



Rethinking Global Health

Report of a Chatham House Conference
held on 10–11 March 2009



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Contents

Preface	iv
Executive Summary and Key Recommendations	v
The Sessions	
1. Leadership and power in the global health agenda	1
2. Health and stability in nations disrupted by conflict	4
3. Migration and global health	6
4. Pandemics and emerging infectious diseases	9
5. Counterfeit medicines and health security	11
6. Climate change and the global health agenda	14
7. The financial crisis and global health	16
8. Maintaining commitments in global health in a time of challenge	18
Annex: Conference Panellists	20

Preface

This report draws together the main themes and ideas which were raised during the course of the conference on 'Rethinking Global Health' which Chatham House hosted on 10–11 March 2009. As such, it is one of the first published products of the Chatham House Centre on Global Health Security, which was established at the institute during the course of 2009.

The establishment of the Centre reflects the fact that matters of individual and collective health security are increasingly interlinked with other, broader aspects of international affairs. The global impacts of health pandemics, the rise in counterfeit medicines, the role of health provision in post-conflict environments and the centrality of effective healthcare to economic development are all examples of the growing intersection between health issues and other dimensions of international prosperity and security. These topics will now form a central part of the Chatham House research and policy agenda.

I wish to express my thanks to the Department of Health for its generous support in enabling us to establish the Centre on Global Health Security and host this conference. Drawing on their contributions to the Department's September 2008 'Health is Global: A UK Government Strategy', Sarah Hendry and Nick Banatvala at the Department offered great counsel as we sought to define the parameters of our future work in this area. I also want to thank the Pharmaceutical Research and Manufacturers of America (PhRMA) for their co-sponsorship of the March conference and publication of this report.

A special word of thanks is due to Zuzana Feachem at Chatham House, who has sustained the institute's interest in matters relating to global health through the vehicle of successive conferences over the past five years and who pulled together a superb programme for this event. She has also been a key figure within the institute in the launch of the new Centre. I would also like to recognize Nancy Mattison and Jeff Sturchio, who served as the conference rapporteurs and pulled together the multiple strands of the conference findings into this report, and Margaret May who edited and prepared the document for publication.

Finally, I am delighted that the Centre on Global Health Security will benefit from the leadership and deep experience of David Heymann over the coming years. Having become Head of the Centre and one of our Senior Fellows in July 2009 following a distinguished career at the World Health Organization in Geneva, David brings a detailed knowledge of both the medical and policy worlds whose inputs must be combined if we are to develop effective ideas to improve levels of global health security in the future.

Dr Robin Niblett

Director

October 2009

Executive Summary and Key Recommendations

The purpose of the conference on 'Rethinking Global Health: Political and Practical Challenges from Foreign and Security Policy', held on 10–11 March 2009 at Chatham House, was to review a wide range of issues which are important for consideration at the health security and foreign policy interface, thus falling within the realm of the Centre on Global Health Security being established at Chatham House. Some issues were broad, such as leadership and power in global health diplomacy and the impact of climate change. Others were more focused, such as building health systems in countries in conflict, preparing for pandemics or combating counterfeit medicines. The sessions produced a number of conclusions and recommendations for action and further research; these are set out in the overview of each session's discussion and summarized below.

It is clear that as globalization shrinks the world, the interdependence of global health issues is becoming important in both foreign and security policy. Nevertheless too little is known about how to integrate global health into foreign and security policy in ways that ensure both success and continuity. An even stronger evidence base needs to be created to demonstrate, for example, the essential ties between healthy populations, economic well-being and political stability. Such a database will strengthen the ongoing dialogue between the global health community and its counterparts in the foreign and security policy communities.

Key Recommendations from the Sessions

1. Leadership and Power in the Global Health Agenda

The global health agenda is entering a new and complex phase. The focus has gone beyond prevention and control of infectious diseases such as AIDS, malaria, influenza and tuberculosis to more strongly address very basic issues of how health affects development and security. At the same time, direction, and in some cases funding, appears to be shifting towards multilateral organizations where influence remains primarily in the hands of nation-states.

This shifting landscape requires new research and relationships, including:

1. **Better research to understand and shape the movement towards multilateralism** in global health, including innovative options for revitalizing and sustaining multilateral bodies such as the World Health Organization and the World Bank.
2. **Better research on when and how to measure the results** of specific health programmes in terms that are better understood by foreign policy and security communities in order to clearly demonstrate progress and encourage continued funding.
3. The initiation of **in-depth dialogue and continuing interaction between the global health community and the foreign policy and security communities** in order to make clear the interdependence of health and economic stability.

2. Health and Stability in Nations Disrupted by Conflict

The connection between health and security is particularly clear in times of armed conflict. The appropriate role of military health services from developed countries, when present, is somewhat less clear. Often, however, they are critical in both providing local health services and building or rebuilding health infrastructure. Three important issues that merit further debate and research are:

1. How best to establish a **central point of strategic leadership** for efforts to build or rebuild health systems after the withdrawal of military forces.
2. How to achieve the best balance between public health and treatment capacity in **the activities of military health services** during the transition period between cessation of combat and full withdrawal.
3. What **type of medical training is appropriate for citizens** in countries of conflict to ensure that training fits near-term needs and encourages medical professionals to remain in the country.

3. Migration and Global Health

The impact of migration on global health is growing and complex. Migration can greatly burden the capacity of countries to deal with health problems of their own populations as well as those of migrants, affect entire populations through the spread of infectious diseases, and alter the health status of individuals. It continues to be a volatile national and international political issue, which further complicates efforts to deal with its potential health effects. Responding to the global health implication of migration requires a variety of actions, including:

1. Approaches for providing greater support and a more active role for NGOs that are among the only organizations that can **reach illegal immigrants**.
2. How to encourage those bilateral and multilateral **trade agreements that include provisions for migration to also include (a) explicit commitments to ensuring access to health care and (b) improving adherence to existing international agreements**, for example, about the use of antimicrobials.
3. **Examining the push and pull factors** that produce emigration of medical personnel from less developed countries.

4. Pandemics and Emerging Infectious Diseases

Progress in preparedness for a pandemic has been substantial in recent years, and much remains to be done. Knowledge and measures are imperfect in several areas, providing an urgent agenda for debate and action, including the following:

1. **Approaches for detecting and responding to pandemics, and for mobilizing resources**, keeping the very real prospect of an influenza or other pandemic in sight, perhaps by including discussion of it with other major issues that **require a continuous, structured international approach**, such as climate change.
2. How best to improve surveillance at the human/animal interface, with specific emphasis on **animal surveillance and preventing the spread of infectious organisms from animals to humans**, keeping in mind the economic interests of animal husbandry and of hunting/meat preparation practices in rural parts of developing countries.
3. Research and international discussions that fully explore how to ensure that all countries are motivated to cooperate fully with international requirements for surveillance and risk assessment and risk management including **sharing of information** and, when required, **biological specimens**.

5. Counterfeit Medicines and Health Security

Counterfeiting of both brand and generic drugs is a growing and insidious threat to personal and public health worldwide. Counterfeiters most often target developing countries, where it is estimated that as much as 30 per cent of medicines are likely to be counterfeit – including those to treat AIDS, malaria and tuberculosis. Successful measures to combat this problem globally require a wide range of efforts, including the following:

1. Assessing the many **international definitions of counterfeit medicine** as a basis for coordinating and strengthening laws and enforcement.
2. Ensuring effective and continuous **communication to patients and health care professionals** about the dangers of counterfeit medicines and how to help combat them.
3. **Assessing possible mechanisms to ensure better global and regional collaboration** in the developing world to maximize the impact of available resources to combat counterfeiting.

