



Wemos strategy FOR 2019 - 2023

List of abbreviations

CSO	Civil society organisation
DAH	Development assistance for health
EMA	European Medicines Agency
EU	European Union
GAVI	Global Vaccine Alliance
GDP	Gross domestic product
GF	Global Fund
GFF	Global Financing Facility
HRH	Human resources for health
ILO	International Labour Organization
LMICs	Low- and middle-income countries
ODA	Official development assistance
OECD	Organisation for Economic Cooperation and Development
R&D	Research & development
SDGs	Sustainable Development Goals
UHC	Universal health coverage
UN	United Nations
USD	United States dollar
WHO	World Health Organization

“ The right to health concerns us all,
everywhere in the world



Who are we?

We advocate the right to health for all; access to health services and protection against threats to health. We were founded 40 years ago by a group of Dutch medical students who believed that medical interventions in low- and middle-income countries (LMICs) can be effective only if the underlying causes of health problems are addressed. Since then, we have acquired an international reputation for our **rights-based and systemic approach** to health. We target policy-makers and politicians, but also reach out to the public at large.

We believe in using our knowledge base to build bridges, raise awareness of urgent health issues among policy-makers both in the Netherlands and abroad, and strengthen the voices of partner organisations and those without easy access to healthcare.

Our vision

Health is a universal human right. Governments must create the conditions for guaranteeing the health of all their citizens: access to health services and protection against threats to health.

Our mission

We are an independent civil society organisation (CSO) seeking to improve public health worldwide.

- ▶ We analyse Dutch, European and global policies that affect health and propose relevant changes.
- ▶ We hold the Dutch government, the European Union (EU) and multilateral organisations accountable for their responsibility to respect, protect and fulfil the right to health.

Organisational values

Our guiding principle is 'health as a human right', a right that takes precedence over political and economic interests. We believe that the pursuit of health for all in this globalised era is a **shared responsibility**, that it should favour those left behind according to the **equity principle** and that it should take the health of future generations into consideration. In addition, we are aware of how policies in one area can affect, counteract with or undermine policies in another area. We strive for **policy coherence**, for example by addressing the effects of economic policies on health.

Our core values are:

- *Grounded*
- *Critical and constructive*
- *Striving for structural change*
- *A belief in global justice*

Our approach

Our work starts from five fundamental principles that we apply in all our programmes:

1. a human rights-based approach to health;
2. equity and gender;
3. systemic change;
4. mutual learning and knowledge exchange;
5. creating and broadening civic space.

Our primary advocacy targets are the Dutch government, EU institutions and multilateral organisations. Indirectly, through government and global health institutions, we also encourage commercial actors to adjust their *modus operandi* when their actions hinder, counter or prevent the attainment of global health goals.

Human rights-based approach to health

We analyse and address the inequalities, discriminatory practices and unjust power relations which are often at the heart of (health) systems failures, as well as the underlying causes preventing people from exercising their right to health.

Equity and gender

Health equity and gender equality are core to the overarching principle of leaving no-one behind that is common to all UN Sustainable Development Goals (SDGs). Gender roles affect how people live, work and relate to each other at all levels, including in relation to the health system.

Our programmes consistently pay special attention to people, communities, minorities and professions who are at risk of losing out on the right to health. We propose policy alternatives to achieve equity: they are designed to prevent unfair, avoidable differences arising from poor governance, corruption or cultural exclusion.

Systemic change

Ultimately, achieving universal health coverage (UHC) requires not simply addressing power imbalances that perpetuate inequalities, but also actively promoting systemic changes - political, economic and social - both in individual countries and globally.

Poorly performing health systems are an immediate reason why many people lack access to effective health services. A strong health system depends on the right economic, social and political conditions being in place. These may necessitate changes in decision-making and budgeting processes, new financing mechanisms, or different ways of involving stakeholders in the design, implementation and monitoring of policy.

Mutual learning and knowledge exchange

We believe that solutions enabling all people to exercise their right to health are guided by global policies, and are embedded in national knowledge and experiences. Therefore, establishing equal partnerships with national CSOs is an important part of our advocacy approach. This we do through a process of dialogue, sharing knowledge on global policy debates and their significance for the country context, and finding common ground on particular policy issues. Working from this starting point, we consult stakeholders, analyse the political and policy environment, and review studies, national data and policies. We compare our findings with global policy agreements and identify areas where change is needed.

