Meeting Report
University of Peace
November 12-13, 2004

Introduction

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

Context

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

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

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

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

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

Commissioned papers

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

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

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

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

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

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

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

Ricardo Kuchenbecker focused on capacity building. He made a compelling argument to revise the definitions of capacity building. He argued for a more comprehensive approach for capacity building as a core element of technical cooperation. More money and more coordination are not enough. He pointed out that some of the multilateral and bilateral agencies unfortunately do not address CB as a context-dependent issue. He reminded that sometimes the desired civil society network does not exist. "Many recipient countries usually have a weak civil society that is also subordinated to the State, and it is not possible to expect that the NGO sector can regulate the necessary initiatives." He suggested "codes of conduct establishing the role of donors, multilateral agencies and national authorities in technical cooperation initiatives; longer projects that are able to address CB as a core element, intrinsically related to outcome indicators; practical initiatives to assure the transference of skills towards learning-by-doing approaches; and a new model of NGO collaboration and an innovative framework to provide synergy between multilateral/bilateral initiatives in the developing countries."

Huang Yanzhong recommended "Building a Global Bio-Defense Shield". Using the bioterrorism frame as a means of securing US support for an L20 initiative on global infectious disease was controversial. Two main positions on the issue were evident:

1) including bioterrorism on the agenda may divert essential resources and attention away from more critical diseases such as HIV/AIDS, malaria or tuberculosis, (i.e. the security frame threatens to undermine the actual objectives of addressing the infectious disease at the multilateral level);
2) in contrast, the use of a bioterrorism frame may accomplish the same goals as an infectious disease frame, and could be implemented as a re-packaging of monitoring and surveillance initiatives (i.e. the frame is benign and will be used to accomplish the same goals of improving health, regardless of how it is packaged). The frame will be able to secure powerful US support and resources for initiatives that will put into place and maintain the same surveillance systems required to effectively monitor disease outbreaks globally, and must be pursued if any L20 action is to be effective (i.e. the frame is positive because it secures the support of a major player, without which there is likely to be limited chance of success).

Determining the US position in regard to bioterrorism, or health in the security context is necessary to resolve the controversy.[2]

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[2] David Heymann pointed us to the US public record. While the US did reject the proposed Composite Text of the Ad Hoc Group of Biological Weapons Convention, its concerns were based on a circumscribed set of issues. The basis of the rejection was, according to a statement made by Ambassador Donald Mahley in

Criteria

The meeting explored pros and cons of the potential initiatives and actions L20 Leaders might endorse. There was a discussion of criteria to review potential initiatives as "L20 ready". These included G20 value added, substantive benefits, tangible results, symbolic attractiveness, scientific certainty, balance of win-wins, fiscal implications, and organizational feasibility. The effectiveness of an approach must also be judged on whether it can engage these Leaders to make credible long term commitments.

Debate

Several initiatives were judged relatively non controversial, such as a "Global Health Corps" for capacity building, trade incentives (preferences tied to good practices), and an insurance fund to encourage reporting of the bad news regarding emerging pandemics.

There was a spirited debate as to whether increased financial resources were required versus the scope to reallocate resources from existing unproductive and inconsistent programs. The consensus was to limit the L20 focus to infectious diseases, but some bemoaned the gaps with respect to non communicable diseases. Several participants lauded the use of counter bioterrorism initiatives as a hook for attracting US support, noting the positive spillover to infectious diseases. Others saw bioterrorism as an unlikely event, low priority and a needless diversion from priority problems. Others noted we want "security" in the L20 agenda item title, but we don't want to encourage a global "Patriot Act". Others noted that bioterrorism is a subset of infectious diseases and that all infectious diseases can potentially pose a security threat.

There was a debate as to the source of needed resources for mid level countries (e.g. Thailand) – should middle income developing countries raise their own resources by property and income taxes on the rich, rather than rely on ODA?

July of 2001, that the proposed Protocol did not fulfill its objective of *enhancing compliance* to the Biological Weapons Convention. Largely, the US position was that the monitoring mechanisms were inappropriate to the specific context. Mahley emphasized that the "traditional approach that has worked well for many other types of weapons is not a workable structure for biological weapons." Despite their position regarding the Protocol, the centrality of assisting "in the global effort to stem, or at least inhibit, proliferation of biological weapons" was repeatedly affirmed.

The US has since reaffirmed its commitment to "strengthen the international community's ability to detect, diagnose and communicate about disease outbreaks." Specifically, Ambassador Mahley, in his statement to the Annual Meeting of Experts for the Biological Weapons Convention, stated: "We continue to work towards universality and to monitor and encourage compliance. Indeed, implementation of national measures, whether they be of a legal nature or involving surveillance of disease outbreaks, is a central component of compliance, which serves to stem the BW threat." In this same statement, the US also endorsed the WHO program on "Preparedness for Deliberate Epidemics," and the importance for inter-institutional efforts and multilateral efforts in addressing the issue of biological weapons.

