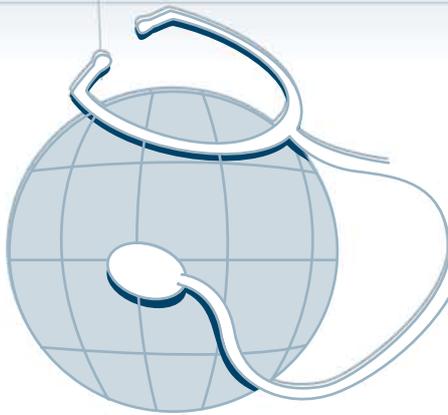




Compass 2020

Germany in international relations
Aims, instruments, prospects



Global Health

A policy field of
underestimated importance

Wolfgang Hein

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The Compass 2020 project represents the Friedrich-Ebert-Stiftung's contribution to a debate on Germany's aims, role and strategies in international relations. Compass 2020 will organise events and issue publications in the course of 2007, the year in which German foreign policy will be very much in the limelight due to the country's presidency of the EU Council and the G 8. Some 30 articles written for this project will provide an overview of the topics and regions that are most important for German foreign relations. All the articles will be structured in the same way. Firstly, they will provide information about the most significant developments, the toughest challenges and the key players in the respective political fields and regions. The second section will analyse the role played hitherto by German / European foreign policy, the strategies it pursues and the way in which it is perceived. In the next section, plausible alternative scenarios will be mapped out illustrating the potential development of a political field or region over the next 15 years. The closing section will formulate possible points of departure for German and European policy.

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Global Health

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Abstract

Globalisation has led to a fundamental change in the requirements for global health. The more rapid spread of disease is now also posing an increased threat to the northern hemisphere, while the socioeconomic consequences of the poor health situation in large parts of the southern hemisphere are hampering development and contributing to social and political instability. At the same time, civil society stakeholders in particular are strengthening the normative meaning of „health“ as a social human right.

In the face of the growing importance of global health as a policy field and the conversely diminishing ability of intergovernmental organisations to deal with these problems effectively, both civil society and private sector stakeholders have increasingly begun to occupy the global political arena. This multiplicity of stakeholders has resulted in a complex architecture of Global Health Governance (GHG), whereby global health problems have increasingly become the focus of international and transnational policy. While the revision of the International Health Regulations (IHR) has helped strengthen the World Health Organization (WHO) in part, the conflicts surrounding access to drugs (and other resources) and the fight against HIV/AIDS are mobilising the entire spectrum of Global Health Governance stakeholders. Due to growing problems surrounding coordination, improving inadequate health services and sanitary conditions in poor countries has not, however, become any easier.

Germany has shown little policy initiative in the area of global health. The Federal Ministry for Economic Cooperation and Development does support projects of note in the fight against HIV/AIDS, yet Germany has played virtually no part in the discourses on central issues of global health policy. In terms of per-capita income, the German contribution to combating HIV/AIDS trails way behind that of other OECD countries. The statements made so far relating to Germany's double presidency (G8 and EU) give little cause to expect any new momentum being given to this policy area.

There are three conceivable scenarios: broad global commitment, with an adequate transfer of resources, can lead to fundamental improvements in the health situation in the developing countries, which in turn has a positive effect on the global control of disease and on social and political stability (1). A very narrow focus by the OECD countries on their own, short-term interests (averting the spread of disease, effective insulation against the health problems in poor countries) is not improbable, in doing so making use of the International Health Regulations and other means of control of epidemics (2). This can, however, easily slide over into a global crisis (3). If this happens, global problems will tend to get out of control. Increasing political unrest in crisis regions will hamper the development of health services and the spread of epidemics will also affect many in the northern hemisphere.

A German „foreign health policy“ could promote the development of scenario (1) if a worldwide social and health policy were to be viewed as part of a global regulatory policy which also recognises rights and obligations in this area, particularly those involving a clear increase in the transfer of resources. Until now, initiatives to make comprehensive improvements to the health situation in poor countries have tended to remain in the background against the control of infectious disease, particularly HIV/AIDS. Any drive for a systematic European policy and for G8 obligations to strengthen Global Health Governance in this sense could provide important momentum for developing global health.

I. From international health policy to Global Health Governance

I.1 New challenges posed by international health problems

Compared with the situation in the 1970s, in which the World Health Organization (WHO) shaped global health policy in keeping with its mission statement, globalisation processes – economic, political and communicative – have led to a fundamental change in the requirements for making progress with the global health situation and with global health policy.¹ The tightening mesh of social relationships in an emerging world society has important consequences, both in terms of the rapid global spread of disease and of the significance being attributed to the social and economic consequences of the poor health situation of a considerable proportion of the world population. A whole range of aspects points to the fact that health has become a key global problem:

