDN's written report. This outlined the work of the JDN, including its participation in a Caring Physicians of the World course, organized in collaboration with the Mayo Clinic in Jacksonville, Florida, and its partnership with the Healthcare in Danger project headed by the International Committee of the Red Cross. It detailed its work at the World Health Assembly and reported on its monthly teleconferences, which had become one of the main ways JDN members kept in touch with each other.

Finally, the Network reported on its new collaboration with the World Federation

for Medical Education. The JDN had been invited to the WFME Executive Council meetings and would in future be the voice for junior doctors at the WFME.

## *Past Presidents and Chairs of Council Network*

The Associate Members received a report of the Past Presidents and Chairs of Council Network.

## *Declaration on Health and Climate Change*

The meeting considered a proposed Declaration on Health and Climate Change calling for urgent action to ensure that the mitigation and adaptation measures agreed at the climate change summit in Paris are followed through. The document was presented by Dr. Yassen Tcholakov, the JDN representative on the Socio-Medical Affairs Committee. He said the wording had been updated to take account of the progress that had been made on the issue.

The meeting agreed that the proposed Declaration be considered by the General Assembly.

## *End-of-Life Conversations*

The meeting considered a proposed Statement on End of Life Conversations, which sets out principles for physicians involved in end of life care.

The meeting agreed that the document should be forwarded to the General Assembly for consideration.

## *Destruction of Smallpox Virus Stockpiles*

A proposed Statement on Destruction of Smallpox Virus Stockpiles was presented by Dr. Caline Mattar, JDN Chair-Elect, on behalf of the JDN. The proposed policy says that remaining stockpiles of the smallpox virus should be destroyed because of the

unacceptable risk they pose to the world's population

The meeting agreed that the document be considered by the General Assembly.

## **Scientific Meeting**

### *"Healthcare System Sustainability"*

WMA President, Sir Michael Marmot opened the day-long meeting by saying that there were major challenges, threats and opportunities and their job was to rise to the challenges and to turn the threats into opportunities. Digitisation and the digital world could be a threat, but it is a potential opportunity. Mass migration could be major threat but it was also a challenge to which they must rise.

People talked about the ageing of the population as a problem. But they should see this as something to be welcomed. After all, it was at least in part a triumph because of the control of major killing diseases and improvement in social conditions.

He said that while the global north grew rich before it grew old, the global south was growing old before it grew rich. Japan and India were both facing a rapid growth of their elderly population and India was having to deal with this at the same time as it dealt with the major medical problems of poverty and deprivation.

Sir Michael ended by praising Taiwan's record in improving health through a combination of improved economic and social conditions that had guaranteed better living conditions for its whole population and attending to the health needs of the population with universal health coverage.

**Dr. Tzou-Yien Lin**, Minister of Health and Welfare, Taiwan, was the first speaker with a talk entitled "The Roadmap for Better

Healthcare in Taiwan'. He talked about Taiwan's development of universal health coverage and the country's compulsory health insurance system. Ninety-three per cent of health care providers had contracts with the system. He talked about the development of long term care in Taiwan and the network that supported it. Statistics for life expectancy, infant mortality and cancer survival were similar to OECD average rates, demonstrating the high quality of medical care in the country.

**Prof. Dr. Frank Ulrich Montgomery**, President of the German Medical Association and Vice-Chair of the WMA, spoke about how the German healthcare system had coped with the influx of migrants and refugees. The healthcare system had been confronted with a major challenge of having to integrate more than one million refugees into the outpatient and inpatient sectors as quickly as possible. The burden of providing medical care had been borne primarily by volunteer doctors, psychotherapists and nursing staff. The system in place was a patchwork as reflected in the inconsistent policies regarding access to healthcare services, billing procedures and benefit eligibility, which varied not only from state to state, but also from municipality to municipality.

There were no uniform and reliable nationwide structures for administering healthcare to asylum seekers in Germany, which had made the situation challenging. However, constructive discussions about these issues had also given rise to potential solutions for improving the system and eliminating bureaucratic hurdles. For example, in order to streamline procedures and ultimately reduce administrative costs, German physicians had supported the idea of introducing a health card providing access to the full range of services available in the statutory health insurance system starting on the date of registration. It could also prevent redundant examinations and delays in medical

treatment resulting from the complicated process of applying for treatment vouchers. In addition, the system could benefit from the reinforcement of financial and human resources in the public health sector at both the state and municipal level.

**Prof. Kenji Shibuya**, Chair of the Department of Global Health Policy at the Graduate School of Medicine, University of Tokyo, spoke about The Sustainability of Health Care in Aging Societies: A Global Perspective.

He said Japan had achieved universal health coverage in 1961 at the time of rapid economic development, while the country was still relatively poor. It had achieved one of the best population health outcomes at relatively low cost with equity over the next half century. However, Japan was now facing a huge demographic and fiscal challenge to the sustainability of its health systems. He reviewed the historical context for Japan's health system development, examined current challenges to its sustainability, and examined ongoing efforts to reform Japan's health system. He said the major objective was to share important lessons in the current debates on global health policy from Japan's experiences.

**Dr. Andrew Dearden**, newly elected Treasurer of the WMA and Treasurer of the British Medical Association, spoke about the general practice system in the United Kingdom and the gate keeper role it played.

The central principles underpinning the National Health Service, which was founded in 1948, were clear: that the health service would be available to all and financed entirely from taxation, which meant that people paid into it according to their means. There had been some changes since 1948 to the way the service was accessed and how people contributed to its funding – for example prescription charges were introduced in 1952, abolished in 1965 and reintroduced in 1968.

The NHS today had one of the lowest spends per capita in the industrial world. According to a study produced by the Commonwealth Fund in 2014 the NHS spent £3,405 per capita, compared to the USA \$8,508, Germany \$4,495 and Australia \$3,800. Yet this same study placed the NHS in first place compared to 10 other health services in the quality, effective, co-ordinated, safety, and patient centred care. The NHS also ranked first place in patients accessing care and the efficient use of resources. It was ranked 2<sup>nd</sup> in equity of care and 3<sup>rd</sup> in timeliness of care.

Yet it had a comparatively low number of beds per capita at 2.8 per 1000 of the population and a low number of physicians per capita too, at 2.8 per 1000.

This efficient and effective use of resources in providing healthcare had been credited in the main to the well-developed and comprehensive primary care services provided by the general practitioner in the United Kingdom and their extended primary care teams acting as gate keepers to secondary care investigations, assessment and referrals.

While no healthcare system was perfect or perfectly cared for the needs of its population the NHS did demonstrate how comprehensive primary care and general practice could help a health care system use its limited resources to the best for its people.

**Dr. Steven J. Stack**, immediate past President of the American Medical Association, spoke about health care reform in the United States. He discussed the history of health insurance reform in the United States, the rationale for reform, and the current state of implementation of the Affordable Care Act. He talked about the AMA's involvement in reform efforts and the challenges physicians – as well as the next U.S. President and Congress – were likely to face in the near-term future.

He said that the enactment of the Affordable Care Act in 2010 was the culmination of a long and contentious battle in Congress to address shortcomings in the health care system that left millions of Americans uninsured. While the Act had achieved notable success in expanding health insurance coverage for millions of people, and in making improvements to quality and efficiency, significant challenges remained. Political resistance to the Act continued, millions remained uninsured or underinsured, and many people still could not afford health coverage. Recent reforms to health care payment and delivery systems also posed significant challenges.

He concluded that only time would tell whether the Act was truly transformative or a failed experiment.

**Prof. Ju Han Kim**, Professor and Founding Chair, of the Division of Biomedical Informatics at Seoul National University College of Medicine in Korea, entitled his talk 'Personal and Private Big Data: Genomes and Health Records'.

He said that a flood of multi-modal high throughput clinical genomic data and personal health records meant that many of the challenges in biomedical research and healthcare were now challenges in integrative and computational sciences for their bidirectional translations. The ability to 'connecting the dots' in the wealth biomedical big data would bring the 'big picture' in a mass of genes, drugs, diseases, and diagnostic, therapeutic and prognostic markers. Precision medicine attempted to determine individual solutions based on the genomic and clinical profiles of each individual, providing opportunity to incorporate individual molecular data into patient care. While a plethora of genomic signatures had successfully demonstrated their predictive power, they were merely statistically-significant differences between dichotomized phenotypes that were in fact severely heterogeneous. Despite many translational barriers,



connecting the molecular world to the clinical world and vice versa would undoubtedly benefit human health in the near future.

He concluded with the words: 'Better health is not a science problem, it's an information problem'.

**Prof. Yu-Chuan (Jack) Li**, Professor in Biomedical Informatics and Dean of the College of Medical Science and Technology at Taipei Medical University, spoke about 'Conquering Medical Errors with Artificial Intelligence'. He said that care was complex and unco-ordinated and information was often not available to those who needed it when they needed it. As a result, they often did not get the care they needed or got the care they did not need. He talked about the reasons for poor quality care in relation to lack of information and went on to discuss AI in relation to medical errors. Medical errors were a leading cause of death, more common than they thought and were a costly system problem. And more than 50 per cent of errors were preventable. He talked about the current problems with health informational technology and the challenges it faced.

**Prof. Chun-Ying Wu**, Professor of Medicine at Taiwan's National Yang-Ming University, talked about Big Data Approach in Health Care Assessment.

He said that big data approach in health care outcome assessment was an important trend. Precision medicine initiatives proposed by President Obama were actually an ultimate big data project. Curing either rare diseases or common cancers did not just require more trials, but also needed linking all the data the researchers or physicians already had. Nationwide cohort studies based on big data had several advantages compared with traditional cohort studies and randomized clinical trials.

He used previous big data research experience based on Taiwan's National Health

Insurance Research Database (NHIRD) as examples to introduce the feasibility of big data approach in health care outcome assessment. Based on big data research, they had found early *Helicobacter pylori* eradication and regular use of non-steroidal anti-inflammatory drugs (NSAIDs) associated with reduced risk of gastric cancer. They had also reported that antiviral therapy reduced hepatocellular carcinoma (HCC) risk in patients with hepatitis B. Antiviral therapy also reduced HCC recurrence in patients with HBV and HCV-related HCC after liver resection or radiofrequency ablation (RFA).

Finally, he said that big data approach could be used to conduct novel clinical studies, to assess effectiveness in real world, to make health policies, and to achieve precision medicine. Big data approach in health care outcome assessment was feasible and useful.

And he concluded by quoting Winston Churchill: 'Now this is not the end. It is not even the beginning of the end. But it is perhaps the end of the beginning'.

**Dr. Florentino Cardoso**, President of the Brazilian Medical Association, entitled his talk 'Health IT: The Essential Infrastructure for Universal Coverage'.

He said that as in other areas, information technology played a key role in the development and optimization of health service. New possibilities in care and management became available thanks to democratizations of information between medicine key players and the society. Some developed countries had expertise in offering services related to remote health care, such as telemedicine, in regions where distance was a critical factor, which had improved in access.

He said that telecommunication enhanced emergency medical services by helping expedite urgent patient transfer, provided remote consultation and supervision of

paramedics and nurses, avoiding treatment delay, reducing mortality and improving quality of life. Furthermore, I.T. was also inserted in teaching and research.

Continuing online education to the physician training, even in places of difficult access and/or poor educational structure. Electronic Health Records systems allowed advances in medical research, access to clinical guidelines, and also utilization of data for epidemiological and statistical purpose.

**Dr. Robert M. Wah**, former President of the American Medical Association, from the National Institutes of Health and Walter Reed Military Center at Bethesda Maryland, USA, spoke about 'Transforming Healthcare with Information Technology'.

He said that as the conversion from paper to digital format progressed across healthcare, the opportunity to use information technology to improve and transform healthcare grew larger. It was important to keep in mind that technology was a tool to help take better care of patients. There were three waves to the change; conversion to digital from paper; networking the digital information together; and then analysing the digital, networked information in new and powerful ways to help population health and personalized medicine. This would provide better information for better decisions in healthcare.

He talked about cumbersome electronic health records and the burden of regulations and what was required to improve their usability. Better information was required for better health care decisions.

**Dr. Mark Sonderup**, Vice Chairman of the South African Medical Association, talked about the problems and pitfalls of eHealth. He said that eHealth encompassed information and communication technologies that had the potential to enhance the

rendering of healthcare, particularly in under-resourced and remote regions.

The case for e health included improved efficiency, improved governance, improved quality of health care, increased value for money and increased access to health care. Several challenges however posed problems and included technical, financing and political issues. For example, work was required to ensure the seamlessness between existing systems and platforms. However, the cost of developing such platforms might be prohibitive and new funding models and commitments from stakeholders such as government and corporates were needed. Furthermore, any eHealth system must be integrated into the existing health systems and physicians might require additional training to ensure that eHealth systems were optimally utilized. Concerning, and a potential pitfall, was that eHealth systems must take into account the legislated protections on the processing and transfer of confidential medical information.

**Dr. Andreas Rudkjøbing**, President of the Danish Medical Association, talked about how eHealth could support citizens and healthcare services, using the example of e-health in Denmark. He said that 20 years ago the Danish Ministry of Health launched a strategy for the public hospitals to implement EHRs – Electronic Health Records. This initiative coupled with a strategy for improving the electronic health data connection was the starting point of the digitalized Danish health care sector. In 2016 all public hospitals in Denmark had an EHR. The strategy had been to implement not only one EHR-system, but to ensure key information was collected and might be transferred between health care providers.

In 2016 every citizen in Denmark had access to his own personal health record through the site “Sundhed.dk”. When logged on it was possible for the citizen to read part of the patient record and see his

own medication data and laboratory test results. GPs had electronic patient records too – and referrals, prescriptions etc. were sent by standardized electronic communication between the GP, the hospital and the municipality.

He talked about the expectations and obstacles relating to the design and implementation of the Danish e-health infrastructure, and about what he saw as the main challenges for health professionals in the Danish e-health care sector in the years to come. These included the sharing of patient records across sectors, their usability, unstable systems and the interaction between patients and doctors.

Throughout the day, panel discussions and questions from the floor, led to lively and informative debates.

## Friday October 21

### Council

Dr. Ardis Hoven took the chair for the reconvened Council meeting.

### Finance and Planning Committee Report

#### *Financial Statement 2015*

The Council approved the Audited Financial Statement for 2015 and agreed to forward it to the General Assembly for approval and adoption.

#### *Budget and Membership Dues Payments*

The Council approved the proposed Budget for 2017 and agreed to forward it to the General Assembly for approval and adoption.

Membership Dues Payments for 2016  
The Council approved the report on WMA Dues Categories 2017 and agreed that it be

forwarded to the General Assembly for approval and adoption.

#### *Royal Dutch Medical Association*

The Council approved the arrangement requested by the RDMA, under which the RDMA would abstain from voting in 2016 and obtain a council seat by declaring 50,000 physicians in 2017.

#### *Auditor*

The Council agreed to the appointment of KPMG as auditor of the 2016 WMA Financial Statement.

#### *Business Development*

The Council agreed to allow the new Treasurer to ask NMAs to review their number of declared members and to make sure they are consistent with the number of members in their association.

#### *Governance Review*

The Council approved the report of the Governance Review WorkGroup and agreed to the proposal for a survey of NMAs and Associate Members to prioritize the goals of the Association and increase members' involvement.

#### *International Committee of Military Medicine*

The Council agreed the Memorandum of Understanding with the International Committee of Military Medicine and forwarded the item to the General Assembly for approval.

### Socio-Medical Affairs Committee Report

Role of Physicians in Preventing the Trafficking with Minors and Illegal Adoptions

The Council agreed that the proposed Statement be sent back to the WorkGroup

for further consideration and that a revised version be circulated among members for comments.

## *Armed Conflict*

The Council agreed that the proposed Statement be sent back to the WorkGroup for further consideration and that a revised version be circulated among members for comments.

## *Occupational Health*

The Council approved the proposed Resolution on Occupational and Environmental and Safety and agreed to forward it to the General Assembly for adoption.