6. Climate Change and the Global Health Agenda

Climate change has emerged as a critical global issue. Its consequences potentially affect health, and key actions that should be spearheaded by the global health community include the following:

1. More **robust, multi-disciplinary research** on the complex interactions between climate, public health and disease.
2. Assessing plans for dealing with and **mitigating the impact of climate change** in economic development programmes and foreign assistance to developing countries.
3. **Developing stronger databases** that permit clear understanding of the importance of health as an integral part of discussions and debates on climate change.

7. The Financial Crisis and Global Health

Today's financial crisis threatens the health status of individuals and populations. It also provides important new opportunities for positive change, however, by calling into question traditional approaches and requiring ingenuity in meeting new and lasting challenges. The health community can contribute by encouraging and participating in the following:

1. Replacing GDP and similar economic indexes with a new measure, a '**global health progress index**', that integrates economic, social, environmental and health aspects.
2. Creating a **more systematic and organized process** for providing health and development assistance, from both private and public sources. Needs assessments would be completed for recipient countries and agreements reached on how best to demonstrate the effectiveness and value of programmes funded.
3. **Increasing self-reliance in recipient countries**, in both economic development and health, by directly empowering local communities under manageable, smaller programmes that include a strong local partnership approach to sustainable funding.
4. In order to safeguard health funding, broadening target audiences to go beyond the health area to **reach spending decision-makers**; expanding arguments to make explicit the strong ties between healthy populations and economic well-being.

8. Maintaining Commitments in Global Health in a Time of Challenge

The global financial crisis will inevitably have an impact on the funding, focus and shape of global

health programmes. Among the important steps in adjusting to this new milieu are the following:

1. Exploring and clarifying **how meeting basic health needs contributes to development and economic stability** as one argument for continued funding at appropriate levels.
2. Assessing **measures of progress at the country level** to evaluate and guide global health programmes and support continued funding.
3. Proposing mechanisms that ensure **involvement of recipient countries more fully** in the design, implementation and assessment of programmes and **expanded public-private partnerships**.
4. Ensuring the **integration of global health into foreign and security policy** by capturing and maintaining the attention of policy-makers and thought leaders in those fields, and building an evidence base that illuminates the connections.

1 Leadership and Power in the Global Health Agenda

The global health agenda is entering a new and complex phase. The focus has gone beyond prevention and control of infectious diseases such as AIDS, malaria, influenza and tuberculosis to more strongly address very basic issues of how health affects development and security. At the same time, direction, and in some cases funding, appears to be shifting towards multilateral organizations where influence remains primarily in the hands of nation-states.

This shifting landscape requires new research and relationships, including:

1. **Better research to understand and shape the movement towards multilateralism** in global health, including innovative options for revitalizing and sustaining multilateral bodies such as the World Health Organization and the World Bank.
2. **Better research on when and how to measure the results** of specific health programmes in terms that are better understood by foreign policy and security communities in order to clearly demonstrate progress and encourage continued funding.
3. The initiation of **in-depth dialogue and continuing interaction** between the global health community and **the foreign policy and security communities in order to** make clear the interdependence of health and economic stability.

Over the past decade, awareness of global health interdependence has prompted major donor countries to explicitly recognize the connections between global health and security. This is a prime motivation for the United Kingdom's 2008–13 Health is Global strategy. Similarly, the European Union's 2007 Reform Treaty reinforces the political importance of health and specifically ties global health to security. Strengthening involvement in global health is one of the four core principles in the EU's first five-year Health Strategy.¹

At the global level, Japan has taken the lead in developing the G8's leadership in critical global health issues. The policy recommendations developed following the G8 Hokkaido Toyako Summit explicitly recognize that the agenda for global health intersects with foreign policy and economic development.² They propose a 'people-centred' approach to global health that highlights the importance of both national security and 'human security', defined as 'the protection of "the vital core of all human lives in ways that enhance human freedoms and human fulfilment"'.³ A critical component of human security is health system strengthening, a far broader perspective than the disease-specific focus that was dominant in the 1990s and early years of this decade. The policy recommendations also include elements of accountability as well as collaboration among public and private international organizations and national institutions in both donor and recipient countries.⁴ Realistically, the report also recognizes that the global financial

1 Commission of the European Communities, 'Together for Health: A Strategic Approach for the EU 2008–2013', White Paper COMM (2007), 23 October 2007.

2 Task Force on Global Action for Health System Strengthening, *Global Action for Health System Strengthening: Policy Recommendations to the G8*, Japan Center for International Exchange, Tokyo, 2009, p. 16.

3 Ibid.

4 Ibid., p. 21.

crisis could result in a pull-back of financial support, as has occurred in earlier periods of economic uncertainty.

As the January 2009 Council on Foreign Relations report so aptly points out, today's critical players include not only the traditional nation-state and international organization actors, but also transnational civil society movements and the for-profit private sector. Meeting the challenge of global health now requires 'multi-actor governance relationships, building on proven public-private partnerships'.⁵

The milieu that shapes the global health agenda and affects the success of programmes continues to evolve. Early programmes were defined primarily by donor countries as part of broader economic development or humanitarian aid policies. With the relentless and devastating spread of HIV/AIDS in the 1990s, however, a period of ebullient expansion in global health policy began. For the most part, the focus was narrow, addressing the widespread diseases deemed particularly damaging: HIV/AIDS, malaria and tuberculosis.

Pluralism characterized this period of activity: HIV/AIDS activism gave rise to a range of NGOs dedicated to global health. Major new, highly ambitious private international donor organizations appeared, such as the Global Fund, the Gates Foundation and the Global Alliance for Vaccines and Immunization (GAVI). The commercial private sector became more active, both in improving the health of the communities where it had operations and, for the health industries, in global health programmes. Public-private partnerships developed and involved a fluid mix of actors. Leading donor countries made aspects of global health a top priority, one example from the United States being the President's Emergency Plan for AIDS Relief (PEPFAR) programme.

The public-private partnerships that became a key feature of the global health landscape during this period provided critical lessons about what is required for success in all global health programmes. A lasting, positive impact requires:

- partners with complementary resources and skills;
- shared, clearly stated goals; agreed and well-defined roles for each participant;
- a framework of collaboration that is adapted to the local culture and needs;
- local ownership and involvement in programme implementation;
- objectives focused on building infrastructure and capacity (facilities) rather than only providing capital;
- multi-sectoral involvement, including all relevant ministries and agencies; and
- results that are measurable and measured.

Although tremendous strides were made, the effect of pluralism on global health progress was not always positive. For example, a central feature of this period that continues today is the absence of effective coordination at both the international and national levels. As a result, recipient countries are sometimes overwhelmed by the number of programmes on offer, the variety of organizations active and the complexity of coordinating activity locally. Competition at the international and national levels among programmes for funding, influence and achievement also detracts from progress.

Today, multilateralism is eclipsing pluralism in the area of global health. A combination of factors is contributing to this shift. First, the 'honour system' of voluntary action to fulfil global health needs has not been as successful as many had hoped. Some consider that funnelling global health projects through multilateral organizations offers a greater degree of accountability.

Second, although the full extent of its impact is not yet clear, the worldwide economic crisis is already diverting attention and financing away from global health issues. Major donor countries still expect to meet current commitments and obligations, although nothing is certain. The demands of the crisis, moreover, are likely to distract enough to create a leadership void in setting the global health agenda that,

5 Laurie A. Garrett, *The Future of Foreign Assistance Amid Global Economic and Financial Crisis: Advancing Global Health in the U.S. Development Agenda*, Council on Foreign Relations, New York, January 2009, p. 28.

by default, will be filled by multilateral organizations. Such disengagement is further encouraged by the declining ability of HIV/AIDS issues to serve as a catalyst or rallying point and to focus attention on the urgency of global health issues.

