L-20 and Global Public Health.

Draft Background Paper for Costa-Rica Meeting

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

Section 1. Why Global Health?

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

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

Section 2. What is the state of global health?

In 1999, Bill Foege in an article reviewing global health in the 20th century referred to "spectacular achievement and spectacular inequities" (Foege, 1999 -AJPH). In aggregate, the life expectancy improvements across the globe in last 100 years are greater than in the all of previous history. From an average life expectancy of less than 40 years at the beginning of the 20th century, we have moved to close to a

doubling for many countries by the beginning of the 21st century. The distribution of this improvement has been impressive starting initially in the wealth countries of the North with the last 50 years seeing even faster improvements in many countries in the South.

Despite the overall progress there are some countries where health has not improved at the same rate as the global averages and/or where despite initial progress there are now trends towards declines in health status. Specifically, the countries of the former Soviet Union experienced significant health reversals in the early 1990s, while in Africa steady gains in child health have been reversed over the last 15 years in about 15 countries due to a combination of epidemic AIDS and deteriorating social and economic conditions.

When viewed from the perspective of MDG achievement, we see two regions of the world, African and Asia, where we are unlikely or very unlikely to meet the health-related MDGs. Looking at absolute levels of ill-health, the extent to which Africa falls far behind is alarming by any and all measures (see slide 1). The Commission on Macroeconomics on Health found that the evidence for ill-health being a rate-limiting step to economic growth was strongest in contexts where the levels of ill-health were the highest. This is certainly the case for Africa where burden of disease levels that are about 4 times the global average and about 100 times the level in OECD countries, continue to exert a massive brake on economic progress.

Globally, patterns and trends in health have been captured in the concept of "health transitions" (Frenk). First, the "demographic transition" (Omran) describes countries moving from high fertility, high child mortality to low fertility and low child mortality. Close to 100 countries in the world now have below replacement fertility. Secondly, the "epidemiologic transition" describes the move from a health situation characterized primarily by communicable or infectious diseases that exert extremely high toll on infants and mothers to a primarily non-communicable epidemiology that is associated with diseases of aging such as heart disease and cancer and lifestyle including accidents and injuries. Whilst in rich countries these transitions occurred over the last century, in poorer countries they are occurring over a much shorter period of time. In the poorest countries especially Africa, it appears that the burden of non-communicable diseases and injuries has emerged on top of an unfinished agenda of high mortality from communicable diseases and high fertility.

The health-related MDGs draw attention to 5 critical health challenges which disproportionately affect Africa. The risk of dying in pregnancy and childbirth is 100 to 1,000 times more likely for an African woman compared to a woman from an OECD country. Almost 20% of all children born in Africa die before reaching their fifth birthday, with corresponding risks of 10% in South Asia, 4% in Latin America and well less than 1% in industrialized countries. The triad of HIV/AIDS, Malaria and Tuberculosis infections and fatalities are similarly disproportionately found in Africa. HIV/AIDS in contrast to malaria and TB represents a relatively new infection that has become the most devastating pandemic in over 500 years. Its control remains elusive and represents not only the largest health but also the largest development challenge globally.

"One world health"
The opening up of borders, the ease of global travel and the forces of migration, commercialization and urbanization have created what some have called the conditions for "microbial unification". This is the concept that a infectious pathogen in one part of the world can find its way to multiple global destinations with large populations very rapidly (in less than 24 hours). The SARS epidemic in 2003 was one such example leaving its regional origins of south-east Asia and seemingly effortlessly establishing itself as a major threat to all public health systems in the world in several weeks. More insidiously, TB, in its various forms e.g. MDR-TB, remains endemic globally due in part to the flow of people. For example, about two thirds of the cases of Tuberculosis in the United States can be accounted for by immigrant populations coming from countries with high TB prevalence. Increasingly global production and distribution channels of food are also being seen to spread widely the health risks associated with differential standards of preparation and preservation. Behaviours too, once seen to be culturally bound, are seen in a more transnational light with respect to health risks such as road traffic accidents, promiscuity and the sex trade, sedentarism and unhealthy diets.

