



**European Perspectives on Global Health**  
A Policy Glossary

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# Foreword

This policy glossary is intended to encourage foundations and other European institutions to play a more active role in global health. It is designed to inform policy deliberations in the wider political, economic and social spheres, setting out the challenges of global health and laying the groundwork for coordinated, cross-sector European action.

European foundations active within the European Foundation Centre and its Europe in the World initiative have recognised the importance of health in an interdependent world and have taken a range of cooperation and networking initiatives with international organisations, political institutions and academic organisations. The initiative has urged foundations to spend 5% outside Europe on global and development issues – particularly the Millennium Development Goals.

The EFC and its members have also recognised that further information and advocacy is needed to mobilise political and social action within Europe, to take the global health agenda forward and to translate European values of sustainable development and a commitment to human rights into action on health as a global public good. In short, the key message is that the European Union should play a more proactive role in global health, together with foundations, the corporate sector, health professional groups, NGOs and other European organisations. These should be brought together through networks such as NEF (Network of European Foundations), Europe's national associations of donors, and European and other national health networks and institutions with an interest in global health. The mechanism for this collaboration should be a European Strategy for Global Health.

The idea of a policy glossary was conceived following a panel at the European Health Policy Forum at Bad Gastein 2004 in which Health Commissioner David Byrne made a strong plea for a more consolidated European approach to global health. It was reinforced at a joint meeting between the EFC's European Partnership for Global Health and the World

Health Organization Regional Office for Europe in Copenhagen in February 2005. Its publication and discussion should raise awareness about global health among foundation and other institution leaders and should serve as a resource on how global health can be strengthened in existing programmes and by new partnership initiatives.

In a globalising world there is no such place as abroad – problems and solutions reach across national borders resulting in the need for international collaboration and abolishing the distinction between internal and external national responses. The processes of globalisation are leading to the internationalisation of health risks and ever greater interdependence. Global health requires cooperation and coordination. There is a need for opportunities to exchange ideas and learn from one another, to develop joint action and to protect, promote and improve health.

The promotion of a European perspective on global health reflects the long tradition of foundations as private civil society entities serving public goals. In a world in which civil society has a global context of social and political change and the state is no longer the only guardian of the public interest, foundations have an even more crucial role in promoting public benefit and the global public good. The distinctive characteristics of foundations allow them to add value as philanthropic "venture capitalists", facilitating change in public policy, acting as independent brokers for new ideas, convening meetings with non-traditional stakeholders and bringing their unique perspectives to issues of common concern. They can promote diversity of thought, search for solutions for action, foster international collaboration, provide working capital for ideas to bring them to the market of mainstream funders, and manage the turbulence associated with new and challenging ideas. This glossary will help foundations add value in advancing the global agenda, recognising that the world is facing an unprecedented set of challenges and that the current system for global problem-solving is ill-equipped to deal with them.

To enable Europe to play a more proactive role in global health, the EU must extend its social and economic policies to embrace global health as a keystone for prosperity, security, and solidarity reflecting Europe's values and commitment to human rights and sustainable development. It must include health (and global health) in all policies, assert its approach to global health governance and establish a societal dialogue and partnerships for global health.

For their part, foundation and other leaders of civil society organisations in Europe need to:

- Examine their priorities for action on health and other social goals in the context of global needs and globalisation
- Take a leadership role in defining and influencing policy and mobilising public opinion around global health through supporting think tanks, working with the media, convening and building alliances in keeping with their mandates
- Invest in research and innovation on global issues and their impact on societies by funding knowledge generation and dissemination; developing

approaches to global challenges; building on the tradition of philanthropy in filling critical gaps in knowledge; and making a reality of "health as good economics", "health as bridge to peace" and "making globalisation work for the poor"

- Build collaboration to leverage resources in order to increase their impact by creating new joint ventures such as public-private partnerships and catalysing new resources and cross-sector collaboration

I commend this glossary and in doing so I would also like to acknowledge the outstanding contribution of Ilona Kickbusch and Graham Lister, the other expert contributors, the support of Anna Roca and Sevdalina Rukanova, and the members of the European Partnership for Global Health of the European Foundation Centre.

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# Introduction

## Global health touches the life of every European citizen

*Health* requires an active process whereby individuals, communities and societies create and maintain well-being and the conditions in which it can be attained. It is a co-production of many actors at every level of society.

*Global health* refers to those health issues which transcend national boundaries and governments and calls for actions to influence the global forces that determine the health of people. It requires new forms of governance at national and international level which seek to include a wide range of actors.

A European approach to global health must be based on three fundamental values to protect and improve health as :

1. A human right
2. A key dimension of human security and development
3. A global public good

Global health concerns all Europeans – it is not someone else’s problem. Globalisation has become part of the life of every European through the “globalisation” of everyday life and part of the responsibility of every politician, as very few policy issues remain only national or European in scope.

Until very recently global health seemed far removed from the policy challenges facing Europe – it was dealt with in the context of development aid. Europe has felt a strong moral obligation to address problems in developing countries and the European Union as a whole is the largest development donor, providing about 55 % of all aid and 65 % of grant aid. Within Official Development Assistance (ODA), programmes address issues such as the spread of HIV/AIDS, access to reproductive health, poverty-related diseases as well as some of the key health determinants, such as the education of girls.

But with the SARS and Avian Influenza outbreaks has come a realisation that global health is also about interdependence. New initiatives have been started

to make European citizens safer from global disease outbreaks, and the consciousness is growing among politicians and citizens that major investments will need to be made both at home and abroad. The activities that have been launched to prepare for a potential Influenza pandemic are a good example.

Global health is also about health risks of a non-infectious nature, such as the global spread of obesity and the threats to health arising from our way of life that international companies and media are exporting across the world. Increasingly, international cooperation is sought on issues such as tobacco control, diet and physical activity, and the use of substances harmful to health.

Global health is not only about disease, it also means taking responsibility for the determinants of health in new ways. For example, European politicians need to understand how farm subsidies in Europe can harm health in poor countries, and European consumers need to be aware of the horrendous health conditions under which many consumer goods are produced. There is a growing understanding that health is part of other policies that try to manage globalisation: trade policy, security policy and foreign affairs.

Global health is also about people – about the many citizens of the world still living on less than a dollar a day, having to cope with disease and abject poverty. It is about solidarity and global citizenship and for this reason Europe must embark on a process to explain to its citizens the importance of taking an active role in global health and global governance for health. Europe cannot be an island in an interdependent world; it must help shape a world where others have access to health and health care as part of their human rights and human dignity.

Finally, global health is about extraordinary opportunities. For example, global pharmaceutical and information technology companies based in Europe hold the key to delivering great improvements to the lives of millions, if only their creativity could be applied to the problems of the poor. We have the potential to address many problems with resources that are minor if compared with

the expenditures on armaments or products harmful to health. As the great public health success in eradicating smallpox has shown: if we can mobilise resources now, we will save Europe and developing countries huge costs and health consequences in the future. In short, global health is not *out there* far away – it is here and Europe must act now for global health.

### European foundations call for a European Strategy for Global Health

In order to secure the health of its people and to act as responsible global citizens, Europe needs to raise public awareness and establish processes and channels to engage all elements of society in responding to the challenges of global health. This requires action by and partnership between many different agencies such as the European Commission, the European Regional Office of the WHO, the European Centre for Disease Prevention and Control and European institutions representing private sector industries, civil society and foundations, as well as close collaboration with actors engaged in global health at the national level.

As an initial step, European foundations have created a European Partnership for Global Health to raise awareness at European and national levels of global health issues, using their position as a bridge between governments, industry and civil society in Europe and developing countries.

The aim of the European Partnership on Global Health is to engage all elements of society across Europe to work together to ensure health at home and abroad through:

- Strengthening global health security
- Promoting global health equity
- Enhancing good governance for global health

The willingness and the capacity of states to cooperate is critical for global health – and the Member States of the European Union bring long-standing experience with a range of transnational mechanisms to the table – from policy networks and open coordination to binding agreements and international law – which can serve as examples.

Europe could create the mechanisms to move beyond voluntary development aid to the agreed financing of global public goods to which all actors contribute, particularly those who benefit most from global restructuring.

### This global health policy glossary is a starting point for dialogue

This glossary is a contribution to social dialogue on global health issues in Europe. It provides an introduction to the key concepts and policy issues with links to further reading in each area to help navigate a complex new policy arena.

It introduces five key policy imperatives that could be the basis for a European Strategy for Global Health. It takes the position that:

Europe must:

1. Make global health a policy priority
2. Include global health in all fields of European policy
3. Assert a European approach to global health governance
4. Establish a European dialogue and partnership on global health
5. Act now for global health

The right to the highest attainable standard of health is a human right. It is one of the most important components of human security and welfare; it is a critical global market for European companies and a major public expenditure. Europe needs a strong dialogue on global health so that politicians, citizens, business, civil society and foundations can engage with the global health agenda and contribute to the clarification of principles, values, intent and directions for global health action. Article 129 of the Maastricht treaty (1992), later expanded by Article 152 of the Treaty of Amsterdam (1997), requires the European Union to check that policy proposals do not have an adverse impact on health or create conditions that undermine health promotion – this principle must be understood to apply to global health matters.



## Five policy imperatives for global health

### 1. Europe must make global health a priority

This section sets the understanding of global health in the context of European health values. It describes the connections between globalisation and global health and analyses the global pattern of health and disease. This leads to a discussion of European strategic priorities in global health, indicating the actions that Europe must take.

### 2. Europe must include global health in all fields of policy

This section introduces health as a part of foreign policy and security policy. The impact of agricultural policy, trade policy, health, the environment and sustainability are then discussed, indicating the actions that Europe must take to ensure that health is part of the deliberations in these policy sectors.

### 3. Europe must assert its approach to global health governance

This section describes the key changes that have occurred in global governance and what they mean for health, introduces key actors and indicates what European action on global governance and health should be. It highlights key areas of international

law for health: e.g. international trade law, international environmental law, international labour laws, international human rights law, international humanitarian law, etc. and provides a short description of new international legal instruments in the health area and proposed new financing mechanisms based on a global public goods approach.

### 4. Europe must establish a societal dialogue and partnership for global health

This section introduces approaches such as public-private partnerships, corporate social responsibility and new approaches to civil society and consumer action for health, as well as new types of policy networks indicating the actions Europe must take to move forward in dialogue and partnership.

### 5. Europe must act now for global health

This section highlights some of the horizontal policy issues that are in urgent need of committed global action where Europe could take a significant lead – based on its values and its enlightened self-interest. These issues include: the improvement of health systems worldwide, knowledge management for health, migration and health, a gender-sensitive approach to global health and reproductive rights and health. Finally, a European strategy on global health is proposed.

# 1. Europe must make global health a priority

Health requires an active process whereby individuals, communities and societies create well-being and the conditions in which it can be attained. It is a co-production of many actors at every level of society.

Global health refers to those health issues which transcend national boundaries and governments and call for actions on the global forces that determine the health of people. It requires new forms of governance at national and international level which seek to include a wide range of actors.

Health sustainability is defined as meeting current health needs without compromising the ability of future generations to meet their own needs.

Health is defined by the *World Health Organization* (WHO) as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. To achieve health, societies, communities and individuals must engage in an active process to create and maintain well-being and the conditions in which it can be attained. Health is a co-production of many actors at every level of society and can only be maintained by continuing action to address the determinants of and threats to health.

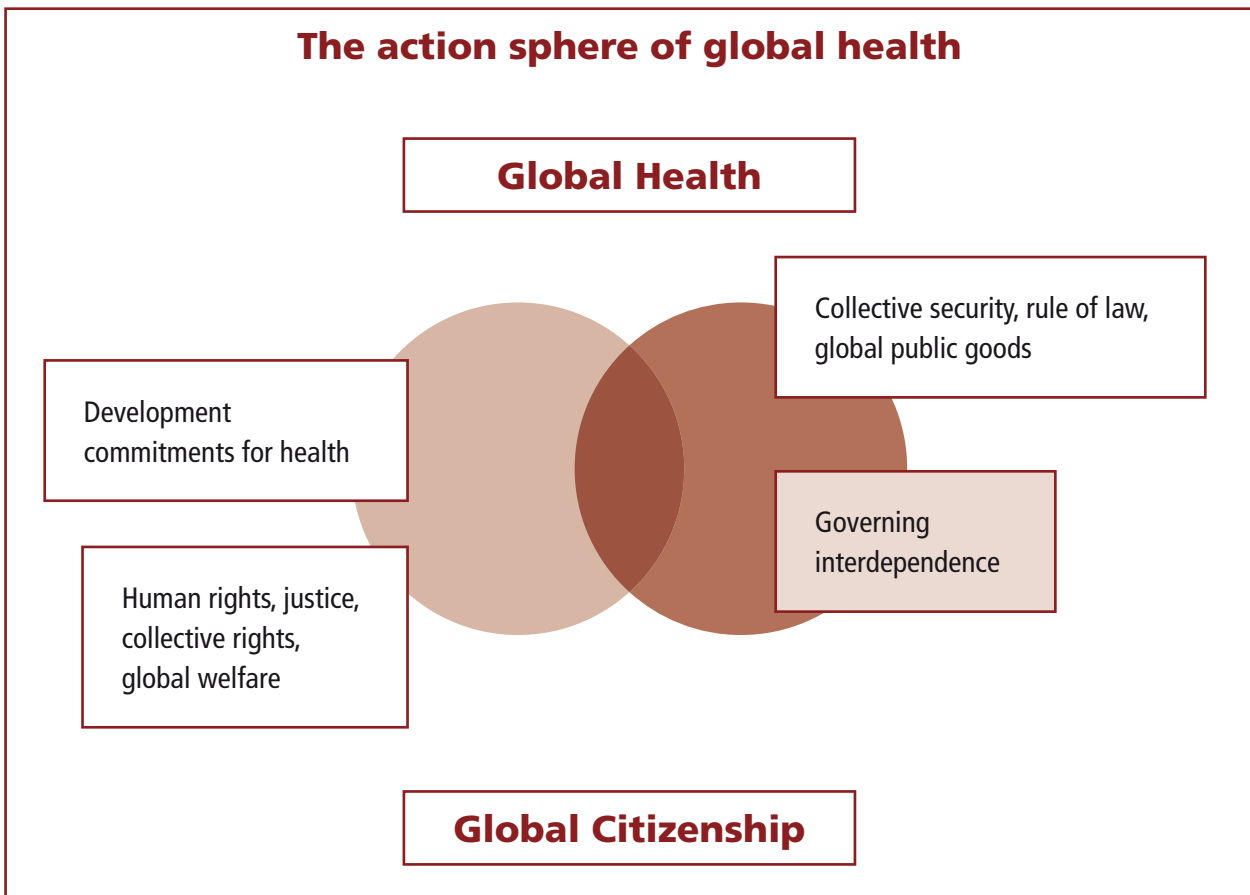
The processes of globalisation are creating new threats to health and its determinants. Health issues that transcend national boundaries include environmental degradation, inequality and lifestyle changes, access to medicines and health knowledge as well as new and re-emerging diseases.

Global health threats are increasingly described as a generational challenge to sustainable development, since if they are not addressed now, they will become uncontrollable threats to the health and security of future generations. Sustainability for health means:

- Addressing diseases such as HIV/AIDS, SARS and Avian Flu, and also determinants of health such as the spread of lifestyles leading to obesity as a global pandemic or addressing the long-term health impact of global warming
- Securing vital global health resources, such as antibiotic agents which are becoming expended as resistance develops through their inappropriate use in rich and poor countries
- Ensuring the sustainability of health systems in rich and poor countries

This calls for a new strategic approach to health governance reflecting the fact that these health issues must be addressed on many different levels by all sectors of society. International action is essential to address these issues not only by governments and international agencies but also by transnational corporations, foundations, non-governmental organisations (NGOs), and organisations of health professionals and consumers.

**Action:** As globalisation is central to the purpose of the EU, it is vital that it should give a high priority to its impacts on global health. It should lead action for global health at the regional level: to protect the health of its citizens, to address global health problems and to establish the conditions in which globalisation will contribute to sustainable development and health. It is proposed that a European Strategy for Global Health, reflecting common European values for health and citizenship be developed.



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### European health values are central to action on global health

European health values are the distinctive set of beliefs about health rights and obligations that reflect European history and identity.

“The Union is founded on the values of respect for human dignity, liberty, democracy, the rule of law and respect for human rights, including the rights of persons belonging to minorities. These values are common to the member states in a society in which pluralism, non-discrimination, tolerance, justice, solidarity and equality between men and women prevail”.

Article Two of the draft of European Union (EU)’s proposed constitution.

European values for health are reflected in many of its legal instruments:

- The European Social Charter, adopted by the Council of Europe (1961, revised 1996) states that: *“Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable”*.
- Article 129 of the Maastricht treaty (1992) requires the EU to check that policy proposals do not have an adverse impact on health or create conditions that undermine health promotion.
- Article 152 of the Treaty of the EU (Amsterdam) 1997 introduced health as a common concern of the union, enabling action to promote and improve health rather than just protecting it.
- The Charter of Fundamental Rights of the EU, adopted in Nice in 2000 states that: *“Everyone has the right of access to preventative health care and the right to benefit from medical treatment under the conditions established by national law and practices.”*
- In its official submission to the European Convention of 2005, the Health Policy Forum requested the European Convention Working Group on Social Europe: “To enshrine as a

cornerstone of Social Europe, the unique existing principles of health equity and universality of access to health services in Europe, while respecting the right of the Member States to organise and deliver health care systems”.

A European approach to global health is based on three fundamental values: to protect and improve health as:

1. A human right
2. A key dimension of human security and development
3. A global public good

Such an approach is confirmed through:

1. The case law of the European Court of Justice which recognises the principles laid down in the Council of Europe’s Convention on Human Rights. This respect for human rights is incorporated into Article 6 of the Treaty. Action is outlined for cases where a Member State seriously and persistently breaches the principles.
2. The European security strategy of 2003 “A Secure Europe in a Better World” which recognises the importance of health to human security and development, while the WHO European Regional Office paper “Investing in Health is investing in Development and Human Rights” makes a strong development case for health.
3. The increasing focus of the EU on the importance of global public goods for sustainable development which underlines the need to address health not only as a development issue but also as a global public good and the recent EU engagement with global health surveillance and health protection in the countries neighbouring the EU.

**Action:** It is important to reach an understanding of European values as they shape global health. This may be a task for the Council of Europe since this body plays a central role in defining values as applied in the European Court of Human Rights in a European Region of 46 states. A statement of European values for global health would also be an important step towards the aim of establishing health in all European

Union policies as proposed by the Finnish Presidency (1 July 2006) and implied by Article 129 of the Maastricht Treaty.

