ISGlobal SEMINAR ON HEALTH AND GLOBALIZATION

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ISGlobal is convening an international close-doors seminar next September (13-14) in order to discuss the main challenges of the health and globalization agenda; define the interests and added value of Southern European and middle-income countries; and sketch a research workplan and alliance strategy for the next two years.

The seminar will be structured around the issues of Governance, Diplomacy and Innovation & Access. Three experts have worked with ISGlobal in the preparation of the agenda (Suerie Moon, Manuel Manrique and Jean-Hervé Bradol), preparing thought papers that are aimed to provide an introduction to the specific issues and a frame for the respective discussions.

In more general terms, there are five arguments that constitute a starting point for ISGlobal in this complex debate on Health and Globalization, as well as a justification for the pertinence of the seminar. While most of these are widely known, it is fair to state them here as part of the introductory information that frames our approach to the discussions[1]:

1. The health boom might be over

The last decade has been remarkable in the amount of resources, the number of actors involved and the sophistication of the institutional architecture in the global health debate. Despite all difficulties and distortions -including profound imbalances in the attention received by certain diseases and actors-, it is difficult not to see global health as one of the political successes of development in the latest years.

But the boom might be over. In a recent paper that describes the challenges of global health governance, Williams and Rushton[2] state that "a range of economic and geopolitical changes that are already beginning to constrain the material resources and undermine the political dynamism that have driven the boom years in global health". This was more bluntly put to us by a renowned expert in an informal exchange of emails: "In the last two years, a combination of austerity policies,

1 ISGlobal would like to thank Marinne Buissonnere, Suerie Moon and Ola Bello for their helpful comments to this note.

2 Williams and Rushton (2011): Are the Good Times Over?: Looking to the Future of Global health Governance. Journal on Global Health Governance, Fall 2011.

donor fatigue, old orthodoxies and ideologies, resentment by other development sectors, and changing priorities have conspired to produce a severe crisis in development assistance for health".

The uncertainty of the health 'golden years' has been apparent in the debates about the post-MDGs era. There is a tendency to dilute the importance of essential services in a development debate where there are other rising stars such as climate, food markets and natural resources. This is not to say that health-related objectives (such as pandemics and child/maternal mortality) will not be relevant in the years to come, but whether they will still play such a paramount role remains a big question[3].

2. The effects of the economic crisis will go far beyond the financial constraints and will affect delicate ideological equilibriums

The fiscal constraints in a number of important donors are already having an impact on the availability and the quality of health resources. The difficulties experienced by the Global Fund in its last replenishment effort were only a disturbing signal of a phenomenon that is much wider. Traditional important donors in this area, such as Spain, have already mutilated their ODA budgets and the rest can only expect them to stagnate in the coming years. The crisis is also hitting international remittances and developing countries' capacity to raise local resources, which is a triple blow for national health budgets and resources.

Equally important, austerity policies are bringing back an old ideological paradigm that questions the pertinence and the effectiveness of public health systems. This will most certainly undermine the effort to achieve a delicate double equilibrium: In the first place, it will pull back the consensus around the importance of promoting virtuous circles[4] between vertical and horizontal strategies. Secondly, it will further exaggerate the influence of the private-sector practices and language in the response to health challenges (and its patrons, for that matter), which are much more resilient to the crisis. As the British multilateral review has recently shown (and not necessarily in a bad way), in a context where 'value for money', 'efficiency' and 'cost-benefit' are the paramount purposes of aid programs, multilateral institutions are likely to be seen with disdain and national governments will see its role reconsidered.

3 An important recent paper by Leach-Kemon et al (2012) shows that levels of funding for development assistance for health have flatlined or fallen in the past year. *See The Global Financial Crisis has Led to a Slowdown in Growth of Funding to Improve Health in Many Developing Countries*, published in Health Affairs (January 2012).

4 Some authors might find the idea of 'virtuous circles' too optimistic. The concept might alternatively be explained by the idea espoused by Jaime Sepúlveda of 'diagonalizing' vertical programs to drive improvements into health systems, e.g. taking advantage of the resources and political attention that vertical programs can generate to build long-term improvements in the health system, such as via health worker training, infrastructure, etc. See, for instance, *Improvement of Child Survival in Mexico: The Diagonal Approach*, published in The Lancet (December 2006).

3. Inequality remains as a critical pending issue in global health policies, and the crisis will only intensify this fact

The evolution of global health policies in the last years has been marked by at least three main sources of inequality: that related to the social determinants of health (as stated by the WHO's Commission); the one arising from the attention received by a handful of diseases (such as HIV-AIDS) and its opportunity cost for other treatments and for national health systems; and, finally, an institutional source of inequality, that has concentrated the decision-making power in the hands of a few governments and (mostly private) institutions, to the detriment of a wider array of actors and a better participatory mechanism.

The first of these three will only get worse in the years to come, as we state in our previous comments. But tangible improvements could be made in the other two, which are necessary conditions for a more just and strategic global health system.