- A more rapid spread of health problems can be observed: on the one hand, as a result of the expansion and acceleration of global mobility (this particularly affects rates of infectious disease) and, on the other, from the globalisation of consumer habits as a consequence of global advertising and cultural assimilation (for example smoking, changing nutritional patterns). HIV/AIDS represents a global threat and new, hitherto unknown diseases, such as Ebola and SARS, are being viewed as examples of the new global health risks.
- The increasing resistance of pathogens to antibiotics holds great dangers. It is the result not only of both excessive use of these drugs by the middle and upper classes and of incomplete courses of treatment among poorer people, particularly because of inadequate medical supervision, but is also a consequence of the widespread use of antibiotics in livestock production. The emergence of pathogens resistant to most antibacterial agents has now become a serious problem in the treatment of tuberculosis and malaria.
- The accelerated spread of drugs and medical technology to virtually all corners of the globe has the potential to help the fight against disease worldwide, yet is increasingly posing ethical problems, since the income-based inequalities in healthcare are becoming ever more evident.
- In the face of the debt crisis and the priority given to macroeconomic restructuring in the 1980s ("getting the macroeconomic fundamentals right"), socio-political programmes (such as health policy) were no longer considered a primary focus of development cooperation. The crisis taking place in primary health care became clear in the 1980s when, in the poorest countries, even the most basic types of provision (vaccinations, pre-natal care) were increasingly suffering from lack of funding.²
- The liberalisation of international trade (including the international regulation of intellectual property rights by the TRIPS Agreement) reduced the level of control individual nations have over the production of and access to drugs, medical equipment, and – with the advent of the General Agreement on Trade in Services (GATS) – also reduced their control to a certain extent over the range of medical services offered.³

1] A good overview of this is provided by Kelley Lee (ed.): *Health Impacts of Globalization. Towards Global Governance*. Basingstoke: Palgrave 2003; Kelley Lee/Jeff Collin (eds.): *Global Change and Health*, Milton Keynes: Open University Press 2005.

2] Cf. David Werner/Sanders, David 1997: *Questioning the solution: The Politics of Primary Health Care & Child Survival*. Palo Alto: Healthwrights 1997.

3] Cf. Koivusalo, Meri: *Global Governance, Trade and Health Policy*, in: Wolfgang Hein/Lars Kohlmorgen (eds.): *Globalization, Global Health Governance and National Health Politics in Developing Countries*. Schriften des Deutschen Übersee-Instituts, 60, Hamburg 2003, pp. 203-224; Maureen Mackintosh/Meri Koivusalo: *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*, Basingstoke: Palgrave 2005.

- Since the mid-1990s, there has been evidence of growing apprehension about the vicious circle of rising poverty and greater vulnerability to health problems in an increasingly global society. People are becoming ill more frequently because they are poor, while the illness in turn simply makes them even poorer – particularly when there is no adequate public health service.
- The governments of the OECD countries are becoming ever more concerned in the face of the international health situation – both about the spread of infectious disease across borders and the possible political and economic instability that is associated with a high incidence of poverty-related disease in some regions of the world (such as HIV/AIDS). This is one reason for the increasingly important role being played by health since the 1990s, including its importance at the G7 and G8 summits and the declarations adopted at these.

As a consequence of these new challenges to global health policy, the institutional structure of this policy field has changed rapidly. Structures have emerged that could be described as embodying prime examples of global governance. In the following, I do not use the term global governance in the normative sense of cooperative networks for solving global problems (such as the UN Commission on Global Governance), but rather use it to refer to, on the one hand, the significance of an increasingly more complex transnational arena for dealing with international political conflicts and, on the other, to a different allocation of responsibilities among governmental and private stakeholders.⁴

Global governance is characterised by the fact that, in a range of policy areas, international governance institutions (in particular the UN system) are, due to their political decision-making mechanisms and bureaucratic structures, often largely ineffective or do not “tackle” problems as they arise. Civil society and private sector actors are consequently able to occupy the global political arena and exert influence themselves even if they are – according to the understanding of traditional politics – in no way whatsoever authorised to do so (such as CSOs⁵ and companies) or have at their disposal few hard power resources (such as most CSOs). The role of these new stakeholders and new political constellations is outlined in the following, using four problem areas as examples.

1.2 The International Health Regulations: successful cooperation to combat the threat of global epidemics

In 1951, the World Health Assembly adopted the International Sanitary Regulations (since 1969: International Health Regulations). These regulations, however, became increasingly unimportant. The key reasons for this were better control of infectious disease in the developed world and a sharp decrease in the incidence of, or complete eradication of, the diseases the IHR were concerned with (such as plague and smallpox). In 1995, talks were begun to revise the Regulations, with these negotiations dragging on considerably at first.

The fact that the negotiations were brought to a speedy conclusion between 2003 and 2005 can be attributed primarily to the experience of the outbreak of SARS (Severe Acute Respiratory Syndrome) and its successful control, which was due mainly to good management by the WHO. The agreement, adopted in 2005, will come into force in April 2007. It can therefore be described as groundbreaking, since, in the event of a public health emergency of international significance, the WHO is granted far-reaching powers and

4) Cf. inter alia Dirk Messner/Franz Nuscheler: Das Konzept Global Governance – Stand und Perspektiven, INEF-Report 67, Duisburg 2003; Mathias Koenig-Archibugi/Michael Zürn (eds.): New Modes of Governance in the Global System, Basingstoke 2006.

5) CSO stands for Civil Society Organisation.

non-governmental organisations are assigned key roles.⁶ The fact that the new IHR are not restricted to previously stipulated diseases is also of fundamental importance. The regulations also cover international health risks from biological, chemical or radiological sources. As in the prior agreement, the aim is both to limit the effects of international dangers to health and to avoid unnecessary restriction of transport and trade.

The WHO has the right to require that member states develop appropriate capacities for monitoring possible international health risks. It can, however, also use non-governmental information sources and, as required, issue recommendations for the restriction of travel and trade without the consent of the government concerned. In the case of SARS, the new IHR model, whose main features had already been agreed upon, was tested successfully, so to speak, and, in the case of bird flu (the H5N1 virus), it can be said that there was at least successful containment.

