The Changing Landscape of Global Public Health: Trends Transforming the Landscape
Kaiser Family Foundation
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RICHARD PARKER: We're trying to recover a little bit of lost time here if you could all please take your seats. We'll have the last two background papers and discussions before then opening up for general discussion. We know it's a long time to ask people to hold off from making comments, but if you'll bear with us we're almost there.

The third presentation of the background paper is by Margaret Kruck from the Mailman School here at Columbia and Julio Frenk from Harvard School of Public Health and Gita Sen from the Indian Institute of Management will be the two discussions for this presentation, so Margaret.

MARGARET KRUK: Good morning everyone and let me add a word of thanks on behalf of the Mailman faculty and a word of welcome in particular to those who have traveled from many parts of the world to join us today. We're delight, just delighted to have you here. I'll be speaking briefly on globalization and its impacts on global health governance.

So first let me start with a little bit of nomenclature. I think it's important to note that the shift from the commonly used term international health to the term now in vogue and very much in use global health is much more than semantics. I think that it underlines the transition from the focus on the state to a much broader focus on supra state

and super national factors including non-state actors and transnational health concerns.

Globalization has been defined in many different ways, but one of my favorite definitions is that globalization is the emergence of a world market place of goods, services, capital and ideas, and marked by heightened migration and much easier migration across boarders.

Underlying all of this is a huge ability and convergence in many areas, in particular the convergence of ideas. This map you might be wondering what shows – this is not a virus. This is not a new disease. Rather this is the 42 countries that have their own version of the American television show American Idol, which is clearly an idea that's taken the world by storm for better or worse.

And here are the 17,000 stores in 49 countries that sale the same non-fat latte that you can get across the street at Starbucks, and again showing the huge convergence in very desperate issues.

Much less fallaciously we've also had the spread of many negative phenomena including the financial crisis. That as many of you know started in the suburbs of this country, the United States, but has now spread to far away places. Many of which did not invest in U.S. real estate. For example I was doing some research in Liberia a couple years ago when I came

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across this headline in the local newspaper in October of 2008. This is the headline from the New Democrat of Liberia that was cautioning – calling for a bracing in the fall of remittances that where coming to Liberia and the huge economic impact that that was going to have in that country.

Another area is of course in the migration of health professionals. Something that's already been raised by other speakers and I just wanted to point out that the immigration of health profession from subtertian Africa, the ratio of immigrating physicians to physicians left behind is highest and therefor most adverse in the very region where disease burden is also highest, which is Sub-Saharan Africa.

So summing up very, very briefly it's clear that globalization has brought a tremendous amount of progress. In fact hundreds of millions have been lifted from poverty in countries such as China, and in particular India and other countries that have been able to respond to opportunities unlocked by the liberalization of trade.

At the same time it is also very clear that the gains in health and gains in wealth have been very unevenly distributed, and here are two examples.

This slide shows preventable deaths. These are deaths due to maternal causes, nutrition, nutritional deficiencies and infectious diseases. And it shows by expanding the boarders of

a typical map where these are concentrated. Preventable deaths today are disproportionally concentrated in Sub-Saharan Africa and South Asia. And these inequities haven't only been magnified across countries, but also critically within countries.

And we've already heard the concerns about equity and we'll hear more about them, but just to make a point that this is maternal mortality – the maternal mortality ratio on the Y axis and three countries in different parts of the world. We have Tanzania, Peru and Indonesia. What you see is the left hand most bar, which is the blue bar, is the maternal mortality ratio among the poorest fifth of women in that country. And on the right hand side the richest fifth.

And what you can see from here is that the chance of dieing is more then double in some parts of the world, very different parts of the world. So there are huge, huge health inequities within countries as well.

In part to respond to the threats and the opportunities brought by globalization we've had an unprecedented global set of actions and policies and key among these has been the millennium declaration. Which as you know was signed by 189 world leaders in the year 2000. And the millennium declaration very explicitly took on a role in redistributing the benefits of globalization. It really saw as its mandate that

redistribution. And specifically important to us in health are millennium goals are four, five and six on child mortality, maternal mortality and the spread of infectious disease.

These goals have committed the global community to achieving quantified and actually quite ambitious targets by the year 2015, which is five years away. I think many of these will not in fact be reached and is one of the challenges before this conference.

What was heartening oppose the MDGs was the tremendous response that I think that at least in part can be attribute to the millennium development goals and in part to the other forces and other recognitions, other sources of recognition that globalization needs to be managed.

And this slide shows the entrance in the – first of all actually the increase in funding for global health between 1990 on the left hand side, and 2008 on the right hand.

Just looking at the difference between the year 2000 and 2008 there's been a doubling just in those eight years of funding for global health activities world wide.

There is one other thing that I would like to draw your attention to in this slide, which is the proliferation of colors. And these are the different actors, the different funders, sources of funding. And what you can see on the right hand side is we have a number that – the light green bar on the

top is nongovernmental organizations for example, in the red on the bottom is bilateral organizations, so country to country assistance and others in between. But we have not only a lot more money, but we have a huge new field of actors, all with ideas.

So amidst the new money and amidst the new actors there've also been a – and I also think again on the background of concerns around globalization, there has also been innovation, tremendous innovation in scholarships, in advocacy and in policy around issues such as equity and vulnerability, women's rights and role, and increasingly concern about accountability of all this programming to society and civil society – and role of civil society in determining the flows of some of these resources.

So I think in a way it's counterbalanced. It's not just about new money coming in, but we've got new concerns – heightened – they're not new concerns actually they're quite old concerns in public health, but I think their contribution is growing in the discussion about solutions.

At the same time all of this expansion and funding and ideas and activity has exposed very large gaps in the knowledge and in needed evidence and in particular I want to highlight a few areas in which evidence is desperately needed, I would say.

One clear area which Professor Jacobs will be addressing in a much more – in a following discussion, is how to scale up in health systems. We know how to maximize efficacy in a small setting. We don't know how to create effectiveness at scale as some have pointed out.

We also need a much more information about how to improve health outcomes for the most vulnerable including the examples from Chile that we just saw. How do we reach those women? How do we change the intractable public health manager's perception of innovation – seeming intractable, hopefully?

There is some new methods and new approaches Dean Freed pointed out, not only do we have huge new challenges, but we have some emerging, exciting approaches and methods to deal with those challenges including the evolution of complex adaptive systems and its application to health and public health, implementation research and many, many others. These are just too focused on the delivery of innovations here on this page.

So all of this leads us to the question that other speakers have already also raised which is who's in charge and how do we gather, how do we balance the problems on the one hand and the promising solutions in the other? There seems to

be the need for an inter mediator and even more over a leader, or a set of leaders who can take these ideas forward.

On the one hand again we have these new challenges and not just new challenges, but challenges across boarders. On the other hand the new money and the new actors have caused a fragmentation, widely acknowledged fragmentation, in global health governance.

In 1990 the world even – this may not look that simple but I promise it only gets more complicated. In 1990 the World Health Organization was really the arbiter, the convener, the policy maker, the policy setter, in global health in terms the flow of funds, the flow of policies, the advice to countries and again the World Health Organization has 192 member states representing multiple perspectives and approaches and recognizing needs.

And underneath that where are a number of other partners and I've listed some of the large bilateral institutions, essentially country to country partnerships, a two way partnerships. This has changed dramatically.

This is 2010 and what we see now, and also what I pointed out in the funding graph, is that we have new partners in 2010 who didn't even exist actually in 2000 when the MDGs were first adopted.

In particular we have the emergence of global health initiatives, which are public, private, multi-stakeholder, often disease focused or single initiative – single area focused initiatives, private foundations with tremendous new resources and a much narrower chains of accountability.

Yet despite this proliferation of money and ideas, or perhaps because of it, I think that there is a new challenge in that low – the challenge of low income countries and their role in governance continues to be very, very problematic at the country level. I think it is still very, very challenging for countries and partners that I work in, in Africa in particular Sub-Saharan Africa to put their ideas forward and to actually coral the partners around national strategies.