## *Boxing*

The Council agreed that the proposed revision of the Statement on Boxing be further revised by the author and then re-circulated among members for comments.

## *Fossil Fuel Divestment*

The Council agreed that the Statement on Divestment in Fossil Fuels be approved and sent to the General Assembly for adoption.

## *Cyber Attacks on Health and Other Critical Infrastructures*

The Council approved the proposed Statement and agreed to forward it to the General Assembly for adoption.

## *Medical Tourism*

The Council approved the proposed Statement and agreed to forward it to the General Assembly for adoption.

## *Medical Cannabis*

The Council agreed that the proposed Statement be revised by the author and

then re-circulated among members for comments.

## *Medical Assistance in Air Travel*

The Council recommended that the proposed Resolution be circulated among members for comments.

## *Tuberculosis*

The Council recommended that the proposed revised Resolution be circulated among members for comments.

## *Access to Health Care*

The Council recommended that the proposed Statement be circulated among members for comments.

## *Injury Control*

The Council approved the revised Statement and forwarded it to the General Assembly for adoption.

## *Traffic Injury*

The Committee approved the revised Statement and agreed to forward it to the General Assembly for adoption.

## *Adolescent Suicide*

The Council approved the revised Statement and agreed to forward it to the General Assembly for adoption.

## *Alcohol & Road Safety*

The Council approved the revised Statement and agreed to forward it to the General Assembly for adoption.

## *Physicians and Public Health*

The Council approved the revised Statement and agreed to forward it to the General Assembly for adoption.

## *Professional Autonomy of Physicians*

The Council agreed that the proposed revisions to the Declarations of Seoul and Madrid be circulated among members for comments.

## *Medical Education*

The Council agreed that the proposed revised Statement be circulated among members for comments.

## *Physician's Role in Obesity*

The Council approved the revised Statement and agreed it should be forwarded to the General Assembly for adoption.

## *Responsibilities of Physicians in Preventing and Treating Opiate and Psychotropic Drug Abuse*

The Council approved the revised Statement and agreed it should be forwarded to the General Assembly for adoption.

## *Review of WMA general policy on Alcohol*

The Council agreed that the proposed revised Declaration should be circulated among members for comments.

## *Water and Health*

The Council agreed that the proposed Statement be circulated among members for comments.

## *Cooperation of National Medical Associations during or in the Aftermath of Conflicts*

The Council agreed that the proposed Statement be circulated among members for comments.

## *Epidemics*

The Council agreed that the proposed WMA Statement on Epidemics/Pandemics be circulated amongst members for comments.

## *Sustainable Development*

The Council recommended to the General Assembly that a workgroup on sustainable development be established

## *Protection of Health Care Facilities and Personnel in Syria*

The Council approved the proposed emergency Resolution and agreed it be forwarded to the General Assembly for adoption.

## **Medical Ethics Committee**

### *Person Centered Medicine*

The Council agreed that the Person Centered Medicine Workgroup be disbanded for the time being.

### *Health Databases*

The Council approved the proposed Statement on Health Databases and Biobanks and recommended that it be forwarded to the General Assembly for adoption. It also agreed that the Statement be called the Declaration of Taipei if adopted by the General Assembly.

### *Participation of Physicians in Pre-natal Gender Selection*

The Council agreed that the proposed revision of the Statement be not be accepted.

### *Quality Assurance in Medical Education*

The Council agreed that the proposed Declaration be re-circulated to constituent members for comments.

### *Declaration of Geneva*

The Council agreed that the WorkGroup should continue its work as proposed.

The Council agreed that the following policies with minor revisions be forwarded to the General Assembly for adoption:

- Declaration of Sydney on the Determination of Death and the Recovery of Organs
- Declaration of Tokyo with guidelines for Medical Doctors concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment
- Statement on Child Abuse and Neglect
- Statement on Weapons of Warfare and Their Relation to Life and Health

The Council agreed that the following policies with major revisions should to be sent out for comment

- Declaration of Malta on Hunger Strikers
- Statement on Assisted Reproductive Technologies
- Statement on HIV/AIDS and the Medical Profession
- Declaration of Therapeutic Abortion
- Statement on Medical Ethics in the Event of Disasters

### *Declaration of Venice on Terminal Illness*

The Council agreed that proposed revisions to this Declaration be postponed until the wider debate on euthanasia and physician assisted dying.

The Council agreed that two new items be sent out for comment:

- Proposed Resolution on Forced Anal Examinations
- Proposed Statement on Bullying and Harassment within the Profession

## **Ceremonial Session of the General Assembly**

Sir Michael Marmot, the outgoing President of the WMA, welcomed the President of Taiwan and other guests to the official opening of the Assembly at the Ceremonial

Session. The event was attended by hundreds of WMA delegates, including more than one hundred visiting physicians from India.

The event began with a traditional Taiwanese drum performance, followed by the release of several large sky lanterns.

Dr. Pi-Sheng Wang, Secretary General of the Taiwan Medical Association, explained that the sky lantern had a long history since the first century and was still a symbol of good luck.

'Every year, at the beginning of the spring season, people would release sky lanterns into the air as a prayer for the coming year. The lanterns are the reflected lives and hopes of the people as the sky lanterns slowly rose aloft. Today, we are here together to make prayer and vows of the brighter future of the medical system and the sustainability of healthcare'.

Dr. Kloiber then introduced the various delegations from member associations and observers of international organizations with the traditional roll call.

Dr. Tai-Yuan Chiu, President of the Taiwan Medical Association, welcomed delegates to the Assembly and paid special thanks to all the national medical associations for supporting the Taiwan Medical Association.

The Assembly was then addressed by President Ing-Wen Tsai. She said that the Taiwan Medical Association was one of the most important NGOs for medical affairs in Taiwan. It played a crucial role in liaising with physicians on a national basis, promoting the advancement of medical technology and common interests and coordinating medical development. She said she was grateful for their long-term support, assistance and advice on the Government's medical policies. It was also thanks



to their members that Taiwan had established an excellent reputation for medical academic research, for innovative technology and medical industry development. She said the WMA played a pivotal role in co-operation between the World Health Organisation and international medical groups.

She went on: 'In the past with the WMA's support Taiwan attended the World Health Assembly as an observer. The WMA also supported Taiwan's quest to join the WHO and the international health regulations network so we can contribute to global health issues. When it comes to health epidemic control or health care there are no borders. Health is a fundamental human right and a universal value. We hope the WMA will continue to support our WHO membership efforts so that we can better contribute to global health matters'.

President Tsai said that in recent years Taiwan's physicians had capably managed the SARS epidemic, the H1N1 swine flu and hundreds of burnt patients from a major dust explosion. This outstanding conduct in a crisis had won international recognition and showed that Taiwan's medical services were second to none. But like many countries, they had an ageing population and this had led to rising medical costs and increased demand on the health system. Because the government believed it had a responsibility to build a comprehensive health system it had proposed a policy to reach several goals. These included a reasonable increase in medical expenses, building a community care system and strengthening the medical disputes mechanism to avoid unnecessary litigation.

She said the government strongly supported legislation to improve physicians' labour conditions and to simplify hospital accreditation and increased government scholarships. In response to the ageing society it was implementing an extended long term

care plan. They hoped to build a high quality, affordable and universal long term care system.

Dr. Ardis Hoven, Chair of the WMA, paid tribute to the retiring WMA President, Sir Michael Marmot, who, she said, had presided with great distinction over the WMA's affairs.

Sir Michael Marmot then delivered his valedictory address.

After presenting Sir Michael with a Past President's medal, Dr. Hoven invited Dr. Ketan Desai (Indian Medical Association) to the rostrum, where she installed him as the WMA's 67<sup>th</sup> President for 2016/17. After taking the oath of office of the President, Dr. Desai gave his inaugural address.

The Ceremonial Session then closed.

## Saturday October 22

The final day began with a new session to inform new delegates about the procedure of the General Assembly and to allow them to question WMA officers. This was in response to comments that some people were not sure what was going on or the agenda was happening too quickly.

## General Assembly

Dr. Ardis Hoven took the Chair at the plenary session of the General Assembly.

### *President Elect*

The election took place for President elect. Four nominations were initially submitted. However, two were withdrawn, one of them, Dr. Osahon Enabulele (Nigeria Medical Association) announcing that he would stand in October 2017.

In a two-way contest, Dr. Yoshitake Yokokura, President of the Japan Medical Association, was elected in a contest against Dr. Adriana Vince (Croatian Medical Association). He will take office in a year's time to serve in 2017/18. Dr. Yokokura, a surgeon, has been a WMA Council member since 2010 and President of the JMA since 2012 and President of Yokokura Hospital since 1990. In his submission for election, Dr. Yokokura said that the world was in a state of uncertainty and the WMA had to address urgent global issues, including health care in danger, climate change and the social determinants of health.

### *Council Reports*

The Assembly considered the reports from Council and took the following decisions.

### *Medical Ethics Committee*

Declaration on Health Databases and Biobanks

Dr. Jon Snædal said the document, one of the WMA's most important policies, was the result of a long process of internal and external consultation. He proposed an amendment to the document relating to the section which stated that no national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for individuals and populations set out in the Declaration. He proposed an amendment to the related sentence which originally stated that 'When authorized by a national law adopted through a democratic process in respect of human rights, an opt-out process or other procedures could be adopted to protect the dignity, autonomy and privacy of the individuals'. He proposed deleting the words 'an opt out process or'. The amendment reflected the fact that NMAs had different viewpoints on this issue. He said the Declaration was a living document and would probably

come up for revision in two or three years' time.

The Assembly agreed the amendment and then approved for adoption the whole document and agreed to name it the Declaration of Taipei.

The Assembly approved for adoption the following documents from the Medical Ethics Committee:

- Revision of the Declaration of Sydney on the Determination of Death and the Recovery of Organs
- Revision of the Declaration of Tokyo with guidelines for Medical Doctors concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment
- Revision of the Statement on Child Abuse and Neglect
- Revision of the Statement on Weapons of Warfare and Their Relation to Life and Health

## *Socio-Medical Affairs Committee*

The Assembly approved for adoption the following documents from the Socio-Medical Affairs Committee:

- Statement on Ageing ([see p. 143](#))
- Revised Resolution on the Implementation of the WHO Framework Convention on Tobacco Control
- Revised Statement on Female Genital Mutilation
- Revised Statement on Body Searches of Prisoners
- Statement on Ethical Considerations in Global Medical Electives ([see p. 147](#))
- Resolution on Zika virus Infection ([see p. 152](#))
- Resolution on Refugees and Migrants ([see p. 151](#))
- Resolution on Occupational and Environmental and Safety ([see p. 149](#))
- Statement on Obesity in Children ([see p. 148](#))
- Statement on Divestment in Fossil Fuels ([see p. 146](#))

- Statement on Cyber-Attacks on Health and Other Critical Infrastructures ([see p. 145](#))
- Revised Statement on Injury Control
- Revised Statement on Traffic Injury
- Revised Statement on Adolescent Suicide
- Revised Statement on Alcohol and Road Safety
- Revised Statement on Physicians and Public Health
- Revised Statement on the Physician's Role in Obesity
- Revised Statement on the Responsibilities of Physicians in Preventing and Treating Opiate and Psychotropic Drug Abuse
- Resolution on the Protection of Healthcare Facilities and Personnel in Syria ([see p. 152](#))

## *Proposed Statement on Medical Tourism*

Mr Bjorn Hoftvedt (Norwegian Medical Association) proposed that this document should be referred back to Council for further consideration. He said it missed the clear distinction between patients seeking health care abroad paid for by the state, which was possible within the European Union, and patients who went abroad for health care paid for by themselves. The problem was the second group who paid themselves because their home state could not offer that kind of health care, such as surrogate pregnancy or a new organ. The shortage of organs and trafficking of organs was an international problem and patients seeking health care abroad for a new organ could stimulate the increased use of illegal organs. Medical tourism not properly organised could spread infections. And not everybody could afford to seek health care abroad. This kind of medical tourism aimed at rich people could widen the gap between wealthy and not wealthy people. And he argued that the WMA had adopted several policies which could be perceived as being inconsistent with this document on medical tourism.

The proposal to refer back was supported by many speakers, and the Israel Medical Association, which submitted the proposed Statement agreed to reconsider the document.

The Assembly agreed to refer the proposed Statement back to Council.

## *Finance and Planning*

The Treasurer, Dr. Andrew Dearden, gave an oral report on the Association's finances. He said the Association had a safe financial basis and its investment strategy was stable. As a result, the Association's finances were in a very positive position.

The Assembly approved and adopted the Audited Financial Statement for the year ending 31 December 2015 and the proposed WMA Budget for 2017.

## *WMA Meetings*

The Assembly agreed that the 209<sup>th</sup> Council Session be held in Riga, Latvia on 26-28 April 2018, that the date of the 69<sup>th</sup> General Assembly in Reykjavik, Iceland be 3-6 October 2018. It agreed that the Turkish Medical Association in Istanbul be the venue for the General Assembly in 2019 and that the Georgian Medical Association in Tbilisi be the venue for the General Assembly in 2020.

The Assembly agreed that the topic of the Scientific Session at the Assembly in 2017 be "Assuring Quality in Undergraduate Medical Education".

## *International Committee of Military Medicine*

The Assembly agreed that the Memorandum of Understanding with the International Committee of Military Medicine be approved and adopted.

The remainder of the Finance and Planning Committee report from Council was accepted.

## *Associate Members*

Dr. Joe Heyman, Chair of the Associate Members, reported on the group's activities and submitted three items for consideration – the proposed Declaration on Health and Climate Change, the proposed Statement on End of Life Conversations and the proposed Statement on Destruction of Smallpox Virus Stockpiles.

The Assembly agreed that the three documents be sent to Council for consideration.

## *Open Session*

Several speakers took the opportunity of the open session to talk about issues relating to their association.

## *Cote d'Ivoire*

Dr. Gabriel Faye (Ordre National Des Médecins De La Côte D'Ivoire) addressed the Assembly on the buruli ulcer disease which was rampant in his country and in many other African countries. He said the dire consequences were fatal for many patients and he urged national medical associations to support the Rotary Club appeal which had been launched to combat this scourge.

## *Venezuela*

Dr. Ruben Tucci (Argentina), spoke of the concern about the state of health in Venezuela. He urged the WMA to intervene with the Venezuelan Government to draw their attention to the state of health of their population. He also urged other organisations and national medical associations to assist the Venezuelan organisation of physicians to take action and such measures as they deemed fit to resolve their current problems.

## *Kuwait*

Dr. Loujain Alkodmani, from the Kuwait Medical Association, said it had been a

pleasure to attend the Council meeting and to be part of the discussion. Unfortunately, the Kuwait Medical Association was the only medical association from the region to be involved at the meeting. She said it was important that different views from different cultures were presented at these meetings and the Kuwait association was committed to try to recruit other NMAs from the region. It was essential that the WMA was and continued to be open to all cultures.

## *Investment in Health*

Dr. Kloiber gave a report on the Commission report on Health Employment and Economic Growth that had reported to the United Nations Secretary General on investment in the health work force. It was headed by the Presidents of South Africa and France and was important for the fact that for the first time it put the emphasis not only on investment in health but also on investment in the health work force. He said that report showed that the health care sector in the world was a very sizeable part of the economy. The size of the world's health sector was more than \$5.8 trillion a year. In the OECD countries, the employment in health and social work had grown by 48 per cent between 2000 and 2014, while jobs in industry and agriculture had declined.

Dr. Kloiber said estimates suggested that globally each health worker was supported by another 1-2 people working. In the low and middle income countries one quarter of economic growth between 2000 and 2011 had resulted from the value of improvements in health. The report to the UN had estimated that the return on investment in health was probably nine to one. This showed that the money that went into health was not simply an expense. It was a return on investment.

He said that the health care systems could lead to six pathways to economic growth –

health production, economic output, increase in social protection, social cohesion in a society, innovation and diversification, and health security.