The impact of these trends is evident in the United States, for example, where the sense of urgency has waned as budgets have shrunk. Although policy details are as yet undefined in the new administration, it is clear that the perspective is broader and now includes, for example, sanitation, water quality, child and maternal health, and family planning.

A third factor in the shift to multilateralism is the emerging influence of a group of countries roughly classified as 'newly industrialized countries' (NICs), including, for example, Brazil, India, Indonesia, Senegal and Thailand. These countries gained considerable experience and skill in the battles over access to care and treatment that surrounded efforts to combat HIV/AIDS in the last two decades. This has created a strong sense of interdependence within the group and a keen awareness of its growing potential power in setting global agendas – and not only in health.

The global health milieu in the near term

The shift to multilateralism, combined with the deep, uncertain and rapidly evolving financial crisis, has far-reaching implications that will affect both who sets the global health agenda and how this will be done. Multilateral organizations, by and large, are not designed to be pluralistic. NGOs, private donor organizations, other private-sector players and regional organizations (such as the European Union) have no formal standing in them. Such participation is thus not guaranteed and in some instances may be resisted. Although these players will still influence the agenda, none is likely to have as great an impact as before.

The financial crisis and related concerns may force the developed donor countries to disengage enough from serious involvement in multilateral organizations to allow the NICs to overshadow other nation-states. This includes even those countries most in need of health aid, many of which have missed opportunities to influence the agenda by being inconsistent and tentative in expressing needs. The agenda may be further skewed if the NICs continue to sidetrack global health discussions by using them as bridges to other, largely unrelated issues. At times, moreover, progress may be delayed by power struggles that surface as disagreement over which multilateral organization is the appropriate forum for debates, policy-making and implementation.

The current shift in leadership and locus of power carries serious dangers. Careful and purposeful priority-setting and coordinated programmes are even more critical in the face of the current international financial crisis, which will constrain resources for global health for years to come. The implications are potentially dire for the health of populations not only in the neediest nations, but throughout the world. Ultimately, serious issues of global political security are involved. Increases in poverty and malnutrition can lead to dangerous political insecurity and instability. At the worst, deterioration in global health provides opportunities and excuses for open conflict; at best, it threatens economic development and capacity-building.

2 Health and Stability in Nations Disrupted by Conflict

The connection between health and security is particularly clear in times of armed conflict. The appropriate role of military health services from developed countries, when present, is somewhat less clear. Often, however, they are critical in both providing local health services and building or rebuilding health infrastructure. Three important issues that merit further debate and research are:

1. How best to establish a **central point of strategic leadership** for efforts to build or rebuild health systems after the withdrawal of military forces.
2. How to achieve the best balance between public health and treatment capacity **in the activities of military health services** during the transition period between cessation of combat and full withdrawal.
3. What **type of medical training is appropriate for citizens** in countries of conflict to ensure that training fits near-term needs and encourages medical professionals to remain in the country.

Health, political stability and human security are interdependent. Too often, access to health care is the first victim of armed combat, as in Afghanistan, Iraq or Gaza, or of civil disorder and failed governance, as in Somalia, the Democratic Republic of Congo or Zimbabwe. Political instability short of armed combat is more likely in countries where access to care is poor and population health thereby suffers. A functioning and sustainable health care system is one essential element in helping break cycles of conflict.

The involvement in combat areas of military forces from countries with modern health systems raises questions about the appropriate role of such forces in local health care. The health services attached to the military are primarily intended to serve their own armed forces. However, this inevitably has an impact on local health status. For example, protecting the troops may include measures to lessen the prevalence and spread of contagious diseases as well as surveillance to provide early warning of natural or man-made outbreaks of disease. The health of the local population is likely to be positively affected as a result.

Health also has a strategic element. Providing access to care engenders trust, something that extremist groups such as Hezbollah and Hamas have used to their advantage. Health services provided by coalition forces in Iraq and Afghanistan have been a positive force in building goodwill and political capital.

Disagreement continues over the appropriate role of the military in providing care and building infrastructure in conflict situations. Those who favour minimal or no involvement argue that the military is not neutral, but is an instrument of political power; lacks the knowledge and experience to meet the needs of the local population; can damage the local infrastructure; and may end its mission before important projects are completed.

Others argue that the role of the military health services fills a void by providing at least some health care for local populations until civilian organizations can take over. In Afghanistan, this has been so extensive at times that civilian needs have competed with those of coalition forces. The military is also rich in logistical support and can deliver care in difficult situations; it provides training for locals as medics; and its personnel are natural bridge-builders with local military and civilian stakeholders in

the health sector, helping create a better understanding of local needs and capabilities. In some cases, as in Helmand Province in Afghanistan, it may help rebuild infrastructure – hospitals in this case – and provide both a minimum income and marketable skills for at least some locals.

Building infrastructure and capacity

Military health services from outside may be invaluable in helping create a functioning and sustainable health care system for countries in conflict. What this requires varies, depending in part on what was in place before the conflict. Rebuilding in countries that had a modern, well-functioning health care system before hostilities, as in Western Europe after the Second World War, is far simpler than in Afghanistan, for example, which did not. Iraq falls closer to the middle of the spectrum; it once had had a modern system, although this had deteriorated in the years before the war.

Efforts to improve capacity over the longer term must take careful account of the local situation. In countries such as Afghanistan, for example, sending citizens to affluent countries to learn the latest in high-tech, modern medicine may be counterproductive. Such training will not fit near-term Afghani needs and the newly trained may choose not to return to Afghanistan. In Iraq, by contrast, where the health system is relatively more robust, physicians have been returning at the rate of 25 per week as stability has increased. More debate and research are needed, however, about just what type of training is best for medical professionals in countries enduring or just emerging from conflict.

Building capacity in health will proceed slowly, if at all, in times of actual conflict. Success depends in part on the sufficiency of other infrastructure – for example, roads, electricity, water and sanitation. Moreover, the deployment of military health services is determined by military strategy, not by local health needs. As the conflict winds down, military assistance in health needs to be strategic, based on priorities and plans that ensure the smoothest possible transition after military withdrawal. More research is needed on priorities during this transition phase of engagement, particularly the relative emphasis on building public health infrastructure versus treatment capacity.

Achieving the objective of building a sustainable health infrastructure requires an appropriate degree and type of involvement from a range of actors. In addition to the military and local authorities, various other actors from within and outside the country may be involved – multilateral bodies, humanitarian organizations and a range of NGOs. One central point of strategic leadership is essential to coordinating a comprehensive development plan and identifying and selecting potential partners. Where that leadership should lie is not necessarily clear, although at a minimum the local legitimate government should be a partner in working towards an agreed strategy. Civilian leadership is desirable, but may be unworkable in situations where the government lacks legitimacy or competency, or where ethnic tensions endanger cooperation. Leadership in the health area then might best be taken by other actors – multilateral bodies, outside states, NGOs or an umbrella organization. This is a critical issue that needs further debate and research.

3 Migration and Global Health

The impact of migration on global health is growing and complex. Migration can greatly burden the capacity of countries to deal with health problems of their own populations as well as those of migrants, affect entire populations through the spread of infectious diseases, and alter the health status of individuals. It continues to be a volatile national and international political issue, which further complicates efforts to deal with its potential health effects. Responding to the global health implication of migration requires a variety of actions, including:

1. Approaches for providing greater support and a more active role for NGOs that are among the only organizations that can **reach illegal immigrants**.
2. Finding ways to encourage those bilateral and multilateral **trade agreements that include provisions for migration to also include (a) explicit commitments to ensuring access to health care and (b) improved adherence to existing international agreements**, for example, about the use of antimicrobials.
3. **Examining the push and pull factors** that produce emigration of medical personnel from less developed countries.