So I want to end with some challenges for public health. I think there are many implications of the forces of globalization and the fragmentation in global health governance. And I think some of them have very urgent challenges that the pose for those of us in public health.

First among those frankly is; what is the role of public health in global health governance? Should we be speaking out more? Should we be taking a greater stand given the close alignment as Dean Freed and many other speakers have pointed out between the core values, core approaches and core

aims of public health and the problems we see before us right now in global health.

Secondly, how do we improve translation of research to policy? Again, Peter Piot has raised this, others have raised this as well; it's not good enough for researchers to publish in their own journals right now. That is not an adequate response. That is not a response commensurate with the size of the problem. I think we need to spend a great deal of more time and money in thinking through how to translate, I think, some of the important findings and literature to realities on the ground for people.

Who are the new allies? Part of the reason for this conference is to bring together not just the expected, but the new faces and may be faces that don't sit together in meetings very frequently and think together about how we can reshape responses. Because it's very clear that silos thinking is not going to get us there.

Another area is – there are clearly a number of different kinds of evidence required for global public health governance. What are those pieces of information needed? When I work in countries I often start with the ministry of health and say what is it you need to know about your healthcare system and how can we help you? And I think conversations have

to involve more partners even then that in shaping research agendas.

And lastly, as training institutions and research institutions I think we're all struggling still with how to promote the equity and how to increase access to those wonderful resources and knowledge and scientific approaches. Outside of North America and Europe and really expand those through out, in particularly in low income countries. And again new technologies are available to us. New ways of thinking and collaborating, the funding and the organizational approaches aren't necessarily there right now to support it. And I think again it's one of the challenges before us in this conference to think through. Let me end here, thank you.

RICHARD PARKER: Thank you Margaret, and for our first discussion Dean Julio Frenk from Harvard University.

JULIO FRENK: Good morning to everyone. I want first of all to thank our host for bringing us together, especially Linda Fried and Richard Parker and of course the other leaders of the organizers Peter Piot and Harrison Spencer for this – convening all of us to analyze this very timely topic.

I read with great interest – I'm going to give you a power point break, okay? No power points. So, I read with great, great interest the background paper prepared by Margaret Kruk on Global Health Governance.

The first thing I would like to say about her paper is I completely agree with her view of globalization. We have this tendency to confuse globalization with global integration and that's a very serious conceptual mistake. The current model of globalization very often at its very essence implies exclusion and of course it implies huge problems of inequity.

Hilary Clinton recently spoke of the wrong side of globalization and I think we must not lose sight of that component. I also share her idea about the way in which the health has actually become much more prominent in the global legend and to my mind really the big difference this decade, this first decade of the 21st century, has been in that health stopped being the concern of only the main experts, like most of us here, and started becoming a central part of the most pressing issues on the global agenda, the agenda of economic development, the agenda of national and global security, the agenda of the mocratic governance and the agenda of human rights protection and promotion. This is the big shift.

I've been active in the global health for about 25 years and this is what I see as the change around the year 2000. And I have – actually part of this, I really think was do also to the amazing leadership of Gro Brundtland as Director General of W.H.O., who having been the person only former head

of government to lead that agency. She had this idea that we needed to broaden the place of health in the global agenda.

But this is to me what explains first of all the huge expansion in funding. It would bring the data from that paper up to 2010. Actually we now see it tripling of funding from, in this first decade, from about a little bit less than 11 billion in the year 2000 to almost 30 billion. But more importantly is the expansion of funding in national budgets.

And then of course a correlation of this has also been this explosion of pluralism in the global health scene that makes the governance question so much more important. So it's really a new era in global health, but that is, to my mind, the essential feature. And this requires indeed public health the fundamental contribution and the big pricing lays out a number of interesting questions which Margaret just summarized in her last slide.

Of course a very major question is how do we navigate this new space? Every speaker has addressed the question you know what is global health? How do we, not in terms of formal definition, but how do we think about it? And it's already been said. I mean very often we're in the presence of what someone has called a linguistic updating, meaning that we just change the word from international to global health, but we really still meaning exactly the same thing.

And to my mind there are two identities I think we need to break. Implicit in the way we think and act is the idea global health, particularly in rich countries, the idea of global health as foreign health. Global health is the health of the others. It's what, you know very often my colleagues at Harvard when they say I'm in global health, it means whatever their doing when they're not in the United States. And that is not global health. Global health is not for a health, nor is global the opposite of domestic.

The second identity is this idea that problems flow from south to north and solutions flow from north to south, a very common misconception.

And the third identity is this idea that we have a simple location of problems. Not this group, which is a very sophisticated group, but very often we still have this identity that the agenda is simple, communicable diseases are the problems of poor countries, and noncommunicable diseases are the problems of wealthy nations.

And one problem we often fail to see is what I like to distinguish between problems only of the poor, for example you got malaria, maternal mortality, are problems only of the poor. But what makes this gestation very complex is that problems only of the poor are no longer the only problems of the poor. The poor also face much higher rates of the chronic diseases,

and I agree with Peter, we should coin a new term, but it's also the fact that the agenda became much more complex and we no longer live in this world of simple dichotomies.

So to my mind the key construct here is the notion of interdependence. What Lee Cachen [misspelled?] paper about 15 years ago called Health Interdependence. And global health has to be about understanding the nature of interdependence as it affects the health sphere. And that of course includes disparities that are derived from the current model of globalization.

We're talking about global public health and the essence of public health is that it takes a population level of analyze. So what is the population when we talk about global health? It is of course the population of the entire world. Beyond the way people happened to be group in nation states. But it also includes not just the people, but the actors that operate on the global stage as Margaret very nicely put it. And these are you know multilateral organizations, transnational corporations, global civil society movements and the emergence of the whole set of new actors.

And very importantly, by the way since we are in a university academic institution, because many institutions are charged with pursuing one of the quintessential global public codes which is knowledge.

But in public health we always, at least it's helped me to think that we have two fundamental objects of study. We study health conditions and then we study the response of society to those conditions.

When we take that to the global level, to me when we study health conditions the fundamental construct to understanding interdependence, is the notion of the global transfer of health risks in notion that a consultation that was organized by the Rockerfeller Foundation in the late 90s in Pocantico, came up as a very important notion, that global transfer of health risks, which occurs as a result of six processes.

The rise of global environmental threats like climate change; the movement of people across national boundaries; the adoption of risky lifestyles like cross cultures. Then one very important that shows that we not only – the problems not only move from south to north, because one form of global health risk is the variance among countries in environmental and occupational health as these standards; the practice of setting shop in countries that have lower regulatory environment. That's a form of active transfer of health risk usually from north to south.

And then the trade in harmful products, another example of risks flowing from north to south, and some of these harmful

products may be legal like tobacco or illegal like carter drugs and then finally the spread of medical technologies which give rise to phenomenal like antimicrobial resistance and other issues.

So when we study health conditions the global transfer of health risks is a fundamental construct to understanding interdependence. But as they say in public health we also study the response to those conditions. And this is also what we need to do at the global level. How do we respond? And this of course addresses the central question of global governance. We respond to a series of institutions both in what the multilateral system, but also increasingly in the civil society system and in the private for profit system. And this organized social response is at the national level, what health systems do.

This is what we're going to talk in the next session, but at the global level we might think of a global health system, not as an organizational entity, but as instead of a structural relationships among those actors that populate the global space.

So this to me, what is this global health system is the key question of global health governance. And let me briefly to finish, address a set of specific issues around governance. To me if you are going to articulate a new vision for global

health in the 21st century there are two fundamental questions, global governance and global ethics.

Let me briefly mention, for global governance, to me, I think we need to address two paradoxes.

The first one is what I call the sovereignty paradox. And this paradox states that in a world of sovereign nation states, and by the way there is – I mean there was a whole literature on the end of the nation state and I'm still going – planning to write a book called the End of the End of the Nation State. Because what happened when those books were written, is the number of nation states actually exploded. So yeah, there's now 192 members of W.H.O. so and then there's about 50 you know quasi national entities out there. So there's no end to the sovereign states. So in a world where the well polished organizing sovereign national state, health condition continues to be primarily a national responsibility.

