Opportunities for the Obama Administration and the G20 *"to Do Good"* for Global Health

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The deepening of globalization in the last few decades spurred by the huge improvements in air travel, increased international trade, the power of the internet and the global labour mobility has made healthcare issues truly global. This is not only because there is increased interdependence in the provision of healthcare between countries but also because of the increase in transnational health risks. Consequently, more than ever before, the world needs effective global health governance. This article argues that the Obama administration working with other G20 countries, and indeed the rest of the world community, can seize this historic moment "to do good" for global health by providing leadership to reform the governance of the World Health Organization (WHO) and by helping address a number of priority global health issues. These priorities relate to: innovation and access to medicines in developing countries; "counterfeit medicines"; the health impacts of climate change; and preparedness for epidemics and pandemics.

INTRODUCTION

In 2008, as Obama made history by being elected the President of the United States, the global health body - the WHO, was commemorating two important historical events. The first was the organization's founding 60 years back.[1] The second was the 30th anniversary of the Declaration of Alma-Ata on Primary Health care (hereinafter, "the Declaration of Alma-Ata").[2] History was also made at the WHO when the World Health Assembly (WHA), in May 2008, adopted a Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (hereinafter "the Global Strategy").[3] A year before, in 2007, WHO had celebrated the 30th Anniversary of the concept of essential medicines.[4]

The marking of all these anniversaries, and the making of history with the adoption of the Global Strategy, should however not obscure the crises and challenges that global health faces today. In the midst of the global economic downturn, the Obama administration and the rest of the G20 can do alot of good for global health by addressing these challenges.

Today, global health faces a number of challenges. The first is a governance crisis. The proliferation of actors and dis-jointed financing coupled with limited leadership and accountability at the WHO means that the world community is not enabled to address global health issues appropriately and effectively. The second challenge relates to the crisis in a number of key priority areas. These include the crisis we face due to: the failure to address the so-called 10/90 gap; increased global trade in sub-standard and dangerous medicines; weak global coordination and preparedness to tackle transnational health risks such as epidemics; and the impacts of climate change on health.

DOING GOOD: THE ROLE OF LEADERSHIP

"Change has come to America" Obama declared during his victory speech. In simple terms, when Obama talks about change coming to America, I assume that he means that by virtue of the change in leadership, there will be changes in the political and socio-economic operations in the country and beyond. For a person who has a keen interest in global health governance the question I ask myself is: What change has come, or is coming, with respect to the approach of America to global health governance?

The ability of the Obama administration and other key global players, particularly the G20 to do good on global health will depend on leadership both at the top and within the ranks. In the current global circumstances, United States leadership will probably matter the most. For the United States to do good on the international stage, it will require engagement and real leadership from Obama himself as well as at the level of Secretary of Health and Human Services (HHS); the head of the Office of Global Health Affairs; and the Assistant Secretary for Preparedness and Response. In addition, the State Department, in particular, the US Global AIDS Coordinator will also have an important role to play.

Of course, for leadership on the Obama administration's side and in the G20 to lead to anything, there has to be similarly enlightened leadership in other countries both in the developed and developing world. The ability of these countries to be real partners will depend on how well they can defend and promote their initiatives based on evidence and facts and their ability to follow through key agendas. This will be critical to avoid a situation where the global health agenda is held hostage by posturing and empty rhetoric. Equally important will be the leadership and sensitivity in key international organizations, in particular, the WHO.

Finally, an understanding of the importance of good global policy on health will be required of the leaders of major funding and development agencies. Private foundations and development agencies which claim to be committed to ensuring better global health outcomes but fail to support efforts at transparency and accountability at WHO or which promote parallel agendas by using their financial clout are clearly not good partners in any effort by the Obama administration or the G20 to do good on global health governance.

