L-20 and Global Public Health.

Draft Background Paper for Costa-Rica Meeting

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This paper aims to serve as a background document for the G-20 leaders meeting on Global Public Health. It begins by making the case for health as a special good both intrinsically and instrumentally. It then provides a global overview of the current health situation and trends from a global health perspective with special attention to health needs of poorer countries and populations. It then examines the ways in which a G-20 of Leaders might tackle global health problems according to three principles: 1) the need to put neglected issues on the global health agenda; 2) opportunities for scale efficiencies in cooperation ; and 3) intersectoral engagement. The paper then addresses three specific but fundamentally different health challenges with a view to assessing the G-20 comparative advantage; the potential benefits from G-20 engagement; and the costs involved in taking action.

Section 1. Why Global Health?

The Copenhagen Consensus process identified "best buys" in global development and among the top 10 identified 4 in health. The reasons relate to the primacy of health as an intrinsic capability or a primary good as well as its instrumental importance. The place of health as a special good has been recognized by many of the great thinkers including Democrit who wrote some 7,000 years ago that "without health nothing is of any use, not money nor anything else" (Democrit, On Diet, 5th Century, B.C.). More recently, close to 400 years ago, Descartes suggested that "the preservation of health is … without doubt the first good and the foundation of all other goods of this life" (Descartes, Discours de la Méthode, 1637). And even more recently the Nobel Laureate James Tobin when considering health coined the termed "specific egalitarianism": suggesting that health should be distributed less unequally than people's ability to pay for it. (Tobin, Journal of Law and Economics, 1970).

Health is also valued for its instrumental properties. Improved health allows individuals to fulfil their other responsibilities and capabilities including education, social interactions, and economic livelihoods. On a population basis there is growing evidence that in the poorest areas of the world improving health is a prerequisite for accelerated economic growth. In addition, from a global perspective, the collective sense of vulnerability from epidemic diseases that threaten our common security raises again the importance of health on the global development agenda.

Section 2. What is the state of global health?

In 1999, Bill Foege in an article reviewing global health in the 20th century referred to

"One world health"
The opening up of borders, the ease of global travel and the forces of migration, commercialization and urbanization have created what some have called the conditions for "microbial unification". This is the concept that a infectious pathogen in one part of the world can find its way to multiple global destinations with large

argument has been accepted, the corresponding responses in either governmental commitments and/or donor assistance have been sluggish at best. At present very few poor countries are spending on health at a level that corresponds with health need. To do so would require massively expanding health spending. The expansion of public sector spending on health, however, is limited by fiscal guidelines relating public sector spending to the size of the economy. These guidelines managed by the International Monetary Fund are designed for government spending as a whole and are not sensitive to the specific sectoral needs of health. Given the outstanding needs of the health sector in poor countries, the appropriateness of these guidelines that fall

health, are less likely to access care and more likely to incur unfair expenditures in the process of accessing care. The strength of the evidence, however, is not matched with a capability or know-how and/or political will to redress and diminish social inequalities in health.

Harnessing the promise of science and technology

Much of what has driven the growth of the global health enterprise stems from the myriad of products - diagnostics, vaccines and drugs, and surgical techniques - that have emerged from large investments in research and development in both the public and private sectors. The spectrum and growth in new products is on the whole very impressive with new "breakthrough" technologies related to imaging diagnostics, micro-surgery, home-based care and therapies emerging rapidly. In recent years, however, there has been recognition that from a global perspective the new technologies are skewed towards the needs of the richest populations - those with significant purchasing power. This skew in the R+D enterprise has been summarized in a ratio known as the 10:90 gap… the observation that only 10% of research resources globally are targeted towards the health needs of 90% of populations living in poor countries. This skew in researc(w)-6.6(v)-5.3I6.5r(6.3c TD-0.0004 Tw in o-5(5(ies reect)8)-1.4( )-5ed

and surveillance systems that have both the non-rival and non-exclusive characteristics of a public good.