I have been a minister of health in my own country in Mexico and I was responsible for anything that happened to the hundred million Mexicans in terms of their health. You know it didn't matter if it was an epidemic coming from somewhere else. It is a national responsibility.

Yet, here's the paradox, the determinacy of that health and the means to deal with those problems are now beyond the control of any one given government. Including the most

powerful governments of the world, so no individual country, no matter how powerful can generate on its own an effective response to most global challenges. This is the sovereignty paradox.

The way to solve this paradox is not for national states to give up, but rather to share sovereignty and the notion of shared sovereignty is the core of the idea of international collective action, which is the whole rational of why we have a multilateral system. It's to generate international collective action.

But this requires a different way of thinking and it requires fundamentally and allocation of functions among all the agriculture. I'll talk a little bit about that.

But let me talk about the second paradox. The second paradox I call the dissonance paradox. Because it has been said, starting with Judy Rodin, her very, very brilliant speech this morning, there is a growing interest in health systems. And we're going to talk about that in the next paper.

But this interest at the national level has not been accompanied by a similar interest at the global level. So the very same agencies that are not offering technical assistance to national governments to rearrange their health systems have been incapable themselves to create a global health system that

follows the same principals of rationality that they preached on individual governments.

So this is the dissonance paradox. We have to think in terms of a global health system, not as an organizational entity, but as a structure set of relationships among actors that perform different functions. And this system as clearly as presented in the paper by Margaret is characterized by this explosion of pluralism. There are now about 120 international agencies and partnerships including very creative ways of new forms of governance, what I call quasi multilateral organizations like GABE or the Global Fund. Of course you innate itself with a whole new form of thinking about the UN system.

The health arena is has been – I mean has had this explosion of creativity in ways of thinking about international collective action. But we have been victims of our own success. I think this is in many respects a welcome development. There has been a lot of innovation of new thinking, but it has created a problem because the problem has that this broad variety of actors has not been able to develop an effective global health system with the capacity to act in a concerted manner.

So, that we have problems of fragmentation as expressed in the background paper, lack of coordination, huge transaction

cost, especially at the country level, and an inefficient overlap of some functions while others remain neglected.

So what are those functions? To my mind, there are three fundamental functions that need to be carried out at the global level. First the production of global public goods, second the management of externalities across countries and third the mobilization of global solidarity.

The most manageable approach to global health only focuses on the last of this and is very important, but there are the other two. And I am very distressed to see – in this context of explosion of funding, the total underfunding of global public goods.

Global public goods are research methods, comparative analyze that can generate shared learning across countries, norms and standards. One of the most, I mean of the things I marvel at is that something so cultural specific as death and the fact that every single country in the world classifies death with exactly the same terminology, international classification of diseases is an amazing achievement. Yet, this is not the sexy part of global health. No one stands here and shows a slide about the – it doesn't get our juices flowing; I think that's about it.

I would like to see Bono you know launch a campaign for the international classification of the diseases. Without that

we couldn’t do anything and this part of global collection action is totally under funded.

The second is of course all the coordination mechanisms to deal, to manage externalities. For example in the face of pandemics, when a country is not immunologically transparent then we fail at that and we made some progress when international health regulations and some others, but this is very important.

And then of course the third big function is the mobilization of global solidarity, which by the way is a much better term and less symmetrical then aide and that includes development financing and then cooperation and humanitarian assistance in a very important manner.

So the first thing we need to do is arrive at some consensus as to the functions and then form should follow function. These discussions should then drive the discussion about the architecture of global health. And which is the key for the global health system.

However it’s not enough just to have this idea. We need ideals and that’s why we also need a new global ethic, which has been said many times, it’s the ethic of universal rights.

But this leads to the third and final paradox and I’ll end with this, which I call the accountability paradox.

Because any world politic constituted by sovereign nation states, the institutions charged with international collective action are accountable to the governments of those nation states and not directly to the people who's universal rights they are supposed to up hold.

And yet, a substantial proportion of those governments have either incapable of meeting the basic needs of their own populations because they are under acute stress like in a disaster or they are chronically failed or frail states, or worse those states are themselves the main perpetrators of violations to those basic human rights.

Since there are no signs of global political authority will emerge accountable to the global population, to me the only way of addressing the accountability paradox is by building the notion of global citizenship and if you think about the notion of citizenship at the national level it emerged through political and civil rights, but at the global level citizenship has to emerge through social rights of which the right to health is a fundamental one.

Right base approach to me opens an enormous field of action for these key functions of global solidarity, because to fulfill this function global actors, both in the public and in the civil society and private arenas, must often act as agents of the dispossessed. And the legitimacy of this role as

serving as agents for this dispossessed lays in the fact that you know health is universal aspiration and it is the corner stone to me of building global citizenship.

I think this is to me the way forward in thinking about global governance. How do we solve the sovereignty paradox by sharing sovereignty through collective action? How do we address the dissonance paradox by thinking about a global health system? And how do we address the accountability paradox by building a global citizenship that starts with the guaranteeing the universal affective exercise of the universal right to health. Thank you very much.

RICHARD PARKER: And for the second discussion for this paper Professor Gita Sen from the Indian Institute of Management. Do you want that – should we bring out the –

GITA SEN: No, I can manage.

RICHARD PARKER: Okay.

GITA SEN: Good morning, thanks Richard. First good comment continuation of the freedom from power point. And the second one is that Julio is a hard act to follow, but some of what he said particularly at the end was in fact very close to the comments that I plan to make.

I have four sets of very quick comments based on some reactions to Margaret's excellent summary of the issues and also picking up on some of the points made by many of the

really excellent, really good, fine presentations and discussions that we've had this morning.

The first one is about, and I'm not going to say anything about globalization. I think both Margaret and Julio have said enough and I agree with everything that they've said, but I'm going to focus my remarks really on the governance questions.

Clearly if we think about it there are two aspects to governance. And sometimes these two aspects tend to get very confused in the ways in which we talk about them.

There is a managerial aspect to governance which is extremely important, issues such as coordination that coherence. If one uses the language of aide effectiveness of government – of country ownership and so on. Many of those are really about getting the management better if not right. And surely we know that, not just in the broad general area of aide effectiveness, but most specifically in the issue of health those managerial management questions are still largely unresolved and have a great deal and there is a great distance that we need to go in order to resolve them.

Among these of course, a dominate one, given all the discussion that we've had already about the emergence of the silos and the rapid proliferation of silos is whether silos can ever become diagonal. That is between the discussion about

vertical programs and the need for horizontal health systems approaches some people like Dean Jameson and others have argued about the importance of having maybe a more diagonal approach. And it's a very relevant and important question I think to ask.

Whether if one starts with a silo one can actually leverage that silo into becoming a mechanism for strengthening health systems? I think the jury is completely out on this. We have no idea. We have no idea as we focus as we do in India under the national rural health system, largely on maternal mortality, whether that will in fact end up strengthening the health system over all or whether it will remain a separately funded silo that will never lead to any further improvements and which will in fact perennially be rocked by the weaknesses of the health system.

And if you're thinking of an area of research, I think certainly this is one where we – to which we need to pay a great deal of attention. But I would call this largely managerial or a management type question.

Although it borders on what is the second aspect of governance which is the accountability issue. And Julio talked about the importance of accountability and to me accountability has a very simple description or definition. It's basically about the recognition, the naming and the taming of power. And in the health world and in health systems power operates in

many and multiple ways. Which in fact the proliferation of initiatives has in fact lead to a proliferation also of the ways and the pathways through which power operates currently, both in the global and as well as in national health systems.

Now non-state status in this regard of the type that Margaret speaks about in her paper, and that all of us know quite well, are in some ways an easy target on this. Money coming in – large sums of money coming in separately with as I think she said in the paper three trusties on a board to determine whether and how it should be spent in the way that it is.