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### Globalisation has a profound impact upon health

“Globalisation can be defined as the “widening, deepening and speeding up of worldwide interconnectedness in all aspects of contemporary social life”. (Held, et al 1999)

“Although responsibilities for health remain primarily national, the determinants of health and the means to fulfil that responsibility are increasingly global.” (Jamison, et al 1998)

The relationship between globalisation and health is a two-way process. There are many direct and indirect ways in which globalisation affects health. The inverse is also true: a society which suffers from a high burden of disease is not in a position to participate effectively in the processes of globalisation and therefore will not be able to share its benefits. And a global disease outbreak can lead to significant human and financial losses all around the world. The interface between globalisation and health has all the ingredients of a vicious spiral, but also the potential for a virtuous circle. Europe is both affected by and contributes to this in manifold ways:

- Globalisation leads to *more rapid spread of health problems*, as a consequence of increasing worldwide travel (infectious diseases) as well as through the spread of consumption habits through global marketing (smoking, changing patterns of food consumption). Lack of control of global disease spread can lead to a range of negative impacts in both rich and poor countries as the SARS epidemic and spread of obesity show.
- Globalisation has helped to *increase scientific and technological knowledge sharing* for the development of medicines, vaccines and medical appliances, which allows new forms of treatment and prevention to develop. It has also improved communication and transport possibilities and thus reduced the technical barriers to access to medical information and treatment. Internet communication has also drastically improved the possibility of tracking and monitoring outbreaks of infectious diseases.

- *Access to medical progress has been more unequal*; as the health sector has continued to grow in developed countries, the economic restrictions for the health sector in many poor countries has increased. Reasons include: pressures on public expenditures, sometimes due to conditions imposed on structural adjustment loans, increasing prices for newly developed medical inputs due to more stringent international property rights rules, low research and development (R&D) expenditures on many tropical diseases, donor focus on disease-specific programmes and lack of priority assigned by some of the countries themselves. Many poor countries also find it increasingly difficult to retain medical staff who are attracted by higher salaries in rich countries.
- *The rapid increase in global interconnectedness* has also transformed the face of international politics. The growing perception of security risks for high-income countries due to health, but also the increasing strength of advocacy organisations in this field and the more active role taken by developing countries in international fora and negotiations related to health has changed the field of international cooperation in health. Many new institutions have entered the field and the roles of traditional institutions have changed.
- *Private actors have rapidly gained importance* as health becomes a major global market. Powerful companies and other private for-profit actors try to defend their strategic position in a liberalised global trade system; this includes food, pharmaceuticals, agricultural products, insurance companies. Global civil society in turn has considerably strengthened its advocacy role and is increasing the pressure on private business to accept corporate social responsibility for global health.

**Action:** “Making globalisation work for everyone’s health” should be at the core of a European strategy for global health.

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### Global patterns of health and disease are shifting

The global pattern of health refers to the distribution of health and the determinants of health that affect the burden of diseases across different countries and regions of the world.

During the past decade a great deal of effort has gone into estimating with greater precision the extent of ill-health and its causes in different countries and regions of the world. Burden of disease estimates both describe the current situation and provide a basis for comparison and describing trends. The most commonly used indicator is the disability-adjusted life year or DALY.

Globally there has been a sustained decline in mortality in all parts of the world in the past century and especially the past three decades. However, there are important exceptions; there have been reversals in life expectancy in Sub-Saharan Africa in the past decade mainly as a result of increased mortality amongst young adults and children due to HIV/AIDS. Health conditions in Central and Eastern Europe have also deteriorated.

In the past fifteen years inequalities in mortality between rich and poor countries and between socio-economic groups within countries have rapidly widened. Accompanying this there have been changes in the pattern of disease in poor countries (especially lower middle income countries) with the rapid emergence of non-communicable or lifestyle diseases in both poor and middle-income communities, with resulting increases in adult mortality and morbidity. In many lower middle-income countries a situation is rapidly emerging where infectious diseases persist *together with* high levels of non-communicable diseases and high levels of violence and injury, often in the same community.

The recent emergence of a 'dual' or 'triple' burden of disease in less developed countries can be traced to processes of globalisation. Continuing rural environmental degradation and accompanying pauperisation of rural communities are resulting in increasingly squalid living conditions. Globalisation, with accelerated movement of humans and animals (and animal products) and more porous borders, is also leading to the rapid spread of both 'old' (e. g.

cholera, TB etc) and new (e.g. HIV, SARS, avian flu) infectious diseases. The increased penetration, as a result of economic globalisation of 'obesogenic' (processed, high fat, high sugar, high salt) diets and increased sedentariness and the spread of global 'bads' (e. g. tobacco, alcohol and habit-forming drugs) largely explain the rise of non-communicable diseases, including mental illness, and contribute to increases in injuries, especially in poor communities.

Europe has a responsibility for contributing to this burden not only as a legacy of colonialism, but as the product of current policies. Trade and agriculture policies prevent rural communities in the developing world from earning their way out of poverty. Failure to counter the migration of health workers has led to the near collapse of health systems in many countries. Failures to provide access to European developments in pharmaceuticals and information technology or to match the Millennium Development Goals with aid and debt relief have made the problems worse.

Many of the CEE states are experiencing a triple burden of poor health and early death, but there has been a lack of awareness of their health problems. The rates of non-communicable diseases are increasing, due to poverty and lifestyle factors and result in much higher death rates due to the failure of health care services. These also contribute to high rates of maternal and infant mortality. Weak health protection services result in lower levels of immunisation, increasing rates of infectious diseases such as HIV/AIDS, tuberculosis and syphilis. Basic conditions for health, nutrition, access to safe water, healthy housing and social order are lacking for many people in CEE. Levels of deaths from conflict and violence amongst young men are three times higher in CEE countries than in the EU and alcohol abuse is a major cause of the decline in life expectancy in several of these countries.

The EU is now starting to address the health and other social and economic problems of countries in the wider region through its 2004 "Neighbourhood Policy".

In Europe as a whole:

- Non-communicable diseases (particularly cardiovascular diseases and mental illness such as depression) represent 77 % of the burden of DALYs.



- Injuries account for 14 % of DALYs, this burden is very high in younger people, with severe social consequences.
- Communicable diseases (mainly tuberculosis, HIV, and emerging diseases) are responsible for 9 % of DALYs. While the burden of these diseases is lower they are as major cause of premature mortality, epidemics can develop at a fast pace and affect the health of large populations, which requires special attention to prevention and control measures.

Within the EU most countries have seen levels of health improve. With tobacco a major preventable risk factor responsible for part of the high burden of non-communicable diseases in Europe, the European Union was among the first to sign the WHO's Framework Convention on Tobacco Control. The European Commission also supported and welcomed the revision and updating of the International Health Regulations as a way to strengthen international cooperation against epidemics of communicable diseases.

However, junk food diets, inactive lifestyles, work-related stress and alcohol abuse are building up health problems for the future. This is recognised in the 2005 EU Green Paper on "Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases". The EU is also seeking to address problems arising from the importation of diseases through agreement on port health measures to control diseases in humans and imported animals and foodstuffs. However, it seems clear that even within countries port health measures are inadequate to control the illegal flows of people and materials. These factors coupled with the increasing cost of supporting long-term care and the declines in informal care threaten the affordability of technical advances in health and care. It seems likely that many EU countries will not be able to afford the levels of health and care service expected by their citizens unless they can address the underlying causes of poor health, including the influence of globalisation.

**Action:** A European strategy for global health should assess the impact of European policies on the global burden of disease, seek ways to reduce negative impacts, and make a positive contribution. The strategy should specifically examine ways of addressing health issues in neighbouring countries

and those from which high levels of legal or illegal migration occur. At the same time it will be important to understand the impact of global health trends on Europe and to seek ways to reduce the impact of globalisation and global health threats on European citizens.

### Europeans must establish strategic priorities for global health

European priorities for global health should be based on fundamental values and must respond to:

- Strengthening global health security
- Promoting global health equity
- Enhancing good governance for global health

Priority-setting for global health action is presently driven by many factors and lacks a coherent approach between European countries, between European organisations and between different parts of the EU. Responses reflect the global burden of disease, the wider impact of health on global political stability and economic development, the perceived impact on Europe, the national interests of EU Member States, the relationship with other partners such as the US, and the successful lobbying or advocacy of non-state actors. It tends therefore to be issue-based and responsive rather than defined by long-term investments in health infrastructures, action on health determinants and intergenerational health sustainability. The European Union and its Member States account for some 55 % of official development assistance provided (about € 50b), however only some 42 % of EU multilateral assistance goes to the poorest countries and about 6 - 8 % is devoted to health. These are broad estimates since there are no clear analyses of the purposes of European aid. If in general Europe has reacted less decisively than the US to the global health crisis, this seems to be because the US has clear policies for global health.

Three examples may illustrate the three strategic priority areas which need to be combined in a common approach:

**Strengthening global health security:** The EU has responded more urgently to issues of health security and the threat of global pandemics and outbreaks that could affect the health of EU citizens, than to the poverty, equity and development challenge. There has been, for example, a long-term accord between the EU and the US to work together to strengthen global health surveillance, initially focused on communicable diseases but now with a wider remit. Since 1998 the EU has funded its own health surveillance programme. Coordination within the EU in preparing response plans for health emergencies has also been emphasised in EU policies and has been strengthened in response to the avian influenza and the threat of a global influenza pandemic.

In 2005 the European Centre for Disease Prevention and Control came into operation. This new agency provides a point of coordination and technical support for the many European public health agencies and laboratories that provide international health surveillance and support for response to health emergencies. It is currently a rather small agency with less than 50 staff, but it is intended to grow to at least 5 times this size over the next five years. While its remit is focused on the protection of EU citizens, this necessarily requires it to play a role in the wider European neighbourhood and globally.

**Promoting global health equity:** The "Programme for Accelerated Action on HIV/AIDS, malaria and TB in the context of poverty reduction" adopted by the Commission and endorsed by the Parliament attempts to establish a balanced programme of action across these diseases and in relation to broader issues of poverty and disease. While there has, in the past five years, been a marked increase in attention and funding given to HIV, TB and malaria, it is still the case that these are grossly underfunded in relation to their impact. Similarly, although the Millennium Development Goals (MDGs) have been declared by Development Commissioner Louis Michel to be central to EU policy, the capacity of underfunded and understaffed developing country health systems to deliver medicines, vaccines and preventive measures is not being adequately addressed. Consequently it is unlikely that the MDGs will be attained in most of Sub-Saharan Africa and several Asian countries.

### **Enhancing good governance for global health:**

The difficulty that the EU faces in taking action to regulate an increasingly globalised food production industry, even when the health of its own citizens is at risk, is that action could be seen as counter to the interests of EU based multinational companies or its agricultural and trade policies. This dilemma can be seen in relation to action on tobacco and health, where subsidies to tobacco growers in Europe were some ten times the total level of health promotion within the EU. Similar conflicts between short-term EU interests and long-term global priorities arise in relation to regulation of multi-national pharmaceutical companies and in relation to the recruitment of health professionals from developing countries to the EU, as discussed in other sections. Following the adoption of the Lisbon Agenda the EU has recognised the need to resolve some of the issues inherent in the EU's position on globalisation. The 2004 communication from the Commission to Parliament on "The Social Dimension of Globalisation - the EU's policy contribution on extending the benefits to all" points out the need to address the issues, but as yet progress has been limited and health has not been considered sufficiently.

**Action:** Strategic priorities for European action on global health should be clarified and restated within a coherent policy framework which is value-based. Three such priorities are proposed: strengthening global health security, promoting global health equity, enhancing good governance for global health. The EU should also devote greater attention to the impact of EU policies on the health and well-being of other countries.

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## 2. Europe must include global health in all fields of policy

The driving forces of globalisation are the cultural, social, economic and technological movements which shape the perception and reality of our world. These are manifested in state policies concerning international relations and security, agriculture and trade, in the policies and practices of multi-national companies and in the everyday lives of global citizens.

Health is no longer seen as a product of development, but is now understood as one of the keys to economic growth. The economic and social impact of bad health can be devastating. The Commission on Macroeconomics and Health estimated that the economies of certain Sub-Saharan countries will shrink by 20% as a result of HIV/AIDS, while the potential impact of a global pandemic such as avian influenza could result in tens of millions of deaths and global recession. Even the minor outbreak of SARS in 2004, which was insignificant in terms of population health impact, was estimated to have resulted in a loss of \$15 billion to the global economy. In poor countries lack of equitable access to health and care means that the poorest pay a higher percentage of their resources for health. This both limits development and is corrosive to society. There are warnings that HIV/AIDS could destabilise the South Asian region and contribute to more failed states. Conversely, good health can be a major source of economic and social development. The rapid development out of poverty by Pacific Rim countries was accompanied by an increase of life expectancy of some 18 years which resulted in a very large increase in productivity.

The link between health and social and economic development within the EU is recognised in Article 152 (ex. Article 129) of the Treaty of the European Union, which requires that a high level of human

health protection should be ensured in the definition and implementation of all Community policies and actions. This was refined in June 2001 during the Gothenburg European Council, which requested that the Commission include in its action plan for better regulation mechanisms for all policy proposals to include impact assessment of their economic, social and environmental consequences, including for health. To date, health impact assessment has rarely been applied to external policy issues, partly because until recently EU foreign policy was relatively undefined.

**Action:** The initiative proposed during the Finnish Presidency of the EU from July 2006 "Health in All Policies" is an important opportunity to consider the impact of both internal and external policies on health. An examination of the health impacts of external policies would make it possible to recognise the positive and negative impact of trade and aid and factors such as the migration of health professionals on both the EU and for resource-poor countries.

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### European foreign policy and health

Foreign policy represents the body of policies a state implements in its relations with other states, either directly or through international organisations, and in its interactions with non-state actors on global issues. The last decade has seen health emerge as a significant issue for foreign policy.

Health has long been a foreign policy issue, but never before has it had the foreign policy profile that it has developed over the past ten years. Health first arose in this capacity as a complicating factor in the trade relations among European states in the 19th century, mainly associated with the quarantine restrictions on ships due to cholera or other disease outbreaks. This link with foreign policy concerns through trade gave health a diplomatic significance it previously did not have and led to the creation of the first international agreements on health matters. As national public health systems improved and anti-microbial technologies emerged in the 20th century, health's link with foreign policy became weaker until it re-emerged in the latter half of the 20th century as part of development and humanitarian concerns. As these were not primarily associated with security and economic interests, health was not considered a priority of foreign policy.

The traditional understanding of foreign policy defined it as distinct from domestic policy. The principles of sovereignty and non-intervention in the domestic affairs of other states kept virtually all of what happened inside a state's borders off limits for purposes of foreign policy.

Most countries' foreign policy pursuits serve four broad functions:

1. Providing security for the state
2. Increasing the state's economic well-being and power
3. Contributing to the political and economic development of other countries
4. Protecting and promoting human dignity

This does not mean that each function is given equal weight in foreign policy decisions.

The last decade has seen health emerge as a significant issue for each of these functions. Developed and developing countries perceive pandemic-communicable diseases as threats to national security. The increasingly intertwined relationship between public health and international trade makes health a central concern in international economics. The Millennium Development Goals (MDGs) prominently feature public health objectives as part of the effort to lift people and regions out of poverty. Global health problems have also increasingly intersected with human rights and humanitarian agendas, whether the issue is access to essential medicines or the effective provision of relief to disaster victims.

For Europe, the health as foreign policy challenge immediately raises the historical difficulties that the Member States of the European Union have had in agreeing to a common foreign policy. EU institutions have competence in trade but not in the other governance areas that foreign policy serves. For the EU, this arrangement creates an artificial division between foreign and trade policies. In addition, EU institutions still have weak formal authority in many areas related to health, which makes integrating health into EU-wide foreign policies difficult, despite the policy directive to consider health in all EU policies.

In EU statements, health is often mentioned as an important factor for development and for managing globalisation but – like many of its Member States – it has not developed a common strategic approach to the management of the two dimensions of global health: development and interdependence. In 2005, the "Commitment to Development" Index ranked 8 European countries in the top 10 for overall commitment, with 9 countries in the top 10 for aid as one of the components of the index. The EU itself has clearly expressed its commitment to scaling up aid and working towards reaching the Millennium Development Goals. In April 2005, the EU published its first MDG report, which highlights its new aid policy as well as the EU's contribution to the 8 MDGs, based on member countries' reports on their policies for ODA. In the 2005 communication "Accelerating progress towards attaining the MDGs: financing for

development and aid effectiveness" COM (2005) 133 of 12/04/2005, the European Commission laid out a series of proposals to enhance funding for development aid by an additional 20 billion euros annually, including specific aid targets to be reached by 2010: an individual ODA target for old Member States of 0.51 % of GNI, and for new members states of 0.17 %; and a collective average target of 0.56 % of the Union's GNI. These targets were accepted by the Council on 24 May 2005 and are now official policy. The EU is also considering innovative sources of financing, such as the principle agreement obtained during the 2005 Council of Economics and Finance Ministers (ECOFIN) on a voluntary levy on airline tickets.

The new aid policy suggests focusing on Sub-Saharan Africa, both through specific support to areas of particular need such as governance, trade, and equity, as well as through an increased volume of aid.

In terms of quality and effectiveness of aid, the EU policy aims at finding synergies in areas of development such as trade, environment, and agriculture, within the notion of "coherence for development". This derives from the policy coherence concept, described in Article I-8 of the EC treaty and also an important part of the proposed constitution. The EU is also striving to untie all aid from trade issues, and to focus on areas where it has a comparative advantage. The framework for this is described in COM (2005) 133 of 12/04/2005. It also includes a discussion on global public goods and the EU's increasing support for a common definition of international public goods with six priority areas: trade, knowledge, peace and security, financial stability, global commons and the eradication of communicable diseases.

The rise of health as a foreign policy issue presents states with difficult challenges. At the level of the individual European state, how health interfaces with foreign policy varies widely, making general observations difficult. A few European countries have embarked on a process of developing a strategy document for global health at the national level,

some within the Ministry of Health in order to have a framework for action between ministries so as to ensure policy coherence. Health's emergence across all four functions of foreign policy has heightened health's political importance but also raised the question of what a domestic health ministry should do globally and how Health and Foreign Ministries should interface. Health as a foreign policy issue does not necessarily lead to improved global health responses. Fears that avian influenza A (H5N1) and pandemic influenza represent threats to the security and economic self-interests of European states increases political attention and provides financial resources for preparing European societies for health threats – but could also lead to less support for development aid in health. Addressing the vulnerabilities of the developing world needs to be kept in focus, and with this in mind the European Commission has further pledged 80 million euros to fight bird flu in Asia. The rise of health as a foreign policy issue creates, thus, a double-edged sword from the perspective of global health.

**Action:** European leaders should take the opportunity presented by the historic rise of health as a foreign policy issue and use it to construct frameworks for common foreign policy approaches to globalised threats. This could create common approaches to other foreign policy challenges that Europeans face.

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### Human security and health

Security is usually defined as the condition of being protected from, or not exposed to, some danger or threat. Human security includes freedom from want and freedom from fear. This means the absence of hunger and illness as well as of violence and war. Human security places the individual rather than the state at the centre of security considerations.

The proliferation of efforts to connect public health and security reveals both the emergence of the political importance of public health and the lack of consensus about what security should mean in international relations and foreign policy. Some experts support only a narrow connection between security and health that flows from the threat of violence from biological weapons. Other commentators would also include virulent, fast-moving communicable disease pandemics, such as pandemic influenza, as security threats. More broadly, human security proponents would expand the range of health threats to individuals that count as security issues beyond contagious pandemics. Security-based arguments and rhetoric have become commonplace in the world politics of public health.

In international relations and foreign policy thinking, security has generally meant national security, or the security of the state from military violence used or threatened by another state. This state-centric violence paradigm shaped how leaders and governments conceived of national security. Anything that fell outside of the threat of military violence from another state was not, by definition, a security issue. Thus, public health problems, such as communicable disease epidemics, were traditionally outside the realm of security policy. Historically, security and health never developed any type of policy relationship.