1.3 Access to drugs and the significance of new stakeholders for global health policy

Drugs have always played a central role in the treatment of disease – and in most societies, they have been developed and manufactured by private stakeholders for a long time. Hence they have also frequently been the cause of conflict between public authorities responsible for health policy and private enterprises pursuing quite different interests in that the latter naturally base research and development on the chances of bringing to market those products which promise a profitable rate of return. With regard to medicines, this causes two kinds of problem:

(1) On the one hand, no profits can be made from drugs or vaccines for illnesses found only in poor countries, meaning that research in this area has long been neglected. This even holds true for very widespread diseases such as malaria and tuberculosis, where the funding provided for research has fallen far short of mirroring the significance of these diseases. The problems surrounding these so-called “neglected diseases” has increasingly become the topic of debate from the late 1980s onwards, resulting in the development of a range of Global Public Private Partnerships (GPPPs) in the 1990s. These cooperative ventures were, for the most part, set up on the initiative of the WHO, being mainly financed by large charitable trusts (particularly the Bill & Melinda Gates Foundation), but also partly from state contributions. Pharmaceutical companies were responsible for the scientific and technical aspects of operation. In the case of the Drugs for Neglected Diseases Initiative (DNDi), Doctors without Borders (Médecins Sans Frontières) took the initiative as a civil society organisation in developing a cooperative framework bringing together international organisations, government institutes in the field of drug research and production and private manufacturers of pharmaceuticals to work on various projects to develop drugs for these diseases.

(2) On the other hand, drugs developed by pharmaceutical companies in response to demand in developed countries are sold at such a high price during the period of patent protection (generally 20 years) that the costs of research and development are easily recovered. In the developing world, however, these drugs can only be afforded by few people. As long as no internationally enforceable patent protection was in place, it was still possible to produce generic versions of these drugs in technologically more advanced countries such as India and Brazil. This changed with the coming into effect of the TRIPS Agreement in 1995, even if its cover was at first not comprehensive due to transitional arrangements.

6] cf. in particular David Fidler: From International Sanitary Conventions to Global Health Security: The New International Health Regulations, in: Chinese Journal of International Law, Vol. 4, 2005, pp. 325–392.

In the case of HIV/AIDS and the antiretroviral (ARV) therapies developed because of demand in the industrialised countries, the situation arose whereby drugs were available that, for practical purposes, turned AIDS into a chronic illness, but at a price which the majority of those affected worldwide could not afford. The problems surrounding access to drugs were made evident by the fact that Indian pharmaceutical companies were manufacturing generic versions and offering them at less than one tenth of the price of the original versions, but these could not be sold in many developing countries in which a TRIPS-compatible patent law was already in force.

1.4 HIV/AIDS as a catalyst for developing Global Health Governance

The problems and the responses to these problems have been pointing clearly, on the one hand, to the close interdependence of international regimes hitherto regarded as separate (not only trade and health, but also human rights and health) and, on the other, to the growing importance of new stakeholders and institutional forms. This has brought about diverse forms of cooperation between civil society, governmental (national and international) and private sector stakeholders. Given the high number of those affected in the developing countries (in 2006, there were approximately 40 million people infected with HIV, of whom around 37 million were in developing countries) and the perception of HIV/AIDS as a global threat, this illness has become an effective catalyst for developing new structures in international health policy.

Reference was made earlier to the disputes surrounding access to antiretroviral drugs. The sharp reduction since 2000 in the cost of first-generation antiretroviral therapies has for the first time placed treatment within the financial reach of those infected with HIV in developing countries. However, other quite separate methods of combating the disease (prevention, diagnosis and monitoring) require considerable funds that far exceed the amounts traditionally provided as aid in the health field.

Since the mid-1990s, this situation has been leading to innovative approaches such as those mentioned above. For one, an attempt was made to create synergies: UNAIDS (the United Nations Programme on HIV/AIDS) was founded in 1995/96, with the primary aim of improving coordination between the organisations involved in the fight against HIV/AIDS (including CSOs). This attempt failed, however, largely due to the relative inflexibility of the international organisations involved, with the key developments (the G8 Initiative and the establishment of the Global Fund, the mobilisation of CSOs to improve access to drugs) taking place outside the sphere of UNAIDS.

The establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) represents the farthest-reaching initiative in terms of international health funding. Its purpose stems from the G8 proposal to make considerable funds available for the fight against HIV/AIDS and it was supported by UN General Secretary, Kofi Annan. Since some G8 members refused to allocate the funds via a UN organisation (which was seen as not sufficiently "result-oriented"), an independent fund was established, based on the PPP model (state governments, representatives of private enterprise and civil society organisations as decision makers; IGOs only as non-voting members of the Executive Council). PPPs (particularly the so-called Accelerated Access Initiative) were also established as a vehicle for enabling pharmaceutical companies to make drugs available cheaply to developing countries in the spirit of Corporate Social Responsibility (CSR) without affecting patent rights. Diverse initiatives by CSOs supported the demands of developing countries that they be able to make use of the flexibilities in the TRIPS Agreement and to do so safely. These flexibilities made it possible to import generic versions of drugs (via so-called parallel imports) and grant compulsory licenses for the production of generic drugs

(Doha Declaration of 2001 and subsequent negotiations). In addition to this, mention should be made of the US programme, PEPFAR⁷, which, as a bilateral programme, makes considerable funds available for combating HIV/AIDS. In the end, the WHO engaged in this process more actively again with the “3 by 5 Initiative” (aiming to treat three million people in 2005). When it became clear that, despite a considerable increase in treatment levels, this target could not be achieved, the plan became that of “universal treatment by 2010”.