That is a perfectly valid question to ask, but in some ways it may be a far to easy a target letting go a lot of the other ways in which such things as the public goods aspects that Julio spoke about are in fact left as nobody's baby in the government's agenda. The cross national brain drain for instance that Margaret speaks about in her paper. Who's addressing that? Who is responsibility is it to insure that all of the expenditures that are made on training health workers in one part of the world it then ends up subsidizing health systems in other and much better off and much better financed parts of the world?

Medical costs, the explosion of medical costs and the fact that the cost of drugs and pharmaceuticals have gone

through the roof, what do we – where and how are we able to deal with this at the global level that we need to when we know perfectly well that it is one of the major reasons for the medical poverty trap that so many countries are currently facing?

The problem we have and you have in this country, in alcohol, tobacco and firearms department, but what about the global process food industry which is probably singularly more responsible for the diabetes and cardiac problems that are exploding in countries like India and others? Do we have any mechanisms to control or even to regulate or even modify or even you know make it an ethic question? I think we don't. And I think these are extremely important issues around accountability.

Because the synergy, again as Julio said, between what we can do at the global level and what's possible at the national level is very, very great and if there's an absence of synergy there what you can do at the global level is far more difficult to do at the national level. And McDonald's is only the tip of the iceberg in this regard.

So it's little wonder then that at national level governance there is so little focus, there is talk, but so little actual focus on ethic questions, on issues of what to do

about rising costs, or on who is being the most affected by each one of those problems.

At the global level the W.H.O. commission on the social determinance of health raised a number of issues. Some people say it raised too far, too many issues. But, and perhaps it did, but at another level where is W.H.O. actually taking this forward or doing anything with it? Having been part of the work of that commission for more than two years I can say it's no where.

We see it picked up by civil society groups, researchers, academics, here and there, but it's not made a significant dent on major debates around the global governance and what ought to be happening in that field.

The second set of points that I make is, and this is something that I didn't find in Margaret's paper and I think is perhaps something we ought to pay attention to, is if we're talking about global forces that are in the middle to help, we really ought to pay attention to the global, regional and national manifestations of anti-secular forces including those that end up being significantly anti-women, anti-young people, homophobic and with serious health implications across those. Can local global governance and health really go forward without a human's right basis, which is what these questions raise in significant ways?

When you have a G8 meeting in Toronto taking place, as happened before the MDG meeting, on maternal mortality and safe abortion, let alone family planning, are not even have to be fought to get onto that agenda. Then I think that we see the proliferation and expansion of these forces which as people interested in public health we have to be deeply concerned about.

Silence on these issues, on the issues of the most recent thing that came rapidly across my email two days ago was the Ugandan Newspaper that published openly the identities and names of a hundred gay people with a yellow banner headline across the front which said hang them. And these are issues that are politically difficult, but if we don't address them as public health people then in fact we have – we are missing what ought to be a very serious aspect of our mandate in terms of rights and health. And I think that as a collectivity we ought to pay far more attention to this problem.

The third question which is linked to this is where is the space for civil society in our discussions about global governance? Research and the successes, failures, the potential of civil society engagement is in fact sourly lacking. And I say this as someone who myself worked very closely, sometimes at odds with different subgroups of the civil society and I'm a bit tired of civil society either

patting it's self on the back or being held up as the, you know, this is where you should go.

We now can adequate investigation of what works, what doesn't in the way that would for anything, any set of actions or anything else.

The Global Fund and GABE are being held up these days as being the models for better movement of getting stakeholders from the community more engaged and involved in processes of governance. Are these exceptions or are they actually going to be pot breakers? And I think the jury is very much out on that as well.

But one thing that we do know is that much of the directions of moving health towards human rights that has taken place in the last two decades, has been because of civil society movement. Not only the old arguments for health for all and all matter, but all the new movements, whether around HIV, or against woman's rights or increasing the youth coalitions speaking about what their rights and their engagement ought to be in the process.

Perhaps the knowledge that works this conference moving towards might be a very good way in which to insure that in fact these voices and these experiences that come in a far more important way into the debates and the discussions.

Finally, my last point about governance is that some where here we have what one might call a right hand, left hand problem. The one not knowing what the other is doing or the one knowing, but unable to do anything about what the other is doing. Different aspects of globalization and what is happening in that regard stand parallel and outside to the discussion.

I was fascinated by – I think it was Alastair's presentation of our, you know those dots about who said what. All of the climate change resource discussions were these briefs dots somewhere on one corner hardly mentioned at all and yet if one pays any attention to the debates and discussion around climate change and the kind of population movements that, that is almost certainly going to lead to, we have a major public health – I won't say catastrophe – set of issues in the making that we really need to be paying much more attention to.

The one that we do pay more attention to, but I'm not sure how well we pay attention to those, is of course trade agreements and the impact that the trade agreements have been having on public health.

And I want to end on a last note which may not be a very optimistic one, but in this regard, but in our attention to the World Trade Organization Doha and the forward movement

that public health was able to make, or thought it was able to make at Doha we haven't paid as much attention to the bilateral and the regional trade agreements. And one of the biggest challenges at this point in the context, especially of Catterina's discussion about the possibility of new directions and reverse engineering happening through China, India and so on.

One of the biggest threats in that regards is a currently being negotiated EU bilateral agreement with India, which would effectively put a complete closure to the possibility of India functioning as any place from which you will get cheap pharmaceuticals in the future. If that goes through that option is closed, but if you look at who's making the argument around those or who's mobilized around those there's hardly a public health presence in those debates and those discussions. Thank you very much.

RICHARD PARKER: So for our last presentation the paper on transforming health systems and achieving equity in health written by Professor Marian Jacobs from the University of Cape Town and we'll have Kevin DeCock from the Center for Disease Prevention and Control and Carmen Barroso from the International Planned Parenthood Federation-Western Hemisphere Region as the two discussants. Marian, thank you.

MARIAN JACOBS: Good afternoon and clearly the introduction of this platform is an attempt to promote equity in this meeting. Let me just start by thanking the Linda and Richard and Alastair and Bonnie and Colby and others that have made it possible for me to be here. And to say that if Gita said it was hard to follow Julio, think what it's like for me.

Because among other things if you go to Goggle and you enter Health Systems you get about four and a half million entries and of those four and a half million entries a substantial number would either be written by Julio or you would have had something to do with it.

So it's extremely intimidating to be up here, but I'm comfortable. In fact this morning I had breakfast with a very eminent public health academic who told me that he's chairing a committee on a topic about which he knows nothing. So that's very comforting for me.

[Laughter]

So let me start by just kind of capturing in a very short presentation of what has happened over the last decade in relation to health systems. And people have already spoken about the work of the commission on social determinance of health and the recommendations that they made for the three major things that if one wanted to achieve health equity one need to consider the social determinance of health and also

look at improving daily living conditions, tackling the equitable distribution of power, money and resources and most importantly measuring and understanding the problem and assist the impact of action, which Gita just spoke now.

The second big thing that's happened in the last decade to put emphasis on health systems is of course the primary health care revitalization initiative and Sonja spoke about this earlier too. This was a resulted in two documents that are freedom and certainly me coming from Africa was the world health report of 2008, which spoke about now more then ever we need to go back to the principals of primary health care and the second was a meeting held in Ouagadougou in 2009 which resulted in a declaration.

And this was for Africa, but it has relevance I think for the global community. And a range of issues with which we're all familiar the Ouagadougou Declaration called for country ownership, resources, equity of access, harmonizing aide, health financing, health workforce partnerships and more. And I want you to just remember this.

And of course the last was a series of old health reports in the last decade. Each of which have had – have made some recommendation about health system strengthening and we know that on the 22nd of November the report of health system financing, the route universal coverage will be launched and

really again, emphasis the importance of looking at what this thing is and what we need to do about it. Particularly since the issue on health systems was of course unleashed by the management of the – or the capacity, or likely of systems to cope with the AIDS epidemic.

So what do we have in 2010? We have a couple of new policies in the global north which haven't been mentioned yet. First is in this country. The Patient Protection and Affordable Care Act and what I read about it is that 47 million Americans are not covered by health insurance and the other is in a package called mirror, mirror on the wall written quite recently. There was a report that the U.S. is not doing as well as many of its other northern counterparts.