The end of the Cold War opened a new debate about what security means and a more diverse range of issues began to appear on the national security agendas of states, ranging from terrorism to environmental degradation. In addition, other concepts of security, most notably the idea of *human security* promulgated by the United Nations

Development programme, began to challenge the traditional dominance of national security. Human security placed the individual rather than the State at the centre of security consideration.

The United Nations Development Programme's (UNDP) 1994 Human Development Report is considered a milestone publication in the field of human security, marking the point where the concept gained international acceptance. The UNDP report states that human security consists of two basic pillars: the *freedom from want* and the *freedom from fear*. This means the absence of hunger and illness as well as of violence and war. Considered further, possible threats to human security were categorised into seven main categories: economic, food, health, environmental, personal, community, and political security.

During the 1990s and early 2000s, health has been increasingly connected with different concepts of security. Experts have referred to this process as the "securitisation" of public health. The diversity of ways in which public health has been securitised is impressive. Threats of biological weapons proliferation among state and non-state actors led many countries, especially the United States, to see national and international public health capabilities as critical national security assets should responses to biological violence be required. The UN Security Council considers HIV/AIDS a threat to international peace and security. Strategic visions of reforming the United Nations prominently emphasised the importance of public health to the concept of "comprehensive collective security." The World Health Organization (WHO) presented its new strategy against the global threat of communicable diseases as one that would strengthen "global health security." Finally, the increasing threats individuals and populations face from different disease problems directly connected public health with the human security concept.

The securitisation of public health has important implications for the individual and collective efforts of European countries on both health and security policy. The Member States of the European Union have long been in pursuit of a common strategy or approach to security problems, and the new linkages between security and health raise questions and perhaps opportunities for the EU's desire for a common

security policy. Future EU action in this regard could productively clarify where European countries are presently with respect to the securitisation of public health and how EU institutions can exploit the present reality to enhance a European-wide security-health policy linkage.

European countries can also support efforts beyond Europe to integrate public health and security thinking. For example, Europe can be a leader in backing the WHO's strategy of achieving global health security through the new International Health Regulations and other global initiatives. Europe could also help least-developed and developing countries reformulate their security and health policies to improve public health capabilities against pandemic, regional, or indigenous health dangers.

Many in the world of public health are not, however, enthusiastic about the link between security and health because they perceive it undermines, intentionally or not, the ethos that health is a fundamental human right and should be pursued for that reason. With many security approaches, the sceptical position holds, comes the tainted baggage

of state self-interest and the willingness of the strong to ignore or bully the weak. Europe could become the world's vanguard in finding ways to calibrate security and health interests in a sustainable manner in order to ensure what UN Secretary-General Annan called biological security -- the security of individuals and populations from intentionally caused and naturally occurring public health threats.

**Action:** Human and biological security risks should be assessed both for citizens of the EU and for the world. This should lead to a clear quantification of health risks alongside all other threats to human and biological security as a basis for investment in prevention measures. A European human security report should include health risks as a central component and find a balance between security and health interests.

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### War and health

War is a man-made disaster causing loss of catastrophic proportions resulting in significant physical damage or destruction, loss of life and permanent change to the natural environment and calling for humanitarian concern over people's welfare, the alleviation of suffering and compassion. Wars lead to destruction of health infrastructure, cause flight of capital (both social and financial) and the diminution of resources.

The method of waging war is to render the enemy incapable of fighting through their destruction, injury, or undermining of support systems such as government, infrastructure, community, ideology, religion or culture. Thus wars destroy individuals, families and communities including health infrastructure as well as disease prevention and health promoting efforts. Recent evidence points to the perniciously deleterious effects of war trauma on the mental and physical health of individuals, families and communities. Such mass trauma has contributed to retarded economic development and to the emergence and maintenance of diseases and epidemics in the world with consequent public health implications. These effects may span generations with significant negative impacts on the public health and socio-economic development of affected societies.

Wars may be waged between states or between groups within states as in Bosnia and Rwanda or by groups spanning states such as Al-Qaeda.

The recent phenomenon of so-called "low-intensity" warfare causes more casualties among civilians than among combatants. Such wars have characterised modern warfare, resulting in millions of civilian casualties worldwide and creating massive population displacements, refugees, epidemics and significant human suffering as well as trans-generational effects such as genocides, perpetual poverty and marginalisation. Often civilians are targeted, as human shields, in genocides, the rape of women and the use of child soldiers. The phenomenon of gender-based sexual violence directed to women, as a weapon of war, has increased in recent wars as was seen in Bosnia and Rwanda. The long-term mental

and physical health fallout of such traumatisation and their public health implications to global health has yet to be fully investigated.

In modern warfare, weapons have increasing lethality and armies do not distinguish between combatants and non-combatants, resulting in mounting civilian casualties and destruction of environments. The weapons used in these wars are almost always manufactured and imported from Europe (France, UK, Germany), the USA and the Russian Federation. There is a massive trade in small arms of which there are more than 640 million worldwide.

Asymmetric warfare refers to the ability of groups to wage war on more powerful adversaries by using non-conventional means, including suicide bombs, bio-terrorism and guerrilla tactics. This has been a feature of what is now called the war against terrorism. Since there are many ways in which biological agents could be used as terrorist weapons, this has been a major cause of the securitisation of public health.

The long-term mental and physical health fallout of war and its public health implications for global health has yet to be fully investigated. But studies show clearly that war has major direct and indirect, immediate and long-term implications for global health.

Over 60 countries of the world today are affected by war, especially poor countries, resulting in massive human displacements and affecting more than 19.2 million people worldwide as refugees, internally displaced persons or the war-traumatised. Hunger (famines) and disease (epidemics) increase. Europe is the destination of many of the people who flee from the disasters of war in their countries. Often such refugees suffer a triple health burden: the trauma of war and displacement, the diseases to which they have been exposed, and lack of access to health and social support in the country to which they flee due to language and cultural barriers and lack of provision.

The European Commission's Humanitarian Aid Office (ECHO) includes in its mandate the provision of emergency assistance and relief to victims of armed conflicts, and the European Rapid Response Force (ERRF) has growing capability to provide peacekeeping forces. Where war brings with it a major health risk the European Centre for Disease Prevention



and Control and WHO will be involved. And where there are refugees or internally displaced persons UNHCR will also be engaged. In all cases a range of health-related non-governmental organisations (NGOs) will provide support and assistance.

However, recent experience illustrates the problems of providing health care in post-conflict situations. Often one of the most urgent tasks faced is to provide some form of medical service and to instigate public health protection measures. This has proved difficult for military forces who are often ill-equipped to provide such services and find it difficult to work with other agencies and NGOs. This proved a particular difficulty in Afghanistan, where the use of white vehicles by military forces led to a leading NGO pulling out of health care provision. While it may have previously been assumed that health workers would be treated as neutrals and that health services might provide a bridge to peace, experience in Iraq suggests that health workers are being targeted by insurgents. It is also clear that the presence of military forces can itself bring health problems, such as increasing levels of HIV/AIDS infection.

**Action:** Policies need to be put in place to address all these challenges, including weapons manufacture and

trade, policy on refugees and immigrants, and global health surveillance in war-torn areas. The impact of warfare and modern weapons on health should be examined in greater detail to develop policies for peace and health and to derive new codes of conduct for European forces in conflict situations, whether as combatants or peacekeepers. The role of the ERRF and ECHO in providing health relief and in working with other agencies and NGOs should be examined to establish the required competence and to limit possible negative impacts on health.

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### European agricultural policies and health impacts

In the EU, as in most developed countries, agriculture policy has diversified beyond securing food supply to include rural development and environmental protection. There is a need to examine the Common Agricultural Policy of the EU within the context of a European Strategy for Global Health.

Agricultural subsidies of approximately US\$1 billion per day (780,000 million euros) in all countries of the Organisation for Economic Cooperation and Development (OECD), including EU Member States can no longer be justified on the basis of lack of food security. In fact, food surpluses stimulated by subsidies have negative health impacts in developed as well as in developing countries and have been a major problem for the agriculture sector in developed countries since the 1970s.

Agricultural subsidies transfer money to farmers, and thereby affect production decisions, incomes, international trade and the environment. In 2003 a reform of the EU Common Agricultural Policy (CAP) partially decoupled agricultural support from production levels in order to lower production incentives. However, according to an OECD report from 2004 this is not expected to lower production levels to any significant extent, except in the case of rice.

Indirect evidence strongly suggests that some elements of the CAP have negative health impacts. In the year 2000, non-communicable diseases caused 86% of deaths and 77% of the disease burden in the region, with cardiovascular disease alone causing 23% of the total burden. The top seven factors found to be responsible for the bulk of the European non-communicable disease burden are tobacco use, excessive intake of alcohol, high cholesterol, low fruit and vegetable intake, being overweight, having low levels of physical activity and high blood pressure. Agricultural products have a major influence on six of these key disease risk factors. Chronic non-communicable diseases are the major cause of adult illness in all regions of the world, responsible for an estimated 35 million (or 60%) of all world deaths in 2005. There is growing concern at the rapid worldwide

increase in obesity. Clearly this worrying trend is caused to a large extent by excessive consumption of fat, sugar and alcohol, constituting more than 50 percent of dietary energy in a typical Western diet.

In the light of this disease burden, agricultural subsidies, for example, to support sugar, fat and alcohol production run counter to public health objectives. Furthermore, measures which keep prices of fruit and vegetables high by limiting availability and use of import tariffs clearly counteract the nutrition goal of increased fruit and vegetable consumption, especially for low-income households. Agricultural practice in Europe is also a burden on the environment, due to nitrogen and pesticide leakage into ground water, a further cause for health concern.

The negative health impacts outside of the European region are mainly caused by trade policy as a consequence of market distortions caused by agricultural policy. While globalisation has extended access to a wide variety of foods all year round and thus contributed to public health, significant problems remain. Whereas trade barriers have been abolished or greatly reduced for most industrial goods, and export subsidies have been abolished, barriers to free trade in agricultural commodities are still in place, justified on the grounds of food security or rural development.

The health effects in developing countries are mainly through negative impacts on the income of farmers. One prominent example is the sugar sector. Sugar beet production is highly protected in the EU; guaranteed prices maintained by subsidies stimulate overproduction at costs three times the world market price due to higher production costs. The EU sugar surplus is exported at subsidised prices ("dumping") thereby destroying the markets and livelihoods of farmers in developing countries, who remain in poverty and in poor health even though they are capable of producing cane sugar at competitive world prices. In the sugar reform of 2006 some progress has been made in that guaranteed minimum sugar prices will be cut. This is expected to lead to a fall in production of about one-third of current levels over the next few years.

Overproduction of food and other agricultural products due to agricultural policies in OECD countries and the resulting distortions in international trade have been heavily criticised by developing countries,

by several NGOs, EU Member States and academics. While the Directorate for Agriculture of the EU Commission is reluctant to accept that there are negative health impacts within the EU, there is a growing awareness of the damaging effect on health and poverty in developing countries of the CAP.

In this context, agriculture subsidies must be seen alongside trade tariffs and other barriers to trade. The EU has relatively low tariff barriers for developing countries and as part of the Doha trade round has offered to eliminate all export subsidies for agricultural products. However, implementation of the Doha agreement has generally been slower than many developing countries would wish, despite the fact that in some instances the initial impact of reducing subsidies will be to increase prices for some food importing developing countries.

The WHO, in its global strategy on diet, physical activity and health, has taken the stand that "Member States need to take healthy nutrition into account in their agricultural policies" with reference to overproduction of unhealthy commodities that contribute to obesity and non-communicable diseases.

The decision to phase out tobacco subsidies by 2010 can be seen as a partial victory for public health. It also paves the way for policy change in other commodity sectors such as the ongoing reform of the fruit and vegetable sector and the upcoming reform of the wine sector.

**Action:** There is a need to examine the Common Agricultural Policy of the EU within the context of a European Strategy for Global Health. This should both highlight areas of public health concern within the EU and examine the impacts of agriculture and trade policies on health in developing countries. The strategy should involve both politicians and consumer organisations, since they need to be able to identify how to shop ethically and healthily and to expose current policies which act against this.

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### Trade policy and health

Trade policies are plans and actions affecting international commercial exchange of goods or services, and in particular the regulation of exchanges and multilateral agreements governing the application of tariffs or non-tariff barriers to trade. Europe needs a coherent strategy on trade and health in relation to trade within the EU and with other countries.

The World Trade Organization (WTO) is the principal international institution for the management of international trade. It was created at the Uruguay round of trade talks in 1994 when it was agreed to transform the General Agreement on Tariffs and Trade (GATT) into a permanent institution. WTO is an intergovernmental institution of 149 member states, with responsibilities for providing a forum for trade negotiations, handling trade disputes and monitoring national trade policies.

The leading normative organisation on trade regulation is WTO and the key agreements affecting health are:

- Trade-Related Aspects of Intellectual Property Rights (TRIPS)
- General Agreement on Trade in Services (GATS)
- Technical Barriers to Trade Agreement (TBT)
- Agreements on Sanitary and Phytosanitary Standards (SPS)
- Trade in agricultural products is also covered by WTO agreements.

Since the inception of GATT more than 50 years ago, Article XX guarantees a member's right to take measures to restrict imports and exports of products when those measures are necessary to protect the health of humans, animals and plants. Similarly, Article XIV of the GATS authorises members to take measures to restrict services and service suppliers for the protection of human, animal or plant life or health under relevant conditions. These health exceptions

indicate the importance that WTO Members assign to national autonomy in the protection of health. This has been clearly established in WTO jurisprudence and reiterated in the TBT and SPS agreements. To make use of the health exceptions, WTO agreements generally require the health measures be no more trade-restrictive than necessary. Determining whether a measure is "necessary" involves a process of weighing and balancing a series of factors which include the importance of the interests protected by the measure, its efficacy in pursuing the policies, and its impact on imports or exports.

Trade liberalisation can affect health in various ways. The impact may be direct, as when a disease crosses a border together with a traded good or when a disease outbreak causes disruptions in trade and traffic. The impact may equally be indirect, for example, reducing trade tariffs may lead to lower prices for medical equipment and health-related products, such as drugs and blood products; or changing international rules concerning patent protection affects access to essential medicines, diagnostic devices and transfer of technology, potentially affecting national health systems. Conversely, national and international health standards and rules can have important implications for trade, such as the Codex Alimentarius standards, the International Health Regulations, or the Framework Convention on Tobacco Control.

**The TRIPS Agreement** affects public health to the extent that it may limit access to affordable medicines in some countries. The areas of intellectual property covered by the TRIPS Agreement relevant to health include: patents, trademarks, copyrights, and undisclosed information, including trade secrets and test data. In respect of each of these areas, the Agreement defines the minimum standards of protection that must be adopted by each member. Yet, while it introduced a multilateral framework for intellectual property rights, and obliges WTO members to adhere to minimum standards of intellectual property protection and enforcement, it does not prescribe a universal or harmonised intellectual property regime.

In each area of intellectual property rights, it allows governments to provide for exceptions, exclusions and limitations to these rights, for example in relation to patent rights whereby the TRIPS Agreement permits

compulsory licensing, parallel imports and other exceptions to exclusive patent rights. In this manner, the provisions in the TRIPS Agreement may be used to strike an appropriate balance between creating incentives for innovations, and the need for access to technology and information.

Although it was generally acknowledged that the TRIPS Agreement contained sufficient flexibility to permit implementation consistent with public health, developing countries faced difficulties in their attempts to implement safeguards such as parallel imports and compulsory licensing in their domestic legislation. The legal challenge by the pharmaceutical industry of a provision that enabled parallel imports in South Africa's Medicines and Related Substances Amendment Act (Act No. 90 of 1997) and the US-initiated complaint against Brazil in the WTO dispute settlement system over a provision in the Brazilian domestic legislation on compulsory licensing, were two of the better-known cases that prompted developing countries to demand a clarification in the WTO.

The interpretation and scope of the flexibilities in the Agreement and the use of these flexibilities to improve access to essential medicines were the main source of debate, which culminated in the adoption of the **Doha Declaration on the TRIPS Agreement and Public Health**. This declaration clarified that countries were within their rights to make use of measures, such as compulsory licensing and parallel imports, for public health purposes and to ensure access to medicines. Compulsory licensing, for instance, would allow countries to enable generic production of new products, and thus create the necessary pressures for price competition. Equally important, WTO Members, in singling out pharmaceutical products for special treatment, have also recognised that health products need to be treated differently in certain circumstances. The Doha Declaration thus represents an agreement between WTO Members that public health considerations should condition the extent to which patent protection is implemented.

The EU and its Member States played an active role in Doha discussions concerning access to medicines. The proposal which it put forward would have taken a broader view of health needs providing access to a

range of drugs and not just those defined as meeting the needs of specific medical emergency conditions. The declaration represented a compromise reached with the US which had demanded more stringent controls on intellectual property rights.

However, the Doha Declaration had left one issue unresolved. In Paragraph 6, the Doha Declaration had recognised that developing countries without manufacturing capacity would face difficulties in making effective use of compulsory licensing. Since the TRIPS provision restricts exports of products manufactured under compulsory licence, countries without manufacturing capacity dependent on foreign generic producers would have a problem sourcing adequate supplies of generic medicines produced under compulsory licence. To resolve this problem, the WTO General Council Decision on the Implementation of Paragraph 6 of the Doha Declaration on TRIPS and Public Health established a system to permit the production and export of generic versions of patented medicines by waiving the restriction on exports under compulsory licence. The system permits countries wishing to import generic medicines, to do so from a foreign producer under certain conditions of eligibility and notification of the TRIPS Council. Members recently agreed to convert the WTO Decision on Paragraph 6 into an amendment of the TRIPS Agreement.

The TRIPS Agreement, the Doha Declaration and the WTO Decision on Paragraph 6 (and subsequently, the amendment of the TRIPS Agreement when it comes into effect), now collectively comprise the international legal framework governing the rights of countries to take measures to protect public health. Since intellectual property rights are territorial and governed by domestic laws, it will be necessary for specific provisions, where none exists, to be effectively enacted in domestic law to enable their use within each country. For this reason, it is important for countries to implement the TRIPS flexibilities appropriately within their domestic legislation.

**The GATS** may be applied to the international trade in health services, including health insurance and health care provision. The definition of trade in services in the Agreement hinges on four types of transactions or "modes of supply", namely: the cross-border supply of services (e.g., telemedicine,



e-Health), consumption of services abroad (patients who travel abroad for medical treatment), commercial presence (establishment of health facilities in the country concerned), and presence of natural persons (foreign doctors or nurses who seek to practice in other countries). Informed and evidence-based approaches are needed to manage any future efforts to liberalise health-related services so as to ensure greater access to affordable, better-quality, and effective services, leading to increased choice for consumers and greater equity in health outcomes.

In the past, most services were not considered to be tradable across borders. Much has occurred to alter the tradability of services, including health services. Advances in communications technology, including the development of e-commerce, as well as regulatory changes in many parts of the world have made it easier to deliver services across borders. In many countries, changes in government policy have left greater room for the private sector – domestic as well as foreign – to provide services. Partly as a result, services have become the fastest-growing segment of the world economy, providing more than 60 % of global output and employment.

