

HOUSE OF LORDS

Select Committee on Intergovernmental Organisations

1st Report of Session 2007–08

**Diseases Know No
Frontiers: How effective
are Intergovernmental
Organisations in
controlling their
spread?**

Volume I: Report

Ordered to be printed 7 July 2008 and published 21 July 2008

Published by the Authority of the House of Lords

London : The Stationery Office Limited
£price

HL Paper 143–I

The Intergovernmental Organisations Committee

The Intergovernmental Organisations Committee was appointed by the House of Lords in November 2007 with the orders of reference “to consider how contemporary issues of international policy are addressed through United Kingdom membership of intergovernmental organisations (excluding the European Union), including their impact and value for money”.

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NOTE:

(Q) refers to a question in oral evidence

(p) refers to a page of written evidence

The Report of the Committee is published in Volume I, HL Paper 143–I.
The Evidence of the Committee is published in Volume II, HL Paper 143–II.

FOREWORD—What this report is about

We were appointed in November 2007 as a new ad hoc Select Committee of the House of Lords to review the effectiveness with which intergovernmental organisations (IGOs) are operating in specific fields and how the UK is making use of its membership of those organisations to ensure that their objectives are being met. For our first inquiry we have examined how IGOs are tackling the global spread of infectious diseases.

The twentieth century witnessed remarkable advances in many parts of the world in standards of public health and in the conquest of killer diseases, such as smallpox and poliomyelitis. However, during the second half of the century the advent of globalisation (in particular, increased international trade and travel) and changes in human lifestyles (for example, greater human-animal contact) have enabled new infections to emerge and to spread much more rapidly around the world. The onset of HIV in the 1980s and the outbreaks of SARS and avian influenza in the 1990s are striking, but by no means the only, examples. On average, a previously unknown infectious pathogen emerges somewhere every year. At the same time a number of infectious diseases, including some—such as tuberculosis and malaria—which were previously close to eradication, have developed resistance to antibiotics and in their resistant form they are much more difficult to treat. These problems cannot be tackled solely by States within their own borders: effective intergovernmental action is needed.

In recent years there has been a substantial and welcome upsurge in funding for infectious disease control from governmental, intergovernmental, charitable and private sources. At the same time, however, there has been a significant increase in the number of organisations involved, with the result that the landscape of international health has become, in the Government's words, "crowded and poorly coordinated". We have taken evidence from many of these organisations, and it is clear to us that, while there is an urgent need for rationalisation of effort, it is unrealistic to think in terms of imposing coordinating structures from above. The process has to be evolutionary rather than revolutionary, but it needs leadership. There is no doubt in our mind, and in the minds of most of those from whom we have taken evidence, that that leadership function must rest with the World Health Organisation (WHO) and that, given appropriate strengthening of its management arrangements, WHO's remit and resources should be developed in order to encourage and support collaboration and rationalisation among the many actors on the international health stage.

Many of the new initiatives for tackling the spread of diseases are vertically-based—meaning that they are targeted at combating specific diseases, or groups of diseases, rather than improving the quality and quantity of health systems generally (the horizontal axis). While vertical disease-control campaigns are necessary to bring serious outbreaks of disease (such as HIV, malaria and tuberculosis) under control, they are likely to prove unsustainable without parallel investment in horizontal health care structures. Vertical campaigns may have the side-effect of strengthening general health services, but conversely the recruitment of health care staff in developing countries to fight specific diseases can denude basic health services of the doctors and nurses they need to fulfil their normal functions. There is therefore a need for vertical campaigns to be structured and managed in such a way that they complement essential strengthening of horizontal infrastructures. The need for more horizontal investment is particularly acute in the area of infectious disease surveillance. Though Britain and many other countries have effective surveillance systems and though WHO operates a competent international surveillance network, many developing countries are seriously deficient in this respect. On the basis that a chain is as strong as its weakest link, there is a need to direct greater investment into this vital area of global disease control.

Similarly, there has been a tendency in recent years to focus more on the treatment of infectious diseases and less on their prevention. Such an imbalance of investment is not only not cost-effective: it can be counterproductive. For example, while the provision of antiretroviral drugs has done much to preserve the lives of HIV sufferers, by this very fact it risks increasing the incidence of the disease unless it goes hand in hand with effective prevention measures. We consider that the Government should use its influence within the relevant IGOs to achieve some rebalancing of investment.

A number of other issues have come to our attention where we consider that action is needed. One of them concerns the close linkage between human and animal diseases. We have been told that three out of four new emerging infections in humans have come from animals. Yet there is little coordination between the intergovernmental systems for conducting surveillance of human and animal diseases, to the point where, as has been shown in the case of avian influenza, we are all too often failing to pick up animal infections until they have jumped the species barrier to humans. There is a need for better coordination here at the intergovernmental level.

The UK is a highly-respected player in the field of international health by reason of its sound policies, its high technical expertise and its commitment of money and staff. The Government is developing a Global Health Strategy involving all Whitehall departments with an interest under the leadership of the Department of Health. While we commend this imaginative initiative, we hope the Government will give due weight, in regard to leadership issues, to the expertise, resources and experience of the Department for International Development and the Foreign and Commonwealth Office in addressing the international dimensions of the Strategy.

We feel it appropriate to conclude on a sobering note. We have been told that an influenza pandemic is overdue and that, when (rather than if) it comes, the effects could be devastating, particularly if the strain of the virus should be of the H5N1 variety that has been seen in South East Asia in recent years. While much progress has been made in the last ten years in improving global surveillance and response systems, much remains to be done if we are to detect new strains of the virus and counter them before they have had the chance to spread. That requires more intergovernmental investment in potential source countries in surveillance programmes. This is unlikely to hit the headlines and its impact may not be immediately apparent, but it is vital to us all.

Diseases Know No Frontiers: How effective are Intergovernmental Organisations in controlling their spread?

CHAPTER 1: INTRODUCTION

1. We were appointed by the House for the 2007–08 session of Parliament “to consider how contemporary issues of international policy are addressed through United Kingdom membership of intergovernmental organisations (excluding the European Union), including their impact and effectiveness and value for money”.

Defining Our Role

2. The European Union (EU) was excluded from our terms of reference because the House already has a European Union Committee. What this exclusion precludes is an in-depth examination by us of EU activity in a given field. It does not, however, preclude exploration of the boundary line between EU and other intergovernmental activity: indeed, it is essential to our task of examining action by non-EU intergovernmental organisations that we should look at how such action fits together with what is being done under the auspices of the EU.
3. We also recognised at the outset that our focus was to be on *intergovernmental* organisations (IGOs) rather than on international ones. The distinction is important. There is a wide range of organisations (for example, OXFAM, *Médecins Sans Frontières* or the International HIV/AIDS Alliance) whose activities are international in character. IGOs, on the other hand, are organisations (such as the United Nations, OECD or NATO) whose members are national governments. Even here, however, there are distinctions to be drawn, in particular between intergovernmental action, when a number of governments agree to collaborate for a common purpose, and action by intergovernmental organisations, where a recognised IGO acts in the name of and on behalf of all its Member States. Our focus is on the latter.
4. We interpret our role as being to examine how the British Government is making use of its membership of such organisations in order to achieve objectives which meet both UK interests and those of the international community generally. In order to be able to address this question we have found it necessary to examine the effectiveness of the IGOs themselves and the way they function. But it is important to recognise that in doing so our primary objective has not been to attempt to audit the performance of the organisations but to reach a view of how effectively UK influence is being brought to bear within them and whether appropriate value for money is being obtained.

5. We acknowledge that in the post-Cold War world there is much discussion about the need to reform IGOs. Structural reform of IGOs is, of course, the responsibility of the governments who are their members, but in much of the writing about this problem there is a wide recognition that creating new ways of working within and between existing IGOs can be an important part of the reform process. Indeed it has been pointed out to us that creating and developing networks between existing IGOs and NGOs is a useful way of getting international support for them. The British Government is a major participant in these organisations and the Government's policy can have an effect greater than the financial input alone, although that is also very significant.

Choosing Our Inquiry

6. We considered a number of areas of IGO activity which would be suitable for inquiry, including Peacekeeping, Human Trafficking, Disarmament and Controlling the Proliferation of Weapons of Mass Destruction. One subject, however, commanded clear support as deserving a clear-cutting and urgent inquiry—namely, controlling the global spread of infectious diseases.
7. It was once thought that, with rapid advances in medical science, the twentieth century had seen the main killer diseases—such as smallpox, poliomyelitis, tuberculosis and malaria—brought under control. That is not, however, what health or national security experts now think. Medical science has indeed advanced, but lifestyles have changed substantially and sometimes in a way that threatens to undermine its achievements. During the last 50 years trade and travel between nations have increased at a considerable rate—the number of international tourist journeys alone rose from 25 million in 1950 to over 800 million in 2005, while world trade has grown more than 20-fold over the same period. As a result infections which were once limited to specific parts of the globe are now able to spread more easily and rapidly to others, often before we are aware of their potential. Within many poorer countries there has been substantial urbanisation, which obliges millions of people to live together in close proximity and often poor conditions of hygiene and which creates a fertile ground for the spread of infectious diseases. There have also been significant changes in agricultural practices and ecology generally, not to mention changes in climatic conditions.
8. There is also increasing evidence that a number of killer diseases, including tuberculosis and malaria, are becoming resistant to once-effective antibiotics. And, of course, there are new and deadly infections emerging. Though most publicity has been given to the Human Immuno-deficiency Virus (HIV), which if uncontrolled often results in the lethal disease of AIDS, there are many others, including SARS (Severe Acute Respiratory Syndrome), ebola and avian influenza, which, unlike HIV/AIDS, have the potential to cause rapid and devastating sickness and death across much of the world if they are not detected and checked in time.
9. For these reasons we decided as a committee that our first priority should be to examine the action which is being taken through IGOs to control the global spread of communicable diseases. We were agreed, however, that we should not look at intergovernmental management in a vacuum but that it would be helpful if we could relate what was being done to certain specific diseases. This, we hoped, might provide us with working illustrations of the problems which the relevant IGOs are facing and of good and bad practice in

dealing with them. The diseases we selected are all highly infectious and all pose serious problems for global health if not controlled. They do however differ from each other in some important aspects and thereby furnish examples of different issues.

10. **HIV** is an infection which was recognised in the 1980s and has spread globally since then. In 2007 some 33 million people were estimated to be living with HIV. During the same year 2.5 million people became newly infected and 2.1 million people died of AIDS. HIV is an infection which, though concentrated mainly in sub-Saharan Africa and parts of Asia, has spread worldwide. But, unlike the other three infections on which we have focused, its spread is largely attributable to lifestyle factors, in particular sexual behaviour. There is as yet no cure or vaccine, though antiretroviral (ARV) drugs have proved to be effective in retarding the onset of AIDS and thereby prolonging the lives of those infected.
11. **Pandemic influenza** might be said to be at the opposite end of the spectrum. At the time of going to press, there has been no recent outbreak of pandemic influenza reported. Historically, however, such outbreaks have occurred on average three times every century, and the last outbreak was in 1968. The last two pandemics (1958 and 1968) were caused by relatively mild strains of the virus, but the next one could have more serious consequences, especially if it should come in the form of a virus, such as the H5N1 variety, which is common in birds and poultry, which has already jumped the species barrier to infect humans and which might at some point in the near future become capable of human-to-human transmission. The Government's evidence to us on this was sobering:

“While there has not been a pandemic since 1968, another one is inevitable, whether or not it arises from H5N1. Estimates are that the next pandemic will kill between 2 million and 50 million people worldwide and between 50,000 and 75,000 in the UK. Socio-economic disruption will be massive” (p 2).

In other words, we have in pandemic flu an infection which is not yet with us but which, when it arrives, is likely to have a devastating, if relatively short-lived, impact.
12. **Tuberculosis (TB)** and **malaria** might be said to fall within these two extremes. Here we have infectious diseases which have been around for centuries, and steady progress was being made until about 30 years ago towards eradicating them. In both cases effective antibiotics had been found and, in the case of malaria, house-spraying with DDT was proving effective in controlling the mosquitoes which spread the disease. In both cases, however, the disease has begun to develop resistance to conventional antibiotics and there has been some fall-away in DDT spraying as a result of fears of side-effects for human health and the environment. In addition, the rise of HIV has had a considerable impact on the incidence of TB, which is present harmlessly in a large proportion of the world's population but is able to develop into pathogenic form where natural immunity to infection has been compromised. According to the London School of Hygiene and Tropical Medicine, TB is the most common cause of death in people infected with HIV.
13. In selecting these four diseases, therefore, as illustrations of intergovernmental health management we have attempted to cover a

spectrum of disease types. There are, we recognise, many other serious infections, including ebola, SARS, pneumococcal disease and leprosy, and our choice does not imply that there is not a need for concerted intergovernmental action to deal with them. The ones we have selected are intended simply as working examples of how IGOs are going about their task.

Acknowledgements

14. Our Call for Evidence, which was issued on 10 December 2007, is shown at Appendix 2. In response we received 56 submissions of written evidence, and we subsequently took oral evidence, in London, Geneva and Paris, from 34 persons or organisations. Volume II of this report shows all the evidence received, both written and oral. We would like to thank all those who assisted us in this way: without their help our inquiry could not have been carried out.

CHAPTER 2: INFECTIOUS DISEASES

15. This inquiry is about how Intergovernmental Organisations (IGOs) are tackling the spread of infectious diseases. However, before examining the IGOs themselves it is necessary to consider some important aspects of disease control. Infectious diseases cannot be considered in isolation from the world in which they occur and spread, and their control is a multi-faceted process which goes far beyond the popular image of doctors giving injections or pills to sick people. In this chapter therefore we address some of the key factors influencing the spread and control of infectious diseases.

The Wider Picture

16. In 2000 the United Nations adopted 8 Millennium Development Goals (MDGs) for achievement by 2015, and at the UN Summit in September 2005 these goals were re-affirmed. Three of these—reducing childhood mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases—are focused on health. The remaining five, however, which include eradicating extreme poverty and hunger, achieving universal primary education and promoting gender equality, address conditions which have an important bearing on improving health and combating the spread of infectious disease, just as improving health care will have an important impact on them.