So the question is, is that Patient Protection and Affordable Care Act looking at Health Systems in this country and looking at health equity and equity of access to healthcare?

The second one is a new white paper from the U.K. called Equity and Excellence: Liberating the NHS. Sounds very progressive, but when one realizes that this is the 15th revision of the U.K. health policy and I'm assuming health system in 50 years it is a little bit scary, particularly if we are expected to take our direction from there.

So that's one set of things that we have. We also have a global discourse on issues related to health systems and health equity on universal coverage, health financing, scaling up, human resources for health, civil society, country ownership and so on. Those are the themes that pervade the discussions on health systems and health equity in the literature and in many meetings and declarations. And all in all everyone agrees that health systems are the target and country ownership essential.

We have also various declarations on aide and how international aide should be made available, Paris Declaration, Cairo gender and so on. And we know that this lots of global health funding, oh we hear there's lots of global health funding. So with that what is reality in the global staff in relation to her systems? Well first of all in paper written by the People's Health Movement for – it was written for civil society and called to health systems agenda for developing countries. The paper raises all the issues that we know affect health systems in the global size.

The inadequacy of resources; the fragmentation, which is caused by uncoordinated global efforts; the affects structure adjustment, and regulated private sector and so on and so forth. So that's the one thing.

Also in relation to the global staff these are large groups of people convened under the offices of the W.H.O. called the Maximizing Positive Synergy Collaborative Group and they recently published a paper looking at the impact of global health initiatives on national health systems. And they realized that there are problems with the way in which global health initiatives undermine the propensity of countries to develop and strengthen their health systems and they're made for recommendations saying, talking about infusing the health systems agenda with the same energy that has been applied to other global health initiatives to extending the targets to seeking alignment, looking for more evidence and increasing funding.

And again the interesting thing yet another declaration now from Venice and we move from Paris to Accra to Venice, an actual plan in which a very, very detailed action plan in which there's a special section on what the research institution should be doing.

The third thing in terms of the global start is the international development aid and this paper by Devi Sridhar from the Global Health Governance Project at University of Oxford raised seven very important challenges in which he talks about what international aid the challenges for strengthening again health and health systems in the South, talks about the

proliferation of initiatives and concern about the dream of coordination which is sometimes a nightmare.

The second is noting that global health aid is six to 66-percent of national health budgets. Apparently Mozambique 66-percent of national health budgets are accounted for by global aid.

The need to maybe not look so much at new players, but look how the old players can be reformed and I think Margaret picked up on that in her paper. The downside of donor influence on agendas and the fact that much of the global aid goes around government or through Northern Institution so, in order to get aid in the South you have to be linked to an institution in the North which may or may not take more or less than what the South is getting.

So again, a seat of recommendations for donors to be more accountable, for strengthening of national plans and leadership, and to let to look at lessons from South-South Collaboration.

What about my own country with the issue of national health insurance is high on the popular agenda and also on the agenda of the state. This information sheet comes from a group called Shield which is an initiative, some people from Shield are here, it is a collaboration looking at health insurance and

economics involving civil African countries, also countries from outside of Africa both in the South and the North.

And to the paper which was put together by Diane McIntyre from our own university shows that in fact the poorest 40-percent of the population have about one fifth of the benefits. If you look at the graph the percentage share of need was based on a estimate of self assessed health need and you will see what proportion of the budget actually goes to those who are in greatest need.

So we have a problem of inequity, Jerry spoke about it last night, and despite having a very progressive constitution and also having come through legislated discrimination we nevertheless have one of the highest [inaudible] efficiency in the world and we continue to struggle with issues of equity which is why we are looking at universal health system in South Africa and looking at the design implications.

And if you look at this graph again produced by health economics unit at my university you will see that looking at three scenarios the cost of introducing a universal health system depending on the cost of the package of care that goes into it could be almost as high as 25-percent of our GDP or it could be as low as 6.4-percent.

So those calculations are still being done and I think the more recent publications suggest that we may be able to

introduce universal health coverage through a national health insurance system if we look very carefully at what it is that we are trying to do. So, it's not enough if you're looking at universal coverage in order to look to attain health care equity if you just look at financing, there's more to universal coverage than financing.

And I think that this ecosystems graphic is probably familiar to most here which looks at the different impacts in the ecosystem on an individual self. And it's clear that if one wants to go for universal health coverage in order to have equity of access to health care, one would have to look at what the nature of the health care service is, what the health system actually looks like, particularly looking at human resources and other resources, it would be desirable to have a policy and legislation which has equity at its core, that there be a national plan so that one includes all the social determinants in that system, the political wall which we saw in South Africa can be so damaging if it's not there to access in our case in the antiretrovirals, the issues of social justice and human rights which both Julio and Gita have eluded to are absolutely fundamental.

We are fortunate in that we have a constitution in which human rights are central, but that doesn't mean that

we've managed to translate that into a system which can actually be universal.

So, what does our experience also shown us that if we're thinking of human resources for your universal health care and for health equity we have to look at institutional capacity and retention, and it's that institutional capacity that's needed in order to generate the kinds of graphs that Diane McIntyre and others have done. The capacity for health economics needs to be in countries, the capacity for health systems research needs to be strengthened within countries so that we don't have to depend on consultants or institutions from outside our countries, and that's fairly fundamental.

We need capacity in our systems and to make sure that our systems enable people to stay in the system. In the movie last night there was an obstetrician I think in Uganda, who spoke about being the only obstetrician in the health care service for 400,000 people or more. I hope that he hasn't moved into one of the global health initiatives in Uganda or worse taken up a position outside of his country which is what often happens.

And the third is to look at capacity of human resources in the services and looking at the skills and capacities that are needed and issues of task shifting and so on. So, global plans for health systems what have we got beyond 2010, we have

at least 10 world health reports, one coming up now. Each one of them making recommendations and I wasn't able to find any assessment of where those plans and recommendations have actually gone and what has happened to them.

Similarly with a commission on social determinants of health, and Gita spoke about it earlier, wonderful recommendations, many, many meetings of two years people travelling all over the world to meet and where are we now, fantastic action plan but we go on then to the next action plan.

We have declarations on aid, we have joint learning initiative on human resources for health that lead to a global health workforce alliance, we have declarations on primary health care for Africa and globally, we have all these global health initiatives. Julio spoke about 120 of these global health plans in architecture, and then we have some newer global health initiatives like the medical education partnerships initiative, like the consortium of universities with global health, the grand challenges and the GI'd [misspelled?] recommendations that came out of Canada. So, lots of plans, lots of intentions.

And then just on the 22nd of September, this is a new law going, ending poverty from the NDTs. And I read through this thing from the general assembly and I may have been

missing something but it didn't look very different from – the calls weren't very different from those that were made at the beginning of this millennium.

So, what was interesting though is that there's a piece in the new plan for accelerating progress in promoting global public health for all. And it has the same call, the PHC principles strengthening national health systems, affordable primary care and so on and so forth. And in very fine print right at the bottom of one section is this piece about further promoting research development, which comes at the end of quite a long list.

So, my question is, is there hope for country ownership and sustainability of health systems in those countries that are most vulnerable and which need to be targeted if we want global equity both in terms of access to health care and also in terms of outcomes.

These people were interviewed and they were asked about what they thought the possibilities were for countries to strengthen their national health systems, and I'm not going to read it for you. Lola Dare is Nigerian Executive Secretary of ACOSHED, Hernan Rosenberg from PAHO and most from the London school, and Ron Waldman who I'm not sure if he's here but he's from this institution. And all in all they have comments to

make about whether there is help for that kind of strengthening of health systems in those countries that need it most.

So, what do we have, what do countries in the global South have that we can use in our efforts to strengthen our systems. Well, we've got information and there is, this is an open access journal and in the very recent – there was a very recent volume on scaling up health services in low and middle income countries, one of the editors of that volume is right in the room here, and they raise a number of issues for scaling up, which is another one of the current fashions in the global health discourse.