Dr. Kloiber invited all national medical associations to be part of the process by following the development and implementation of this report. The World Health Organisation and the UN would stage a number of events in the coming month to promote the report and the WMA would be part of this by reminding the UN that it had a specific focus on the social determinants of health.

## *Dr. Xavier Deau*

Dr. Deau, delivered a brief speech of thanks, marking the end of his time as an immediate past President. He said he would continue to seek to build while others destroyed, he would keep searching for peace in the midst of war, keep crying out while others preferred to keep silent and he would continue to love even while some distilled hatred. Independence, freedom and solidarity were the three key words of his inaugural address. He said he would continue to promote human rights and he thanked all of those who welcomed him during his Presidency.

## *Chicago Assembly*

Dr. David Barbe, President elect of the American Medical Association, invited all those present to the next General Assembly to be held in Chicago in October 2017.

## *Taiwan*

The Assembly closed with a brief speech of thanks from Dr. Wu, chair the Taiwan Medical Association organising committee for the meeting. He said this had been the first time Taipei had hosted the WMA. He thanked the WMA for an excellent meeting and said the Taiwan Medical Association



tion would continue to play an active part in the WMA.

The meeting thanked Dr. Wu and the Taiwan Medical Association for hosting the meeting.

### *African Initiative*

WMA Past President Dr. Margaret Mungherera spoke about the need for the WMA to continue work on the African continent and on the African medical initiative she had started during her presidency. African national medical associations needed to be strengthened and supported. She reminded delegates about a meeting to be held on the social determinants of health in February next year in South Africa. And she emphasised the importance of the mentoring project under which stronger associations

were twinned with smaller associations to assist them.

### *Thanks*

The Assembly ended with Dr. Kloiber thanking all those who had helped to organise the meeting.

### **Council**

The week ended with a brief meeting of Council, convened to consider items submitted to it by the Assembly.

### *Medical Tourism*

The Council decided to circulate the proposed Statement on Medical Tourism to NMAs for comment.

### *End-of-Life Conversations*

The Council considered the proposed Statement on End of Life Conversations, which sets out principles for physicians involved in end of life care.

This led to a debate about what to do with the paper. The Council eventually agreed to a proposal to postpone consideration of the document indefinitely.

The Council agreed to circulate the proposed Statements on Climate Change and Smallpox to NMAs for comment.

*Mr. Nigel Duncan  
Public Relation Consultant,  
WMA*





## WMA Statement on Ageing

*Adopted by the 67<sup>th</sup> WMA General Assembly, Taipei, Taiwan, October 2016*

### Preamble

The world is undergoing a longevity extension at an unprecedentedly rapid pace. Over the last century, some 30 years have been added to global average Life Expectancy at Birth (LEB) – with more gains expected in the future. By 2050, LEB is projected to reach 74 years with an ever-increasing number of countries reaching 80 years and beyond. In 1950 the total number of people aged 80+ was 14 million – by 2050 the estimated number is 384 million, a 26-fold increase. The proportion of elderly will more than double from 10% in 2015 to 22% of the total population in 2050. These improvements are very variable; many of the poorest communities in all countries and a larger percentage of the population in the poorest countries have gained little in terms of life expectancy over this period of time.

The increase in longevity has been paired with a decreasing number of children, adolescents and younger adults as more and more countries experience Total Fertility Rates below replacement level, raising the average age in these countries.

The challenges of aging in developing countries are complicated by the fact that basic infrastructure is not always in place. In some cases, populations in developing countries are aging more quickly than infrastructure is being developed.

Longevity is arguably the greatest societal achievement of the 20<sup>th</sup> century but it could turn into a major problem during the 21<sup>st</sup> century. The World Health Organization (WHO) defines Active Ageing as “the process of optimizing opportunities for Health, Lifelong learning, Participation and Security in order of enhancing quality of life as individuals age”. This definition presupposes a life course perspective as the determinants that influence active ageing operates throughout the life course of an individual. These are social determinants of health and include behavioral determinants (life-styles), personal determinants (not only hereditary factors which are, overall, responsible for no more than 25% of the chances of ageing well but also psychological characteristics), the physical environment where one lives as well as broad social and economic determinants. All of these act individually on the prospects of active ageing but also interact among themselves: the more they interact and overlap, the higher the chance of an individual ageing actively. Gender and culture are crosscutting determinants, influencing all the others.

### General principles

#### Medical Expenses

There is strong evidence that chronic diseases increase the use (and costs) of health services rather than age *per se*.

However, chronic conditions and disabilities become more prevalent with advancing age – therefore health care use and spending rise in tandem with age.

In many countries health care spending for older persons has increased over the years as more interventions and new technologies have become available for problems common in older age.

#### Effect of Ageing on Health Systems

Health care systems face two major challenges in the longevity revolution: preventing chronic disease and disability and delivering high quality and cost-effective care that is appropriate for individuals regardless of age.

In less developed regions the disease burden in old age is higher than in more developed regions.

#### Special Health Care Considerations

The leading diseases contributing to disability in all regions are cardiovascular diseases, cancers, chronic respiratory diseases, musculoskeletal disorders, and neurological and mental diseases, including the dementias. Some common conditions in older age are especially disabling and require early detection and management.

Chronic diseases common among older people include diseases preventable through healthy behaviors and/or lifestyle interventions and effective preventive health services – typically cardiovascular disease, diabetes, chronic obstructive pulmonary disease and many types of cancer. Other diseases are more closely linked to ageing processes and are not understood well enough to prevent them – such as dementia, depression and some musculoskeletal and neurological disorders.

While research may eventually lead to effective disability prevention or treatment, early management is key to controlling disability and/or maintaining quality of life.

Older persons may be more vulnerable to the effects of accidents within and outside the home. This will include risks when operating machinery such as road vehicles, but also risks from handling other potentially dangerous equipment. As older people continue to work these risks must be assessed and managed. Those who suffer injuries may have their recovery complicated by other medical vulnerabilities and comorbidities.

## Considerations for Health Care Professionals

Health care for elderly people usually requires a variety of professionals working as an articulated team.

Education and training of health professionals to treat and manage the conditions common in the elderly are generally not sufficiently emphasized in undergraduate curricula.

## Reducing Impact on Health Care

A comprehensive continuum of health services needs to be adopted urgently as population age.

It should include health promotion, disease prevention, curative treatments, rehabilitation, management and prevention of decline, and palliative care.

Different types of health care providers offer these services, from self and family/informal care – sometimes in a voluntary capacity – to community-based providers and institutions.

## Establishing Optimal Health Care Systems

Universal Health Care coverage ideally should be provided to all, including elderly people. The vast majority of health problems can and should be dealt with at the community level. In order to provide optimal community care and ensure care coordination over time it is critical to strengthen Primary Health Care (PHC) services.

In order to strengthen PHC to promote active ageing, WHO advanced evidence-based principles for age-friendly PHC in three areas which should be considered: information/education/communication/training, health management systems and the physical environment.

The health sector should encourage health systems to support all such dimensions of care provided to individuals as they age given the importance of health to ensure quality of life.

## Specificities of Health Care

Many formal systems of health care have been developed with an emphasis on “acute or catastrophic care” of a much younger population, often focused on communicable diseases and/or injuries. Health systems should emphasize other needs, especially chronic diseases management and cognitive decline, when treating the elderly.

While acute care services are essential for people of all ages, but they are not focused on keeping people healthy or providing the ongoing support and care required to manage chronic conditions. A paradigm shift is needed to avoid treating chronic diseases as if they were acute conditions.

Medical conditions in older age often occur simultaneously with social problems and both need to be considered by health professionals when providing health care. Doctors, particularly specialists, should bear in mind that elderly patients may have other concurrent chronic diseases or comorbidities that interact with each other and that their treatment should not lead to inadvertent and preventable induction of complications.

When initiating a pharmacologic treatment for chronic disease in an elderly patient, prescribers should generally start low (doses) and go slow (increasing the doses) to accommodate the specific needs of the patient.

If the patient cannot decide for him/herself, due to the high prevalence of memory and cognitive problems in old age, physicians treating elderly patients should actively communicate with the family, and frequently with the formal caretaker, to better educate them about the patient's health condition and about medication administration, in order to avoid complications.

When considering different therapeutic options, physicians should always seek to find out the wishes of the patient and recognize that for some patients quality of life will be more important than the potential results of more aggressive treatment options.

## Education and Training for Physicians

All physicians should be appropriately trained to diagnose and treat the health problems of older people, which means mainstreaming ageing in the medical curriculum.

Secondary health care for the elderly should be provided as necessary. It should be holistic, including taking into consideration psychosocial as well as environmental aspects. Physicians should also

be aware of the risks of elder abuse and measures to be taken when abuse is identified or suspected. (See the WMA Declaration of Hong Kong on the Abuse of the Elderly.)

Every doctor, particularly general practitioners, should have access to information and undergo training to identify and prevent polypharmacy and adverse drugs interactions that may be more common in elderly patients.

Continuing medical education on topics relevant to the ageing patient should be emphasized in order to help physicians adequately diagnose, treat, and manage the complexities of caring for an ageing population.

## WMA Statement on Cyber-Attacks on Health and Other Critical Infrastructure

*Adopted by the 67<sup>th</sup> World Medical Assembly, Taipei, Taiwan, October 2016*

### Preamble

Advancements in modern information technology (IT) pave the way for improvements in healthcare delivery and help streamline physician workflow, from medical record keeping to patient care. At the same time, implementing new and more sophisticated IT infrastructure is not without its challenges and risks, including cyber-attacks and data breaches.

Cyber security threats are an unfortunate reality in an age of digital information and communication. Attacks on critical infrastructure and vital assets of public interest, including those used in the fields of energy, food and water supply, telecommunications, transportation and healthcare, are on the rise and pose a serious threat to the health and well-being of the general public.

With the proliferation of electronic medical records and billing systems, the healthcare sector is especially susceptible to cyber intrusions and has become a prime soft target for cyber criminals. Healthcare institutions and business partners, from the smallest of private practices to the largest of hospitals, are vulnerable not only to the theft, alteration and manipulation of patients' electronic medical and financial records, but also to increasingly sophisticated

system breaches that could jeopardise their ability to provide care for patients and respond to health emergencies. Especially disconcerting is the threat posed to a patient's fundamental right to data privacy and safety. In addition, repairing the damage caused by successful cyber-attacks can entail significant costs.

Patient data also demands protection because it often contains sensitive personal information that can be used by criminals to access bank accounts, steal identities, or obtain prescriptions illegally. For this reason, it is worth far more on the black market than credit card information alone. Alterations to or abuse of patient data in the case of a breach can be detrimental to the health, safety and material situation of patients. In some cases, breaches can even have life-threatening consequences.

Current security procedures and strategies in the healthcare sector have generally not kept pace with the volume and magnitude of cyber-attacks. If not adequately protected, hospital information systems, practice management systems or control systems for medical devices can become gateways for cybercriminals. Radiology imaging software, video conferencing systems, surveillance cameras, mobile devices, printers, routers and digital video systems used for online health monitoring and remote procedures are just some of the many IT structures at risk of being compromised.

Despite this danger, many healthcare organisations and institutions lack the financial resources (or the will to provide them) and the administrative or technical skills and personnel required to detect and prevent cyber-attacks. They may also fail to adequately communicate the seriousness of cyber threats both internally and to patients and external business partners.

### Recommendations

1. The WMA recognises that cyber-attacks on healthcare systems and other critical infrastructure represent a cross-border issue and a threat to public health. It therefore calls upon governments, policy makers and operators of health and other vital infrastructure throughout the world to work with the competent authorities for cyber security in their respective countries and to collaborate internationally in order to anticipate and defend against such attacks.
2. The WMA urges national medical associations to raise awareness among their members, health care institutions and other industry stakeholders about the threat of cyber-attacks and to support an effective, consistent healthcare IT strategy to protect sensitive medical data and to assure patient privacy and safety.
3. The WMA underscores the heightened risk of cyber intrusions and other data breaches faced by the healthcare sector and urges

medical institutions to implement and maintain comprehensive systems for preventing security breaches, including but not limited to providing training to ensure employee compliance with optimal data handling practices and to maintain security of computing devices.

4. In the event of a data security breach, healthcare institutions should have proven response systems in place, including but not limited to notifying and offering protection services to victims and implementing processes to correct errors in medical records that result from malicious use of stolen data. Data breach insurance policies could be considered as a precautionary measure for defraying the costs associated with a potential cyber intrusion.
5. The WMA calls upon physicians, as guardians of patient safety and data confidentiality, to remain aware of the unique challenge cyber-attacks could pose to their ability to practice their profession and to take all necessary measures that have been shown to safeguard patient data, patient safety and other vital information.
6. The WMA recommends that undergraduate and postgraduate medical education curricula include comprehensive information on how physicians can use modern IT and electronic communications systems to full advantage, while still ensuring data protection and maintaining the highest standards of professional conduct.
7. The WMA acknowledges that physicians and healthcare providers may not always have access to the resources (including financial), infrastructure and expertise required to establish fail-safe defence systems and stresses the need for the appropriate public as well as private bodies to support them in overcoming these limitations.

## WMA Statement on Divestment in Fossil Fuels

*Adopted by the 67<sup>th</sup> WMA General Assembly, Taipei, Taiwan, October 2016*

### Preamble

As noted by the 65<sup>th</sup> World Medical Assembly in Durban in 2014, physicians around the world are aware that fossil fuel air pollution reduces quality of life for millions of people worldwide, causing a substantial burden of disease, economic loss, and costs to health care systems.

According to World Health Organization data, in 2012, approximately “7 million people died, one in eight of total global deaths, as a result of air pollution” (WHO, 2014).

The United Nations’ Intergovernmental Panel on Climate Change (IPCC) notes that global economic and population growth, relying on an increased use of coal, continues to be the most important driver of increases in Carbon Dioxide emissions. These emissions are the major component of an accelerating the amount of human fossil fuel Greenhouse Gas (GHG) emissions despite the adoption of climate change mitigation policies (IPCC, 2014).

The burden of disease arising from Climate Change will be differentially distributed across the globe and, while it will affect everyone, the most marginal populations will be the most vulnerable to the impacts of climate change and have the least capacity for adaptation.

### Background

In many densely settled populated cities around the world, the fine dust measurable in the air is up to 50 times higher than the WHO recommendations. A high volume of transport, power generated from coal, and pollution caused by construction equipment are among the contributing factors (WMA, SMAC 197, Air Pollution WMA Statement on the Prevention of Air pollution due to Vehicle Emissions 2014).

Evidence from around the world shows that the effects of climate change and its extreme weather are having significant and sometimes devastating impacts on human health. Fourteen of the 15 warmest years on record have occurred in the first 15 years of this century (World Meteorological Organization 2014). The vulnerable among us including children, older adults, people with heart or lung disease, and people living in poverty are most at risk from these changes.

The WMA notes the Lancet Commission’s description of Climate Change as “the greatest threat to human health of the 21<sup>st</sup> century”, and that the Paris agreement at COP21 on Climate calls upon governments “when taking action on climate change” to “respect, promote and consider their respective obligations on human rights (and) the right to health”.

As the WMA states in its Delhi Declaration on Health and Climate Change, “Although governments and international organizations have the main responsibility for creating regulations and legislation to mitigate the effects of climate change and to help their populations adapt to it, the World Medical Association, on behalf of (...) its physician members, feels an obligation to highlight the



health consequences of climate change and to suggest solutions. (...) The WMA and NMAs should develop concrete actionable plans/practical steps” to both mitigate and adapt to climate change (WMA 2009).

## Recommendations

The WMA recommends that its national medical associations and all health organizations:

1. Continue to educate health scientists, businesses, civil society, and governments concerning the benefits to health of reducing greenhouse gas emissions and advocate for the incorporation of health impact assessments into economic policy.
2. Encourage governments to adopt strategies that emphasize strict environmental regulations and standards that encourage energy companies to move toward renewable fuel sources.
3. Begin a process of transferring their investments, when feasible without damage, from energy companies whose primary business relies upon extraction of, or energy generation from, fossil fuels to those generating energy from renewable energy sources.
4. Strive to invest in companies upholding the environmental principles consistent with the United Nations Global Compact ([www.unglobalcompact.org](http://www.unglobalcompact.org)), and refrain from investing in companies that do not adhere to applicable legislation and conventions regarding environmental responsibility.