Section 3. The potential role of an L-20 in global public health

There are myriad forums where critical issues in global health governance are discussed but almost none that involve heads of state. Notable efforts in the past involving heads of state relate to specific one-off events such as the 1991 UN Declaration on the Rights of the Child, or the UN General Assembly Special Session

1) Redressing Errors of Omission:

This area of G-20 engagement could be broken down into three areas: i) country or region health crises; ii) neglected global health priorities; and iii) leadership lacunae.

i) Country or regional health crises:

Despite remarkable progress in global health in the last 50 years, in the last 10 years we have witnessed some extremely disturbing trends. The former socialist economies of the Soviet Union have experienced "reversals" in life expectancy. Initially analyses pointed to a disproportionate decline in adult male survival, although more recent evidence points to deterioration in health for women and more worryingly perhaps for children. That the reversals in health status in these countries have received so little international attention is alarming. Similarly, although the health crisis in Africa has received a lot of attention in terms of HIV/AIDS, less attention is being paid to the fact that in at least 15 countries, there are significant declines in child survival. G-20 leaders could draw attention to these "health crisis" countries and regions and ask whether enough is being done or whether new action is required.

ii) Neglected global health priorities;

G20 leaders could take up specific health issues that have failed to register as they should on the global health agenda. These health challenges can be considered in terms of unfinished agendas, imminent threats and future challenges. The unfinished agenda relates primarily to premature death of infants and children and their mothers during child-birth – the large majority of which are preventable with existing low-cost technologies or interventions. Even though ambitious MDGs have been articulated for maternal and child health, their achievement is unlikely without more realistic reckoning of what is required. Gs-TJTsurvS(chitas)5.3(7(z)-0.1(at)6.)-9.1(ectk-5(al)(Tc0.004h7.1( )5.0001twf(

credible leadership role for WHO, they could also strengthen the demand for the development of low cost and effective strategies to stem the burden of NCD s. The leadership required, however, is also at the level of heads of state as the issues involved in dealing with NCD s go well beyond the health sector and include food policy; trade and tobacco; financing of public systems etc. (see below – intersectoral engagement)

iii) Leadership lacunae;

Many of the crises in health reflect failures in leadership at the highest levels. Despite signing on to many conventions and agreements, the track record of many leaders to following through on commitments is lamentable. About 70% of childhood deaths globally are easily preventable as are most deaths of child-bearing mothers. Shouldn't leaders in those countries where preventable child and maternal deaths are unacceptably high be held accountable? The L-20 could label the laggards, invite them to the table for frank discussion and offer constructive advice based on diverse experiences and perspective around the table. Given the composition of the L-20, such discussions are likely to illuminate other dimensions of these problems where more effective leadership is required such as the uncertainty of long-term donor funding, the constraints of current public sector financing frameworks, and the loss of skilled health personnel through migration.

The migration of health professionals from poor countries to rich is an issue that that would be more likely to register and be dealt with credibly in the L-20 as compared to the G-8. A leader from a country like South Africa or Nigeria for example would make reference to the evidence on the growing "loss" of professionals from their countries to the North facilitated by professional recruiting agencies hired on behalf of national health schemes in the North facing their own acute shortages. Countries like the Philippines or India might reveal their export-oriented strategies whereby health workers are trained for work in the North in recognition of the importance of worker remittances. Countries like the UK might be quicker to recognize that their "ethical recruitment" policies are failing. There is no shortage of complexity in dealing with this issue --- one that could be relegated easily to the straight jacket of a definitive study --- however, there is an acute need for action. The L-20's informal and inclusive but direct and deliberative modus operandi could help to accelerate some credible options for moving forward quickly and thereby fill the current leadership void.

2) Scale efficiencies in cooperation

A number of health issues require or would benefit enormously from more effective global cooperation rather than independent and uncoordinated efforts at country level. As noted above, global epidemic control is more efficiently and effectively attained through strengthening international health regulations and the capabilities of WHO. The role of the L-20 would not be to define the content of the International Health Regulations but rather to see how various components of their implementation might be enhanced and insure that they don't get stuck in bureaucratic backwaters. Specifically, the L-20 leaders might commit their governments to looking at how to do business differently – to move from inefficiencies that emerge at national level to global scale efficiencies. In health research for example, the global public health

if it is done at the expense of a nation's health and possibly its development, then it needs to serious reconsideration.

Section 5.. Some considerations on process

Above and beyond these illustrative areas where the G-20 could help to set the agenda in global health, there are several process issues in the design and operation of such a mechanism that need to be considered in the context of current arrangements in global public health.

Twenty heads of states from around the world is likely to produce a healthy balance of perspectives on any given health issue. It is clear, however, that some issues might benefit from a slightly different balance in participation of countries. On an issue like pharmaceutical capacity, it might be better to ensure that close to 100% of the manufacturing for export industry are represented. On issues like best practices in ODA or harmonization, having stronger representation from a greater diversity of recipient countries may be helpful. Mechanisms to support flexibility in participation or even rotation (while preserving sufficient continuity) might help to enhance the credibility of the G-20 forum amongst those not at the table.