Poverty

17. Professor David Harper, Director-General of Health Improvement and Protection at the UK Department of Health, told us that there was a recognition that, “in order to make improvements in the health area, whether nationally or internationally, very often the key players are outside the health sector” (Q 11). All those who gave evidence to us were agreed that there was a particularly close link between disease and poverty. The World Health Organisation (WHO) told us that its experience and that of its partners “has reinforced the lesson learnt on how poverty breeds HIV, TB and malaria and how they lead to further impoverishment of families, as well as how disease control efforts can dovetail with poverty alleviation and human rights initiatives”(p 205). Professor Janet Hemingway, of the Liverpool School of Tropical Medicine, was more forthright:

“Health benefits go hand in hand with economic development: there is no question about that ... Unless there is something that tackles poverty alongside health systems, you are fighting a losing battle in many ways. Somehow you need to think, not just of health in its own silo, but ask what it is, for the region or for the country, that is going to give it the economic benefit that goes hand in hand with the health improvements that you are trying to put in. If you can tie those together, you can get something that is sustainable” (Q 115).

18. The socio-economic drivers vary from one infectious disease to another. The Royal College of Physicians summed it up this way:

“Tuberculosis is closely linked to poverty and social crowding. Influenza is affected by lifestyle, social crowding, sharing space with animal reservoirs and international travel. Malaria is predominantly related to

lifestyle and changes in land use, and HIV is related to lifestyle and poverty” (p 127).

Dr Nils Billo, Executive Secretary of the International Union Against TB and Lung Diseases, explained the connection between tuberculosis and poverty in practical terms:

“TB is a disease of the poor and marginalised. It is very difficult to get these people to the treatment centres. Their first worry is not the disease, it is getting food for their families, so the last thing they do when they are almost dead is they go to get treated ... There needs to be a holistic approach” (Q 1072).

Population Growth

19. One of the main causes of poverty is increasing population levels. Global population growth over the last 50 years has been dramatic, rising from 2.5 billion in 1950 to 6 billion at the end of the 20th century. The numbers are continuing to rise and, on present estimates, the world’s population will reach over 9 billion by 2050. These overall figures, however, mask differing regional trends. The UN Population Division has estimated that between 2000 and 2050, while the population of Europe will decline by some 14%, that of other regions will increase—in some cases substantially. It is estimated that by 2050 the population of North America will have increased by 28%, that of Asia by 45% and that of Latin America and the Caribbean by 58%. Over the same period the population of Africa is forecast to grow by 130%¹.
20. Population growth has resulted, to a large extent, from overall improvements during the second half of the twentieth century in global health standards, which in turn have stemmed from improvements in public health generally and from advances in medical science which have made possible the control—and in some cases (for example, smallpox) eradication—of serious infectious diseases. Population growth is now, however, itself threatening global health by creating conditions, such as urbanisation and overcrowding, where infectious diseases can spread more easily, especially where basic public health services, such as clean water and sanitation, are not available. In some parts of the world rising populations are also leading to increasing encroachment on previously uninhabited areas of land, both for agriculture and habitation, and thereby bringing humans into closer contact with wild animals and exposing them to pathogens to which they have no immunity and which can jump the species barrier and infect them with previously unknown illnesses. It is no exaggeration to say that a continuance of present rates of population increase threatens the achievement of most, if not all, the MDGs.

Governance

21. Another cause of poverty and disease is the absence, in many developing countries, of sound governance. There was concern among those who gave evidence to us about the extent to which the substantial resources which were being provided to developing countries, whether to reduce poverty or improve health services, were reaching their intended recipients. Professor Gill Walt, Professor of International Health Policy at the London

¹ United Nations Population Division, *The World at Six Billion*, (New York, UN, 1999), Pages 5–6

School of Hygiene and Tropical Medicine, believed that there was a need to invest some global health funding in the development of good governance in the countries who are recipients of external aid. “We need to feel confident”, she told us, “that we have managerial and financial capacity in the countries” (Q 95). Professor Neil Ferguson, of Imperial College London, endorsed this view. “Quite often”, he told us, “it is a failure of governments in the countries concerned. They are simply failed states and it is very difficult to operate in that backdrop” (Q 236). Dr Billo told us that “we make a big mistake by saying we do not have the technology, we do not have the science; we have the science and we have the technology but what is lacking is the management. In many countries basic management is deficient” (Q 1071).

22. Other witnesses drew our attention to another aspect of the governance problem—namely, a tendency in some developing countries to compartmentalised planning and management of resources. Professor Sir Michael Marmot, from University College London, who chairs the World Health Organisation’s Commission on Social Determinants of Health, posed the question:

“What is the role of the Minister of Health ... if you argue that the key drivers of health lie outside the healthcare system? The levers which the Secretary of State can reach are all within the healthcare system, so those are the ones for which he tends to reach, but the main drivers are elsewhere” (Q 224)

Dr Imelda Bates, from the Royal College of Pathologists, agreed. Commenting on the absence of joined-up government in many developing countries, she told us:

“On the ground, in the villages, people are doing these things all the time as an integrated thing. It is not really formalised. At ministry level, it is really difficult to get the ministry of education to talk to the ministry of finance to talk to the ministry of health” (Q 307)

23. The British Government recognises the governance problem. We were told that its provision of international development funding was tailored according to the perceived competence of the recipient country to manage it. Dr Stewart Tyson, from the Department for International Development (DFID), told us that, “where we have grave concerns about governance and accountability, we would use project approaches ... As things developed, we would try to put in place a mixture of approaches” (Q 27).

Globalisation

24. There was general agreement among our witnesses that the expansion of international travel and trade which has taken place during the last 30 or 40 years had tended to promote economic development and thereby provide a sounder basis for the building of stronger health care systems, which in turn provide a necessary foundation for the control of infectious diseases. On the other hand, as we have remarked above, both these phenomena have involved significantly greater movement of people and goods between countries, which makes the global spread of disease easier. The movement of animals, we were told, could be a particular hazard. According to the UN Food and Agriculture Organisation:

“Globalisation and intensification of agricultural production systems and the international movement of animals, animal-derived products and

associated commodities have the potential to rapidly spread a disease that originates in one location across the globe ... Much of the spread of HPAI [highly pathogenic avian influenza] can be attributed to trade in poultry and poultry products, particularly the informal trade” (p 475).

25. Dr Richard Coker, of the London School of Hygiene and Tropical Medicine, agreed:

“Over the last 20 years most [emerging diseases] have come from animals. They have come from animals either because of the movement of animals or because of the differences in how we look after our animals. With BSE, with SARS, with pandemic influenza, the driving force is the economy. That is what drives our changes in practice and the movement of goods. That is what threatens public health” (Q 127).

Education

26. There was general agreement among those who gave evidence to us that, among the various social determinants of infectious disease control, education and training had a key role to play. Professor Ann Johnson of University College London (UCL), told us:

“If one takes the view, which I do, that primary health care and health systems are important for the long-term sustainability of these programmes and the developing world, then you have to have a strong education infrastructure ... If they have education, so employment follows, so greater prosperity follows, child development improves, nations improve their overall wealth ... You cannot have doctors and nurses without a sustainable infrastructure in the education sector” (Q 225)

27. The lessons to be drawn from all this are clear enough. Just as we cannot seriously address disease control outside the context of general health care standards (see below), so it is not sensible to consider how health can be improved in isolation from general social and economic well-being. Many of the countries which are the sources of serious infectious diseases and where these infections are difficult to control have suffered, and in some cases are still suffering, severe social and economic dislocation as a result of war and civil conflict, migration, political instability, and, more recently, climate change. Attempts to improve health services and to control infectious diseases will be effective only if determined action is taken in parallel to address these wider issues.
28. **We therefore recommend that at the High Level meeting called by the UN Secretary-General for September 2008 the Government not only re-affirm the MDGs but give a lead in ensuring that adequate resources are committed and targeted in particular on those areas where progress is lagging (including health).**
29. **We recommend also that the Government support and contribute to an increase in resources being allocated to family planning throughout the developing world and back other consensual programmes designed to slow world population growth.**

Horizontal and Vertical

30. A recurrent theme in the evidence we have taken is the linkage between control of infectious diseases and the state of local health infrastructures. This was referred to by Dr Tyson, from DFID, as “a critical issue whose time has come, this focus on building health systems for the longer term or focusing on short-term deliverables against specific diseases” (Q 21). We were told, however, that a large proportion of donor funding for disease control in developing countries went into what are known as ‘vertical’ programmes—that is to say, programmes designed to target specific diseases—rather than into the ‘horizontal’ strengthening of general health systems. Vertical disease-control programmes have many strengths. They are able to focus resources on health issues of serious concern and to produce easily measurable results. There is, however, a downside. Dr Tyson described it this way in relation to PEPFAR—the US President’s Emergency Plan for AIDS Relief:

“In Zambia PEPFAR works through contracting NGOs, gives them short-term targets and very rounded targets. They have to get so many people on treatment by the end of Year Two, Year Three, Year Four. How do they do it? They put an advert in the paper in Lusaka and they hire 400 health workers. Where do they take them from? They move them from one part of the health system, where they are delivering children and providing general health services looking after kids, to work just on AIDS. This is a no-win/no-win situation; it is robbing Peter to pay Paul” (Q 21).

31. Others endorsed the importance of an adequate supply of health care workers. Dr Julian Lob-Levyt, Executive Secretary of the Global Alliance for Vaccines and Immunisation (GAVI), referred to shortages of doctors, nurses, paramedics and community health workers as “the biggest challenge for sub-Saharan Africa” (Q 812). Dr Stefano Lazzari, Senior Health Adviser at the Global Fund to fight AIDS, Tuberculosis and Malaria, told us that “there are very few qualified health workers in many poor countries and those who are good and qualified often migrate to better places, including the UK” (Q 620).
32. Others drew attention to problems of sustainability. While a concentrated focus of resources on tackling specific diseases can make a considerable difference to alleviating the burden of those diseases, whether such efforts are sustainable into the longer term depends on the degree to which they are embedded in local health services, which in turn depends on how the programmes in question are carried out. Dr Coker recounted an example from his own experience:

“We were working in Russia, in the prisons and in the civil sector, on TB control, Multi-Resistant TB control and HIV control. What we did was to implement the WHO vertical DOTS² programme, which was probably unsustainable once funding had been removed because it was not integrated into the broader health system” (Q 96).

Dr Coker continued:

² Directly-Observed Therapy Short-Course, a WHO-sponsored TB control programme directed at ensuring that anti-tuberculosis drugs are taken regularly in order to ensure that the disease does not recur in antibiotic-resistant form.

“An NGO³ was working there and the NGO had brought in its own doctors, its own laboratories, expensive systems and set up a completely parallel system to the Russian system which was costing huge amounts and was clearly going to be unsustainable” (Q 108).

33. Apart from these considerations, dealing with infectious diseases in watertight compartments can sometimes lead to unsound clinical practice. Dr Christopher Conlon, from the Royal College of Physicians, took the view, based on his experience of working with HIV-related illness in Zambia, that “in practice you cannot separate different diseases because they interact. HIV and TB is a good example ... many people come into hospital with fever in the tropics and they call it malaria, but actually they have HIV or TB or something else” (Q 284).
34. The evidence we received on this issue was, however, far from being all in one direction. A number of our witnesses pointed to strengthening effects which vertical disease control programmes can have on general health care services. Dr Paul Gully, from WHO, argued that, “if one can reduce the burden of important disease—HIV, TB, malaria, meningitis, yellow fever—then, in fact, one is reducing the burden on a health system which then has greater ability to deal with other things” (Q 523). Diana Weil, of the Stop TB Partnership, told us that “in TB at the service level many people work on multiple diseases, so if you can invest in building that capacity or expanding the number of community health workers, then that will have a follow-on effect for other diseases” (Q 720). Ms Weil also pointed to dangers inherent in focusing external aid on health care infrastructure. “Most governments”, she told us, “do not have very specific national health plans ... What you could be funding is just the old practice of over-funding of hospitals, not enough financing of primary care, no clear deliverables” (Q 749).
35. All those who gave evidence to us were clear that it is not a question of vertical *or* horizontal disease control. Dr Tyson told us that “there is a lot of talk about whether we need vertical approaches or whether we need horizontal approaches. We need both. We need to be building the long-term system to deliver ... against the future challenges as well as the current ones, and we need the benefits of short-term targeted investment” (Q 21). Alastair Burt, Chief Executive of Target TB, endorsed this view. “We need a combination of the two”, he told us. “We need good vertical health systems. We need the specialist inputs, but they have to be embedded within a good horizontal system” (Q 483). Dr David Heymann, Assistant Director-General at the WHO, believed that, “vertical programmes, if they are implemented properly, will end up in a strengthening of the health system” (Q 506). Dr Lazarri suggested that “what you want to avoid are the two extremes, programmes which are too vertical, that are not sustainable in the long term or very hard to sustain—and we have had plenty of experience of those—as well as programmes that are so broad but lacking focus and concrete results, that become difficult to sustain in the sense that you do not get the required investment” (Q 621).
36. Professor Marmot believed the tide might be turning:

³ Non-Government Organisation

“The whole idea of developing a health system just foundered after 1978⁴. We have had the vertical programmes but there has been almost nothing else, and at long last WHO is re-discovering the importance of primary healthcare ... The only game in town has been vertical programmes, and we need to re-discover how important health systems, primary healthcare, must be to make vertical programmes work better” (Q 221)

Professor Johnson told us that “people are now talking, to some extent, about diagonal programmes—that is, of course, trying to invest in vertical programmes but making sure that they interface with horizontal programmes” (Q 220). Dr Sylvia Meek, Technical Director of the Malaria Consortium, was cautiously optimistic. She told us:

“The disease control initiatives are pulling quite a lot of resources in, which are being used to strengthen health systems, and what I think is very good at the moment is that, if the disease control programmes can start to articulate and quantify what the systems parts of doing their jobs are, then we could really make good progress” (Q 483).

37. It is clear to us that this is a complex issue and that what is really needed is a balance of investment between programmes which target specific and serious diseases and others which address the condition of underlying health care systems. Where that balance lies will vary from one country to another and from one disease to another. We have noted that a number of organisations which target specific diseases are now devoting a proportion of their resources to improving basic health care⁵, and we welcome that. It is clear, however, that substantial external investment will be required in the health care infrastructures of many developing countries if a proper balance between the two axes is to be achieved. Where is that investment to come from? Dr Billo believed this was the responsibility of the governments of the developing countries concerned:

“It is not possible that DFID, the Swiss Development Corporation or USAID can fund that. The Global Fund can do quite a lot, but basically it is the governments that need to put more money into infrastructure and health personnel to make sure that these programmes not only have an existence on paper with two or three people at the top in the capital but that all the centres, the cities, the peripheral health facilities, are properly staffed, have adequate medicines available and adequate infrastructure” (Q 1092)

Dr Billo added, however, that the World Bank should also invest in this area.

Dr Vallat agreed. He told us:

“For 30 years the World Bank has considered priorities other than health and culture. The Bank funded more infrastructure in industry and not in health, but for the last five years the World Bank has been changing its priorities. We think they have to do more because the issues of sectoral investment have changed, but not sufficiently. We would like the World Bank to take that more seriously” (Q 1122).

