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NEW REALITIES FOR GLOBAL HEALTH SECURITY: A PATHFINDER FOR THE INTERACTION COUNCIL

by

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Background

At its 32nd Plenary in June 2015, the IAC noted how health security was a global concern with the potential to affect us all. The recent outbreak of Ebola virus disease (EVD) in West Africa had indicated not only how regional disease outbreaks can have global implications, but the uncertainties over where and when epidemics will occur. The IAC recognized that threats and challenges such as these require global solutions, rooted in multilateral cooperation. It recommended that states must be better prepared for sudden disease outbreaks, that disease surveillance be increased, health systems strengthened, and responses improved through multilateral cooperation and adequate funding for the WHO.

Fundamental to health security is access to resources. Healthcare professionals from the developing world however are often recruited to work in affluent countries, exacerbating problems in their home countries in the healthcare field. Nor are vaccines and anti-virals always readily available and affordable. The IAC identified these as issues that should be addressed to improve global health security.

The IAC also noted how health security begins with the security of individuals from health threats: collective security in health begins with individual security. Moreover, health security should not be limited to discussions of epidemics, but also concerns non-communicable diseases. Nor can human health be divorced from animal health and food security – a 'One Health' approach is required.

Trends in global health to note since the 32nd Plenary

This section identifies some of the developments and trends subsequent to the 32nd Plenary that are particularly noteworthy:

1. Weaknesses in the international response to the West African outbreak of EVD led to an official Review of the WHO's performance chaired by Dame Barbara Stocking and to the decision to consider revisions to the International Health Regulations. Both of these developments suggest a movement towards stronger ***global governance for health*** and improved capacity to act in large-scale health emergencies; but the challenge will be to ensure that this movement succeeds in realizing improved responses to major health crises. A second independent report on Ebola, commissioned by the medical journal *The Lancet,* was published in November quickly followed by a flurry of further reports (many of which were critical of a perceived lack of independence on the part of the Stocking Review). This strongly indicates that concern over the WHO in particular and global governance for health in general remains a live topic.

2. The Ebola outbreak highlighted weaknesses in national ***health systems***, not only amongst the very poorest states, but more widely. This created a movement, endorsed by the IAC, arguing the need for health systems strengthening in addition to better outbreak response. In a parallel move, universal health coverage and a 'whole society' approach to health has also received heightened profile. Taken together, they represent a contrasting – and potentially competing - narrative to that which focuses simply on disease surveillance and outbreak response.
3. The ***Sustainable Development Goals*** contain a series of ambitious health targets, as well as targets on poverty reduction which will have a bearing on health globally. The SDGs will focus the attention of major international agencies, including the UN system, as well as national priorities for development aid. There was some disappointment over the failure to adopt an eighteenth SDG explicitly focused on global health security, as endorsed by the IAC; however SDG 3's focus on 'healthy lives' did indicate a welcome broadening of the agenda to include both non-communicable and communicable diseases, as well as structural issues such as workforce availability (an issue highlighted by the IAC at its 32nd Plenary), access to medicines (especially the implications of patent protection) and health risk protection. SDG 3 also mentions Neglected Tropical Diseases, reflecting a growing concern that the focus on HIV, malaria and TB in the first decade of the twenty-first century has obscured the attention required by other diseases. SDG 3.4 also reflects – albeit briefly – the growing concern over mental health, including dementia, which is especially evident in Europe and North America.
4. The global economic forecast suggests that ***major funding initiatives***, such as those seen in the first decade of the twenty-first century, are unlikely for the foreseeable future. The SDGs meanwhile appear to have shifted the focus away from aggregated results at the regional and global level to measurable national results, with responsibility for development more clearly placed in the hands of individual nation states.
5. Interest in ***'one health'*** approaches – whereby human health is seen as being intimately connected to animal health and food security - are gathering momentum. For example, the Rockefeller Foundation and The Lancet have combined to call for a new discipline of planetary health, 'safeguarding human health and the natural systems that underpin it.'
6. The requirement to 'fast track' the approval of vaccines during the 2014-15 Ebola outbreak raised a series of immediate ***ethical issues*** concerning the use of drugs which had not gone through full testing. Wider debates over the ethics of new

