



Meeting: "The G20 at Leaders' Level?"
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The G20 and Global Public Health

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There are myriad forums where critical issues in global health governance are discussed but almost none that involve heads of state. Notable efforts in the past involving heads of state relate to specific one-off events such as the 1991 UN Declaration on the Rights of the Child, or the UN General Assembly Special Session on AIDS in 2001. These events represent important milestones but lack the rigour and regularity necessary to ensure compliance with or significantly alter the global health agenda.

For most of its nearly 30 history, the G7/8 has not focused on global health in a major way. From the mid-1980s through the 1990s there were periodic discussions on infectious diseases. In 2000 in Okinawa, however, with the recognition that health is central to economic development, the G8 pledged a quantum leap in the fight against HIV/AIDS, TB and malaria. G8 leaders made good on this pledge the following year in Genoa in supporting the launch of the Global Fund to Fight AIDS, TB and Malaria. In 2002 in Kananaskis, a G8 Africa Action Plan included actions to combat AIDS, strengthen health systems, eradicate diseases – especially polio – immunize children and support health research. A Health Action Plan emerging from Evian last year outlined similar objectives but with new provisions related to the threat of SARS.

With the emergence of billion dollar global funds and an increasing proportion of ODA going to address the AIDS pandemic, one might be tempted to conclude that the world's leaders are catalyzing the action necessary to combat illness and expand opportunities for health globally. Although the recent movement is in the right direction, both the scale of the proposed efforts and the rate of change are wholly inadequate. We are not on track to achieve the health-related Millennium Development Goals (MDGs) by 2015: in 15 countries in Africa trends in child survival indicate a net deterioration. Plans for scaling up health systems are being paralyzed by antiquated, inappropriate and unquestioned frameworks governing the role of the public sector in economic development. And despite the clarion of SARS, and now Avian Flu, the world's leaders – political and business – continue to systematically under-invest by several orders of magnitude in an efficient and effective global system of outbreak surveillance and response.

A G20 could help to drive the global health agenda.

By G20, I understand an informal, regular gathering of national leaders representing the current global diversity from an economic and social development perspective. The G20 would address critical or tough issues through some "honest talk" and "head-knocking" with a view to instilling the political consensus necessary to drive forward the short and longer-term agendas of relevance to global interdependence.

Given this definition, I foresee three ways of conceptualizing the way in which a G20 process could make contributions to setting a more balanced and equitable agenda for global health.

Redressing Errors of Omission:

This area of G20 engagement could be broken down into three areas: i) country or region health crises; ii) neglected global health priorities; and iii) leadership lacunae.

i) Country or regional health crises

Despite remarkable progress in global health in the last 50 years, in the last 10 years we have witnessed some extremely disturbing trends. The former socialist economies of the Soviet Union have experienced “reversals” in life expectancy. Initially analyses pointed to a disproportionate decline in adult male survival, although more recent evidence points to deterioration in health for women and more worryingly perhaps for children. That the reversals in health status in these countries have received so little international attention is alarming. Similarly, although the health crisis in Africa has received a lot of attention in terms of HIV/AIDS, less attention is being paid to the fact that in at least 15 countries, there are significant declines in child survival. G20 leaders could draw attention to these “health crisis” countries and regions and ask whether enough is being done or whether new action is required.

ii) Neglected global health priorities

G20 leaders could take up specific health issues that have failed to register as they should on the global health agenda. These health challenges can be considered in terms of unfinished agendas, imminent threats and future challenges. The unfinished agenda relates primarily to premature death of infants and children and their mothers during child-birth – the large majority of which are preventable with existing low-cost technologies or interventions. Even though ambitious MDGs have been articulated for maternal and child health, their achievement is unlikely without more realistic

reckoning of what is required. G20 leaders could catalyze the action necessary to get these MDGs on track. They could support the development and financing of specific multilateral leadership mechanisms, call for greater accountability from political leaders where progress is lacking and identify more realistic and tangible strategies to strengthen the systems necessary to improve maternal child health.