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

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

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

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

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

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

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

- Capacity building is critical.[4]
- We need to build civil society into our analyses. The approach must avoid being paternalistic.
- Schemes for Vaccine development were supported as important in building for the future.
- Improvement of surveillance is critical; it will facilitate adjustment to unexpected events.
- Developing countries have to put more money on the table, but a solution must be found to the IMF and World Bank imposing caps on government budgets that are legitimate in macroeconomic terms, but highly inappropriate in health sector terms.
- The prospective contribution of faith-based communities should not be overlooked, bearing in mind the potential for skewing of the agenda and real difficulties with respect to certain initiatives.
- Pharmaceutical companies are key players and must be borne in mind in any strategic approach.
- The private sector – not just “big pharma” – but also biotech, private healthcare, and insurance industries must also be remembered.
- Must focus on prevention as well as surveillance and response – clean water, etc.
- Health is inextricably linked to other things we are considering for L20 , education, environment, even terrorism.

Factors important to various players were reviewed:

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

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[4] The L20 may be excited by a "big idea" on which to demonstrate Leadership along the lines of the "creation of a new global health cooperation compact". This would imply revision of the international health assistance architecture, including the optimization of financing arrangements for health development. The focus of this should be very much on improving DELIVERY AT COUNTRY LEVEL to help poor people and accelerate achievement of the health MDGs. Components of this initiative could include:
- streamlining existing assistance arrangements, so as to reduce current inefficiencies and transaction costs;(i.e. identifying what to do less of)
- reinforcing or expanding support for existing good health assistance channels; (ie. what to do more of)
- supporting new channels of partnership and delivery (ie. what additional things to do)
The expected impact of this initiative would be to (a) remove bureaucratic and other blockages; (b) get bigger returns from existing investments; (c) thus making a case for additional investments from donors into health under the "global health cooperation compact".
The L20 could either set up a commission to look into the above...or work could be done on this beforehand so that some concrete conclusions are presented to the L20 summit (having been discussed beforehand in the pre-Summit sherpa-led process).

- In South East Asia it will be important to find a way to keep the issue of human resources across the board on the table – especially the supply of health professionals in developing countries.
- It will be relatively easy to convince Brazil about the advantages of L20 consideration, especially the element of joint learning. Brazil is now sharing knowledge of treating HIV/AIDS with other countries.
- Development of surveillance and improvement in human skills are very important to developing countries. The US will be concerned about intellectual property and undermining trade markets. Measurable results are important, and efforts to get measurement criteria should be pursued. The US will not accept a lot of proposals and is generally against multilateral approaches. Surveillance is an exception. A key US focus is clean water.

Other points made included:
- Proposals for major institutional reforms should be avoided. A counter view, with respect to the Bretton Woods institutions' strictures on Health care budgets was that "60 years was enough".
- The L20 agenda needs to be kept simple.
- Support can be mobilized by focusing on human security (especially preempting bio terrorism).

There was the concern that not all infections but selected infectious diseases were being discussed, with implicit criteria for selecting. Does the term "global infectious diseases" refer only to those acute and epidemic diseases that pose a potential threat to the developed world - HIV/AIDS, SARS, Ebola, possibly tuberculosis[5] and influenza? What about other acute epidemic infections, largely confined to the developing world such as cholera and typhoid, or non-acute or non-epidemic infections again confined to the developing world such as yellow fever, malaria and schistosomiasis? If so, countries beyond the G8 will be quick to recognize the self-interested nature of such an agenda. Governments of poorer countries may agree, on the surface, to support the building of a "bio-shield" in order to obtain much needed funding, but their commitment to actually implementing yet another donor-led scheme designed to benefit rich countries is soon likely to flounder. The initiative needs to be framed in a way that there is true "buy in".

There was a sense that the L20, by agreeing to invest in a coordinated manner, in their own public health sectors (some of which are under funded), for a common shared goal, could set a very powerful example for other countries to follow in attaining the same common goal.

[5] Tuberculosis was ignored for two decades, despite continuing to kill millions in the developing world, until the early 1990s when tuberculosis rates begun to rise again in deprived communities in high-income countries, and drug resistant forms of tuberculosis began to pose a risk.

Summary:

The challenge is to find a balance between a focus on infectious diseases and the need to take a broad public health approach to addressing them - strengthening the ability to prevent infections, and to control and treat infections once they are reported. The task involves building up health information systems, improving diagnostics, making drugs and other treatments more readily available, training health personnel, and tackling "upstream" factors that contribute to infections (e.g. clean water and sanitation).

The key difference from vertical initiatives, which focus on specific diseases for a set amount of time, is that the initiative would seek to invest and develop the health infrastructure to tackle all infections in a coherent and sustainable way. The L20 could set out a clear strategy for taking this broader approach, reconciling the vertical versus horizontal dilemma that has plagued international health policy for decades. Developing such an agenda and strategy should include an inventory/overview of what other initiatives are currently doing (e.g. Global Fund, WHO, Bill Gates etc.), what aspects of infectious disease prevention, control and treatment they are undertaking. An investment in strengthening systems and resources for coping with all major infections across all countries would seem a sensible way forward.

The conclusion of the meeting was that Global Infectious Diseases was a very promising topic for L20 discussion. There was consensus that the issue of infectious disease justifies a Leaders summit, given the rising incidence of infectious diseases and the impacts both on human development and national/international security. There are a wide range of potential initiatives, and many options of putting them together to construct a balanced win-win-win package. There are quite a few good initiatives, but some incoherence among the proposals. It will be important to be selective.