FOSTERING MULTILATERALISM FOR GLOBAL HEALTH: DOING GOOD BY RETHINKING GOVERNANCE AT WHO

The globalization of health risks due to increased interconnectedness and transnational health threats such as Avian Flu, the impacts of climate change on health coupled with increased international trade in health products and services means that the world, more than ever before, requires coordinated multilateral action in the area of health. The proliferation of actors (nationally, regionally and internationally) in the health arena – from civil society organizations, patient and

industry groups to philathrocapitalists – pose important challenges for the efficient and effective governance of global health. Two main challenges arise – ensuring coordinated policy-making and directing financial resources to the areas of most need.

WHO touts itself as ”the directing and coordinating authority for health within the United Nations system.”[5] As such, WHO considers itself as being responsible “for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.” While WHO currently plays these roles, to some extent, alot more could be done to improve the performance of the organization and ensure it can respond adequately to global health challenges. In this context, the Obama administration and the G20 can do alot of good if they focus sufficient attention to rethinking the governance structure of the organization.

In rethinking the governance of WHO two main issues need to be addressed. First, financing of WHO and global health, taking into account the financial crisis. Second, the transparency and accountability of the WHO to the global community. The two issues need to be addressed in addition to the broader UN Reform which the Obama administration should support.

The WHO Medium-Term Strategic Plan for 2008 – 2013 and Program and Budget for 2008-2009 confirms that the assessed contributions by Member States to the budget of the organization are falling while voluntary contributions by donors and other entities are rising.[6] The increasing financial role of private foundations, such as the Bill and Melinda Gates Foundation, while generally welcome, raises important governance questions. To what extend are these entities shaping the priorities of the organization? Are these foundation’s priorities providing incentives for WHO and its departments or regional offices to work on certain areas or diseases as opposed to others? Does WHO have an adequate structure to tackle undue influence by these entities?

Reforming the WHO Executive Board

To ensure that donors and private foundations do not become the ultimate power centres in global health governance requires that the United States and other G20 countries work to increase their contribution to WHO and put in place structures that check against undue influence of private foundations and donors. Here one major change that can help a lot is to reform of the Executive Board of WHO.[7]

The idea that health technocrats are essentially the only people qualified “to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work” needs to be rethought. Interdisciplinary input would likely be the best way for the WHO to lead the world in addressing the challenges of global health in the 21st Century. Further, the pretension that the said 34 individuals (who make up the Executive Board) act in their personal capacities and are “objective” needs to be dropped once and for all.

To reform the current structure requires two broad changes. First, the composition and representation in the Executive Board as well as its functions need to change. Second, a new committee-based structure needs to be established to bring in the right expertise to address the substantive programmatic and policy issues.

In terms of the structure of the Executive Board one can contemplate a structure where the WHO Regional Committees [8] elect representatives answerable to the regions with their role limited to a certain set of executive functions. These functions would include programme development; administration, budget and finance; and audit functions.

Substantive issues would then be transferred to programme-based committees, to be established by the WHA, in which all WHO Member States and observers can participate. It is these committees that would address specific issues and propose actions by the WHA, including resolutions, as needed. These committees need not be permanent but could be established based on each five-year strategic plan. With such a structure, each Member State would determine the right expertise required for each committee. This means that if there is a malaria committee, for example, the countries would send malaria experts and so on.

Establishing A System of Observers at WHO

Every world citizen needs to have a say on how global health is governed. This is because each one of us is susceptible to transnational health risks which are not confined within our local areas or national boundaries. In order for WHO to continue to be the premier global institution for health, much more transparency and accountability is required of the organization to all stakeholders. The importance of this matter cannot be overemphasised, especially in the context of the increasing financial influence of private foundations. Here, the most important area where the Obama administration, the G20 and other key players can "do good" relates to reforming the structure of observership at WHO, that is the relations especially between WHO and public interest non-governmental organizations (NGOs).

WHO's principles and approach to its relations with NGOs is, simply put archaic.[9] In summary, WHO recognizes only one category of formal relations with NGOs, namely, official relations. To establish such official relations requires that:

- Contacts are first made between the NGO and the WHO Secretariat to "create mutual understanding and assist in developing mutual interests" through exchanges of information and reciprocal participation in technical meetings;
- Once a number of specific joint activities have been identified, collaboration may move to the stage of working relations through an exchange of letters between the NGO and the WHO Secretariat;

- Only after at least two years of working relations with the WHO Secretariat can an NGO apply to the Executive Board for official relations.