And so there is we have information, we have networks like [inaudible] that can actually pull information together. We have institutions and programs with potential in the global South, we don't necessarily need to have our capacities strengthened, we need to have the resources in order to do that.

We have schools of public health, in fact in Africa all the schools of public health are meeting in the next couple of days in Nairobi, we have many, many medical schools, we have research institutions across the global South, I see somebody from [inaudible] is here, we have MPH programs, we have modules, in health systems and health policy, so we have all the ingredients, and that doesn't mean to say we've got it all,

but at least there is the other beginnings of those ingredients.

We have many, many knowledge networks and collaborations and to name just a few the alliance for health policy and health systems research, Sonia is a member of the board, they're having a big meeting on health systems research in Montreal in the middle of November. This is strategies for health insurance in less developed countries which includes a number of African countries in partnership with institutions like the London School and Karolinska Institute. There's a global health workforce alliance is Equinet, the Consortium on Research for Equitable Health Systems HEPNet, there's a joint learning network supported by Rockefeller to which Judith Rodin mentioned that this morning this is just the beginning of a list of many, many knowledge networks and collaborations.

And then we have civil society and I've noted Gita's concerns about civil society but we have some evidence that some organs of civil society have had impact. The Treatment Action Campaign in South Africa that led to the change in direction for antiretrovirals. And then of course there's the people's health movement and just an advertisement for them, they are putting together the third global health watch, they're calling for case studies and perhaps the outputs of

this meeting could go into the global health watch as one piece for the consideration.

And then lastly, there's lots of funding and collaboration. And let me just – I noticed that Allister [misspelled?] had this picture in his collage this morning is consortium of universities for global health which tends to be not a global consortium but largely a U.S. consortium.

And then there's all this new money coming from the Obama administration, $63 billion for global health, and we heard this morning about the $20 billion U.S. The question is how much of this support in aid actually gets to those places where it's meant to have the greatest impact.

So I'd to suggest that, there are three things we may want to talk – what I want to think about. The first is expanding concepts, not just of global health but particularly of the issue about which I was asked to talk. The issue of, the concept of health care services equity and the issues of equity of access both at a national and global level, and the need to think about health systems equity more broadly in terms of equity of inputs, of processes, of outcome and of impact, which would demand a different thinking about the framework for health systems.

The second is to think about expanding the players. I've noticed that in this meeting there are many, many

representatives of schools of public health but not of medical schools, and here the issues of medical schools are also global issues. It's not just about global public health, but more broadly of health, and I do believe that more institutions should be involved beyond of course all the players we've spoken about, policy makers, civil society and so on.

And the last I'd like to challenge Linda who opened this morning by saying we should have a bifocal view, I think it should be multifocal. So thank you.

MALE SPEAKER: Thank you, Marian. Our first discussant is Kevin DeCock, and I think we need to perhaps in the interest of equity move this back.

KEVIN DECOCK: Good morning, and firstly thank you to the organizers and congratulations to the organizers for inviting me and for hosting this very special meeting. I represent a public health agency, the United States Public Health Agency, the Centers for Disease Control and Prevention. And which obviously has its national counterparts in different countries, not all countries.

A quick word in what we actually see as our role in global health and as we struggle in fact with how should we as an agency adapt to this evolving situation and world, and really we see our role as based on three things. One, working with our country counterparts and we actually have staff in

close to 50 countries to increase health capacity, the capacity to conduct surveillance, the necessary infrastructure for public health laboratory work and so on.

Secondly, to assure that countries can assure their own populations health security, that they have the ability to detect, investigate, diagnose, contain, respond to any particular health situation, any health challenge.

And finally to assure, achieve greater health impact, longer, safer, healthier lives in more places, and that's really what we strive for.

I'm going to frame my comments in 10 questions. I'll speak rather fast to save time. Some of them are perhaps phrased rather bluntly but I hope they'll contribute to the discussion.

I'm struck by two things, one is that many of the questions don't have any obvious answers, at least not yet. And secondly, how many of these questions have actually come up as individual points in the different excellence presentations that we've heard earlier this morning.

So the first is, in this discussion of systems or global health in general, who's in charge? I think 20 years ago, I think the World Health Organization and decision making authority of the World Health Assembly really were quite formidable, and it's sort of fragmented since then. It's

fragmented particularly since the advent of large sums of money, so that those who have the money, that's the golden rule, he who has the gold rules, that is profoundly changed the situation, including interestingly by the philanthropic organizations like the Bill & Melinda Gates Foundation for whom I have a great admiration and respect for that particular foundation. But it is interesting that in terms of accountability it's not clear where that actually lies other than to the benefactor. But they obviously have had a major and very positive influence in global health.

Who sets the agenda, and what do we actually mean by country ownership. It's a phrase that's frequently used, it's used in the Obama administrations, the global health initiative as one of the key principles but it's one that merits better definition.

Where did all this come from, and what are the big ideas in themes, envy, excellent paper that Marian wrote, although she didn't mention it in the presentation just given, she particularly eluded to the 2000 world health report.

I actually think that a lot of this goes, I think that a lot of this goes back about earlier, and I think a very key development actually was the 1993 world development report from the World Bank investing in health. I think that was seminal document and it was through the 90s that various influential

figures emphasized that HIV, TB and malaria were really having a disproportionate impact in Sub-Sahara in Africa, and I think that influenced what's happened since then.

We've heard about the – actually we haven't mentioned the Commission on Macroeconomics and Health although Doctor Brendan [misspelled?] was mentioned. And I think another very important event actually was the evaluation of WHO's three by five program because it was that that gave the reaction to HIV/AIDS treatments scale. Actually the fundamental problem was health systems and it particularly emphasized the human resource issue.

But what struck me over the last, of what's happened over the last few years is that there've been this big themes, the large global health programs particularly PEPFAR the Global Fund, the MDGs, the debate about health systems, the social determinants of health, the reemphasis of primary health care. And all of this could have been pulled together in one vision, and actually what happened is that it all went centrifugal, and some of these things became very competitive and antagonistically if you thought that it was a good idea to have an AIDS program then obviously you were against health systems strengthening. And I think it's coming back together again, but I actually think this debate was in some ways quite destructive.

Question number three, well what is the question? Is it how to strengthen health systems or is it because you can only start from where you are and there's 20 plus billion dollars out there and it's going on things like PEPFAR and the Global Fund. Is the question how do you maximize the benefit of these big and rather vertical initiatives, how do we use those to get to where we want to go. What I think the question is not about, which again was kind of negative, is the global fund a good idea and is PEPFAR bad or good. And a lot of energy's unfortunately gone into that.

I'm troubled about the science, and I'm perhaps reductionist, I'm a clinician by training and I ended up in public health in epidemiology and I respect and agree to some extent with Carlo's earlier comments about the limits of epidemiology, though I do think it's a very elegant science.

I'm struck that whereas in a lot of medical situations, biomedical situations, practical problems can usually be reduced to discreet entities that can be investigated. That doesn't seem to be the case with health systems. And I think with a sort of analogous situation as we are with economic development in low income countries that to my ill informed perspective we sort of don't really understand it, we don't – why is Kenya so far behind South Korea when 30 years ago,

whenever it was, they were at the same – that very frequently thrown out Ghana.

I don't really understand it and I'm troubled, I think we need to do better with communicating the science that is going into our health systems debate. What I do think also is that we need a lot of emphasis on impact outcomes metrics and measurement and communicating clearly.

Where's public health in all of this because a lot of the discussion about health systems actually is about clinical care, it needs to be about both. We at CDC, and this is purely for our own work, it's not suppose to be comprehensive, we had a lot of discussion about this is how to we as a public health agency with a global presence engage in this discussion. And for us the priorities are health information systems and surveillance, research for policy change and program implementation, the development of the work force in the broadest sense and laboratory capacity strengthening, and all of that in support of program implementation and other infrastructure development.

You notice we say nothing about financing, not that that isn't critical, but simply it's just not what we have the greatest expertise in. It is critical obviously.

I show this only to make a comment about public health but also to say actually we do still need clearer definition of

what we actually mean and what the boundaries are of health system strengthening when we talk about it.