⁴ The witness is referring to the date of a WHO Conference, at Alma Ata, where it was agreed that there should be a greater focus on the promotion of primary care. The agreement was not, however, subsequently implemented.

⁵ See, for example, QQ 620 and 801

38. Dr Iain Gillespie, from the Organisation for Economic Cooperation and Development (OECD), felt that the World Bank could do more and would wish to. Others cited bureaucracy and governance as potential obstacles. Dr Lob-Levyt felt that the World Bank's systems for making loans were over-onerous and deterred developing countries from applying. "It can take years", he told us, "to negotiate a loan with the World Bank". Dr Lob-Levyt continued:

"There is a feeling [in developing countries] that loans should only be taken for other sorts of infrastructure—roads, dams, construction—rather than for the social sectors. We need to change that dynamic ... We need to create a World Bank that, perhaps in a more listening mode, is able to really carefully listen to what developing countries say. Rightly or wrongly, it has a reputation of top-down expertise and a certain amount of arrogance, which developing countries do not like. They do not naturally turn to the World Bank for advice because of perceptions of what it has stood for in the past, but that is changing ... The World Bank is an amazing technical resource and ... it is absolutely vital that the World Bank engages 100 per cent on the health sector, otherwise we will never get the Development Goals" (Q 842).

39. Another potential obstacle was in-country governance, to which we have referred above. Dr Bernard Vallat, Director-General of the *Office International des Epizooties* (OIE)⁶, expressed the view that "we first need to be sure that governance is appropriate before putting money into infrastructure. That is why we [OIE] try to convince governments first to adopt the right governance and then to ask for loans or grants to carry out actions in the field" (Q 1123). Dr Billo echoed this theme: he told us that external aid was sometimes available but was not disbursed by donors because of concerns over efficient handling by the recipient countries. As he put it, "the channels of distributing the funding are not well defined and they [donors] are afraid they will get entangled with bureaucracy" (Q 1112).
40. We approached the World Bank for its view of the situation. The Bank referred us to a Brief on its website on Communicable Diseases, which emphasised that "specific efforts to improve country capacity to achieve communicable disease outcomes must be integrated with the country's overall health programme and be aligned with efforts in other sectors that influence health, including water and sanitation, education and agriculture". The Brief also stated that the Bank had "committed US\$ 274 million to prevent, control and treat communicable diseases during fiscal year 2007".
41. The Bank also referred us to a report⁷, published in 2007, setting out its strategic direction over the next 10 years in the fields of Health, Nutrition and Population (HNP). The report acknowledges that, "to realise its full potential and to respond to growing demand from the international community, the Bank needs to raise its health system strengthening contributions to client-country efforts for HNP results in areas where the Bank has comparative advantages". It explains that the Bank is "committed to supporting country efforts to strengthen health system infrastructure" and that it has "comparative advantages in large infrastructure investments, although client countries and country teams will need to decide, on a case-

⁶ World Organisation for Animal Health

⁷ "Healthy Development: The World Bank Group Strategy for Health, Nutrition and Population Results"

by-case basis, bank investments in health service delivery infrastructure”. The Bank’s new strategic direction, says the report, is “to ensure synergy between health system strengthening and priority disease interventions, particularly in LICs [Low Income Countries].” It goes on to say:

“Upon country demand, the Bank will continue to lend for priority diseases and programs. But when doing so, it must stay sharply focused on solving systemic constraints to improving HNP results on the ground and on ensuring synergy in priority disease treatment and system strengthening”.

42. We believe, on the basis of the evidence we have heard, that it is crucial for effective disease control to achieve a proper balance of investment between vertical and horizontal programmes. We are heartened by reports that the climate of opinion appears to be changing and that there is a growing recognition that serious infections will not be brought under control simply by parachuting task forces into countries to address particular diseases. While such initiatives are certainly necessary, they need to be complemented by adequate investment in health care infrastructure. It is clear to us that the World Bank has a major role to play here; and, while we are pleased to hear that there is a recognition of this by the Bank itself and that investment is taking place, we believe there is a need for more and urgent action to address this problem.
43. **We therefore recommend that the Government in its own aid programmes should aim to achieve an effective balance between ‘vertical’ and ‘horizontal’ health programmes and should encourage other donors and the World Health Organisation to do likewise. In this context the Government may wish to explore whether an appropriate percentage of health aid provided through IGOs should be earmarked for the strengthening of health systems.**
44. **We further recommend that the Government should press the issue of investment in health care infrastructures within the World Bank with a view to bringing about an increase in such investment within the framework of sensibly streamlined application procedures and appropriate safeguards in relation to in-country governance.**

Prevention and Treatment

45. ‘Prevention is better than cure’ is a maxim which has been applied to many spheres of life but one which is especially relevant to the field of health, and to global disease control in particular. Its precise applicability, however, varies from one disease to another. In the case of pandemic influenza, for example, prevention means, above all, maintaining an effective global alert and response system and a capability to identify emerging infections and deal with them at source. At the other end of the spectrum, preventing the spread of HIV is more a matter of changing lifestyles, particularly as regards sexual relations and the use of contaminated needles by intravenous drug users. Stopping the spread of malaria is different again: it requires a combination of treatment, through effective drugs, and practical measures, such as the spraying of households and the provision of insecticide-impregnated nets, which will kill the carrier mosquito. Tuberculosis spreads through insanitary and crowded living conditions and through poor nutrition, and its prevention is therefore linked more closely to remedying the socio-economic conditions referred to earlier.

46. WHO stated in written evidence that “the coverage of prevention interventions remains inadequate. Few countries have set targets and indicators for prevention programmes and systematically increased coverage of prevention interventions in the public and private sector” (p 204). Professor Johnson told us that “there has been huge investment in treatment for HIV in the last few years, but actually that has not gone hand in hand with investment in prevention. It is not just investment in prevention, it is actually the attempt to try and integrate prevention and treatment services” (Q 235).

Professor Johnson continued:

“We are treating a lot of people in this country; we are treating a lot of people in Africa. If they remain infectious, they will go on transmitting the infection, so life-long management of HIV, particularly as people live longer, also has to involve prevention services in a clinical setting. It also requires that you have very strong and continuing prevention programmes at the national level, through widespread advertising and education programmes in schools and so on, which have to be sustained, just like vaccination programmes ... A lot of agencies now would see that we have got a mismatch between investment in treatment and prevention ... Once a treatment hoves in sight, the prevention agenda gets forgotten” (Q 235).

47. The message here is clear enough. With many infectious diseases, having an imbalance of investment between prevention and treatment is simply a matter of inefficiency: it is like trying to empty a bath while the taps are still running. In the case of HIV, however, effective treatment through the use of antiretroviral drugs has the potential actually to increase the prevalence of the disease unless it is accompanied by effective and sustained prevention measures. The question of what those measures might be is a difficult one. As the primary causes of HIV are linked to lifestyles, prevention means changing behaviour, which is difficult to implement and which may be undermined by a notion that, with treatments available, perhaps contracting the disease need not be regarded as the end of the world. Nick Partridge, Chief Executive of the Terrence Higgins Trust, described the situation this way:

“We have seen, particularly at local primary care trust level, a significant drop in funding for prevention, continuing difficulties in getting sexual relationship education as part of the core curriculum and continued leadership around the need for ongoing HIV prevention campaigning work, both for those communities at greatest risk and more generally ... Therapy has taken up a progressively larger amount of money. Also, good therapy makes people with HIV less visible in any community because you are healthier; you can remain in work ... At a political level you introduce therapy. That makes people healthier but it certainly does not reduce, it increases, the prevalence of HIV overall ... It creates an ongoing need for funding drug therapy which can squeeze out good prevention campaigns. What is vitally important is that both go hand in hand” (Q 464).

Mr Partridge added:

“Treatment delivery is the easy part. Doling out pills is not that complex. Changing behaviour long term is immensely complex and

weighted with a load of moral, political and cultural stuff that is very tough to do. Prevention has become consistently more complex over the years, whereas treatment has become simpler, clearer and cheaper” (Q 465)

Dr Alvaro Bermejo, Executive Director of the International HIV/AIDS Alliance, observed that “the prevention constituencies are not as powerful as the treatment constituencies, and we need to understand that” (Q 473).

48. Dr Heymann, from WHO, agreed that the balance between prevention and treatment was acceptable in some areas but not in others, and he cited HIV as one of the latter. He added, however, that the shift from prevention to treatment was of fairly recent date. “If you look at what bilateral donors were giving, including the United Kingdom, back in 1990, they would not provide any resources at all for treatment or patient management, it was purely for prevention, purely for vaccines—vaccines were the investments we wanted to make” (Q 525). Though there was now a general recognition that the pendulum had swung too far in the opposite direction, it had been hard to convince some bilateral funders of the need to support certain preventive measures. Dr Heymann told us:

“There is a major financial partner in HIV, the United States Government, which has a bilateral series of programmes on HIV treatment which has not permitted all of the prevention interventions being used. WHO had advocated with the [US] Government, as have many, many others, and in the new allotment of funding prevention is now fully installed ... The United Kingdom and Canada were very helpful with the US Government in helping them understand the importance of prevention in HIV” (Q 526)

49. Mr Elhadj Amadou Sy, Director of Partnerships and External Relations at UNAIDS, believed it was mistaken to see prevention and treatment as competitors. He told us that “the best illustration to show that there is no dichotomy between treatment and prevention is the prevention of mother-to-child transmission, where you treat and, by treating, the result is that you prevent transmission of the infection from a mother to a child”. Continuing, Mr Sy said:

“We have learned that, when we strengthen care activities, prevention works better ... People will not develop health-seeking behaviour which is pretty much related to the kind of prevention we want to see if, on the other hand, the incentives are not in place—that you go for testing and, after that, there is an opportunity to get treatment. If we do not have treatment, we will not have the involvement of people living with HIV in prevention. Evidence has also shown that the best agents of change and the best people who could deliver the messages that can trigger the behaviour change, who can talk to young people, are those who are experiencing the virus in their own bodies and living that experience”.

Mr Sy added, however, that “for every person that we are putting on treatment, we are having three or four new infections in some settings” (Q 383).

50. The situation with HIV is in contrast to the balance of investment between prevention and treatment of diseases, like pandemic influenza and SARS, where global surveillance is the primary tool of prevention. In the view of the London School of Hygiene and Tropical Medicine, global disease

surveillance has improved markedly in the last decade. Expanding on this in oral evidence, Dr Coker told us that “the SARS crisis forced a re-think on global surveillance and was really, in a sense, a dry run for pandemic flu. What became clear through that was that surveillance around the world needed to be better collated, faster and different sources used, so not only full national surveillance programmes but also more informal systems of surveillance needed to be drawn upon” (Q 56). Professor Ferguson endorsed this view:

“A lot has been done on outbreak, detection and response, particularly for acute respiratory diseases, even in some very challenging settings, such as rural Indonesia or Cambodia, where we are picking up single cases, and certainly clusters of cases, in a relatively short timescale given the infrastructure on the ground” (236)

51. Two recent important steps in this direction have been the formation, under the auspices of WHO, of the Global Outbreak Alert and Response Network (GOARN) and intergovernmental agreement of new International Health Regulations (IHRs), both of which we discuss in the next chapter. However, while these important measures indicate a recognition at an intergovernmental level that disease surveillance must be accorded a high priority and while many nations, including the UK, have good quality national systems both for national disease control and for collaboration with GOARN, the fact remains that there are many other countries, especially in the developing world, which do not. WHO stated in written evidence to us that “there is gross under-investment in this system [GOARN] and it depends on strong, capable and transparent national systems, which again are subject to under-investment” (p 203). The Government echoed this view in its own written evidence:

“In many developing countries surveillance of infectious disease is not routine, nor can there be complete reliance upon the diagnoses given nor the cause of death. In developing countries epidemiological studies are not routinely conducted thoroughly in connection with outbreak to identify the source. Improvements in capacity within countries is still the pre-requisite for good diagnostics and surveillance and consistency of data” (p 6).

52. All of which brings us back to the need to invest in basic health infrastructure in order to provide a firm foundation on which more specific disease control initiatives can be built. Professor Johnson regarded international investment in national surveillance as “an issue of global stewardship”. She suggested to us that “investment in these areas in developing countries is extraordinarily important for identifying new and emerging infections and being able to deal with the public health consequences. It is also a form of enlightened self-interest ... because infectious diseases move very rapidly round the world because of the social, economic and other circumstances in which we live” (Q 254). There are signs that, after the SARS outbreak and with the threat an influenza pandemic growing, this view is gaining ground. Dr Scott Dowell, Director of the Global Disease Detection Program at the US Centers for Disease Control (CDC), Atlanta, told us:

“The perception that it is appropriate to invest US taxpayers dollars in global activities has grown, and the lessons from the SARS outbreak of 2003 and other recent outbreaks have not been lost—the idea that one of the ways the US CDC protects the health of American citizens is by

strengthening the ability of other countries to protect the health of their citizens. I have seen a gradual shift, independent of particular Administrations, over the last 10 or 15 years towards increased funding of international health and global health activities” (Q 396).