The very problems surrounding the treatment of HIV/AIDS, however, have again brought the importance of properly functioning health systems more strongly to the fore (even though the WHO and World Bank have long been making reference to this again). Despite the considerable increase in international aid to combat HIV/AIDS since the beginning of this decade, the inadequate infrastructure of the health service in many countries receiving aid has increasingly proved a problem (accessibility of medical facilities, diagnostic capacity, shortage of health service staff, etc.). Aid coming from many different institutions has created problems with coordination and has not exactly made it easier to develop integrated national health systems.

The basic set of problems surrounding the issue of access to drugs in general arises from the relationship between the global requirements for drugs and the manner in which intellectual property rights stimulate pharmaceutical research. In its General Comment No. 14, the UN Committee on Economic, Social and Cultural Rights (CECSR) emphasises that the right to “the highest attainable standard of physical and mental health” obliges member states to make available those drugs, which are indispensable (as stipulated in the WHO list of essential drugs). For this obligation to be taken seriously, either the TRIPS Agreement has to be changed fundamentally or the international community has to find other ways of orienting the criteria for research and access to vital drugs towards global requirements. The decision of the World Health Assembly in 2006 to open talks on a Global Framework for Essential Health Research is an important step in this direction.

1.5 Healthcare systems and sanitary conditions in poor countries: the basis of global health policy

Since the late 1990s, the need to promote all aspects of health, particularly in developing countries, has come more strongly to the fore in matters of international cooperation, along with the focus on reducing poverty. The strong emphasis on health as part of the Millennium Development Goals points to the growing importance of this area, while the Commission on Macroeconomics and Health set up by the WHO has made a convincing case for the importance of health as a precondition of economic development. Strategies for combating and controlling infectious disease, the most important cause of illness in poor countries, are not far-reaching enough, in part because the diseases traditionally associated with the developing world, such as cancer and cardiovascular disease, are on the increase in most developing countries. The large differences in income between the rich and poor regions of the world demand a considerably greater transfer of resources in the global health field – not only to combat infectious diseases such as HIV/AIDS, but also to make overall, country-wide improvements to the health situation in poor nations. To this end, a range of initiatives have come into being in recent years that are analysing the problems of global health financing against the backdrop of the complex structures of Global Health Governance and are exerting increasing pressure on the developed world to rethink its role in global health policy (the Alliance for Health Policy and Systems Research; the Health Financing Task Force; the Global Health Financing Initiative).

7] PEPFAR stands for The President’s Emergency Plan for AIDS Relief. This bilateral US programme of massive funding to combat HIV/AIDS came as a surprise, since it takes possible funds away from the GFATM, the establishment of which was also supported by the US.

This brief outline of the developments in global health policy indicates that in particular in the sociopolitical fields of global governance foreign policy has become very complex. The reality of having to deal with political constellations involving a tangle of various and very different stakeholders with greatly divergent interests does not make it easy for governments to develop a coherent approach. These multi-stakeholder constellations also cause the well-known coordination problems for the developing countries, and these problems have become an issue in the debates over the effectiveness of development cooperation.

Seen from another perspective, this development gives non-governmental stakeholders the chance to exert an influence on global governance that is not possible within a system of intergovernmental relations (based on the aggregation of interests at the level of each nation state). They can do so by not only driving a global debate within civil society but also by participating in political processes. It is now becoming possible to mobilise resources (not only financial resources, but also expertise) that would not generally be made available to traditional international organisations. Beyond this too, there is the possibility of much greater flexibility of political processes, including the overcoming of political barriers in these organisations. The development of a complex architecture of Global Health Governance has undoubtedly placed global health problems more firmly at the centre of international and transnational political processes – even if this does not yet seem to have been fully recognised in German policy on global health.

To meet these challenges, new forms of international health policy must be developed such as those that have been set out under the key phrase of Health Diplomacy⁸. The aim is to use networking, the exchange of expertise and the development of capacity to, on the one hand, bridge the gaps between diplomats and health experts, and, on the other, to close the gaps between the bargaining power of developed and developing countries. Thus new models can be developed for global health as an integrated policy field.

II. German Policy and Global Health

Who makes international health policy in Germany? The problem of ministerial responsibility and coordination between governmental departments in relation to negotiations in areas of global governance has been gaining increasing attention in recent years.⁹ In principle, the ministry with overall responsibility for global health policy is the Federal Ministry of Health, due to its responsibility for cooperation with the WHO. However, other ministries have the main responsibility for dealing with other important international organisations in the health field (the World Bank and the GFATM: Federal Ministry for Economic Cooperation and Development; UNICEF: Federal Foreign Office). Furthermore, due to the development of Global Health Governance, other key players in the field of international health policy come from diverse areas of global governance, for which yet other government departments are responsible.

This situation forms part of the basic problem of current foreign policy: as a result of the globalisation of social relationships, so-called foreign policy problems are connected to a multitude of policy areas. One peculiarity of “foreign health policy” consists, however, in the fact that it is treated as little more than a side issue in virtually all government

8] Cf. Ilona Kickbusch/Gaudenz Silberschmidt/Paulo Buss, Global Health Diplomacy: the need for new perspectives, strategic approaches and skills in global health, in WHO Bulletin 2007 (forthcoming).