Health capacity migrates in two principal ways. First, the migration of health workers – physicians, nurses and others – adds to capacity in the recipient state while potentially lessening capacity in the country of origin. International migration of health workers is substantial, both from developing to developed countries and among developed countries. Estimates are that approximately one-third of UK physicians and one-fifth of Canadian, Australian and US physicians are of foreign origin. The proportion of nurses from abroad in these countries is even higher.⁶

One innovative programme that allows the developing country to benefit from health professionals employed abroad is the MIDA (Migration for Development in Africa) Health Programme, funded by the Netherlands and involving Ghana, Germany, the Netherlands and the United Kingdom. Ghanaian health professionals working outside that country are encouraged to return temporarily, allowing them to serve internships in health institutions in the Netherlands.

Second, health capacity migrates when patients travel abroad for treatment. ‘Health tourism’ is a growing industry that can supplement capacity in the source country, create income for the destination country and, in some cases, increase health capacity there as well. Roughly four million patients travel for treatment each year. The size of the global market is about \$20–40 billion now and projected to exceed \$100 billion by 2012.⁷ Reasons for health tourism include insufficient capacity in countries of origin and cheaper equivalent services in destination countries. Some countries, such as Dubai and Singapore, are developing capacity targeted specifically at health tourists. As yet, most movement is regional and paid for privately by individuals. Some health services and private insurers, however, are experimenting with sending patients abroad for treatment.

⁶ Richard D. Smith, Rupa Chanda, Viroj Tangcharoensathien, ‘Trade in health-related services’, *Lancet*, published online 22 January 2009, p. 33.

⁷ *Ibid.*, p. 31.

Migration and individual health status

The migration of individuals may be legal or illegal, voluntary or involuntary, temporary or longer-term. The International Organization for Migration estimates that there are more than 200 million migrants in the world today, roughly three per cent of the global population.⁸ Those who cross borders voluntarily are a diverse group, including job-seekers, businessmen, students, tourists, and refugees and asylum-seekers. The ultimate health effects of such movements are mixed. Individuals who migrate legally for employment often are healthier, in part because of destination country immigration laws. Once resettled, however, immigrants may encounter cultural and language barriers or discrimination in access to care. Those who return to visit their countries of origin also may transport diseases, on departure or return. In addition, as countries have made the immigration of families more difficult, children may be left behind and suffer a decline in health status.

Clandestine immigration – whether voluntary or as the result of human trafficking – is a serious and growing threat to global health. Although the current downturn in developed economies may discourage some movement, it is only temporary and the developing countries are still worse off. Millions of individuals will continue to migrate illegally each year. Estimates are that the United States alone now hosts at least 12 million illegal immigrants⁹ and the European Union at least eight million,¹⁰ although all such estimates are notoriously unreliable and likely to be low.

The nature of clandestine migration may mean that the migrant spends three to four years in transit to the destination country, travelling through several countries – with exposure to different diseases – on the way. Living conditions both on the journey and at the destination may be poor, lowering resistance and increasing susceptibility to diseases such as tuberculosis. Once the trip is completed, the illegal migrant must remain officially invisible. This not only makes health care difficult to access, but also means that important epidemiologic data are not collected. Even worse is the situation of victims of human trafficking. Estimated at up to four million individuals each year, 80 per cent of them female, these people are even less likely to have access to care and are particularly vulnerable to sexually transmitted diseases, HIV/AIDS and tuberculosis.

Tourism has increased at a rapid rate in the past two decades, with virtually every corner of the world a potential destination. Although this movement can be shut off relatively effectively in acute situations, as with SARS, the sheer number of travellers makes consistent health monitoring virtually impossible. According to the UN World Tourism Organization, international tourist arrivals in 2008 reached 924 million, with 1.6 billion forecast by 2020.¹¹

The migration of disease

Infectious disease transfer most often requires the movement of individuals, although some may migrate via other vectors, particularly food and animals. Control involves measures to forecast and contain a disease outbreak as well as temporarily prohibiting travel to and from an affected region. SARS is a recent example of a successful international attempt to contain the spread of a new disease; HIV/AIDS is an example of the near impossibility of preventing devastating migration of an established one. The threat of disease migration is increasing with the development of drug-resistant organisms that increase the pool of potentially transmittable diseases.

Meeting the challenge

No central point of coordination for this tremendous challenge exists at the global level. The international regulation or coordination that does occur is piecemeal, usually addressing one aspect of movement at a time. Some existing international agreements are very specific and critical to global health – the 2005

8 IOM, Global Estimates and Trends, <http://www.iom.int/jahia/Jahia/about-migration/facts-and-figures/global-estimates-and-trends>.

9 Jeffrey Passel and D'Vera Cohn, *Trends in Unauthorized Immigration: Undocumented Inflow Now Trails Legal Inflow*, Pew Research Center, 2 October 2008, <http://pewhispanic.org/reports/report.php?ReportID=94>.

10 European Union, Immigration – Return of Illegal Immigrants Directive, Global Legal Monitor, Law Library, The Library of Congress (US), http://www.loc.gov/lawweb/servlet/lloc_news?disp3_525_text.

11 UN World Tourism Organization website, <http://www.unwto.org/index.php>.

International Health Regulations are an example. Others are important but poorly implemented – for example, standards and frameworks aimed at minimizing antimicrobial resistance. With respect to much cross-border human migration, however, health ramifications are addressed inadequately, if at all.

The political volatility of migration inhibits the development of a global regime that would integrate efforts across and within the three aspects of cross-border movement. This is unlikely to change in the foreseeable future. Efforts to moderate the negative effects of migration on global health, however, can and should be undertaken with all due speed.

4 Pandemics and Emerging Diseases

Progress in preparedness for a pandemic has been substantial in recent years, and much remains to be done. Knowledge and measures are imperfect in several areas, providing an urgent agenda for debate and action, including the following:

1. Approaches for detecting and responding to pandemics, and for mobilizing resources, keeping the very real prospect of an influenza or other pandemic in sight, perhaps by including discussion of it with other major issues that require a continuous, structured international approach, such as climate change.
2. How best to improve surveillance at the human/animal interface, with specific emphasis on **animal surveillance, prevention and control**, keeping in mind the economic interests of animal husbandry and of hunting/meat preparation practices in rural parts of developing countries.
3. Research and international discussions that fully explore how to ensure that all countries are motivated to cooperate fully with international requirements for surveillance and risk assessment and risk management including **sharing of information and, when required, biological specimens**.

Despite a waning public sense of urgency, the world remains at risk of an influenza pandemic.¹² The HPAI virus¹³ continues to be the most immediate known threat, specifically H5N1, but other novel influenza viruses continue to circulate as well. H5N1 is now at Phase 3 of the World Health Organization's six-level pandemic rating, and the virus meets all the criteria of a high-mortality pandemic except efficient human-to-human transmission. The disease has been reported in more than 60 countries, compared with just 17 at the end of 2005. Entrenched in parts of Asia and Africa, H5 evolves constantly; some strains now show signs of resistance to antiviral drugs, the first line of defence in the event an outbreak. But other novel influenza viruses are also circulating, and in addition to the threat from H5N1, any one of them could develop the capacity to cause a pandemic.