Such changes led governments to include services in trade negotiations, resulting in the GATS at the end of the Uruguay Round. GATS takes a gradual approach to trade liberalisation allowing member states to include or exclude services such as health insurance and care. So far, the liberalising effects have remained limited as most WTO Members have made relatively few commitments that go beyond existing levels of access. However, many fear that opening up health markets in developing countries could lead to foreign companies “cherry picking” the most profitable sectors, to the disadvantage of local health services.

It goes unnoticed that GATS also provides for the control of the international movement of staff for the provision of services. As the latest World Health Report 2006 points out, the migration of health workers to rich countries is a fundamental cause of poor health and health care in resource-poor countries. Yet at present this provision has not yet been applied to the recruitment of health staff from developing countries to rich regions such as Western Europe. Instead, a weaker form of control is applied through conventions and bilateral agreements that have been very

ineffective in stemming the flow of health professional migration.

**The TBT Agreement** on technical barriers to trade can also be relevant to health. WTO rules which govern technical barriers to trade applied for reasons of protecting human health are covered by either the TBT Agreement or the SPS Agreement. Countries face challenges in ensuring compliance with the disciplines of SPS and TBT. This is particularly the case in the areas of food safety, diagnostic devices and medicines’ quality, safety and efficacy, respectively, in which the trade agreement creates obligations to draw up regulations based on science, conduct required risk assessments, and implement international standards through independent and effective national regulatory authorities.

All members have the right to restrict trade for “legitimate objectives” under the TBT Agreement. These legitimate objectives include the protection of human health or safety, the protection of animal or plant life or health, the protection of the environment, national security interests, and the prevention of deceptive practices. The TBT Agreement aims to ensure that product requirements, and procedures that are used to assess compliance with those requirements, do not create unnecessary obstacles to trade. The Agreement applies to product requirements that are mandatory (“technical regulations”) as well as voluntary (“standards”). It covers such requirements developed by governments or private entities, whether at the national or the regional level.

The TBT Agreement strongly encourages the use of international standards, such as WHO standards, and where appropriate for these to be adopted as national standards or technical regulations. Members may depart from such international standards if they consider that their application would be ineffective or inappropriate for the fulfilment of certain legitimate objectives. In such cases, Members are free to set standards at a level they consider appropriate, but have to be able to justify their decisions if requested by another Member to do so.

**The SPS Agreement** contains specific rules for countries which want to restrict trade to ensure food safety and the protection of human life from plant- or animal-carried diseases (zoonoses). Its objective is two-fold: it aims to (i) recognise the sovereign

right of Members to determine the level of health protection they deem appropriate; and (ii) ensure that a sanitary or phytosanitary requirement does not represent an unnecessary, arbitrary, scientifically unjustifiable, or disguised restriction on international trade. In order to achieve its objective, the SPS Agreement encourages Members to use international standards, guidelines and recommendations where they exist. Members may adopt SPS measures which result in higher levels of health protection – or measures aimed at health concerns for which international standards do not exist – provided that they are scientifically justified.

The SPS Agreement encourages the use of international standards. In the area of food safety, the SPS Agreement explicitly recognises the international standards developed by the joint FAO/WHO Codex Alimentarius Commission. This means that if a government has based its requirement, such as a maximum residue level for a pesticide in a food, on a Codex standard, it is presumed to be meeting its WTO obligations.

In the context of sanitary issues such as mad cow disease or avian influenza, the use of SPS has had an increasing impact on EU exports in recent years, prompting the Commission to create a database of SPS exports that provides information on export problems with third countries. EU countries themselves have resorted to using the SPS mechanism. It is expected that this use will increase as other trade barriers are reduced in the future.

**Trade within the European Union** is determined by treaty obligations interpreted by the European Court of Justice (ECJ) and the policies and directives

of the EU. In relation to health services there have been few clear policy directives governing trade within the EU, as health care services are regarded as a matter of subsidiarity, where power is exercised at national government level. In general, governments have resisted opening health care markets. However, this has been challenged in the ECJ by a series of cases which have generally ruled in favour of an open European market, allowing patients from one country to obtain services in another. By contrast the EU has generated a series of policies and directives since 1985 aimed at completing the single market in pharmaceuticals, a project which is still uncompleted. These experiences should be valuable in providing insights into the global problems of regulating the market in health and pharmaceuticals.

**Action:** Europe needs a coherent strategy on trade and health in relation to trade within the EU and with other countries.

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### Health, the environment and sustainability

The environment may be defined as the complex of physical and social conditions that affect the growth development and survival of organisms, including mankind. Sustainability is meeting the needs of the present without compromising the ability of future generations to meet their needs. It is essential to draw together the European agendas for health, environmental protection and sustainability.

Human health is connected in many ways to the environment. Environmental health problems stem from the basic issues of clean water and sanitation, safe housing and nutrition, as well as from the global problems of climate change, air pollution, hazardous waste, or unsafe use of chemicals, often brought about by rapid development. Sustainability demands that these issues are addressed before they create problems of a nature and magnitude that may mean future generations are unable to address them. For example, climate change is likely to be irreversible by future generations and its health consequences may be unaffordable. This is a problem of global governance because it requires mechanisms to take account of long-term impacts and to ensure that the polluter pays for the consequences of actions which may affect health in other countries.

While the complex cause-and-effect relationship between environmental factors and health is difficult to disentangle, it is often possible to measure the impact of environmental exposure on the health of a population. In Europe, this link is reflected in the high burden of disease estimated to be due to environmental causes. Indoor and outdoor air pollution is considered to be the most important factor impacting health, with 20 million Europeans suffering from respiratory problems every day. The overall societal cost of asthma, an increasing problem all over Europe, has been estimated at 3 billion euros per year. Many other issues, such as cancers, neuro-developmental effects of exposure to heavy metals, exposure to electromagnetic fields or different types of chemicals are concerns for Europeans, in particular children. A 2004 study published in the *Lancet*

estimates that 26.5% of deaths in children under 5 in Europe are due to environmental causes. There are pronounced differences between the different regions of Europe, with increased burden in the Eastern countries.

While the development of European environment legislation was given explicit legal basis in the Single European Act in 1987, the EU environmental agenda really developed in the 1990s, covering topics such as pollution control and waste management, as well as nature conservation and environmental impact assessment. In 1997, a new article was introduced in the Treaty of Amsterdam that called for environmental protection requirements to be integrated into the definition and implementation of other policies. This new Article 6 links such integration to the promotion of sustainable development, therefore recognising the relationship between environmental protection, economic development, and social cohesion.

The EU now has a considerable body of environmental legislation, expressed in a series of Environmental Action programmes. The latest one, the Sixth Environment Action programme of the European Community 2002-2012 (6EAP) was adopted in 2001. This programme recognises the importance of sustainable development, and focuses on areas most in need of action and where European initiatives will have a real impact. It identifies four areas to be tackled urgently: climate change, the protection of nature and wildlife, environment and health issues, and the preservation of natural resources and waste management. The strategic approach of the new programme seeks to be innovative and widely inclusive of the different actors of society, including citizens themselves through their consumption patterns, and businesses through more eco-efficient processes and the development of more green goods. The programme also seeks to include environmental concerns in all aspects of European external relations with international organisations and through the support of international environmental conventions. The programme's progress is due to be evaluated at the end of 2006. To prepare for this mid-term review, the Commission has launched an Internet consultation for stakeholders, which will end mid-July 2006.

In practice, concern for human health is what has driven the political priority given to environmental



issues, through policy actions targeted at air quality (Clean Air for Europe, CAFE), water quality, or the regulation of chemicals (Registration, Evaluation and Authorisation of Chemicals, REACH). Following a 2003 proposal from the European Commission, the “European Environment & Health Action Plan 2004-2010” was launched, with the specific goal of creating an integrated environment and health information system to improve knowledge on the links between the sources of pollution and health effects. Indeed, although the quality of water and air has seen improvements since the inception of environmental programmes and the control of chemical through REACH has progressed, as mentioned above there is still much to be done to reduce the environmental impact on health in Europe. The Environment and Health Action Plan was designed to provide scientific information to limit the environmental impact on health and to promote better cooperation between the environmental, health, and research sectors while improving communication on environmental issues.

While additional knowledge of the multi-causal environmental factors of ill health is necessary, this can only constitute a first step in an environmental approach and strategy for Europe. Given the complexity of environmental issues, health policies that address environmental determinants such as transport, urbanisation, use of pesticides and energy policies are essential. For that, an integrated approach is required, with enhanced cooperation between the health and other relevant sectors. Mechanisms to coordinate this cooperation should be put in place, possibly involving the European Centre for Disease Prevention and Control. To respond to the pressing need for environmental protection within its borders, the EU will also need to go beyond data collection and analysis and ensure that its commitment to examine the health impact of all economic and social policies is applied in practice. Given the differences in exposure and resulting inequalities in the burden of environmental diseases by country, targeted actions directed at reducing the environmental impact, particularly in Eastern countries still catching up in terms of economic development, should be considered as well.

To insert these initiatives in a long-term vision, the assessment and management of environmental health risks must be done within a framework

of sustainability. In a proposal made in 2001 to the Gothenburg European Council, the European Commission described a “European strategy for sustainable development”, which explicitly includes environmental degradation and resources consumption as key factors to address in the development of the EU. In 2002, the Commission extended the reach of its sustainable development strategy to the global level.

That same year, the EU and its Member States ratified the Kyoto protocol to the United Nations Framework Convention on Climate Change, which commits most European states to reducing their collective emissions of six greenhouse gases by 8% by the period 2008-2012. This ratification reflects the EU’s commitment to both environmental issues and sustainable development, which relies heavily on addressing the latter. The EU has enduringly been one of the strongest advocates and negotiators for the Kyoto Protocol. At the time of the ratification, the 15 members of the EU working in unison managed to have a maximum impact on the negotiations and the implementation of the Kyoto agreement. The EU is also striving to remain at the forefront of the battle against climate change by working on a strategy post-2012, outlined in a Commission communication on “Winning the Battle Against Climate Change” from February 2005. For now, measures to reduce emissions further in the EU, and at the lowest economic cost, are still needed, such as the EU-wide carbon dioxide emissions trading system, which allocates permits to polluting industries to emit a certain amount of carbon, with the possibility to sell unused permits through the carbon market

Indeed the impacts of European health and environmental protection on global health are manifold. Recent human bio-monitoring data show increased body concentrations of some accumulative substances, reflecting increased contamination of the environment. This process does not stop at European borders. Pollution created in Europe impacts upon the global environment by adding to global warming and the release of pollutants into the air and seas. The full extent of the future impact of climate change is uncertain, it seems likely to destabilise local climatic conditions leading to more extreme weather events. It could halt the flow of the Gulf Stream system bringing severe winters to North East Europe, while at the

same time warming other areas, causing further heat waves, flooding and drought. This process would have drastic effects on the health of Europeans. Indeed, the 2003 heat wave overwhelmed unprepared health care services and killed close to 35,000 people in Europe. A WHO report attributes 150,000 deaths and 5 million cases of illness to climate change and suggests this will double over the next 25 years. It is important to note that the 6EAP includes consideration of the need to adapt the European health and emergency infrastructure to address such issues.

There are many lessons to be learnt by bringing together the health, environmental and sustainability agendas. Within the EU, political positions on the environment and sustainability are clearer and more cohesive than with respect to global health. The position of the EU with regard to the Kyoto Protocol is well-articulated and is starkly different from that of, for example, the US. The issues are also better understood by the public and industry; there can be few major European corporations that do not post some form of environmental policy on their websites but almost none have a policy regarding their health impact. While there are ongoing debates about the application of carbon trading, the fact that a financing mechanism has been introduced and accepted also holds lessons for the financing of global health as a global public good.

The promotion of long-term measures for health, the environment and sustainable development will require

fundamental changes in attitudes and behaviours. This will require awareness and action not just at EU level but also by national governments and health care systems, private sector industries and individuals as consumers and as global citizens.

**Action:** It is essential to draw together the European agendas for health, environmental protection and sustainability, since these are closely linked. They are each concerned with the protection of global public goods and require action at every level of society as responsible global citizens.

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# 3. Europe must assert its role in global health governance

Governance describes how societies structure policy responses to challenges they face and responsibilities they bear. Governance involves government, but the two terms are not synonymous because governance often occurs outside the formal state-based institutional and legal arrangements that characterise governments. Global governance for health describes the structure and processes through which the global health issues are addressed.

In the past, experts tended to analyse national governance (governance with a single state) and international governance (governance between sovereign states). Global governance represents a third level of governance characterised by new actors, new processes, and new norms designed to help societies individually and collectively manage the positive and negative aspects of globalisation.

Global governance has emerged as a critical issue for public health and health policy because globalisation has dramatically affected these policy endeavours and radically changed the challenges and responsibilities societies and their governments face in the health field. Public health is no stranger to the need for states to cooperate with each other to address health problems. International governance of public health began to emerge in the mid-19th century and continued with the *World Health Organization* (WHO) after World War II. Globalisation has, however, rendered the territorial, State-centric approaches of national and international governance increasingly inadequate, because it weakens the ability of formal government and intergovernmental structures to retain control over political, economic, and social phenomena. Globalisation has also empowered non-State actors, especially through new information technologies that allow them to participate more

effectively and efficiently in policy and governance endeavours.

Globalisation has, for example, de-territorialised the dynamics of many social determinants of health, which requires bringing new actors, new processes, and new norms to bear on the task of governing globalised health. Health ministries and international health organisations have inadequate reach and authority to address globalised health determinants. Global governance's emergence does not mean that the quality and effectiveness of national governance and international governance in the health context are unimportant. All three levels of governance are now necessary but not sufficient individually to manage the challenges and responsibilities of health policy in the 21st century. Indeed, it is critical that governments develop a coherent approach to global governance for health across policy sectors at the national level.

Global governance literature often stresses the importance of new actors in the governance of issues that transcend territorial borders. This phenomenon is true with respect to global health governance because experts have repeatedly emphasised the growth of the involvement of non-state actors (e.g., non-governmental organisations, multinational corporations) in creating and managing globalised health problems. The global capabilities of these new actors produce new governance processes as states and international organisations address or access these capabilities for governance purposes. A prominent new governance process in global health is the public-private partnership, which attempts to harness governmental, intergovernmental, and non-governmental contributions to improve aspects of health in the world. Global health has also seen the proliferation of policy networks and new financing mechanisms that include public and private participants.

In addition to new actors and new governance processes, global governance involves the creation and pursuit of new norms as the objectives of

governance activity. In health, the last decade has witnessed a shift from the traditional coordination of state interests through intergovernmental diplomacy to state and non-state actor collaboration on the pursuit of global public goods for health. Other new norms with direct relevance to global health include the responsibility to protect vulnerable populations from violence and disease when governments are unable or unwilling to do so.

Europe constitutes a major force in the emergence of global governance:

- First, Europe significantly contributes politically and economically to the processes of globalisation that have produced the need for and reality of global governance mechanisms.
- Second, Europe's own radical governance experiment unfolding in the form of the European Union, offers a model and precedents for how state and non-state actors should shape global governance processes and norms.
- Third, Europe is itself vulnerable to the health consequences of globalisation, as the crises involving bovine spongiform encephalopathy (mad cow disease) and avian influenza reveal.
- Fourth, global governance mechanisms for health depend on European financial and political support, as illustrated by European involvement in many public-private partnerships and in supporting new international legal regimes designed to improve global health.

**Action:** Europe's commitment to enhancing global governance for health should be strengthened in five important ways. First, European policy makers should support and advance the idea that public health is, in the 21st century, itself a marker of good governance at every level. Second, European leaders

should more effectively integrate health objectives into their policy strategies for security, economic well-being, development, and human rights and humanitarian assistance. Such integration should target achieving policy coherence with respect to health and other important governance pursuits. Third, European governments and EU institutions should continue to build and support new regional and global governance mechanisms that will strengthen global governance for health, such as the European Centre for Disease Prevention and Control and the WHO's new International Health Regulations. Fourth, European countries need to develop policy coherence in their approaches to global health at the national level through better cooperation between policy sectors. Fifth, European policymakers can strive to ensure greater coherence in existing global governance structures and international institutions and support UN reform.

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## Key actors in global health

Key actors in global health are those actors which either individually (like international organisations of influential nation-states) or as collective actors have an identifiable impact on global health. They must be considered important partners for European policy makers depending on the issues involved and the interests they pursue in specific global health activities.

In order to locate entry points for “good” global governance for health, a better understanding of the present institutional architecture and the constellation of interest and actors in global health is necessary. While in general *international health* circumscribes the purview of the representatives of nation-states interacting within the defined boundaries of an international organisation such as the WHO, *global health* is characterised by a growing and complex assemblage of actors, interacting on a wide variety of converging and conflicting interests. The rapid growth of actors and activities in global health can at first glance mask the governance problems inherent in this new system. The key players are:

**Nation-states** play a central role in global governance for health. Donor countries individually or collectively exert an important influence on global health affairs. Individual countries, depending on their financial and political strength, develop bilateral cooperation projects of considerable importance (e. g. US President’s Emergency Plan for AIDS Relief (PEPFAR) in the fight against HIV/AIDS), might influence strategies of international organisations through contributions for specific projects or by withholding regular contributions, might take specific political positions in decision making (e. g. in *World Trade Organization* (WTO) affairs) or might collectively push for specific programmes. The power of certain donor countries also has played an important role in creating new institutions outside UN Organisations like the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). There continues to be a significant power imbalance between recipient countries and donor countries and between the North and the South.

**Organisations for cooperation among industrial countries** have assumed an increasingly important role for the coordination of interests among these countries and for the preparation of initiatives. The Organisation for Economic Cooperation and Development (OECD) has long played a role in monitoring health performance and coordinating aid efforts. Since the late 1990s, the G7/8 has become an important actor in global health, motivated by the growing perception of health as a risk to global security. Health plays an increasing role in G8 meetings; the G8 were instrumental in developing the proposal for a large global health fund to fight major infectious diseases (in particular HIV/AIDS) and in securing and coordinating the commitment of the most powerful industrial nations to supporting global health activities, e.g. in the context of supporting the achievement of the Millennium Development Goals.

During recent years, **organisations of middle-income countries** (like Brazil, India, China, South Africa) have increasingly taken specific positions in international politics and international organisations. This involves to some degree taking a leading position in new groupings of Southern countries (like the “Group of 20 or 21” in WTO negotiations; “Friends of Development” in World Intellectual Property Organization (WIPO)). With respect to global health governance (GHG), they play a growing role, above all in the fields of expanding the options for the development of local pharmaceutical R&D and improving access to medicines in developing countries.

**Regional organisations** such as the European Union, Association of East-Asian Nations (ASEAN) and the Organization of American States (OAS) have significantly strengthened their health portfolio and on the other end of the spectrum municipal actors are engaging in worldwide cooperation to address local problems. The Regional Offices of the WHO aim to promote common public health strategies within six regions. **The European Union** as a regional organisation constitutes a special case as it coordinates activities of its Member States and (basically through the EU Commission) develops its own politics in global affairs. Due to a lack of a common strategy in many fields of global health, and a conflict with its Member States as to independent action of the Commission in global health matters, the



impact of the EU, however, has remained considerably below its potential.

For the **United Nations**, it is particularly the United National Development Programme (UNDP) as the “UN’s global development network” which has for a long time stressed the important role of health in global cooperation. UNDP played an important role in advocating the importance of social development and poverty reduction in times before the World Bank took up these topics again. The central UN institutions have only in recent times become somewhat more involved in health issues (UN General Assembly and Security Council Meetings on HIV/AIDS and ensuing activities; endorsement of the Millennium Development Goals), UN Specialised Agencies and the World Bank are among the key actors in the field of global health.