Among the many imminent threats, new infectious epidemics are perhaps most topical. SARS and now avian flu reflect the new global reality of one world health. Effectively dealing with this reality necessitates supporting the global architecture related to outbreak monitoring and response along with the capacity to implement the measures necessary to minimize spread and impact. The G20 with its more global reach (compared to G8) could assess the extent to which there is global preparedness and prevail upon the key actors, many of whom are found beyond the health sector, to work with the global health system more effectively.

In terms of more prospective and longer-term threats, the G20 could raise and wave the flag on non-communicable diseases (NCDs). This endemic problem is fast emerging in every country of the world fuelled by ageing populations and life-style changes, e.g. diet, exercise and smoking. Worryingly, however, the state of global preparedness is abysmal. Symbolic of this is that the World Health Organization (WHO) division working on NCDs has but one person to deal with diabetes and only two persons to deal with stroke. G20 leaders could not only help to secure a more credible leadership role for WHO, they could also strengthen the demand for the development of low cost and effective strategies to stem the burden of NCDs. The leadership required, however, is also at the level of heads of state as the issues involved in dealing with NCDs go well beyond the health sector and include food

policy; trade and tobacco; financing of public systems, etc. (see below – intersectoral engagement).

iii) Leadership lacunae

Many of the crises in health reflect failures in leadership at the highest levels. Despite signing on to many conventions and agreements, the track record of many leaders to following through on commitments is lamentable. About 70% of childhood deaths globally are easily preventable as are most deaths of child-bearing mothers. Should not leaders in those countries where preventable child and maternal deaths are unacceptably high be held accountable? The G20 could label the laggards, invite them to the table for frank discussion and offer constructive advice based on diverse experiences and perspective around the table. Given the composition of the G20, such discussions are likely to illuminate other dimensions of these problems where more effective leadership is required such as the uncertainty of long-term donor funding, the constraints of current public sector financing frameworks, and the loss of skilled health personnel through migration.

The migration of health professionals from poor countries to rich is an issue that that would be more likely to register and be dealt with credibly in the G20 as compared to the G8. A leader from a country like South Africa or Nigeria for example would make reference to the evidence on the growing “loss” of professionals from their countries to the North facilitated by professional recruiting agencies hired on behalf of national health schemes in the North facing their own acute shortages. Countries like the Philippines or India might reveal their export-oriented strategies whereby health workers are trained for work in the North in recognition of the importance of worker remittances. Countries like the UK might be quicker to recognize that their “ethical recruitment” policies are failing. There is no shortage of

complexity in dealing with this issue – one that could be relegated easily to the straight jacket of a definitive study – however, there is an acute need for action. The G20's informal and inclusive but direct and deliberative modus operandi could help to accelerate some credible options for moving forward quickly and thereby fill the current leadership void.

Scale efficiencies in cooperation

A number of health issues require or would benefit enormously from more effective global cooperation rather than independent and uncoordinated efforts at the country level. As noted above, global epidemic control is more efficiently and effectively attained through strengthening international health regulations and the capabilities of WHO. The role of the G20 would not be to define the content of the International Health Regulations but rather to see how various components of their implementation might be enhanced and insure that they do not get stuck in bureaucratic backwaters. Specifically, the G20 leaders might commit their governments to looking at how to do business differently – to move from inefficiencies that emerge at national level to global scale efficiencies. In health research for example, the global public health needs for a malaria vaccine or a new drug for tuberculosis are not sufficiently lucrative markets for significant private sector investment in research and development. G20 leaders could endorse transnational, virtual drug or vaccine development efforts by pooling funding to innovative public-private partnerships, spreading the risks, and inefficiencies of each country supporting its own independent mechanisms and efforts, e.g. an AIDS vaccine. There is a cascade of other areas for cooperation on development and access to drugs that the G20 composition could facilitate given its

likely inclusion of the large majority of the multinational drug manufacturers (including generics).