53. Indeed, Dr Dowell observed that this was one of the requirements of the new IHRs—that wealthier WHO Member States should work with less wealthy ones to improve their disease surveillance capacities. The CDC itself has established six Global Disease Detection (GDD) Centers in various parts of the world, which act as regional centres for monitoring the emergence of infectious diseases as well as building local surveillance capacity. All the GDD Centers, Dr Dowell told us, are collaborations between the CDC and the Host Nations, with the involvement of other partners including WHO.
54. Another area of infectious disease surveillance, which we understand is currently being pursued by the University of California, is that of viral forecasting—namely, research into patterns of emerging infections with a view to developing risk-based forecasts of what the next one might be and where it might appear. Dr Dowell, from the US Centers for Disease Control, felt this was “an interesting area of investigation”, while adding that “it is early in its infancy and there is a lot of work to be done”. It seems to us, however, that with further work viral forecasting has the potential to make infectious disease surveillance a proactive rather than a reactive function.
55. The situation we face here is in many respects analogous that that which we have discussed in the previous section. It is not a question of prevention *or* treatment but rather one of finding the right balance between the two activities. If treatment programmes are seen as being essentially fire-fighting activities designed to bring epidemics under control, it is natural that they should focus, in their early stages at least, on treating those who have already contracted the diseases in question. This must not, however, blind us to the longer-term need to take action in parallel to deal with the causes of the diseases: only in this way can we expect to see their incidence diminish over time. There is no magic formula here: the balance to be struck will vary from one disease to another. However, we do believe that in one area at least there is a strong case to be made for significant additional international investment in prevention activity—namely, in the alert and response systems needed to give early warning of and to allow prompt countermeasures against newly-emerging infections. Although investment in this area is likely to be costly, we have to consider the social and economic impact across the world in the event, which is said to be far from unlikely, that a new virulent pathogen, such as SARS or H5N1 influenza, were not promptly detected at source.
56. **We believe that it is an integral part of Britain’s own defences against the spread of such pandemic outbreaks of disease that warning and preventive systems in developing countries be strengthened and that, where necessary, the resources and skills to effect this are provided. We therefore recommend that the Government should consider urgently how greater priority can be accorded, both in its bilateral funding of developing countries and in the resources which are provided through organisations of which the UK is a Member, to bringing infectious disease surveillance and response systems up to an effective level.**

A Moving Target

57. One of the problems of disease control is that the diseases themselves do not remain static: they evolve so as to render themselves resistant to antibiotics. In the UK we have become familiar with this phenomenon in recent years in the form of methicillin-resistant staphylococcus aureus (MRSA). But it is also a growing problem in other areas. Two strains of drug-resistant tuberculosis—multi-drug-resistant tuberculosis (MDR-TB) and Extensively-Drug-Resistant tuberculosis (XDR-TB)—have emerged. Indeed, during the course of our inquiry the UK saw its first recorded case of XDR-TB. UNITAID described the situation to us as follows:

“The number of multi-drug-resistant tuberculosis [MDR-TB] cases is increasing due to resistance to first-line treatments. It is estimated that at least 450,000 individuals worldwide have contracted a multi-drug-resistant form of tuberculosis. A very small percentage receives appropriate treatment, the cost of which is very high (approximately \$4,000 [per course of treatment] at the high end of the range)” (p 264).

58. Tuberculosis is by no means unique as a disease which is developing resistance to antibiotics. WHO stated in evidence:

“Resistance has developed to almost all of the previous antimalarial medicines that were used, sometimes taking just a few years to spread worldwide. Therefore it is critical that the efficacy of artemisins, the only effective medicines against drug-resistant parasites, be protected (p 207)”.

In the case of HIV/AIDS too there is evidence of resistance to antiretroviral therapy, though in the view of Professor Mike Catchpole of the UK Health Protection Agency (HPA) its progress had been slowed by the use of multiple drug therapies (Q 141). A particular problem in the case of HIV is the increased exposure which the virus brings to infection from other diseases, especially tuberculosis. We address in the next chapter the question of whether there is a need for greater integration of efforts to treat HIV and TB. Suffice it to say here that TB is the largest single killer of people suffering from HIV and, in the view of Dr Bermejo of the International HIV/AIDS Alliance, prevention of TB is best addressed through prevention of HIV infection (QQ 436 and 438).

59. Antimicrobial resistance arises out of inadequate diagnosis and treatment. A number of those who gave evidence to us emphasised the crucial role which good diagnostics play in combating the spread of infectious diseases. Failure to diagnose the presence of an infectious disease obviously hampers its treatment and facilitates its spread. Equally, however, inaccurate diagnoses can lead to inappropriate treatment and contribute to the growth of antimicrobial resistance. Dr Helen Williams, from the Royal College of Pathologists, said;

“If you look at drug-resistant TB—either multi-drug-resistant or extensively-drug-resistant TB—the whole future of that programme depends on having a developed capacity for not only diagnosing TB but diagnosing drug-resistant TB. The whole issue of diagnostics extends beyond the individual patient and the appropriate use of drugs in that patient. It is also using drugs in people who do not need them, so you have exposure and development of resistance” (Q 317).

Dr Williams added:

“Unless you reasonably accurately diagnose what someone has, then you risk using precious drugs and precious resources wrongly and treating people inappropriately. You also risk—which is clearly a major issue with HIV, TB and malaria—inducing resistance in the organisms” (Q 328).

60. It is not, however, just a matter of poor diagnosis. Professor Borriello, Director of the HPA’s Centre for Infections, drew our attention to the problem of poor prescribing of drugs:

“There may be a need for more interaction on accepting common approaches to antimicrobial prescribing. One of the things that is very different throughout the world is antimicrobial prescribing as well as access to antimicrobials. A number of countries have over-the-counter, unrestricted sales and a number of countries do not. The hard evidence as to the extent to which that difference in access contributes to the resistance seen in those countries is not readily available” (Q 142).

Diana Weil, from Stop TB, agreed. She believed that, if the supply of uncontrolled and poor quality drugs is not halted, “we are going to be in deep trouble five or ten years down the road” (Q 750).

61. The incidence and spread of drug-resistant disease strains has, however, been poorly studied. Dr Heymann told us that “we have drugs going out in massive quantities from the Global Fund and there are not systems in countries that are monitoring resistance to these drugs. These are public goods, they must be preserved and we need to strengthen surveillance activity” (Q 572). His colleague, Dr Gully, commented that “very few countries have good surveillance of antimicrobial resistance, even in a lot of developed countries. Even if you had good surveillance, you would also have to ensure a good response ensuring close collaboration of the healthcare sector, physicians and nurses” (Q 574).
62. Experts have been calling for drug resistance to be put on the global health agenda. Among our witnesses Dr Lazzari, from the Global Fund, expressed surprise that antimicrobial resistance was not yet seen as a global priority. “There is a gap there”, he told us (Q 646). He believed there was a need for “a global movement that is approved by the World Health Assembly and becomes a global priority” (Q 647), with regional and global networks to carry out testing.
63. To a large extent, we have here yet another manifestation of the need for ‘vertical’ disease control action (in this case the supply of antimicrobial drugs to infected people) to be complemented by a ‘horizontal’ capability to ensure that there is intelligent prescribing and that prescribed drugs are used as intended. Indeed, this is a prime objective of WHO’s DOTS⁸ programme for the treatment of tuberculosis. DOTS aims to ensure that TB sufferers are supplied with the correct medicines and that they take them as prescribed over the full period required, which can be many months. It is, however, a programme which is heavily dependent on the availability of health care workers, often in remote areas, and on the cooperation of patients. This is something which, in Dr Heymann’s view, only WHO and the countries concerned can do. Yet, as we have seen, it is here—in the building up of

⁸ Directly Observed Therapy Short Course

competent and adequately-staffed healthcare infrastructure—where there are serious deficiencies and where investment is needed if campaigns to combat specific killer diseases are to take root.

64. There are also cost implications. The cost of second- or third-line medicines to combat drug-resistant forms of diseases is far higher than that of first-line treatments. DFID itself recognises this dimension of the problem in its published AIDS Strategy:

“The prices of antiretroviral drugs have been falling steadily, but second-line drugs are still very expensive. Drug resistance, which forces people to move from first-line to second-line therapies, escalates costs”⁹.

65. **We therefore recommend that, in achieving an appropriate balance of investment, both of UK bilateral aid and of funding provided through IGOs, and in using its influence within the World Bank to encourage increased investment in health care infrastructure, the Government should regard the building up of in-country surveillance and diagnostic capabilities for antimicrobial resistance as a high priority component.**

Access to Medicines

66. Access to medicines is influenced by a range of factors, including the price of medicines, the existence of sufficient and sustainable financing arrangements, the condition of local health services and supply systems, the proper selection and use of medicines and the level of research and development undertaken for new drugs. During our inquiry we attempted to establish what impact one of these factors—Intellectual Property Rights (IPR) or Patents—had on access to medicines by those who need them.
67. In recent years there have been breakthroughs in the development of drugs to treat many of the world’s most serious infectious diseases or to deal with resistant strains which have emerged. Developing new drugs, however, is one thing: ensuring that they can be readily accessed by the sick people who need them is another. Drug development is an expensive and risky enterprise: firms who undertake it employ highly qualified staff, sometimes for many years, and with no guarantee that the investment will be recovered. A number of witnesses emphasised the role that IPR played in providing the incentives necessary to encourage companies to make major investments in the development of new drugs.
68. There are, however, some real problems with the patent system as applied to global health. There is the obvious difficulty that, by conferring temporary exclusivity on a pharmaceutical product, patents can result in the price of new medicines being beyond the reach of people in the world’s poorer countries. There is also the reciprocal problem that the unaffordability of many new drugs in developing countries, which is often where the greatest need for them lies, means that there is less incentive for pharmaceutical firms to invest in the research and development needed to bring about necessary innovation.
69. A key issue here is what is known as TRIPS—the World Trade Organisation (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights.

⁹ “Achieving Universal Access—The UK’s strategy for halting and reversing the spread of HIV in the developing world”

TRIPS, which came into force in 1995, requires WTO Member States to adopt minimum standards of intellectual property protection that are often greater than the protection previously granted. The patent system has been criticised by global health campaigners and some independent experts for a number of reasons. It has been argued that, by conferring temporary exclusivity on new medical products, patents shield these products from the effects of competition, thereby putting the price of new medicines and vaccines beyond the reach of poorer people, many of whom may need them most. Thus, the International HIV/AIDS Alliance wrote that “new and future ART [anti-retroviral treatment] will not be so cheap. New intellectual property legislation in countries like India is pricing treatment beyond the reach of poor countries and poor people” (p 181).

70. Others argue that the TRIPS Agreement contains exceptions, exclusions and qualifications designed to mitigate the potentially adverse effects of patents on access to medicines in poor countries. WTO noted that “the TRIPS Agreement contains considerable flexibility in regard to patent rights, for example transition periods, compulsory licensing, government use, other limited exceptions and parallel imports” (p 572) and drew our attention to a Ministerial Declaration (the Doha Declaration) on the TRIPS Agreement and Public Health which was adopted in 2001.
71. The Doha Declaration, the Government told us, states that “the TRIPS Agreement ‘does not and should not prevent Members from taking measures to protect public health ... and, in particular, to promote access to medicines for all’. The Declaration highlighted the flexibilities that exist in TRIPS to facilitate access to medicines” (p 13). The Government added that “many pharmaceutical companies have instituted differential pricing policies for selected products and countries, under which they charge lower prices in least developed and low-income countries, in particular for drugs targeted at HIV/AIDS, TB and malaria”.
72. A number of those who gave evidence to us were inclined to be sceptical as to the effectiveness of the TRIPS flexibilities. UNITAID stated in written evidence:

“Despite the Doha Declaration in 2001 and the possibility for developing countries to make use of the TRIPS Agreement flexibilities and especially to be able to issue compulsory licences, its use has been very limited so far. Bilateral or regional free trade agreements are superseding global agreements in many countries” (p 266).

Dr Bermejo, of the International HIV/AIDS Alliance, told us:

“The flexibilities introduced to the TRIPS Agreement on paper have been very good, they are the type of thing we need; but it has been the implementation of them that has been difficult ... A number of countries, when signing up to a Free Trade Agreement, either have been asked to introduce into their domestic legislation some legislation that would prevent the exercising of those flexibilities or that has been written into the Agreement itself” (Q 425).

UNAIDS argued that,

“based on an analysis conducted on some recently concluded bilateral trading agreements, countries appear to be committing themselves to obligations that extend significantly beyond those contained in the

TRIPS Agreement and which may prove contrary to the objectives contained in the Doha Declaration” (p 153).

And Mr Philippe Petit, from the World Intellectual Property Organisation (WIPO), gave it as his view that

“there is little doubt that bilateral or regional trade agreements may be dangerous for the flexibilities and exceptions in the TRIPS Agreement, since the strongest partner may impose its conditions more easily than would be the case in a multilateral framework and in the framework of the WTO” (Q 873).

73. Dr Elhadj Amadou Sy, Director of Partnerships and External Relations at UNAIDS, saw a need to balance incentives to developers against affordable prices for consumers. In his view the solution was “to support countries in negotiating differential pricing, because we have seen that in some countries some pharmaceutical companies are able to reduce the price of the drugs by 80%”.

74. How can this conflict between providing financial incentives to pharmaceutical companies to develop new medicines and ensuring that they are affordable by sick people in some of the world’s poorest counties be resolved? Dr Silberschmidt, from the Swiss Federal Office of Public Health, suggested to us that one of the problems in ensuring exploitation of trade agreements relating to the supply of pharmaceuticals was that there are too few officials in developing countries who have the necessary expertise to negotiate and make use of the required flexibilities. In his view there was a need to train ‘health diplomats’. He told us:

“There are very, very few good negotiators both in the bilateral and multilateral fields on the recipient’s side ... If there is a free trade agreement negotiation and Nigeria, Kenya or whoever has a competent health diplomat from the Ministry of Health involved in the negotiation, the outcome will be significantly better”(QQ 614,615).

Dr Sy, from UNAIDS, echoed this view, referring to the need to “build up capacity and support developing countries in their negotiations with partners” (Q 384).

75. We therefore recommend that the Government should support, within WHO and other relevant IGOs, the development of health diplomacy training to enable developing countries to make the fullest use of the flexibilities in the WTO’s Doha Declaration on TRIPS.

76. We recommend also that the Government should consider whether the UK might provide a lead either by establishing relevant training courses in this country, perhaps under the auspices of DFID, for suitable officials from developing countries or by sponsoring officials from developing countries to attend existing courses, such as the Summer Programme on Global Health Diplomacy at the Graduate Institute of International Studies in Geneva or by seconding suitably-trained UK officials to support selected developing countries in their negotiation of individual agreements.

77. We further recommend that the Government should throw its weight against the inclusion, in bilateral or regional trading agreements, of proposals inhibiting the use by developing countries of the Doha flexibilities.

78. It is clear to us that getting medicines to those who need them at affordable prices cannot be left to the operation of the TRIPS Agreement, even with the flexibilities provided by the Doha Declaration, and that other, complementary mechanisms are needed. Our attention was drawn to a number of such mechanisms which are being pioneered in order to improve access to medicines. ‘Push’ mechanisms provide additional resources to reduce the risks and costs of pharmaceutical research and development: they include basic research funding and product development public-private partnerships (PDPs). ‘Pull’ mechanisms are designed to create a more visible market for the downstream fruits of research and development and thereby to stimulate investment by pharmaceutical firms. They include the International Finance Facility for Immunisation (IFFIm) and Advance Market Commitments (AMCs).

BOX 1

The GAVI Alliance

The GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation) is a public-private partnership (PPP), established in January 2000. Its partners include National Governments, UNICEF, WHO, the World Bank, the Gates Foundation, the vaccine industry, research and technical health institutions, and civil society organisations

GAVI’s mission is to save lives and improve health by increasing access to immunisation in poor countries through the raising and disbursement of funds for the purpose. By the end of 2007, GAVI had received funds and long-term pledges from donors exceeding \$US 7.5 billion. WHO estimates that in the first seven years of its existence GAVI has averted 2.9 million future deaths.

