Health Diplomacy Monitor

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Health Diplomacy Monitor

The Health Diplomacy Monitor aims to report and inform readers about key international negotiations currently underway which have a significant impact on global health. The objective is to “level the playing field” by increasing transparency and making information about the issues and proposals being discussed more readily available.

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in this issue

Editorial: The UN General Assembly High-level Plenary Meeting: A turning point for the MDGs? 2
The outcome of the UN MDG Summit 4
Innovative financing for development takes a step forward at the 2010 UN Summit 6
Learning Lessons from the H1N1 Pandemic 9
Consultations on the future financing of the WHO 12
WHO European Region under new administration 14
The 61st WHO Meeting of the WPRO 16
Health at the G20 Seoul Summit? 19
The impact of trade agreements on health in the African region 21

A Word from the Editor

This fourth issue of the Health Diplomacy Monitor reflects the diversity of forum where responses to health challenges are discussed and negotiated. We follow-up on our last special issue on the health –related Millennium Development Goals (MDGs) published at the beginning of September, before the UN MDG Summit in New York on September 20-22 with an article from Adam Karamdt-Scott reviewing the results of and reactions to this event. At the meeting, several heads of state proposed to mobilize resources to achieve the MDGs through a currency transaction tax. To understand the context for this proposal, Rene Loewenson prepared a review of the recent discussions around innovative financing mechanisms for health and development. We also invited Sigrun Mogedal, former Ambassador for AIDS and Global Health Initiatives in the Norwegian Ministry of Foreign Affairs, to comment on the outcome of the MDGs. She argues that UN was successful in elevating health from a sector to “a cross-cutting outcome area where all the MDGs must contribute” but that the challenge now is to have the global agenda “address the full spectrum of cross-cutting challenges” that have an impact on health outcomes, not just focusing on the health sector as a field of intervention. In this manner, global health diplomacy goes much beyond the traditional arena of health interventions.

This issue also offers two articles about the regional meetings of the decentralised structure of the World Health Organisation. David Gleicher summarises the discussions which took place in Moscow at the European Region of WHO (EURO) focusing on the pro-

posals put forward by the new regional director, whereas Adam Kamradt-Scott reviews three new strategies adopted at the Western Pacific Region (WPRO) meeting which took place in Malaysia. Bente Molenaar provides an update on the independent review committee which is inquiring into the work of WHO during the H1N1 pandemic and more generally into the functioning of the International Health Regulations adopted in 2005. Mark Pearcey reports on the recent dialogue within the WHO about the financing of the organisation and its role and functions within the global health architecture more generally. He notes that 80% of WHO funds are voluntary contributions from member states and from non-state actors, 90% of which is earmarked for specific purposes. This financing context places real constraints on the activities the organization can undertake to achieve its many mandates.

This issue concludes with two articles that do not focus on traditional health forums but examining how negotiations in these arenas can have an impact on global health. Rangarirai Machemedze summarizes recent concerns in the Sub-Saharan region over trade negotiations with the EU and how they could limit the capacity of government to improve health systems and population health. Finally, Jenilee Guebert and Robin Lennox look at the forthcoming G20 Summit in Korea; the G20, unlike the G8, has not yet focused on health directly, but they have touched upon the related issues of aging populations, climate change, food security, and development. These latter two topics are expected to receive special attention from the member of this new global forum in the coming months.

- Chantal Blouin

Editorial

The UN General Assembly High-level Plenary Meeting: A turning point for the MDGs?

Sigrun Mogedal

Everything possible was done to build the momentum for the Member States of the United Nations to agree on making the High Level Plenary Meeting of the UN General Assembly a turning point; reminding all of promises made, and only five more years to go for reaching the Millennium Development Goals (MDGs).

UN institutions were put to work to document evidence and progress. Member States examined their commitments and achievement. Non-state actors raised their voice and contributed their ideas. New initiatives were developed and old ideas were challenged in terms of adaptation to new realities.

With Heads of State called together, the meeting was a test on readiness to take shared responsibility for necessary change to achieve the MDGs. The resulting thirty-two page outcome document “Keeping the Promise” is a compilation of the negotiated agreements related to economic and social development, reached through numerous UN International Conferences, Political Declarations and High Level meetings under the auspices of the Economic and Social Council (ECOSOC) over the last 30 years.

Read this way, rather than bringing a convincing message about a turning point for the future, the document highlights missed opportunities in acting on what has already been agreed to. Barriers to moving forward are hardly mentioned and strategies to overcome them remain largely vague. The outcome of the High Level Meeting can therefore be seen as mixed and fragile as the uneven successes and progress documented in the UN Secretary General’s report to the meeting.

But this is not the only way to read the outcome and

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not the only story to carry forward about the High Level Meeting. While the negotiations hardly represented a breakthrough, it can be argued that the meeting succeeded in bringing messages of progress and new energy.

Side meetings and events are increasingly becoming more powerful in agenda setting than the formal deliberations in the UN General Assembly. The way the Secretary-General's Global Strategy for Women's and Children's Health made its way to the forefront of the overall messages from the meeting is a case in point. A result of a year of strategic development and mobilisation among key partners, the Strategy was presented with enthusiasm at a side event by the Secretary General and a cross regional panel of Heads of States. Even though difficult to integrate in the formal negotiations, the political breakthrough and commitments to joint action on maternal mortality, set in a context of a cross cutting focus on the health of women and children, has the potential of becoming a turning point.

Convincingly, the UN has elevated health from a sector to a cross-cutting outcome area where all the MDGs must contribute. This comes as a result of the political mobilization for the Global Strategy for Women's and Children's Health, combined with a number of key UN General Assembly processes over the last couple of years, including the reports and resolutions on Global Health and Foreign Policy and the 2009 ECOSOC Annual Ministerial Review, followed by the 2010 Coordination Segment on implementing the internationally agreed development goals and commitments in regard to public health.

This is a major achievement for global and national public health, but will now need to be followed up in ways that address the full spectrum of cross-cutting challenges with impact on health outcomes, not only through attention to global and national "health sector" governance. While the outcome document from the MDG Summit highlights the interconnectedness and the required synergies and coherence in development governance, governance challenges that impact on development and health in the domains of rights, security, trade and humanitarian affairs are only briefly mentioned.

The mobilization to ensure that HIV was not lost in the broader MDG debate succeeded. The negotiations and the side events also bridged the gap between a separate focus on HIV/AIDS and all the MDGs, and to synchronize the commitments of the UN High Level sessions on AIDS with the broader MDG process for run-up to the 2015 target. This can be effectively followed up in the next High Level Session on AIDS in June 2011.

Another major contribution is the persuasive message on the status of women and gender empowerment as a multiplier across the MDGs, calling for a re-energized effort to address root challenges of gender rights, vulnerabilities and violence – in poverty and other situations of marginalization, in war, crisis and peace.

The negotiated outcome document combines a return to the basics while still adding something new. In promoting public health for all, the outcome document brings back the integrated primary health care approach, the social justice and rights imperatives, and participation of civil society as in the Alma Ata Declaration, together with conditional cash transfer, new technology and innovative finance. Dealing with the critical gaps in the health workforce has now moved to centre stage.

Social protection, reflecting the Copenhagen Social Summit, is strengthened with new arguments for a "social protection floor," minimum levels of social security and health care for all, and universal access to public and social services. It is recognized that the commitments made by developed and developing countries in relation to the MDGs requires mutual accountability, both for international financial assistance (more ODA, more effective and more predictable) and domestic investment. Mutual accountability is also required, for enabling international policies and for national policies and governance that favours development, particularly for populations and groups at the margins. It is also clear that better mutual accountability requires better data, improved information flows, and more transparency.

To achieve a major breakthrough, attention needs to be shifted away from a global level repetition of consensus and bracketed texts of disagreement to moving forward on what is known to work and on known barriers to results. A national level drive must include a broad based engagement of governments, parliaments (only briefly mentioned in the outcome document) and citizens in setting and owning policies, priorities, and strategies for achieving the MDGs.

Additionally, at the international and multilateral level, there is a need for change, turning the focus to responsiveness to the efforts of countries, enabling policies, and broader inclusion of actors. More than any time before, the UN now calls for participation in decision making of civil society and non-state actors. For this to be real, the UN can no longer limit its own deliberations to member states only. Moving forward on more inclusive UN institutions and processes will be an indicator of the kind of change necessary for a real turning point.

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The outcome of the UN MDG Summit

Photo: World Health Organization - Europe Offices

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Background

The Issue:

In September, the High-Level Plenary Meeting on the Millennium Development Goals (MDGs) was held in New York. The meeting, which was held in conjunction with a range of related side-events, brought together world leaders and other dignitaries to assess the progress made to date and strengthen their resolve for achieving the MDG targets by 2015. The meeting was generally hailed as a success, with new initiatives being launched, particularly targeting maternal and child health.

Global Health Impact:

The deadline for achieving the health-related MDGs (in addition to the non-health MDGs) is now less than five years away. Considerable progress has been made in meeting a number of health-related targets, yet equally, these gains vary widely both within and between countries. In the wake of a global financial crisis, floods, and other natural disasters, previous gains in health are even now being rolled back.