WHO's approach to relations with NGOs is archaic because it does not recognize the function of NGOs as watchdogs and advocates of alternative world views. In other words, it can be argued that WHO does not recognize the concept of "observers".

The WHO structure essentially means that the role of NGOs as independent observers is severely restricted since the organizations in official relations have to have agreed with the Secretariat on "mutual understanding and interests"! Contrast this approach, for example, to the approach of the World Intellectual Property Organization (WIPO), which deals with a much more obscure subject - intellectual property. WIPO's approach to observership is meant to ensure "the inclusion of stakeholder organizations and interest groups as observers at the formal meetings of Member States and to involve NGOs, IGOs, industry groups and all other stakeholders as widely as possible in consultation processes and debates about current issues."[10] Such a broader understanding of the role of stakeholders in both substantive issues and governance of WHO will be required going forward.

In concrete terms, this means that:

- The WHA should change the principles on NGO relations to recognize the concept of observers (as conceptualized by WIPO, for example) as opposed to the current concept of special relations which requires cozying up with the Secretariat for at least two years. The result would be that the WHA would establish basic requirements and rules about admission and all organizations that meet these requirements and comply with the rules would be entitled to admission without having to work or otherwise please the Secretariat.
- The WHA would decide on admission of observers to it and delegate the same power to the specialized committees.

OPPORTUNITIES "TO DO GOOD" ON GLOBAL HEALTH PRIORITIES

In addition to the governance reforms discussed in section 3, the Obama administration and the G20 can also 'do good' for global health in a number of priority areas. In particular, the approach to issues related to innovation and IP, sub-standard medicines and counterfeits, emergency preparedness and climate change will be critical.

Doing Good on Innovation, Health Research and Access to Medicines

The relationship between patents and access to essential medicines, especially in developing countries has been a point of major controversy in international IP policy-making. On the one hand, developing countries and health groups have argued against current approaches to patent rights in the pharmaceutical sector on the basis that the monopoly-based approach relies on

high medicines prices to be paid by everyone as funding for research and development (R&D). This approach puts these essentials out of the reach of those who need them most since the majority of the world population is poor.

On the other hand, developed countries, such as the US, have argued for stringent minimum rules on the basis that such protection was essential for innovation.[11] Without resorting to the name calling, intimidation or insults, in the way that certain industry lobbyists have done[12], a small but dedicated group of civil society organizations, academics and researchers decided to find a way in which the legitimate concerns of industry and innovative businesses regarding incentives and funding could be addressed while assuring access to essential medicines for all. It is through these efforts that we now have the WHO Global Strategy and Plan of Action on Public Health, Innovation and IP.[13] We now face the challenge of implementation and monitoring.

The Global Strategy "*aims to promote new thinking on innovation and access to medicines as well as … provide a medium-term framework for securing an enhanced and sustainable basis for needs driven essential health research and development relevant to diseases which disproportionately affect developing countries…*" To do good, the Obama administration and the G20 will have to do a number of things.

First, there is need to politically and financially support the implementation of the Strategy by providing the necessary resources to all the relevant stakeholders. This means that resources should not only be made available to WHO but also to other stakeholders including academic and research organizations as well as civil society organizations.

Second, the Obama administration and the rest of the G20 should insist that the expert group on financing comes up with workable solutions and not shortcuts.[14] Here the US, in particular, can do alot. This is because part of the reason why this issue has not been fully addressed relates to the fact that pharmaceutical industry groups, with the tacit support of the US government, have been hostile to the idea that there are alternative ways to provide incentives for innovation other than through IP protection. While the US should, of course, argue its case, there is reason to believe that a more honest debate can be encouraged if the right signals come from the US administration. Just as in the case of trying to address the financial crisis, sustainability of proposed solution is key and the Obama administration cannot go wrong by focusing on sustainability as the test to judge various proposals.