As part of its drive to find new ways of raising and disbursing funds for immunisation, GAVI has helped to develop the International Finance Facility for Immunisation (IFFIm) and Advance Market Commitments (AMCs). With the former, donor countries make 10–20 year, legally-binding aid commitments, against which IFFIm borrows on capital markets. AMCs are mechanisms to attract private sector investment into new vaccine products for poor countries by guaranteeing purchase volumes at agreed prices over a period of time.

79. Dr Lob-Levyt, from GAVI, told us more about IFFIm and AMCs:

“The International Financing Facility, in which the UK Government was a major driver, allows us to have ten years of legally binding finances. We can go to countries and say ‘We can enter into ten-year programmes to support you, so that you can build your budgets’ and industry responds well when they see a market where there was not a market before ... So we see the competition build up as more companies come in ... The next step beyond that is the Advance Market Commitment, which is basically saying, at its simplest, ‘If you produce a vaccine in this disease area, with this effectiveness, and at a price at the end of the day that is affordable’ (and we will set the price) ‘we will buy it’” (Q 815).

80. We consider that ‘pull’ mechanisms, such as IFFIm and AMCs, have much to offer. While leaving commercial risk with the product developer, which is

where it should lie, they offer an attractive and stable market and have the potential to stimulate competition. Organisations such as UNITAID and the Global Fund to fight AIDS, Tuberculosis and Malaria are in a strong position, with their long-term funding streams, to provide such incentives. It is important, however, that there should be rigorous analysis of options so that investments are not wasted. OECD suggested to us in evidence that it was well-placed to provide the necessary analytical capability (Q 1038).

81. **We therefore recommend that the Government should support, both bilaterally and multilaterally, the development of sound long-term funding mechanisms which are able to offer incentives to pharmaceutical companies to develop new medicines at prices which can be afforded by poorer countries.**

Natural or Intentional?—The Threat from Bioterrorism

82. While the predominant threat from infectious diseases arises from those occurring naturally, in the world in which we live today the possibility has to be recognised that infections could be released deliberately for political purposes as an instrument of international terrorism. We therefore sought the views of many of those who gave evidence to us as to the effectiveness of intergovernmental arrangements for dealing with this problem.
83. There was agreement that the potential for deliberate release was there. Indeed, Professor Borriello of the HPA suggested that successes in combating some serious infectious diseases, such as smallpox, could actually increase the impact of such incidents on the population at large:

“As the world eradicates certain pathogens, the population becomes naïve; there are no vaccinations, therefore the release of such an organism, if it is retained, could have quite devastating effects” (Q 178)

Professor Borriello drew attention also to the danger that an animal pathogen might be deliberately engineered to infect humans, while Professor Ferguson felt that animal pathogens might be used not so much to infect humans as to cause economic dislocation.

84. On the other hand, there was general consensus among those who gave evidence to us that the improved arrangements which were being established for detecting and controlling the accidental spread of infectious diseases were, to all intents and purposes, identical with those which were needed for detection and response to incidents involving deliberate release. Indeed, Professor Johnson saw concerns over the latter as an important factor in the building of improved capabilities for the former. She told us:

“Concerns about bioterrorism probably have strengthened our health protection function in this country ... It has been one of the drivers for improving the health protection structure. The Health Protection Agency has been significantly strengthened over the last decade and taken on a broader range of activities” (Q 255).

Professor Ferguson took the view that “it is much more cost-effective to invest in dual-capability response measures which can be used against acute natural occurrences as well as deliberately-introduced agencies than the very specific measures against particular pathogens, which may or may not be used, are very expensive to develop, and you do not get very good value for money for the size of the investment when you actually do it” (Q 256).

85. Dr Scott Dowell, from the US Centers for Disease Control in Atlanta, agreed on the need for dual-use strategies. “If we focus on strengthening capacity to deal with naturally occurring events”, he told us, “then we have got most of the way to dealing with bioterrorist events as well” (Q 418). Dr Maureen Baker of the Royal College of General Practitioners believed that “the work that has gone on in the UK on pandemic planning is a very good model for dealing with a major outbreak of communicable disease, however it arises” (Q 361). Dr Williams, from the Royal College of Pathologists, told us:

“The detection of any disease, whether it is bioterrorism or a naturally occurring one, depends entirely on having a good infrastructure, which is about having alert clinicians when patients present, it is about having good diagnostics available, people thinking outside of the normal things when something is abnormal and having good surveillance systems and good communication systems in place” (Q 361).

86. Dr Silberschmidt told us that the new International Health Regulations implicitly covered terrorist-inspired events as well as naturally occurring outbreaks of disease (Q 602). Professor David Fidler, from Indiana University School of Law, agreed that the preparations for and response to naturally occurring and deliberately released pathogens were similar. “Anything you do to prepare for a biological weapons attack”, he told us, “will stand you in good stead if it is an outbreak of naturally occurring infectious diseases, and vice versa” (Q 1016). He also concurred with Professor Borriello’s view that the eradication of certain diseases, such as smallpox, and the subsequent cessation of vaccination could leave populations more at risk in the event that a terrorist organisation were to gain possession of such pathogens and succeed in disseminating them.
87. **We have concluded that, so far as controlling the spread of infectious diseases is concerned, the deliberate release of toxic organisms should not be considered as in a separate category from the normal arrangements for controlling natural outbreaks. We recommend that the Government should support, both nationally and intergovernmentally, generic surveillance and response systems which are capable of addressing both deliberate and naturally-occurring outbreaks of infectious diseases.**

CHAPTER 3: INTERNATIONAL HEALTH: THE INSTITUTIONAL LABYRINTH

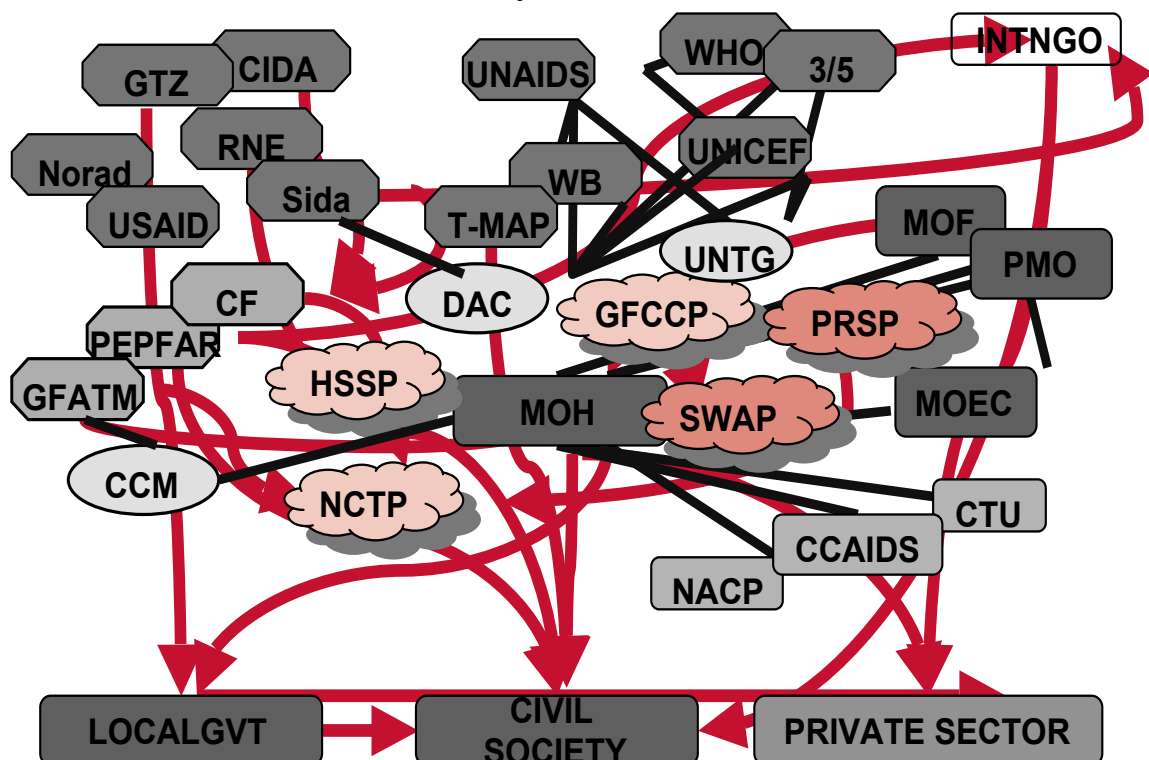
88. In this chapter we review the interaction of the various actors on the international health stage, particularly those concerned with infectious disease control. We look in some detail at the role of the World Health Organisation (WHO) and then turn to address a number of the key issues which have arisen during our inquiry, including the synergy with which the various bodies are working under the existing system and the case and scope for some rationalisation of global health governance.

The Field of Players

89. The Government wrote in evidence to us that “intergovernmental organisations, including the UN agencies, development banks, global funds and health partnerships, have a central role in health and specifically the control and spread of infectious diseases”(p 2). IGOs, however, are far from being the only players on the global health stage. Research Councils UK drew attention to NGOs, many of them (such as Stop TB) operating through partnerships, some of them including IGO representatives(p 521); and Professor David Fidler, from Indiana University School of Law, believed that recognition of the growing non-State dimension was crucial to understanding the changing nature of global health management. “The [global health] governance task”, he wrote, “now extends beyond getting IGOs to function more effectively because non-State actors play significant and increasingly influential roles” (p 379).
90. A list of the main organisations involved in controlling the global spread of infectious diseases is at Appendix 4. Figure 1 illustrates the institutional labyrinth. There may be said to be five main groups:
- **Intergovernmental Organisations** with either wholly or partially health-related mandates, including the World Health Organisation, the World Bank, UNAIDS and UNICEF;
 - **National Governmental Organisations** operating internationally in the field of infectious disease control, including the UK Department for International Development, the US Centers for Disease Control and the US Presidential Emergency Programme for AIDS Relief (PEPFAR);
 - **Non-Governmental Organisations**, such as *Médecins Sans Frontières*, the Malaria Consortium and the International HIV/AIDS Alliance;
 - **Public-Private Partnerships**, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID and the Global Alliance for Vaccines and Immunisation (GAVI);
 - **Private Foundations**, much the largest of which is the Bill and Melinda Gates Foundation.

FIGURE 1

The Institutional Labyrinth of International Health



Source: Mbewe, WHO

91. There has been a sharp increase in the number of such bodies in recent years and this has brought with it a major increase in aid for health programmes. But, according to Dr Tyson (DFID), it has also been driven by a perception that existing international arrangements to control specific diseases are inadequate. In many cases these organisations achieve effective *ad hoc* cooperation with each other. For example, Dr Lob-Levyt spoke to us of GAVI's collaboration with WHO and the World Bank (Q 801), while Dr Jorge Bermudez, Executive Secretary of UNITAID, pointed to cooperation with WHO in his organisation's purchase and supply of drugs to combat infectious diseases:

"We rely on WHO technical expertise. We are an operational unit ... WHO is not a procurement agency or a funder of products. They have a model list of potential medicines, they have a [medicines] pre-qualification scheme that works within the UN system" (Q 672).

The cooperative mode has bred a new kind of partnership organisation, including civil society representation and conferring social leverage as well as producing better information.

BOX 2**The Global Fund to fight AIDS, Tuberculosis and Malaria**

The Global Fund is a worldwide Public-Private Partnership dedicated to raising and disbursing funds to combat HIV/AIDS, TB and malaria. It was founded in 2002, following a UN Special Session on HIV/AIDS. Since its creation the Global Fund has become the predominant global funder of programmes to fight AIDS, TB and malaria, with approved funding of US\$ 10.1 billion covering more than 550 programmes in 136 countries.

The Global Fund does not implement programmes directly, relying instead on local practitioners, and it has created a system of grant administration and oversight in each recipient country. Global Fund grants are disbursed following needs assessments, which are carried out at country level and in which the countries themselves, often through Country Co-ordinating Mechanisms, identify the gaps in their programming and resources.

The Global Fund Board consists of 22 representatives of donor and recipient governments, of NGOs, of the private sector (businesses and foundations), and of people affected by the three diseases. The World Bank, UNAIDS, and the World Health Organization participate as non-voting members. The Board employs about 335 staff, who work at the Secretariat's headquarters in Geneva.

92. Nonetheless, while these attempts to control infectious diseases may be justified in terms of their individual objectives, there is no doubt that, in terms of the overall picture, the fragmentation of effort results in some significant problems, including multiplication of overhead costs. Professor Walt, from the London School of Hygiene and Tropical Medicine, noted that “the [individual] donors have their own agendas, they have their own constituencies to whom they are responsible, they all want to attribute changes to their own inputs” (Q 76). As observed in the previous chapter, there has been a tendency for individual organisations to focus on bringing treatments for individual diseases rather than on addressing the problem of infectious disease control in the round. And there has also grown up a problem of in-country coordination of effort which has sometimes imposed substantial administrative burdens on recipient countries. In Dr Tyson’s words, “each of them has their own structure, their own process, their own interaction with countries, and it causes large problems, not least of which is transaction costs for government” (Q 1). The Government summed up the situation by saying that “the current architecture is crowded and poorly coordinated. Within the diverse group of organisations there is no agreed vision or clarity over roles” (p 3).
93. One of the reasons for this absence of collaboration among many of the players is their method of financing: they are competing for funds and the incentive to cooperate is often outweighed by the need to raise funds. However, the advent of institutions like the Global Fund which channel funds across more than one disease area has helped to reduce fragmentation of effort.

The World Health Organisation

94. There was general agreement among our witnesses that WHO occupied a central position in combating the global spread of infectious diseases. There was, however, a recognition, within as well as outside WHO, that the world had changed since it was created and that these changes were now affecting WHO itself. In this section, therefore, we look in more detail at the role of WHO and how it is evolving, at the organisation's internal structure and at the interface between WHO and the newly-established European Centre for Disease Prevention and Control. We also look at funding levels.

BOX 3

The World Health Organisation

The World Health Organization (WHO) was founded in 1948 and has its headquarters in Geneva. It is the United Nations agency charged with monitoring and promoting global health.

WHO's role is to provide international leadership on global health. Its main functions are;

- to set norms and standards for health;
- to formulate and articulate evidence-based health policies;
- to provide technical support to countries;
- to monitor and assess health trends;
- to conduct disease surveillance and alert Member States as necessary.

In addition to its Geneva-based headquarters, WHO has Regional Offices in six regions—Europe, Africa, The Americas, South East Asia, Eastern Mediterranean and Western Pacific—and over 140 Country Offices. It has an approved budget for the biennium 2008–2009 of US\$4.2 billion and employs around 8,000 staff, most of them located in Regions and Member States.

