Meeting Report
University of Peace
November 12-13, 2004

Introduction

The meeting was convened on the campus of the University of Peace in San Jose, Costa Rica. The purpose of the meeting was to determine if Global Infectious Diseases was a suitable topic for a summit meeting of Leaders from 20 major countries. The criterion for being on an L20 Agenda was that Leaders could make a difference. Can Leaders reasonably be expected to endorse substantive initiatives that would break a deadlock? Could they be expected to resolve a hitherto intractable problem or a problem that lacks a clear person in charge or crosses several boundaries – across organizations and responsibilities? Can they produce progress that could not be expected from other organizations or fora.

Context

The meeting began with a reminder of the parameters of a politically sustainable deal for an L20 contribution. Those include broad international participation - notably by the United States and also by key developing countries - and a package of promises and actions that span many issue-areas, as different countries have widely varied interests and priorities. The question of funding and sensitivity to cost was front and centre. Some felt that the L20 Summit cannot (or should not) be perceived as a pledging conference.

The meeting was reminded of three attributes that a Leaders' level forum could offer. First, only Leaders can make tradeoffs across policies and institutions, breaking deadlocks and offering coherence to the agenda[1]. Leaders are often attracted to forums where they can pursue personal views and can transcend the bureaucracy. Second, Leaders often have longer time horizons than line ministers - they can outline long-term visions and indicate concrete steps as intermediate milestones. Third, complex cross-cutting commitments may be more credible when adopted at the Leaders' level as they involve commitments to peers, and institutions can be tasked to follow-up and assess progress. Such commitments are often difficult to characterize precisely and thus not amenable to codification in binding legal instruments, putting a special premium on credibility rather than legalistic enforcement.

The special character of commitments made by Leaders was noted. Leaders do not develop complex legal instruments. International and domestic commitments would be

[1] Given that the infectious disease challenges are often multiple (Flu pandemic, SARS, HIV/AIDS, TB, Hepatitis) and multidimensional (e.g., the need to consider factors such as poverty, deprivation, disempowerment, gender inequality and access to health services), it is important to adopt a systematic approach (multi-sectoral, multifaceted, global) that goes beyond public health sectors and existing assistance programs (which often face financing and coordinating problems). The needed credibility and authority in implementing such a systematic approach can only be brokered in a Leaders' summit.

required. Domestically, Leaders *direct, commit, and instruct* other ministries in their governments to act. Internationally, Leaders *ask and delegate.*

Commissioned papers

The background paper was written by Tim Evans (WHO) and laid out the many dimensions of the problem, including cogent arguments as to the significance of the problem. A series of competitive short briefing notes – "conjectural communiqués" were commissioned. Authors (David Heymann, David Fidler, Anil Soni, Ricardo Kuchenbecker, and Huang Yanzhong) were each asked to outline a definition of the Global Infectious Diseases issue that will galvanize L20 Leaders and the architecture/design of an attractive win-win solution, a package the L20 Leaders could endorse and pursue. Ruth Levine offered a contribution of a "L20 ready" initiative. The meeting also explored the roadmap to promote the process of gaining consensus on the best route to establishing an L20 Leaders Summit Process. Participants reviewed the positions of major players to determine "how to get there from here".

Tim Evans' background paper reviewed the state of global health and discussed the Global dynamics and disparities of the Health Care economic sector. He reviewed the need to scale-up interventions that work, overcoming the "Inverse Care Law", and the scope for harnessing the promise of science and technology. He focused on the international dimension to health challenges in poor countries. Finally, he conceptualized the way in which an L20 process could make contributions to setting a more balanced and equitable agenda for global health by using three chapeaux:
-*Redressing errors of omission*;
-*Scale efficiencies in cooperation*;
-*Catalyzing complimentary action beyond the health sector*
and suggested a series of promising initiatives in each area.

David Fidler's paper presented 14 initiatives under the headings: Leadership, Stewardship (e.g. Strategic Support for WHO's Global Outbreak Alert and Response Network), HIV/Aids Pandemic, Making Economic Globalization work for Global Health, and Global Access to Health Technology and Know-How (e.g. Global Health e-library, and Accelerating Influenza Vaccine Development and Supply).

David Heymann presented a cogent argument to strengthen capacity for outbreak detection and response nationally, and in developing countries bilaterally or through multinational mechanisms. He recommended increasing the robustness of the WHO-coordinated international system for outbreak alert and response as a safety net if national capacity fails to detect and contain. He also proposed to establish some type of risk management/insurance fund to provide incentives for countries to comply with the IHR and take steps to protect themselves and others from potential high short term economic losses.

Ruth Levine's contribution was an ingenious proposal whereby donors would make a legally binding commitment, in advance, to contribute most of the cost of buying a vaccine, at a guaranteed price, if it were developed. This would create a market of

sufficient size and certainty to create an incentive for firms to invest in the development of vaccines for neglected diseases. Ruth described how the scheme would work in practice.