Finally, there is also a need to avoid a multiplicity of half-baked new initiatives and to promote transparency at the WHO. Since the adoption of the Global Strategy we have already seen a raft of new proposals which claim to seek to address issues of access but which fall far short of the sustainability test. While it is beyond the scope of this article to analyse each of these new initiatives one can point, for example, to the Barton/Pfizer proposal on a trade agreement to regulate national medicines pricing and reimbursement programmes.[15]

Overall, if WHO succeeds *in missing this opportunity* to address the 10/90 gap, the issues will come back again to occupy the international policy forums that could be utilised to address other issues. It must be remembered that

while we have known of the 10/90 gap for a long time the initiative to look for innovative solutions did not come from within the WHO Secretariat but rather through the efforts of civil society and NGOs, countries such as Kenya and Brazil, academics and researchers and a few funding agencies.

Doing Good on WHO's "Counterfeit Medicines" Agenda

There is increasing alarm regarding trade in, and the supply of sub-standard and deliberately or fraudulently mislabelled medicines. It is such medicine which WHO refers to as "counterfeit medicines".[16] Globally, however, while WHO has a working definition[17], there is no agreed definition of 'counterfeit medicines' among the WHO member states. This is problematic because in international law, there is an agreed definition of the term "counterfeit" as applied to trademark infringement.

In particular, under the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) counterfeit trademark goods are defined as "any goods, including packaging, bearing without authorization a trademark which is identical to the trademark validly registered in respect of such goods, or which cannot be distinguished in its essential aspects from such a trademark, and which thereby infringes the rights of the owner of the trademark in question under the law of the country of importation."

To address the "counterfeit medicines" problem WHO, in 2006, created a global coalition of stakeholders called IMPACT (International Medical Products Anti-Counterfeiting Taskforce).[18] At the 124th session of the WHO Executive Board in January 2009, the WHO Secretariat presented a report, based on the work of IMPACT, in which it proposed a draft resolution on the subject.[19] The discussion on the report and draft resolution was, however, marred by controversy leading to the withdrawal of the draft resolution. The main controversy relates to the conflation of substandard and deliberately or fraudulently labelled medicinal products, which is the problem WHO should be addressing, with issues related to enforcement of trademarks and other IP rights, which are trade issues.[20]

In this area, the Obama administration and G20 can "do good" by:

- Refocusing attention on the health impacts of sub-standard and deliberately or fraudulently mislabelled medicines and away from IP rights issues; and
- Stopping the cynicism and hypocrisy in terms of trying to attain trade objectives (IP rights enforcement) by claiming to be interested in saving African children dying from "counterfeits."

This applies both in the context of the WHO IMPACT programme as well as in the context of broader IP rights enforcement initiatives where there is increasing use of public health claims to attain trade objectives in IP rights enforcement.

Doing Good to Address the Impacts of Climate Change on Health

The Intergovernmental Panel on Climate Change (IPCC) has highlighted a range of health impacts as a result of climate change.[21] Indeed, climate change impacts on human health are already a reality. According to WHO "Climate change is a significant and emerging threat to public health, and changes the way we must look at protecting vulnerable populations."[22] This means that climate change is likely to significantly erode the gains that have been made in ensuring the promotion and protection of the right to health especially in developing countries.

The Obama administration, in particular, can do a lot of good in this area in two main ways. First, every effort must be made to ensure that the Copenhagen process results into a viable agreement to replace the Kyoto Protocol. The Obama administration has committed to making the United States a leader on climate change. [23] This is an important reversal of the Bush administration's obstructionist policy. This commitment needs to be followed by action. At the second level, the Obama administration can "do good" for global health by supporting a robust climate change and health programme at WHO.