I am personally troubled because of my work by the relationship and again sometimes communicated apparent antagonism between health, acute public health interventions and the whole issue of economic development. We know that health is wealth and wealth is health, we know that the lessons from the commission on macroeconomics and health that health investments can lead to develop and certainly development leads to health or is associated with health. There are very interesting outliers, the United States being one of them in the negative sense.

But what I'm troubled by in this discussion is that it – and this is actually a rights issue, that sometimes this emphasis on systems and the long-term view of development seems to forget that actually we have huge responsibilities to both cohorts who are currently alive or currently being born, as well as those for the future. And the term sustainability, which is the development community uses so often is I think a truly troubling one, because in many of the places that we work disease is far more sustainable than any particular part of the health system.

In these discussions on health systems I do argue that we have to put more emphasis on health outcomes. I mean health

systems strengthening has to lead to improved health indicators, and there has to be much better communication around the impact that we are seeking and hopefully achieving and to use a sentence that in an article at [inaudible] and I wrote a year or 18 months ago, health systems have to be seen as for as actually serving real people, people with identities who actually suffer from health problems that have names. It's not systems just for the sake of having a system.

What's wrong with vertical, well we know there's plenty wrong with vertical and that's to some extent what's stimulated this whole debate. But we do face somewhat of a conundrum that – and I think sometimes we sort of play things down too much. We have achieved extraordinary successes over the last 10 to 20 years. If you look at the mortality reduction in Africa that has occurred because of the scale up of AIDS treatment programs, or AIDS services in general, the trends in tuberculosis, the extraordinary reductions in malaria that have happened in just the last few years, vaccine coverage, the almost eradication, not yet but the almost eradication of polio.

All of these are quote rather vertical interventions. The experience of Zambia in the 1990s when it dismantled it's tuberculosis program to make it integrated with the rest of its

system was actually quite disastrous and led to escalation in tuberculosis very bad program performance and real problems.

So, we have to sort of accommodate these observations and some of these requirements may also circumcision for HIV prevention, not a magic bullet as Peter reminded us, but interestingly the only intervention for which we have three randomized control trials that show the greatest benefit of almost all our proven interventions are 60-percent reduction in incidents in men. If ever we're going to use that benefit, and there's a dire need to do so, it isn't going to come quickly from investing in general health systems and hoping that in 20, 30, 40 years maybe circumcision coverage will be rather high. It's going to have to be – if we want to do this, it's going to have to be much more targeted sort of intervention and the same is true for some of the neglected tropical disease interventions. So this is not easy and we have to bring these views together.

Who's going to pay the issue of that's come up of financing? Global health needs global financing. I think we should communicate that and advocate around it. And I also think there's enough money in the world to pay for health.

I do think there's a need for political pressure on others who could step up to the table to do so, including some of the emerging economies, the oil rich economies and so on.

And there are very interesting cultural links that could be exploited to do that.

I think scientific work on innovated financing mechanisms deserves much more attention. Very small levies on very frequent transactions that are practiced widely across the world could actually raise substantial sums of money. One thing that clearly does not work and just exploits the most vulnerable is point of care charges which often cause more problems than they solve.

And finally, what is the answer. There is no one answer, that is clear. I don't know what the — we don't really know what the answer is, but there's some interesting points thrown out, many of them have come up in discussion this morning.

The issue of equity I think merits a lot more discussion. Do we talk about it simply because it's the right thing to do, or do we talk about it because it's smart from a public health perspective, is it actually you get a disproportionate impact if you focus your interventions on the most vulnerable. And I think that's a very important question. Do you go for, in public health benefit, do you go for big countries, Nigeria, Ethiopia, etc, China, in terms of years of life gained or do you go for groups that are particularly disadvantaged.

Interestingly, UNICEF in its recent policy has just made equity the very center of its approach. Business approach is incentives, meaning incentives we do that, that's done to some extent in clinical medicine I think as it was mentioned but actually using incentives for populations to remain HIV negative, not to smoke, to do various healthy lifestyles and so on. And certainly better science.

In conclusion I don't think we know, but we have to do better. Thank you very much.

MALE SPEAKER: So for our last discussant, Carmen Barroso from IPPF/WHR.

CARMEN BARROSO: I think organizers of conferences should take into account the height of speakers so that they don't have to move back and forth the platform. [Laughter]

Standing between you and lunch I'm keenly aware of the need to stick to the five minutes I was asked to make some comments, and I really appreciate that I was invited to speak about equity because that is I think at the crux of the matter. I'd like to make three comments on aspects that I believe our discussions should go beyond the current debates.

First, Marian mentions the need to redress the inequities regarding the poor and vulnerable. But I think we need to impact who are the vulnerable. We should look at equity beyond the major inequities regarding income and wealth. These

are of course, the most glaring inequities but there are others which are rampant but do not receive much attention.

I would like to focus on two in particular because they affect huge numbers being a large proportion of the population, and I'm referring to age inequities and gender inequities. Gender inequities plague health systems in many ways, in the workforce and lack of attention to victims of gender based violence, etc, etc, etc, I don't need to mention those to you.

Adolescents in particular have much more restricted access to health services. And health services seldom cater to their needs. One of the reasons they are neglected is that on many aspects they are a relatively healthy bunch. The services that the health systems could offer them in a friendly manner though, have wide ranging implications for the rest of their lives.

Take for instance tuberculosis prevention. Take for instance access to contraceptive services, an area in which unmet need of adolescents tends to be twice as large of that of adults. An unwanted pregnancy at this age can be life threatening, especially when an unsafe abortion is seen as the only solution possible. It can also be life transforming whatever the course of action taken.

Of course there are many other mental and physical health needs of adolescents that usually go unattended. They

are so important that I suggest that we start talking about the poor, the adolescents, and other vulnerable groups. Let's stop their invisibility and let's stop adding them at the end as an afterthought, as a footnote.

My second point is that we need to pay more attention to the diverse components of health systems. Linda gave us definitions of health systems. Peter said we probably don't need to define the boundaries of health systems. But I have the feeling we are living in a platonic world of ideal types. When Catherina [misspelled?] presented this stark realities of differences between the public and the private health systems in Chile, and that's not only in Chile of course.

So, Marian mentioned briefly the role of the private sector but most of the time when we talk about the public health system, we are talking about the government sponsored systems or we talk about the whole system without examining the differences of the various components.

We should think about the equity implications of the four profit sector, the religious nonprofit sector, and the secular nonprofit sector. The equity implications are quite significant when for instance the religious sector, which you know plays a major role in many countries, refuses key services that it deems unacceptable from their particular set of values, as is the case of contraception and abortion, again my favorite

area, should the secular nonprofit be strengthened to counterbalance those inequity. Consideration of the four profits sector is also important for discussion that is much needed about targeting the poor and promoting universal access. Is targeting the poor the most efficient way of promoting equity or is reinforcing double standard of poor care for the poor.

My third point expands on what Marian said about the contribution of civil society towards holding governments accountable and she also mentioned importance of political will, social justice and human rights. Actually, strengthening and redesigning health systems to achieve equity is as much or more a political then a technocratic question.

Richard for instance has raised the underrepresentation of the South in global health systems decision making. How can equity be promoted in health system until there is broad political democratization, so that the poor and other disenfranchised groups are empowered to demand the equitable health systems they need.

The enormous difficulty of promoting change in the U.S is a clear demonstration that the promotion of greater equity is not in the hands of some enlightened specialist such as ourselves, but depends on control of public opinion and the creation of political will.

The same way, and I would say remember that Gita and others also mentioned the important role of social movement in global public health, including Alma-Ata the HIV movement and more recently the youth movement.

So the same way the social determinants act powerfully in effecting the health outcomes well beyond the inputs of health systems, also the broader political and social forces establish the parameter within which the health systems will work either reinforcing inequities or mitigating them.

Judith's support for a global citizenship seems in the right direction, so should we discuss how we develop it? The need to give serious thinking to gender inequities and to the invisibility of adolescents, the importance of critical thinking about the private for profit, the religious and the secular nonprofit sectors, and the fact that the empowerment of the disenfranchised is essential for tackling inequities in health systems.