Anil Soni presented a series of prospective L20 initiatives under 5 headings: Strengthening technical assistance, expanding human capacity; ensuring access to medicines; increasing financial resources; and supporting vaccine development.

Ricardo Kuchenbecker focused on capacity building. He made a compelling argument to revise the definitions of capacity building. He argued for a more comprehensive approach for capacity building as a core element of technical cooperation. More money and more coordination are not enough. He pointed out that some of the multila

There was a critique of Ruth Levine's proposal to guarantee a future market for development of new vaccines for poor countries – "must we line the pockets of venal drug companies?" There was a discussion of the required balance between focus on vertical interventions versus concentration on enabling factors to increase system capacity. There was some skepticism about Debt for Health swaps, a la Environment debt swaps; it was argued that in the unlikely event it could be sold for LLDC s, it could not be sold for India and Brazil. There was a question of whether new goals should be set (a New Vanguard Pledge – see David Fidler's conjectural communiqué) versus reinforcing the focus on the MDGs. Regional funds, in lieu of global funds were not supported – coherence problems, lost scale economies and poor coordination were noted as reasons.

There was considerable discussion of the need to reconsider IMF and World Bank strictures; the absolute laws of economics were invoked in response. The promise of ICT and e-libraries was raised, with a discussion of the limiting constraints on the ground.

There was sympathy for finding a way to work "security" into the mix. "Capacity building and system strengthening" also had vigorous backing. One participant observed that discussion of international health institution reform has to bring in more than the L20, which, for example, would not include Sweden.

Observations

In discussing the long list of credible proposals presented, the following points were made:

- It will be important to situate health in the context of global governance. There has to be some incremental money on the table – some financial commitments by the developed states.
- In what ways could an L20 Health initiative emerge as a genuine partnership between the industrialized countries and key developing countries?[3]
- In selecting initiatives, we need to ask "what it is about health that would grab G20 Leaders?". There are many issues that might attract them. One has to first and foremost look at ideas, not money. One thing that can attract attention is a medical breakthrough.
- It will be important to engage different constituencies. It is the key to breaking logjams. There are always different groups working on a problem. Countries can have quite varied perspectives. It is important to tackle problems that society has

[3] We must find a balance between a focus on infectious diseases and the need to take a broad public health approach to addressing them. This suggests that efforts to build health systems that strengthen efforts to detect, prevent, control and treat infectious diseases, in general, could form the basis of an L20 initiative. This would avoid focusing on selected acute epidemic infections threatening certain western countries, or using language that suggests that the developing world or terrorists are poised to threaten western countries deliberately or otherwise with infections. This particular use of the term "health security" is a real turn off to governments in the developing world. Indeed, it has been described as rather offensive and can get used by all sorts of unsavory groups elsewhere to promote discriminatory health policies (e.g. screening migrants for HIV/AIDS, promoting fears of "filthy foreigners").

not figured out. It is necessary to show that L20 action will have advantages for each problem.

Capacity building is critical.[4]

We need to build civil society into our analyses. The approach must avoid being paternalistic.

Schemes for Vaccine development were supported as important in building for the future.

Improvement of surveillance is critical; it will facilitate adjustment to unexpected events.

Developing countries have to put more money on the table, but a solution must be found to the IMF and World Bank imposing caps on government budgets that are legitimate in macroeconomic terms, but highly inappropriate in health sector terms.

The prospective contribution of faith-based communities should not be overlooked, bearing in mind the potential for skewing of the agenda and real difficulties with respect to certain initiatives.

Pharmaceutical companies are key players and must be borne in mind in any strategic approach.

The private sector – not just "big pharma" – but also biotech, private healthcare, and insurance industries must also be remembered.

Must focus on prevention as well as surveillance and response – clean water, etc.

Health is inextricably linked to other things we are considering for L20 , education, environment, even terrorism.

<u>Factors important to various players were reviewed:</u>

In China the Ministry of Health (the influential Minister is Vice Premier) will be interested in technical assistance. The impacts of improved health on economic development and Chinese internal political stability are important selling points that will resonate with the Chinese Leadership. They learned a lot from the SARS experience.

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[4] The L20 may be excited by a "big idea" on which to demonstrate Leadership along the lines of the "creation of a new global health cooperation compact". This would imply revision of the international health assistance architecture, including the optimization of financing arrangements for health development. The focus of this should be very much on improving DELIVERY AT COUNTRY LEVEL to help poor people and accelerate achievement of the health MDGs. Components of this initiative could include:

- streamlining existing assistance arrangements, so as to reduce current inefficiencies and transaction costs;(i.e. identifying what to do less of)

In South East Asia it will be important to find a way to keep the issue of human resources across the board on the table – especially the supply of health professionals in developing countries.
It will be relatively easy to convince Brazil about the advantages of L20 consideration, especially

Summary:
The challenge is to find a balance between a focus on infectious diseases and the need to take a broad public health approach to addr