In terms of participation beyond the G-20 leaders, it would be important to include the leaders of the multi-lateral health agencies - WHO, UNICEF, WB, UNFPA - and other major players in global health or relevance to a specific G-20 agenda from the private sector (for-profit, not-for-profit and civil society), professional groups and academia.

The G-20 should maintain close with the major health forums such as the World Health Assembly. Specific attention should be paid to the recently created WHO/WB High Level Forum on Health and Development which is organizing its second official meeting in Abuja in December 2004. Although the HLF doesn't attract heads of state, its aim for high level engagement (beyond Ministers of Health) with balanced participation is similar to a G-20 for global public health. The forum might represent a possible precursor to a G-20 focusing on health and as such should be evaluated in terms of lessons learned.

The G-20 should limit agenda items for any specific meeting and set a clear 2-3 year time horizon to assess whether it is in fact value-added.

Section 4. Potential areas for G-20 leaders focus.

Although specific papers have been commissioned on specific health topics, to push the concept of the G-20 further, this section considers three distinct areas in global health where the G-20 could devote its energies as a means of developing a framework as to how the G-20 might consider setting its health agenda. A priori, we think that the following issues should be considered:

a) the rationale for G-20 consideration. This should make reference to at least two distinct dimensions of the G-20: 1) the advantages gained via the specific assemblage of twenty countries in terms of population covered, market share, production capacity, representativeness of requisite diversity etc; and 2) what "leaders"/heads of state engagement confers to the specific issue that others Ministers etc. can not;

b) the potential benefits of L-20 action on a specific issue; global equity, efficiencies (scale, and within systems), quality and timeline for benefits;

c) the cost and other hurdles to G-20 action;

and d) how the multi-lateral system could play a constructive role in implementation;

4. 1) Protecting Our future: Preventing and controlling global epidemics

- combating the international spread of disease outbreaks (SARS, Avian Flu, Smallpox ..)
- ensuring that appropriate technical assistance reaches affected states rapidly
- contributing to in country epidemic preparedness and capacity building

Why the G 20

- [illegible]

What is required and how quickly can we expect results
3 components

- investment in national capacity for outbreak surveillance and response
- investment in the international system for outbreak alert and response
- investment into a risk management/insurance fund to provide incentives for countries who comply with the IHR and take steps to protect the regional or global public good and are themselves then subject to a high short tem economic loss.

With adequate resources we can expect a fully operation system - functioning national surveillance and response capacities linked to an strong and enabling international alert and response system in five years time.

How much will it cost - where will the financing come from
Estimated costs for three components : 300 million Can $ per year for 5 years

Funding sources : In addition to traditional development cooperation funds and funding from the Ministries of Health (contributing to this global public good is in their direct interest) the private sector investment banks, insurance companies and other risk management companies

- action is required quickly to begin to redress the shortcomings of the global labour market and identify new avenues for investment. The World Health Assembly passed a resolution on the migration of health workers last year which was helpful in signalling the importance of the issue, however, pragmatic ways forward especially in the short to medium term were difficult to identify.

G-20 Action

- A short-term plan to redress the imbalances in the workforce which leave poor populations without life saving services. Such a plan might include removing ceiling on hiring in the public sector immediately, eliminating ghost workers from the public sector payrolls, improving remuneration and benefits of health workers based on work productivity, reducing by one-half the training time for professionals and creating new multi-skilled cadres. The plan would also identify ways in which the under-employed, or early retired, or simply globally committed health "workforce" might play a more important role in the short-term.
- developing a medium to longer term strategy based on projections of global

- Timely window of opportunity. The UN convened in 2003 the first World Summit on the Information Society and will hold its second in 2005. The World Health Organization will propose an e-Health strategy to its World Health Assembly in 2005.

Good buys in e-Health

G20 leaders could champion various novel initiatives in the near term with relatively modest financial commitments ($150 million over 5 years from development aid):

- A Global Observatory for e-Health Systems to monitor progress in bridging the digital divide, and gather evidence for national policy making (cost-effectiveness, best practices, etc.)
- Regional e-health platforms in local language. Language is emerging as the new borders in the global information village. Automatic translation will be an increasingly important and effective tool. e-Health platforms could link countries across development gradients (e.g. Brazil and Portugal with lusophone countries in Africa).
- A Global e-Health Library. Access to health information for all is a dream possible. can offer universal access to quality information around the world. Components for such a global umbrella are already emerging and can be brought together and resourced appropriately.
- A venture capital fund to support public-private enterprise for e-Health in developing countries and emerging economies (including efforts in research and development of new applications and products)