The **WHO** is according to its constitution the “directing and co-ordinating authority on international health work”. Member governments govern the WHO through the World Health Assembly (WHA, all member states) and the Executive Board (32 member states). Formally, all countries have the same influence on WHO’s strategies and policies. As two-thirds of its total financial resources are extra-budgetary and depend on donor countries, the real power relations differ from this ideal. Interaction of the governments of member states inside WHO are very important and – in spite of the multiplication of important actors in global health – WHO continues to be the central forum of global health. As a governmental organisation it also plays an important role in initiating the development of international law in health. Although being accountable to the WHA and being the ‘servant’ to the member states, the secretariat has a certain autonomy and has an impact on WHO’s strategy and policies. In comparison to the United Nations Children’s Fund (UNICEF) or the UNDP, WHO does not have a strong function of programme implementation in developing countries.

**The World Bank** is basically a development bank with the aim of fighting against poverty and enhancing development in poor countries – which it does based on a specific interpretation of the development and adjustment processes. As an organisation it also brings together the nation-states; however, economically strong countries have greater voting power inside the organisation according to

their capital contribution and shares. As an actor, the World Bank has power due to its ability to provide resources, which it is able to get both from private capital markets and the member states.

Among the other UN Organisations **UNICEF** plays the most important role in health, concentrating due to its mission on children’s health. As the co-sponsor of the Alma-Ata Declaration and the Bamako Initiative (improved access to essential drugs, concentrated efforts to reduce maternal and child mortality, etc.) and a strong programme to support children’s health in developing countries, UNICEF is a central actor in health advocacy for women and children and in the practical work of promoting global health.

The Joint UN programme on HIV/AIDS, **UNAIDS**, created in 1996 as successor of the Global programme on AIDS (GPA) of WHO, is a new kind of entity in the UN system uniting ten UN Organisations and also including non-state actors. UNAIDS can be seen as an attempt by the UN to react to institutional developments in global health and to improve the effectiveness of the global fight against HIV/AIDS. Besides the co-sponsoring UN Organisations, delegates of 22 governments from the North and the South and of five NGOs are members of the programme Coordinating Board, the highest body of UNAIDS. Although the NGOs are only non-voting members, the participation of non-state actors in a formal decision making body is a novelty for the UN system (apart from the tripartite International Labour Organization (ILO)). UNAIDS’ objectives are to coordinate HIV/AIDS-related activities with the UN system and of other actors and to advocate a global reaction against HIV/AIDS.

A growing number of **highly diverse new organisations, networks and alliances** focusing on discrete and measurable areas of action have superseded the simple division of delivery mechanisms between bilateral and multilateral health agencies. Next to new organisations such as the GFATM and UNAIDS an increasing number of public-private partnerships such as the Global Alliance on Vaccines and Immunisation (GAVI) are engaged in reducing the infectious disease burden in the poorest countries. While they have shown partial success based on their adherence to new public management they reach their limits of action as they all compete for the same

set of financial resources which still mostly reside in the Official Development Assistance (ODA) budgets of nation-states. Frequently their conditionalities and the increase in vertical programmes puts additional burdens on the receiving countries.

**International organisations without a health mandate but with important impacts on health** should also be counted among the key actors in global health. While the World Bank directly entered the field of global health in the 1970s, in close cooperation with the International Monetary Fund, for a long time it has been directly involved in the management of foreign exchange problems and adjustment policies. In particular, during the 1980s and early 1990s, the so-called Bretton Woods institutions were severely attacked by NGOs and global social movements for their rather one-sided pressure for “sound economic policies” based on structural adjustment frequently disregarding the impact of monetary policies and liberalisation strategies on social development. Due to the absolute priority given to austerity programmes for fiscal adjustment and the favouring of cost-recovery principles in social services, the construction of primary health care systems in poor countries fell in disregard.

**The WTO** has been another international organisation with important impacts on global health. In particular, the Agreement on Trade-Related Intellectual Property Rights (TRIPS) created problems regarding access to new, patented medicines which are sold at high prices allowing pharmaceutical companies to recover their R&D costs. As long as developing countries were not prevented from producing much cheaper generics, the results of patent protection were basically limited to industrialised countries, which were in a position to cope with these problems through health insurance and public health systems.

Health services are delivered by public and private actors. The large play a decisive role in the development of new, highly effective medicines and thus also for the treatment of most diseases. Their inherent for-profit orientation has led to a concentration of research and development on the diseases of industrial countries with a capability to pay high prices for patented drugs – to the neglect of research on diseases mainly prevalent in poor countries. Due to their specific interests they have

been the major initiators and fervent defenders of the TRIPS agreement. Nevertheless, due to increasing public pressure through civil society organisations but also UNICEF and WHO (and to a certain degree by shareholders) corporate social responsibility has become a factor of increasing weight in corporate behaviour, leading to cooperation for the provision of global public goods in the form of global public-private partnerships (GPPPs). In general **business actors** in health have become central. Health is now one of the largest private markets in the world; industries that endanger health – such as tobacco and alcohol – are amongst the most influential global industries, as are industries with a high relevance to health, such as the food industry. Health has also become an important issue at the **World Economic Forum**. Medical and pharmaceutical research is a key area of research and technology development, and a major factor in innovation and competition between companies, regions and nations. But in many cases, health agendas and economic growth and investment agendas compete rather than complement one another, and innovation is focused on the needs of the rich rather than the poor countries – as in pharmaceutical development.

Though NGOs have played a role in global health for a long time (for example, the Red Cross and religious and philanthropic organisations), during the last two decades their impact has considerably increased. They now constitute a dense network of actors, which play an important role in the delivery of health services as well as in advocacy work. **A set of strong new non-state players** is defining priorities and approaches. As global communication becomes easier and cheaper the role of non-governmental organisations has become much more prominent both in setting agendas and in delivering services, for example Médecins sans Frontières (MSF) or Care International. Foundations as major new players have gained high influence in agenda setting through their resource-based power in global health, in particular the Bill and Melinda Gates Foundation, which spends about US\$1 billion on global health annually. An increasing number of global health initiatives – also within the WHO – are dependent on support by this foundation. The pharmaceutical industry and other parts of the private sector are increasingly involved in not-for-profit activities and alliances to improve

health in rich and poor countries. The leading role of some large NGOs like MSF and Oxfam has increased their impact on public opinion; the MSF has also demonstrated its strength with the creation of the Drugs for Neglected Diseases Initiative as a new form of developing Research and Development. The rise of human right organisations has linked advocacy for public health with fighting for a broader field of human development.

In general during the recent two decades the number and diversity of influential actors in global health has increased considerably. This has helped to boost financial and personnel resources available for health-related strategies and it has led to a considerably larger public awareness of and involvement in global health affairs. On the other hand, there is now a larger array of actors with different interests involved (e.g. security, protection of own population against trans-border spread of diseases, fighting poverty, enhancing development, making profits, human rights), who, of course, also use their political and financial resources to support their specific positions.

Compromises between actors with different interests, including private actors like pharmaceutical companies and NGOs are an essential feature of

Global Health Governance. This frequently creates a lack of transparency, accountabilities to very different publics and a lack of legitimacy for GHG as a whole. The politics of the EU and its Member States fits into this picture, with many different forms of reaction to different issues and different forms of involvement.

**Action:** The development of policy coherence for global health within the EU could be an important factor for making the EU a strong actor for the better integration of global health governance, without forgoing the advantages of the involvement of many different actors. Europe must be in the lead in establishing a global health architecture that respects the diversity but articulates, resolves and ensures transparency, accountability and joint action.

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## Financing for global health

The resource streams for global health are difficult to calculate as they come from a wide array of sources. Dominant in the global health discussion is financing through foreign aid but other sources of finance have increased significantly. Of increasing importance is global public goods financing. Europe needs to explore new financing mechanisms to ensure the three strategic priorities of global health: security, equity and good governance.

The discussion of financing for global health is usually dominated by a debate on funding for development and a call to donor countries to increase their support of developing countries. Lately, an additional debate on financing global public goods – such as global disease surveillance systems – has emerged, and the UNDP is suggesting a new approach to global public finance. The neglected area of financing for global health is the financing of the regular budget of international organisations – such as WHO. There is a tendency to fund diseases, issues and programmes – as discussed below – but not governance structures. This though has led to a significant weakening of a number of international organisations. Europe should be at the forefront of exploring new financing and governance mechanisms that ensure all three strategic priorities of global health: security, equity and good governance.

The most comprehensive study on resource needs for global health is still the report of the **Commission on Macroeconomics and Health (CMH)**, commissioned by WHO and directed by Jeffrey Sachs, while other estimates tend to focus on the resource needs for single issues or diseases.

The CMH report starts with the observation that “only a handful of diseases and conditions are responsible for most of the world’s health deficit: HIV/AIDS; malaria; TB; diseases that kill mothers and their infants; tobacco-related illness; and childhood diseases”. In order to improve health in the developing world additional financing especially in three areas is required: scaling-up of existing interventions, R&D, and global public goods. The report states that effective interventions exist to prevent

or cure most of the above-mentioned diseases. Both national and international spending, however, are insufficient to meet the challenges. While total spending on health per person/year amounts to nearly \$2000 in the developed world, it is only \$11 in the least developed countries (with \$6 being public domestic spending, \$2.3 being donor assistance and the rest being out-of-pocket expenditures). In order to scale up the existing interventions and to prevent 8 of the 16 million deaths per year from the above mentioned diseases, \$34 per person/year would be necessary. The CMH report thus recommends that the developing countries should increase their budgetary spending on health by an additional 1 % of GNP by 2007 and 2 % by 2015, while donor countries should help to close the gap by increasing from the current levels of health-related ODA of approximately \$6 billion per year to \$27 billion by 2007 and \$38 billion by 2015.

More recent studies do not focus exclusively on health, but deal with the resource needs for the entire process of the Millennium Development Goals (MDGs). The study of the **“High-Level Panel on Financing for Development”** that served as input for the “International Conference on Financing for Development” in Monterrey 2002 was the first to specify the amount of ODA that is required to meet the MDGs and gives the often cited figure of \$50 billion/year, supplemented by \$3 billion/year for humanitarian aid and \$15 billion/year for the provision of global public goods, leading to a total of \$68 billion/year or a doubling of the current levels of aid. Other studies basically confirm these quantities, while NGOs like Oxfam (2002) assume a global need of around \$100 billion/year. The report of the Millennium Project (2005) estimates the resource needs to be even higher and states that in order to achieve the MDGs, ODA of \$135 billion/year (= 0,44 % of GNI) will be needed in 2006 and that international funding will have to rise to \$195 billion/year (= 0,54 % of GNI) by 2015.

This logically leads to the question of where the additional money should come from. The report of the Millennium Project does not say much in that context; it only vaguely mentions the option to “frontload” ODA through capital markets via the International Finance Facility (IFF), as proposed by Gordon Brown, the UK Chancellor. Other studies go further on these

issues and list other options like global taxes, for example: on currency transactions, carbon emissions, airline tickets, weapon sales or profits of Transnational Corporations (TNCs), voluntary contributions (e. g. a global lottery, donations) or further debt relief. They state that these possible financing mechanisms should be additional to existing financing (and point to the danger of a crowding out of traditional ODA spending on health), that it is necessary to balance between conditionality on the one hand and the need for sustainable and predictable financial flows on the other hand, that issues of donor harmonisation, governance and participation of southern actors should be addressed, and that possible new mechanisms should be discussed in the context of debt relief and trade reform.

Among the most prominent of these suggestions is the so-called **Tobin Tax** or currency transaction tax (CTT), a global tax on currency transactions. The idea behind this tax is twofold: to reduce speculation and volatility in currency markets, and to generate revenues that could be used for global development purposes. It is estimated that a universal currency transaction tax of 0.1 % could yield \$132 billion per year and a pure European tax (given the political resistance especially of the US and Japan) would still generate revenues of \$16 billion per year. If a two-tier system were to be introduced, with a second, much-higher rate applying when price movements exceed a pre-established limit, revenues could even triple. Until now only Belgium and France have adopted legislation on a CTT; however, this will not come into force without the participation of other EU states.

Another promising option is a **tax on airline tickets**. At the UN Millennium+5 Summit in September 2005, the "Lula group" persuaded 66 countries to support such a proposal and to sign the "Declaration on Innovative Sources of Financing for Development". The European Commission also released a staff working paper that analyses how a contribution on airline tickets might be used by EU Member States as a source of development aid. Depending on how many EU states participate and whether governments make the tax voluntary or compulsory for passengers, it could raise between 568 and 2,763 million euros annually. So far 13 countries have either proclaimed their intention or taken

corresponding decisions, among them 4 European countries (France, Norway, Cyprus and Luxembourg).

One new mechanism that was introduced recently is the **International Finance Facility for Immunisation (IFFIm)**, a pilot scheme in support of the GAVI. The idea behind it is to leverage additional money from the international capital markets by issuing bonds, based on legally-binding long-term donor commitments. This pilot project should demonstrate that it would also be possible to realise a larger IFF that could raise up to \$50 billion per year. The support for that initiative, however, is limited so far as the principle of frontloading ODA through capital markets is perceived increasingly critically by governments and NGOs.

Another new mechanism to add to global health financing is **Public-Private Partnerships**. They can promote cooperation between state and non-state actors both from the national and international level and contribute to the funding of global public goods and the development of a "new public finance". While most of the money for GPPPs comes from public sources, private foundations play an increasing role. The Bill & Melinda Gates Foundation has committed more than \$6 billion in global health grants to organisations worldwide, with a large share going to GPPPs. Recent studies estimate that GPPPs currently contribute to 2.2 % of all ODA (with a growth from \$1.41 billion in 2000 to \$2.47 billion in 2003) and that they make up for nearly 14 % of all international funding in some developing countries. GPPPs' commitments in many African countries exceed 1 % of GDP and 5 % of government consumption expenditure. Thus the consequences of GPPPs for macroeconomic stability and the question of the added value of these funds have to be discussed.

Among the most prominent GPPPs is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), which became operational in January 2002. By February 2006 it had approved \$4.9 billion to support programmes in 131 countries and received pledges of more than \$8.6 billion up to 2008. The GF is the leading financing mechanism in the case of tuberculosis and malaria, where it contributes 66 % and 45 % of all international funding, respectively. In the case of HIV/AIDS, the GF strongly interacts with other financing institutions like the World Bank and

the bilateral agencies and makes up approximately 20 % of all international funding. It originally aimed at an additional contribution of \$15 billion/year. It became clear, however, that it would not be able to mobilise that amount of resources and the latest calculations estimate a need for \$3.5 billion in 2006 and \$3.6 billion in 2007. In order to meet these needs, additional pledges by donor countries and by private actors will be necessary.

A number of key issues are beginning to emerge which put into question some of the financing mechanism issues raised above: they would need to be part of an intensive discussion at European level and are therefore mentioned only in passing. They include: the effectiveness of the foreign aid mechanism, the balance between funding development in health and global public goods for health (such as global disease surveillance systems), the need to fund good global governance infrastructures, the problematic approach to programme funding that can reduce investments in health systems, the importance of direct private investments in countries compared to foreign aid, the role of debt relief in freeing up resources to support health within a country and the opening of European markets – such as in agriculture – to allow poor countries to compete.

**Action:** Europe should embark on a critical assessment of financing for global health and develop a common approach to international cooperation in support of global public goods and in support of foreign aid. It should explore new financing mechanisms (possibly like the carbon tax) to ensure the three strategic priorities of global health: security, equity and good governance.

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## European approaches to international laws for health

International law represents the body of rules and principles that regulates the conduct of, and relationships among, states; the operation of international organisations; the relations between states and natural or juridical persons; and – in some cases – the conduct of persons towards each other. Europe should promote the development of a new framework of international laws on health.

Historically, international law has been a central mechanism in international governance. Relations between states occur in a condition of anarchy, meaning that states recognise no common, superior political authority. In this context, international law serves as a critical process that allows states to coordinate their behaviour and cooperate on problems of mutual concern. Over time, international law has evolved to regulate not only inter-state relations but also the relations of states with their citizens (e.g. human rights) and obligations persons owe each other as human beings (e.g. a duty not to commit crimes against humanity).

For global health today, some of the most important areas of international law are: international trade law, international environmental law, international human rights law, international humanitarian law, international labour law, international law on arms control, and international law on specific health problems (e.g., communicable diseases).

Global health has experienced major controversies with respect to the impact of international trade law in the **WTO** on public health, particularly with respect to WTO treaties on intellectual property rights (TRIPS) and trade in services (GATS). The controversies merely reinforce how important international law has been, and will continue to be, for the pursuit of global health.

From the moment health emerged as a diplomatic concern in the mid-19th century, international law has been important to the pursuit of health objectives in international relations. Use of international law for

public health began with the international sanitary conventions adopted in the late 19th century, continued with the formation of the **WHO** in 1948, and expanded in the latter half of the 20th century to cover many activities that affect health or the social determinants of health. Much of the international law of relevance to health developed in the second half of the 20th century. It emerged outside WHO, which did not frequently utilise its powers to create international law for public health purposes. WHO's reluctance to adopt binding international legal instruments, or "hard law," demonstrated a preference for using "soft law," or non-binding conventions and agreements with states on how they should approach international health problems.

Globalisation has heightened the importance and stimulated major new international legal initiatives in global health. First, the processes of globalisation created the crisis in emerging and re-emerging infectious diseases in the 1990s; and this crisis led to the adoption in May 2005 of the new **International Health Regulations** (IHR 2005). The IHR 2005 constitute a radically new international legal regime designed to strengthen global health security against public health emergencies of international concern. They establish a new basis for cooperation in the event of international public health emergencies, by defining the *circumstances* under which health events should be reported in terms of their potential risk to international health. They require states to maintain the capacity to monitor and respond to such circumstances, with assistance and support from WHO or other states.

Second, globalisation contributed to the emergence of a pandemic of tobacco-related diseases in the 1990s; and WHO moved to counter this growing threat with the first treaty ever created under the treaty-making authority in the WHO Constitution, - the **Framework Convention on Tobacco Control** (FCTC). Like the IHR 2005, the FCTC is a seminal development in the use of international law for global health purposes. Third, a number of developments linked to globalisation's destabilising effects have generated renewed attention to the human rights aspects of (1) public health problems (e.g., discrimination evident in the HIV/AIDS pandemic; quarantine and isolation in the SARS epidemic); and (2) activities that affect public health (e.g. the impact of TRIPS on the human right to have access to essential medicines).



Europe's experiences with international law and health place it at the forefront globally in terms of the use of international law to benefit human health. The institutions of the European Union have addressed, through its various treaties, public health threats to safety, health at work, environmental degradation, the spread of communicable diseases and the broader impact of social and economic policies on health.

The **Council of Europe**, which both predates the European Union and has a wider regional membership, has taken the lead in developing international law that protects public health as a human right not only as an issue for the European region but as a global imperative. The "European Convention on Human Rights and Fundamental Freedoms" was introduced in 1953, the **European Commission on Human Rights** started work in 1954, and the European Court of Human Rights was established in 1959. Any state wishing to become a member of the European Union must first sign and ratify the European Convention on Human Rights and accept the jurisdiction of its court. The Court took an increased role in relation to health issues when individuals were granted leave to take petitions and cases to the court in 1998.