The Role of Diplomacy:

The MDG Summit was an important diplomatic event meant to garner support, reinvigorate, and refocus the international community's attention on achieving the MDGs. The meeting concluded with the production of a 32-page "outcome document" that contained a 19-point action plan for accelerating progress in achieving the targets by 2015. However, the Summit Outcome Document arguably needs to be seen as reaffirming the international community's commitment to fulfilling the MDG targets, rather than a strategic framework outlining new practical measures to be implemented.

The Summit

The High-Level Plenary Meeting of the General Assembly on the Millennium Development Goals ('the MDG Summit') was held at the United Nations in New York, from September 20-22, 2010. The meeting attracted over 180 high-level dignitaries, ambassadors, and world leaders including U.S. President Barak Obama, French President Nicolas Sarkozy, Chinese Premier Wen Jiabao, and U.K. Deputy Prime Minister Nick Clegg [1]. The purpose of the summit was both to assess the progress made to date in achieving the MDGs, and reinvigorate the international community's commitment to meeting their agreed targets. Over three days, the meeting was broken up between a series of general plenary sessions where delegates were invited to make statements not exceeding 5 minutes duration, (though in typical UN style, most went over 10 minutes), and six round-table discussions (each hosted by two heads of state) where technical matters and next steps were discussed [2]. Throughout the Summit, delegates noted one after another their concern with the lack of progress and the need to accelerate efforts to achieve the MDG targets by 2015. Much of the summit's focus in this regard centred on the progress made to date within Africa, and there was general agreement that much more needed to be done to assist African countries to meet their commitments. South Africa's Minister for International Relations and Cooperation, Ms. Maite Nakoana-Mashabane, summarized this view succinctly, observing that there was a need for all nations to develop "a far greater sense of urgency" with the warning that "If Africa fails to meet the MDGs, the world has failed!" [3].

Concern was particularly expressed over the lack of progress in achieving the health-related targets. The Japanese Prime Minister, Naoto Kan, for example, called for "additional, drastic efforts" announcing his government's commitment to provide USD$5 billion over five years towards advancing the health-related MDGs and a further USD$3.5 billion towards education-specific initiatives [4]. This new commitment, known as the "Kan Commitment" also included an announcement for a further USD$800 million for the Global Fund for HIV/AIDS, TB and Malaria ('the Global Fund') – a commitment that was later confirmed at the Global Fund's Third Replenishment Meeting the following month in October [5]. Similarly, the Chinese Premier, Wen Jiabao, announced at the closing of the Summit China's commitment to contribute USD$14 million to the Global Fund within the next three years, as well as plans to "build 200 schools, dispatch 3,000 medical experts, train 5,000 local medical personnel and provide medical equipment and medicines to 100 hospitals, giving priority to women's and children's health and the prevention and treatment of malaria, tuberculosis and HIV/AIDS" [6].

The concern regarding maternal and child health (MDG 4 and 5) was expected. As reported in the previous edition of the Monitor [7], the G8 meeting in Canada earlier this year announced commitments equating to a further US$5 billion in funding to support additional progress being

made in maternal and child health as efforts to date had been "unacceptably slow" [8]. Consultations had been underway in the lead up to the Summit on a new strategy to tackle this issue, and the United Nations Secretary-General, Ban Ki-moon, subsequently announced at the end of the Summit a new Strategy for Women's and Children's Health that was accompanied by an estimated USD$40 billion in additional funding to support maternal and child health-related activities [9].

Yet despite a general consensus amongst participants that there was a genuine need for accelerated efforts, the meeting was not entirely tension-free. On one side, for instance, a small number of countries expressed concern over a lack of transparency in how official development assistance (ODA) can be occasionally disbursed, particularly in terms of foreign aid by public proclamation. Donor countries also voiced some unease over the sporadic misuse of funds, stressing the need for recipient governments to remain accountable and align assistance more closely with their national strategies for development. Indeed, even the Secretary-General's new strategy on maternal and child health encountered some resistance due to the fact that the consultation process to develop the strategy was viewed as not having been sufficiently inclusive. In part, however, it was the style of the meeting and the Secretary-General himself (who reportedly made an effort to engage more closely on a one-to-one basis with delegations) that has been attributed with ensuring the meeting was valuable and viewed as a success.

The Outcome Document & Next Steps

The outcome document that was agreed to at the conclusion of the Summit reflected many of the views that delegates had expressed throughout the meeting. The document underscores, for example, the "deep concern" that countries hold regarding the lack of progress in achieving the MDG targets and the need to "redouble … efforts" ahead of the 2015 deadline. In addition, the push for greater transparency and accountability in the distribution of ODA was acknowledged, as was the need for countries to take greater ownership of their development and aligning international assistance with their specific needs.

In addition to these more general observations and commitments, considerable attention has been given throughout the document to supporting African countries meet their targets. Special mention has also been made of the need to support both landlocked and small island states, as well as assisting post-conflict countries. Although prior to the Summit questions were being asked as to whether leaders should begin forming a framework for post-2015, all discussion around this topic was intentionally avoided throughout the meeting. Instead, delegates remained focused on the next five years, and in the outcome document countries have outlined a general plan of action and series of commitments to achieve the MDG targets accordingly. The document specifies, for example, the need to facilitate the "expeditious delivery of commitments already made by developed countries in the context of the Monterrey Consensus and the Doha Declaration", reforming international financial institutions to make them more responsive, encourage greater collaboration and engagement with the private sector, and strengthen regional and sub-regional cooperation.

The bulk of the outcome document remains dedicated to outlining measures that can be taken under each of the eight MDG targets to accelerate progress. Under MDG 6 on HIV/AIDS, TB and Malaria and other diseases, for example, the document emphasises the need to support countries that are combating HIV co-infection with TB by scaling up in-country programs to identify all new cases of TB. In this regard the Summit Outcome Document arguably needs to be seen more as reaffirming the international community's commitment to fulfilling the MDG targets, rather than a strategic framework outlining new practical measures to be implemented.

In summary, the MDG Summit attracted a notably high-level of political interest and participation. In part, this can be attributed to the large number of MDG-related side-events that were held in the week leading up to, throughout, and immediately after the Summit. These events ranged in topics from specific MDGs (such as maternal health) to broader matters of financing and sustainability, to state building in post-conflict areas, enabling leaders to meet informally with peers while attending multiple events. At the same time, the majority of interest in the event must be attributed to the impending deadline for achieving the MDGs, which is now less than five years away. Mr Denny Abdi, First Secretary of the Indonesian Permanent Mission to the United Nations, summed up what was evidently the view of many delegates calling the summit "a huge success". Mr Abdi went on to note, however, that the challenge for the international community now is to "use the momentum from the success from this meeting to start anew. We must engage in broad consultation, and we must engage our partners, including regional organisations, to achieve these targets. It will not be easy, but peoples' lives are depending on us" [10].

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Innovative financing for development takes a step forward at the 2010 UN Summit

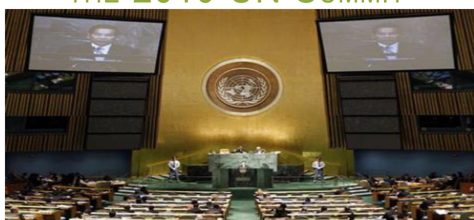

Photo: reuters.com

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Background

The issue

On September 20-22, 2010, when world leaders gathered in New York to examine what needs to be done to meet the Millennium Development Goals (MDGs), several heads of state proposed a new bold step to putting resources behind their promises through a currency transaction tax.

Global Health Impact

The UN Secretary-General's report in March 2010, "Keeping the Promise" called for accelerated progress to meet the MDGs. It noted that both knowledge and resources exist to achieve the MDGs, and that unpredictable and insufficient international financing is blocking progress [1]. The director of UN DESA's ECOSOC Support and Coordination Division, Nikhil Seth observed that collectively, the global community was "falling short" in achieving the MDGs due to a failure to resource them [2]. New mechanisms for health financing, in addition to overseas development aid, are described in more detail below. Those already launched have been projected to raise a further approximately USD$1billion annually, according to sums indicated. Several world leaders raised a new initiative at the MDG Summit for an international multi-currency transaction tax estimated to raise USD$30 billion per year.

The role of Diplomacy

Multilateral tax funding has been blocked in the past by concerns over democratic oversight and how the revenues will be spent. A diplomatic initiative by sixty countries in the Leading Group on Innovative Financing for Development (LGIDF), revived the call for such a tax at the 2010 UN Summit. The Summit recognised in its draft resolution that "innovative financing mechanisms can make a positive contribution" and called for such financing to scale up and supplement, but not substitute, traditional sources. It is likely that attention will grow around effective means to levy global economic activity to pay for global public goods, raising new resources for health and new challenges for African health diplomacy and systems to encourage, orient, and effectively apply these resources.

Why the need for innovative financing?