## WMA Statement on Ethical Considerations in Global Medical Electives

*Adopted by the 67<sup>th</sup> General Assembly of the World Medical Association, Taipei, Taiwan, October 2016*

### Preamble

Medical trainees are increasingly participating in global educational and service experiences, commonly referred to as ‘international medical electives’ (IMEs). These experiences are normally short term, i.e., less than 12 months, and are often undertaken in resource-limited settings in low-and middle-income countries.

Although IMEs can provide valuable learning experience, this must be weighed against the potential risks to the host community, the

sponsor organization and the visiting trainee. Successful placements help to ensure that there are mutual benefits for all parties and are built upon an agreed understanding of concepts including non-maleficence and justice.

Published ethical guidelines, such as the Ethics and Best Practice Guidelines for Training Experiences in *Global Health* by the Working Group on Ethics Guidelines for Global Health Training (WEIGHT), call on sponsor institutions (i.e., universities and organizations facilitating electives) to commit to sustainable partnerships with host institutions and local communities. All parties are also called upon to work collaboratively in creating professional guidelines and standards for medical electives.

In turn, trainees undertaking IMEs must adhere to relevant ethical principles outlined in WMA ethical documents, including the WMA's Declaration of Geneva, the WMA International Code of Medical Ethics and the WMA Statement on the Professional and Ethical Use of Social Media.

## Recommendations

Therefore the WMA recommends that:

1. Sponsor institutions work closely with host institutions and local communities to create professional and ethical guidelines on best practices for international medical electives. Both institutions should be actively engaged in guideline development. The sponsor organization should evaluate the proposed elective using such standards prior to approval.
2. Guidelines should be appropriate to local context and endorse the development of sustainable, mutually-beneficial and just partnerships between institutions and the patients and the local community, with their health as the first consideration. These must take account of best practice guidelines, already available in many countries.
3. Guidelines must hold patient and community safety as paramount, and outline processes to ensure informed consent, patient confidentiality, privacy, and continuity of care as outlined in the WMA International Code of Medical Ethics.
4. Guidelines should also outline processes to protect the safety and health of the trainee, and highlight the obligations of the sponsor and host institutions to ensure adequate supervision of the trainee at all times. Institutions should consider means of addressing possible natural disasters, political instability, and exposure to disease. Emergency care should be available.
5. Sponsor and host institutions have a responsibility to ensure that IMEs are well planned, including, at a minimum, appropriate pre-departure briefings, which should include training in culture and language competency and explicit avoidance of any

activity which could be exploitative, provision of language services as required, and sufficient introduction and guidance at the host institution. Post-departure debriefing should be planned on return of the trainee, including reviewing ethical situations encountered and providing appropriate emotional and medical support needed.

6. It is expected that the trainee will receive feedback and assessment for the experience so that he/she can receive academic credit. The trainee should have the opportunity to evaluate the quality and utility of the experience.
7. Trainees must be fully informed of their responsibility to follow instructions given by local supervisors, and to treat local host staff and patients with respect.
8. These guidelines and processes should be reviewed and updated on a regular basis as sponsor and host institutions develop more experience with one another.
9. National Medical Associations should develop best practices for international medical electives, and encourage their adoption as standards by national or regional accrediting bodies, as feasible, and their implementation by sponsor and host institutions.

## WMA Statement on Obesity in Children

*Adopted by the 67<sup>th</sup> WMA General Assembly, Taipei, Taiwan, October 2016*

### Preamble

Childhood obesity is a serious medical condition and a major public health concern affecting many children. Childhood obesity is emerging as a growing epidemic and is a challenge in both developed and developing countries. Due to its increasing prevalence and its immediate and long-term impact on health, including predisposition to diabetes and cardiovascular abnormalities, childhood obesity should be viewed as a serious concern for public health. The increase in childhood obesity may be attributed to many factors:

Recent studies show that marketing targeted at children has a wide influence on the shopping trends and food preferences of households all over the world. Special offers, short-term price reductions and other price promotions and advertising on social as well as traditional media all play a role in increasing product demand.

Many advertisements are in conflict with nutritional recommendations of medical and scientific bodies. TV advertisements for food and drink products with little or no nutritional value are often scheduled for broadcast hours with a large concentration of child viewers and are intended to promote the desire to consume these products regardless of hunger. Advertisements increase children's emotional response to food and exploit their trust. These methods and techniques are also used in non-traditional media, such as social networks, video games and websites aimed at children.

Unhealthy dietary patterns, together with a sedentary lifestyle and lack of exercise, contribute to childhood obesity. The sedentary lifestyle is the most predominant one in the developed world today. Many children typically spend more time than ever in front of screens, rarely engaging in physical activities.

International corporations and conglomerates that manufacture foods and beverages are not always subject to regional regulations that govern food labeling. Concern for profits may come at the expense of corporate responsibility for environmental and public health issues.

Products containing large amounts of added sugar, fat, and salt can be addictive, especially when combined with flavor enhancers. In some countries, not all ingredients are required to be listed on food labels and manufacturers often refuse to release data on methods employed to maximize consumption of their products. Governments should require that all ingredients in food and beverages be clearly labeled, including those proprietary ingredients intended to increase consumption of the product.

Socioeconomic disparities also correlate with increasing rates of childhood obesity. The link between living in poverty and early childhood obesity continues to negatively affect health in adult life [1]. Exposure to environmental contaminants, sporadic medical checkups, insufficient access to nutritious foods and limited physical activity lead to obesity and other chronic illnesses that are all more prevalent among children living in poverty.

### Recommendations

1. A comprehensive program is needed to prevent and address obesity in all segments of the population, with a specific focus on children. The approach must include initiatives on price and availability of nutritious foods, access to education, advertising and marketing, information, labeling and other areas specific to regions and countries. An approach similar to that on tobacco in the WHO Framework Convention on Tobacco Control is advocated.
2. International studies stress the importance of adopting an integrated approach to education and health promotion. Investment

in education is key to minimizing poverty, improving health and providing economic benefits.

3. Quality education offered in formal settings to children aged 2 to 3 years, combined with enrichment activities for parents, and sufficient supply of nutritious food and beverages may help to reduce the rate of adolescent obesity and reduce its health implications throughout the life course. Developing early healthy eating practices and experiencing flavors of healthy food when very young appear to be positive factors in prevention of childhood obesity.
4. Governments should invest in education related to menu design, food shopping including budget setting, storage and preparation so that people are better equipped to plan their food intake.
5. Governments should seek to regulate the availability of food and beverages of poor nutritional value, by a range of methods including price. Attention should be paid to the availability close to schools of establishments selling products of poor nutritional quality. Governments should seek to persuade manufacturers to reformulate products to reduce their obesogenic effects. Where possible government and local authorities should seek to manage the density of such establishments in the area.
6. Governments should consider imposing a tax on non-nutritious foods and sugary drinks and use the additional revenue to fund research and epidemiological studies aimed at preventing childhood obesity and reducing the resulting disease risk.
7. Ministries of health and education should regulate food and beverages that are sold and served at educational and healthcare facilities.
8. Given the scientifically proven link between the extent of media consumption and adverse effects on body weight in children, the WMA recommends that the advertising of non-nutritious products be restricted during television programming and other forms of media that appeal to children. Regulators should be aware that children access television programs designed for adults and ensure that legislation and regulation also limits marketing associated with such programs.
9. Governments should work with independent health experts to produce sound guidance on food and nutrition, with no involvement of the food and drink industry.
10. Governments and local authorities should subsidize and encourage activities that promote good health among their residents, including providing safe spaces for walking, bike riding and other forms of physical activity.
11. Parents have a crucial role in fostering physical activity in their children. Schools should incorporate daily physical activity into their daily routine. Participation in sport activities should be possible for everyone regardless of their economic situation.
12. National Medical Associations should support or develop guidelines and recommendations to ensure that they reflect

current knowledge of prevention and treatment of childhood obesity.

13. National Medical Associations should work to raise public awareness on the issue of childhood obesity and highlight the need to tackle the rising prevalence of obesity and its health and economic burden.
14. Clinics and Health Maintenance Organizations should employ appropriately trained professionals to offer classes and consultation in selecting appropriate amounts of nutritious foods and beverages and attaining optimal levels of physical activity for children. They should also ensure that their premises are exemplars in the provision of healthy food options.
15. Educational facilities should employ appropriately trained professionals who educate for healthy lifestyles from an early age and allow all children, whatever their social environment, to practice regular physical activities.
16. Physicians should guide parents and children in how to live healthy lives and emphasize the importance of doing so, and must identify as soon as possible obesity in their patients, particularly children. They should direct patients suffering from obesity to the appropriate services at the earliest possible stage, and conduct regular follow-ups.
17. Physicians and health professionals should be educated in nutrition assessment, obesity prevention and treatment. This could be accomplished by strengthening CME activities focused on nutritional medicine.
1. WHO Commission on Social Determinants of Health (Closing the Gap in a Generation) 2008.

## WMA Resolution on Occupational and Environmental Health and Safety

*Adopted by the 67<sup>th</sup> WMA General Assembly, Taipei, Taiwan, October 2016*

### Preamble

Occupational and environmental health and safety (OEHS) is an integral part of public health, and the primary health care (PHC) system in particular, since it is often the first level of contact of individuals, the family and the community with a health system, bringing health care as close as possible to where people live and work [1].

Workers represent at least half of the world's population and are the backbone of many economies, but may have inadequate access to occupational and environmental health services [2]. Decent work sums up the aspirations of people in their working lives. It involves opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives and equality of opportunity and treatment for all women and men (ILO).

Every 15 seconds, a worker dies from a work-related accident or disease [3], and each year there are 160 million cases of work-related/occupational diseases; 313 million work accidents occur annually and over 2.3 million people die as a result of work accidents and occupational diseases [4].

Despite this, the proportion of work accidents and occupational diseases that are recorded and reported is incredibly extremely small. It is estimated that only less than 1% of occupational diseases are recorded [5].

The United Nations Development Programme's Sustainable Development Goals 3, 5, 8 and 13 call for action in health promotion for all people of all ages, gender equality, decent work and management of the impact of climate change; OEHS is well positioned to impact positively within the work place on all the above mentioned sustainable development goals.

Physicians have a critical role in preventing and protecting from, diagnosing, treating and reporting work accidents and occupational diseases. Information, skills and functions of physicians form the basis of service models that vary by countries and constitute key elements in addressing OEHS. In addition, physicians should strive for inclusive working life so that even employees with disabilities are given opportunities to stay integrated in decent working life.

Despite many governments and employers' and workers' organizations place greater emphasis on the prevention of occupational diseases. Prevention is not receiving the priority warranted by the scale and severity of the occupational disease epidemic.

Physicians and National Medical Associations can contribute to the identification of problems, development of national reporting systems and formulation of relevant policies in the field of OEHS.

Unsatisfactory and unsafe working conditions play a significant role in the development of occupational diseases and injuries, which

are, in their turn, a cause of mortality among working population. Women bear the brunt of the work-related burden which often makes them a more vulnerable group in working life.

## Recommendations

1. Physicians should play a pivotal role in the development of a workforce that is trained in the social determinants of health, and raise workplace awareness about the social determinants of health.
2. The field of OEHS should be accorded the necessary importance in both graduate and post-graduate medical studies.
3. All workers should have access to risk based OEHS services from the first day of work, and extending beyond the last day at work in order to account for occupational diseases with a long latency period. Service content should be standardized and the role of physicians in the planning and implementation of OEHS systems that are essentially preventive/protective must be recognized.
4. National Medical Associations should act proactively and encourage the expansion of the scope of OEHS services, prevent and reduce occupational diseases, and injuries, reproductive health and protect the environment. They should also promote workplace gender equality, and improve recording and reporting systems. In addition, they should focus on capacity building, teaching and training, collaborative research and improving the qualifications of their members in this field.
5. National Medical Associations, together with governments, should take an active role, where appropriate, in the formulation and development of national systems that facilitate OEHS prevention, and recording and reporting occupational diseases in their respective countries and lead their member physicians in efforts to be made in this area.
6. Occupational diseases and injuries are often addressed in the context of insurance and compensation. Where these mechanisms are not in place, national medical associations should advocate for the protection of workers through by means of insurance or social security.
7. NMAs should engage in establishing "medical causality" in the context of reporting accidents and diseases, and inform the public that the health impacts of hazards and risk factors inherent to working life can be established and recorded only through a well-developed reporting system.
8. As part of medical care, physicians who are evaluating workers' compensation patients should be accredited in occupational and environmental medicine. The first contact may be with the patient's regular physician who should routinely obtain history on patient's occupation and environmental exposures. If the physician establishes a relationship between the diagnosis and these exposures, he/she must report it to the relevant authority and



ideally refer the patient for an evaluation by a accredited occupational and environmental medicine physician.

9. National Medical Associations should consider forming an internal body for addressing the problems of physicians working in this area and encourage them to contribute to related scientific studies
10. National Medical Associations should promote opportunities for physicians to benefit, in their daily professional practice, from systems identifying environmental/occupational risks and hazards having an impact on workers', including pregnant workers, health and safety. In this context, apart from the lists of WHO International Classification of Diseases and the International Labour Organisation (ILO), they should promote an easy-to-use system for "exploring, recording and reporting environmental risks and factors" that physicians can use easily.
11. Governments should collaborate in setting up an international system to assess occupational hazards and develop strategies to protect the health of workers.
12. Governments should establish legislative frameworks that protect the rights and health of workers, including reproductive health and health effects of work at home.
13. The active participation of employers' and workers' organizations is essential for the development of national policies and programmes for the prevention of occupational diseases.
14. Employers should provide a safe working environment, recognising and addressing the impact of adverse working conditions on individuals and society.
15. When rendering services for an employer, physicians should advocate that employers fulfil minimum requirements set in the International Labour Organization's (ILO) occupational standards, especially when such requirements are not set by national legislation. Physicians must maintain their autonomy and independence from employer.

1. World Health Organization. Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.
2. World Health Organization. Workers' health: Global plan of action. WHA 60.26.
3. International Labour Organization [internet]. Safety and health at work. ILO; [updated 2016; cited 2016 January 19]. Available from: <http://www.ilo.org/global/topics/safety-and-health-at-work/lang--en/index.htm>
4. Safety and health at work, ILO The Prevention of Occupational Diseases. World Day for safety and health at work 28 April 2013.
5. The Prevention of Occupational Diseases. World Day for safety and health at work 28 April 2013.
6. National System for Recording and Notification of Occupational Diseases Practical guide
7. International Statistical Classification of Diseases and Related Health Problems (ICD-10) In Occupational Health. World Health Organization Geneva 1999.
8. Improving Workers' Health Worldwide: *Implementing the WHO Global Plan of Action on Workers' Health*. GOHNET NEWSLETTER NO. 22. November 2013 Edition.

## WMA Resolution on Refugees and Migrants

*Adopted by the 67<sup>th</sup> World Medical Assembly, Taipei, Taiwan, October 2016*

### Preamble

Currently, a very large number of people are seeking refuge and/or asylum; some are fleeing war zones or other conflicts, others are fleeing from desperate poverty, violence, and other injustices and abuses with potentially very harmful effects to mental and physical health.

The global community has been ill prepared for handling the refugee crisis, including addressing the health needs of those seeking refuge.

The WMA recognizes that mass migration will continue unless people are content to stay in their birth countries because they see opportunities to live their lives in relative peace and security and to offer themselves and their families the ability to live lives with opportunities for fulfilment of various sorts, including economic improvement. The global community has a responsibility to seek to improve the lot of all populations, including those in countries currently with the poorest economies and other key factors. Sustainable development will give all populations improved security, and economic options.