We envision our partnerships with national CSOs as a mutual learning process. Together, we develop joint advocacy messages to voice both globally, and in individual countries under the leadership of national CSOs. Ultimately, partnership helps to create an open space in which national partners strengthen their capacity for advocacy and for disseminating messages based on an understanding of global issues and how they affect national policies. At the same time, this enables us to use national experiences to enrich our analysis of health-related global policies and political trends.

Creating and broadening civic space

If true change is to come about, there needs to be a deliberate shift in the power balance in favour of those who are most affected. This also applies to our advocacy approach: we acknowledge that many civil society opinions and views are either not heard or are overshadowed by those of large international CSOs. By working with national civil society partners,



With 16% of the world's population and 24% of the world's disease burden, Sub-Saharan Africa receives just 1% of global health spending and employs only 3% of the global health workforce

we are able to jointly identify discrepancies between global health policy intentions and national health outcomes, and propose alternative policy options.

Current trends in global health

'Global health' is the term used to describe health issues arising from interdependencies resulting from globalisation, with cross-border causes and consequences. Global health is becoming a growing topic of debate in foreign policy, in contexts of development cooperation, trade and investment, national security and diplomacy.

Shifting power dynamics

Power dynamics in the global health arena are shifting. The private sector is playing a more and more important role. The SDGs also call for more private-sector involvement, with SDG 17 calling for an increase in both public-private partnerships and civil-society partnerships. This poses challenges to democratic and transparent decision-making and may further fuel health inequities in case policy choices are driven by commercial rather than public interests.

Imbalances

Low-income countries have the highest burden of disease, but the lowest global health expenditure and the lowest number of health workers. Currently, at least half of the world's population does not have full access to essential health services. On average, life expectancy in low-income countries is less than 60 years, compared with over 75 years in high-income countries. Sub-Saharan Africa accommodates 16% of the world's population and accounts for 24% of the world's disease burden, but receives just 1% of global health spending and is home to only 3% of the global health workforce. Almost a quarter of African physicians work in high-income countries, whilst they received their training in low-income countries.

Underfunding

While there is a continued need for additional funds for health globally, the donor landscape has changed rigorously during the past two decades. The World Health Organization's (WHO) 2017 progress report on SDG3 identified underfunding as a major cause of low health status and inequities in access to healthcare. An estimated USD 274 billion of additional annual spending on health is needed by 2030 'to make



Worldwide, nearly 70% of people employed in the health sector are women. However, they are often underrepresented in national decision-making on health and in the global health debate

progress towards the SDG 3 targets in the progress scenario, while USD 371 billion would be needed to reach health system targets in the ambitious scenario'. These are daunting figures. Although spending targets differ from one country to another, it is clear that many LMICs do not have sufficient domestic resources to adequately fund health services.

New forms of finance

There is a widespread move towards the adoption of new forms of 'innovative financing' and the use of public resources for leveraging private finance to invest in a range of assets (such as equities and bonds) in all sorts of different fields, including health. This trend is reflected by the World Bank's Maximising Finance for Development agenda, an approach that has been readily adopted by bilateral and regional donors. The Dutch policy document on Foreign Trade and Development Cooperation (2018) also emphasises innovative types of finance

and leveraging private-sector funding, in addition to existing forms of support for private-sector activity in low-income countries and emerging markets.

Tax losses

Global tax losses amount to an estimated USD 500 billion annually. The world's biggest pharmaceutical companies are dodging an estimated USD 3.8 billion in tax per year across 16 countries. While this affects the right to health worldwide, the greatest impact is felt in countries with low public budgets. If tax and other domestic revenues rose by 2% of gross domestic product (GDP) by 2020, this would add USD 144 billion to LMICs' resources – the equivalent of aggregate aid disbursements in 2017. Unfortunately, the problem of tax avoidance and tax evasion is both well-known and persistent. The European Commission and the Organisation for Economic Cooperation and Development (OECD) are working on measures to remedy the problem, but progress is slow.