Meeting the global demand for health needs is estimated to cost US$31 billion annually in 2009, increasing to US$67-76 billion annually by 2015 [3]. African countries, whose total average health expenditure per capita in 2007 at US$153 (purchasing power parity) is only 16% of the global average, have a significant shortfall on meeting this demand [4]. The global financial crisis has exacerbated this shortfall, creating a budget revenue hole of $65 billion in low and middle income countries, of which aid has filled only one-third [5]. Low income countries were found in 2009 to have cut MDG spending, especially on education and social protection, and to have increased anti-poor sales taxes [5]. The financial deficit on resources to meet the Millennium Development Goals overall is estimated to reach between US$324 - $336 million in 2012-2017, including a shortfall of about US$168-$180 million in official development assistance (ODA) [6]. As Professor Jeffrey Sachs recently pointed out: "*….for several MDGs, we know what works but we don't yet have a funding mechanism to connect the proven interventions, the necessary financing, and the strong management needed for implementation*" [7].

What options exist to addressthe resource needs for the MDGs?

One response to the resource gap is to stop the net transfer of financial resources out of developing countries. Global Financial Integrity (2010) estimated that between 1970 and 2008 the outflows due to trade mispricing alone from Africa were as great as ODA inflows [8]. However, this issue merits its own focused attention and is not the subject of this piece.

Another response is for the international community to fulfill their own long-standing promises of ODA [1]. While domestic financing is a priority for all countries, almost all low income countries (LICs) could absorb much more aid without negative economic consequences, whereas they have much less space to borrow or to raise taxes. However to meet the MDGs, ODA needs to be more predictable, adequate, and consistent [5].

In part, existing bilateral and multilateral commitments need to be met. The year 2010 is an important one for the Global Fund, for example, as it faces a replenishment need of between $13 and $20 billion over three years (2011-2013). But, as discussed below, there is also a growing understanding that business as usual will not be enough. President Nicolas Sarkozy of France and Prime Minister Jose Luis Rodriguez Zapatero of Spain both raised in their addresses to the 2010 UN Summit the need for innovative financing, especially through a new tax on international currency transactions. President Sarkozy stated: "We can decide here to implement innovative financing, the taxation of financial transactions. Why wait? Finance has been globalized. Why shouldn't we demand that finance contribute to stabilizing the world through a minuscule tax on each financial transaction?"[9]

Current initiatives on innovative financing for health and development

Calls for innovative options have mounted in recent years. In 2000, the UN set up a panel under the chairmanship of Ernest Zedillo to review the financing of development and particularly of the MDGs. The report concluded that "…if global taxation is considered desirable…new sources of international finance, especially a currency transactions tax and a carbon tax" should be seriously discussed [10]. Nobel prize-winning U.S. economist James Tobin first proposed a small levy on currency trading in 1972 to penalize short-term speculation after the United States abandoned the gold standard and floated the dollar. His idea found no takers then, and lay dormant until the French-based anti-globalization movement ATTAC (the Association for the Taxation of Financial Transactions for the Aid of Citizens) began campaigning for it in the mid-1990s [10]. The Tobin and Zedillo proposals met strong opposition at that time from affected business interests (such as banks and oil companies) and from governments such as the USA, unwilling to turn even a limited taxing authority over to a multilateral agency, especially where they doubted the mechanisms for democratic oversight and how the revenues will be spent [11].

However, the November 2008 UN Follow-up International Conference on Financing for Development to Review the Implementation of the Monterrey Consensus in Doha continued the call for innovative development financing. Countries had already formed a caucus to explore the options. In 2006, France, Spain, Brazil, Chile and others launched the Leading Group on Innovative Financing for Development (LGIFD), a body that brings together countries (currently 60), various international institutions, and non-governmental organisations to promote discussion and action on innovative development financing mechanisms [12]. Most recent new recruits at the 2010 UN Summit to the group were the Bill and Melinda Gates Foundation and the UN Food and Agriculture Organization. The LGIFD motivated the formation of UNITAID, an international facility for the purchase of drugs to combat HIV/AIDS, malaria and tuberculosis. Launched by Brazil, Chile, France, Norway and the United Kingdom in 2007, UNITAID raised US$1.5 billion in three years, 65% of which came from a micro-tax scheme on air tickets [13].

Other countries have since come on board with further financing options. In September 2009, exactly a year before the 2010 Summit, at the peak of a financial crisis, a Taskforce on Innovative Financing for Health Systems, launched by UK Prime Minister Gordon Brown and World Bank President Robert Zoellick in 2008, announced a series of options for new financing measures to raise US$5.3 billion to improve access to free health care, recommending only options that had a clear sponsor for implementation. These included a US$1 billion expansion of the International Finance Facility for Immunisation (IFFIm); a new mechanism for making voluntary contributions when buying airline tickets, expected to raise up to US$3.2 billion by 2015; US$515 million for results-based funding programmes for health; US$360 million worth of debt conversions in the Global Fund's Debt2Health Initiative; launch of a VAT tax credit pilot scheme called De-Tax, expected to raise up to US$220 million a year in VAT resources; and a commitment to explore a second Advance Market Commitment for life-saving vaccines [3]. The Taskforce also argued for greater pooling of global funds into a coordinated, streamlined, programming approach to support health systems [3].

Further, in March 2010, the UN with country partners and the American Society of Travel Agents, launched 'MASSIVEGOOD' an offshoot of UNITAID, that would give travellers in the United States - and then in the United Kingdom, Germany, Spain, Austria and Switzerland – the option when purchasing tickets, booking a hotel room, or renting a car online, the option to make contributions of between $2 and $50 through their internet purchase [13]. The scheme is expected to bring in an additional $600 million to $1 billion in four years, managed through UNITAID's Millennium Foundation and used to purchase treatment of children for HIV/AIDS, bed nets treated with insecticide to prevent malaria, and treatment for tuberculosis.

A new level of financing now proposed through a currency transaction tax

One of the options the 2009 Task Force pointed to was the currency transaction levy proposed earlier by Tobin and Zedillo. Financial flows had increased sevenfold since 2000, with a volume of transactions worldwide of about $3.6 trillion daily for foreign exchange, of $210 billion daily for bonds, and $800 billion for stocks. A tax levy of five cents for each $1000 exchanged could bring in more than $30 billion per year [12]. The proposal lacked a sponsor in 2009, and civil society activists and the Government of France undertook to take it to wider stakeholders [14].

That dialogue has since taken place. At a high level meeting in Paris on 1 September 2010, sixty countries in the LGIDF, including France, Britain, and Japan agreed to a common position to support the introduction of an international multi-currency transaction tax to raise funds for development aid as the most feasible option to deal with the financial deficit in global public assets and in international development [6]. European Union leaders broadly supported the proposal, but struggled to convince the United States to put it on the G20 agenda. While the idea was barely discussed at the last G20 meeting in Toronto, in August 2010, President Sarkozy highlighted that it would be one of his key objectives during France's chair of the G20 from November 2010 [10]. Working with the permanent mission to the UN, he organised a high level session on Innovative financing for MDGs on 21 September as a side event to the recent UN Summit. At the session Bernard Kouchner, foreign minister of France, held up a five-cent coin saying: "This will be the tax on a 1000-dollar transaction. It is impossible not to accept that. Especially when you have in mind that the result of such a tax would be 40 billion dollars a year...".[15]

The deliberations at the UN Summit indicated that a much wider group of countries now hold the view that traditional ODA is not sufficient, and various forms of innovative financing, including the financial transaction tax, are now on the formal agenda. Helen Clark, Administrator of the United Nations Development Programme, observed at the Summit that in a context of significant climate and development challenges, "UNDP believes that applying innovative financing mechanisms, such as a financial transaction tax, offers a promising way of complementing ODA with a potentially significant, sustainable and additional resource flow to achieve the MDGs by 2015 and sustain progress in the longer term"[16]. The UN Summit Draft Resolution of the General Assembly noted in Article 60 the positive contribution that innovative financing mechanisms can make as a 'voluntary' means of mobilizing resources complementary to traditional sources and called for scaling up of initiatives [17].

Two sets of voices now need to be heard. The first is that of African countries (and their civil society and parliamentarians), as their populations face the largest resource shortfall in meeting the global goals. Rwandan President Paul Kagame co-chairs the UN MDG Advisory Group with Spanish Prime Minister Jose Luis Rodriguez Zapatero, and has yet to speak on these options. Yet Madagascar, Mauritius and Niger have, for example, already introduced the surcharge on airline seats and Benin, Burkina Faso, Democratic Republic of Congo, Côte D'Ivoire and Mali are reported to be set to introduce it [18]. How will African health diplomacy and systems engage to orient and effectively apply these resources, including for areas that have high capital demand, such as African-led product research and development innovation?

The other voice is that of the USA. Hecht, Palriwala, and Rao of the Center for Strategic and International Studies argued in March this year that the United States should become a more engaged participant in shaping and backing efforts in this area. "Doing so could yield important health and economic benefits for millions of people in the world's poorest countries and also generate important political and economic gains for the United States" [18]. For the African countries, there is an argument that delays in taking bold measures prejudice not just goals, but lives. For the USA there is an argument that it is not too late to come to the table.

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Learning Lessons from the H1N1 Pandemic: The International Health Regulations Review Committee meets in Geneva for a third time

Photo: The Canadian Free Press

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Background

The Issue

The International Health Regulations (2005) is an international legal instrument that is binding on all the Member States of WHO.[1] The revised IHRs entered into force on June 15, 2007, following an extensive revision process. Members States have until mid-June 2012 to ensure they have built and/or maintained "core capacities" to conduct disease surveillance and respond to a Public Health Emergency of International Concern (PHEIC). In April 2009, the emergence and worldwide spread of the H1N1 influenza virus presented the first real test of the revised IHR framework. Several criticisms of the WHO Secretariat's response to H1N1 have since emerged, including the Secretariat's links with pharmaceutical manufacturers; the decision to declare a Phase 6 (Pandemic); and the WHO's definition of a "pandemic."