Doing Good to Ensure Global Preparedness to Tackle Epidemics and Pandemics

In today's globalized world, interconnected by trade and a range of other webs, the spectre of global epidemics and pandemics is very real. The outbreaks of SARS, the Avian Flu and most recently Influenza A(H1N1) have already demonstrated the dangers. WHO correctly argues that, "The world requires a global system that can rapidly identify and contain public health emergencies and reduce unneeded panic and disruption of trade, travel and society in general." For the world to have such a system, however, the global community needs to have confidence in international institutions. In particular, WHO needs to inspire confidence in this area.

Unfortunately, the handling by WHO of issues around the sharing of Avian influenza virus and related patent and vaccine accessibility issues has dented the confidence of many developing countries in a fair global system.[24] The Obama administration and other G20 countries can "do good" in this area by speeding up the resolution of the pending issues on virus sharing and vaccine availability to inspire the necessary confidence in the a global system to deal with such translational health risks.

The are a number of key issues which have been brought up by developing countries with respect to the Avian influenza virus sharing system run by the WHO. These include that:

- There is inequity between developed and developing countries in terms of access to vaccines due to the cost and limited manufacturing capacity. It is argued that developed countries knowing the limited manufacturing capacity, have stockpiled and placed advanced order for the vaccines in case of a pandemic leaving developing countries exposed.

- Though the human viruses needed for R&D for vaccines come predominantly from developing countries, such as Indonesia, there is no system of benefit-sharing when the results of the R&D are commecialised.
- The WHO Global Influenza Surveillance Network (GISN) centres, which are based in developed countries, such as the UK and US, have, in contravention of WHO guidelines, passed on viruses received from developing countries to third parties including pharmaceutical companies, which, in turn, have patented and commercialised the resulting vaccines without the knowledge or permission of the virus contributing countries.

To address these problems, developing countries led by Indonesia, have proposed new WHO guidelines which would, among other things:

- Restrict virus recipient from seeking or asserting IP over the viruses or any derived substances;
- Require the placing of the gene sequences of the viruses in databases on which would be attached fair and equitable benefit sharing conditions;
- Require developed country vaccine manufacturers to grant non-exclusive, royalty-free licenses to developing country manufacturers;
- Require provision of access and transfer of technology; and
- Require the setting aside of a certain level of vaccines for developing countries through an international stockpile maintained by WHO.

These demands have so far not been met, in part, due to resistance to accepting the terms and conditions related to benefit-sharing and restrictions on IP by countries such as the US. The US in these and other related negotiations, such as the negotiations on the relationship between the Convention on Biological Diversity (CBD) and the WTO TRIPS Agreement, maintains that the issues related to benefit-sharing should be left to contracts while patent should not be restricted since IP acquisition is indispensable in supporting R&D.

CONCLUSION

The Obama administration and the G20 have a range of opportunities to "do good" for global health governance. To succeed in doing good will require credible leadership not only at the top but within the ranks in the United States and in the other G20 countries. Success will also, however, depend on leadership by the Director-General of WHO. Change, at least in part, can come to the handling of global health if the Obama administration and other G20 countries focus attention on reforming and improving the governance of WHO and addressing the priority global health issues highlighted in this article.