Health Care Economies - Global dynamics and disparities .
Globally, the health care sector as a proportion of global economy has grown enormously over the last 100 years representing between 3-4 trillion dollars. This growth of health care economies has consistently exceeded the rate of growth of GDP in OECD countries over the last 50 years. There are a number of factors underlying the extraordinary growth of this sector relating to issues such as technological capability, consumer demand and aging populations as well as the relation of the health sector as a whole to other sectors of the economy. Although OECD countries are continuously battling the rising costs of health, the upward pressures on spending appear remarkably resilient in most settings. And given the demographic changes of aging populations, there is active expansion of most health systems to more adequately respond to unmet needs.

The collective size of OECD health economies has important implications around the world. Most importantly, the inability to meet workforce needs from within has lead to an acceleration in "health worker migration" -- the flow of skilled health personnel -- from poorer to richer health economies. In some countries, such as the Philippines and India this global demand has been recognized with training institutions oriented towards producing health workers for the global market above and beyond national needs. In other countries, especially poorer countries in Africa, workers are leaving at increasing rates accentuating the already deadly shortfalls in the national workforce. The likelihood of sustained growth and unmet labour needs in OECD health economies suggests health worker migration will continue to grow in the medium to long term. The magnitude of these global flows of health workers cannot be ignored in planning realistically the workforce needs in poor countries with their own needs for expansion of the workforce.

In 2002, the WHO released the report of the Commission on Macroeconomics and Health. The report argued that improvements in health can lead to growth in the economy and thus argued that much larger national and donor investments in health are merited especially in least developed countries. Although the rationale of this

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

The need to scale-up interventions that work.

The global pursuit of the MDGs and those specific to health (Maternal Health, Child Health, HIV/AIDS, TB and Malaria) has led to calls for "scaling up". Although there are no formal definitions of this term, it refers generally to the need to take proven, low-cost, life-saving interventions from unacceptably low population coverage e.g. <20% and dramatically expand this coverage to a more satisfactory level e.g. >80% of the population. Encouragingly, the opportunity to improve health is not constrained primarily by an absence of technology: with existing interventions, 85% of the burden of illness in a Tanzanian district could be eliminated. The Bellagio group on Child Health found that about 2/3rd of childhood burden of disease could be averted with existing, low-cost interventions. The challenge, therefore, in low income countries is primarily about how to apply what we know works: what some have referred to as the "know-do" gap (Pang et al 2004). With the emergence of billion dollar funds to support priority health challenges such as childhood immunization, HIV/AIDS, TB and malaria there has been a growing awareness of the extent to which systems (or lack thereof) constitute the primary barriers to progress (Travis et al 2004). More specifically the shortages of health workers, the absence of reliable supply chains for diagnostics and drugs, and financing systems that incur impoverishing direct and indirect expenses on patients and their households are some of the major factors preventing the opportunity of health improving low cost interventions from being made more widely available. As these systems constraints and barriers are being encountered in an era of increased donor financial resources there is a growing awareness that the knowledge and know-how to overcome these barriers is in extremely short supply.

Overcoming the "Inverse Care Law".

Julian Tudor Hart presciently wrote in 1971 in a Lancet article entitled "The Inverse Care Law" that the availability of good health care varies inversely with the needs of the population served From his study in Wales, the Inverse Care Law has been found to be robust across countries rich and poor, across different age groups, and different health problems. Research into this behaviour of health systems provides a set of insights related to social gradients underlying both the risks to ill-health and access to health care. The importance of the distributional outcomes in the evaluation of health systems performance was recognized in the World Health Report in 2000. As systems increasingly measure distributional outcomes in health risk, outcomes, access to care and the costs of accessing care, the evidence is growing on the extent to which less privileged or more marginalized populations are at greater risk, have poorer