9] Cf. inter alia Walter Eberlei/Christoph Weller, Deutsche Ministerien als Akteure von Global Governance. Eine Bestandsaufnahme der auswärtigen Beziehungen der Bundesministerien, Duisburg (INEF Report, Issue 51) 2001.

departments concerned. The Federal Ministry of Health concerns itself with international health policy only when German interests are clearly affected (e.g. the control of epidemics, bird flu) or if it seems absolutely necessary for diplomatic reasons (such as with the Federal Government's strategy for combating HIV/AIDS developed together with the Federal Ministry for Economic Cooperation and Development and submitted as a response to an obligation to this effect arising from the UN General Assembly Special Session on HIV/AIDS in 2001).

The homepage of the Federal Ministry of Health allocates only a low priority to the central problems of international health policy. It is in fact emphasised that Germany contributed 5% (41 million US dollars) of the entire budget of the WHO for 2004/2005. This is only the case, however, if the voluntary contributions to the WHO are disregarded. Effectively, however, the WHO was funded for the most part from voluntary contributions, which amounted to more than double the obligatory contributions (1.94 billion US dollars by comparison with a scheduled budget of 880 million US dollars in the same years). The Federal Government's share of these voluntary contributions was, however, minimal (only a few 100,000 euros). Since the voluntary contributions facilitate the promotion of certain initiatives, this can be seen as evidence of a comparably limited German commitment to issues of Global Health Governance. This interpretation is also confirmed by the low level of German participation in those international commissions set up on the initiative of the WHO which have in recent years been channelling and furthering the debate on the central problems surrounding the future development of global health. These commissions include the Commission on Macroeconomics and Health, the Commission on Intellectual Property Rights, Innovation and Public Health and the Commission on the Social Determinants of Health).

This low level of commitment is particularly regrettable given the traditionally significant role played by Germany in international medical research on infectious disease, including tropical diseases. Of course, the financing of WHO Cooperating Centers is an important contribution, but there is hardly any evidence of important international health policy initiatives originating even from these. With few exceptions, this also holds true for the fight against HIV/AIDS: the work of the Federal Ministry of Health is, in this respect, essentially oriented towards Germany, with hardly any reference being made to the key problems set out above in relation to the international fight against HIV/AIDS (one exception are the activities of the "3 by 5 Initiative" in Eastern Europe).

The Federal Ministry for Economic Cooperation and Development is, however, responsible for cooperation with developing countries – and therefore also for the fight against HIV/AIDS in these countries. This involves the Global Fund (GFATM) and thus the largest share of Germany's financial contribution to international health policy. Through its German Agency for Technical Cooperation (GTZ), the Federal Ministry for Economic Cooperation and Development supports a whole range of projects in the fight against HIV/AIDS. Additionally, Germany is also represented in the management of the Global Fund. The BACKUP¹⁰ initiative in particular, which primarily supports partners in managing cooperation with the Global Fund, can be seen as groundbreaking, especially as it is bringing together bilateral and multilateral cooperation and thus helping overcome the problems of coordinating national health policies and Global Health Governance institutions. Given the problems already outlined surrounding access to drugs, it seems, moreover, that a project supporting the development of research capacities and, particularly, of pharmaceutical production facilities in low-income countries is pointing in the direction we should be taking.

10] Building Alliances – Creating Knowledge – Updating Partners.

In the fight against HIV/AIDS, of all the obligations that are accepted in principle, nowhere near all of them are in actual fact fulfilled. Thus a detailed paper issued by Action against Aids Germany¹¹ stresses that, with regard to the G8 and EU Council presidency, there is no telling “whether the Federal Government will see to it that the challenge posed by HIV/AIDS is put on the agenda [of the G8 and EU] as a matter of priority” (p.6). Germany, it is stated, is still trailing far behind in terms of making a proportionate financial contribution to combating the pandemic.¹² On the whole, the status Germany grants the health sector in terms of development policy seems to be rather low. In the past few years, only one position paper on sexual and reproductive health was put forward and likewise there were very few statements on Germany’s contribution to implementing the Millennium Development Goals (MDGs), but no plan at all for better financing of health systems in developing countries (which is a central requirement for implementing the health-related MDGs). To achieve this, cross-departmental initiatives would also undoubtedly have been necessary. The way in which responsibilities are divided up between the Ministry for Economic Cooperation and Development and the Ministry of Health really does become a problem here. The Ministry for Economic Cooperation and Development is not actually responsible for initiatives concerning global health in general.

If it is accepted that it has been becoming ever more evident on the international level in the last few years that the central problem of global health policy lies in the extreme inequalities between rich and poor countries, then this division of responsibilities causes great difficulties. In the context of the WHO and a whole range of initiatives, these problems have been the subject of more thorough debate in recent years, particularly with regard to the necessity for solid financing of the development of health services (see the initiatives mentioned above). The Ministry of Health is paying hardly any attention to this issue at all, while the Ministry for Economic Cooperation and Development ultimately has only limited responsibility for this area.¹³ So far, Germany is excelling in these initiatives only by its degree of absence.