The WMA recognizes that warfare and other armed conflict, including continuous civil strife, unrest and violence, will inevitably lead to people movement. The worse the conflict the higher the percentage of people who will want to leave the conflict zone. There is a responsibility for the global community, especially its political leaders, to seek to support peace making and conflict resolution.

The WMA recognizes and condemns the phenomenon of forced migration, which is inhumane and must be stopped. Such cases should be considered for referral to the International Criminal Court.

### Principles

1. The WMA reiterates the WMA Statement on Medical Care for Refugees originally adopted in Ottawa, Canada in 1998 which states:
  - Physicians have a duty to provide appropriate medical care regardless of the civil or political status of the patient, and governments should not deny patients the right to receive such

- care, nor should they interfere with physicians' obligation to administer treatment on the basis of clinical need alone.
- Physicians cannot be compelled to participate in any punitive or judicial action involving refugees, including asylum seekers, refused asylum seekers and undocumented migrants, or Internally Displaced Persons or to administer any non-medically justified diagnostic measure or treatment, such as sedatives to facilitate easy deportation from the country or relocation.
  - Physicians must be allowed adequate time and sufficient resources to assess the physical and psychological condition of refugees who are seeking asylum.
  - National Medical Associations and physicians should actively support and promote the right of all people to receive medical care on the basis of clinical need alone and speak out against legislation and practices that are in opposition to this fundamental right.
2. WMA urges governments and local authorities to ensure access to adequate healthcare as well as safe and adequate living conditions for all regardless of their legal status.

## WMA Resolution on the Protection of Health Care Facilities and Personnel in Syria

*Adopted by the 67<sup>th</sup> WMA General Assembly, Taipei, Taiwan, October 2016*

The World Medical Association (WMA) notes with great concern the recent and repeated attacks on health care facilities, health care workers and patients in Syria, especially in Aleppo. These attacks have killed and injured civilian people, and the most vulnerable among them, children and patients. Since the beginning of the war in Syria in 2011, an estimated 270 health care facilities have been attacked and 760 health care workers have been killed. The WMA is profoundly concerned by this development, as health care facilities and personnel should, according to the international law, be protected by the parties of the conflict.

Therefore the WMA

- Deeply regrets and condemns the recent and recurring bombings of the hospitals in Aleppo, considering these as a violation of human rights;
- Reaffirms its statements on "Healthcare in Danger" and demands all countries to ensure the safety of healthcare personnel and patients in conflict situations;

- Calls on all countries to fully implement the UN Resolution 2286 (2016) which demands all parties to armed conflicts to fully comply with their obligations under international law, to ensure the respect and protection of all medical personnel and humanitarian personnel exclusively engaged in medical duties, of their means of transport and equipment, as well as hospitals and other medical facilities;
- Demands an immediate and impartial enquiry into the attacks against health care facilities and personnel, and actions taken against those responsible in accordance with domestic and international law.

## WMA Resolution on Zika Virus Infection

*Adopted by the 67<sup>th</sup> WMA General Assembly, Taipei, Taiwan*

Recognizing that the WHO has designated the Zika virus infection a global health emergency, the WMA provides the following recommendations:

- WHO should work with ECDC, CDC and other disease control organisations to better understand the natural history and current epidemiology of Zika virus infection.
- Information should be disseminated widely to advise and protect all women and men who live in or must travel to Zika-affected areas and who are considering becoming parents. Advice should also include recommendations for women who are already pregnant who may have been directly exposed to the Zika virus or whose partners live in or have travelled to Zika-affected areas.
- Relevant agencies, including WHO, should gather data on the efficacy of different mosquito control methodologies, including the potentially harmful or teratogenic effects of the use of various insecticides.
- Work on diagnostic tests, antivirals, and vaccines should continue with an emphasis on producing a product that is safe for use in pregnant women and public funding should be assured for this research. When such products are developed states should ensure that they are available to, and affordable by, those most at risk.
- States which have witnessed the delivery of a number of babies with microcephaly and other fetal brain abnormalities must ensure that these infants are properly followed up by health and other services, and provide support to families seeking to cope with a child with developmental abnormalities. Wherever possible research on the consequences of microcephaly should be published, to better inform future parents, and to allow the development of optimal service provision.

## Health Care Reform in the United States: Past, Present and Future Challenges



Steven J. Stack

Enactment of the *Affordable Care Act* (ACA) in 2010 was the culmination of a long and contentious battle in the United States Congress to create a more sustainable health care system by addressing shortcomings that left millions of Americans uninsured. Six years later, the ACA has achieved notable success in expanding health insurance coverage for millions of people, and in making improvements to quality and efficiency.

However, significant challenges remain. Many people still cannot afford insurance, costs continue to rise significantly in certain sectors, and health insurers are dropping out of unprofitable markets. Complicating matters, the political environment in the United States remains uncertain, with the incoming president having run on a platform of repealing and replacing the law.

A closer look at the past, present and future challenges of health care reform –

specifically, the *Affordable Care Act* – in the United States may be helpful for world observers during this time of uncertainty and change.

### Why reform was needed

Perhaps the best way to describe the impetus behind the ACA – also known as Obamacare, as it was strongly endorsed by our current president, Barack Obama – is through a story. My specialty is emergency medicine and I am in active practice in Lexington, Kentucky. I ask you to imagine that it is the year 2009 – seven years ago. The year before the *Affordable Care Act* passed.

A typical patient who I may have seen at that time is “Delores”. Delores is 60 years old, eighty pounds overweight, and diabetic. She does not have health insurance. She has trouble managing her diabetes, and comes to the Emergency Department when her blood sugar spikes. Delores epitomizes much of what was unsustainable about the American health care system a few years ago, and the reason health reform was necessary. She is aging, she has a chronic condition, and she is uninsured. Because she is uninsured, she does not have a regular source of health care or the medications she needs. She waits until she is truly ill before she seeks care. And because she waits, her care is unnecessarily expensive, irregular and without primary care follow up.

This pattern of care was far more expensive than it would have been had she been able to prevent her blood sugar from spiking through regular use of medications and regular visits to the doctor.

If you multiply Delores’s story by millions of others, you see some of the primary reasons why the United States’ health care system was unsustainable.

Estimates at the time the ACA was debated showed that nearly 50 million Americans were uninsured; health care costs were soaring; and an epidemic of chronic conditions was sweeping the nation, to the point that nearly half of American adults had a chronic condition such as heart disease or diabetes. It was clear that major changes were needed to reduce the impact of chronic disease, of skyrocketing costs, and of human misery.

### Political division and health reform

The *Affordable Care Act* debate was preceded by numerous other attempts to expand health insurance coverage in the last century. Beginning in 1912 and continuing throughout the 20<sup>th</sup> century, many American presidents from Theodore Roosevelt to Bill Clinton tried, and largely failed, to implement a national health insurance program. There are a few notable exceptions. During the 1960s, President Lyndon Johnson and Congress successfully enacted a health insurance system for older Americans and the disabled, called Medicare, and an insurance program for the poor, called Medicaid. In 1997, Congress passed and the President signed legislation called the State Children’s Health Insurance Program, or S-CHIP, which provides insurance for children in families with modest means. And then, in 2003, Congress expanded prescription drug coverage for seniors through what became Part D of the Medicare program. Other than those examples, there has been a clear pattern of failure.

International observers may wonder why the U.S. does not simply adopt a single-payer system like other countries. One

answer, for good and for bad, is capitalism. But, I think a more salient factor is Americans' long history of self-reliance, and a fear of too much intrusion by government into our lives. During the debates over the *Affordable Care Act*, for example, one side saw the legislation as a government takeover of health care, the slippery slope, they said, to socialism. The other side saw it as a step towards making health care a universal right – available to all, regardless of their ability to pay. Each side felt this was a moral imperative – to refrain or to reform.

Viewed this way, the debate over health reform is more about individualism versus collectivism than Republican versus Democrat. It is a disagreement that reflects deep-seated views on the roles and responsibilities of both individuals and the government in society. It's an argument that continues to this day. The ACA, debated from 2008 – 2010, is considered to be one of the most controversial and divisive pieces of legislation in recent American history. Not a single Republican in the House of Representatives or the Senate voted for the final bill. Political careers have been launched – and ended – solely on the basis of a candidate's position on this one issue. And even though the bill became law, the debate is not over.

Opposition to the *Affordable Care Act* continues. Consider that the Republican-controlled House of Representatives has tried to repeal or defund the ACA more than 60 times! So far, however, attempts to repeal the legislation or to invalidate major provisions in the courts have been mostly unsuccessful. Similarly, efforts to refine the law, not at all uncommon in an undertaking this enormous, have also been unsuccessful. Politics keeps us from both repealing the legislation, and improving it. The status quo could change, though, as a result of America's recent federal elections, as I will describe later.

## The American Medical Association and the Affordable Care Act

The debate over the 2010 *Affordable Care Act* was extremely contentious within the American Medical Association (AMA) as well as the nation as a whole. But behind the AMA Board of Trustees' decision to support the legislation was the recognition of a number of things:

First, the status quo was no longer an option. As I illustrated through the example of Delores, America's health care system was simply unsustainable. It was too costly, and too many people with treatable medical problems were falling through the cracks.

Second, if we took the politics out of the issue, it would be impossible to justify denying meaningful health care to tens of millions of patients. In fact, access to health care is one of the primary founding principles of the AMA. We knew that people without access to insurance were living sicker and dying younger – something to which physicians are professionally, personally and morally opposed.

And third, achieving real, substantive health system reform would take time. Lasting change often comes slowly. And that has certainly been the case with health care reform.

Ultimately, after a long and passionate internal debate, the AMA decided to support the legislation – not because it was perfect – but because many of its major provisions were consistent with AMA principles and policies:

- Expanding health insurance coverage for the uninsured;
- Making health coverage more affordable;
- Preventing denials of care and coverage, including those for pre-existing health conditions;

- Investments in prevention and wellness initiatives.

Supporting the ACA gave the AMA another advantage: *the ability to be constructively engaged* throughout the process. Instead of sitting on the sidelines, we were actively involved in shaping the legislation. We worked with lawmakers from both parties and key members of the Administration to get as much AMA policy reflected in the legislation as possible, and to exclude those items we opposed. After a protracted political battle, Congress passed the *Affordable Care Act* in March of 2010. President Obama signed the legislation on March 23, 2010.

## Major elements of reform

So what provisions are in the *Affordable Care Act*? What does the legislation do? Perhaps most important, the ACA made substantial reforms in the private health insurance markets. In an effort to reduce the number of uninsured Americans, new health insurance exchanges, or marketplaces, were created for consumers to shop for and purchase health insurance plans. Subsidies were offered for individuals with qualifying incomes so they could afford to purchase coverage. For the first time, all Americans were required to purchase health insurance. Known as the "individual mandate," this provision was included to ensure that enough young and healthy patients would purchase insurance to offset older patients whose care is more expensive, as well as ensure that individuals could not forego coverage until they become ill or injured. The law also stopped insurers from denying coverage to people who had pre-existing conditions, and eliminated a practice where insurance companies would pay only up to a certain limit for each individual. These insurance practices were particularly problematic if the person had a serious disease such as cancer, or a traumatic injury involving lengthy hospitalizations. And, it



allowed young adults to stay on their parents' health insurance until age 26.

Other major elements of health reform contained in the *Affordable Care Act* include an emphasis on prevention. Private insurers are now required to cover a range of recommended preventive health services including immunizations, well visits and contraceptives without requiring any patient cost-sharing. The Medicaid program was expanded, to provide coverage to individuals earning less than 133 percent of poverty-level income. This provision was challenged in the courts, however, and because of a Supreme Court decision, individual states are able to decide whether or not to provide that level of coverage.

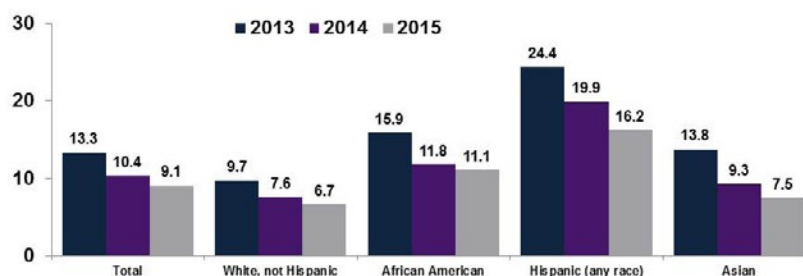
The ACA also set up several demonstration programs to test and evaluate a variety of new payment models. For example, the legislation established a Center for Medicare & Medicaid Innovation at the Centers for Medicare and Medicaid Services to test care models to improve quality and slow the rate of growth in Medicare costs, and a National Bundling Pilot Program to improve coordination, quality and efficiency of services when patients are hospitalized. We recognized that it is not enough to expect to control costs solely by insuring more individuals. Physicians and hospitals must also improve the quality and delivery of care to reduce costs.

## Results of the *Affordable Care Act*

Six years have passed since the *Affordable Care Act* became law. Implementation of the bill has come in phases, with the legislation not fully implemented until 2014. However, we can draw some important conclusions from the data that is now available.

First, it is undeniable that the ACA has increased access to health care for tens of millions of men, women and children:

## Decline in Percent Uninsured by Race and Ethnicity



Note: Percentages reflect people uninsured for the entire calendar year.  
Source: US Census Bureau, Health Insurance Coverage in the United States, 2014 and 2015

**Chart 1.** Decline in Percent Uninsured by Race and Ethnicity

- 20 million people have gained coverage because of the ACA;
- 6.1 million young adults have gained coverage;
- 137 million patients have private insurance coverage of preventive services with no cost-sharing;
- 12.7 million patients have signed up on exchanges; and
- 15.7 million additional people have enrolled in the Medicaid and CHIP programs. This includes people who were already eligible for Medicaid, but who had not previously enrolled.

Next, there have been significant declines in the percentage of racial and ethnic minorities who are uninsured. The percentage of African Americans who were uninsured dropped from nearly 16 percent in 2013 to 11 percent in 2015. The percentage of Hispanics who were uninsured dropped from more than 24 percent to 16 percent during the same period. (See Chart 1) African Americans, Hispanic Americans and Asian Americans have traditionally had higher rates of uninsured than non-Hispanic whites, so we are pleased to see significant gains for these underserved populations. There have also been signifi-

cant declines in the percentage of uninsured in every age group and income level. (See Charts 2, 3)

Finally, for health reform to truly be successful, not only must more people have access to care, but costs must also be sustainable. Right now we spend about \$3 trillion a year on health costs – a staggering amount. While it is unlikely we will ever spend less on health care from year to year, the evidence suggests that the rate of increase in health care costs is going down. According to a 2016 report of the Robert Wood Johnson Foundation published by the Urban Institute, the United States is on track to spend \$2.6 trillion less on health care between 2014 and 2019, compared to initial projections made right after passage of the ACA in 2010.

## Future challenges and opportunities

For American physicians, the ACA is one of a number of developments that have ushered in seismic changes in health care. Other factors are rapid advancements in technology, especially health information

technology, a shift in demographics and changing patient expectations. For American physicians, a key question is “How can we best adapt to change?” The American Medical Association has decided that it is critically important for physicians to lead, and to help shape the future, rather than simply being affected by it. The AMA is actively involved on the state and federal levels, with legislators and regulators, try-

ing to address some of the challenges created by the ACA. For example, some people still cannot afford to purchase health insurance, even with subsidies. Or, they are purchasing insurance with low premiums, but with such high deductibles that their level of out-of-pocket costs is unaffordable. That’s why the AMA is supporting efforts to make the cost-sharing obligations under the exchange plans with high deductibles

more affordable, and to allow low-to-moderate-income families who only have access to unaffordable employer-sponsored coverage to receive financial assistance to purchase health coverage through the exchanges. In another example, prescription drug spending continues to rise faster than overall health spending. That’s why the AMA is supporting market-driven initiatives to control pharmaceutical costs, as well as improvements to ensure that the pharmaceutical marketplace operates efficiently and effectively.

