

Notes on Canadian Conference on International Health, 2009

The first day of the conference was devoted to a simple theme:

1. We have global responsibilities

... as individuals, as professionals, and as citizens of one of the richest countries in the world. Drawing on many years of research on extreme poverty as a violation of human rights (for reasons many of which are rooted in its unavoidable impacts on health), Thomas Pogge pointed out that: "Using its latest International Poverty Line (\$1.25 per day or \$38 per month, in 2005 international dollars), the World Bank counts *1.4 billion* poor people living *28%* below this line on average." The amount it would have taken (before the financial crisis) to bring everyone in the world up to this standard is therefore \$70 billion per year, or 0.15% of the value of the world's economic product (0.33% at Purchasing Power Parity, or PPP).

"With a more realistic poverty line of \$2.50 per day or \$76/month," he continued, "the Bank counts *3.14 billion* poor living *45%* below this line on average." To eliminate poverty measured in this way would have cost \$500 billion per year, or 1.1% of the value of the world's product (2.2% at PPP). Although Prof. Pogge did not expand on this point in his presentation, concentrating instead on the specifics of his proposal for a Health Impact Fund to finance pharmaceutical innovation, he has argued extensively in his published work that moral responsibility for eliminating poverty is rooted in the principle of not doing harm; that a web of interconnections links the economies and societies of rich and poor countries; and that the grievous harms associated with poverty are beyond serious dispute. Thus, moral responsibility follows causal responsibility across national borders, because it is not difficult to envision an alternative international order that would avoid the infliction of harm in the form of poverty. Indeed, his figures show that, with the richest one percent of the world's households holding two-fifths of its total wealth, "the problem is tiny in economic terms."

2. Money matters

The theme that money matters ran through many sessions in the conference. At the micro-level, participants learned (for instance) that cost issues create barriers to antenatal care in Bangladesh, and that protection against financial risks from illness continues to be minimal in much of Latin America. At the macro level Jeffrey Sachs, in his concluding address, described the "iron law of poverty" that deprives even well intentioned governments of the opportunity to provide a minimal standard of health care for all their citizens. He noted that while providing a minimal package of basic health services in a low-income country would cost \$40-\$50 year (an estimate from the Commission on Macroeconomics and Health updated to today's dollars), governments in low-income countries can realistically expect to mobilize only a fraction of that amount from domestic resources.¹

¹ "Let's recognize the iron laws of extreme poverty involved here. A typical tropical sub-Saharan African country has an annual income of perhaps \$350 per person per year, of which much income is earned in kind (as food

But the imperative of reducing health inequities is not just about money, as important as that is, but also about redistributing decision-making power within national and international institutions that now exclude a majority of the world's people from meaningful participation. This point was made clearly by the WHO Commission on Social Determinants of Health, which noted that: "Inequity in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources." Further relevant observations were made throughout the conference sessions that addressed Global Health Diplomacy (see point 5, below).

3. Power and powerlessness matter

Perhaps the most obvious inequities arise from the vastly unequal distribution of power in the global marketplace, but power relations organized by gender, race, and multiple other dimensions also have important influences on health. Conference participants learned about special problems associated with improving the health status of such vulnerable populations as migrants, the Roma in Europe, and indigenous peoples worldwide (including of course in Canada). The phrase "vulnerable populations" is useful, yet at the same time connotes a passivity that is entirely at odds with the resilience demonstrated by such populations as they confront long odds against their survival. Further, like a focus on poverty, a focus on vulnerable populations arguably invites dichotomous thinking that distracts attention from the socioeconomic gradients in health that are ubiquitous in societies rich and poor alike, and from the interaction of multiple dimensions of advantage and disadvantage – what feminist researchers now refer to as intersectionality.

Global health researchers must be especially concerned about ethical issues that arise from disparities between North and South, and between researchers and the populations they study within national borders. Participants learned (for instance) about difficulties in interpreting ethics guidelines in ways that actually ensure local impact, effective dissemination and ongoing collaboration, and about well-intentioned efforts to improve international medical education that in practice create situations in which participants practice beyond their competencies. Arguably, these are specific instances of the more general problem of how to translate a cross-border "ethic of care" into policies, programs and professional practices that actually do good rather than harm.

4. Accountability matters

This brings us to the several dimensions of the need for accountability. At a micro-level, the problem of ethics review of projects involving Northern researchers and Southern participants is one instance of the

production for home use), rather than as money income. The government might be able to mobilize 15 percent of the \$350 in taxes from the domestic economy. That produces a little over \$50 per person per year in total government revenues (and in many countries, much less). This tiny sum must be divided among all government functions: executive, legislative, and judicial offices; police; defense; education; and so on. The health sector is lucky to claim \$10 per person per year out of this, but even rudimentary health care requires roughly four times that amount. (In rich countries, public spending on health is \$2,500 per person or more.) Foreign aid is therefore not a luxury for African health. It is a life-and-death necessity" (Sachs, 2007).