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

Harnessing the promise of science and technology

Much of what has driven the growth of the global health enterprise stems from the myriad of products - diagnostics, vaccines and drugs, and surgical techniques - that have emerged from large investments in research and development in both the public and private sectors. The spectrum and growth in new products is on the whole very impressive with new "breakthrough" technologies related to imaging diagnostics, micro-surgery, home-based care and therapies emerging rapidly. In recent years, however, there has been recognition that from a global perspective the new technologies are skewed towards the needs of the richest populations - those with significant purchasing power. This skew in the R+D enterprise has been summarized in a ratio known as the 10:90 gap… the observation that only 10% of research resources globally are targeted towards the health needs of 90% of populations living in poor countries. This skew in research resources relative to health needs from a global perspective has catalyzed a set of innovative partnerships that aim to develop new vaccines and drugs for AIDS, TB, malaria and other conditions. The need for technology to support the needs of the poor more satisfactorily is also expressed in MDG 8: *"In cooperation with the private sector, make available the benefits of new technologies, especially information and communications"*. The potential of the ICT revolution in health is just beginning to be uncovered with expectations of a new set of technologies that will facilitate patient care at home, reduce hospitalizations and enhance the quality and efficiency of systems more generally. With the recent WSIS in December 2003 and its focus on ICTs for the poor, there are opportunities to ensure that this next wave of medical and health system technologies has the needs of poorer health economies more squarely on the agenda.

In addition to the generation of new technologies, there is growing awareness of the regulations and trade agreements that govern access to these technologies. The DOHA round of the WTO in 2002 focusing on trade related intellectual property and compulsory licensing opened new global policy channels with the aim of enhancing access to life saving drugs in poor countries.

The International Dimension to Health Challenges in Poor Countries.

The WTO DOHA round is indicative of the growing awareness of the importance of global forces that are shaping health opportunities across all countries. The global ground rules for trade can impact the health sector either directly through trade in health services, flows of health workers, and access to medicines or more indirectly through exposure to environmental and consumption risks. Importantly a global health impact assessment is being applied to processes that were once thought not to be the purview of the health sector. Beyond the official trade for a, the WHO Tobacco Free Framework Convention (TFFC) represents a new tool to bring a stronger health consciousness to global behaviour in an effort to stem the devastating health consequences of Tobacco. There has also been increasing interest in the concept of "global public goods for health" -- health goods like information, research,

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

There has always been a high degree of international engagement in the health problems of poor countries but in recent years there has been an impressive expansion of financing for health development and a concomitant emergence of new actors including NGOs and philanthropic foundations. There have been efforts in the past not only to coordinate within the health sector writ large but also across the development and UN sector more widely. The absence of adequate coordination has led to chaotic and often duplicative or parallel approaches. Within the health sector the mushrooming of initiatives each with their own coordinating mechanisms e.g. GFATM and CCMs, have overwhelmed some of the earlier coordination efforts of partners at country level through the Sector Wide Approaches or so-called SWAps. The orientation of the donor community around the MDGs and efforts to align with primary financing mechanisms has brought the development community together at country level through Poverty Reduction Strategies (PRSs/c) and Medium Term Expenditure Frameworks. Despite these efforts, viewed from below at either the district or country level, the numbers and ambitions of independent initiatives each with their own ways of doing business creates conditions that are akin to a "perfect storm" - the gale force winds tossing around understaffed district health personnel in a frothing sea of activity. This realization has led to renewed calls for help under the banner of "harmonization", and greater coordination on strategy, financing and monitoring and evaluation of health and development assistance.

Diversity - multi-lingualism and multi-culturalism of growing importance in health systems considerations.

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

There are myriad forums where critical issues in global health governance are discussed but almost none that involve heads of state. Notable efforts in the past involving heads of state relate to specific one-off events such as the 1991 UN Declaration on the Rights of the Child, or the UN General Assembly Special Session 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 1990 s 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 esp. 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 G-20 of Leaders could help to drive the global health agenda.

By G-20, we understand an informal, regular gathering of national leaders representing the current global diversity from an economic and social development perspective. The G-20 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, there are three ways of conceptualizing the way in which a G-20 process could make contributions to setting a more balanced and equitable agenda for global health.