The Convention deals with civil and political rights; it recognises a fundamental right to life but does not go further in specifying rights of access to health and care services. These rights are specified in the European Social Charter first adopted by the Council of Europe in 1961 and revised and reaffirmed in 1996. The Charter is part of the proposed new constitution of the EU, which has not yet been ratified. It is important to note that ratification of these conventions and charters requires the adoption of state laws giving recognition and precedence to international laws and courts.

Because the European Union is fundamentally a legal agreement between states, with an independent legal process for settling disputes at the **European Court of Justice (ECJ)**, many issues that might otherwise be considered matters for agreements between states are adjudicated through a legal process. Thus, for example, the right to treatment in certain cases, to obtain health

services beyond the borders of a particular Member State, the application of working hours directives to health, action on tobacco and other products have all been subject to legal action at the ECJ.

Treaties and agreements covering basic environmental emergencies were concluded at a relatively early stage in the development of the European Union, as for example, the Seveso Directive of 1982. Laws and directives concerning health and safety at work and other issues touching mental and physical health at work such as working time and discrimination at work have also been prominent in EU legislation and directives. Given the emphasis of the EU upon employment and trade it is also unsurprising that consumer protection was an early priority.

The **Amsterdam Treaty of 1997** calls for all EU social and economic policies to be subject to health impact assessment, while the 2004 policy reflection Enabling Good Health for All looks forward to the establishment of mechanisms for health impact assessment to ensure that all sectors become accountable for their policies and actions on health, and the health theme to be taken up by the Finnish presidency of the EU in 2006 will be "Health in All Policy".

In addressing health environmental concerns, it has been increasingly realised that many issues encompass the whole of the European region and its near neighbours. The EU through its Directorate for Health and Consumer Affairs has developed a close partnership with the European Office of the WHO to address regional concerns as exemplified by the WHO Protocol on Water and Health of 2005.

Like other regions, Europe faces the challenge of improving compliance with the great body of pre-existing international law relevant to health. For example, the recent Environmental Policy Review highlights the fact that, while the EU has passed more than 200 laws on environmental health, including 140 Directives on issues such as water quality and waste treatment, more than a third of all infringement cases, where the failure of governments to implement EU laws are investigated, relate to environmental issues.

Improved compliance involves strengthening European performance under the regimes and increasing political, financial, and technical assistance to least-developed and developing countries that lack

compliance capacity. Such assistance is badly needed for creating the surveillance and response capacities demanded by the IHR 2005. States that either will not or cannot comply with international law render such law ineffective and threaten to subject it to derision. The development of the **European Centre for Disease Prevention and Control** (ECDC) as an agency for the coordination of EU capacity to monitor and respond to threats to public health is therefore vital to the effective application of IHR.

European countries have generally been strong supporters of legal action to protect global health; see, for example, the speech by Marc Danzon, WHO Regional Director for Europe, on the inauguration of the European Centre for Disease Prevention and Control. The European Union has supported the FCTC, not only by adopting it at EU level but also by introducing directives on tobacco advertising and initiating action against those governments which have failed to comply and has thus been instrumental in the adoption and implementation of these new international legal regimes.

EU action on diet, physical activity and health has not sought to introduce new legal instruments, developing instead a European Platform for Action involving European consumers, producers and legislators with the aim of supporting but not leading actions at other levels. In a similar way the EU has worked with producers on Codex Alimentarius Committees to define standards for food safety and Sanitary and Phytosanitary Committees to define food and product safety.

Europe's relationship with the international law relevant to global health is, in many ways, a leading indicator of the potential effectiveness of international law's contribution to the betterment of human health. The legal framework provided by European Conventions and Charters based on explicit values for life and health provides a model for the development of international law recognised and supported by the laws of Member States.

The constitution and funding of the EU itself shows how such a legal framework may be supported by institutions and agreed programmes of joint action and funding. These represent a significant step forward from the Bretton Woods institutions because they are backed by law and funding arrangements rather than transitory international agreements. In the current debate on the reform of UN institutions and the emergence of global governance for health, the EU should press for the further development of global laws and funding arrangements for health as a human right and global public good.

It should also see the emergence of regional institutions such as the EU itself as important elements of global governance for health. This requires strategic partnership between the EU DG for Health and Consumer Affairs, the DG for Development, the WHO Regional Office for Europe, the Council of Europe and other regional institutions such as the European Centre for Disease Prevention and Control. Acting together, such institutions could lead cross-government and cross-sector action for global health. The EU can also provide support and assistance to equivalent institutions and strategic partnership in other regions, such as the New Partnership for Africa's Development.

**Action:** Europe should promote the development of a new framework of hard and soft international laws concerning all three dimensions of global health (security, equity and governance) based on health as a human right and a global public good.

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## Politics of global health

The politics of global health encompasses political strategies of states and non-state actors for purposes of protecting and promoting human health, referring to issues which are beyond the capacity of individual countries to address through domestic institutions (Kent Buse). The role of Europe in global health politics should be strengthened.

Beyond the multitude of initiatives and actors, certain fields and strategies of primary importance emerge which begin to constitute a sector which one might rightly call the “politics of global health”.

Politics of global health has existed for quite a long time (cf. sanitary conferences in the 19th century; the League of Nations Health Organization) but had played a more important role only in specific fields (infectious diseases, cooperation in medical research, vaccination programmes). WHO was established in 1946 as a specialised agency of the United Nations to “act as the directing and co-ordinating authority on international health work” (WHO Constitution, Article 2a). For about three decades this role was not challenged by any other organisation. The World Bank started to work in the health sector in the 1970s as part of its basic needs strategy. The Alma-Ata Declaration (1978), stressing the right to “Health for All” and the importance of establishing systems of Primary Health Care in all countries, was an expression of the same orientation, as was the WHO Essential Drugs Strategy, established in 1977.

The 1980s saw a re-orientation of politics towards a market-oriented structural adjustment and trends towards the privatisation of health systems; fiscal austerity reduced the financial means available for health systems in many poor countries. It was in reaction to new and/or intensified challenges through globalisation that the politics of global health changed its face in the 1990s. This new face can be characterised by three main elements:

1. A re-strengthened interest in the North, specifically in the United States, in the health situation in developing countries due to new threats from infectious diseases, but also related to the re-

discovery of poverty as a political problem (instability). In addition to that, health threats inherent in consumption habits and environmental degradation are more broadly perceived. Frequently this has been formulated in terms of an extended concept of “human security”.

2. An increasing consciousness of global responsibilities and obligations stimulated by global civil society in a large sense (including radical social movements, different types of non-governmental organisations and also religious groups). The right to health has been increasingly defended as one of the most important human rights and the importance attached to the Covenant on Economic, Social, and Cultural Rights in general has considerably increased. This has been reinforced by the increasing attention of the media which has helped to draw a larger part of the general public into global health politics and to create a field of public interest and debate.
3. There has been a growing trend to limit the range of public sector activities and to give more space to forms of private activity in the economy and to private actors. This has been linked to an increased international movement towards deregulation, in particular in the context of the WTO. In the 1990s, this led to pressure on international organisations to refrain from supposedly interventionist demands and “politicised” (in this case mostly North-South) strategies, accompanied by reductions (at least in real terms) of their budgets.

Thus, it is possible to discern a seemingly contradictory tendency towards increasing commitments to poverty alleviation and health, (MDGs, Poverty Reduction Strategy Papers (PRSPs)), including new international agreements on global health, while at the same time reluctance among key actors in global health to strengthen existing multilateral institutions, in particular, but not only, on the part of the US government. This was accompanied by the strengthening of institutions concerned with “global market creation” – primarily the transformation of GATT into WTO, but also of a number of smaller organisations ruling on specific aspects of international economic relations like the Codex Alimentarius. This did not help to build strong national health systems but has favoured the role of

civil society organisations and private foundations in health and the rise of new organisational forms like GPPPs in fields where private actors do not supply important goods which public actors as well are not in a position to produce (such as medicines in the field of neglected diseases). In general, the retreat of the state from delivering public goods and services in combination with the perception of growing threats has favoured problem-oriented approaches, in particular strategies to focus on specific diseases.

The politics of fighting HIV/AIDS and other infectious diseases is a good example of this development. The recognition of the growing threat from these diseases has led to a significant increase in financial and knowledge resources. The creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria as a separate organisation outside the UN system and the increasing importance of private foundations in GPPPs to the strengthening of R&D activities as well as the access to available medicines in the field of neglected diseases constitute important examples of these tendencies. Private actors (in particular civil society organisations) can also be found at the forefront of conflicts with pharmaceutical companies and TRIPS on problems of access to medicines due to the expansion of patent right systems into developing countries.

Nevertheless, *increasingly the lack of transparency, lack of accountability and the problems of coordination due to the proliferation of actors in this field have been recognised* and the deficiencies of national health systems, above all in poor countries, is again recognised as a major problem. These problems are also recognised in the more general field of development cooperation and this context have led to important agreements like the Rome Declaration on Harmonisation and the Paris Declaration on Aid Effectiveness, which contain insights and strategies that are also important for global health.

On the other hand, *globalisation also has increased the need for binding international agreements,*

which has been an element of strengthening WHO as an international governmental organisation. The new International Health Regulations and the Framework Convention on Tobacco Control can be seen as important indications of this. In addition, the WHO is asserting its position as the central authority in global health by initiatives to improve global understanding on some central issues cutting across narrow institutional borders and academic disciplines, for example: the Commission on Macroeconomics and Health, the Commission on Intellectual Property Rights and Innovation in Health and the Commission on Social Determinants of Health.

In the recent past, the European Union and European countries have played an ambiguous role in the politics of global health. On the one hand, they have defended rather narrow economic interests mostly in the context of WTO and TRIPS and in relation to the migration of health workers from the South into Europe. On the other hand they have contributed to the increase in resources for international health activities by giving support for health system development in poor countries and bridging the digital divide between Europe and the South and by putting in general a stronger focus on humanitarian aid and support for the provision of global public goods such as health and environmental protection.

**Action:** The role of Europe in global health politics should be reinforced by better coordination within Europe itself, for example by initiating a European global health strategy process to clarify Europe's values, strategic priorities, and preferred governance approaches.

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# 4. Europe must establish a societal dialogue for global health

## Corporate responsibility for health

Corporate responsibility is the obligation of a business to be accountable to all of its stakeholders, including shareholders, employees, communities in which businesses operate, suppliers and customers for the sustainability of its operations and activities not only in financial terms but also in relation to its social, health and environmental impacts.

Some elements of corporate responsibilities are underpinned by legislation and regulations, for example: those concerning obligations to pay taxes, account for financial performance, and protect the health and safety of employees and consumers. Other aspects of corporate responsibility, referred to as corporate social responsibility, may be seen as voluntary actions which exceed minimum standards of behaviour and may be monitored against standards of good practice. These depend upon the value that company boards and employees, shareholders, customers and other stakeholders ascribe to good practice and the extent to which they are aware of these actions and impacts of the business.

The importance of ensuring that Transnational Corporations (TNCs) are socially and environmentally responsible was recognised in the *tripartite declaration on multinational enterprises and social policy adopted by the International Labour Organization (ILO)* in 1977. In 1999 Kofi Annan called on TNCs to commit to a *global compact for responsible globality* and similar themes were evident in the United Nations Conference on Trade and Development (UNCTAD)'s World Investment Report of 2003 and the UN Sub-Commission on Human

Rights of the same year. In 2005 the UN Secretary-General named a special representative on human rights and trans-national corporations to "identify and clarify standards of corporate responsibility and accountability for trans-national corporations." The United Nations has come to realise that the corporate responsibility agenda is bound to fail if it is not embedded in a framework of binding rules.

In 2001 the Commission of the *European Union Green Paper* on this topic defined corporate social responsibility as "*a concept whereby companies integrate social and environmental concerns in their business operations and in their interaction with their stakeholders on a voluntary basis*". The paper went on to stress the principle of voluntarism in corporate social responsibility, but argued that it was important for long term shareholder value and sustainability.

Support for voluntary action to take responsibility for health may be backed by labelling – it has been proposed that the EU should establish a mark for goods produced under acceptable conditions. It is also important to gain public recognition for those TNCs that meet guidelines for social responsibility, including health impacts. The Nuffield Trust has proposed a "Global Health Award" as an encouragement to those demonstrating best practice in this field. It is equally important to identify those TNCs which do not meet acceptable standards in order to inform and organise consumer action.

However, the responsibility of TNCs for health is wider than simply compliance with voluntary codes such as the Organisation for Economic Cooperation and Development (OECD) guidelines for TNCs. Adherence to international conventions and national regulations on health and safety at work, environmental standards and consumer protection must be backed by international and local enforcement action to

avoid what has been termed a “race to the bottom” in which states compete to attract international investment by lowering standards and costs for health and safety environmental standards and labour conditions.

*The Bangkok Charter for Health Promotion in a Globalised World* of 2005 stressed that TNCs have a responsibility to ensure health and safety in the workplace, and to promote the health and well-being of their employees, their families and communities. They should also contribute to lessening wider global health impacts, such as those associated with global environmental change by complying with local, national and international regulations and agreements that promote and protect health. Ethical and responsible business practices and fair trade exemplify the type of business practice that should be supported by consumers and civil society, and by government incentives and regulations.

It is important to note that TNCs often operate through local subsidiaries and contractors that feel a lesser obligation to comply with international standards, since they are less visible to consumers and other stakeholders. The compensation case fought by South African asbestos miners in the UK courts against a TNC-operated subsidiary showed that TNCs can be held to international standards of health and safety. And the case brought by the EU against RJR Nabisco and Phillip Morris over links with smugglers and narcotics traffickers in Spain and links with money launderers in the Caribbean is another example of corporate responsibility backed by legal sanctions.

If corporate responsibility for health and environmental sustainability is to spread through European TNCs, it must be made attractive to businesses by recognising best practice and championing leading companies so that shareholders

and customers can distinguish between well-performing companies and others. It is also important to engage the private sector, shareholder and consumer groups in formulating standards of good practice and methods of audit so that they are owned by the stakeholders.

**Action:** The EU should take steps to engage with the stakeholders of TNCs to formulate standards of good practice in relation to corporate responsibility for the environment and global health. This should lead to recognition through accreditation, labelling and awards. Possibly a EU representative on human rights, health and trans-national corporations could be considered following the UN model.

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### Civil society action for global health

The term “civil society” broadly refers to social relationships and organisations outside either state (government) functions, or market-based relations that define people simply as “consumers” rather than more collectively, for example as citizens, neighbours or colleagues. In a narrower context, civil society includes organised groups concerned with public interests. Civil society organisations constitute a broad grouping that incorporates non-governmental organisations (NGOs) and less formally organised groups that may be based in local communities, such as youth groups or women’s groups. For the purposes of this glossary organisations aimed at promoting private business interests are excluded from this category.

Historically, organised citizen groups have played an important role in the process of health development. One of the best-known examples concerns the industrialising towns of 19<sup>th</sup> century England when mass protest and popular self-organisation around squalid and dangerous living and working environments spurred reforms and legislation that led ultimately to improved living and working conditions and sustained health improvement. Since that time there have been innumerable instances of popular mobilisation securing social reforms relevant to health.

It is increasingly accepted that for public sector bureaucracies to work effectively, efficiently and fairly, they need to be held to account – internally through transparent rules and codes of ethical conduct, and externally to elected officials and the public. Public or community involvement is also necessary for the successful implementation of health programmes, particularly those that adopt a developmental and comprehensive approach to health. All too often, community involvement in health is given inadequate attention, used as a cover for the derogation of state responsibility, or to rubber-stamp centralised decisions. The spectrum of forms of community engagement ranges from community involvement in implementation and service delivery to the assertion

and monitoring of rights, to involvement in local planning and decision making and to challenging policies and presenting alternatives.

In many health care systems there is a need for community empowerment, which implies a change in the balance of power within health care systems to allow communities to assert themselves and demand accountability from policy makers, managers and providers. In some countries, this will require social mobilisation to force a shift in power, especially where there is a large gap between the interests of the state and communities, or between the interests of health care providers and patients. Here, the assertion of health rights and monitoring of public health activities can assume importance. A further step in this direction is the actual monitoring of health services by communities, which has been shown to be effective in some parts of India.

Effective and appropriate community involvement can also be enhanced by health care systems. This can occur through formalised structures and forums (such as district health committees, clinic committees and hospital boards), as well as informally by inculcating a culture of consultation and respect for lay people. Health care systems can also disseminate information about local health services and the rights of service users, as well as publicise disparities in key indicators such as maternal mortality ratios and immunisation coverage rates. However, because communities are in themselves stratified, community involvement cannot be as viewed as simple or a technocratic fix – it requires commitment from health workers to promote equity and prevent privileged groups from gaining preferential benefits.

The current status of civil society involvement in global health results from a number of forces. Conservative economic policies have resulted in fiscal restraint and the substantial withdrawal of the State in many countries from health care provision. Consequently, local and international non-governmental organisations and civil society groups have assumed a more prominent role in both service delivery and in advocacy. A notable area of civil society involvement in service delivery is that of assistance in humanitarian crises and emergencies, where organisations such as Médecins sans Frontières both contribute resources and technical expertise that



often surpass that of host country governments and also sometimes play an important advocacy role.

Certain aspects of globalisation have further undermined the ability of developing country governments to provide health care for their populations. For example, the development of agreements under the World Trade Organization (WTO), notably Trade-Related Intellectual Property Rights (TRIPS) and its interpretation by powerful corporate interests and governments, has already threatened to circumscribe countries' health policy options. The best-known case relates to the recent legal battle around the attempt by South Africa to secure pharmaceuticals, especially for HIV/AIDS, at a reduced cost. In 1997 Nelson Mandela signed into legislation a law aimed at lowering drug prices through "parallel importing" – that is importing drugs from countries where they are sold at lower prices – and "compulsory licensing", which would allow local companies to manufacture certain drugs, in exchange for royalties. Both provisions are legal under the TRIPS agreement as all sides agreed that HIV/AIDS is an emergency. This was confirmed during the WTO meeting in Doha in 2001. The US administration did not bring its case to the WTO but instead, acting in concert with the multinational pharmaceutical corporations, brought a number of pressures (e.g. threats of trade sanctions and legal action) to bear on the South African government to rescind the legislation. This followed similar successful threats against Thailand and Bangladesh. However, an uncompromising South African government, together with a vigorous campaign mounted by the local Treatment Action Campaign (TAC) and international AIDS activists and various health NGOs, forced a climb-down by both the US government and the multinational pharmaceutical companies.

The above example is an unusual one of collaboration between a local social movement (TAC) and international NGOs with a specific focus and expertise, and an alliance with a national government. International NGOs sometimes perceive their role as acting as a conduit to communicate the demands and needs of poor people in developing countries. A recent example is the "Make Poverty History" campaign. While such a role is important, tokenism must be avoided. International NGOs in developed countries need to work with and through southern-based NGOs, and UN

agencies and intergovernmental bodies must find ways to create a more prominent involvement of southern-based NGOs, academics and health institutions in shaping the international health policy agenda.

Globalisation has increased the need to engage with actors and policies from beyond the local area: this poses a particular challenge for civil society. Social movements may need to bring together the concerns of multiple communities and then find ways to present collective views and concerns at the national or international level. This form of community involvement requires an advanced level of organisation, capacity-building and civil society networking. The most active and coherent global health-related networks have been organised around women's and reproductive health issues and have been influential in population policy as well as around opposing the commercialisation of infant feeding.