Falling levels of official development assistance (ODA)

Even with improved tax collection, 48 countries would still lack the domestic resources to fund universal health, education and social protection, and would need an extra USD 150 billion annually to meet these needs. Aid can support underfunded health systems, but development assistance for health (DAH) has flatlined since 2011. After two decades of growth since 1990, it actually fell to a total of USD 37.4 billion between 2016 and 2017. On average, OECD donor countries devote 0.31% of their gross national income to development assistance (USD 147 billion in 2017), a level that falls far short of the 0.7% they promised nearly 50 years ago – a pledge renewed in the SDGs.

New donors

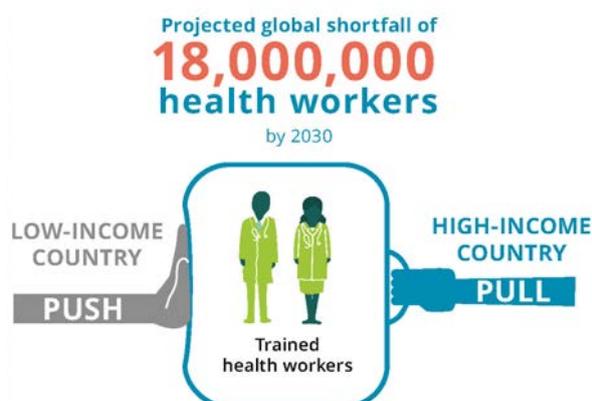
There has also been a shift in the sources of development assistance from traditional bilateral donors in OECD countries towards 'non-traditional' bilateral donors such as China. The emergence of philanthropic foundations is another trend: some 26 philanthropic foundations donated a total of USD 6.1 billion in 2017. Though this is still a modest amount compared with ODA, these 26 foundations were together the second largest funder in the health and reproductive rights sector. As an ever larger share of WHO funding comes from philanthropic donors, the WHO's strategy and priorities are dictated more and more by its funders rather than by the member states represented on its governing bodies.

Three leading global health partnerships

Three public-private global health partnerships are key external funders in global health and greatly influence funding priorities. Two of them, the Global Vaccine Alliance (GAVI) and the Global Fund to fight AIDS, tuberculosis and malaria (GF), started off as vertical funds, targeting specific diseases or aspects of the health system. In recognition of the many interlinkages between health system components, both funds increasingly incorporate health systems support and are taking steps towards funding health worker training and salaries. The relatively new Global Financing Facility (GFF) is the funding mechanism hosted by the World Bank for the UN Global Strategy for Women's, Children's and Adolescent's Health, and is becoming increasingly important as the main funder of action in relation to sexual and reproductive health and rights.

Human resources: a shortage of health workers

A special committee formed by the International Labour Organisation (ILO), the OECD and the WHO predicts a shortage of 18 million health workers by the year 2030, primarily in LMICs. This is due to various trends, such as an ageing world population, changing lifestyles and a global rise in the incidence of non-communicable diseases. All these trends require changes in health service delivery models and mean a greater demand for health workers.





Two billion people, most of whom live in low- and middle-income countries, are unable to acquire essential medicines

While many of the predicted 40 million new jobs that will be created will be located in higher-income countries, the burden of disease will be higher among the LMICs. Higher-income countries also offer higher salaries and better working conditions, thus creating an important pull factor on already scarce human resources for health (HRH) in LMICs. The picture is compounded by the rise of for-profit and not-for-profit private-sector health service delivery, even in LMICs. Working in the private sector is generally regarded as more attractive, which is why many staff are leaving the public health sector.

Women underrepresented

The majority of health workers are women. In particular, nursing, midwifery and community health work are female-dominated professions. Worldwide,

nearly 70% of those total employed in the health sector are women. However, women working in these professions are often underrepresented in national decision-making on health and in the global health debate.

At the receiving end, we also see that inadequate health service delivery disproportionately affects women and children. Sustained, adequate investment in a well-trained, motivated, supported and effectively deployed health workforce can therefore help greatly to improve the health of women and children, leading to better educational outcomes and improved household stability, including generated income.