A third issue is that health insurance marketplaces are failing to attract enough younger, healthier people who would offset the cost of coverage for older, less healthy people. This is a contributing factor to insurers trying to maintain profitability through health insurance mergers, restricting physician and hospital networks, or discontinuing their participation in the marketplaces. The AMA is very actively involved in opposing mergers that would limit access to care or increase the cost of care. But we know insurers are important partners in keeping the system alive, so we work to ensure that our policies are fair and data driven.

Decline in Percent Uninsured by Age

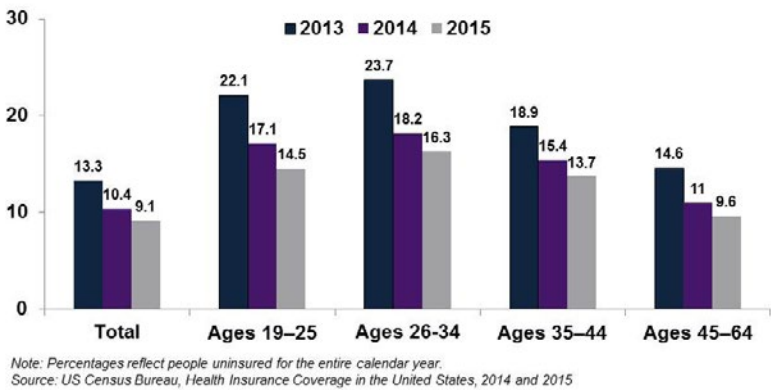


Chart 2. Decline in Percent Uninsured by Age

Decline in Percent Uninsured by Income

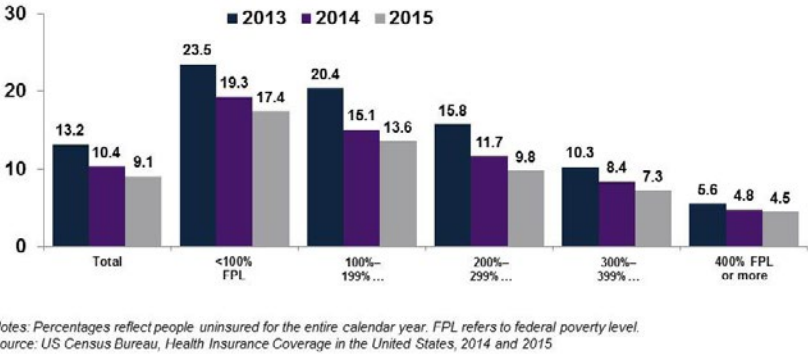


Chart 3. Decline in Percent Uninsured by Income

Presidential and Congressional elections

The future of the *Affordable Care Act* is uncertain in the wake of America’s recent federal elections. Businessman Donald Trump was elected president. Republicans still hold majorities in both chambers of Congress, although their margins were reduced slightly. The incoming president and Republican leaders in Congress are expected to attempt to repeal much of the ACA and replace its provisions with alternate private sector options. Shortly after the election, president-elect Trump indicated he was open to keeping some key provisions of the ACA intact, including the prohibition on denying coverage to individuals with pre-existing

conditions, and provisions allowing young adults to remain on their parents' insurance until age 26. So, while the ACA may not be completely dismantled, at the very least it appears there will be substantial modifications.

## AMA core principles regarding health care reform

As a mission-oriented organization, dedicated to improving the health of the nation, the AMA's policy objectives do not change as a result of elections. Shortly after the election, the AMA's House of Delegates reaffirmed its commitment to health care reform that improves access to care for all patients, and signaled its intent to actively engage the incoming Trump Administration and Congress in discussions about the future of health care reform. The AMA will be steadfast in advocating for the core prin-

ciples and priorities that we have long stood for when it comes to reform:

- Coverage for all Americans;
- Pluralism;
- Freedom of choice;
- Freedom of practice
- Universal access for patients.

We have made clear that any new reform proposals should not cause individuals currently covered as a result of ACA provisions to become uninsured. The AMA also supports reform efforts focused on improving delivery of care, professional satisfaction, and physician practice sustainability. And finally, the AMA also supports more efficient and effective use of the \$3 trillion currently spent on health care.

## Final thoughts

The *Affordable Care Act* was an attempt to create a more sustainable health care system in the United States. What is undeniable

is that the ACA has allowed more people like Delores, the patient I told you about earlier, to become insured. That, combined with the law's emphasis on prevention, should mean that more patients receive care earlier and more reliably. We hope this will lead to better health outcomes and will also reduce costs. Only time will tell if history will judge the *Affordable Care Act* to be truly transformative, or as a failed experiment. The AMA will fight for the principles I laid out earlier, regardless of what our political leaders may or may not do. As physicians, we know what needs to be done to create sustainable health care for our patients, for our communities, and for our countries. It is up to us to do all we can to support plans and programs that embody those principles and to work together to convince our leaders to do so as well.

Steven J. Stack, MD

Immediate Past President

American Medical Association

E-mail: [AMA.President@ama-assn.org](mailto:AMA.President@ama-assn.org)

# Health System Sustainability with Regard to Global Migration and Refugees: the Case of Germany

## Introduction

Healthcare systems are regularly faced with new challenges. In 2015, the arrival of large numbers of refugees in countries across Europe had considerable impact on the health-care situation in these countries.

By the end of 2015, around 1,000,000 people had crossed the German borders as refugees, approximately 477,000 of whom submitted formal applications for asylum. We only count the people coming in – no one keeps track of those leaving the country. Some moved on to other European countries like Sweden or Norway. Some never registered but stayed on, and quite a few

have even gone back home. Europe didn't easily fulfil their dreams and proved a disappointment. Therefore it is difficult to determine how many undocumented people have remained in Germany either because they have been denied asylum or simply because they chose not to register. We estimate the number of the "undocumented" or "illegals" to be between 140,000 and 330,000 individuals.

The German healthcare system was confronted with the major challenge of having to integrate these individuals as quickly as possible. The German Medical Association at all times made it clear that every patient we see comes to us as a patient, a sick person

seeking help and relief and not primarily as a refugee, an asylum seeker, an undocumented person or even an illegal person. We heavily defend the position that there is no such thing as an "illegal" person in the health care system.

However: The legal system in place is a patchwork of sometimes inconsistent policies regarding access to healthcare services, billing procedures and benefits eligibility, as this varies not only from state to state, but also from municipality to municipality. Therefore we could not rely on regional or local governments provisions alone. As the number of arrivals peaked, medical volunteers played an important role in

complementing the official healthcare system. It was our duty as a profession to organize help for those in need. And we are proud to say we managed.

Our Chancery Angela Merkel was heavily criticised for her words “Wir schaffen das” – we can manage.... It was the same spirit we heard from American President Barak Obama when he said “Yes, we can”. Today we can say: we managed, and we could....

## The German health care system

In order to put these challenges into some context, I would like to take a few moments to point out some features of the German healthcare system:

Germany has a population of around 81 million. Total expenditure in the healthcare system amounts to € 328 billion (\$ 427 billion PPP) per annum (2015), which equates to €4,050 (\$ 5,300 PPP) in spending per capita and an 11 per cent share of GDP.

We are among the richest countries of the world. We have access of virtually all inhabitants to nearly all health services. There is no medically indigent person in Germany.

Our system is characterised by the so-called Bismarck model, which provides comprehensive health insurance financed by contributions from the employers and the employees and a smaller subsidy by the federal Government. These contributions are all collected into a healthcare fund and then distributed to the insurers. As a result, 90 per cent of our population is insured in the statutory health insurance system in just over 100 insurances. The remaining 10 per cent of the population – civil servants and the self-employed in particular – is privately insured in approx. 50 companies. The fed-



*Frank Ulrich Montgomery*

eral level primarily provides the framework and defines the structure of the statutory health insurance system. But as mentioned before – Germany is a federal country with 16 federal states. These states are responsible for the provision of public healthcare, for planning hospital capacities and for covering the investment costs of hospitals. And we have rich states and poor states and we have different political parties and all sorts of coalitions ruling the states. And that's where the problems start. I will go into more detail later on.

Outpatient care is carried out in the private practices of around 150,000 practice-based physicians. These physicians then refer patients to hospitals in cases where inpatient treatment is necessary. In total, Germany has 485,800 doctors who are all compulsory members of our State Chambers of Physicians. You see: we don't seem to have an overall shortage of physicians. In fact the physician per capita ratio of Germany is one of the highest in the world.

We see approximately 20 Mio. cases each year in hospital and perform close to 18 Mio. operations. We have over 500 Mio. consultations in private practices. All in all

almost 7% of the German workforce work in the health care sector – that is more than four million people.

## The medical treatment of refugees in Germany

But how do refugees fit into this picture? And which legal provisions govern the medical treatment of refugees in Germany?

In Germany, anyone who is politically persecuted has the constitutional right to asylum – and this persecution does not necessarily have to originate from the government of his home state. It may also be religious persecution, persecution on grounds of sexual behavior, tribal disputes or sheer unbearable violence.

Asylum seekers are individuals whose access to healthcare is regulated by federal law and the scope of medical services offered to asylum seekers depends upon the duration of their stay and their administrative status:

The federal law in question grants asylum seekers for the first 15 months access to treatment only in cases of acute illness and pain and emergency. Women who are pregnant or who have recently given birth are eligible to receive medical and nursing care, as well as access to midwives, medication and surgical dressings. The law also covers officially recommended vaccinations and a compulsory preventive medical examination. We – the GMA – have always and persistently contested this federal bill as it did not cover chronic disease and access to preventive medicine in general. It is a shame that we as physicians see chronic disease and are not allowed to treat it!

But things are even worse. In practical terms, the 16 federal states shape policy details with their municipalities. Refugees



are placed in different states on the basis of a special distribution key. It is sheer luck whether you end up in Berlin, Munich or somewhere in the lowlands of rural Germany. And it is sheer luck, what sort of service you get.

The extremes are: In some states the asylum seekers have to request treatment vouchers – valid 24 hours – from the municipal social security offices. This is an administrative act determined at the discretion of officials who are not physicians and who do not have a medical background. And in some states sick persons had to queue for hours to obtain these vouchers. Other states hand out electronic health access cards which offer access to physicians. However – the range of services is limited to the catalogue of acute diseases I mentioned earlier on.

The decision to give shelter to hundreds of thousands of refugees has impacted each German municipality differently. Public health services, volunteer physicians, nurses, psychotherapists and many other volunteers from the general public form the backbone of every early refugee medical care.

Several larger cities were dramatically overburdened – like Berlin in 2015, for example, where new arrivals often had to wait for days before getting registered – and/or treatment vouchers. There are, however, also accounts of stable conditions in larger reception centres, for example in Munich, where the medical care of refugees, asylum seekers and their children is coordinated by an volunteer medical organisation called Refudocs, in conjunction with the relevant state authorities, with the ultimate goal of reducing bureaucratic hurdles.

In other federal states or cities, newly arrived refugees are examined by doctors from the local health authority immediately upon admission. Depending on the size of the city, further on-site care was then carried

out by practice-based physicians through decentralised accommodations.

After fifteen months asylum seekers are transferred into the general statutory health care system. They are eligible to the same services as all Germans.

Generally speaking, transferring asylum seekers into the general social benefits system immediately upon their arrival would be, in the eyes of the German Medical Association, a humane and unbureaucratic solution and avoid a complicated parallel system.

This could prevent administrative costs resulting from the streamlining of procedures, delayed medical examinations resulting from the cumbersome process of applying for treatment vouchers, and even redundant examinations. In fact, an expert commission established by the Robert Bosch Foundation last year came to the conclusion that the most cost-effective solution is to fully integrate asylum seekers into the established health insurance system from the first day on. And that for the last twenty years has also been the position of the GMA!

Despite these and other efforts to alleviate the administrative burden of providing asylum seekers with access to medical care, there is still more work to be done.

## Psychotherapy, undocumented refugees and unaccompanied minors

One aspect of refugee healthcare that has not yet been dealt with sufficiently is access to psychotherapeutic care. Studies have shown that approx. 40% of refugees are suffering from post-traumatic stress disorder, but the services available for traumatised refugees are not yet able to meet the demand for care, resulting in long waits for appointments.

Psychotherapy is an essential treatment method for those suffering from PTSD. Only independent and qualified evaluators can recognise whether a refugee requires psychotherapeutic treatment, and all too often, these challenges are amplified by a shortage of qualified interpreters and fear on the part of medical professionals that their own expertise is inadequate for treating extremely traumatised individuals.

And, of course, there is a social aspect to this issue as well. The process of being granted asylum can take years and even then asylum may be limited to a number of years. These refugees simply lack the most basic securities in life. How can they integrate into the strange and foreign society they live in? They feel like cliff-hangers without a stable perspective in their life. We as physicians have to point out, that all psychotherapy and all psychologic treatments are completely futile if we don't offer the refugees stable perspectives in their lives!

Let me briefly mention another group of refugees: illegal and undocumented individuals. Due to fear of deportation, these are often very hesitant to seek out medical treatment and therefore wait until a physician has to be called. Children of parents without legal residence status are sometimes totally cut off from medical services. Some patients wait until their disease has progressed so far that they virtually "carry their head under the armpit" as a German proverb says, before they see a nurse or a doctor.

If you allow me now a short intermediate résumé: we encountered a wave of refugees in 2015 that confronted us with an administrative but no real medical problem. 70% of the refugees were young males between 17 and 30 years of age. They suffered from the typical conditions of lack of food and sleep, starvation, unbelievable hygienic conditions and accidents. A few cases of tuberculosis,

hepatitis and HIV – nothing really challenging.

Health care capacities where there, physicians and other professionals quickly volunteered to cover temporary lacks in services and by integrating the refugees into our society we will overcome even the remaining problems of culture and language that do still exist.

Refugees are requested to integrate into their host society. This is correct. But we must never forget. Integration is a process – not a prerequisite for asylum seekers. You have to learn a new language and understand a new culture. It takes time and effort and needs help by professionals and by society as a whole!

Actually we have experience with similar numbers of refugees. Between 1986 and 1992 more than six million “Russian Germans” immigrated into Germany. They were descendants of Germans that had migrated into western parts of Russia in the 18<sup>th</sup> century, had been relocated to Siberia and Kazakhstan in the Stalin era and now returned to the homelands of their grandfathers. 3.6 million stayed in Germany and still live – mostly integrated – amongst us. They never posed a threat to our health-care system. No one was afraid of a lack of capacities. No one ever contested their rights and privileges.

Their most valuable privilege was: they were allowed to work from the first day on. Apart from giving them something to do and preventing tribal Ghetto structures – under the Bismarck idea of equal contributions from employers and employees they immediately contributed to their own social insurances and they paid taxes. That is what integration means.

What do we learn from this experience? Give refugees a fast and low-threshold approach to the labour market and they will integrate automatically and quickly.

Keep them out of work and you will encounter the typical criminal problems of young underprivileged youths.

Integration is a two way process of give and take. If I ask someone to integrate, I also have to move a little bit.

Let’s now finally talk about the sustainability of healthcare systems under these circumstances.

## Outlook

The German healthcare system is facing extensive challenges. These are primarily demography, the translation of scientific progress into everyday service and the education of physicians and other health care professionals. Mass migration into Europe of people searching for peace and relief has pushed public services to their limits in some German municipalities. Of course, in comparison to the situation in Syria’s neighbouring countries and along the Balkan route this was not really critical. Volunteers – especially volunteer healthcare workers – helped to solve the biggest bottlenecks we were facing in Germany. This experience has reiterated the importance of healthcare planning in terms of meeting medical needs and anticipating surges in capacity.

Refugee healthcare was also a key point of discussion at this year’s German Medical Assembly in Hamburg. These and other discussions within the German medical profession have brought to light some of the practical and administrative challenges of providing care within Germany’s federal system. In order to create reliable and sustainable healthcare conditions, it is important that we devise and implement national solutions which lower the threshold for healthcare access for refugees, minimise red tape, expand human and financial resources in the public health sector, and clarify medical, administrative,

financial and legal accountability among public authorities. This requires a consistent approach at the federal, state and municipal levels. And it is also imperative that we address the transparency of distributing refugees and funding – including at the European Union level.