need for improving mechanisms of accountability. At the macro-level, the need for such mechanisms is demonstrated by broken promises like the Millennium Development Goals (MDGs). Participants were told (for instance) that minimal progress was been made between 1990 and 2005 with respect to the MDG of reducing maternal mortality, which accounts for more than 500,000 deaths a year, almost exclusively outside the high-income countries; that baseline data for assessing progress toward several of the Goals are too poor to permit reliable assessment of progress; and that United Nations agencies have actually retreated from earlier commitments in order to make the record of progress toward the goals appear less dismal. All these represent broken promises on the part of the international community, the high-income countries in particular. One of the advocacy achievements reported on in conference symposia was the effort by civil society organizations to advance recognition (in 2008) of maternal mortality as a human rights issue in a United Nations Human Rights Council resolution. Implementation remains elusive, but the case study demonstrates the value that civil society organizations can add in holding governments to account for the ways in which they discharge responsibilities to the global community. More generally, conference participants learned of efforts by a variety of civil society organizations to increase the accountability of the leaders of the G8 nations on such issues as progress toward the MDGs – especially important in the Canadian context given Canada’s role as host of the 2010 G8/G20 Summit.

5. An emerging field: Global Health Diplomacy (or foreign policy for global health?)

The Summit, like previous ones, may reflect the importance of the emerging field and practice of global health diplomacy (GHD), the theme of the second day of the conference. Participants heard GHD defined (by WHO’s Alex Ross) as “all multilateral and bilateral negotiations and related activities (consultation, facilitation, dialogue, etc), formal and informal, aiming at, or leading to new or changed framework conditions, standards and policies, in all kinds of forms (treaty, code, set of rules and principles, partnerships, etc) legally binding or voluntary, with a formal validity extending geographically to the entire planet.” This definition adds valuable clarity in terms of the distinction between global diplomacy, primarily concerned with the process of negotiation, and the much more fundamental and demanding domain of health foreign policy, or perhaps foreign policy for health – the domain of the Oslo Declaration (Ministers of Foreign Affairs of Brazil, 2007).

Against the background of the conference’s discussions of global responsibilities, it is necessary to keep in mind tensions between the health implications of foreign policy driven by national interests (the conventional and, according to the “realist” school of international relations theory, the inevitable approach) and one driven by a commitment to values such as health equity that go beyond national interests. In this line, the question has been asked with respect to trade policy: “Do the strong do what they will, while the weak suffer, or are trade and health governance mechanisms capable of producing more symmetry between trade and health interests ...?” (Fidler, Drager, & Lee, 2009). In this respect, it is worth quoting one of the recommendations of an Institute of Medicine report (from the United States) that was referred to at several points of the conference: “In a public address, the President should declare that the dominant rationale for U.S. government investments in global health is that the United States has both the responsibility as a global citizen, and an opportunity as a global leader, to contribute to improved health around the world” (Committee on the U.S. Commitment to Global Health,

2009). A further level of complexity is added by the need to integrate a gender dimension into all areas of health foreign policy. Given inspired national leadership, GHD could well emerge as a new avenue for countries to discharge their global responsibilities – for instance, by

6. Developing global health strategies

Participants in a day-long preconference workshop were asked to take part in an exercise aimed at developing Canada's global health strategy. The country that is often identified as a leader is the United Kingdom, with its *Health is Global* document that identifies five areas for action: Better global health security; stronger, fairer and safer systems to deliver health; more effective international health organizations; stronger, freer and fairer trade for better health; and strengthening the way we develop and use evidence to improve policy and practice (HM Government, 2008). For any national government, this challenge is complicated by the rapidly expanding range of actors involved in GHD/health foreign policy. These now include not only national governments, their bilateral aid agencies and WHO, but also the World Bank and International Monetary Fund, a variety of new multilateral organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria that were established at least in part to circumvent the perceived shortcomings of existing organizations, and the Bill and Melinda Gates Foundation. Perhaps the most important single message from the conference is that *this new and complex landscape of global health governance creates problems, but also offers abundant new opportunities for national leadership and collaborative action*. On this point, conference participants were asked:

7. Is there a need for alternative Grand Challenges?

In the opening plenary session, Solomon Benatar – referring to the Grand Challenges for Global Health initiative of the Bill and Melinda Gates Foundation – wondered whether the time is right for alternative Grand Challenges that would instead emphasize social determinants of health and the global value shift that he argued is needed to deal with the multiple problems presented by economic inequality, health disparities and climate change. The idea is not new: in 2005 the University of Toronto's Anne-Emanuelle Birn published an article critiquing the Grand Challenges' emphasis on technological solutions and proposing alternatives that would be guided by such goals as addressing inherently global issues, supporting "integrated political, social, and medical means of reducing social inequalities in health" and improving agricultural output and nutrition in developing countries (Birn, 2005). (In concluding remarks, Amir Attaran pointed to the precipitous drop in development assistance for agriculture as an indication of the misplaced priorities of the donor community.) Taking social determinants of health seriously as a way of reducing health inequities arguably requires a fundamental shift in emphasis toward what Sir Michael Marmot, the Chair of the WHO Commission, many years ago referred to as "upstream" influences. How can Canada build on the leadership potential that has already been amply demonstrated by our research community?

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