OUR THEORY OF CHANGE

OUR VISION

All people can exercise their right to health:

ACCESS TO HEALTH SERVICES
and
PROTECTION FROM HEALTH THREATS

IMPACT

The right systemic (i.e. economic, social and political) conditions must be in place to allow people to exercise their right to health

POLITICAL WILL FOR POLICY CHANGE

WHAT WE DO

PLANNING, MONITORING & EVALUATION, COMMUNICATIONS

ADVOCACY
Open dialogue with Dutch and international policy-makers and decision-makers

EVIDENCE-BUILDING
Policy analysis and knowledge products

COALITION-BUILDING
Reinforcing common messages in priority areas

CONNECTING NATIONAL & GLOBAL

OUR VALUES

- Grounded
- Critical and constructive
- Structural change
- Global justice

OUR ADVOCACY ROLES

- Expert
- Initiator
- Facilitator
- Critic
- Watchdog

OUR FOCUS AREAS

FINANCE FOR HEALTH

All governments should allocate sufficient (sustainable and flexible) funding to investments in a high-quality, resilient and gender-sensitive health system that is accessible to all citizens.

HUMAN RESOURCES FOR HEALTH

Everyone, everywhere should have access to skilled, motivated and properly supported health workers.

ACCESS TO MEDICINES

Everyone, everywhere should have access to high-quality, affordable medicines that meet their medical needs.



The process of change

In order for all people to be able to exercise their right to health, the right economic, social and political conditions must be in place, at both global and national levels. We believe that these conditions need to start with evidence-based national and global policies and regulations that address underlying power imbalances.

The process of policy change starts when national and global decision-makers and policy-makers come under pressure to change and, by taking action, demonstrate that they have the political will to address key health system constraints and systemic barriers. Only when they are convinced that change is needed, a coherent set of effective policies can be developed and implemented to create the right systemic conditions. Once these policies are in place, we work with and through civil-society mechanisms to hold the Dutch government and EU and global health institutions accountable for enforcing these policies, allocating sufficient funding to them and adjusting them when necessary.

Our aim is to help create the political will and action that is needed to achieve our three main goals:

- All governments should allocate **sufficient** (sustainable and flexible) **funding** to investments in a high-quality, resilient and gender-sensitive health system that is accessible to all citizens.
- Everyone, everywhere should have **access to skilled, motivated and properly supported health workers**.
- Everyone, everywhere should have **access to high-quality, affordable medicines** that meet their medical needs.

These goals form the core of our three programmes:

1. Finance for health
2. Human resources for health
3. Access to medicines

Lack of access to essential medicines

Two billion people, most of whom live in LMICs, are unable to acquire essential medicines, thus running the risk of causing major harm to their health – or even hastening their death. Growing concerns have been voiced in recent years that access to medicines is no longer just a problem affecting LMICs. It is also becoming a problem in high-income countries including the Netherlands, due to the rising prices of medicines.

High prices of medicines

High prices are caused by flaws in the system for performing research into, developing, producing and marketing medicines, as well as in intellectual property rights, patent law, trade laws and, more recently, in regulatory measures to incentivise the development of orphan drugs. Most of these laws and regulations have a global scope and impact.

Our programmes



Finance
for health



Human resources
for health



Access
to medicines



Finance for health

OUR FOCUS

Big funding gaps still need to be overcome before the health-related SDGs can be attained. Most LMICs do not raise sufficient domestic resources to achieve UHC, and are far from achieving the twin health spending targets of at least USD 86 per capita per year and at least 5% of GDP.

Big funding gaps still need to be overcome before the health-related SDGs can be attained

We will seek to raise the volume of public resources devoted to health during this strategy period by:

1. ensuring that international aid is both better aligned to recipients' needs and of better quality;
2. encouraging international financial institutions to adopt policies that increase the fiscal space for health; and
3. advocating criteria for ODA allocation to private-sector instruments for health.

CHANGE NEEDED

- ▶ Bilateral and multilateral development partners should increase and align their ODA to co-finance UHC strategies in countries that cannot raise sufficient domestic resources, particularly those with significant HRH finance gaps.
- ▶ International financial institutions and development partners should actively support the efforts of LMICs to increase the fiscal space for health and HRH, by strengthening the national and international enforcement of tax laws and by phasing out harmful policy conditionalities that unduly limit a country's spending options.
- ▶ Development partners should apply criteria so as to ensure that, where ODA is used to promote private-sector involvement in health in LMICs, this helps the countries in question to attain development goals, does not cause harm and is in line with aid effectiveness principles.
- ▶ CSOs should have both the capacity and opportunities to effectively monitor and influence finance for health at both national and international levels, and to advocate alternative financing models where appropriate.