The 61st World Health Assembly requested a formal review of the IHR. In January 2010, the Executive Board accepted the request by the 61st WHA to formally review the IHRs and the DG's proposal to use the recent H1N1 pandemic as a test case for that review. The mandate of the committee is to consider both the functioning of the IHR more broadly and to consider the WHO Secretariat's response to the H1N1 pandemic more specifically. The report will identify lessons learnt and recommendations to improve responses to future public health emergencies.[2] The independent IHR review committee currently has 26 members drawn from the IHR roster of experts.

Global Health Impact

The IHRs exist as the primary legislative instrument to prevent the spread of infectious diseases, and minimize disruptions to international traffic and trade. Without robust disease surveillance systems, new and resurgent diseases have the potential to spread unchecked, causing human suffering and death, as well as economic damage. It is therefore critical that every Member State fully implement the revised IHR.

The Role of Diplomacy

International efforts will be necessary to ensure that low- and middle-income countries become compliant with the revised IHRs. Many low-income countries will require significant resources and technical support to implement compliance measures. Member States have until 2012 to comply with requirements under the IHRs.

Introduction

The independent review committee met for a third time on September 27-29. As with the two previous meetings, the plenary sessions of the meeting were open to press, in an effort to increase transparency. The IHR committee, which has solicited information from a wide range of actors, has over the second and third meetings heard from over 40 individuals and delegations from Member States, industry and various organizations [2]. Interviewees were given the chance to present an opening statement before answering questions from committee members. At the third meeting, the review committee heard from the WHO itself for the first time. Director-General Chan acknowledged the need for a review, noting that evaluating the WHO's performance and the operation of the IHR is being "taken very seriously." Dr. Chan firmly denied allegations of undue influence on the WHO by the pharmaceutical industry, and in her opening statement to the committee she said that "never for one moment did I see a single shred of evidence that pharmaceutical interests, as opposed to public health concerns, influenced any decisions or advice provided to the WHO by its scientific advisers." The review committee met for 3 days, hearing from a wide range of witnesses. This was the first meeting of the committee following the DG's statement of August 10 that the world no longer was in an influenza pandemic. The committee is expected to finalize their report in time for the World Health Assembly in May 2011.

Debates to Date

In its work, the independent independent review committee must maintain a balance. While it is evaluating the Secretariat's responses to the recent H1N1 pandemic experience, it must also assess how the International Health Regulations facilitated the response to this public health emergency of international concern. Early on, it was decided that the committee would also look at some of the more controversial issues surrounding the WHO's handling of the pandemic, including questions of undue influence of the pharmaceutical industry and questions around the definition of "pandemic" and the system used to indicate the different phases of the pandemic. The chair of the committee, Dr. Harvey Fineberg emphasized the dual mandate of the committee, noting that the final report will deal with both aspects, drawing out lessons learnt from both the handling of the H1N1 specifically and also the IHR more generally. The committee will meet twice more before submitting their report to the DG [3].

Critics ranging from Council of Europe parliamentarians to journalists writing for the British Medical Journal have leveled serious accusations of undue influence by pharmaceutical companies and a lack of transparency around the management of the pandemic by the WHO. In June, the Parliamentary Assembly of the Council of Europe (PACE) passed a strongly worded resolution (resolution 1749), stating in part "grave shortcomings have been identified regarding the transparency of decision-making processes relating to the pandemic which have generated concerns about the possible influence of the pharmaceutical industry on some of the major decisions relating to the pandemic. The Assembly fears that this lack of transparency and accountability will result in a drop in confidence in the advice given by major public health institutions." [4]

An article published by the British Medical Journal, raises questions about how the WHO managed conflict of interest among scientists who had active roles in pandemic planning for the past decade [5]. The Director-General has strongly defended the WHO, noting, "The bottom line […] is that decisions to raise the level of pandemic alert were based on clearly defined virological and epidemiological criteria." [6] Dr. Fineberg has confirmed that the independent review committee will consider the specific criticism leveled by the BMJ article and the PACE report.

In contrast to past critiques, most people addressing the committee at this third meeting of the review committee were complimentary of the overall efforts and coordination of the WHO. The IHR (2005) is relatively new, and several witnesses noted that it would take some time for Members to be in full compliance with this legal instrument.

Communications and definition of pandemic

More than ever, the recent H1N1 pandemic demonstrated the importance of effective risk communications and the importance of the media. Ms. Feig, Director of the department of Communications, noted that the WHO has limited capacity to rapidly respond to new forms of media such as, for example, social media. She noted, "…we went to war with an empty war chest."

For example, there has been significant debate around the definition of 'pandemic' the WHO used. At a press conference held on September 29, 2010, Dr. Fineberg reiterated that the committee will carefully consider when definitions were used, and the implications of using certain definitions. The committee will consider the issues of

severity and spread. He recognized that a lesson for the future is that definitions need to be clear and consistent.

The WHO relies on a phase system to guide pandemic preparedness and response at the global level. It has a newly revised (2009) six-phase system in place, which groups and describes the levels of the pandemic. "Phase 1-3 correlate with preparedness, including capacity development and response planning activities, while Phases 4–6 clearly signal the need for response and mitigation efforts." Declaration of phase six indicated that there is a global pandemic underway. [7] At the recent committee meeting, DG Chan admitted, "the phased approach to the declaration of a pandemic was rigid and confining." In her testimony to the review committee, she noted that the different phases were intended to ease anxiety, but that, in some cases, they actually contributed to increasing anxiety among the public.

Operation of the IHR

Article 43 of the IHRs allows States (Parties) to take additional health measures in response to specific health risks or public health emergencies of international concern. The text of article 43 outlines that the measures should not be more restrictive of international traffic and not more invasive to persons than reasonable available alternatives that would achieve appropriate levels of health protection. Nevertheless, some witnesses expressed concern that Members had implemented such measures in a manner inconsistent with the IHR.

Dr. Claude Thibeault, consultant to the International Air Transport Association (IATA), representing the airline industry, noted that their members operated in an environment of rapid change, as countries introduced measures such as health declaration cards. Dr. Thibeault noted that there were no standardized cards, and in some cases airlines could not find information about rapidly changing public health measures at the point of entry. He noted that some countries did not follow WHO recommendations and that there was room for improvement on this issue. Dr Anthony Evans of the International Civil Aviation Organization echoed concern outlined by Dr. Thibeault. This testimony brings to the forefront the important issue of Member States complying with the International Health Regulations. Unless States comply, unevenness in the implementation will continue.

Lack of transparency of the emergency committee

Under Article 48 of the International Health Regulations framework, emergency committee members are selected from an IHR roster of experts, or, where appropriate other expert advisory panels of the Organization. Representatives from the affected regions are also on the committee. The Director-General calls the committee, and the committee reports to the DG. The anonymity of emergency committee members caused much criticism of the WHO, by for example, the BMJ. The DG noted in her testimony that the IHRs are silent on this issue, and that they had made a decision that would protect the members of the emergency committee from outside influences.

The committee heard from Dr. John MacKenzie, professor of tropical infectious diseases at Curtin University in Australia and former member of the independent review committee. [8] He was also on the emergency committee. He noted that, in his view, it is essential that the members on the emergency committee should remain anonymous due to the many external pressures from governments, industry and others that could be put on members. He suggested that article 48 of the IHR is not as clear as it should be in terms of the mandate of the emergency committee. Dr. Mike Osterholm, director of the Centre for Infectious Disease Research and Policy at the University of Minnesota said the emergency committee did a good job. He added that in terms of perceptions it might have been useful to make the membership public.

Next Steps

The committee will meet again in early November 2010 and have a final plenary session in January 2011. Dr. Fineberg, chair of the committee, emphasized that further work will continue between now and then. He noted that the committee hopes to complete a draft report by January. He also noted that there is still time for further evidence to be heard by the committee. Following completion of the report, the Director General is due to submit the final report of the review committee to the 64th World Health Assembly in May 2011. It will then be up to Member States what they do with the recommendations provided by the independent review committee.