A current example of a developing global network is the recently-created People's Health Movement (PHM). The PHM is a large global civil society network of health activists supportive of the World Health Organization (WHO) policy of Health for All and organised to combat the economic and political causes of deepening inequalities in health worldwide and revitalise the implementation of WHO's strategy of Primary Health Care. The PHM, formed in 2000 at a People's Health Assembly attended by 1500 delegates from over 90 countries, now comprises a range of NGOs and community-based organisations and is playing an increasingly active advocacy and educational role at both national and global levels. It has already had some success, in alliance with selected country governments, in clarifying and strengthening WHO's position in revitalising its commitment to the principles of Primary Health Care.

European organisations play a major role in this dialogue and many donors from the North increasingly support civil society actors from the South. The European Union Institutions increasingly acknowledge the need to include civil society in the policy process and have created a special European Health Forum to dialogue with non-governmental organisations and patient groups. The Commission has had frequent consultations with civil society in decision making related to health, for example ongoing consultation of the European Commission Green Paper on Mental



Health, or past ones on pharmacovigilance or the health effects of smokeless tobacco products. This reflects the recently expressed desire for EU institutions, including the Commission and the Parliament, to "bring Europe closer to its citizens". As part of a new community programme launched in 2006, the Commission has proposed three lines of actions to encourage active European citizenships, including "Active Citizens for Europe", "Active Civil Society in Europe" and "Together for Europe."

**Action:** the dialogue on a European health strategy must seek to engage civil society and be continuously aware of the interface between local and global health action. It must explain to European citizens the added value of taking an active role in global health and be responsive to civil society concerns.

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### Consumer protection and global health

Consumer protection is a critical dimension for global health action and aims to protect from risks and threats to health which are beyond the control of citizens wherever they might live or travel.

In an interdependent world the mobility of goods, services and people calls for new forms of protection. It is an important signal that the European Commission has proposed to combine the public health programme with the consumer protection programme because so many public health issues are directly linked to easily accessible products in the global marketplace: food, drink, tobacco, alcohol, health care products, to name but a few. The communication from the Commission is entitled **“Healthier, safer, more confident citizens”** and brings together the Public Health and Consumer protection policies and programmes under one common framework. It has three joint core objectives:

1. To protect citizens from risks and threats, which are beyond the control of individuals and cannot be effectively tackled by Member States alone (e.g. health threats, unsafe products, unfair commercial practices).
2. To enhance the ability of citizens to take better decisions about their health and consumer interest.
3. To mainstream health and consumer policy objectives across all EU policies in order to put health and consumer issues at the centre of policy making.

This approach takes into account the increasing interface between public health, the role of the modern citizen in health and the importance of the role of the market in either endangering or supporting health. It also recognises the increasing importance of trans-border and global dimensions of health and safety, and highlights the need to integrate health and consumer concerns into other Commission policies, such as the regulation of markets and citizens' rights. Finally, it is explicit about citizen and consumer empowerment. It states: *“Consumer*

*and health organisations need active, expert and articulate voices”* and gives clear indications how the Commission will support such organisations. In order to implement this joint programme the Commission has proposed a significant increase in resources.

The Commission paper clearly maps out actions that need to be taken in relation to consumer protection in the Internal Market by *“ensuring a common high level of protection for all EU consumers, wherever they live, travel to or buy from in the EU, from risks and threats to their safety and economic interests.”* This includes:

- Better understanding of consumers and markets
- Better consumer protection regulation
- Better enforcement, monitoring and redress
- Better informed and educated consumers

Such an approach reflects the many issues that also arise as consumer concerns in global health. The EU policy proposal is a breakthrough that recognises this connection in the face of the tobacco, alcohol and obesity epidemics. Policies must aim to empower consumers in ways that have not been considered before.

Within Europe, consumers are active in assessing not only products that could endanger their own health or that of others, they are increasingly interested in quality comparisons within the field of health care as cross-border health increases. Newspapers and journals are developing report cards and rankings on health services and systems in order to provide the consumer with better information for informed choice and action. For example, the Euro Health Consumer Index (EHCI) ranks the national health care systems across the EU in areas that are important to the consumer – patients' rights and information, waiting times for common treatments, care outcomes, customer-friendliness and access to medication. The Index is compiled from a combination of public statistics and independent research. The 2006 index describes the user-friendliness of national health care systems in all the 25 EU Member States and Switzerland. Evidence-based consumer health information is gaining increasing importance as are patient rights and patient safety within the European context. An example is the speech by Commissioner David Byrne to the European Parliament in which he called for a co-ordinated multisectoral and population-wide approach to obesity.

But new challenges are emerging as countries like China and India become global consumers – a recent study showed that China has overtaken the US in the consumption of basic agricultural and industrial goods. This means not only pressure on the country's national resources – but also globally. The Kyoto Protocol considers China a developing nation, and it is therefore currently exempt from cutting greenhouse gas emissions.

**Action:** Approaches to consumer protection and public health such as those spearheaded by the European Commission could gain importance as a model for global consumer safety.

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### Public-private partnership

Public-Private Partnerships (PPPs) are hybrid forms of regulation between state and non-state actors and can broadly be defined as “collaborative relationship among multiple organisations in which risks and benefits are shared in pursuit of a shared goal” (Carlson 2004).

In the health sector Public-Private Partnerships play a role especially in three contexts: in the provision of health-related services in the European countries themselves, as a mechanism of development cooperation in bilateral relationships, and as a global means to tackle health-related problems that transcend national boundaries.

PPPs consist of two basic types of actors – State and non-State actors – that can be further differentiated by their level of activity and their respective sector. The main State actors represented in Global Public-Private Partnerships (GPPPs) come from the national level (governments, bilateral agencies), the local level (administrative bodies, local governments) and the international level (international organisations). The non-state actors can be further divided into those from the private sector (for-profit companies, business associations, foundations) and those from the civil society sector (grass-roots organisations, national NGOs, international NGOs).

In global health PPPs started to gain importance in the beginning of the 1990s. In a phase where the UN system was increasingly criticised for being bureaucratic and ineffective and where nation states were losing regulating authority due to globalisation processes, cooperation with non-state actors in the form of GPPPs seemed a promising way forward in order to address issues that could not be solved in the national context or by single actors alone. This specific type of partnership can be defined as: “collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organisation, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour”.

Today there are about 80 GPPPs in the health sector, differing in terms of legal status, disease focus and area of activity, and ranging from small initiatives for single issues to large institutions for multiple diseases. In order to structure the complex field of GPPPs in health and other fields, a number of typologies have been developed, including the following three.

A first way to map different types of partnerships is by their legal status. Are they legally independent entities or are they hosted inside an existing organisation, and if so, in what type of organisation? Starting with these criteria, Widdus (2002) distinguishes between four types of GPPPs: those with a public sector host (e.g. national, bilateral or multinational institution), those with a commercial host (e.g. pharmaceutical, private medical, or non-health related for-profit company), those with a non-profit host (e.g. non-governmental organisation, educational and research institution, or civil society group), and those which operate independently from any host organisation with their own legal authority. While approximately 40% of all GPPPs have a public sector host, non-profit and independent hosts each account for roughly 25%, and commercial hosts are the least common – about 10%.

A second way to categorise GPPPs is by their disease focus. Do they cover mainly the most prominent infectious diseases like HIV/AIDS, Tuberculosis and Malaria or are they targeted at the so-called neglected diseases (defined as “diseases affecting principally poor people in poor countries, for which health interventions – and research and development – are regarded as inadequate to the need”)? Do they concentrate on communicable or non-communicable diseases or do they have no specific disease focus at all but focus on health system development or other issues? It can be observed that GPPPs focus mostly on communicable disease (with AIDS, Tuberculosis and Malaria alone accounting for nearly half of all GPPPs) and increasingly also on neglected diseases (approx. 20%), while non-communicable diseases, reproductive health and health system development are only at the centre of approximately 10% of all GPPPs.

A third typology, developed by the United Kingdom Department for International Development (DFID), is based on the area of activity and distinguishes between partnerships active in Research & Development (product discovery, development of

new diagnostics, drugs and vaccines), GPPPs in the area of technical assistance and service support (service access, provision of discounted or donated drugs), GPPPs that concentrate on advocacy activities at global and national level (including resource mobilisation) and partnerships in the area of financing (provision of funds for specific disease programmes). An analysis of health GPPPs applying this typology shows that the last type of GPPP is relatively rare (with the Global Fund to fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunisation (GAVI) being the most important actors in this category), while advocacy is a central activity of approximately 20% of all GPPPs (e.g. Roll Back Malaria (RBM), Stop TB, Global Campaign for Microbicides (GCM)) and the vast majority of GPPPs concentrate on R&D (e.g. International AIDS Vaccine Initiative (IAVI), Drugs for Neglected Diseases Initiative (DNDi) and Medicines for Malaria Venture (MMV)) or service support (e.g. Action Aid International (AAI), the Coartem Partnership and Netmark Plus).

The different participants interact in GPPPs on a voluntarily basis in order to pursue common goals and shared objectives. They aim at sharing risks and benefits, using the comparative advantages of the different types of actors, and pooling their specific resources (e.g. financial resources, technological know-how, human resources, management capacities, public reputation, advocacy skills). In order to coordinate the activities of the various actors, GPPPs tend to follow a network approach, with horizontal interactions and lean administrative structures. Most GPPPs have some kind of executive board for decision-making purposes that is accountable to the partners of the GPPP, and a broader stakeholder forum that enables the different constituencies of the partnership to participate and express their views. GPPPs are expected to combine the positive aspects of public regulation (binding decisions) and private regulation (autonomy), while avoiding their negative aspects (lack of flexibility, negative externalities). It remains to be seen, however, how the potential of state and non-state actors can be combined in practice. This depends on the governance structure and network management, and factors like mutual trust, learning processes and communication structures are important factors.

Critics argue that policy making in and through GPPPs can be associated with a number of problems. First, the inclusion of non-state actors raises questions of legitimacy and accountability. While state actors are legitimised through elections and can be held accountable by mechanisms of democratic control, non-state actors have not been formally legitimised and are only accountable to their members or supporters. This can be considered problematic as it may lead to an undue influence of private interests, a limited legitimacy of the GPPP, and an undermining of public policy making. Second, the large number of GPPPs can cause coordination problems, as most of the partnerships focus on single diseases or activities and aim to produce goal-oriented outputs in their specific area. The sum of these activities, however, does not necessarily lead to a coherent policy but can contribute to fragmented approaches to global health. Third, GPPPs, compete with each other and with other actors in global health for scarce resources and influence. The proliferation of GPPPs might lead to a distortion of funding and a further verticalisation of health policies.

It is therefore important to monitor the performance of GPPPs carefully and to pay more attention to their impact at country level. This requires the development of appropriate systems for monitoring and evaluation and mechanisms of accountability. At global level, a clearer division of labour between the various GPPPs and other actors is necessary to avoid duplication of activities and to improve coordination in global health.

**Action:** a careful analysis should be made of European involvement in global public-private partnerships and its policy consequences. Criteria for participation should be developed in the light of health system development and policy coherence.

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### Global policy networks

Policy communities are no longer purely national – an extensive exchange takes place between like-minded actors at multiple levels of governance through policy networks and leads to exchange on policies, innovation and experiences. Europe needs to increase its engagement in policy networks at global level.

Policy communities that were previously national have become increasingly open to global influence and are increasingly interlinked in a system of global governance. Slaughter states in her influential book on policy networks: *“Understanding ‘domestic’ issues in a regional or global context must become part of doing a good job. Increasingly, the optimal solutions to these issues will depend on what is happening abroad, and the solutions to foreign issues, in corresponding measure, by what is happening at home.”* Thus, even policies enacted at the national level may be considered global to the extent that they are co-determined by global policy actors. An increasing number of such policy networks in health have been created and are engaged in active exchange and policy transfer. The European open method of coordination introduced by the European Council of Lisbon in March 2000 is very important to such mechanisms, providing policy actors in health the opportunity to exchange experiences widely and a range of special mechanisms, regular meetings and conferences, websites and publications support this effort.

Similar exchanges happen in the global health arena, with specialist groups meeting to discuss issues related to global governance in general, but even more so on specific health care reforms and disease-based approaches. The WHO expert committees and meetings allow for debate and a seeking of consensus that is presented to the World Health Assembly after acceptance in the specialist arena. In particular, foundations enable projects and meetings to explore innovations in health. New think tanks have emerged – particularly in the US – that operate in a transnational space and influence the global governance process.

Analysts maintain that global policy networks are gaining increasing influence as information technology allows for the rapid sharing of knowledge and the pressure for reform at country level increases.

Some case studies show that a relatively small group of people have been able to influence both global and national policy development in health in this way through affiliation with international organisations and major foundations. In response there has been a move to ensure more accountability through involving yet other networks such as parliamentarians, who are accountable to an electorate. Increasingly, parliamentarians – for example through the Inter-Parliamentary Union – want to play a more active and an oversight role in global governance.

Very little analytical work has been done on the global policy processes for global health yet it appears that it is dominated by the United States and the English-speaking world and is influential in both developed and developing countries. A particularly attractive way to co-determine national policy development by global policy actors is to engage in in-depth country studies and reviews.

**Action:** European actors – in particular foundations – should study the increasing importance of policy networks in global governance and apply the results to an engaged effort to promote European perspectives to global health. They should contribute further to establishing global norms for action in policy networks in close cooperation with developing countries.

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# 5. Europe must act now for global health: Four select policy areas to shape the global health agenda

## Europe should support the improvement of health systems worldwide

A health system organises and manages the actions necessary to achieve and maintain the goals of health for all. It requires the active cooperation of many people and agencies, including health and care specialists but also other branches of central and local government, business organisations, schools and communities, NGOs, foundations, families and individual citizens.

Health systems in poor countries, particularly those in Africa, are under increasing strain, they face a growing burden of disease, as described in a previous section, and diminishing public sector budgets. In many countries salaries are insufficient to retain clinical staff in rural areas, so they move to the cities in order to be able to supplement their income from private patients and “gratitude payments” and an increasing number migrate to Europe where they can earn more. Health systems in Africa and other near-neighbour states represent the front line of global health surveillance for Europe but the capacity to monitor global disease threats depends upon local capacity for public health and health service provision.

For these reasons, Europe needs to increase its investment in global health systems in partnership with developing countries. This could take many forms including: budgetary support for health ministries, support for training and staff development, further

twinning and other two-way relationships between health services, cooperation on health systems research and agreement on staff exchanges and migration. While health aid is increasing, the European Development Fund has been slow to support human resources for health. Much of current aid is focused on disease-specific programmes, which both create additional problems of coordination for health ministries and draw staff and resources away from basic health care.

The New Partnership for Africa’s Development (NEPAD) “Health Strategy” of 2003 proposed action on seven key problems facing their health systems:

- Strengthening government commitment and stewardship
- Building secure health systems and services
- Strengthening programmes to reduce the burden of disease
- Providing skilled care for pregnancy and childbirth
- Enabling individual action to improve health
- Mobilising sufficient sustainable resources
- Improving equity for the poor displaced and marginalised

This strategy, which included a commitment to increase government health spending to 15 % of GDP, could provide the basis for partnership between Europe and African countries to support health systems, promote innovative reforms and train and retain health personnel. Innovation and training must be born out of local needs and experience recognising the huge disparity between countries even within Africa. Thus it is essential to build capacity for health

system research and training in developing countries – as agreed at the Kananaskis G8 meeting of 2002 but not yet implemented.

The range of experience available across the European region provides a rich vein of knowledge of health system innovation and development. The European Observatory on Health Systems and Policies, which is supported by many different European institutions, provides access to this knowledge as a resource for global health. The potential exists to combine this academic knowledge with the practical experience of the leadership of health systems and training and development of staff both in Europe and in developing countries. Many hospitals and other health organisations across Europe already support some form of twinning and knowledge exchange for clinical staff. This could be extended to support leadership and human resource development for health.

Human resources for health include, but are not limited to health professionals. It is increasingly recognised that the majority of care and basic health knowledge is provided by individuals and local communities. Thus, support for health systems must also include consideration of how to mobilise and empower local communities and traditional health providers in developing countries.

Innovations in health service provision must be matched by new approaches to investment in global health as a global public good. This may involve reclassifying some elements of support for health systems, currently regarded as aid, to recognise their global impact, as well as offsetting the costs of training staff who migrate to Europe. Innovations such as the International Finance Facility, which recognises the importance of investment for health as a global public good need to include investment in developing health systems as well as in specific drugs. Such investment must also engage the private and voluntary sectors in Europe as partners in the development and funding of new health system solutions.

Europe should be a major force in supporting investment in health systems and human resources for health in developing countries. Europe's voice in health is a crucial element in global health development.

**Action:** Europe should increase investment in global health systems and support the development of a global virtual college for health systems leadership and management providing the opportunity to build knowledge and share experience of health system development and innovation. This could be a focus for both aid and exchange between health systems.

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### Europe should lead research and knowledge management for global health

Health research is investigative work undertaken on a systematic and rigorous basis using quantitative and qualitative methods to generate new knowledge that seeks to impact on human physical, social and psychological well-being. (Queensland Health)

Knowledge management for health is a set of principles, tools and practices that enable people to create knowledge and to share, translate and apply what they know to improve health and the effectiveness of health systems. It is an integral skill for health for clinical and public health practitioners.

Health research is essential for achieving and maintaining a state of good health. The spectrum of health research encompasses:

**Biomedical research:** Basic research (involving the physical and biological sciences including chemistry, genetics, molecular biology, pharmacology, toxicology, etc) leads to understanding of the biological nature of diseases, while applied research and development translates this knowledge into the creation of products (drugs, vaccines, diagnostics, medical appliances) to prevent, treat or ameliorate disease states.

**Health policy and systems research:** Research on policy formulation, relationship of policy to evidence, prioritisation; health systems management, functions, efficiency, effectiveness, system factors affecting access, scale-up, monitoring and evaluation.

**Social sciences and behavioural research:** Research on social, political, economic, environmental determinants of health and their relation to equity, access, lifestyle and health-seeking behaviours.

**Operational research:** Research on factors affecting functioning of programmes, effectiveness of targeting, impact on behaviour, disease burdens and public health.

The 1990 report of the Commission on Health Research for Development identified that far too little

health research is devoted to the needs of developing countries and that every country should conduct a programme of essential national health research. The Commission recommended that developing countries should aim to spend the equivalent of 2 % of their national health budgets on health research and that donors should allocate 5 % of their programme support for the health sector to research and research capacity strengthening. In January 2006, a resolution (EB117.R6) of the World Health Organization's (WHO) Executive Board recommended that member states consider implementing this, and the resolution was adopted by the World Health Assembly in May 2006.

It is now widely understood that the determinants of health extend far beyond the health sector and that "research for health" must encompass not only the immediate causative agents of diseases but also social, political, economic and environmental factors that contribute to the health status of individuals and populations. The Commission on Social Determinants of Health, established by WHO in 2005, is now conducting studies and gathering evidence that will contribute to this picture and it should be emphasised that research is needed into the health impact of every sector of activity.