Likewise, G20 leaders given the inclusion of both donor and recipient countries could focus more realistically on the shortcomings in the current behaviors in development assistance (errors of commission!). As a recent analysis of ODA policies has concluded, aid works best when it is part of an overall, coherent, nationally-owned strategy, designed within a medium and long-term framework. It works least well when it is assigned to projects that are specific to each individual donor, externally designed and poorly harmonized, subject to complex and burdensome reporting and accounting techniques. For example, the likelihood of success and the efficiency of Canada's support for AIDS treatment scale-up in Tanzania and Mozambique could be improved significantly if a fraction of the \$100 million were invested in coordinating mechanisms linked to other AIDS treatment efforts and systems strengthening efforts in those countries. As Peter Piot stressed in his recent Presidential speech to the World Bank, we need "three ones", one national plan, one investment plan, and one monitoring and evaluation system. Achieving such coherence requires a much stronger commitment of donors to invest in the multi-lateral mechanism at country level and a retreat from country-level bilateralism. The G20 could endorse the principles and recognize best practices for effective multi-lateral coordination at country level.

Catalyzing complimentary action beyond the health sector

The health agenda relies on important support or cooperation from other sectors such as finance, trade, education and local government services. The requisite coordination across sectors is often difficult to achieve without high level leadership facilitation.

The mobilization of significantly increased resources for health development through the Global Fund for AIDS, TB and Malaria is an interesting example of the challenge of intersectoral coordination. On the one hand, the mobilization of a billion dollar fund is testimony to the power of G8 leadership. G8 leaders' commitment to addressing diseases of poverty and recognition for a significant expansion of health care in poor countries led to the successful capitalization of the GFATM. On the other hand, the lack of sensitivity or planning to address the constraints inherent in the rules that govern public sector financing in low income countries reveals a limitation of the G-8 that might be overcome by a more inclusive mechanism. A G20 could ask whether financing frameworks that dictate expenditure ceilings and debt ratios in the name of "fiscal sustainability" are commensurate with effectively addressing destabilizing health crises. G20 leaders' attention to this area could induce some badly needed reflection and reform on the instrumentalities of financing for health development in the larger framework of development financing. Managing public sector debt to minimize the risk of fiscal and monetary instability is critical; however, if it is done at the expense of a nation's health and possibly its development, then it needs serious reconsideration.

Some considerations on process

Above and beyond these illustrative areas where the G20 could help to set the agenda in global health, there are several process issues in the design and operation of such a mechanism that need to be considered in the context of current arrangements in global public health.

Twenty heads of states from around the world is likely to produce a healthy balance of perspectives on any given health issue. It is clear, however, that some

issues might benefit from a slightly different balance in participation of countries. On an issue like pharmaceutical capacity, it might be better to ensure that close to 100% of the manufacturing for export industry are represented. On issues like best practices in ODA or harmonization, having stronger representation from a greater diversity of recipient countries may be helpful. Mechanisms to support flexibility in participation or even rotation (while preserving sufficient continuity) might help to enhance the credibility of the G20 forum amongst those not at the table.

In terms of participation beyond the G20 leaders, it would be important to include the leaders of the multi-lateral health agencies – WHO, UNICEF, WB, UNFPA – and other major players in global health or relevance to a specific G20 agenda from the private sector (for-profit, not-for-profit and civil society), professional groups and academia.

The G20 should maintain close with the major health forums such as the World Health Assembly. Specific attention should be paid to the recently created WHO/WB High Level Forum on Health and Development which has just completed its second meeting. Although the HLF does not attract heads of state, its aim for high level engagement (beyond Ministers of Health) with balanced participation is similar to a G20 for global public health. The forum might represent a possible precursor to a G20 focusing on health and as such should be evaluated in terms of lessons learned.

The G20 should limit agenda items for any specific meeting and set a clear 2-3 year time horizon to assess whether it is in fact value-added.