Should a high-mortality pandemic occur, the cost to the global economy is estimated at more than \$3 trillion. Although roughly \$2 trillion of this would affect developed economies, developing countries would bear the heaviest impact in terms of mortality and losses in GDP. While 12 per cent of the total cost would be due to mortality and 28 per cent to illness and absenteeism, as much as 60 per cent would be attributable to reactions to the pandemic, such as reduced travel and avoidance behaviours. Recovery would take years.

Projections of impact are dire despite the great strides that have been made in preparedness. The revised 2005 International Health Regulations, for example, provide an important framework for a pandemic and for other public health crises. A 2008 report by the UN System Influenza Coordinator and the World Bank showed that 95 per cent of countries surveyed have a pandemic plan in place,¹⁴ although these vary considerably in quality and few have been fully operationalized. SARS showed that the world is willing to work together; even those countries harmed by the measures taken were cooperative. Whether the resolve would hold in the event of the rapid spread of a deadly virus is less certain.

12 This conference took place before the swine flu outbreak. However, the rapid decline in popular and political anxiety within one month of its detection confirms the concerns raised in this conference panel.

13 Highly pathogenic avian influenza.

14 UN System Influenza Coordinator and the World Bank, *Fourth Global Progress Report: Responses to Avian Influenza and State of Pandemic Readiness*, October 2008.

Capacity within the pharmaceutical industry to produce vaccines has tripled over the past two to three years. Vaccines based on various strains of H5N1 are constantly being developed and could mitigate the impact of an initial outbreak. Developing a vaccine to address the actual pandemic virus, however, will take an estimated minimum of 12 to 16 weeks owing to both scientific limitations and production requirements. Since most vaccines manufacture takes place in a few developed countries, some concerns remain about equitable access to them should a virulent virus quickly span the globe. The fear is that supply countries might decide to limit the export of vaccines in short supply.

Elements of effective preparedness

A comprehensive, global, multi-sectoral plan is essential and must incorporate all aspects of society – social, political and economic. Government agencies and civil society at all levels, down to the individual, need to be active. Particularly critical will be public information that can encourage appropriate behaviour and avoid panic. Globalization and virtually instant communication by cellular phones and the Internet may be a mixed blessing: important information can be disseminated rapidly, but message content will be very difficult to control.

At least as important as preparedness for disaster are effective measures that can forewarn or forestall it. In particular, this requires vigilance in the animal sector, entailing constant screening of both domestic and wild animals for potentially transmissible diseases.

Current weaknesses

The ability to accurately identify a potential pandemic *before* it occurs is obviously critical. At present, this is less than adequate in two respects: access to human virus specimens, and animal surveillance and control.

In 2007 several countries, including Indonesia, stopped sharing influenza virus isolates with the WHO global influenza surveillance network. This is of great concern, especially because avian viruses are enzootic in Indonesia, which had reported 114 of 256 human deaths as of 30 March 2009.¹⁵ Indonesia's decision to stop sharing viruses was based on its perception that the outside world would benefit more from having its virus samples than would Indonesia itself because access to antivirals and vaccines might not be ensured in a pandemic. In reality, should a pandemic originate, lack of access to Indonesia's influenza virus would not stop the development of vaccine based on virus strains provided from other countries, but if the pandemic virus developed in Indonesia, vaccines produced from strains originating in other countries could potentially be less effective.

Programmes are in place and others are being developed that fulfil the need for more equitable sharing of benefits as advocated by Indonesia. For example, leasing agreements already allow local production of some antiviral drugs in developing countries; technology transfer programmes are in progress, intended to build capacity for vaccine production in developing countries; and buying plans already allow developing countries to reserve access to vaccines and pay prices pegged to their GDP.

Experts agree that a pandemic – be it influenza or another type of highly contagious disease – will most likely start as a cross from animals to humans. Surveillance and control of animals is therefore an absolutely essential component of forecasting and preventing an outbreak. Many countries cooperate in sharing animal viruses, but animal health services in many countries lack the capacity to monitor effectively and take the necessary steps. Issues other than capacity are also involved. Cultural and economic sensitivity is essential in convincing animal owners to agree to vaccination, report sick animals and/or destroy animals that may carry a virus. Particularly in developing countries, the animal–human relationship is culturally complex. Financial compensation alone may not be enough to ensure effective action.

15 http://www.who.int/csr/disease/avian_influenza/country/cases_table_2009_03_30/en/index.html.

5 Counterfeit Medicines and Health Security

Counterfeiting of both brand and generic drugs is a growing and insidious threat to personal and public health worldwide. Counterfeiters most often target developing countries, where it is estimated that up to 30 per cent of medicines are likely to be counterfeit – including those to treat AIDS, malaria and tuberculosis. Successful measures to combat this problem globally require a wide range of efforts, including the following:

1. Assessing the many **international definitions of counterfeit medicine** as a basis for coordinating and strengthening laws and enforcement.
2. Ensuring effective and continuous **communication to patients and health care professionals** about the dangers of counterfeit medicines and how to help combat them.
3. **Assessing possible mechanisms to ensure better global and regional collaboration** in the developing world to maximize the impact of available resources to combat counterfeiting.

Counterfeiting of both brand and generic drugs is a growing and insidious threat to both personal and public health worldwide. The World Health Organization defines a counterfeit medicine as ‘a medicine, which is deliberately and fraudulently mislabelled with respect to identity and/or source. Counterfeiting can apply to both branded and generic products and counterfeit products may include products with the correct ingredients or with the wrong ingredients, without active ingredients, with insufficient active ingredients or with fake packaging’.¹⁶ Bulk ingredients used to make medicines also may be counterfeited. The sale of counterfeit medicines occurs in both the developing and the developed world. As of 2006, the WHO estimated that more than 30 per cent of the medicines on sale may be counterfeit in parts of Africa, Asia and Latin America, and 20 per cent in many of the former Soviet republics.¹⁷ An estimated 200,000 children die each year as a result. In the developed world, an estimated one per cent of medicines are counterfeit.

Several factors have made the counterfeit drug trade lucrative:

- it is much more profitable and far less risky than the sale of narcotics and other substances of abuse;
- legal and regulatory frameworks are insufficient, absent or corrupt in many developing countries;
- penalties are often minimal or altogether absent;
- differing laws across countries seriously complicate enforcement;
- patients may knowingly purchase cheaper counterfeits, believing them to be better than nothing;
- incentives along the supply chain for ignoring or encouraging counterfeits are greater than for stopping them.

Most counterfeit medicines in Africa arrive from India and China. Local efforts in those countries to spur economic development appear to override broader public health concerns at times by either allowing or encouraging the manufacture of counterfeit medicines. In developed countries, stronger regulatory

16 http://www.who.int/impact/impact_q-a/en/index.html.

17 World Health Organization, ‘Counterfeit Medicines,’ Fact Sheet 275, 14 November 2006.

frameworks, more sophisticated health systems and better informed patients mean that the problem is less pronounced, although it is increasing and also life-threatening.

Not surprisingly, the drugs most often counterfeited are those in greatest demand. Both generic drugs and those with unexpired patents are counterfeited. In the developing world, this includes the WHO 'essential drugs' and, particularly, treatments for HIV/AIDS, tuberculosis and malaria. In the developed countries, it includes medicines for the most prevalent life-threatening diseases, for example, those for lowering cholesterol, treating heart disease and diabetes, and combating cancer. Given the slow and unpredictable progression of many of these diseases, some may progress to the point where treatment is ineffective before either patient or health professional realizes that a useless counterfeit drug has been used.