4. The proliferation of global health institutions and the interest of traditional powers does not guarantee a more efficient and democratic system, nor the reinforcement of multilateralism

The rapid increase in actors and resources has been accompanied by a remarkable level of institutional, financial and political innovation. However, the old, less-operative system has not been replaced by a reliable mechanism of governance. The WHO remains questioned and underfunded, but there are no proper alternatives in place, and the discussions for its reform are painfully slow. The recent discussions around a global treaty that would deal with innovation and intellectual property are only an example of the right discussions, not necessarily placed in the most enabling political and institutional context.

We operate in a governance conundrum. As an expert recently said to us in an informal exchange of emails: "Making choices and formulating policies on the matter of healthcare have gradually ceased to be the sole prerogative of the institutions that had hitherto held the mandate and the responsibility for doing so. This new situation poses fundamental questions about governance and accountability. Who decides policy? How are decisions made? And who is accountable to whom?"

Most importantly, those governments that traditionally played a role in building multilateral responses to this situation might now be shifting their position. A recent blog post by Amanda Glassman on the Global Health Initiative of the Obama Administration not only showed the dilution of the original commitments, but also the risks of a 'diplomatization' of US Health Policies in the sake of unilateral interests. Little more can be said about an absent EU, which lacks common vision and in the future could even reduce its resources.

5. Medium and emerging powers are arriving into this debate and that should be encouraged

The global health debate has been traditionally dominated by an Anglo-Saxon view. From academic centers to donors and philanthropic institutions, the relevance of US and British (and Scandinavian) resources has been paramount. This bias has been intensified by the political importance of MDGs (and therefore Africa and certain diseases) as the main reference for health and development indicators, and it has also helped to underpin a market-oriented view of a number of the main solutions implemented in the last years.

The latter speaks highly about the leadership of these countries and institutions in the global health debate, a commitment that should be cherished in the years to come. But it is clearly not enough. There's a huge hidden potential in a number of countries and regions that could be labeled as 'medium and emerging powers' and which participation in the global health debate has up to now been insufficient.

In the first place, regions like Southern Europe could be much more active: they are donors in the health sector (important ones, in some cases, like Spain in the last 10 years); they have solid relationships with developing regions that have not necessarily been on the spot in the global health debate (such as Northern Africa and Latin America); and they are present in global governing bodies such as the G20.

Pretty much the same could be said about the main global and regional emerging powers (not just BRICS but others such as Morocco or Colombia), but in this case there are a number of additional characteristics that increase their relevance for this debate and the importance of their involvement:

- They have a broader pool of diseases: most suffer traditional poverty-related diseases such as malaria or TB, but the prevalence of NCDs in their morbidity rates and health spending is very high as well.
- Most are still dependent on the access to cheap sources of medicines and treatments, but some (Brazil, India, Thailand) are manufacturers themselves.

- They distrust those multilateral decision-making processes where they have a relatively weak influence, but they are strategically building alternative structures of global governance (WTO, G20, regional initiatives).
- Some of them receive aid, but many they are active donors in some critical areas of economic and social development.

ISGlobal is convinced of the central importance of this debate. We need a better understanding of middle-income countries in the H&G debate: What are their needs and objectives? Do they have a common strategy? What are the unique perspectives and added value? To what extent does it underpin or distract other global and regional objectives? What kinds of strategies would create more effective and equitable governance, and better health for people (and which people)?

Our methodological approach for this seminar

The success of the seminar will be determined by its capacity to define an added value for new partnerships and regional approaches, as well as exploring creative solutions for the challenges surrounding the health and globalization debate. In order to do that, and in consultation with the issue experts that are helping us to organize the event, we have decided to take a methodological approach that is based on three elements:

1) Bringing together the political and the scientific agendas: While we have come a long way in the mutual understanding of scientific and political concerns, more can be done to break the endogamic approaches and establish virtuous circles among these issues, which are at the core of ISGlobal's mandate. For that purpose, we take the first session on the Governance of global health as a general entry point, an umbrella that covers both and involves every actor, and then dive into the challenges of the Governmental (Diplomacy) and the scientific (Innovation & Access) debates.

2) Offering an enabling discussion environment for a variety of views and actors: there's a need to further stimulate the dialogue between actors (governments, multilateral institutions, industry, civil society, think tanks and academia) in order to tackle the risks of the new health and globalization scenarios and underpin its opportunities. Part of this dialogue is to pose some of the most delicate questions, such the role of new actors and the challenges in the agenda-setting process, so it is critically important to guarantee an enabling environment for discussions. Presence in the seminar is subject to invitation, it will aim to achieve a full participation of invited experts and all meetings will take place under Chatham House rules.

3) Defining the expected outcomes: During the seminar, we will try to identify the elements described in the table below, which encapsulates some tangible outcomes of the discussion.

Core issues	Policy Research agenda	Partners