The year 2007, however, with the presidency of both the EU Council and the G8, offers opportunities to set new priorities in the field of international health policy. On the whole, the statements issued so far fluctuate between two aims: on the one hand, a return to the “traditional” key themes of the G8 – the global economy and international trade and finance relations – and, on the other, “strengthening the endeavours of the G8 to support the disadvantaged sections of the world’s population”. In the same vein, there is also talk of “strengthening the African health systems, particularly in the fight against HIV/AIDS”.¹⁴

In the government declaration on the double presidency, delivered on 14 December, 2006 by the Chancellor, Angela Merkel, anyone looking for the words “health” or “developing countries” will search in vain. The “situation in the African countries” is first mentioned in relation to migration to Europe. The question of European foreign and security policy is raised primarily with regard to “threats from weapons of mass destruction and international terrorism” and military operations and peace missions abroad – as if there had never been any discussion of an expanded concept of security. Yet it is stated in one

11] Joachim Ruppel/Sonja Weinreich, Stop AIDS. Keep the Promise. Globale Krise und Deutschlands Beitrag zur Globalen Antwort (Aktionsbündnis gegen AIDS), Berlin, May 2006.

12] Cf. *ibid.*, p. 7. Based on its gross national income, Germany trails far behind in the commitments it has made to funding HIV/AIDS, at 59.6 US\$ per 1 million GNI, as compared with the United Kingdom (\$303.0), the Netherlands (\$442.8) and Sweden (\$376.2) (cf. Jennifer Kates/Eric Lief, International Assistance for HIV/AIDS in The Developing World, The Kaiser Family Foundation, July 2006).

13] In the Bundestag Committee on Economic Cooperation, a hearing did in fact take place on „Social security systems in developing and newly industrialised countries“. Among those present was Mary Robinson as representative of the Health Financing Task Force, but it seems it is still completely open in terms of to what extent this will result in any farther-reaching initiative.

14] Cf. Regierung Online, http://www.g-8.de/nn_93938/Content/DE/Artikel/2006/10/2006-10-18-schwerpunkte-deutsche-g8-pr_C3_A4sidentschaft.html.

short sentence that “we want to give new hope to Africa during our G8 presidency”. All of this gives very little cause to expect that health will play a similarly central role to that in 2006 during the Russian presidency, when the first meeting of the health ministers of the G8 nations took place and a total of 52 commitments to combating infectious disease were set out.

The low status accorded global health is also evident in the “18-month Programme of the German, Portuguese and Slovenian Presidencies” adopted by the European Council on 11 December 2006. Only three of 170 points are concerned with the health policy within the EU, of which one relates to cooperation with the WHO (cooperation with the Framework Convention on Tobacco Control and in implementing the IHR). In the section on external relations, “multilateral cooperation” and “human rights” are mentioned only in brief (without reference to health), while a somewhat longer section deals with “development policy”. Under this heading, “poverty related and sexually transmittable diseases” are mentioned as just one subject area without any elaboration on this.

III. Scenarios – global cooperation or increasing global health crises?

Scenarios are meant to identify possible ways in which a complex system can develop, in order to reveal points of reference from which policy-makers can take strategic action. Since the full complexity cannot be illustrated here and is not ultimately of any real significance for these purposes, and since relevant policy decisions and the institutional changes instigated or decided upon can rarely be predicted over the longer term, we can only concern ourselves here with those “ideal types” of development deemed possible based on the supposed dynamics of different constellations of stakeholders.

III.1 A comprehensive global health policy: improvement of the conditions for health in poor countries and control of transborder problems

The fundamental importance of international health policy and in particular of improving the health situation in poor countries has been emphasised in various contexts in the last ten years (G7/G8; Millennium Development Goals; Commission on Macroeconomics and Health). Scenario (1) is based on the following premises: by the year 2020, considerable progress has been made in the fight against HIV/AIDS and the goals of improving health systems – in the broader sense, the fight against poverty – and in establishing reliable systems of a global transfer of resources, as a kind of global revenue sharing. This progress is supported by an influential global civil society.

The threat of the global spread of infectious disease has been reduced by a further strengthening of the IHR. On top of this, increasing account has been taken of the fact that one cause of the emergence and spread of new epidemics are catastrophic sanitary conditions, which in turn limit the possibilities of stopping an outbreak in the early stages. At the same time, it has been recognised that, for any containment of HIV/AIDS to be effective and for there to be any real stabilisation of the development processes in the southern hemisphere, a health system covering the entire region and including all social groups is required. In effect, then, it has been recognised that an appropriate transfer of resources is in the rich countries’ well understood own interests. This ties up with the historical experience of the industrialised countries, i.e. that a comprehensive system of social security promotes political stability and further socioeconomic development.

In parallel with this, transnational norm-building processes have created standards strengthening the concept of the human right to health (within the context of increasing political acceptance of economic, social and cultural human rights overall). This has led to a reappraisal of intellectual property rights along with new mechanisms for promoting research into and development of products that are important for the supply of global public goods.

The structures of a world confederation are emerging more clearly in 2020: on the one hand, in line with the principle of subsidiarity, local and national competencies have also been strengthened in the poorer countries, so that, in terms of health policy, public authorities can ensure adequate minimum care for all. This is also being achieved through close coordination with various transnational stakeholders who are providing the necessary aid. On the other hand, there are elements of global statehood due to a strengthening of international law, the further development of a global civil society and the more binding nature and increased flexibility of international cooperation. This is secured on one side by pressure from civil society and on another by the complementary forms of informal deliberations and mandatory decision-making bodies. The contributions of private companies to social security in the sense of Corporate Social Responsibility (CSR) are governed not only by appropriate political incentives and offers of cooperation (for example, PPPs), but also by more intense transnational debate at the level of civil society. The global participation of stakeholders with only limited power at the national policy level improves cohesion at the global society level (one approach since the beginning of the new millennium has been that of strengthening civil society through the poverty reduction strategies of the World Bank). EU policy towards its new, less developed members has served as a model for such a strategy for development and security through integration. At the same time, the interdependence of different areas of global governance has been more keenly recognised. It is true that poverty reduction strategies, global environmental policy, the regulation of international trade and the implementation of human rights continue to fall within the remit of various organisations, however the discourses on the interdependencies of various regimes have become increasingly institutionalised.