OVERALL GOAL FOR FINANCE FOR HEALTH

All governments should allocate sufficient (sustainable and flexible) funding to investments in a high-quality, resilient and gender-sensitive health system that is accessible to all citizens.



How are we planning to push for these changes?

1. EVIDENCE-BUILDING

We will analyse key issues and collect evidence on:

- factors constraining the fiscal space for health that hamper the achievement of international targets and recommendations on UHC, including HRH, in Kenya, Malawi, Tanzania, Uganda and Zambia (currently our focus countries);
- the potential impact of the GAVI, GF and GFF health financing models on the achievement of UHC and on the funding of health worker salaries. We will focus particularly on CSO involvement, results-based financing, gender equity, private-sector involvement and debt;
- economic policy conditionality: its implications for health spending and possible alternatives in country case studies;
- the effects on health outcomes for the poor of ODA support for private-sector involvement in health systems finance, governance and service delivery.

2. COALITION-BUILDING

We will develop joint advocacy positions and strategies with our CSO partners, including solutions for the following issues:

- national and global barriers that hinder HRH investments in countries with a critical shortage of health workers (aligned with the HRH programme described below);

- opportunities and barriers for GAVI, GF and GFF contributions to fiscal space for health in individual countries;
- gaps in national or multilateral policy frameworks for guiding or restricting the use of ODA funds for supporting and involving the private sector in the health sector.

3. ADVOCACY

We will lobby governments and regional and global institutions:

- Global advocacy: working through our international networks, we call upon global actors, i.e. multilateral and bilateral development partners, to:
 1. adjust policy advice and conditionality so that they foster equitable finance for health and HRH;
 2. hold GAVI, GF and GFF accountable and push for reforms to advance health system funding and strengthen inclusivity; and
 3. apply public health criteria to guide the use of ODA funds for promoting private-sector involvement.
- National advocacy: we will work together with national CSOs to align advocacy messages and strategies for boosting and improving health spending.



Human resources for health

OUR FOCUS

A strong, effective health workforce is critical for achieving UHC. However, the health workforce is unevenly distributed across the world. The biggest staff shortages are in those countries with the highest disease burden. We know most maternal and neonatal deaths are preventable in the presence of skilled health workers; they are a key factor in reducing mortality rates. A number of factors affect health worker shortages, including insufficient

Most maternal and neonatal deaths are preventable in the presence of skilled health workers

training and recruitment, a higher level of demand from a growing and aging world population, and health worker migration. We look at both push and pull factors affecting health worker mobility.

CHANGE NEEDED

- ▶ Countries with significant HRH finance gaps should raise their domestic resources for HRH in line with global targets.
- ▶ Global actors should co-invest as donors in LMIC health workforces in line with international instruments for HRH. This includes being prepared to support health worker salaries where needed (for a certain period of time).
- ▶ Governments should invest on a long-term basis in planning and forecasting, and also in the recruitment, development, training, retention and management of the health workforce in LMICs.
- ▶ Global actors, such as the OECD, the ILO and the WHO, and governments of source and destination countries should reform existing policies and develop new policies and public finance models so as to mitigate the adverse effects of health workforce mobility and migration, in line with global recommendations.

OVERALL GOAL FOR HUMAN RESOURCES FOR HEALTH

Everyone, everywhere, should have access to skilled, motivated and properly supported health workers.



How are we planning to push for these changes?

1. EVIDENCE-BUILDING

We will analyse key issues, review existing evidence and collect new evidence on:

- the fiscal space for HRH in Kenya, Malawi, Tanzania, Uganda and Zambia (currently our focus countries) in order to understand the key obstacles to stronger investments in HRH;
- a political economy analysis of stakeholders at a national level (including CSOs, governments and development partners) in the field of HRH, so as to identify our lobby allies and targets;
- national HRH policy and strategy documents and its implementation, in order to understand the national HRH challenges and opportunities for CSOs to be involved in advocacy;
- health worker mobility and migration, in particular from a gender perspective.