The public sector has several key roles to play in supporting, underpinning and enabling health research. These include support for: basic research that addresses significant global health challenges, including attention to 'neglected' diseases such as tropical parasitic diseases; the development of new drugs and vaccines for neglected diseases, particularly through funding of public-private partnerships like the International AIDS Vaccine Initiative, the Medicines for Malaria Venture and the TB Alliance which are addressing specific Millennium Development Goal (MDG) targets; and capacity building to ensure that developing countries can themselves conduct the health research that is vital to improving the efficiency and effectiveness of their health systems.

Globalisation has been enabled by the rapid development of information and communications technology, which has made it possible to develop and share knowledge faster than ever before. It is estimated that more than 90 % of information is now accessed in electronic form, whether by broadcast,



telephone or the Internet. Since 1996 there has been an investment of \$1 trillion in the Internet, providing online access to information for one-eighth of the world's population.

The explosion of information brought about by the Internet and by developments in knowledge has had a particular impact on the practice of medicine. Medical knowledge doubles every 7-10 years; in 1997 it was estimated there were 40,000 articles published each year relevant to general medicine, in 2005 an electronic library for general medicine estimated it reviewed 100,000 articles in that year.

Information resources are not equitably shared; for large areas of the developing world access to Internet information is difficult and expensive. In high-income countries, more than 40% of people use the Internet and it costs them less than 2% of average salary, but in low-income high-mortality countries less than 1% of people have access and it costs more than 30% of average salary. While some medical schools in developing countries have Internet access, in many cases the quality of connection is poor and the cost high. It is also expensive for the public to gain access to information to enable them to look after their own health.

Thus while in Europe online and telephone information services for doctors and the public have been successful in providing access to health knowledge, these are not available in the developing world. Poor people in rural areas often have to rely upon the information they can obtain from family members and friends. They may then gather what monies they can to go and purchase what they hope is the right medicine, which they then share around in the hope that it will be effective. This is the very opposite of a knowledge-based health service; it is expensive and dangerous.

Knowledge resources for poor countries could be very effective in both supporting continuing medical information and providing better health information for rural people. Technical solutions to the delivery of information with limited Internet access are available using Internet conferencing facilities and/or low-cost portable hard drives and providing access from mobile phones. Indeed such technology may hold the key to delivering medical services in areas where it is very hard to locate highly trained staff due to lack of resources and support facilities.

Health knowledge must be relevant to local culture and resources and must be organised around the needs of users. This may mean using a mixture of traditional resources such as school education materials, book-based libraries, as well as local intranet, mobile phones and hand-held computers. The starting point must be a local appreciation of health knowledge and information needs and how it can best be developed within the local health system. Thus while Europe has a great many information resources it could offer the developing world, it will be important to start by supporting local skills in knowledge management for health alongside views on the leadership and innovation of health systems as described in the previous section.

**Action:** Europe needs to strengthen its commitment to all dimensions of global health research and aim to allocate 5% of its programme support for the health sector of developing countries to strengthen research and research capacity. It should take the lead in the analysis of the local and national impact of global processes as well as the study of global health policies and governance.

Europe should support the development of knowledge management for health in developing countries and assist them in developing information products and services to meet the needs they identify.

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### Europe must support global policies for human resources for health

The World Health Organization defines health workers as all people engaged in actions whose primary intent is to enhance health. Europe must support and be at the centre of the efforts to address the human resources crisis.

Globalisation has increased the movement of people across national borders in search of better labour markets and improved quality of life. The push and pull forces underlying international migration also apply to the health sector. The root causes for migration of health workers are related to inadequate remuneration and promotion, limited opportunities for continued education and training, poor working environment, heavy work load, lack of conducive environment for the development and education of their children. Among the pull factors are prospects for better remuneration, better opportunities for continued education and improved living conditions. The unmet demand for well-trained health workers in developed countries is an important pull factor.

The WHO defines health workers as all people engaged in actions whose primary intent is to enhance health. This includes mothers and carers, community health workers and traditional birth attendants. Formal health workers can be classified into two major groups: the health service providers (two-thirds of the formal health workers) and health management and support workers (one-third of formal health workers). WHO estimates the number of full paid health workers worldwide at 59.2 million – a conservative estimate. There is a significant gender imbalance in the health workers' distribution: 70% of doctors are male and over 70% of nurses are female. The global shortage of formal health workers is estimated to be 4.3 million workers.

It is acknowledged that there is a global, chronic shortage of trained health workers, most critical in developing countries. Demographic and epidemiological transition and high disease burden, compounded with migration and poor human resource management are some of the major causes of the current human resources crisis. There is no global

consensus on the best strategies to address the problem. Data on real numbers, profile, distribution and migration is scanty and difficult to compare in a systematic manner. Migration of health workers from rural areas to urban centres, as well as their regional and international migration, is on the increase, with a major impact on the health system and the quality of services provided.

Although detailed and accurate data is not available for most countries and difficult to compare, it is estimated that emigration of skilled health personnel from developing to developed countries has significantly increased over the past years, with some European countries recruiting foreign trained personnel on a large scale. It is estimated that more than 25% of physicians and nurses in the UK, US, Australia and Canada are foreign trained. It is estimated that 15,000 foreign nurses were recruited into the UK in 2001 and 35,000 more are needed by 2008. With increasing needs for highly skilled health personnel in developed countries – due in large part to the ageing population and epidemiological transition – it is anticipated that this trend will continue over the coming years.

There have been concerns raised over ethics of recruitment of health workers by developed countries and in some cases official policy has stopped direct recruitment for national health systems. But migration continues through professional agencies specialised in outsourcing skilled workers from developing countries. In Europe, it is estimated that there are 1,890 health workers per 100,000 population.

In Sub-Saharan Africa (SSA), the average ratio of physicians and nurses per 100,000 people is 15.5 and 73.4 respectively. In selected developed countries, this ratio is 311 and 737.5. The emigration of trained health personnel and other causes (such as HIV/AIDS and macroeconomic policies) can only worsen this already serious situation. The depletion in human capital further reduces the potential for economic growth. Mode 4 of service supply under the General Agreement on Trade in Services (GATS) presents the opportunity for economic gains from the remittances of migrated health workers. However, such remittances at present do not assist the health economies of developing countries which are put at great risk by

the continuous outflow of skilled workers, trained over several years at significant cost.

Although there is no consensus on the way forward to manage the human resources crisis, several proposals have been made and the EU should seize this opportunity to take the lead in addressing this increasingly important issue.

There are incipient efforts being made in this regard. As a corollary to the May 2005 communication on "A European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action" (COM (2005) 179), which identified the lack of health workers as a major barrier to fight the three diseases, the European Commission issued the "EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries" (COM (2005) 642 final). This communication outlines concrete actions to be taken by the Union at the national, regional, and global level, in support of human resources capacity building, including mobilising funding for training programmes and the development of a health workforce in developing countries, promoting the ethical recruitment of foreign workers, working with the health worker diaspora and promoting return programmes, strengthening the social dimension of globalisation, and promoting decent work as a global goal for all. This plan of action was discussed and ratified by the EU Council during the General Affairs and External Relations Council meeting in Luxembourg in April 2006. Furthermore, as proposed by WHO, there is a need to develop and implement strategies in source countries (adapt training to needs and demands, improve working and living conditions), in receiving countries (fair treatment of migrant workers, responsible recruitment policies, etc.) and internationally (implementation of ethical recruitment policies and codes of practice, etc.), in order to mitigate the impact of international migration on the health workforce crisis.

There is also a need to develop strategies to address the shortfall in human resources to contribute to the achievement of the internationally agreed goals, such as the Millennium Development Goals, deal with the increasing burden of non-communicable diseases both in developed and developing countries and confront the threat of emergencies and epidemics such as avian flu.

Adequate management of supply and demand requires careful planning of needs in the various categories of health workers, taking into account the possibility of innovations in working practice. Training institutions, private sector and civil society should be involved in this process.

**Action:** Adequate working conditions and financing are critical to sustained human resources for health policy. This would require a global and long-term commitment and cooperation, enhanced governance and strong leadership. The EU is well-positioned to take the lead on an international agreement on the migration of health professionals.

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### Europe should lead a gender-sensitive approach to global health

A gender-sensitive approach to global health is one based on recognition of the socially constructed and other differences between genders with regard to health needs and contributions as a central focus for decision making and action on the determinants of health, with the aim of achieving equity. There are still unacceptable gender-based differentials in health between and within countries.

**Globalisation** has led to increased attention to women's development and health. However, no society treats its women as well as its men, whether measured by gender gaps in economic activity, educational attainment, or political representation. Although women typically live longer than men, they also report worse health status and a higher prevalence of morbidity. Thus there are still unacceptable gender-based differentials in health between and within countries.

Globalisation has both positive and negative impacts on women's health, and these impacts are unequally distributed among different groups of women. For example, foreign direct investment has expanded women's employment opportunities and, hence, their economic autonomy. Globalisation has also aided the international transfer of reproductive technologies, such as contraception. The closer integration of societies, particularly through telecommunications and the Internet, has mobilised the international women's movement. At the same time, many features of globalisation pose a threat to women's health. For example, economic migration from the South to the North enhances women's earning power, but it also exposes them to the threat of exploitation and discrimination. Some forms of reproductive technology, such as antenatal ultrasound, are prone to abuse, such as when they are used to assist sex-selective abortion.

In theory, **trade liberalisation** in the developing world is expected to stimulate demand for labour-intensive manufactured goods in sectors such as

textiles, apparel, electronics, and food processing. Women are an attractive source of labour for firms because of their lower wages (relative to men). For this reason liberalisation of foreign direct investment is linked to increased female employment, for example, through multinational enterprises operating in export processing zones.

An empirical study done by the network Women in Development Worldwide (WIDE) showed that trade between the European Union and some Latin American countries in the period 1995 to 1999/2000 increased by 23.4%. However, in the case of Mexico, for example, there was no relationship between increased trade liberalisation and improved gender equality. Indeed, the effects of trade on gender equality are quite mixed – both positive and negative. Generating jobs for women is not a sufficient guarantee for enhancing development for women in relation to increased wages and improved working conditions. A number of significant obstacles besides occupational segregation prevent achieving gender equality, including women's over-engagement in household tasks and child care; women's lack of access to land, credit, transportation, and other resources; and the absence of women's voices in political and macroeconomic decision making.

Gender biases in international trade policies have been critiqued and brought to the attention of the world by a number of organisations, such as the Informal Working Group on Gender and Trade, a network of more than 30 civil society organisations (CSOs). CSOs such as Development Alternatives with Women for a New Era (DAWN), International Gender and Trade Network, Alternative Women in Development (United States), WIDE, Women Working Worldwide (United Kingdom), and Women's Environment and Development Organization have advocated for the mainstreaming of gender in international trade agreements. In contrast to several international organisations—such as the United Nations Economic and Social Council (UNESCO), Asia-Pacific Economic Cooperation, and the World Bank—which have made attempts to mainstream a gender perspective in all their activities, the World Trade Organization (WTO) has been slow to incorporate a gender perspective into its policies. Gender mainstreaming in the EU trade officials concerned with trade agreements would be a good start.

**Poverty** is known to be a strong determinant of poor health and premature death. Poverty among marginalised people, among whom many are women, has worsened under globalisation. Market and trade liberalisation have resulted in feminisation of poverty (70% of the world's poor are women), reduced the public provision of care, leading to worsened women's development, and increased the care burden. Thus, women's health cannot be improved without strategies that specifically reduce poverty. Globally, leading causes of women's death include: HIV/AIDS, pregnancy, and childbirth, malaria and tuberculosis, which all mainly affect poor women. The HIV/AIDS pandemic in particular has eroded traditional family and social support mechanisms, which has worsened women's development and health.

The **Millennium Development Goals** are regarded as a potentially powerful policy tool to further the agenda of gender equality and women's human rights. The MDGs have however been criticised for not complying with the broader Millennium Declaration and for neglecting women's sexual and reproductive rights. The Millennium Declaration affirms the importance of gender equality and women's human rights, as well as the need to combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Thus the MDGs are unlikely to be reached unless the concerns of gender inequality and discrimination against women are addressed by every aspect of the MDGs, not just a few specific goals focusing on women.

**Gendered violence** is another important determinant of women's health requiring global attention and a strategy. For example, forced sex and unwillingness to use condoms make women more vulnerable to HIV and other infections. Furthermore, while the pharmaceutical development of antiretroviral therapy (ART) has contributed to a substantial reduction of mother-child transmission risks, doses of ART are available to a small number of women and are too expensive for many in low-income countries.

*Human trafficking and smuggling* are a major form of people movement today. At the world level, estimates reach as high as 700,000 women and children being

moved across international borders by trafficking rings each year. In particular, there is great concern about the increase in the numbers of women and children trafficked into the EU from Central and Eastern European countries, partly due to the worsening of the economic situation in these countries. The trafficked are usually expected to engage in forced domestic labour, sex work, false marriages, and indentured labour. Trafficking in women for the purpose of sexual exploitation has increased in recent years, which is associated with the development of the sex industry. At the European level there are no reliable statistics.

Since 1996, the EU has been actively engaged in developing a comprehensive and multidisciplinary approach towards the prevention of and fight against trafficking in human beings involving all relevant actors in society. In 1997, the DAPHNE Initiative was launched to combat violence against children, young people and women. Since the Amsterdam Treaty came into force in May 1999, the EU's actions to combat trafficking in human beings are explicitly mentioned under Title VI.

Women's health has substantial implications for *economic development* and growth. There is evidence from various studies that women's well-being and literacy boosts economic growth and improves population health. Women are custodians of the health of family members and community and play an important role in sustaining good health and well-being for the communities in which they live. Their informal contribution to care is unpaid and unrecognised in all parts of the world, in spite of the fact that women's unpaid contribution is estimated to contribute to almost 30% of the world's Gross Domestic Product (GDP). This is in addition to their contribution to subsistence agriculture and other informal sector activities.

Thus women's access to basic economic resources, health care services, family planning that are needed for their health should be considered as a basic human right. Yet because of limited access to education and employment, strategies towards health improvements are difficult to achieve and improvements in women's health that were achieved due to increased international visibility and political commitment have been threatened by the HIV/AIDS pandemic not only in Sub-Saharan Africa and Asia, but also in many



countries in Europe and by ideological opposition to access to reproductive health and rights.

The European Union has been active in promoting women's reproductive health, in particular through aid for policies and actions on reproductive and sexual health and connected rights, one of the two thematic areas of the Europe Aid Cooperation Office. The European Commission, through its Directorate General on Development, has affirmed its conviction that the Millennium Development Goals should be linked to the health and rights of women and children, as well as its commitment to the implementation of the Millennium Declaration.

Similarly, countries of the EU have affirmed, both at the global and regional level, their beliefs in reproductive health and rights as a development priority. At a meeting organised by the Government of Sweden and the United Nations Population Fund in Stockholm in May 2005, over 20 developing and developed nations put forth the "Stockholm Call to Action: Investing in reproductive health and rights as a development priority", by which they committed, among other things, to mobilise political commitment on this topic in national and global meetings, strengthen health systems to support reproductive and sexual health, invest in efforts to increase women's decision-making power in all aspects of their lives, and continue work towards improved aid effectiveness on that topic. In January 2006 in Riga, Latvia, parliamentarians from the newly incorporated Baltic countries expressed similar concerns and their wish to contribute to an increased awareness on the subject. Through the Riga parliamentary statement of commitment, they committed in particular to giving high priority to sexual and reproductive health and

rights in international development policies at the national level and in European institutions.

**Action:** There is a need for the EU to develop a policy that spells out its gender mainstreaming strategy in reference to macroeconomic components, such as trade, economic cooperation, political dialogue, and humanitarian aid. A political will and commitment for gender issues and women's health are needed. Responsibility and accountability should be strategically placed at the highest level (EU Commissioners, heads of unit, and heads of delegation) and gender issues should be a regular agenda item in discussions between the EU and partner countries.

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# Conclusion

## A European Strategy for Global Health

A European strategy for global health is a process of engaging all elements of society in dialogue to raise awareness and develop a common commitment to values and goals for action to address the threats and opportunities posed by global health.

The European Partnership for Global Health aims to engage all elements of society across Europe to work together to ensure health at home and abroad through: strengthening global health security, promoting global health equity, and enhancing good governance for global health.

Such a strategy should tackle global health problems that directly or indirectly threaten populations living in Europe, global health problems which European policy and actions make worse, and global health solutions to which Europe can contribute. It would also explore new governance structures involving cooperation between countries and across sectors and new mechanisms for financing global health.

It would aim to bind the new multitude of global health actors to a common purpose. The willingness and capacity of states to cooperate becomes a critical dimension of transnational regimes for health – and the Member States of the European Union bring long-standing experience with a range of transnational mechanisms to the table – from policy networks, open coordination to binding agreements – which can serve as examples at the global level.

This requires partnership among many different agencies such as the European Commission, the European Regional Office of the World Health Organization (WHO), the European Centre for Disease Prevention and Control and European institutions representing private sector industries, civil society and foundations. European foundations have created a **European Partnership for Global Health** to raise awareness at European and national levels of global health issues, using their position as a bridge between governments, industry and civil

society in Europe and in developing countries. They are keen to work with the European Regional Office of WHO, the European Commission, the Council of Europe, civil society representatives and business partners to move this agenda forward. Of primary importance are five priority actions:

- 1. Europe should exercise leadership on global health**, by developing a European Strategy for Global Health, to mobilise society and establish goals and directions reflecting common European values for health and global citizenship.
- 2. A statement of European values for global health** would be an important step towards setting Europe's global health agenda and establishing mechanisms for global health governance.
- 3. "Making globalisation work for everyone's health" should be the orientation of the European strategy for global health.** This means a more engaged contribution of the EU and of European countries to global health governance and clear priorities for action on global health.
- 4. The new public health and consumer protection policy should be strengthened through a global dimension**, and the directive to include health in other policies needs to be understood to include global health dimensions such as the impact of the Common Agriculture Policy, trade negotiations and foreign policy on global health. The aim of establishing health in all European Union policies must include global health.
- 5. Europe should promote the development of a new framework of international laws** concerning all three dimensions of global health (security, equity and governance) based on health as a human right and a global public good.

European foundations through the European Foundation Centre and its European Partnership for Global Health will engage partners throughout Europe to move in this direction.

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## **About the European Partnership for Global Health**

The European Partnership for Global Health (EPGH), an EFC member-led network, aims to create a strong European voice and strategy on global health. EPGH will initiate, facilitate and implement actions that aim to mobilise political will and to address global health challenges from a European perspective founded on European values, experience and understanding of health as a basic human right for all.

The Partnership seeks to become a reliable and innovative broker and catalyst of ideas towards its goals, bringing together European and national-level policy makers, health professionals' networks, non-profit organisations and business. The EPGH was launched under the EFC's Europe in the World brand.

## **About the European Foundation Centre**

The European Foundation Centre (EFC) is a membership association that promotes and underpins the work of foundations and corporate funders active in and with Europe. Established in 1989 by seven of Europe's leading foundations, the EFC today serves a core membership of more than 200 members, associates and subscribers; 350 community philanthropy initiatives; as well as a further 50,000 organisations linked through a network of 58 information and support centres worldwide.

The Centre is an independent international not-for-profit association under Belgian law. Membership of the Centre implies commitment to the EFC brand. Members agree to adhere to the principles and objectives set out in the Prague Declaration, and to a voluntary and self-regulatory Code of Practice endorsed by members and revised and updated on an ongoing basis.