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Consultations on the future financing of the World Health Organization

Photo: http://transfer-factors.info

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Background

The Issue

The World Health Organization (WHO) relies on two main sources of funding: 1) assessed contributions, which are membership dues which comprise the general budget; and 2) voluntary contributions, which are funds voluntarily donated to fund activities outside the regular budget. [1] Today, 80% of WHO funds are voluntary contributions, and 90% of these funds are earmarked for specific purposes. [1; 2] The WHO conducted an informal consultation involving participants from 27 member states, from 12-13 January 2010 [1]. Participants also included senior officials and ministers, who were speaking in their personal capacity [2; 3]. Two key issues dominated debate: (1) how to align WHO priorities with available funds; and (2) how to ensure greater predictability and stability of financing. [2; 3]

Global Health Impact

Discussion on financing raises two important issues: WHO legitimacy and its role in global health governance. In the 1990s, for instance, large increases in voluntary contributions from a small group of wealthy states raised questions about the World Health Assembly's (WHA) impartiality and democratic legitimacy. [1] Moreover, questions are now being raised about the influence of non-member contributions. In 2008-09, for example, an estimated 31% of voluntary contributions were provided by the private sector and NGOs. [1]

Where governance is concerned, the issue of financing raises important questions about WHO's core functions and priorities moving forward. Sixty years after its constitution was drafted, how should WHO's mandate as the directing and coordinating authority of international health work be understood in the changed landscape of global health? [1; 2] In her address to the informal consultation, WHO Director General (DG), Dr. Margaret Chan, acknowledged that "the WHO can no longer aim to direct and coordinate all of the activities and policies in multiple sectors that influence public health today." [4]

Role of Diplomacy

Diplomacy will serve an important role in establishing sustained financing for the WHO and setting key priorities for its future order of business. Critical to this process will be input generated from two sources: (1) a web-based consultation with member states, launched shortly after the informal consultation; and (2) feedback from WHO's Regional Committees, which had the issue placed on their agendas for 2010. [3]

Preliminary insights from the Informal Consultation:

It was agreed that discussion on the future financing of the WHO cannot take place without preliminary agreement about the WHO's core functions and competencies. Participants to the informal consultation identified core tasks that the WHO is uniquely well-positioned to perform. These include global norms and standard setting, surveillance and response to public health emergencies (e.g. epidemics), the facilitation of negotiations between member states, and its role in coordinating the health cluster in humanitarian situations. [2] However, questions were raised about the WHO's performance/capacity in the area of development, partnerships, country support, and technical collaboration. [2]

Where financing is concerned, participants identified the current model as unsustainable; in particular, the high level of voluntary funds. Discussion thus highlighted elements of a reform agenda. This included "tighter definition and alignment of core funding with priorities and core business; a more disciplined and coordinated approach to resource mobilisation; exploration of new processes for raising funds, identifying new donors and sources of finance; and better communication of WHO brand, impact and success" [2].

European member states have demonstrated high levels of interest on this issue and figure to be important actors in the reform agenda moving forward – in total, European member states contribute 53% of the WHO's voluntary funds and 43% of assessed funds. [3] To-date, EU member states have voiced strong support for WHO, but seem to be moving away from earmarked funding to a more flexible approach. [5] The EU Council:

> … called on EU Member States and the Commission to support an increased leadership of the WHO at global, regional and country level, in its normative and guidance functions addressing global health challenges as well as in technical support to health systems governance and health policy, given its global mandate […] and to gradually move away from earmarked WHO funding towards funding its general budget. [1; 6]

Likewise, the future financing of WHO was discussed at the Sixth Session of the WHO's Regional Committee for Europe (RCE) in Moscow, 13-16 September 2010. [3] A source close to the discussions at the RCE indicated that frank discussions took place between the delegations and Dr. Margaret Chan who acknowledged that the WHO had difficulty in turning away voluntary funds, even when they were not aligned with WHO priorities. Member states replied by calling on the WHO to reject these funds in an effort to improve credibility, accountability and transparency. In addition, member states called for a return to the core functions of WHO, as laid out in its constitution.

The evolving discussion outside the WHO architecture

At a high-level event, hosted by the EU from 10-11 June 2010, senior officials spoke about the future role of WHO in global health governance. [7] Insights gleaned from the two day event highlighted a number of key points that speak to the issue of future financing of the WHO and its core functions. Speaking in a personal capacity, Liu Peilong, Senior Advisor to the Chinese Ministry of Health, voiced support for a strong WHO to achieve five essential functions: "reaching consensus on shared values upon which the various roles and responsibilities of actors are based; to engage all stakeholders and to ensure coherence, alignment and harmonization; to establish regulatory frameworks that include treaties, regulations, norms, standards and guidelines; and to mobilize sufficient resources to meet agreed priorities and to distribute them appropriately." [7]

The web-based consultation and next steps

Official responses to the web-based consultation will be consolidated in late October and will form the basis for an Executive Board (EB) paper in January 2011. [2] In terms of next steps, the responses have generated several options. Amongst these, Norway and Switzerland – which have both taken keen interest in this issue – have suggested two options, respectively. First, the Norwegians have proposed the establishment of a Commission in line with the Commission on Public Health, Innovation and IP. [8] According to their response to the web-based consultation:

> … the issues [of financing for WHO] are broad and link to overall governance for global health. Following a preliminary discussion in the EB/WHA, we would suggest that a Commission be established to enable to address the issues in a comprehensive manner, The Commission's work should be brought to WHO governing bodies. There may however, be a need for an inter-governmental process to reach a final result. [8]

Second, the Swiss have proposed to put WHO's role in global health governance on the agenda of the 128th WHO Executive Board, under the heading 'WHO's role in global health governance and the Future of WHO Financing.' [9] Although Switzerland does not believe any changes to the WHO's Constitution are required, it notes that matters of financing and governance could be partly addressed through a WHA resolution and changes to the Rules of Procedure of the WHA and EB. [9] Indeed, "Switzerland expects that the 128th EB will define a clear roadmap for the necessary reform process. After a detailed debate during the 128th EB this might need further consultations in order to reach a resolution at the 64th WHA in May 2011." [9] The suggested resolution should define issues and modalities of the reform process. [9]

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WHO European Region under new administration

Photo: World Health Organization Europe Offices

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Background

The Issue

The recent sixtieth session of the European regional committee (RC) meeting, held in Moscow 13-16 September 2010, was the first held under a new WHO Regional Director (RD) for the Europe Region. The prominent issues under discussions included the RD's proposed vision for the direction of the work of the Regional Office and issues related to governance and health in foreign policy as a new area for WHO regional action.

Global Health Impact

The European Region of the WHO (EURO) consists of 53 states. It is comprised of some of the world's wealthiest countries, its most advanced health systems, and its most generous donors. It is also home to many emerging economies, both large and small, with diverse trajectories for population health and wealth. Average life expectancy in the region can vary by up to 17 years.[1] Health priorities in EURO include cancer, heart disease and chronic diseases, but there is also an unfinished agenda on communicable diseases such as malaria, measles and rubella, and emergent risks such as multi-drug resistant tuberculosis, antimicrobial resistance, and a recent polio outbreak that threatens the region's polio free status established in 2002.

The Role of Diplomacy

While observers are familiar with the WHO global secretariat headquartered in Geneva, the decentralized organizational structure of WHO delegates crucial authority and responsibility to the six WHO Regional Offices and their Regional Directors. The six regions (EURO, PAHO, AFRO, EMRO, SEARO, WPRO) meet annually in Regional Committee where region specific issues are discussed and positions on global issues are explored. Each regional committee elects a standing committee of Member States (SCRC) which should take negotiations forward in the region and also works closely with Member States from their region who sit on the WHO Executive Board. As such, global negotiations are critically linked to regional negotiations, and the active participation of its Member States.

The Regional Director lays out her vision

The regional committee meeting which took place in September was the first held under the leadership of Regional Director Zsuzsanna Jakab, who was elected in 2009 and confirmed at the Executive Board meeting in January 2010. The meeting was a crucial test of her plans for EURO.

Seven strategic initiatives provide the backbone of Mrs Jakab's vision. The first is the development of a new European Health Policy called "Health 2020." It will be developed through revitalized partnerships with Member States and other key stakeholders, underpinned by the principles of public health, prevention, with a strong focus on health as a multisector issue, and on the social determinants of health. On the latter, she commissioned a new European review on the social determinants of health and the health divide, to be led by Professor Sir Michael Marmot, to feed in the preparation of the Health 2020 strategy [2].

The remaining six components of her vision focus largely on health governance in the region. In her address to the RC, Mrs Jakab emphasised her goal of turning the Region Office in Copenhagen into a centre of excellence for health policy and to strengthen the regional committee as the premier arena for policy dialogue and decisions to shape the work of WHO in the region, keeping with her promise to Member States that they would be in the driver's seat when it comes to the WHO's work in the region. Whereas her predecessor had opted for a more decentralised approach, Mrs Jakab aims to invest in bringing the expertise and intellectual capital back to the regional office. Mrs Jakab has initiated a review process of the necessity to maintain country offices in all 53 states.

Member States warmly welcomed the vision of the new RD. Many Eastern countries sought to emphasise national priorities, such as Turkmenistan, which wanted to ensure that sufficient resources would be available to combat malaria in the region, Kazakhstan, which underscored the need for health systems strengthening and a stronger, tighter net of risk assessment systems, and Belarus, which spoke of bringing local standards for healthcare up to world standards and ensuring equal access to care. Some EU countries chimed in: Finland raising concerns about alcohol control and Latvia with health systems financing. The Polish representative welcomed "the return to a focus on public health," where Slovenia said they could "feel the winds of change."

Other European nations placed emphasis on the details of the governance agenda. Switzerland, which gave substantial financial support to commission a review of the

state of European health governance [3], underscored the importance of the debate on the future financing of the WHO and how this discussion cannot be separated from the debate on the role Member States want the WHO to play. The Swiss put forward that the WHO must play a coordinating role in global health.