Combating counterfeiting

Combating counterfeiting is possible, including in developing countries where the milieu is less than ideal. For example, in 2001 Nigeria undertook a determined campaign to address the problem of counterfeit medicines by raising public awareness and dramatically increasing surveillance. As a result, dozens of counterfeiters have been arrested and convicted, and this has driven many others out of the country. Part of the success story is an informed public that, once aware of the dangers, was instrumental in turning in both products and counterfeiters. The impact is evident in estimates that counterfeits accounted for around 16 per cent of the total market in 2006, down from as much as 40–70 per cent.¹⁸ A barrier to further progress is that it is not unusual for penalties to be light or even minimal, relative to the counterfeiter's potential gain: fines of US\$40–80, or between three months and five years in jail. Only about 20 per cent of WHO member states – all developed countries – have well-developed regulations against counterfeiting. Thirty per cent of the remaining countries have no drug regulatory system at all and 50 per cent vary in the extent and sophistication of regulation and implementation.¹⁹

In 2006, the WHO created the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), the first global initiative. All WHO member states participate voluntarily, joined by other global and regional intergovernmental bodies, law enforcement agencies, national drug regulatory authorities, customs and police organizations, NGOs, associations representing both brand and generic pharmaceutical manufacturers, associations of medicines wholesalers, health professionals and patients' groups. The goal of IMPACT is to reduce the trade in counterfeit medicines by building coordinated networks worldwide that will raise awareness, stimulate adoption and implementation of effective legislation, develop technical and administrative tools to support strategy and action at all levels, and encourage coordination of all efforts. Serious disagreement persists, however, over IMPACT's definition of counterfeit, which some claim raises intellectual property protection issues and endangers continued access to legitimate generics.²⁰ Much of the opposition has been led by India and Brazil, which have growing generic medicines industries. Although IMPACT has begun to develop and implement programmes, its ability to affect global counterfeiting may be hampered by lack of consensus on definition.

Actions required

Effectively combating counterfeiting worldwide requires actions at the local, national, regional and global level and somewhat different approaches in developing and developed countries. In developed countries,

18 World Health Organization, IMPACT, 'Counterfeit Medicines: Update on Estimates', 15 November 2006, www.who.int/medicines/services/counterfeit/impact/TheNewEstimatesCounterfeit.pdf.

19 World Health Organization, *Effective Drug Regulation: A Multicountry Study* (Geneva: World Health Organization, 2002), p. 11.

20 'The term counterfeit medical product describes a product with a false representation of its identity and/or source. This applies to the product, its container or other packaging or labelling information. Counterfeiting can apply to both branded and generic products. Counterfeits may include products with correct ingredients/components, with wrong ingredients/components, without active ingredients, with incorrect amounts of active ingredients, or with fake packaging. Violations or disputes concerning patents must not be confused with counterfeiting of medical products. Medical products (whether generic or branded) that are not authorized for marketing in a given country but authorized elsewhere are not considered counterfeit. Substandard batches or quality defects or non-compliance with Good Manufacturing Practices/Good Distribution Practices in legitimate and medical products must not be confused with counterfeiting.' See European Generic Medicines Association Press release, 8 December 2008, www.egagenics.com/pr-2008-12-08.htm. See also www.who.int/impact.

where Internet purchases pose a particular threat, better information is needed about patients' buying preferences and behaviour. At the same time, both patients and health care professionals must be made more aware of the existence and seriousness of the problem, and how to avoid and report counterfeits.

Developing countries pose a more complicated challenge, both because health and regulatory systems generally are less rigorous than in developed countries and because the issue may not be a high enough priority to receive the necessary resources. Regulatory systems that are adequately staffed and funded are important. Equally important are information campaigns to make patients aware that counterfeit medicines are ineffective and often lethal.

Many developing countries, particularly in Africa, lack the resources to undertake an ambitious anti-counterfeiting campaign alone. Regional approaches may offer a way to maximize the impact of the resources that are available. This may include adopting sufficiently similar definitions and laws to counter cross-border activities as well as building and sharing a central surveillance service and testing laboratory. This would improve capacity for monitoring imports and make it more difficult for counterfeiters within the region to maintain a foothold.

At the international level, consensus and consistency in definitions and laws are important to strong enforcement efforts; expanded monitoring and testing are crucial. Criminal penalties for violators need to be strengthened to fit the crime. Measures need to be taken in countries where counterfeit is known to be rife – India and China, particularly – to remove incentives for purposeful counterfeiting or slipshod manufacturing.

Effectively stemming the flow of counterfeits therefore requires a wide range of measures, including international recognition of the existence of the problem and extent of the harm; agreement on global and regional measures; programmes to raise awareness among patients, the ultimate victims; and measures to monitor and improve distribution channels. Ultimately, however, the most important factor is the political will to address the issue, disentangling it from related international property issues that have been unnecessary barriers to progress.²¹

21 Roger Bate, *Making a Killing: The Deadly Implications of the Counterfeit Drug Trade* (Washington, DC: AEI Press, 2008).

6 Climate Change and the Global Health Agenda

Climate change has emerged as a critical global issue. Its consequences potentially affect health, and key actions that should be spearheaded by the global health community include the following:

1. More **robust, multi-disciplinary research** on the complex interactions between climate, public health and disease.
2. Assessing plans for dealing with and **mitigating the impact of climate change** in economic development programmes and foreign assistance to developing countries.
3. **Developing stronger databases** that permit clear understanding of the importance of health as an integral part of discussions and debates on climate change.

Climate change may profoundly affect the health of populations worldwide through a number of effects. These include, for example, glacier retreat that will cause seas to rise, producing costly flooding in coastal areas and, over time, permanently displacing billions of people. Smaller glaciers will mean a reduced fresh water supply for countries downstream, such as Bangladesh, where higher salinity levels are inching northward. Extreme weather events and their consequences will be more frequent and more severe – heat waves, temperature inversions, storms, floods and droughts. Temperature ranges will be altered, changing agricultural productivity and the geographic locale of disease vectors.

Human health is being and will continue to be affected in a variety of ways. The impact of climate change already appears measurable – for example, increased mortality during longer and more extreme heat waves in Europe and the United States; more frequent sandstorms in China that increase the incidence of eye and respiratory diseases; persistent droughts in Africa that cause famine and encourage conflict. Some conditions are likely to increase: diarrhoea, for example, owing to an absence of fresh water. Others may increase in prevalence or spread to new areas: malaria, for example, and other diseases now thought of as ‘tropical’. Weather disasters may increase the numbers afflicted by diseases often associated with them, such as cholera and typhoid.

Changes in climate can affect nutrition. Crops are affected by the availability of water, the length of the growing season and temperature ranges. Traditional staples may become more difficult or impossible to grow. Animal health and productivity are determined by the availability of water, grazing land and, for some species, temperature ranges. Disruptions in food supply not only affect nutrition, but also are powerful stimuli for migration.

Lasting alterations in agricultural patterns and yields raise serious security issues. History is replete with examples of conflict over access to water and productive land. Africa already suffers from seemingly intractable armed conflict in drought-stricken regions, for example. Recent research strongly suggests a positive correlation throughout human history between periods of climate change and war.²² Potentially, then, climate change can threaten economic, social and political stability.

22 David D. Zhang et al., ‘Global climate change, war, and population decline in recent human history’, *Proceedings of the National Academy of Sciences of the United States of America*, PNAS 2007 104:19214-19219, <http://www.pnas.org/content/104/49/19214.full>.

Addressing the challenges

A strong consensus exists that climate change is occurring. Less agreement is evident, however, about the longer-term extent and nature of the threat. The predictive models that are important for effective and efficient response are still imperfect. Although lack of certainty should not provide an excuse for inaction, more robust research is needed on the complex interactions between climate change and public health. This must include projections that provide a useful and reliable basis for policy-making, rather than only alarming statistics.