The Role of WHO

95. Founded in April 1948, WHO has just celebrated its 60th birthday. Its headquarters are in Geneva, but it has six Regional Offices¹⁰ and 147 Country Offices. Its activities are directed and overseen by the World Health Assembly (WHA), which comprises governmental representatives from all WHO's 193 Member States and which meets annually in Geneva. The WHA appoints the Director-General (currently Dr Margaret Chan), who runs the organisation from day to day; and it formulates WHO policy, reviews and approves the programme and budget, and considers reports and proposals from the Executive Board. This latter is an expert body, comprising 34 members qualified in the field of health: its principal function is to give professional advice to the WHA and to give effect to the policies and decisions which the Assembly takes.
96. WHO is not itself a world health service: providing health care is a national responsibility and WHO has no authority over the national health services of its members. In written evidence to us WHO described its key roles as

¹⁰ Africa, the Americas, South East Asia, Europe, Eastern Mediterranean and Western Pacific

“articulating policy options, setting norms and standards, shaping the research agenda, providing technical support to countries, assessing epidemiological trends, monitoring and evaluation, and harmonizing and aligning partner implementation strategies and goals with national health sector plans and initiatives”(p 205). Dr David Heymann, an Assistant Director-General of WHO, put it more succinctly during our visit to Geneva. “Our function for 193 Member Countries”, he said, “is to set global policies, norms and standards and hope that others will work with them” (Q 514). If this seems a somewhat modest remit for an organisation employing some 8,000 staff, it should be remembered that the great majority of WHO’s staff are not in Geneva; they are based in the Regions and Member States. WHO is, therefore, primarily a guiding rather than an intervening organisation. “They are not a directive organisation. They are a body to give technical advice to government” (Q 480). This description, by Paul Sommerfeld, Chair of Trustees at TB Alert, underplays WHO’s role to some extent. The organisation does other things too: it analyses the non-health determinants of health, such as poverty, transport systems and education; its in-country staff work with governments in developing countries to prepare sensible health plans and it sends staff into Member States, by invitation, to help deal with health crises. But Mr Sommerfeld’s statement underlines the essential point that WHO has no power to enforce the standards it sets or to intervene directly in health care in Member States.

97. WHO is able to influence the world health scene by virtue of its position as the primary UN intergovernmental body concerned with global health. Dr Tyson, from DFID, told us:

“WHO is the body that governments trust. They see that it is their organisation, it is the first place they will go to for a source of technical advice and they [WHO] are in a very privileged position” (Q 35)

Professor Walt referred to the perception of WHO around the world, especially by middle- and low-income countries. “It has legitimacy, it has a sense of being more neutral than any American organisation or any British or European organisation” (Q 68).

Professor Marmot, from University College London, echoed these views:

“It is the first point of call of most developing countries’ ministries of health if they have any crisis whatsoever, particularly an infectious disease crisis, they will call on the WHO local office and then on Geneva, and they [WHO] have status because they are being representative” (Q 237).

Others¹¹ took a similar view.

Times are Changing

98. This situation is, however, changing, albeit in an evolutionary rather than a revolutionary manner. WHO may sit at the centre of global health policy-making, but it has been overshadowed in resource terms by newly-emerging funding organisations, such as the Bill and Melinda Gates Foundation, the Global Fund for AIDS, Tuberculosis and Malaria, and PEPFAR (the US President’s Emergency Fund for AIDS Relief). The Gates Foundation and

¹¹ See, for example, Dr Julian Lob-Levyt, Executive Secretary of GAVI (Q 825)

the Global Fund, for example, each have \$2 billion-a-year budgets, which is significantly greater than WHO's own core budget. Professor Hemingway, from the Liverpool School of Tropical Medicine, felt that there was some unease in WHO about this situation:

“The landscape has changed around the World Health Organisation, and I think the World Health Organisation has actually found it quite difficult and has felt challenged by that change around it. Gates is an obvious one, but there are also other foundations starting to come up and it is having to share that space that it is used to being a master of” (Q 67).

BOX 4

The Gates Foundation

The Bill & Melinda Gates Foundation is a charitable body formed in 2000. Headquartered in Seattle, the foundation is led by CEO Patty Stonesifer and co-chair William H. Gates Sr., under the direction of co-chairs Bill and Melinda Gates, and trustee Warren Buffett. In 2006 it reorganised into three programmes: Global Development, Global Health, and United States.

The mission of the Foundation's Global Health Programme is to encourage the development of life-saving medical advances and to help ensure they reach the people who are disproportionately affected. It focuses its funding on two main areas: (1) access to existing vaccines, drugs, and other tools to fight diseases common in developing countries, and (2) research to develop health solutions that are effective, affordable, and practical.

The importance of The Gates Foundation in the global health landscape stems, in particular, from the scale of the funds it makes available for investment. For the year ended December 2007, grants paid for the global health programme totalled around \$916m out of a total of some \$2 billion across all programme areas. As at 31 March 2008, the Foundation had around 540 employees and supported work in more than 100 countries.

Professor Hemingway felt that at the top management level WHO was beginning to work with other powerful bodies in the global health world but that “some of those lower down the system are still intent on fighting”. She cited the extension of the role of the Gates Foundation from the funding of infectious disease control into its delivery. “That is where you have seen more and more tension building”, she told us, “because WHO do believe that the foundations are actually starting [to encroach] onto their territory” (Q 93).

99. Others took a somewhat more optimistic view. Professor Ferguson, from Imperial College London, felt that WHO and The Gates Foundation “have achieved a good deal more coordination than has been seen in the past” (Q 209). Dr Lazarri, from the Global Fund, spoke of collaboration:

“We rely on the WHO, UNAIDS and other technical partners for policy/strategy guidance, where the resources should go and what are the most appropriate interventions, what provides the best results in different conditions—because the Fund is not a technical agency. We rely on their work in providing the global guidance” (Q 635)

100. Another important driver for change in WHO has been the emergence of new strains of highly-infectious disease, such as SARS and avian influenza, which, unless detected, identified and checked expeditiously, are capable of causing devastating pandemics. Of course, pandemics themselves are not new. But the substantial increase over recent years in international trade and travel has created a situation where, unless highly infectious diseases are quickly brought under control in the country of origin, they can spread rapidly throughout the world and create grave global health problems.
101. There was consensus among our witnesses that the SARS and avian influenza outbreaks which had occurred during the last 10 years had focused attention on the need for an effective global disease surveillance system and on WHO as the best-placed organisation to manage it. As a result of these outbreaks, we were told by Pat Drury, of WHO's Department of Epidemic and Pandemic Alert and Response, "over the past four or five years there has been a large amount of money that has come in and been invested at a national level and in the international system because of the threat of a pandemic" (Q 538). As mentioned in the previous chapter, one of the steps taken has been to establish, under the aegis of WHO, the Global Outbreak Alert and Response Network (GOARN) and the Global Early Warning System for Major Animal Diseases (GLEWS). Another has been agreement on the first ever updating of the 1969 International Health Regulations (IHRs), which in their new form were described to us by Professor Fidler as "the most radical development in the history of the use of international law on global health problems" (p 378). Indeed, it is in the field of disease surveillance that the development of WHO's role has been most marked, and it is to this function therefore that we now turn.

Surveillance

102. WHO's development over the last 10 years of a more up-to-date disease surveillance system rests on two main pillars—the setting up of the GOARN and the GLEWS and the negotiation and bringing into force of new IHRs. The easiest way to understand the issues is, perhaps, to approach them via an examination of the new IHRs.
103. The new IHRs, in theory, revise those which had existed since 1969. In practice, however, they represent a step change in the way the emergence of infectious diseases is detected. Professor David Harper, of the UK Department of Health, described the 1969 regulations as "a very passive set of regulations" which required notification to WHO of only four infectious diseases—plague, yellow fever, smallpox and cholera. The new IHRs, by contrast, cover all Public Health Events of International Concern (PHEICs). Under the new IHRs each WHO Member State must create and nominate a Focal Point with responsibility for monitoring such health events nationally and, where necessary, reporting to WHO any incidents with the potential to threaten international health. The creation of National Focal Points was described to us by Pat Drury, of WHO, as "the single most significant structural change" in the way global health is being managed (Q 584). The UK's Focal Point is the Health Protection Agency.

BOX 5**The International Health Regulations**

The International Health Regulations (IHR) 2005 are an international legal instrument, binding on 194 countries, including all WHO Member States. Adopted on 23 May 2005, and coming into force on 15 June 2007, they replaced the earlier IHR 1969 which had become increasingly ineffective.

The aim of the IHR 2005 is to help the international community protect against the spread of disease while avoiding unnecessary interference with global travel and trade. Whereas the IHR 1969 applied to three infectious diseases—cholera, plague and yellow fever—the IHR 2005 have a much broader scope. They apply to any diseases, irrespective of origin or source, that could present significant harm to humans.

The IHR 2005 establish a new global public health surveillance system. Under the Regulations, each State Party has obligations to prevent and control the spread of disease inside and outside its borders and to report potential “public health emergencies of international concern” to the WHO. In order to fulfil these obligations, States Parties are required to develop and maintain their disease surveillance capabilities. Recognising that, in some countries, non-governmental information sources can provide information on public health risks more rapidly than official sources, the IHR 2005 permit WHO to collect and use information from multiple sources, including the media and NGOs.

104. Dr Silberschmidt, of the Swiss Federal Office of Public Health, agreed that the new IHRs represented a significant change in global health management. He believed that “the IHRs have really brought us into the 21st century on what disease control is”. He continued: “They are binding, they are universal around the world, they are an algorithm which does not bind them to known diseases any more but makes them relevant to all diseases independent of their origin” (Q 602).

He added: “Another strength, which is quite significant for an international treaty, is that it explicitly allows the use of non-State information” (Q 602).

105. This last point is important and calls for some clarification. Under the previous IHRs Member States had an obligation to report outbreaks of specified diseases to WHO. There was, however, no constitutional basis for WHO to challenge non-reporting if it suspected a cover-up by a Member State wishing to avoid the unwelcome consequences of disclosure for its international trade or travel. Under the new regulations, WHO is able to use other sources of information about infectious outbreaks—for example, the media or the internet—as a basis for approaching a Member State and requiring it to confirm or deny what is being alleged and, where necessary, to supply details. Though a non-declaring State might possibly continue in denial, such a situation is unlikely where the event in question is already receiving worldwide publicity. It is in the interest of the State being challenged either to come clean—and so to get international help—or to provide convincing evidence that the reports are incorrect. In this situation, though some witnesses expressed concern to us that the new IHRs remained

unenforceable¹² in the sense that formal international sanctions could not be employed against a non-compliant Member State, Professor Fidler is probably right that such sanctions are not necessary. “There is not an enforcement provision”, he said, “but look at the way in which the incentives and the dynamics of the rules are set up and you start to see that the enforcement of this starts to drive off the creation of reciprocal self-interest that States have to comply” (Q 965).

106. We have referred above to the creation of the GOARN (Global Outbreak Alert and Response Network) as the other recent development in WHO’s role. GOARN consists of a network of some 140 technical institutions around the world and is responsible for monitoring reports of PHEICs, assessing their significance for global health and, where necessary, taking action to help bring infections under control. The concept underlying both the IHRs and the GOARN is that Member States should themselves detect, identify and respond to emerging infections, with WHO adopting a monitoring role. But, where surveillance and diagnostic systems are weak, particularly in developing countries, it is sometimes necessary for WHO teams to be invited to investigate outbreaks and to initiate any necessary countermeasures. This reinforces our observation in the previous chapter—that global surveillance of the emergence of infectious diseases can only be as effective as its constituent parts and that it is in every country’s enlightened self-interest to ensure that the surveillance infrastructure of developing countries is upgraded to an acceptable standard.

BOX 6

Global Outbreak Alert and Response Network

The Global Outbreak Alert and Response Network (GOARN) is a partnership of different institutions and networks (it has been described as a “network of networks”). Launched in April 2000 its role is to coordinate reports of and responses outbreaks of infectious disease and to provide a framework for delivering support to countries. In essence, GOARN’s role is to act as a “global safety net”, complementing rather than replacing national surveillance systems. Its activities are coordinated by WHO’s Department of Epidemic and Pandemic Alert and Response.

There are currently around 140 GOARN partners, including scientific institutions in Member States, surveillance initiatives, networks of laboratories, IGOs and NGOs. Since 2000 GOARN has responded to around 90 events, with more than 500 experts providing field support to some 40 countries. It played a crucial role in helping to contain the SARS outbreak in 2003.

Structure

107. We have mentioned above that WHO conducts its activities via six Regional Offices and over 140 Country Offices. In written evidence WHO described this as “a strong network which is well structured” but added that “the network is inadequately staffed, especially at country level. There are increasing demands for implementation support from governments, other technical agencies, NGOs and civil society partners, as well as donors supporting disease control at country level” (p 205).

¹² See, for example, QQ 49, 560 and 934

108. We encountered mixed views as to how well this pyramid management structure operates. We heard complaints of excessive bureaucracy in WHO's headquarters, but we also heard praise for the programme of managerial reform being undertaken by the present Director-General, Dr Margaret Chan. A number of witnesses spoke of a disconnect between WHO Headquarters and the Regional Offices, particularly the Regional Office for Africa (known as AFRO). Dr Bates, from the Royal College of Pathologists, commented that "AFRO seems to be much more autonomous somehow. Whenever you go to headquarters in Geneva and talk to them about something, it does not necessarily percolate down to AFRO and vice versa" (Q 275). Dr Conlon, from the Royal College of Physicians, concurred with this viewpoint. "There is often a disconnect", he told us, "between what is happening in Geneva and what is happening on the ground, and even on the ground the Regional Office is quite far away from where the fieldwork may be going on and where programmes are being implemented" (Q 277). And Professor Hemingway, referring to an AFRO project to set up a surveillance system for pesticide resistance, spoke of "a complete lack of understanding ... as to the level of complexity of what they need to put together if they are going to properly integrate information" (Q 60).
109. Others were more optimistic. Dr Tyson spoke to us of efforts by WHO headquarters "to bring them [the Regional Offices] more into the fold" (Q 33) and we were told of improvements, especially in the last 12 months, in the linkage between Headquarters and the Regions (QQ 13, 35). There was general agreement that some of the difficulties at least arose because the Regional Directors, like the Director-General, are elected rather than nominated and therefore saw themselves as responsible to the countries who had elected them as well as to WHO globally (QQ 513). Indeed, Dr Heymann went so far as to speculate whether WHO "spends more time collaborating internally than it does with its external partners" (Q 530) and to suggest that resolving the question of the election of Regional Directors might be "the key issue" in improving WHO's performance (Q 581). Dr Tyson believed that, "if you ask any DFID adviser in Africa, they would say the weakest link of WHO is the Regional Office" (Q 33).
110. There was agreement that much good work took place at the Country Office level (for example, in providing technical assistance to countries in preparing disease-control programmes for funding by outside agencies and generally playing a valuable role in Country Coordinating Mechanisms¹³ for external assistance), though Dr Bates felt that some of them were insufficiently independent. "Whenever you go to them", she told us, "they always refer you back to the ministry. They will not work separately from the ministry ... They sit on the fence" (QQ 289, 290).
111. **Reforming WHO's internal structure is an essential, though challenging, prerequisite of improving global health governance. While it is true that some progress has been made and that the Regional and Country Offices are now more willing to cooperate following the SARS experience, a more fundamental overhaul of the relationship between headquarters and regions and a review of the current procedures by which Regional Directors are appointed seems overdue. Given the threats to global health which we face from newly**

¹³ See Paragraph 151 below

emerging infectious diseases, a dysfunctional organisational structure within the world's principal policy-making, standard-setting and surveillance body simply cannot be afforded. We therefore recommend that the Government should bring its influence to bear, along with that of other like-minded Member States, to ensure that a fundamental review is initiated of the inter-relationship between WHO Headquarters and its Regional and Country Offices and of the system of appointment of Regional Directors so that WHO as a whole is better structured to meet the contemporary challenges of global health management.