Belgium, speaking on behalf of the EU, expressed enthusiasm for the new regional health policy and the governance reform agenda. The EU called for clarification on exactly how the participatory processes implied in her vision will be organized, and in what became a standard emphasis on Member State authority and efficiency throughout the remainder of discussions, they called for the addition of the words “in full respect of national competencies” and “while taking advantage of synergies and avoiding duplication of work” into the text of the resolution on the RD’s vision. [4]

A regional focus on governance and foreign policy

Following a traditional conception of WHO regional committee meetings, one might expect highly technical discussions on ongoing regional medical crises which would involve mostly technical experts. But today’s RCs have become increasingly political, accessible beyond technical circles, and increasingly performed by trained negotiators. In Europe, many countries, Switzerland and Norway in particular, have shown leadership in this transition by increasingly providing diplomacy and negotiation training for their delegations. For example, the Swiss delegation to the RC was comprised of both Ministry of Health and Ministry of Foreign Affairs staff. As a result, interest in the concept of health diplomacy is growing across the region, and the regional director arranged for a technical briefing on global health and health diplomacy at the RC[5]. The key points presented by this briefing centred around the changing nature of public policy, which requires more and more engagement on the international level to successfully address national aims, the advent of “global health diplomacy” and the increasing momentum behind these negotiation processes as a means to address health concerns within the WHO and in other arena such as the WTO, the G8, and the UN General Assembly.

Linked to the adoption of the resolutions on Global Health and Foreign Policy in the UN General Assembly [6], the European Region also supported a stronger integration of health in foreign policy agendas by adopting its own resolution on the topic. The resolution put forward by the regional secretariat recognizes that global health is an integral component of achieving security, prosperity, equity,and dignity at the national level, across the WHO European Region and across the international community, and as such is a strategic interest of foreign, health, and global policies [7].

The resolution urges Member States and requests that the Regional WHO secretariat do more to create stronger coherence between health, foreign and development policy; to increase training of diplomats and health officials in this area; and to foster research and an expanded understanding of the innovations in cross-cutting government strategies that are already beginning to appear in national polices in the European region. Understanding that exploration of this issue is still in early days, this resolution is a firm signal from the European Member States that this is an area in which they give WHO mandate to act. The EURO resolution is similar to the UNGA resolution in that it is a starting point and both urge the improvement of our understanding of this new area of international relations as well as the need to start building capacity in countries. The EURO resolutions are in many ways a response to the UNGA resolution’s call on the UN system and its member states to explore how foreign and health policy coordination and coherence can be strengthened at the national, regional and international levels.

Switzerland, France and Norway in particular have greatly supported the advancement of health in foreign policy as a new area of discussion where the UN and WHO Europe should be active. More Western European countries such as the UK, Netherlands and Sweden have begun to innovate in how they approach and understand global health, and how they work with WHO EURO. This begged the question whether or not this is a pet issue of richer states with little to do with the interest of less developed economies—a question that was voiced at the RC as an intervention by the Israeli representative. The response to this came from the representative from Kazakhstan, who pointed out that with complications brought on by new trends in immigration and violent conflict at the region’s borders, in Afghanistan for example, the issue of coherence between health and foreign policy was indeed an issue of interest to all countries within the region.

Conclusions and next steps

The ease at which resolutions appeared to be adopted at this RC was striking. For the most part, propositions seemed to go unchallenged. Some minor changes where proposed, often by the EU to incorporate moderately stronger language in favour of Member State authority. Notable also was the level of transparency and accessibility of the meeting. Before the RC, the regional director held an open online consultation on her proposed vision—a first for a EURO RD-elect—and the meeting was web broadcasted live to the general public, another first time event for the European Region.

In the coming months, WHO EURO will be busy planning for and implementing the plethora of requests that have come out of the RC resolutions related to the RD's new vision, including extensive governance reforms in the Regional Office itself, which the RD will be expected to report progress on at the 61st Regional Committee to be held in Baku, Azerbaijan, 12-15 September 2011 [8]. For the new regional health policy, the Regional Office is currently holding internal discussions to clarify how the development and consultation processes of Health2020, including partnerships with countries, pan-European institutions, civil society and the scientific and academic community, will be conducted. The issue of partnerships for health in the WHO European Region extends beyond the regional policy, and a separate strategy on partnerships is also to be developed in the coming months and presented to the next RC [9].

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The 61st WHO Meeting of the Western Pacific Region (WPRO)

Photo: Flickr

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Background

The Issue

The 61st session of the regional World Health Organization committee for the Western Pacific was held in Putrajaya, Malaysia, from October 11-15, 2010. This was a significant meeting principally because several key strategies for regional health were reviewed and endorsed. These notably included the Regional Strategy on Health Systems Strengthening and Primary Health Care, the 2010 Asia-Pacific Strategy for Emerging Diseases to combat the spread of infectious diseases, and the Framework for National Health Policies, Strategies and Plans.

Global health impact

The Western Pacific Regional Office (WPRO) currently comprises 37 member states. Although technically it is just one of six World Health Organization (WHO) regional offices, due to the fact that its membership includes the Peoples' Republic of China that has a population equivalent to one-fifth of the world's entire population, this annual meeting can have a disproportionate impact upon global health outcomes.

The Role of Diplomacy

WPRO is the principal forum for advancing human health initiatives throughout the Asia-Pacific region, surpassing other regional and sub-regional bodies such as the Association of South East Asian Nations (ASEAN) and the Asia Pacific Economic Community (APEC) in terms of its technical expertise and influence.

The 61st WPRO Meeting

The 61st session of the regional World Health Organization committee for the Western Pacific was held at the Putrajaya, Malaysia, from October 11-15, 2010. Approximately 140 senior officials from the region's 37 member states attended the meeting. The meeting was comprised of a series of plenary and technical working group meetings where representatives had the opportu-

opportunity to make short presentations and/or speeches on each successive agenda item with simultaneous translation provided in the three official languages of the region (English, French, and Chinese). A core focus of the meeting was on reviewing three key strategy documents for the region that included:

- The Regional Strategy on Health Systems Strengthening and Primary Health Care (HSS);
- The 2010 Asia-Pacific Strategy for Emerging Diseases (APSED); and
- The Framework for National Health Policies, Strategies and Plans (NHPS).

The HSS Strategy

The consultation process to develop a region-wide strategy on health systems strengthening (HSS) and primary health care (PHC) began in late 2008 after a request by the Asia-Pacific Regional Committee. The Committee's request came in the form of resolution WPR/RC59.R4 and followed the publication of the World Health Report 2008 that emphasised the need for developing robust and resilient health systems that were based on PHC principles in order to meet the Millennium Development Goals (MDGs) targets [1]. In September 2008, the Regional Committee requested that WPRO begin proceedings to develop a strategy, based on the "core values of primary health care," to strengthen health systems throughout the region [2]. A draft of the strategy was then produced and disseminated for member states' comments, with the WPRO Secretariat conducting over 240 key informant interviews with representatives from 28 of the region's 37 member states to obtain feedback and further input on the draft. The strategy was then reviewed at a senior steering group meeting in February 2010, and after further revisions, a final draft of the regional strategy was submitted to the 61st Regional Committee for endorsement [3].

Representatives attending the Regional Committee noted their appreciation of the Secretariat's work in developing the strategy, and observed that it is both timely and important for improving PHC systems throughout the region. Dr. Lokman Hakim bin Sulaiman, Director of the Disease Control Division in Malaysia, noted,

"We see this strategy to be particularly important for Malaysia as we move towards becoming a high income country by 2020. The strategy is also very timely for us, as the government is reviewing and restructuring the current health system to respond to the challenge of ensuring universal health coverage based on solidarity and equity, with a focus on building a social safety net for vulnerable groups. We firmly believe primary health care will help us ensure our health system becomes more effective and efficient" [4].

The 2010 APSED

The Asia-Pacific Strategy for Emerging Diseases (APSED) was originally developed and endorsed in 2005 to serve as a common framework to strengthen national and regional capacities to manage emerging diseases [5, 6]. The first strategy document, which has enjoyed widespread support, was also used to assist countries enhance their pandemic influenza preparedness, and following its entry into force, satisfy the core capacity requirements of the International Health Regulations (2005). The strategy established five priority areas of work that included a) surveillance and response, b) laboratory capacity, c) collaboration between animal and human health on zoonoses, d) enhancing infection control, and e) risk communication [5]. The original agreement established a five-year timeframe and therefore, was due to expire in late 2010. Considerable progress was made in enhancing regional outbreak alert and response under the terms of the APSED (2005) framework [7, 8]. Indeed, a number of countries established event-based surveillance systems to detect emerging disease events, rapid response teams designed to conduct disease outbreak investigations were trained, and field epidemiology training programs were established in Viet Nam, the Lao People's Democratic Republic, Cambodia, and Mongolia [7]. In short, the 2005 APSED framework had come to be widely viewed by government officials and health professionals alike as very beneficial. Thus, in July 2009, the Fourth Meeting of the Asia Pacific Technical Advisory Group on Emerging Infectious Diseases recommended the WHO undertake a review of the 2005 framework with a view to developing a new APSED. Over the following year, WPRO conducted a series of consultations throughout the region, both on a country-by-country basis as well as in wider bilateral and multilateral contexts. The outcome of this process was that a new draft framework – APSED (2010) – was developed, and in July 2010 the Fifth Meeting of the Asia Pacific Technical Advisory Group on Emerging Infectious Diseases endorsed the new framework.