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

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

ii) Neglected global health priorities;
G20 leaders could take up specific health issues that have failed to register as they should on the global health agenda. These health challenges can be considered in terms of unfinished agendas, imminent threats and future challenges. The unfinished agenda relates primarily to premature death of infants and children and their mothers during child-birth – the large majority of which are preventable with existing low-cost technologies or interventions. Even though ambitious MDGs have been articulated for maternal and child health, their achievement is unlikely without more realistic reckoning of what is required. 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 G-20 with its more global reach (compared to G-8) 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 (NCD s). 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 NCD s 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 NCD s. The leadership required, however, is also at the level of heads of state as the issues involved in dealing with NCD s go well beyond the health sector and include food policy; trade and tobacco; financing of public systems etc. (see below – intersectoral engagement)

iii) Leadership lacunae;

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

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

2) Scale efficiencies in cooperation

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

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. AIDS vaccine. There is a cascade of other areas for cooperation on development and access to drugs that the L-20 composition could facilitate given its likely inclusion of the large majority of the multinational drug manufacturers (including generics).

Likewise, G-20 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 Presidential speech to the World Bank in 2003, 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 G-20 could endorse the principles and recognize best practices for effective multi-lateral coordination at country level.

3) 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 G-8 leadership. G-8 leader's 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 G-20 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. G-20 leader's 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 to serious reconsideration.

Section 5.. Some considerations on process

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

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

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

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

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

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

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

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

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

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

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

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

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

Why the G 20

- key global public good for health - investments beyond the means or incentives of any single government- this good is undersupplied, underfinanced; need collective action; all countries must have capacity - outbreak alert and response is as strong as its weakest link; all countries will benefit

- actual and potential economic losses of global disease outbreaks far outweigh investment costs needed US$ 30 billion SARS; US$ 30 billion (Asia only) Avian flu. Investments needed for international and national response capacity as well as for incentives for countries to comply with International Health Regulations.

- G20 is an appropriate group to help drive this initiative both through its political leadership and potential influence in insuring resources are mobilised. (The G8 frames these issues as global security - an issue that is relevant for a limited group of countries - the UN system has this on its agenda but will not be able to mobilise adequate resources in a timely manner)

- Essential elements are already in place:
  - international rule about to be adopted: revised IHR
  - global outbreak and response network up and running - GOARN
  - guiding principles for International outbreak alert and response agreed upon
  - WHO track record established - SARS, Avian flu, Ebola

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

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

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

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

Funding sources : In addition to traditional development cooperation funds and funding from the Ministries of Health (contributing to this global public good is in their direct interest) the private sector investment banks, insurance companies and other risk management companies as well as airlines have already expressed interest in contributing to a "fund" that would contribute to lower the risk of global epidemics and their potential economic costs.

4.2. Ensuring all health systems have enough workers globally

Background
In virtually all health systems, the workforce is the decisive factor that translates (or doesn't) the opportunity of meeting health system objectives of better health, responsive health care and fair financing. The workforce spans a spectrum from the home health worker (often mothers) to the sub-sub-specialist as well as the health researchers, administrators, managers and policy makers. In most systems this represents between 50 and 75% of total costs of the health sector. Despite this centrality, the workforce rather paradoxically is quite neglected as a focus for policy and improvement of health systems. This "neglect" has led to a global crisis. The dimensions of this crisis are multiple and manifold. Most worrying perhaps are the more than 50 countries globally where shortfalls of health workers means that essential health services are not provided e.g. emergency obstetric services. Ironically, many of these countries are net exporters of skilled staff further accentuating the short-falls and reflecting both the locally inhospitable work environments and the allure of "greener pastures" elsewhere. The growing health economies of the OECD represent an increasingly powerful magnet for the global health workforce given their own insatiable appetite for more personnel. Unaddressed, the global labour market is likely to move further away from any semblance of equitable equilibrium in either the medium or longer term.

Why the G-20

- The composition of the G-20 is likely to comprise countries on the various parts of the HR spectrum from net importers (OECD), to net exporters by strategy (India, Brazil), to net exporters by default (South Africa, Nigeria).
- the Leaders could bring the necessary intersectoral stick that is required to move policy and initiatives in this area that specific Ministers (Health, Finance, Education, Immigration) are unlikely to on their own.