Resources

112. One of the main constraints on WHO's activities is resources. The WHA approves WHO's budget in May every other year for the following biennium. The 2006–2007 budget was approved at US\$3,313 million, though this was subsequently increased to US\$ 3,670 million to cater for a scaling-up in the response to avian influenza. The approved budget for the 2008–2009 biennium is US\$ 4,200 million. It is important to understand that WHO's budget comprises two main elements—a core budget (otherwise known as Assessed Contributions), which comprises mandatory annual subscriptions from Member States to defray the organisation's operating costs and to fund what are agreed by the whole membership to be essential programmes; and additional funding (known as Voluntary Contributions), which consist of discretionary funds made available by Member States and others earmarked to support specific programmes. Assessed Contributions account for only US\$ 959 million of the current WHO budget. This means that WHO has to manage a wide range of core activities, including Epidemic and Pandemic Alert and Response and providing WHO staff to developing countries to give technical support, out of less than 25% of the total funding available. The greater part of the budget (Voluntary Contributions) tends to go on more specific objectives, such as immunisation and vaccine development, against which they have been predicated by their donors.
113. **We therefore recommend that, when budgetary negotiations for the next biennium get under way, the Government should support a re-balancing of WHO's budget in order to make more funds available for the core budget.**
114. **Infectious diseases pose a major threat both to this country and to the wider world, and we believe that WHO will need additional funding if it is to be able to respond effectively to these threats on behalf of the international community. The UK is already a major funder of WHO and we are mindful of current budgetary constraints. We recommend however that the Government, in concert with other Member States, should work towards an increase in financial contributions to WHO.**

WHO and Europe

115. The Stockholm-based European Centre for Disease Prevention and Control (ECDC) is not an IGO but an agency of the European Union. It was established in 2005. Its role is principally to conduct disease surveillance on behalf of the 27 EU Member States, on whose resources it draws in order to carry out its task. Its Director, Dr Zsuzsanna Jakab, told us:

“The European CDC ... is built on the fact that the European Member States have very strong national bodies with very strong infrastructures. The founding fathers of ECDC took a very wise decision when they said that we should not duplicate. We do not want you to have research institutions belonging to ECDC directly; we do not want you to have laboratories linked to ECDC; we do not want you to follow the American model of the US CDC. What we want you to do is to network with the European institutions, network with the European nationals. This is the thought process behind ECDC” (Q 895).

116. ECDC’s remit covers the 27 Member States of the EU. All these fall within the parish of the European Regional Office of WHO (known as EURO). According to Professor Catchpole, from the Health Protection Agency, ECDC has provided added value in some areas of work, such as helping to improve the epidemiological capacities of some of the newer EU Member States. He told us:

“If you put that question to someone from one of the smaller States in Europe, they would say they absolutely feel that they get huge value from knowing that ECDC is there. We have a tremendous resource of experts and expertise that can provide us with information and advice on how to deal with SARS or other emerging problems. They do not have that expertise and depth in other parts of Europe” (Q 152).

117. Dr Jakab told us that “there is no overlapping in the roles and in the mandate of WHO and ECDC” (Q 893). She believed there was synergy between the two organisations and that “collaboration and partnership are absolutely vital” (Q 893), citing a Memorandum of Understanding which was signed three years ago with EURO. In addition to annual high-level meetings, there were quarterly conferences with WHO and day-to-day cooperation on operational issues between ECDC, EURO and WHO Headquarters.
118. Dr Jakab referred to ECDC as “the European CDC in the development phase” (Q 894). Did she therefore see ECDC evolving into an organisation along the lines of the US Centers for Disease Control (CDC), which is based in Atlanta but which has outstations in many parts of the world? Dr Jakab felt that, in terms of their respective constituencies (strong national/state health structures and limited responsibilities at the federal level), “the power and the mandate of the European CDC and the US CDC do not differ too much” (Q 896). The main differences lay in their relative resources and reach.
119. Our terms of reference exclude in-depth inquiry into the effectiveness of EU agencies or institutions, though they do permit us to examine the interface between EU and non-EU activity. Most of those who gave evidence to us took the view that there was a role for an EU agency like ECDC and that initial tensions were beginning to be resolved and synergies achieved. With just three years of experience, it is too early to judge. **We believe however that it will be important that duplication and overlap does not occur and that ECDC does not become a further complicating factor in an already complex system of global disease management.**

Synergy and Coordination

120. In this section we look at some areas where there appears to us to be an absence of synergy in the way in which the various actors on the international

health stage are operating and at the case for rationalisation of global health governance in order to promote better use of available resources.

Human and Animal Health

121. Professor Borriello, Director of the Centre for Infections at the UK Health Protection Agency, told us that it was a mistake to think of human health as something which exists apart from that of animals. “We need to view ourselves”, he said, “as part of the mammal population of the planet” (Q 163). Professor Borriello said that “we are part of a big common reservoir [of diseases], but for centuries our concentration on identifying the pathogens and/or combating them has concentrated on ourselves as a species and ignored the rest of the mammal population”. New infections from animals were emerging, partly as a result of improved diagnosis but also as a result of human lifestyle changes. He explained:

“There is increased exposure to wild animals by what you might consider naïve populations. Earlier in our existence there was not a lot of contact. For centuries there was none other than with domesticated animals. Now there is increased contact either in zoos or with exotic pets or by foreign travel, going to these sorts of places to see wild animals. Then there is pressure in Africa and other parts of the world, the use of bush meat and encroachment. It is increasing the risk” (Q 163)

122. It is now widely accepted that increased contact with animals was probably the source of the current HIV epidemic. Professor Borriello told us that SARS may have arisen from the consumption of bush meat. Already there has been animal-to-human transmission of avian influenza found in poultry. Though as yet the virus has not developed the capability to move between humans, if and when it does the result could be an influenza pandemic of devastating proportions. Controlling the spread of infectious diseases among humans needs, therefore, to have regard to what is happening in the world of animal health. It is very important therefore for information about existing and potential animal infectious which could jeopardise human health to be known to the relevant authorities. As Professor Peter Chiodini, Head of the HPA’s Parasitology Reference Laboratory put it, “synergy between the veterinary specialist and the medics is crucial to control” (Q 167).
123. The problem is that in many countries the two disciplines operate separately rather than in an integrated manner. Professor Borriello told us:

“The one area where interaction is not sufficiently strong is on what you would call fully integrated surveillance, where we can match patterns of human disease and newly emerging syndromes in humans to newly emerging syndromes in animals or diseases in animals and to have the two bits of intelligence in some way brought together” (Q 165).

In the UK, continued Professor Borriello, there was the National Expert Panel for Newly Emerging Infections, enabling a sharing of veterinary and medical data. Elsewhere, he said, including many European countries, “the health, the vets and the food have no linkage whatever” (Q 168).

124. The problem is partly one of local capacity. Dr Conlon told us:

“Most countries that I have come across in the tropics have medical schools of some sort but very few have vet schools. Again, the expertise, if it is available, tends to go to commercial farming rather than

husbandry or surveillance of animal diseases. It is a real problem. If you think about most of the epidemics over the last few years that have derived from animals, it has usually been the human disease that has pointed to the problem in a retrospective analysis, finding the animal source” (Q 332).

Dr Conlon added, a propos the recent outbreaks in humans of avian flu:

“Strengthening local vet services would have allowed people to have got onto the poultry culling and other control measures in South East Asia more quickly ... Once humans get a disease, it is pretty hard for any organisation to stop it moving” (Q 339).

125. Part of the problem also, however, is what appears to be an absence of joined-up thinking and effective coordination by the relevant international bodies. We have described above the new International Health Regulations and the much improved capability they bring to the detection and identification of emerging threats to human health. Unfortunately, the parallel international rules requiring declarations of the outbreak of zoonoses—diseases originating in animals—still follow the old regime. Dr Paul Gully, from WHO, put the contrast this way:

“Changes to the International Health Regulations in terms of being able to respond to rumours, as opposed in the past to official notifications, have made a huge difference. We are now able to go to a country, through a region, to ask specifically what is going on, and that country realises that the world knows a particular country has a problem. Other sectors, such as agriculture, do not have that. For example, the OIE, the World Organisation for Animal Health, can only respond to a report from a country, an official report, and it does make a huge difference” (Q 530).

126. The new IHRs, we were told, could be used to pick up indirectly the emergence of zoonoses. Dr Gully again:

“The IHR do not relate to a specific number of diseases which are human diseases—Polio and SARS, for example. They relate to public health emergencies or events of international importance, and that would be open to interpretation as to what those applied to” (Q 552).

We were to some extent reassured to hear that, in practice, WHO works informally with the two main bodies monitoring animal health—the OIE¹⁴ and the FAO¹⁵—under the auspices of the Global Early Warning System for Major Animal Diseases (GLEWS), whose role was described to us as “disease-tracking, information-sharing and multi-disciplinary action” (Q 562). Nonetheless, given that some three quarters of emerging infections in humans originate from animals, this asymmetry between the new IHRs governing threats to human health and the regulations governing the declaration of diseases in animals is worrying.

127. We have considered whether the new IHRs should be amended so as to cover explicitly threats to human health from diseases which are detected in animals? Dr Silberschmidt (Swiss Federal Office of Public Health) thought not. “They [the IHRs] are too young”, he said, “and need further

¹⁴ *Office International des Epizooties* (World Organisation for Animal Health), based in Paris.

¹⁵ UN Food and Agriculture Organisation (FAO), based in Rome

strengthening and implementation to have formal revision at this point” (Q 604). Dr Heymann (WHO), on the other hand, believed that amendment was possible if the necessary political consensus was there¹⁶. While we take Dr Silberschmidt’s point that it is preferable to allow new rules to bed down before considering amendments, we take the view that the risks arising from the present disjunction between the management of animal and human diseases are too great for it to be allowed to continue. New infections, many of them originating in animals, are appearing every year and, as things stand, are sometimes coming to notice only after they have jumped the species barrier to infect humans; and their global spread is greatly facilitated by the large and increasing volume of international travel and trade. While in many cases such transmission may not have dramatically damaging consequences, in the case of, say, a pandemic of avian influenza the time gained through detecting—or lost through failing to detect—the emergence of a virulent strain of the virus in poultry before it has had the chance to infect humans could make all the difference in averting a global disaster.

128. **We therefore recommend that the Government should pursue, as a matter of urgency, through its membership of the relevant IGOs the creation of an event-reporting system for animal diseases along the same lines as the new IHRs relating to human health and should encourage the building up of much stronger systems of cooperation between the bodies dealing with human and animal health in sharing information and handling reports of disease outbreaks.**

Tuberculosis and HIV/AIDS

129. According to UNAIDS:

“Up to 70% of TB patients are also infected with HIV in the African countries hardest hit by HIV infection. Many opportunities to provide integrated care are being missed because of poor collaboration between TB and HIV programmes. In 2005 only 7% of TB patients were tested for HIV and less than 0.5% of people living with HIV were screened for TB” (p 152).

The UK-based charity *Results UK* has written that, “despite the link between the two diseases being acknowledged as far back as the 1980s, efforts to control TB and HIV/AIDS remain largely independent of one another”¹⁷.

130. Others, while accepting that there had been problems of dealing with the two diseases in an integrated manner, believed that the situation was improving. Dr Coker, of the London School of Hygiene and Tropical Medicine, said:

“Over the last 15 years or so the focus was initially on TB control and in parallel HIV control, and never the twain met and patients did fall between the gaps. I think over the last five years, admittedly belatedly, that problem has been recognised and there are efforts to try to ensure that patients do not fall between the gaps, and there are policies developed by WHO to try to address that problem” (Q 117)

Dr Alvaro Bermejo, from the International HIV/AIDS Alliance, concurred. “The intergovernmental organisations”, he told us, “have played an

¹⁶ See Q 569

¹⁷ “An Inadequate Response”, *Results UK*, November 2007

important role in that change, particularly WHO; and the Global Fund [for AIDS, TB and Malaria], by nature of picking up funding for the three diseases, has tended to generate some greater integration” (Q 436). And we heard that the Programme Coordinating Board of UNAIDS was meeting in Thailand, with TB-HIV integration as its main agenda item (QQ 436, 728).