These are the three points I would like to leave with you for consideration, and I look forward to the discussion. Thank you.

MALE SPEAKER: There is a delicate balance between hunger and indigestion, I'm aware that it's about five and half hours since you might have eaten a croissant or a Danish pastry and lunch is awaiting us. And yet also this morning we've had a

huge amount of material to assimilate and we very much want to begin to model a discussion of that and the digestion of that. The good news is that all of our program this afternoon and all of our program tomorrow is very much directed at the opportunity to digest the diverse contentions and suggestions that were made this morning.

It feels though that we shouldn't go to lunch without giving the opportunity for a handful of people just to give some initial reaction in a declarative way to some of the contentions and the suggestions that have been made.

There are microphones on the tables, I'd like you to – if there's something you'd like to say, let's try and make it a sentence or two, this is not the time for speechifying, we have our stomachs to fill, but it is the time to have a sense from people who've not spoken as a reaction, either in terms of agreement and affirmation or in terms of controversy.

Christina at the back, can you take a microphone and stand, you'll be switched on.

CHRISTINA ZAROWSKY: Thank you, it's on? Thanks very much for a stimulating all though lengthy morning. I'm Christina Zarowsky, I'm with the University of Western Cape. I left a Canadian very nice funding agency rather smug IDRC a year ago, and let me tell you it looks totally different being on faculty at a historically black university, which means

relatively little money and relatively little prestige, so that colors all of my reactions to so far what this morning has been sharing.

I just wanted to raise a couple of comments. One was, for me anyway, perennial ambivalence between excitement at the can do Americanism and also some discomfort at the kind of triumphalist ever new, ever innovative, ever better movement. And our we at risk rather of ever greening in the pharmaceutical tradition rather than true innovation. How can we think about creating spaces to remember history, to remember social theory, to think about that, to learn from each other, to create opportunities and processes and mechanisms where we can actually innovate in our own environments without constantly feeling like okay well, commission for social determinants of health that's last week's conceptual framework, we need another one today.

So that's the – kind of the big concern about that. I kept thinking of reading over somebody's shoulder on a bus in Ottawa about there being too medieval institutions active in the world today. One is the church and the other is the university, for good [inaudible]. So can we not – can we be a little less protestant where we create a new sect and a new church for every new movement. Can we remember a bit of our history, can we remember Wallerstein, those of us who trained

in social sciences a couple of decades ago. Can we learn across our disciplines, and also just thinking across disciplines and across our constituencies.

My experience so far in a year with managers and practitioners in South Africa is that far from being incapable of absorbing change and innovation, they are barraged constantly by change and innovation and are doing their best to try to absorb it and to manage that in a widely changing landscape.

Last comment, I don't know if the bifocal metaphor was meant to be ironic, in Canada bifocals are passé, even multifocals are passé, we're inter-progressives, so cannot shape our thinking.

MALE SPEAKER: Robert.

ROBERT CARR: Yes. I'm Robert Carr from the International Council of AIDS Service Organizations. I spent the last 10 years doing a lot of community organizing and addressing health systems issues for particularly vulnerable groups, which is a background for what I want to say briefly that I am struck by attention that kept repeating itself throughout the presentations that I'm really hoping we'll be able to manage as we go through the next day and a half.

Which is between the level of sophisticated systems level abstracted analysis of how health systems work, how

health systems could be reformed. And the tension between that and remembering that the point of health systems is really to increase the health of people on the ground who are very diverse, especially people who are particularly marginalized, particularly excluded from systems as a whole, but are particularly hard hit by exclusion from health systems.

So we heard for example, some of that coming through in the last speaker who spoke about the needs of adolescents, this has a lot of challenges if we go back up to health systems. For example, around whether or not government on the issues of country ownership whether or not they're prepared to provide section reproductive health services to adolescents. That's just one example. There are multiple constituencies that we could talk about like that, but I'm really hoping that over the next day and half we can continue to try and remember who the beneficiaries of health systems are meant to be. Thank you.

MALE SPEAKER: Gary.

GARY COHEN: Hi, I'm Gary Cohen with Becton Dickinson. We cast the net very wide this morning, that's my impression which is great from the standpoint of taking a holistic view but I would really hope that as we go into this afternoons discussions we'll be able to focus on some actionable constructs to try to cull down this broad base set of

information that we had to a series of areas that can represent meaningful follow through from the conference.

And one construct that I think may be helpful looking at these issues systemically, is to try to determine where are we acting on symptoms, investing and treating symptoms, versus where are we trying to remove barriers that could enable us to deal with the symptoms more effectively, and where are we dealing with underlying causes.

And to make that a more poignant or meaningful statement, if you think about HIV/AIDS the majority of the investment today goes to symptoms, people can track the disease, and we invest in antiretroviral treatment.

I think one of the speakers this morning said 80-percent or so of today's investment in HIV/AIDS goes for treatment. And we know that we'll never win the battle against HIV that way because people are still contracting the disease more rapidly than they can be put on treatment.

And we talk about barriers, health system strengthening has emerged since let's say 2006, is a primary barrier to further expanding treatment access, and even there as we make the additional investment which is absolutely necessary and will carry benefits well beyond HIV/AIDS, it's still not going to effect the underlying causes. And the last speaker spoke about gender inequities is clearly emerging as one of the

several underlying causes if you look at the prevalence among young females, particularly in high prevalence regions, it's way, way out of proportion. For example in Swaziland the country with the highest HIV prevalence in the world, 38-percent prevalence among females in the 20 to 24 year age cohort versus 11-percent for males.

And I think evidence would indicate that investment in reducing the underlying causes are the most cost effective, certainly in this example that I use, investment in the outcomes so the symptoms are the least cost effective. But they also tend to be the most challenging because you deal often with behavioral issues as opposed to therapeutic interventions. And I do think we have to put more focus on these behavioral issues that impact underlying causes as a means of getting ahead of some of these issues. But all that was just as an example to say let's think about some actionable constructs that we can take all this great information from this morning and drive it forward.

MALE SPEAKER: Thanks very much. A final word before lunch, Howard.

HOWARD FRUMKIN: Thank you, Howard Frumkin from the University of Washington School of Public Health in Seattle. If we were a gathering of ecologists and zoologists here to talk about the global health of butterflies or rodents, you can be

sure that we would have put species habitat at the center of our discussion. But I'm struck by how peripheral human habitat has been to the discussion this morning.

These are the issues in the Northwest are probably no accident, in the Northwest part of Allister's slide this morning, climate change with all the implications that we'll have for agricultural output, for infectious disease risk and so on, depletion of resources such as water, land, petroleum. And I'll note in passing that the good news story in last night's wonderful documentary was the women in difficult labor who got a ride to the district hospital. She might not have gotten that ride if gasoline had been selling for $15 a gallon instead of $4 a gallon as it will before long.

I want to urge that if global health is in fact a new paradigm, part of that paradigm needs to be that we think geographically, we think in resource terms, we think in ecological terms and understand that many of the physical changes in the world are the context in which human health exists. So I urge that in our discussions it won't be easy this afternoon because this set of issues, fundamental as it is, doesn't fit into any of the four buckets that we've got for our discussion, very important omission, but this very much needs to be at the heart of our discussion.

MALE SPEAKER: Thanks very much Howard. I'm standing over here partly as a signal to where your lunch is. We are going to go through there. There are bags for the lunch, you can either stay in that corridor area or if you want to go through to the square open outside you're very welcome to, but the bags are very clearly marked in terms of what's in them. There include vegetarian and non-vegetarian option.

And a process thing I was disappointed on having to cut out two or three people who then wanted to speak but the whole of this afternoon, and all of tomorrow is very much to give the opportunity for those voices in these tables to begin to shape discussion. And very much as Gary was suggesting to drill down from this visionary level towards concrete actions and agendas.

So enjoy your lunch, please come back at 5 to 2:00 so we can start promptly at 2:00. Thank you.

[END RECORDING]