III.2 Limited cooperation: containment of global threats to health

Scenario (2) assumes a continuation of the trends currently being seen, particularly that of a successful development of means of controlling infectious disease globally. The G8 are continuing to concentrate on fighting these diseases, since this represents the clearest threat to rich countries. More comprehensive models of financing "health" cannot be successfully pushed through because of the financial "restraint" of these countries and their primary focus on their own interests.

This also holds true for their position on intellectual property law. Countries with a strong pharmaceutical industry are trying to undermine through bilateral trade agreements the recognition of the TRIPS flexibilities achieved. There are some attempts to counteract the negative consequences of this policy in particularly critical areas (such as HIV/AIDS) with generous programmes and, beyond this, to promote voluntary concessions from the pharmaceutical industry, such as favouring poorer countries with differentiated prices for drugs and participating in PPPs. Against the backdrop of the rich countries' aims of promoting their own economic interests and values (such as in the case of PEPFAR, with the great reluctance to promote condoms in the fight against HIV/AIDS), those multilateral agreements that are not, as in the case of the IHR, clearly in the interests of these countries are losing ground.

Scenario (2) is based on the assumption that this policy approach will in fact, in the medium term, be successful in averting larger-scale global health crises, but that the trends towards unequal development will continue worldwide. The more successful countries in East and Southeast Asia will succeed in developing their social systems. But the willingness to support poor countries in this field remains very limited. The development of international civil society is also stagnating in terms of global social policy. Initiatives in this area are losing momentum in the face of expected successes failing to materialise, while conservative interests are increasingly managing to mobilise counterforces. Within this context, global governance is only having success in those instances requiring the coordination of measures to insulate the industrialised countries and more advanced regions of the south from the consequences of extreme poverty.

III.3 A world society without global policy: the increasing threat posed by infectious disease and disease-promoting conditions

Scenario (3) is a global crisis scenario. Global problems are tending to become uncontrollable. Political conflict in crisis regions is on the increase and is hampering the consolidation of statehood, and thus also the development of health systems. Even in countries still showing high rates of growth at the start of the new millennium, social and political conflict is now intensifying due to growing inequality; environmental and health crises are also on the increase. These conflicts are in turn leading to stagnation in the global economy, with it becoming ever more difficult to finance the existing standards of care in the health services of the industrialised countries. The efficacy of international organisations such as the WHO and WTO (World Trade Organization) is being increasingly blocked by conflicts of interest. Thus the WTO has become less significant in the face of a system of bilateral and regional trade agreements, since the rich countries are not prepared to make any real compromises with the developing countries.

In view of the increasing levels of conflict in poor countries and the lack of means of control in regions of conflict, the spread of epidemics cannot be fully halted and these are now doing considerable damage in the industrialised countries too. After successful containment of infections in the previous years, at some point between 2015 and 2020 the long-dreaded global flu epidemic breaks out as a result of the mutation of a virus in the densely-populated Niger delta. Beginning around 2010, the resistance of pathogens to existing drugs for treating malaria and tuberculosis had been increasing in many regions of Africa. The programmes to combat HIV/AIDS are proving only partly successful and large numbers of people are dying because their continued treatment cannot be financed. The burden on the health systems in many poor countries is becoming ever greater, while aid from Europe and the US is diminishing due to the global recession. Through tourism and, in particular, migration, the incidence of tuberculosis is also rising considerably in the rich countries, with resistance becoming an increasing problem with this illness too.

On the whole, it seems most likely that, in the short to medium term, the second scenario will materialize. Given unfavourable conditions, however, a sudden metamorphosis into the global crisis scenario, which leads to a vicious cycle, cannot be ruled out. This would be most likely to happen if political conflicts were to hinder successful cooperation within the context of the IHR. However, the first scenario need not remain a mere utopia if international cooperation can successfully be developed beyond responding to acute threats. An essential requirement for this, however, would be a more positive attitude towards multilateralism and a greater willingness on the part of rich countries to make economic compromises, not only in the sense of "simple" transfers of resources, but also in relation to mechanisms for controlling the global economy (TRIPS, GATS) and in accepting their responsibility for providing global public goods for health.

IV. Political options: visions and resources

Germany's international health policy remains very strongly oriented towards the spread of infectious disease, not only in terms of the German research capacities allocated to this, but also in respect of the focus on how to respond to possible threats. This approach is however no longer appropriate (if it ever was) for the great challenges posed by global health. It is an absolute must, then, that a paradigm shift takes place, which sees health policy as a policy for implementing a social human right and for strengthening social integration, including that of global society. This new approach would be an appropriate response to the international scientific and political discourses being held in the past few years as to the meaning of "health" in global policy. With regard to this, much greater resources are required than have hitherto been provided, both to revive the discourses within Germany and to ensure greater participation of German scientists and politicians in international discourses.