Assuming that climate change does accelerate, the earliest and most severe threats are in the developing world. The burden of disease can be expected to increase and to shift. Strengthening the public health and health care systems in these vulnerable countries is an essential response. A first step is ensuring that the health sector knows and is prepared for the type of change that can be expected.

Because the potential impact of climate change is far broader than on health, however, the response should be as well. Economic development should be a major focus and specifically include planning for both mitigating and dealing with climate change. Current efforts to reorganize international financial structures should explicitly include effective measures intended to speed development, which will, in turn, better prepare poor countries for the disease and health impacts of climate change.

Both the public and private sectors need to be realistic about the serious medium-term commercial and public impacts of climate change. Responses must be multi-disciplinary and multi-sectoral, incorporating efforts both to mitigate climate change and adapt to it. More fully integrated approaches are essential in both research and efforts to address core issues. The health community has a critical leadership role to play in this evolution. Although this certainly includes encouraging and participating in targeted research, it also must involve making a stronger case in all fora – public and private – and at all levels of activity. Serious progress requires that governments see climate change as a very real threat to national and international security and as basic to self-interest. The problem is truly global; only a global response will be sufficient.

7 The Financial Crisis and Global Health

Today's financial crisis threatens the health status of individuals and populations. It also provides important new opportunities for positive change, however, by calling into question traditional approaches and requiring ingenuity in meeting new and lasting challenges. The health community can contribute by encouraging and participating in the following:

1. Replacing GDP and similar economic indexes with a new measure, a **'global health progress index'**, that integrates economic, social, environmental and health aspects.
2. Creating a **more systematic and organized process** for providing health and development assistance, from both private and public sources. Needs assessments would be completed for recipient countries and agreements reached on how best to demonstrate the effectiveness and value of programmes funded.
3. **Increasing self-reliance in recipient countries**, in both economic development and health, by directly empowering local communities under manageable, smaller programmes that include a strong local partnership approach to sustainable funding.
4. In order to safeguard health funding, broadening target audiences to go beyond the health area to **reach spending decision-makers**; expanding arguments to make explicit the strong ties between healthy populations and economic well-being.

Today's financial crisis will have diverse and long-term effects on health worldwide. For an indeterminate period of time, governments will have less to spend both on health care for their own populations and on aid targeted towards health in other countries. Philanthropic bodies too are likely to have less funding to make available. The commercial private sector's ability to participate in improving global health may be affected by contracting markets and profits.

Countries and subpopulations will be affected differently. Countries in the developing world will experience both an immediate impact and longer-term effects. In greatest danger are countries dependent on external aid to fund a substantial portion of their health budgets as donor commitment is jeopardized by competing priorities and less discretionary spending. Much of the developing world also will be affected by declining exports, currency devaluation, falling remittances and reduced inward investment. The subpopulations hardest hit will be those living in poverty – before or as a result of the crisis – as access to a wide range of human services becomes more difficult. An estimated 100 million have already returned to poverty. Subpopulations that will be particularly challenged are women and children and those living in rural areas.

Changes in the global economic climate will also have an insidious effect on future health that may never be completely visible. As economies and markets contract, funding will contract for health research. Improvements in prevention, care and treatment may be fewer as a result and understanding about how best to build healthier societies, for example, may progress more slowly.

The ultimate danger is that goals in health will drift away from the WHO's positive definition of health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.²³ Whether and to what extent this occurs depends in part on the depth and length of the

23 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

financial crisis. The silver lining in the crisis, however, is that it can provide the necessary motivation for substantially improving efficiency and effectiveness in health systems.

A new approach

The financial crisis offers an important opportunity to reassess existing systems and arrangements at all levels – international, national and local. The discontinuities introduced by the crisis can help identify areas in greatest need of reform. Research over the past two decades has led to a better understanding of economic, social and environmental determinants of health. Today's challenges offer an opportunity to apply this knowledge and to add to it.

At the international level, new measures of progress should be considered, perhaps measures that replace GDP with a 'global health progress index' that, at a minimum, includes economic growth, environmental status, and human health and well-being. Far broader than the 'Human Development Index' now in use by the UN Development Programme, this new measure could be used both to set objectives and to ensure political accountability. The index might serve as the backdrop for efforts such as reconsidering and adjusting the roles and structures of the International Monetary Fund and the World Bank and/or re-evaluating developing-country debt burdens.

As health funding pools and paths change with the crisis, a fresh look at donor-recipient interactions is crucial. A major issue is the extent to which aid programmes have an immediate humanitarian or a longer-term development objective; approaches and expectations are very different for the two. One way to clarify objectives and maximize the impact of available funds is to produce a needs assessment for each recipient country. Donors would base decisions on these assessments, thereby rationalizing and giving greater structure to the process overall.

Approaching funding from the viewpoint of the donor will be more important in maintaining flows of funding from both public and private sources. Donors will be more concerned about achieving a return on their investments in the form of successful programmes. Achieving success and demonstrating a return are more likely in open partnerships that specify targets, identify milestones and assign accountability.

Recipient countries will need to shift towards greater self-reliance in response to likely delays and potential declines in funding from outside. A crucial element will be local community efforts, both in health and in commerce. Not only can this help ride out the current crisis, but it can also build local capacity that will have positive long-term consequences. As part of this, micro-financing and micro-lending, already successful in some parts of the developing world, should be expanded to empower more local businesses in more countries. Partnerships that involve the for-profit private sector can be invaluable in providing not just financial support but leadership and training based on solid experience.

The role of health advocates is more diverse and perhaps more important than ever. On the global level, today's economic problems offer important opportunities to broaden the perspective on health and to initiate new, more integrated approaches. At the same time, solutions to the most immediate health needs at the global and local levels require both persistence and flexibility. Debates about funding health will be continuous; to ensure sufficient funding, they also must be multi-sectoral. In these discussions, arguments about the human benefits will continue to be important, but they will not be enough. Explanations of the relationships between human health and economic well-being, such as improved productivity, must be a constant component of the dialogue. Successfully increasing awareness of these strong interdependencies will have a lasting effect by providing a solid basis for a continued focus on health, long after the global financial crisis is past.

8 Maintaining Commitments in Global Health in a Time of Challenge

The global financial crisis will inevitably have an impact on the funding, focus and shape of global health programmes. Among the important steps in adjusting to this new milieu are the following:

1. Exploring and clarifying **how meeting basic health needs contributes to development and economic stability** as one argument for continued funding at appropriate levels.
2. Assessing **measures of progress at the country level** to evaluate and guide global health programmes and support continued funding.
3. Proposing mechanisms that ensure **involvement of recipient countries more fully** in the design, implementation and assessment of programmes and **expanded public-private partnerships**.
4. Ensuring the **integration of global health into foreign and security policy** by capturing and maintaining the attention of policy-makers and thought leaders in those fields and building an evidence base that illuminates the connections.

The worldwide financial crisis carries with it a serious threat to global health, made more poignant by coincident changes in health priorities and the feasibility of global responses. Globalization may hasten threats from new and emerging diseases; new types of health-related challenges will arise from climate change and resource shortages. At the same time, the ways in which the world community meets challenges are evolving as stakeholders consider issues such as international and transnational alliances, and multilateralism versus pluralism,

Leading donor countries have issued assurances that both international and bilateral aid and assistance will continue, recognizing explicitly that needs may become more urgent as the consequences of the financial crisis worsen and spread. The G8, for example, remains committed to improving global health; its Health Experts group provides momentum by identifying priorities and presenting an annual review. At the July 2008 Toyako Summit, the G8 reaffirmed its pledge of \$60 billion for health and confirmed as objectives eradicating polio, ensuring universal access to HIV prevention, treatment and care, and delivering 100 million bed nets to fight malaria. A high-level task force created at that meeting continues to work with and support the G8 in July 2009 by identifying innovative sources of financing for health systems.