The “Take Home Messages” of my speech should be:

1. Don’t be afraid of refugees.
2. Give them medical services, stability and security and give them work.
3. To obtain this, work with the professional organizations and not against them.

For more than 2000 years, the Hippocratic Oath has embodied the physician’s obligation to help patients regardless of their origin, nationality, ethnic affiliation or social status. For medical care is a basic human right, not an act of charity.

Allow me to close with a quote from a colleague. Dr Jenny de la Torre, a Berlin-based physician originally from Peru, who is known in Germany as the “Angel of the Homeless” for her treatment of homeless persons in Berlin. She expresses what it means to be a physician in the following words:

“I am not an angel, nor am I Mother Teresa. I am just a doctor.”

*Prof. Dr. Frank Ulrich Montgomery*  
E-mail: [monti@montgomery.de](mailto:monti@montgomery.de)

## 2<sup>nd</sup> WVA/WMA Global Conference on One Health

Moving forward from One Health Concept to One Health Approach  
10–11<sup>th</sup> November 2016

Kitakyushu City, Fukuoka Prefecture, Japan

### Summary

On 10 and 11<sup>th</sup> of November 2016, in Kitakyushu City, Fukuoka Prefecture, Japan, the World Veterinary Association (WVA) and the World Medical Association (WMA) in collaboration with Japan Medical (JMA) and Veterinary (JVMA) Associations held the 2<sup>nd</sup> Global Conference on 'One Health' with the theme: *Moving forward from One Health Concept to One Health Approach*.

The conference was attended by more than 600 participants from 44 countries around the world with approximately 30 lectures covering different One Health issues.

The aim of the 2GCOH was to strengthen the links and communications and to achieve closer collaboration between Physicians, Veterinarians and all appropriate stakeholders to improve the different aspects of health and welfare of humans, animals and the environment.

The Opening Ceremony of the 2GCOH was opened with the remarkable presence of their Imperial Highnesses, Prince and Princess Akishino. In his address to the 2GCOH delegates, Prince Akishino highlighted the importance of the One Health approach to address public and animal health challenges.

After short welcome speeches session by the representatives of WVA, WMA, JMA, JVMA, the FAO/OIE/WHO Tripartite, Japan Ministries of Health and Agriculture and from the directors of Fukuoka region

and Kitakyushu City, the conference started with different sessions on the One Health Concept, Zoonotic diseases, Antimicrobial resistance, Veterinary Education of One Health Concept and other aspects One Health.

Summarizing the two full days of lectures and presentations, the WVA and WMA emphasised the need for:

- **More advocacy for sustained political attention** in particular at national level, on One Health issues to ensure health (human, animal, and environment) is the priority when developing policy.
- To ensure a focus on **environmental health** is included in One Health discussions moving forward (e.g. antimicrobial contamination from aquaculture, agricultural uses, contamination resulting from human uses).
- To encourage further development of **educational and experiential training programs** in One Health that are multi-disciplinary in nature and bring together students of human and veterinary medicine.
- To support more **cross disciplinary continuing professional development programs** for human and animal medical practitioners that address One Health.
- To encourage **additional resources for research in preventative strategies** to enhance One Health concept and approach.

The 2GCOH resulted in the historic signature on the [Memorandum of Fukuoka](#) by WVA, WMA, JMA and JMVA. The 4 associations agreed to move from the validation

and recognition stage of the "One Health Concept", to the practical implementation stage:

1. Physicians and veterinarians shall promote the exchange of information aimed at preventing zoonotic diseases and strengthening cooperative relationships, as well as to undertake further collaboration and cooperation aimed at creating a system for zoonosis research.
2. Physicians and veterinarians shall strengthen their cooperative relationships to ensure the responsible use of important antimicrobials in human and animal healthcare.
3. Physicians and veterinarians shall support activities for developing and improving human and veterinary medical education, including understanding the One Health concept and approach to One Health challenges.
4. Physicians and veterinarians shall promote mutual exchange and strengthen their cooperative relationships in order to resolve all issues related to the creation of a healthy and safe society.

Following the successful 2GCOH, the WVA and WMA received a number of proposals from Veterinary and Medical Associations to hold the 3<sup>rd</sup> Global Conference on One Health in their countries showing their great interest to enhance the collaborations between the veterinarians and physicians to work together on One Health issues.

To be continued at the 3<sup>rd</sup> GCOH...

## The UN-2030 Sustainable Development Goals and the *One Health* Concept: a Case for Synergistic Collaboration Towards 'a Common Cause'



George Lueddeke

### Introduction and global challenges

The early decades of the 21<sup>st</sup> century have reminded us of the pressing need to find ways forward for a world that seems to be facing, what some have called, an 'ingenuity gap.' That is, as highlighted in my new book on global population health and well-being [1], we are facing complex and unprecedented socioeconomic, environmental and geopolitical problems for which there appear to be no 'ready-made' solutions. Conventional 20<sup>th</sup> century reductionist thinking – understand, predict, control, provide – is no longer adequate in an interconnected and uncertain world faced with confronting climate change, armed conflicts, economic volatility, urbanisation, social intolerances, ideological extremism, humanitarian crises, pandemics, famine and migration, to name but a few intractable global issues.

On many fronts we seem to be living in a dichotomous world, where 'the gap widens

between right and reality' [2]. To illustrate, 2 billion out of 7.4 billion people – most in Africa – do not have access to surgical procedures of any kind [3], and close to a billion people are undernourished. Paradoxically, the number of people who are overweight or obese has increased to over a billion "in countries from Columbia to Kazakhstan," leading to "diabetes, heart disease, and high blood pressure" [4]. And, while there are examples of decreasing global hardships, for example, 'people living on less than \$1.25 a day having declined from a high of 1.9 billion in 1981 to a low of 1.4 billion in 2005,' dropping 'from 52.0 to 25.7 per cent during this period' [5], huge discrepancies remain.

It is becoming increasingly clear that as we head into this century most people – over 5.5 billion out of around 7.4 billion – live in the global South and East – while resources and services – including most medical and nursing schools – remain largely in the North and West.

This imbalance is brought into sharp focus in Africa where the population now exceeds 1.2 billion people with an estimate of 9 billion by the end of this century. Similar to other nations in southeast Asia, 'Africa faces a quadruple burden not only must it tackle communicable diseases (e.g. HIV/AIDS, malaria, tuberculosis, and most recently Ebola), it must also confront an increasing number of non-communicable diseases, many of which can be traced to problems of modernity, where there appears to be considerable incongruence between our lifestyle today and our genetic make-up evolved over millions of years. In addition, poverty illnesses (e.g. perinatal/maternal), violence and injury continue to undermine health and well-being and quality of life in general. The continent has 24% of the world

disease burden but only 3% of the world resources and 1% of the doctors. Doctor to people ratios are as high as 50,000:1 in several African countries and over 20,000:1 in several nations, such as Bhutan and Papua New Guinea. In effect, for many in these nations "health systems," as we define them in the literature, are non-existent. In the North and West the doctor-inhabitant ratio is about 300:1' [6].

And, although globalisation has the potential of benefiting everyone, the facts indicate that 'the gap between those who enjoy the fruits of wealth and those who rely on the wage packet for their income' is growing each year [2], and that, as the latest Ipsos MORI Social Research study has concluded, 'the majority (61%) of populations of 25 nations<sup>1</sup> think their countries are 'off on the wrong track' and that re-direction is required [7]. Given recent events in the UK and the US there can be little doubt that 'people are desperate for big change, and most desperate are the poorer, working class and industrial communities that have borne the brunt of the technological changes and spending cuts of the globalisation era' [8, 9].

### The UN 2030 sustainable development goals (SDGs)

On 25 September 2015, 193 Member States of the United Nations General Assembly ratified the UN 2030 Sustainable Development Goals (SDGs) or Global Goals, as they are also called [10]. The 17 SDGs

<sup>1</sup> Argentina, Australia, Belgium, Brazil, Canada, China, France, Britain, Germany, Hungary, India, Israel, Italy, Japan, Mexico, Poland, Peru, Russia, Saudi Arabia, South Africa, South Korea, Spain, Sweden, Turkey and the United States.



and 169 targets superseded the 2000-2015 UN Millennium Development Goals [11], which, while raising the profile and funding of global health and making variable progress on the eight agreed goals, failed to fully address the broader concept of economic, social and environmental development and, in particular, according to UN Secretary-General Ban Ki-moon, tackling root causes.

Extending the nature and scope of the MDGs dramatically, the SDGs, as shown in Figure 1, are 'a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity' [10]. They are intended to be 'integrated and indivisible, global in nature and universally applicable' while 'respecting national policies and priorities.'

According to Johan Rockström, Director of the Stockholm Resilience Center, 'the SDGs are maybe the biggest decision in history...a much more complex agenda, which requires humans to reconnect with their planet' [12].

The SDGs provide a synthesis of major global issues and place collaborative partnerships (#17) at the centre of strategic implementation strategies. Their consideration cannot come too soon as, according

to Marco Lambertini, Director General of WWF International, observes in the introduction to the WWF *Living Planet Report 2014* (Summary):

*In less than two human generations, population sizes of vertebrate species have dropped by half....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 own planet, our only home. We ignore their decline at our peril* [13].

In his plea for transformative change the Director General challenges global leaders to respond to three main questions: 'What kind of future are we heading toward?...What kind of future do we want?' [and], 'Can we justify eroding our natural capital and allocating nature's resources so inequitably?'

His concerns go beyond the immediate UN-2030 global goals and demand finding, first and foremost, a lasting 'unity around a common cause.' His message is intended for the public, private and civil society sectors and implores these stakeholders to be proactive, to "pull together in a bold and coordinated effort," for "Heads of State" to think globally; businesses and consumers, 'to stop behaving as if live in a limitless world' – before facing inevitable and potentially disastrous consequences [13].

## Making a fundamental mindshift in this century

The WWF Director-General's core argument also reflects a recurring theme that runs through my current publication [1]. In short, to sustain the planet and its people in the long term requires making a fundamental mind – or paradigm shift this century: moving away from a stance held by many stakeholders, such as Governments and Big Business, that see, as Pope Francis laments, 'the world as a means to an end' [14], and 'a place made especially for humans and a place without limits'[15] to one that recognises that the survival of the planet and people depends on evolving a future that is 'compatible with our needs as human beings but also an outer world that is compatible with the needs of our ecosystem' [15]. The overarching goal – the common denominator to pull us together regardless of 'race, colour, religion, sex, or national origin' – must surely be creating 'healthy people on a healthy planet' [16].

## One Health historical perspectives and linking the UN global goals to One Health values

The present focus on One Health builds on historical roots going as far back as ancient Greece and Hippocrates (c.500 BCE) [1], and well-known reformers in the 19<sup>th</sup> century, such as *Dr. Rudolph Virchow* (1821-1902), German physician-pathologist, who coined the term "zoonosis," and Canadian physician *Sir William Osler* (1849-1919), father of modern medicine [17]. In the 20<sup>th</sup> century *Sir John McFadyen* (1853-1941), a UK veterinarian and physician, considered the 'founder of modern veterinary research, 'built bridges across human veterinary fields in infectious disease and comparative medicine,' while in the US veterinarian *Dr. Calvin Schwabe*, considered the 'father of veterinary epidemiology,'



**Figure 1.** The UN-2030 Sustainable Development Goals

framed the concept and coined the term One Medicine [17]. *Dr. James Steele* (1913–2013), called the “father of veterinary public health,” founder of the US Centers for Disease Control and Prevention’s (CDC) veterinary division in 1947, co-authored *Confronting zoonoses through closer collaboration between medicine and veterinary medicine* [18] and advocated the One Health concept (then referred to as “One Medicine”) during much of the 20<sup>th</sup> century, long before it became fashionable.

In the past few decades One Health has been championed by individuals, such as veterinarian *Dr. Roger Mahr*, former president of the American Veterinary Medical Association (AVMA), who along with physician *Dr. Ronald Davis*, then president of the American Medical Association (AMA), passed a One Health resolution in 2007. In the intervening years physician *Dr. Laura Kahn*, veterinarian *Dr. Bruce Kaplan*, and physician *Dr. Thomas Monath*, as co-founders, spearheaded the establishment of the One Health Initiative (OHI) [19], while veterinarians *Drs. Cheryl Stroud* and *Joann Lindenmayer* have been leading developments for the One Health Commission (OHC) [20]. These organisations complement those in the World Veterinary Association (WVA) [21], representing over 500,000 veterinarians across the world on six continents, and the World Medical Association (WMA) [22] with 112 Constituent Members and 1013 Associate Members, presently headed by

Presidents’ *Dr. René Carlson*, a veterinarian and *Dr. Desai Ketan*, a physician, respectively. It appears that for all these inspirational and committed leaders One Health is unquestionably the core concept that represents global ‘unity around a common cause’ – bringing together human, animal, environmental health and well-being – to which the world needs to aspire and also advocated strongly earlier by the WWF Director General [13].

Inherent in the concept is the need to adopt ethical responsibilities that are rooted in interdependencies and the sanctity of life [23], which were also at the root of UNESCO Director-General Irena Bokova’s appeal, envisioned a few years ago, for ‘a new humanism that reconciles the global and the local, and teaches us anew how to build the world’ [24]. Moving in these directions may yet offer us the best chance to “free the human race from the tyranny of poverty and want and to heal and secure our planet,” espoused in the UN direction-setting report, ‘Transforming our world: the 2030 Agenda for Sustainable Development’ [10]. It is for these underlying reasons that governments and organisations, such as the United Nations (e.g., Office for Sustainable Development, the UN High-level Political Forum), the World Health Organisation, the World Bank and the Commonwealth, are encouraged to consider adoption of the One Health triad, as shown below (Figure 2) as an integral structural component of fram-

ing policy and enabling action plans, shifting from a mantra of ‘Health in All Policies,’ to ‘One Health in All Policies’ [1]. As a filter for decision-making – or as the late Nobel laureate, Douglass North, defined the purpose of institutions as ‘the humanly devised constraints that structure political, economic and social interaction’ [25], – the guiding or principled question ‘to what extent does the policy initiative/action impact on the sustainability of life on this planet?’ seems vital to embedding a critical global common good. Following this path might lead not only to creating ‘social benefit’ but also ‘sustainable economic development and job creation’ or long-term prosperity in the long run [26].

## One Health and well-being: implications for preparing health professionals

In *Educating for a Sustainable Future: A Transdisciplinary Vision for Concerted Action* [28], UNESCO highlighted that ‘education is the most effective means that society possesses for confronting the challenges of the future.’ The significance of this resolve was also captured in the UN’s Earth Charter, which emphasises the importance of integrating into ‘education and life-long learning the knowledge, values, and skills needed for a sustainable way of life (Principle 9)’ [23].

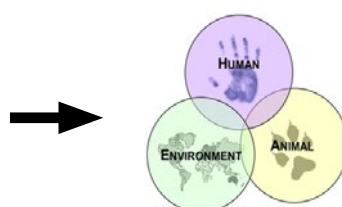
More recently, the UN 2030-Sustainable Development Goals (SDGs) reinforce this principle, declaring that by 2030

*All learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture’s contribution to sustainable development (SDG 4)* [10].

### SUSTAINABLE DEVELOPMENT GOALS



### IMPLEMENTATION



**Figure 2.** Linking UN-2030 Global Goals to One Health and Well-Being [27]

While the rhetoric is certainly going in the right directions, the impetus for taking forward the means for our survival as a species, which depends on sustaining the health and well-being of the planet and people, has regrettably not yet been taken forward in health education generally, including veterinary and human medicine.