Given the considerable importance of global health policy, German policy should in turn give it significantly more weight. In terms of the well understood German interests, it is not sufficient to concentrate on defending against health threats to Germany. Supporting the traditional strengths of German tropical medicine is certainly a key factor for helping in the fight against neglected diseases, but this can only lead to effective advances if the findings are incorporated into a more comprehensive policy for improving healthcare provision in the countries affected. It is not enough simply to comply with those international obligations that are more or less formally established (contributions to the regular budget of the WHO, contributions to the Global Fund).

Many interests regarding the developing countries are ultimately world order interests that also encompass social and health policies in other parts of the world. It should be borne in mind that this is ultimately about global regulatory policy, i.e. not a "soft" world order with no armoury of possible sanctions, but about the foundations of binding, global rights and obligations. If one thinks of the international policy of promoting good governance and its connection to poverty reduction strategies (see Scenario (1) above), this is not as utopian as it perhaps at first sounds. The development of democratic systems first requires fundamental social change, which is based on the everyday interests of the people concerned.

Two areas of global health policy are of central importance if the course is to be set in the direction of Scenario (1) as a long-term objective: on the one hand, the strengthening of national health policy in the poor countries (using the mechanisms of global health governance) and, on the other, the mobilisation of sufficient financial transfers. As the Commission on Macroeconomics and Health has convincingly argued, these amounts are certainly considerable, but are well invested given the possibility of achieving considerable progress in development in the medium to long term and saving on treatment costs. The health-related Millennium Development Goals can be seen as benchmarks in this respect.

Developing Global Health Governance structures can, as shown, mobilise additional resources, open up opportunities for participation and improve the position of poor populations through advocacy activities. The entry of new stakeholders, however, creates considerably greater complexity. This brings with it the problems of how to rationalise the allocation of these resources, which often overstretches the organisational capacities of the recipient countries. Similar debates in other areas of development cooperation have led to an international discourse on the basic effectiveness of aid and to

the Paris Declaration on Aid Effectiveness. Properly functioning health systems can only be developed if the recipient countries themselves have effective control over the funds through national authorities, with simultaneous strengthening of local competencies.

It is also important that the WHO be strengthened again – and indeed particularly in its role as initiator of new discourses and, as the case may be, subsequent negotiations: this happened, for instance, in 2004–2006 with the Commission on Intellectual Property Rights and Innovation in Public Health, giving rise to initiatives regarding negotiations on a Global Framework on Essential Health Research. A definite requirement would be a more active German participation in the Commission on the Social Determinants of Health with the prospect of an initiative to promote health and well-functioning health systems in poor countries (including not only decentralised insurance systems, but also the development of concrete forms of international financing) and improve the framework conditions for health (access to clean water, sanitary facilities, etc.). Any such strengthening of the role of the WHO as a forum for global health policy demands greater commitment to providing voluntary contributions.

Despite all the debates about the finance required to effectively improve the health situation in poor countries, the concrete political initiatives so far have concentrated on the G8 and the fight against infectious disease. Given the shortfall in financing the Global Fund, any such expansion of the horizon in terms of negotiations seems unrealistic. Nevertheless, given the set of problems outlined here surrounding global health, it seems that this will be inescapable in the medium term. When this happens, the fact that there are indeed considerable synergies between the financing of “health” and the financing of the fight against HIV/AIDS must be taken into account.

In the short term, the German EU and G8 presidency offers opportunities to take the initiative in this area. This chance should under no circumstances be thrown away. A leading role should definitely be taken not just in solving internal problems of the European Union and the North Atlantic region. Also, in terms of intellectual property law, the aim should not be just coordination with the US in order to push through particular economic interests in the face of China and India – it is just as necessary to incorporate the issues relating to TRIPS and the access to drugs.

The EU Parliament adopted two notable resolutions on HIV/AIDS¹⁵ last year. These require the provision of additional financial aid, in order to secure, among other things, the aim of universal treatment of those infected with HIV by 2010 and to ensure long-term treatment of all patients, to strengthen public health services and regional and national production capacities for generic drugs and to simplify the procedures for granting compulsory licences. These are promising attempts in the direction of an EU strategy on Global Health Governance which in turn could serve as points of reference for initiatives on the part of the German government. Placing emphasis on these areas could herald the start of a new era of EU global health policy.

In terms of the G8 too, the provision of global public goods should have priority over national and sector-specific interests. The German presidency should not only solidly support the commitments to the fight against HIV/AIDS already made by the G8 since 1999, but also set an important political agenda by expanding these activities to the promotion of health in general.

15] Cf. European Parliament Resolution on HIV/AIDS: Time to Deliver of 6 July 2006 (<http://www.europarl.europa.eu/sides/getDoc.do?objRefId=124436&language=EN>) and European Parliament Resolution on World AIDS Day of 30 November 2006 (<http://europa.eu/bulletin/en/200611/p129006.htm>).

The mobilisation of huge resources to improve the global health situation, one effect of which would be easier control of infectious disease, is of course a long-term project. Yet if such a project were initiated and pursued vigorously, this would make it possible for Germany to assume a strong role in international health policy and to incorporate more effectively the promises of its own medical research into any global policy. Admittedly, in the international health policy field, strong instruments would then have to be developed to ensure effective coordination between the various government departments involved. Switzerland has begun developing target agreements on foreign health policy between all departments concerned. This could also represent a first step in the right direction for German policy.

A comprehensive health policy of this kind can be incorporated into a framework of resolute international cooperation to achieve the Millennium Development Goals and is in principle also required by the International Covenant on Economic, Social and Cultural Rights, which is in fact applicable international law. Such a policy is also in the well understood interests of the OECD countries.

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