The new APSED (2010) framework seeks to build on the progress made to date by encouraging sustainable national and regional capacities, forming new and enhancing existing partnerships to ensure public health security through preparedness planning, prevention, and the early detection of and rapid response to public health emergencies. To achieve this objective, the original five priority work areas of the 2005 strategy have been strengthened, and three new focus areas have been added – public health emergency preparedness; regional preparedness, alert, and response; and monitoring and evaluation [7]. Based on the Fifth Technical Advisory Group's recom-

mendations, the strategy was then submitted to the 61st regional meeting where member states were officially invited to review and endorse the new APSED (2010).

Delegates expressed their warm appreciation for the new APSED (2010) framework, noting the progress that has been made under the former strategy. Dr. Takeshi Kasai, the WPRO Director of Health Security and Emergencies, summarized what was the view of many at the meeting, noting,

"The original APSED, which was endorsed in 2005, has proved a useful framework for Member States, WHO and partners to work collectively to ensure a better prepared region, and good progress overall has been made in strengthening the capacity required for managing the region's emerging disease threats. The 2009 H1N1 pandemic clearly demonstrated the value of investment in capacity building and more proactive preparedness-based activities implemented" [9].

Dr Kasai went on to further note,

"Building on the foundation that has been laid out, Member States made their commitment during the Regional Committee Meeting to further enhance their capacities so that the remaining gaps in capacity development could be filled. The adoption of this updated Asia Pacific Strategy for Emerging Diseases unanimously by Member States represents a vital step of moving even further towards ensuring a safer and more secure Region through collective efforts. WHO will continue to work collectively with its Member States and partners, in accordance with our mandate and responsibilities, to contribute positively to regional health security" [9].

The NHPS Framework

The impetus for developing a Framework for National Health Policies, Strategies and Plans commenced in March 2009 following a meeting of the WHO Global Policy Group (GPG) which is comprised of the most senior level of management drawn from the six WHO regional offices and central headquarters in Geneva. The GPG's decision to focus increased attention on national health policies and strategies was based on the perceived need for greater coordination and consistency across the board in order to meet the health-related MDG 4, 5 and 6 targets [10]. The decision also reflected, however, concerns over the future financing of the WHO in the wake of the global financial crisis and the changing nature of its core business of assisting countries [11]. On the May 24, 2010, the decision was taken by the GPG to "urgently develop a common framework for national health policies, strategies and plans" as well as to provide guidance to WHO regional and country offices to support their respective member states accelerate progress in achieving MDGs 4, 5 and 6 through new funding made available via the Global Fund for HIV/AIDS, TB and Malaria (Round 10) [12]. The production of the draft NHPS framework was the culmination of this work, and each successive WHO regional office had been requested to review and comment on the proposed text ahead of the 127th Executive Board meeting that is due to be held in January 2011. Pending the outcome of that review, it has been proposed to then submit the NHPS Framework to the 64th World Health Assembly in May 2011 for consideration.

Delegates attending the Regional Committee meeting for the Western Pacific region welcomed the draft framework, and expressed their general support for the document ahead of its review at the Executive Board and the next World Health Assembly next year. As the host country of the meeting, Malaysia was amongst those countries voicing its in-principle support, stating, "Malaysia welcomes the call for greater coordination and consistency through a common framework for national health policies, strategies and plans to meet the health-related MDG 4, 5 and 6 targets" said Dr. Lokman Hakim bin Sulaiman, Director of Malaysia's Disease Control Division [9]. At the conclusion of the meeting Dr. Henk Bekedam, Director of the Division of Health Sector Development, observed

"Member States recognize that a strong and robust national health planning process is one of the best ways for a country and its health system to (1) express its vision and values for, and (2) bring increased coherence to, its health sector" [13]. Given that the 61st Regional Committee meeting was the last of the six WHO regional office meetings for this calendar year, the draft framework will now be referred to the 127th Executive Board meeting in January for further discussion and consideration.

Next steps

Although it is likely that several Member States from the region will be participating in other health-related negotiations over the coming months (such as the Open-Ended Working Group meeting on Pandemic Influenza Virus-Sharing and Other Benefits in mid-December), the next official meeting for all Member States will be the 64th World Health Assembly in May 2011.

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Health at the G20 Seoul Summit?

Photo: blogspot.com

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Background

The Issue

The leaders from the Group of Twenty (G20) will meet for their fifth summit on November 11-12, 2010 in Seoul, Korea. The leaders have focused primarily on economic and financial issues, but have continuously widened their agenda to address other topics. While they have not yet addressed health in a direct way, they have touched upon the related issues of aging populations, climate change, food security, and development. Health is likely to be addressed in a similar way again at the Seoul Summit, but whether or not there will be a more focused effort to address the topic remains uncertain.

Global Health Impact

The related Group of Eight (G8) has played a major role in governing global health, particularly since 2000 - from establishing the Global Fund, to committing to eradicate polio and to provide universal access for HIV/AIDS treatment. At the most recent Muskoka Summit in June, the leaders pledged $5 billion to tackle maternal, newborn, and child health. Serious advancements have been made as a result of the leaders' commitments. The G20 is in a position to have a similar impact.

The Role of Diplomacy

The G20 is an example of the highest level of diplomacy, where leaders from the most systemically significant countries reach agreements and make commitments on a variety of global issues. Informal, flexible summit-level clubs, like the G8 and G20, have the advantage of being able to quickly come to a consensus and implement decisions. They also feed into negotiations that take place at the United Nations and in other forums, such as the Asia Pacific Economic Cooperation meetings.

Global Health at the G8

The G8 has influenced global health since the late 1970s, and increasingly so since 2000. At their most recent summit in Muskoka in June, health was a top priority. The leaders acknowledged how far behind Millennium Development Goals (MDGs) 4 and 5 were and they pledged $5 billion dollars to increase support for maternal, newborn and child health initiatives [1-3]. Korea, a member of the G20, also contributed to the initiative. The G8 leaders also committed to replenish the Global Fund, to tackle neglected tropical diseases, HIV/AIDS and polio, and to focus their efforts on training medical professionals. They emphasized the importance of accountability and released a report which tracked progress on 56 past development and development-related commitments [4]. They noted that the G8 had met most their health commitments. In 2011, a second accountability report will be produced that will focus specifically on health and food security [5].

The Expanding G20 Agenda

The G20 is comprised of the most powerful developed and emerging countries, who cooperate and coordinate to address matters that transcend borders. It was first created at the finance ministers' level in 1999 "as a new mechanism for informal dialogue… to promote cooperation to achieve stable and sustainable world growth that benefits all" [6]. Since that time, actors, including academics, politicians and individuals from the WHO, have argued that the group should address global health chal-

lenges [7-10]. In November 2008, the G20 was elevated to the leaders' level to tackle the global financial crisis.

At the leaders' level, the G20 has remained primarily focused on economic and financial issues. Many members, including Canada, have argued that while they are still in the midst of the economic and financial crisis, the G20's agenda should not expand. Rather, it should remain focused on the challenge it was created to govern [11]. However, like the G8, the G20 has slowly started to address other topics, including corruption, energy, climate change, food and agriculture, and development. But other than promises to meet the MDGs by their 2015 deadline and to strengthen social safety nets, including funding for public healthcare, they have yet to tackle global health challenges in a substantial way [12].

The leaders have made progress on some health-related issues, most notably on food security. At the Pittsburgh Summit, the G20 endorsed the 2009 G8 L'Aquila Food Security Initiative [13]. At the Toronto Summit, the leaders committed to closing "agricultural productivity gaps, including through regional and South-South cooperation, amidst growing demands and mounting environmental stresses, particularly in Africa" [12]. They committed to exploring innovative solutions to address food and agricultural challenges, and are scheduled to report on their progress at the Seoul Summit.

The leaders also established a working group on development, which is being co-chaired by Korea and South Africa. Their first meeting took place in Seoul on 19-20 July [14]. A group has been tasked to outline a development agenda and to establish an action plan, which will be submitted to the G20 personal representatives and leaders for adoption and implementation [15].

Health at the Seoul G20 Summit and Beyond

When the leaders meet for their fifth summit in November, it is possible that global health issues will be discussed. However, it is more likely that they will expand on health-related issues, particularly food security and development. The Koreans have articulated that they want to use their summit to broaden the G20's development agenda. It will be one of the key deliverables of the summit. They have been pushing for a differentiated development approach, focused on economic growth, which is meant to compliment other more traditional approaches that have been used by the UN and G8. They are exploring innovative financing mechanisms that could be used. Such mechanisms would support the MDGs and other development-related initiatives. All members have supported this approach.

In 2011, the French will take over as chair of the G8 and G20. Health will be on their G8 agenda. It is likely to feature more prominently on the G20 agenda as well, particularly if the leaders can get the financial and economic crisis under control. The health-related agenda will be expanded, as the French have already indicated that they are planning to host the first G20 agricultural ministers meeting in the lead-up to the G8 summit in June. Thus, food security will be an important issue at both the G8 and G20 summits.