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

G-20 Action

- A short-term plan to redress the imbalances in the workforce which leave poor populations without life saving services. Such a plan might include removing ceiling on hiring in the public sector immediately, eliminating ghost workers from the public sector payrolls, improving remuneration and benefits of health workers based on work productivity, reducing by one-half the training time for professionals and creating new multi-skilled cadres. The plan would also identify ways in which the under-employed, or early retired, or simply globally committed health "workforce" might play a more important role in the short-term.
- developing a medium to longer term strategy based on projections of global needs, demand and supply such that labour force disequilibria are minimized.
- Third, based on the projections, develop more effective self-sufficiency strategies amongst OECD countries. For the net exporter countries facing severe shortages a special health training or education fund could be established to generate the necessary numbers of workers in the setting of the anticipated accelerated out-migration.

Benefits.

- Greater policy coherence within OECD countries. Rather than becoming a more embarrassing and undercutting issue, i.e. "poaching of low cost workers from countries in greatest health need", it can become an area where shared problems are being actively managed.
- Greater Aid effectiveness i.e. billion dollar funds more likely to yield results with workforce in worst off countries
- More balanced health systems development: health systems in poorest countries are given an opportunity to grow and begin to be seen as credible places for provision of care.
- Revitalization of education and training institutions in developing countries
- Bringing development financing policies to be more supportive of health sector needs.
- Decrease the likelihood of entertaining into options that have little or no yield e.g. restricting individual movement, bilateral compensatory agreements, and codes of practice.

The costs of successful engagement.

The short-term action plan in deficit countries could be financed with GFATM resources. The modelling of medium and longer term needs could be done well with an investment of $10 million/year over five years. The Health Education Fund would become a major pillar of ODA and would represent a much heavier longer term investment in the order of $500 million/year.

Human resource issues face a number of challenges that any plan could not overlook. 1) There is currently little available expertise globally. 2) Managing the workforce in a dramatic way requires overcoming professional turfism, intersectoral inertia, rigid public sector financing rules and public sector pay packages. 3) The set of actors is significant and no doubt governments will have to deal with the sizeable transaction costs.

The multilateral implications.
The are a multitude of multi-lateral actors that have to be engaged in the health workforce issues. To articulate systems normative needs and shortfalls/excesses the health-related agencies lead by WHO with inputs from UNFPA and UNICEF. The international workforce issue require inputs from the Global Commission on Migration and the IOM. The important fiscal implications of expanding workforces in poorest countries requires inputs from the IMF and the WB. New training opportunities and labour laws to deal with the workforce would benefit from inputs from UNESCO and ILO as well.

4.3 Leveraging the emergence of e-health

Background

- Like the invention of written language and the movable print, the revolution in information and communication technology will transform society in radical ways.
- The application of ICT in the health sector (for clinical, educational and administrative purposes) is called e-Health and promises much needed gains in efficiency and equity for this sector.
- Positioned at the intersection of medical informatics, public health and business, e-Health is emerging as the third industrial pillar in health systems in OECD countries (after pharmaceutical and the medical equipment industries.)
- As yet, this potential has not been realized in the poorest communities. The world needs to bridge the digital divide and fast track developing countries to realize the full potential of the global knowledge economy.

Why the G20

G20 countries are well positioned to leverage e-Health for themselves and catalyze concrete platforms and transnational initiatives to fast-track less developing countries.

- The G20 group multilingual background and the rich spectrum of ICT development can facilitate the development and adaptation of e-health platforms for less developed countries.
- G20 countries are leaders in e-Health. The European Commission and the United States are making major commitments to an e-Health future. Health Canada's info highway and the NHS IT project in the UK are well established. Important e-Health progress occurring in India, South Africa, and other countries.
- International agencies are in the early stages of mobilization, including the ITU e-Strategies Unit, the World Bank's InfoDev program, and UNESCO's eLearning efforts including virtual universities.

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

Good buys in e-Health

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

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