pharmaceuticals and treatments have been in evidence for some time, particularly concerning advances in decoding the human genome and in synthetic biology. These are likely to continue as medical and bio-technologies continue to advance. However, the debate over health and ethics is broader than this, as recent events have demonstrated. These include issues concerning health and social justice, which are implicit in the SDGs, while attacks on aid workers delivering health (both deliberate and as collateral damage) suggests that their previously inviolate status in conflict zones is no longer a given.

7. In April 2014, the WHO reported that ***anti-microbial resistance*** (AMR) now represented a serious threat to world health. In June 2015, the UN Secretary General hosted a briefing on AMR for all member states and inter-governmental agencies, while the WHO, OIE and FAO have now adopted resolutions on joint measures to combat AMR. The cost of inaction is estimated to be in the region of 10M additional deaths and US$100 trillion by 2050. The burden would be global, but would fall heaviest in Africa and Asia (with both regions projected to have ten times the mortality compared to Europe, North America or Latin America). Calls for global cooperation to meet this challenge are now being articulated, including the G7's October 2015 'Berlin Declaration on AMR', which called for a high level meeting at the UN on AMR in 2016.
8. COP21 drew attention to the impact of **environmental change** on human health. Despite the agreement reached in Paris, continued changes to the natural environment are likely to lead to further direct and indirect negative health consequences. These include social changes with negative health results (for example, the growth of 'climate refugees'), to changes in disease vectors.

The IAC may also wish to note that, following its Plenary in Wales, the Welsh Government is taking forward the challenge of global health. A draft 'Pathfinder on Global Health' has been prepared and was presented to the IAC's expert group on global health in March 2016. The aim is to develop an exemplar for how devolved authorities might respond to the challenge of global health. The 'Pathfinder' identifies not only how global changes affect a devolved authority, but also show how a small country such as Wales can contribute to the improvement of health globally.

Ongoing Concerns

Three major gaps can be identified which continue to limit progress on global health in general and responses to health emergencies in particular:

- A political gap, between the need for action and the willingness to take action. This is particularly the case outside health ministries. Not least, although some Heads of State appear to have recognized the need for action, they remain in the minority
- A budgetary gap, between funds needed and those available. One estimate from the US National Academy of Medicine, for example, claims that a further $4.5B per anna is required to secure global health – which amounts to about $0.62 per person per year.
- An accountability gap, not only for international organisations with a role in global health, but the wide range of other organisations (including some charities and civil society organisations) involved in an increasingly complex global health architecture.

Major concerns include the need for:

improved cooperation and joined up policies on health. The requirement is not simply for better coordination between health organizations and across health issues, though this is a very real deficiency in the current global health system. It also includes a requirement for better cooperation between heath and other sectors (including trade), across borders, between animal and human health, and the relationship with the environment. There is a developing consensus that global health policy cannot be limited to health ministries, but opportunities to improve cross-sectoral action remain largely under-developed and/or poorly implemented.

making global health governance work. There is now widespread consensus that the WHO should remain the lead organization in global health. Doubts however remain over whether it can deliver. This is especially if its role develops from one of providing normative and technical guidance, to one which incorporates a capacity to act in global health emergencies. Similar concerns are expressed over the International Health Regulations. The likely recommendation of the review panel is that they not be renegotiated, but rather that the current Regulations be more fully implemented. Securing the political will and necessary financing for this will be challenging.

building sustainable health systems. The Ebola crisis revealed inadequacies in large-scale response mechanisms. Understandably much attention has therefore focused on 'downstream' responses to health crises. This needs to be balanced however with 'upstream' improvements to health systems to prevent such crises occurring, or to limit their development. Health systems need to be resilient and adaptive, but in many of the most vulnerable countries they remain a critical weakness with potentially global consequences. Sustainable health systems also require the promotion of healthy lifestyles and responding to the global determinants of health: non-communicable diseases such as diabetes, and related