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[1] The WHO Constitution came into force on 7 April 1948, the day that is celebrated as the World Health Day, leading to the formal establishment of the organization.
[2] The Declaration of Alma-Ata was adopted at the International Conference on Primary Healthcare which took place in Alma-Ata in the USSR from 6 – 12 September 1978.
[3] The Global Strategy is contained in WHO Resolution WHA61.21 (available at http://www.who.int/gb/ebwha/pdf_files/A61/A61_R21-en.pdf). The Global Strategy aims to: "Promote new thinking on innovation and access to medicines and to provide a medium-term framework for securing an enhanced and sustainable basis for needs driven essential health research relevant to diseases which disproportionately affect developing countries."
[4] The concept of essential medicines can be traced back to 1977 when a WHO expert panel assembled the first model list of essential medicines. For details about the concept and its evolution see the WHO website at http://www.who.int/features/factfiles/essential_medicines/en/index.html (last accessed on 14 March 2009).
[5] See the "About" page of the WHO website at http://www.who.int/about/en/ (last accessed on 14 March 2009).
[6] The Strategic Plan and Budget document is available on the WHO website at http://www.who.int/gb/e/e_amtsp.html (last accessed on 15 March 2009).
[7] The Executive Board of WHO is made up of 34 individuals "technically qualified in the field of health" each of whom is designated by a Member State elected by the WHA. Further information on the Executive Board can be found on the WHO website at http://www.who.int/governance/eb/en/index.html (last accessed on 14 March 2009).
[8] WHO has six regional committees: The African Regional Committee; the Regional Committee for the Americas; the Regional Committee for Eastern Mediterranean; the Regional Committee for Europe; the Regional Committee for South East Asia; and the Regional Committee for Western Pacific.
[9] See the WHO "Principles Governing Relations between the World Health Organization and Nongovernmental organizations. Available at http://www.who.int/gb/bd/PDF/bd46/e-bd46_p5.pdf (last accessed on 14 March 2009).
[10] See WIPO's observers page at http://www.wipo.int/members/en/admission/observers.html (last accessed on 14 March 2009).
[11] For detailed discussions see, for example, Sisule Musungu "The TRIPS Agreement and Public Health" in Carlos Correa and Abdulgawi Yusuf, eds., *Intellectual Property and International Trade: The TRIPS Agreement,* 2nd Edition (The Netherlands: Kluwer Law International, 2008) and "Benchmarking Progress in Tackling the Challenges of Intellectual Property, and Access to Medicines in Developing Countries", *Bulletin of the World Health Organisation* 84, no. 5 (2006): 366-369.
[12] See e.g., the op-ed of Tom Giovanetti in the *Washington Times* on the WIPO Development Agenda at http://washingtontimes.com/news/2004/oct/13/20041013-091045-3952r/ (last accessed on 15 March 2009).
[13] WHO Resolution WHA61.21 (available at http://www.who.int/gb/ebwha/pdf_files/A61/A61_R21-en.pdf).
[14] The expert working group was established under the Global Strategy "to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases". See paragraph 4(7) of Resolution, WHO Resolution WHA61.21.
[15] See a discussion on the proposal and a copy of the letter by Barton and Pfizer CEO to Senator Baucus at http://www.wcl.american.edu/pijip/go/barton (last accessed on 3 April 2009).

[16] See WHO's website at http://www.who.int/medicines/services/counterfeit/overview/en/ (last accessed on 15 March 2009) on counterfeits.
[17] WHO definition is that "A counterfeit medicine is one which is deliberately and fraudulently mislabeled with respect to identity and/or source. Counterfeiting can apply to both branded and generic products and counterfeit products may include products with the correct ingredients or with the wrong ingredients, without active ingredients, with insufficient active ingredients or with fake packaging."
[18] Details on IMPACT can be found on the WHO website at http://www.who.int/impact/en/ (last accessed on 15 March 2009).
[19] The report and draft resolution are available at http://www.who.int/gb/ebwha/pdf_files/EB124/B124_14-en.pdf (last accessed on 15 March 2009).
[20] For a discussion on the controversy see e.g., ICTSD, "WHO Executive Board Grapples with IP Issues", *Bridges Weekly Trade News Digest* 13, no. 3 (2009). Available at http://ictsd.net/i/news/bridgesweekly/38853/ (last accessed on 14 March 2009).
[21] For a discussion see the IPCC fourth Assessment Report, *Climate Change 2007: Synthesis Report* (Geneva: IPCC, 2007), 48.
[22] See the WHO webpage on Climate Change and Health (http://www.who.int/globalchange/climate/en/).
[23] See the White House webpage on energy and environment at http://www.whitehouse.gov/agenda/energy_and_environment/ (last accessed on 15 March 2009).
[24] For a discussion of some of the issues that have been raised by developing countries see e.g., Martin Khor and Sangeeta Shashikant, "Sharing of Avian Flu Virus to be a Major Issue at WHA", Third World Network. Available at http://www.twnside.org.sg/title2/avian.flu/news.stories/afns.003.htm (last accessed on 15 March 2009).