Despite such assurances of continued support, the global economic crisis will inevitably create or accelerate change in the global health landscape. As noted above, aid flows will be affected seriously; currency fluctuations and disruptions in international trading patterns will add to the turbulence. Moreover, in a time of tighter budgets, all donors, public and private, will be more adamant about requiring clear evidence of results. Accurate and convincing measures of impact at the country level will be essential. To provide that, new research is needed, demonstrating in particular how meeting basic health needs contributes to development and stability.

To maintain global health as a key focus, however, the natural links between global health and foreign and security policy must be made much clearer. The United Kingdom's Health is Global strategy is an excellent example of a concerted effort to seek national alignment of global health and foreign policy.²⁴ A principal goal of the strategy is to improve health in order to reduce poverty in the least developed countries, thereby contributing to stability. Health is Global seeks both to amplify the positive synergies of global health and foreign and security policy, and to better manage explicit trade-offs if the two conflict.

24 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702.

Addressing new realities

The financial crisis will further highlight a continuing issue in global health: leadership and coordination. Currently, 26 UN agencies, 20 global and regional funds, 90 global health initiatives and 40 bilateral donors are active in the global health arena.²⁵ The inevitable result for recipient countries is confusion and problems of coordination; for assistance as a whole, overall inefficiency is inescapable. Efforts to address this problem began before the financial crisis; they are likely to be accelerated by it.

New initiatives at the international level include the International Health Partnership (IHP) initiated in September 2007. Involved are both donors and recipients: governments, multilateral organizations, international NGOs and developing countries.²⁶ The overarching goal is to improve the way in which international agencies, donors and developing countries work together to develop and implement health plans. IHP aims to improve coordination among donors, raise the voice of developing countries in planning, focus efforts more sharply, and help recipient countries create effective means for tracking progress.

The G8 has exercised a leadership role and acted as a catalyst in global health for the past decade, spurring, for example, the United States' PEPFAR, malaria initiative and Millennium Challenge Account/Corporation; the broader G20 has explicitly recognized the importance of global health as a driver of development; the 'Health 8'²⁷ works to coordinate conceptual and practical approaches among multilateral bodies, private international donor organizations and the for-profit private sector. Leadership, then, is evolving, although it is still dominated by donor countries, multilateral organizations and the large international private donors.

The experiences of the for-profit private sector can provide important examples of how to structure successful efforts, as well as initiating or participating in specific programmes. For example, working in partnership with others, several pharmaceutical companies have been instrumental in making it possible to treat seven of the world's neglected tropical diseases for as little as \$0.50 a day. Dozens of other examples of pharmaceutical industry involvement in developing countries worldwide demonstrate the effectiveness and importance of the partnership approach.²⁸ ExxonMobil's malaria initiatives make clear that companies outside the health care industries can also be committed to improving health. With a workforce in Africa that numbers in the thousands, and as one of the largest foreign direct investors in the continent, ExxonMobil has invested approximately \$40 million to support efforts to fight malaria since 2000. In March 2009, it partnered with eight southern African countries, initiating a new effort to eliminate malaria that, for first time, applies business principles in setting targets, milestones and responsibilities and in financing. These partnerships show the importance of working closely with local leaders and communities. In the face of potentially shallower funding streams, success at the local level is more critical than ever.

Tailoring aid and interventions to fit the recipient's needs – not just the donor's objectives – is also essential. Listening carefully to recipients should be the first step in planning, whether at the global or local level. Moreover, vastly improving the capacity within recipient countries to monitor and evaluate progress is in the interest of all parties. Success and lasting effect will be more likely when developing countries take ownership of global health programmes, adopting a more active role that can produce its own momentum.

Many of today's global health challenges, moreover, are regional and subregional. Yet effective partnerships at these levels are still rare. In some cases, this is because regional institutions lack the necessary power and credibility; in others, appropriate alliances may not exist. Addressing this gap is very important to the future of global health.

Although the traditional flow of assistance has been from the developed 'North' to the less developed 'South', in some cases 'South-South' interactions may be more effective than 'North-South' exchanges, including in promoting better health systems and standards of health. As the emerging economies strengthen further, encouraging such relationships deserves greater thought and attention.

25 UK Department for International Development, The International Health Partnership Launched Today, Key facts on health sidebar, 5 September 2007, <http://www.dfid.gov.uk/news/files/ihp/default.asp>.

26 Benin, Burkina Faso, Burundi, Cambodia, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Nepal, Niger, Nigeria, Rwanda, Uganda, Zambia, African Development Bank, Gates Foundation, European Commission, Global Fund, GAVI, OECD, UNAIDS, UNICEF, UNFPA, WHO, World Bank, Australia, Canada, Finland, France, Germany, Italy, Netherlands, Norway, Portugal, Sweden, United Kingdom, <http://www.internationalhealthpartnership.net/>.

27 WHO, the World Bank, UNICEF, UNFPA, UNAIDS, GAVI, the Global Fund and the Gates Foundation.

28 See www.globalhealthprogress.org.

Annex: Conference Panellists

- Richard Odoi Adome** Professor and Head, Department of Pharmacy, Makerere University Faculty of Medicine, and Board Member, National Drug Authority, Uganda
- Dr Nicholas Banatvala** Head of Global Health, International Division Department of Health, UK
- Roger Bate** Legatum Fellow in Global Prosperity, American Enterprise Institute
- Richard Black** Environment Correspondent, BBC News
- Dr Diarmid Campbell-Lendrum** Specialist in Climate Change and Health, World Health Organization
- Dr Manuel Carballo** Executive Director, International Centre for Migration and Health
- Lisa Carty** Deputy Director, Global Health Policy Center, Center for Strategic and International Studies
- Hon S Ward Casscells MD** Assistant Secretary of Defense for Health Affairs, USA
- Tim Finch** Assistant Director and Head of Migration, Equalities and Citizenship Team, Institute for Public Policy Research
- Professor Wolfgang Hein** Head of Research, Programme 3, GIGA (German Institute of Global and Area Studies)
- Sarah Hendry CBE** Director of International and Public Health Delivery, Department of Health, UK
- Dr David Heymann** Assistant Director General for Health Security and the Environment, and Representative of the Director General for Polio Eradication, World Health Organization
- Yanzhong Huang** Associate Professor and Director of the Center for Global Health Studies, John C Whitehead School of Diplomacy and International Relations, Seton Hall University
- Andrew Jack** Pharmaceuticals Correspondent, *Financial Times*
- Olga Jonas** Economic Adviser, Operations Policy and Country Services, The World Bank
- Dr Mohga M Kamal-Yanni** Senior Health and HIV Policy Adviser, Oxfam GB
- Professor Ilona Kickbusch** Director, Global Health Programme, Graduate Institute of International and Development Studies, Geneva
- Ambassador John E Lange** Former Special Representative on Avian and Pandemic Influenza, US Department of State
- Ivan Lewis MP** Parliamentary Under-Secretary of State, Department for International Development, UK
- Lt Gen Louis Lillywhite CB MBE** Surgeon General, Ministry of Defence, UK
- Dr Rhona MacDonald** Senior Editor, *The Lancet*
- Rt Hon Lord Mark Malloch-Brown KCMG** Minister of State for Africa, Asia and the United Nations, Foreign and Commonwealth Office UK
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- Dr Sigrun Møgedal** HIV/AIDS Ambassador, Ministry of Foreign Affairs, Norway
- J Stephen Morrison** Director, Global Health Policy Center and Senior Vice President, Center for Strategic and International Studies
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