Despite the reality that most human illnesses in history are caused by zoonotic diseases and that of the 1,415 microbes that are known to infect humans, more than 70% come from animals [29], few contemporary health curricula reflect causes, possible consequences, *prevention* and treatment. In addition, in many schools scant attention is given to environmental factors that may affect human and animal health through contamination, pollution and poor conditions that may lead to new infectious agents. Taken as a whole, it is becoming apparent and urgent that we need to go beyond teaching not only 'a relatively simple animal-human dyad, but also take the 'the root causes of human well-being (and ill health) in the dynamics of complex ecological systems' much more seriously [30]. According to the authors of 'Integrating a One Health Approach in Education to Address Global Health and Sustainability Challenges [31,1], 'less than 3% of the total veterinary curriculum in the U.S. is devoted to public health issues, resulting in fewer than 2% of current veterinarians working in public health.' With regard to medical education, the authors also observe that, given the "anthropocentrism" of traditional medical curricula and medical education, 'medical training maintains a strict focus on human health.'

Moreover, while adopting a 'bottoms-up' change model approach, the post-graduate students, who at the time were studying at Duke University Oxford University, UNC Gillings School of Public Health, and North Carolina State University, asserted that 'One Health educational programs could benefit significantly from the creation of 'Centers of

One Health Excellence [COHE]], 'possibly with "seed" funding provided by a number of organizations (e.g., WHO, CDC, United States Agency for International Development [USAID], the UN's environmental program, foundations) [1]. These could collaborate with national, regional, and global and educational institutions, government agencies, and public-private partnerships, develop blended curricula, advance multidisciplinary research, and inform 'plans that acknowledge the balance of the environment and health in achieving sustainable development' [31,1].

## The World Veterinary Association(WVA) and the World Medical Association (WMA) 2<sup>nd</sup> global conference on One Health

A significant step in 'building capacity for a healthier world' was recently taken by the WVA-WMA in association with the Japan Veterinary Association and the Japan Medical Association at the 2<sup>nd</sup> Global Conference on One Health (GCOH) – Moving forward from One Health Concept to One Health Approach, held 10-11 November in Kitakyushu City, Fukuoka Prefecture in Japan [32]. With more than 600 participants from 44 countries, the conference focused on four main themes: Zoonotic and Foodborne Diseases, Antimicrobial Resistance, Environmental Hazards -exposure to humans and animals, and The Future of the One Health Concept. The resultant *Memorandum of Fukuoka* underscores the importance of *preventing* zoonotic diseases, collaboration and cooperation aimed at creating a system for zoonosis research and giving priority to support activities for developing and improving human and veterinary medical education, including applying the One Health concept and approach to One Health challenges along with the 'creation of a health and safe society.'

## Creating the world we need through One Health education

In a post WVA-WMA conference summary document, Dr Chiang Johnson, WVA president-elect, emphasised the need for political action in progressing One Health policies, focusing on environmental health, and advocating the development of multidisciplinary One Health human and veterinary education and training programmes, including continuing professional development (CPD). It may be noteworthy to mention that WVA-WMA support for additional resources for research in preventive strategies to enhance One Health also parallels the recommendations of the post-graduate student authors arguing for 'Centres of One Health Excellence,' discussed previously [31,1].

Key resolutions reached at the WVA-WMA 2<sup>nd</sup> Global Conference on One Health (GCOH) underpin current One Health Commission (OHC) [20] in association with One Health Initiative [19] efforts, announced in a previous OHC-OHI Press Release [32], to give the younger generation 'a better deal' for helping to shape a sustainable world. A basic assumption behind the Commission's funding proposal, summarised in a concept paper, 'Preparing Society to Create the World We Want through One Health Education' [34], is that the best opportunity to achieve meaningful societal change and prepare future leaders to create a healthier world must be seized early on in children's lives as they form fundamental views of their places on the planet and carry those views forward into adulthood.'

In a recent conference/webinar, The World We Need [35], the One Health Education Task Force shared findings of a global One Health education survey and highlighted developments to date with regard to the proposed funding initiative supporting learning K-12+ learning opportunities that



focus through team-building on the formation of:

- basic values and responsibilities with respect to “the community of life” [32];
- knowledge with respect to the interconnectedness of life on our planet;
- real world application skills underpinned by interdisciplinary teamwork, creativity and group problem-solving; and
- a global network of One Health education providers who are committed to supporting learners and teachers in their quest to realize a more sustainable world.

A possible side-benefit of the One Health education initiative with a view to future generations and the creation of closer relationships with the natural world – especially ‘in our technology-dependent age’ – is that it may address a phenomenon, coined by American writer Richard Louv, as ‘nature deficit disorder,’ or ‘a diminished ability to find meaning in the life that surrounds us’ [36]. Reconnecting with the natural environment may raise awareness of ‘how important nature is for children’s development, affecting “everything from a positive effect on the attention span, to stress reduction, to cognitive development and their sense of wonder and connection to the earth...”

At more advanced post-secondary or higher education levels, for example, the early years of undergraduate human and veterinary medicine, recent articles such as ‘One Health training, research, and outreach in North America’ [37], appearing in *Infection Ecology & Epidemiology* – the One Health Journal, and initiatives proposed by the Planetary Health Alliance [38] should prove informative for those planning development opportunities. In terms of interdisciplinary education, more consideration might also be given to shared topics using cross-cutting problem-based learning activities that are high on the global SDG/One Health agenda [39], including

- Global health and well-being challenges
- SDGs and the One Health concept and approach

- zoonotic diseases
- antibiotic resistance
- food safety and security
- ecosystem and environmental health
- land degradation and urban development
- agriculture and sustainability
- health impact of water
- energy usage
- biodiversity...

## Concluding comments

By means of summary, in a chapter contributing to Jekel’s *Epidemiology, Biostatistics, Preventive Medicine, and Public Health* [40], Dr. Meredith Barrett and Dr. Steven Osofsky compellingly affirm that ‘Issues of global environmental change, global health, emerging disease, and sustainability present some of the most complex and far-reaching challenges of the 21<sup>st</sup> century.’

Furthermore, given the enormity of the universal transformation required in the decades ahead and along with a growing voice representing public health and related health professionals [41], the authors stress that ‘individual disciplines cannot address these issues in isolation.’ The best way forward is to tackle ‘the fundamental causes of global health and environmental threats.’ For these researchers ‘One Health offers a logical path forward by recognising not only the interconnected nature of human, animal, and ecosystem health but also by acknowledging the potential to fundamentally ‘inform health and environmental policy, expand scientific knowledge, improve healthcare training and delivery, improve conservation outcomes, identify *Upstream* solutions, and address sustainability challenges.’

As we continue to strive toward a new ‘life-sustaining’ world order in this decade and beyond, there can be little doubt about the vital importance of linking the UN-2030 Global Goals to the holistic One Health concept. Adopting a *One Health in All Poli-*

*cies* [1] approach may not only be an ‘idea whose time has come’ but also, as evidenced at the PAHO/WHO 17<sup>th</sup> Inter American Ministerial Meeting on Health and Agriculture in July 2016 [42], a progressive step in the right direction.

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*George Lueddeke, Med, PhD  
Chair, One Health Education Task  
Force, One Health Commission*

*Consultant in Higher and Medical Education  
Southampton, United Kingdom*

*E-mail: [glueddeke@aol.com](mailto:glueddeke@aol.com)*

## Health Negotiations at COP22, 7–18 November 2016

### Overview

The twenty-second session of the Conference of the Parties (COP 22) in Marrakech, labelled as the “African COP” and the “COP of Action” followed the adoption of the Paris Agreement (PA) in 2015 and brought about many commitments and climate actions with respect to the implementation of the PA and hosted multiple important health events. Furthermore, numerous items important for health in relation to adaptation, loss and damage and multi-stakeholder engagement were negotiated.

### Moving from ADP to APA

The Ad Hoc Working Group on the Durban Platform for Enhanced Action (ADP) was established in December 2011 to develop a legal instrument that is applicable to all Parties through two main work streams: the 2015 agreement and pre-2020 ambition. The ADP concluded its work in Paris in December 2015, right before COP21, and submitted a draft agreement text and conclusion addressing various issues such as capacity building, technology development and transfer, loss and damage and finance, to be considered by COP21. After the closure of the ADP and the adoption of the Paris Agreement, the Ad Hoc Working Group on the Paris Agreement (APA) was established to prepare the agreement for entering into force. The APA was requested to develop guidance to nationally determined contributions (NDC), create modalities for the transparency framework for action and support, and global stocktake, and facilitate and promote compliance.

In Marrakech, the negotiations were going a bit slower than expected with the developed countries calling for urgent efforts while the developing Parties, in particular the African Group, demanding the developed countries to show leadership and provide guidance. On November 14, at the closing plenary, the APA

mandated the Parties to submit their Nationally Determined Contributions (NDCs) to climate action under the Paris Agreement by April 1, 2017 in addition to submissions in relation to adaptation communication, transparency framework and compliance and implementation of the Paris Agreement. The APA will convene again in Bonn in May 2017.

### Health had a high profile at COP 22

Health had quite a high profile at COP 22, hosting the Action Agenda “Health Day” on Friday, November 11. It provided several examples of how the public health community can support action towards the implementation of the Paris Agreement. Namely, the new divestment from fossil fuels policy adopted by the WMA at its most recent General Assembly was presented. Additionally, a high level ministerial meeting was also organized during COP by WHO, UNEP and the Moroccan Government on November 15. It aimed at bringing together Ministers of Health and Ministers of Environment to launch a global initiative on health, environment and climate change, to promote better management of climate risks to health, and low carbon, climate resilient, sustainable and inclusive development aimed at ensuring good health and well-being, with the help of WHO, UNEP, WMO, UNFCCC and other interested Parties.

UNFCCC, in collaboration with WHO and WMO, held the 10<sup>th</sup> Forum of Nairobi Work Program (NWP) on health and adaptation that addressed changes in geographical distribution of disease, new and emerging diseases, and their impacts on social and economic structures, issues of malnutrition, waterborne disease, vector-borne disease and disaster impacts and the effects of climate change on health and productivity in the workplace. A synthesis report will be presented and adopted by the Parties in Bonn, in May 2017.

Other health events that were held include the following:

1. Climate Change, Human Migration and Health on November 9 by *USPC, Charité – Universitätsmedizin Berlin, Université de Genève, Université Internationale de Rabat, Université de Liège, and the Lancet Countdown on Health and Climate Change*. It focused on enhancing the health of climate migrants and possible indicators for migration, health and climate change;
2. Conference on Climate and Health Care on November 14 by *Health Care Without Harm and the Mohammed VI University Hospital of Marrakech*. It discussed the vital role of health care sector to mitigate climate change impacts and develop low-carbon models of care;
3. Lancet Countdown: Tracking Progress on Health and Climate Change on November 14 by *Lancet and UNFCCC*. This press conference marked the official launch of international and multi-disciplinary collaboration between researchers, health practitioners and policy-makers;
4. Interministerial Meeting on Health, Environment and Climate Change on November 15, by the Ministry of Environment and the Ministry of Health of Morocco, in partnership with the World Health Organization and the UN Environment Programme. It brought together over two dozen Ministers and high level officials from both the health and environment sectors who signed the Declaration for Health, Environment and Climate Change;
5. UN High Level Side Event on Climate Change and Health – SDG3: good health and wellbeing, on November 15. It emphasized the importance of a sustained country progress in achieving SDG3 and SDG13 through sustainable low carbon policies.

Despite the various well-structured side events and forums by the health sector to address health as an important vital aspect to implement and achieve the Paris Agreement, COP22 ended with few decisions taken on important elements for health:

most elements were forwarded for a decision to be taken at a later point in time in the coming years. At the closing plenary, the Parties adopted the Marrakech Action Proclamation that expressed the irreversible momentum on climate. Poverty, food security and agriculture were addressed but with no mention to health or its co-benefits.

COP22 launched a set of climate actions, called Marrakech Partnership for Global Climate Action, to be implemented by the Parties and other stakeholders. Health was mentioned as part of the suggested thematic approach for multi-stakeholder engagement in addition to gender, education, and decent work.

## Divestment from fossil fuels

COP22 hosted a historic breakthrough when 48 climate vulnerable countries committed to 100% renewable energy by mid-century. It was announced during the Climate Vulnerable Forum (CVF) chaired by Ethiopia. The CVF vowed to end energy poverty and protect water and food security through committing to renewables and adopt de-carbonization plans. Members of the CVF pledged to help each other to ensure support is given in terms of capacity building, finance and technology.

The participating Parties also committed to advocate for an international collaborative system to provide adequate support to climate change adaptation and mitigation action to developing countries through engaging all countries, the United Nations system, international financial institutions and other global governance structures with a particular initial focus on protecting food production and other domains such as health and human rights.

Furthermore, the work of the WMA on fossil fuel divestment was shared during the Health Action Day and other participants from healthcare organizations were encouraged to follow suit and adopt divestment policies.

## Adaptation to climate change impacts

There has been good progress on the work of the Nairobi Work Programme (NWP) on impacts, vulnerability and adaptation to

climate change as many submissions by the Parties were reviewed at COP 22. Furthermore, it is important to note that many of those highlighted the importance of health. Additionally, while financing for adaptation was a contentious issue in the discussions during COP 22, clear commitments to financing for adaptation were expressed by many Parties and a clear way forward in determining the best mechanism for such financial flows has now been established and we may expect the outcomes of future work in this area.

## Loss and Damage

While the Paris Agreement set the tone for action in the coming years, details around the implementation of loss and damage still remain unclear. One of the most contentious issues, that of financing for loss and damage, has been pushed to future discussions. Nevertheless, at this past COP 22, there has been good progress: namely through the completion of the first review of the work of the Executive Committee of the Warsaw International Mechanism (WIM) on Loss and Damage that is now set on developing its five year workplan. Additionally, the newly started work aiming to bring together technical expertise on the topic of non-economic losses will be crucial for how health is addressed by the WIM and, thus, will be followed by health actors in the years to come. The WMA remains committed to contribute technical expertise on health and climate change, including on non-economic loss and damage.

## Way forward

Given the progress at COP 22, there are many new areas that the health sector may contribute to in the coming years. Firstly, on a national level, medical organisations are encouraged to continue work in line with the recently adopted WMA Statement on Divestment from Fossil Fuels, namely, by encouraging “governments to adopt strategies that emphasize strict environmental regulations and standards that encourage energy companies to move toward renewable fuel sources” and by beginning “a process of

transferring their investments, when feasible without damage, from energy companies whose primary business relies upon extraction of, or energy generation from, fossil fuels to those generating energy from renewable energy sources.”<sup>1</sup> Additionally, as the Parties continue working on their national adaptation plans, the health sector can ensure adequate consideration of public health using health in all policies methods. As the Parties confirm their NDCs at the beginning of 2017, this also remains a potential area to address through national level advocacy to ensure that commitments acknowledge the true level of impact on health and that measures are taken to minimize their negative consequences. Secondly, on the international level, the UNFCCC has now set an agenda of work for many elements directly originating from the adoption of the Paris Agreement that will need to be addressed, namely, the Expert Group on non-economic losses, created under the WIM, will need to find ways of accounting and addressing health losses from climate change impacts, financial flows towards the health sector will need to be established from mechanisms under the convention and under the Paris Agreement. Finally, on all levels, the health sector actors involved in climate change have a responsibility of contributing to capacity building in this sector so that clinicians can take into account the expected health outcomes, policy-maker can develop the necessary safeguards to protect people from health impacts of climate change and to reduce the contribution of the health sector to climate change.

*Lujain Al-Qodmani, MD, Kuwait*

*E-mail: [lujainalq@gmail.com](mailto:lujainalq@gmail.com)*

*Diogo Martins, MD, Public Health Resident,*

*Portugal, MSc Public Health LSHTM, UK*

*E-mail: [diogo.correiamartins.md@gmail.com](mailto:diogo.correiamartins.md@gmail.com)*

*Yassen Tcholakov, MD, MIH, Public Health*

*Resident, McGill University, Canada*

*E-mail: [yassentch@gmail.com](mailto:yassentch@gmail.com)*

<sup>1</sup> WMA Statement on Divestment from Fossil Fuels, World Medical Association. <http://www.wma.net/en/30publications/10policies/f13/>



*Wishing you, your family and your medical  
association a Happy New Year!*