'lifestyle' issues such as obesity, are now global issues not only because they affect the lives of a significant percentage of the global population, but because the determinants are genuinely global in nature. We must therefore broaden the debate on health system strengthening to address global health determinants more fully.

greater awareness and clarity on who global health security is for. There is a widespread – and sometimes justified - belief in the global south that global health security is a vehicle to reflect northern concerns, rather than a genuinely global issue; and that issues appear on the global health security agenda because they resonate with northern concerns. This undermines the potential for progress in advancing truly global health security. The global health security agenda must therefore be genuinely global, with the focus on promoting the health of all. There also needs to be greater sensitivity to different contexts - that what might work in one region is not guaranteed to work elsewhere. During the Ebola crisis, the WHO belatedly recognized this with its call for social anthropologists but this awareness has yet to be more widely incorporated into global policy.

Action areas

This section identifies three areas on which the IAC might wish to focus in order to realize their recommendations made at the 32nd Plenary.

1. Preparing for Global Health Emergencies as an Issue of National and Global Security

   The 2014-15 Ebola crisis was a failure in global governance for health. Specific failures were evident in surveillance, in warning and in action. For this, the WHO received considerable criticism leading many to call for its reform and some for its replacement. As German Chancellor Angela Merkel commented at the 2015 World Health Assembly, however, the WHO remains the only health body with sufficient legitimacy to take the lead in developing global health governance. What is required is for the WHO to change and for member states to accept its developing role in tackling large-scale health emergencies. Traditionally the WHO has focused upon providing expert, technical advice while its authority has been 'loaned' by member states, who have overridden WHO's advice when it has seemed to be in their best interests to do so. This is no longer sufficient if future large-scale health crises are to be prevented or mitigated. Rather, to protect global health security, the WHO requires increases in both its operational capacity and independence to allow it to act. Further, improved compliance with the International Health Regulations is essential. In general, WHO member states still need to be persuaded, as Gro Harlem Brundtland commented almost two decades ago, that 'there are

no health sanctuaries'. Responsible sovereignty may require ceding authority to the WHO in large-scale health emergencies; but the WHO must also demonstrate its competence to act effectively in such circumstances.

2. Developing, Protecting The Health Workforce and Health as Bridge to Peace

The 2014-15 Ebola outbreak was made more serious by the lack of indigenous health capacity in West Africa. The good work done by MSF and other aid agencies served to highlight how impoverished the health sector was in this region, both through lack of investment and also through the migration of health workers in a global market. Deficiencies in local, accessible clinics, as well as trained health personnel, are not unique to this part of West Africa; but they may have global consequences when epidemics are not contained at an early stage. Moreover, humanitarian concerns are raised by the unequal distribution of trained health personnel globally. The issue therefore is not only one of global health security, but also one of global social justice.

The health workforce is also increasingly at risk in conflict areas. Its inviolate status is no longer universally accepted; rather it is seen in some areas as part of the struggle. The independence of health workers should be recognized and protected. One way of promoting this would be to revitalize the concept of 'health as a bridge for peace.' This uses health as a progressive element in conflict resolution, through initiatives such as 'days of tranquility' for vaccine delivery and the building of inter-communal health centres. Key to this is the idea is the idea that health transcends conflict and difference. This would assist in re-establishing health as being both neutral and inviolate.

3. Anti-microbial resistance and one health and planetary health

AMR is likely to become one of the defining health issues for the next generation. Its effects will be global, but its costs will be to the health security of individuals. Action now may mitigate the effects for the future, but cannot be taken by states independently. Rather, dealing with AMR requires global cooperation and cross-sectoral action. This is increasingly being recognized, but momentum is only slowly building. Support for global action and the development of concrete plans are required. The problem of AMR however is a 'one health' problem – resistance is emerging not simply because of over use in human health, but in animal health as well. Addressing AMR requires a one health approach, but can also be used as a springboard for wider policy engagement with the links between animal, environmental and human health.