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The impact of trade agreements on health in the African region: The case of Economic Partnership Agreements (EPAs)

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Background

The Issue

African countries are currently negotiating an economic partnership agreement with the European Union to replace the preferential trade agreements that guided their relationship for the past 30 years from 1975 to 2007. The proposed EPAs cover a wide range of issues including trade in goods, services, agriculture, fisheries, investments, competition policy, intellectual property and other trade related issues. As a result, EPAs are likely to impact on health, public revenues for health and health care including access to medicines and to affect other determinants of health such as food security. Without careful analysis during the negotiations, EPAs could have negative impacts on the health systems and population health in Africa.

Global Health Impact

Sub-Saharan African countries have experienced health crises as a result of the late 1980s and early 1990s IMF/World Bank-led Structural Adjustment Programmes (SAPs) that are deemed to have weaken their health systems [1]. SAPs entailed market reforms in the African economies including the health sector. These reforms resulted in increased cost recovery for health care; a growth in private and voluntary provision; falling public budgets for health care; a shift in spending from preventive to curative services; increased commercialisation of public services and out of pocket charges (fees) for public health services; a shift in government role away from direct provision with more contracting out of services to providers and liberalisation of health insurance and a shift to insurance for different groups, pre-paid plans and user charges, rather than tax-based financing. [1] There have been concerns trade commitments in the EPA would translate into more market-based reforms and the negative effects they have been associated to.

The Role of Diplomacy

African countries are still negotiating EPAs with the European Union. Therefore, there is the opportunity to sign an agreement that have clauses that explicitly protect health, or that does not created barriers to achieving national health objectives and commitments.

Introduction

The EPAs that are being negotiated by the Africa, Caribbean and Pacific (ACP) countries on one hand and the European Union on the other are essentially Free Trade Areas covering trade in goods, services, trade related areas and other non trade issues. Negotiations on EPAs started in September 2002, to establish a new set of trade arrangements compatible with the World Trade Organization (WTO) and were supposed to come into force on 1 January 2008. Although this deadline was missed, most of the countries in Africa initialled interim EPAs with the EU "to avoid trade disruption", while others have already signed. [2] The interim EPAs cover only trade in goods but contain a rendezvous clause that mandates the negotiations to cover all the other issues as mentioned above in a full and comprehensive EPA, which was to be concluded by the end of 2008 and extended to end of 2010.

The African countries are negotiating the EPAs under the following regions: West Africa, East and Southern Africa (ESA), Central Africa (CEMAC), Southern Africa (SADC EPA). However, towards the end of 2007, the East African Community (EAC EPA configuration) was formed from the ESA grouping.

There have been concerns regarding the negative impacts the EPAs can have on health systems and population health in Africa. This debate has focused on three main areas of concerns: the impact of trade liberalisation on public revenues, the opening of health services to foreign investment, and the impact of agricultural liberalisation on food security and poverty.

EPAs can reduce public revenues

The interim EPAs provide for the removal of tariffs on 80% of EU imports. This would have a significant impact on government revenues in Africa, given the importance of trade taxes as a major source of public revenue. Trade taxes are still major sources of revenues in most of the African regions. In 2005, as noted by the IMF, around 32 percent of sub-Saharan (SSA) imports came from the EU, "suggesting that—in the long-term—about 1/3 of current tariff revenues (or about 10 percent of non-resource revenues) would be lost from full trade liberalization with the EU." [3] In the Common Market for Eastern and Southern

Africa (COMESA) countries trade taxes account for 4,2 percent of their total GDP while in the Southern African Development Community (SADC) the taxes account for 6,1 per cent of the GDP. In central and West Africa though the taxes account for 1.8 and 3,9 per cent respectively [4]. In smaller countries such as Lesotho, Namibia and Swaziland trade taxes account for over 50 per cent of their total fiscal revenue. [4] Although previous liberalisation programmes in Africa has resulted in some non-resource middle income countries being able to offset revenues lost from trade taxes by mobilising additional domestic revenue sources, others still rely on relatively high trade taxes (such as Namibia and Swaziland).

The long term effects of EPAs can be substantial, as revenues from tariffs from EU imports dwindle and more heavily taxed imports from outside the EU are displaced. The health sector, amongst other social services sectors is likely to receive less budgetary allocations as a result of the revenue loss from duties charged on EU imports. Most of this funding has been going to financing primary health care, including commitments to meet the health related MDGs. These are likely to receive less funds at time when most of the African countries are failing to meet the Abuja Declaration of committing 15% of their national budgets to health.

Risks associated to health services liberalisation

All the five African EPA regions have committed themselves to negotiate trade in services under the interim EPAs that has been agreed upon. Some of the regions like the ESA are already, together with the EU, in the process of developing rules in the services negotiations. Of the twelve service sectors included in the General Agreement on Trade in Services (GATS), at least five are directly related to health care. Professional services under the business service sector deal with services offered by health professionals. The distribution service sector relates to services in pharmaceutical retailing. The education service sector involves the training and education of health professionals. The financial sector deals with health insurance and flows of foreign capital for investment in private hospitals. The health and social services sector includes hospital services, medical and dental services, diagnostic services and management of health service facilities. [5] EPAs negotiations are still going on although no conclusion has been made on the services sector. An earlier services draft negotiating paper of the Eastern and Southern African countries (ESA/EPA/Draft working text/August/2008) confirmed that the scope and coverage of the EPA services would be "those as listed in WTO 120." [6]

Given this wide array of health related services, there are concerns that health services could be further liberalised thereby putting health care provision more in the hands of foreign private operators. The World Health Organisation and the World Trade Organisation have noted that trade in health services carries risks and in some cases, has exacerbated existing problems regarding access and equity of health services and financing, especially for poor people in developing countries. For example, such trade can be associated to a rise in the "brain-drain" of health professionals to high income countries, or to establishments catering to foreign patients, and to situations where for-profit private, hospitals receiving foreign investment "target more lucrative markets and disregard the needs of remote regions and disadvantaged groups.' [7] All these lead to problems in access to and quality of health services.

The negotiations on EPAs should take the above into consideration. EPAs are supposed to be WTO compatible and developments at the WTO on services negotiations should at least inform the negotiations at the regional level for consistency. There have been concerns expressed by African researchers that, given the absence of progress at the WTO negotiations on services in Geneva, African countries may run the risk of going beyond what is required by the WTO, the so called WTO plus obligations when they continue negotiating with the EU. Few countries in Africa have committed their health services to liberalisation under GATS. Only Burundi, Malawi, Rwanda, Zambia and Congo RP have made GATS commitments in the health sector. Balancing the benefits from such commitments and the costs should be an integral part of these countries' analysis when it comes to implementation. [8]

EPAs and food and nutrition security

Another health risk associated to the EPA is the impact of agricultural liberalisation on food and nutrition security in Africa. Agricultural trade liberalization can have an impact on domestic food prices and access to food, as it affects the price of imported foods and the income of domestic farmers. [9] The ESA, EAC and West African regions have agreed to negotiate with the EU provisions for agricultural trade liberalisation. The EU has interpreted agricultural liberalisation to mean complete removal of tariffs on up to 80% of products coming from the EU. The EU will reciprocate by complete removal of tariffs on 100% of products originating from Africa countries with the exception of sugar and rice which have been given transitional periods of up to 2015. However, as the negotiations on the goods agreement has shown, the EU has not shown flexibility in allowing an infant industry protection or safeguard. The same is feared to happen in agriculture where countries like South Africa have reiterated the need for an agricul-

tural safeguard to accompany the liberalisation schedules.

With the EU subsidising its agricultural sector to the tune of US$56 billion in 2009, it is likely that agricultural liberalisation will result in African countries losing their autonomy to produce and feed their populations due to massive competition from EU products. Most African farmers produce for local consumption. Research by the Food and Agriculture Organisation has shown that farmers who produce for the export market tend to benefit from trade liberalisation. [11] However, those who produce for the local market face the competition of subsidised products that often depress prices and in some instances force them out of production. This affects health in two ways. First the farmers find it difficult to continue production thereby affecting their and the country's food self sufficiency. Relying on imported products exposes them to the volatility of international prices of the food products. This may limit their access to nutritious food which is essential for their health. Secondly, the competition with imported products may reduce prices thereby affecting their incomes, which traditionally have been low. Households with poor incomes have failed to access health services especially in situations where the services have been liberalised and being offered by private institutions. With poor nutrition many people in Africa, particularly children and the vulnerable are susceptible to various diseases.

Next steps

Both the EU and African countries are determined to conclude EPAs. But African countries are arguing that they can only conclude EPAs that support their development strategies and do not affect regional integration initiatives. Health care provision is one of the major developmental issues that will be affected by EPAs. The different African regions are at various stages of negotiations with the EU and the deadline of end of 2010 to conclude the eight-year old negotiations is unlikely to be met. Indications in the various regions point to the fact that negotiations will spill into 2011. The joint meeting of the African, Caribbean and Pacific (ACP) countries trade ministers meeting with their EU counterparts in October 2010 did not give any impetus to the negotiations. The ACP countries are demanding developmental EPAs. It is now left to the EU-Africa summit of Heads of State and government scheduled for end of November 2010 to give political impetus to the negotiations. Without that, the technical negotiations are deadlocked and stalled.

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