2. COALITION-BUILDING

We will create and contribute to global CSO partnerships and support national CSOs in relation to:

- the establishment, support and strategic use of the Health Workers for All Coalition (HW4All), including measures to ensure that the coalition is sustainable;
- national and global barriers that hinder investment in HRH in countries with a critical shortage of health workers;
- critical issues regarding health workforce mobility and migration, including gender-based issues.

3. ADVOCACY

We will implement an advocacy plan targeting governments and regional and global institutions for the effective implementation of SDG Target 3C:

- Global advocacy: working through the HW4All Coalition and other global networks, we will call upon global actors to implement strategies, policies and frameworks, in particular the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) and the Global Strategy on Human Resources for Health: Workforce 2030 (2016), and the five-year action plan (2017) for financially supporting health workers (push factors) and mobility and migration (pull factors);
- National advocacy: working together with CSOs, we will translate global strategies, policies and frameworks into national contexts.

The Health Workers for All Coalition (HW4All) represents global, regional and



local groups of CSOs, academic institutions, and professional health workers' associations and unions. The coalition advocates access to health workers for all in order to exercise the right to health and achieve universal health coverage.



Access to medicines

OUR FOCUS

The current system of medicines development lacks fair pricing, based on transparent Research & development (R&D) costs, as well as rules on fair intellectual property rights and responsible licensing; there are no conditions attached to licences on medicines that are developed with public money in terms of access and affordability. At the same time, a growing number of drugs are marketed at extremely high prices. This trend compromises the right to health and equal opportunities for leading a healthy life and undermines the financial sustainability of the health system.

A growing number of drugs are marketed at extremely high prices

CHANGE NEEDED

- ▶ The Dutch government should develop and propose more stringent legislation to create fair pricing models for medicines, and adopt requirements for transparency in pricing and cost at both national and EU levels. Alternative business models for the financing of R&D in relation to drugs should be developed and promoted.
- ▶ In order to guarantee the availability and accessibility of medicines, the Dutch government should set conditions regulating the way in which universities and other institutions use public funding for medical research and development; these should include conditions for the transfer of knowledge and intellectual property to the commercial sector.
- ▶ Dutch policy-makers should have the political will to counteract the pharmaceutical industry lobby and check the undue influence exerted by the pharmaceutical industry over decisions taken by the Dutch government, the Dutch Medicines Evaluation Board and the European Medicines Agency (EMA).
- ▶ In order to inform decision-making procedures, the EMA should fully disclose all elements related to the development of medicines, including sources of funding and data on clinical trials.

OVERALL GOAL FOR ACCESS TO MEDICINES

Everyone, everywhere should have access to high-quality, affordable medicines that meet their medical needs.



How are we planning to push for these changes?

1. EVIDENCE-BUILDING

We will analyse key issues and collect evidence on:

- developments in Dutch drug policy, including the Dutch position on EU policy;
- the policies pursued by and the operation of the EMA and national drug regulators;
- the use of Dutch public funds for research and development in relation to high-priced medicines;
- funding mechanisms for drug development and alternative business models;
- the impact of the pharmaceutical industry and the undue influence it exerts over public policy-making, for example by the Dutch Medicines Evaluation Board and the EMA;
- alternative business models for R&D of medicines.

2. COALITION-BUILDING

We will develop joint advocacy positions and strategies with our CSO partners, including solutions for the following issues:

- as a founder member, and the current coordinator, of the Dutch Medicines Network, we will seek to achieve alignment with the European Alliance for Responsible R&D and Affordable Medicines. We will agree on alternative business models based on fair pricing principles, standards of transparency in relation to the cost and pricing of medicines, more effective and efficient drug assessment procedures,

and the collection of data on conflicts of interests at the EMA and national medicine regulators;

- working together with the European Alliance for Responsible R&D and Affordable Medicines, we will share experiences in order to align advocacy strategies and produce shared messages.

3. ADVOCACY

We will lobby the Dutch government and Dutch Members of Parliament and Dutch Members of European Parliament for:

- more stringent legislation to create fair pricing models for medicines both within the Netherlands and throughout the EU, including regulations on the way in which universities use public funding for medical R&D;
- the independence of the Dutch Medicines Evaluation Board and the EMA.



Colophon

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For an extended version of Wemos' Strategy for 2019-2023, including notes,
see [www.wemos.nl/en/What's new](http://www.wemos.nl/en/What's_new) > Publications

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