131. WHO’s part in this improving situation was emphasised by Dr Haileyesus Getahun, Medical Team Leader at the Stop TB Partnership. He said that “WHO took the leadership in 2004 to provide countries with clear policy and strategy clarifying what needs to be done. We have a 12-point policy which is simple and clear, and we have promoted that policy with advocacy” (Q 723). Dr Getahun told us that in Ethiopia the numbers of TB-infected patients tested for HIV had risen from 20,000 in 2002 to 700,000 in 2006 and that the emphasis now was on testing HIV-infected people for TB.
132. We were pleased to hear of these moves towards more integrated campaigns to control the spread of TB and HIV/AIDS. Nonetheless, it is clear that some problems remain. Diana Weil, Senior Policy Adviser at the Stop TB Partnership, felt that the focus on AIDS at a political level could sometimes result in the threat from TB being relegated to a subordinate position and in a failure to give adequate recognition to the problem of TB-HIV co-infection. “In many countries”, she said, “you have HIV/AIDS Commissions, which operate at a political level which is far higher than any TB programme, which is basically in communicable diseases in the public health authority ... For AIDS authorities, TB is one of the many issues they are concerned about but it often gets lost in the mix” (Q 725). Ms Weil cited the UK as an example of a country which had produced AIDS strategies inadequately covering TB-HIV co-infection. We found this view echoed by *Results UK*¹⁸:
- “The UK Department for International Development (DFID) recognises the importance of coordinated planning and implementation of TB and HIV/AIDS activities in order to scale up treatment of TB among HIV-infected people and increase enrolment onto HIV treatment programmes. Despite this knowledge, neither TB nor TB/HIV co-infection is fully incorporated into DFID’s current strategy on tackling HIV/AIDS”.
133. Dr Tyson, from DFID, explained that “in many countries, such as Tanzania, Uganda, Malawi, we are providing substantial resources into the budget or health budget of the country to enable the government to deliver on its priorities as reflected in the national plan. In essence, we are putting money into the Government’s systems, so how governments spend that is of great interest to us, but we cannot say to them ‘We want you to carve out ten per cent of it to strengthen your work on HIV/TB’” (Q 36) Dr Nils Billo, Executive Director of the International Union Against Tuberculosis and Lung Disease, recognised the rationale behind DFID’s strategy but pointed out some of the problems. “Unfortunately”, he told us, in many instances I would say the money sticks at the top. It maybe goes one level down but it does not trickle down to where it is really needed. That is the problem” (Q 1107). There was, Dr Billo felt, an issue of governance, commenting that “many countries have millions of dollars in the bank and are not using them, so they are not getting it to where it should be” (Q 1109).

¹⁸ “An Inadequate Response”, *Results UK*, November 2007

134. These strictures of DFID's approach to the problem of TB-HIV co-infection surprised Gillian Merron, Parliamentary Under-Secretary of State at that department. "That", she told us, "is what the updated strategy is all about". Ms Merron continued:

"We are fully aware that we need to do more to bring services together. We are not just supporting the integration of AIDS services with other health services, including those for TB; our updated HIV/AIDS strategy sets out ... a health spending target over seven years ... of £6 billion".

"Please be assured", she added, "the coordination [of HIV] with TB services is very central" (Q 1160). DFID also outlined, in a supplementary note, specific projects which it was supporting to promote the integration of HIV and TB treatments (p 454).

135. DFID's HIV/AIDS Strategy Document¹⁹ contains the following:

"Stronger links must be forged between TB, malaria and HIV services. In particular, in hyper-endemic countries, TB and HIV are fuelling each other, and the need for integration is made more urgent by the steep rise in drug-resistant TB infections. In places where the TB burden is high, progress has been made on screening for TB and HIV and on treating both diseases, but more needs to be done to make these services more accessible"

The Document states that "we will spend £6 billion on health systems and services up to 2015. This will help maximise progress on AIDS through closer integration of AIDS, TB, malaria and SRHR [Sexual and Reproductive Health and Rights], including maternal and child health services".

136. We are pleased to hear that the Government's updated HIV/AIDS Strategy recognises the need for TB and HIV to be addressed in a more integrated manner and that the substantial funding which is to be provided over the next seven years for health systems and services generally will enable more attention to be paid to this problem. We remain concerned, however, by Dr Tyson's statement²⁰ that the UK is not in a position, as a donor, to require recipient governments to allocate a portion of funds received to addressing TB-HIV co-infection. While we recognise the need for country ownership of health programmes and for bilateral aid to be tailored to the individual needs of each recipient country, we consider that UK funding to combat HIV/AIDS in developing countries should be conditional on the adoption of an integrated approach to fighting TB-HIV co-infection.
137. **We therefore recommend that the Government should continue to encourage the development of integrated strategies for combating TB and HIV and should satisfy itself, before committing funds to fight one or both of these two diseases in developing countries, that there is adequate local recognition of the problem of TB-HIV co-infection and that there are sound programmes in place to address it.**

¹⁹ "Achieving Universal Access—The UK's Strategy for Halting and Reversing the Spread of HIV in the Developing World"

²⁰ See Paragraph 133

Inter-organisational Collaboration

138. In an area of international activity as crowded with actors as infectious disease control, with different constituencies, objectives, management structures and funding systems, it would be surprising if there were anything approaching perfect synergy. Generally speaking, witnesses from individual organisations tend to see their own interactions with others, understandably, as collaborative, while other commentators have been more inclined to dwell on apparent non-cooperation.
139. UNITAID is an organisation founded in 2006 by five countries—Brazil, Chile, France, Norway and the UK—but now with 27 participating countries plus the Bill and Melinda Gates Foundation. Its purpose is to fund the supply of essential drugs to people suffering from infectious diseases. UNITAID’s Executive Secretary, Dr Jorge Bermudez, described his organisation’s working relationship with the Global Fund for AIDS, TB and Malaria:
- “In HIV/AIDS, everybody knows that the Global Fund has a very big programme on first-line antiretrovirals, so we do not now work with first-line antiretrovirals. There was a gap in paediatric antiretrovirals, because nobody was addressing that. In TB we are working with multi-drug resistant TB and the Global Fund says UNITAID is responsible for that, and we work with them and other organisations addressing multi-drug resistance” (Q 668)
140. Similarly, Louise Baker, of the Stop TB Partnership, spoke of an external evaluation which had been carried out to establish the added value of her organisation:
- “We stop our Partners doing the same thing”, she told us, “we complement each other rather than do the same thing and compete. Certainly in the evaluation it appears that the added value of the Partnership has been about developing a common strategy, so that there is no counter-messaging. We are all very much in line with each other and driving in the same direction, and there is none of the squabbling that you might get if there was not a common plan” (Q 713).
141. The general thrust of these and other comments was endorsed by Professor Ferguson of Imperial College London. “I am encouraged”, he told us, “by the degree of coordination now compared with 10 or 15 years ago”. Professor Ferguson continued:
- “It is a free market of different interest groups interacting. My perception is that it is a market working quite well generally at the moment ... It is not perfect, but it works quite well and arguably better than the alternative, which might be a more directed approach” (Q 208).
142. On the other hand, we heard some examples where the degree of synergy taking place was rather less than the pictures painted above. We were told by Dr Bermejo, of the International HIV/AIDS Alliance, of country-level programmes for drug treatment and drug control which appeared to be working against each other. In Dr Bermejo’s words:
- “We have countries supported by UNODC [UN Office on Drugs and Crime] instituting and being given guidance and technical support around drug control for measures that really criminalise drug users and

those in possession of drugs. What we see in many cases is services that need to meet their targets waiting outside some of our clinics, for example where methadone is being prescribed as substitution maintenance therapy or where drug users are coming to get their treatment and they are being detained outside the doors”.

We recognise that UNODC is not a health-oriented IGO. Nonetheless, we are concerned at the tensions which the situation described by Dr Bermejo reveals between two UN bodies whose overall remits differ but who need to be mindful of each other’s activities.

143. Potentially more serious is an apparent attempt by the Atlanta-based US Centers for Diseases Control (CDC) to create a parallel global disease surveillance network to the GOARN. Dr Heymann of WHO described the position to us as follows:

“CDC, which in the past was a very strong partner in the Global Outbreak Alert and Response Network, is now setting up its own bilateral Global Disease Detection Network. This was a vision of the CDC back in the 1990s when we set up our emerging infections programme, but we were able to convince them at that time to work multilaterally within the GOARN, and they did. Under the current Administration, however, there has been a tendency towards more bilateral relationships, not only with disease detection and response but with influenza, with HIV and malaria ... It causes us very difficult problems, to the extent that many times there is difficulty in knowing who is doing what in a country when there is an outbreak of disease. It is a very difficult issue which at one time was being well coordinated by GOARN” (Q 547).

144. We were also told that, while WHO distributes viral and bacteriological samples to competent laboratories throughout Member States for research into and development of vaccines and antibiotics, the same procedure was not followed in the case of samples obtained within the CDC’s own network of Global Disease Detection (GDD) centres. “Those viruses or bacteria”, we were told, “are not studied in any other laboratories” (Q 550).

145. We had heard from CDC’s Director of Global Disease Detection program, Dr Scott Dowell, that GOARN was regarded, by WHO as well as by CDC, as a ‘network of networks’ and that “we see ourselves as one of the networks that is part of the ‘network of networks’” (Q 415) and that each of CDC’s GDD centres was a collaborative project between the US and the host government (Q 404). When we put the question to Dr Dowell of whether CDC’s GDD Program amounted to doing what WHO should be doing but had not sufficient resources to do, he agreed but with qualifications. He said:

“It [WHO] is a convening and leadership function and they depend on Member States and other organisations to do a lot of the carrying out of the actual work. We hope that what we are doing fits well into the overall umbrella of what WHO is intending to accomplish and that our networks fit into the WHO-led network of networks” (Q 391).

We put WHO’s concerns about parallelism to CDC. We were told that “we at CDC are very interested in seeing that the GDD Centers are part of the international infrastructure supporting IHR and functioning within GOARN”. On the question of sharing virus samples, CDC wrote to us that, “when virus samples are shared and the international network functions

collaboratively ... the world benefits” and that CDC’s collaborating laboratories “take this approach to sharing reagents, knowledge and samples as part of their daily work”. CDC added that, “if there are exceptions to this collaborative approach ... we would like to know about them and to help address and resolve the problems” (p 175).

146. We are pleased to hear that cooperation between the various players on the international health stage is improving. There remain, however, instances where individual organisations appear to be pursuing their own agendas without sufficient regard to the wider picture. Separate UN bodies are following uncollaborative strategies in handling narcotics control and treatment, and the existence of parallel organisations operating in the crucial field of infectious disease surveillance is unjustifiable. On this latter issue, we have noted what CDC has said about the international role of its GDD centres and we concede that, just as the GOARN is weakened by poor surveillance infrastructures, it is also strengthened by the building up of effective ones, whether through national or international resources. We endorse therefore CDC’s GDD network as an integral part of the GOARN’s ‘network of networks’. Our concern is that these national and international capabilities should complement each other in the way they operate.
147. **We therefore recommend that the Government should, via its representatives in the relevant UN agencies, seek to ensure that instances of non-collaborative working are highlighted and remedied. We recommend also that the Government should urge the UN Secretary-General to give WHO a clearer lead role.**

Global Health Governance

The Need for Improvement

148. The question arises therefore of whether there should be more formal global health governance; and, if so, how that might be effected. The Government’s evidence to us here was clear. “The current architecture”, we were told, “is crowded and poorly coordinated. Within the diverse group of organisations there is no agreed vision or clarity over roles ... In the medium term, the Government believes the large number of existing initiatives should be rationalised through mergers”(p 3). Gillian Merron, Parliamentary Under-Secretary of State at DFID, described it in oral evidence as “a situation that we know needs to be remedied”. “There is”, she said, “very much scope to improve the effectiveness and coherence of intergovernmental organisations that are working on health and communicable diseases” (Q 1142).
149. In oral evidence, Dr Tyson told us:
- “Most donors would recognise the need, including WHO, to re-think the architecture, to look where there are possibilities to either merge some of these single issue partnerships or, in some cases, to re-absorb them into the World Health Organisation or another parent body or, in the most extreme cases, perhaps to disband them” (Q 5).

Ms Merron endorsed this view. “We would like”, she told us, “to see mergers amongst some of the international initiatives ... We feel we should brainstorm around mergers—for example, the Global Fund and GAVI—and, in the future, UNAIDS”. She added, however, that the Government took the

realistic view that mergers were not likely to happen in the short term (QQ 1142, 1148).

Professor Chiodini, for the UK Health Protection Agency, agreed that some rationalisation of effort was called for, pointing to “parallel tracking”, waste of resources and duplication of administration under the existing system. He took the view that “some rationalisation and better coordination between all these bodies with good intent and, in some cases, extremely good funding would be beneficial” (Q 194). Diana Weil, from the Stop TB Partnership, felt that that the situation was improving, that “there are more networks now of people communicating at the global and regional levels than there were before”. Nonetheless, she added, “we have a long way to go because, while people say they want to combine efforts, some independent donors and governments still are funding in a very directed route because of their rules and regulations” (Q 748). Dr Lob-Levyt, from GAVI, observed that “we do need to think about respective roles and strengths in the long term and simplify the world for some of the poorest countries” (Q 830). And Professor Rubin, of the University of Pennsylvania, compared the orchestration of global disease control with designing and building an aircraft:

“As good as the World Health Organisation is, as good as the Bill and Melinda Gates Foundation is, there is no systems integrator, and without a systems integrator the plane will not land safely” (Q 914).

150. Nowhere is the need for rationalisation of donor effort clearer than in the recipient countries themselves, where the collective burden of large numbers of National Governments, IGOs, NGOs, Public-Private Partnerships interacting with the host government can be considerable, especially in countries with undeveloped administrative systems. Dr Tyson cited the situation in Vietnam as an example:

“In 2005 [it] had almost 800 donor missions in one year. The combined administrative burden on countries of all these well-meaning partnerships is very significant ... If we look at a typical, highly donor-dependent country, we might see 20 UN agencies, 35 bilateral agencies, 20 global or regional banks or financial institutions and 90 global health initiatives. Trying to get all these to work collectively has ... been one of the greatest challenges” (Q 1).

Professor Marmot referred to “a huge bewildering variety of specific programmes, each with a demand for ‘Do it this way! Account for it this way!’” Recipient countries did not, he told us, have the resources to cope with this “total lack of coordination” (Q 212).

Dr Billo, from the International Union against TB and Lung Diseases, argued that:

“If you look at a TB programme manager or an AIDS manager, one of the major tasks is to organise visits for the WHO, UNICEF, NGOs, and they have hardly any time to work because they are constantly organising visits”.

Dr Billo continued:

“Coordination is hindered a lot of times by the fact that the Global Fund, DFID or NGOs demand different ways of reporting on how money is being used in countries. That is a huge burden on countries to

report on what they are doing. Also, when they have to make applications, these applications are complex. So, on a Global Fund application, for instance, they spend two or three months and the whole system is burdened by that ... There are applications which demand the inclusion of certain things because at the moment the buzzwords need to be used. What happens very often is that governments hire a professional grant writer to use those words, and the buy-in is sometimes not there” (QQ 1099, 1102).

151. The problem has been recognised for some time and there have been initiatives to ensure greater coordination. Some of the organisations which have emerged in the last few years—for example, UNAIDS, the Global Fund, the Stop TB Partnership and the Roll-Back Malaria Partnership—are themselves a recognition of the need for greater coordination and harmonisation of donor in-country efforts. The Paris Declaration of 2005 involved a commitment by over a hundred States, IGOs and NGOs to increase efforts to harmonise and align the provision of aid to developing countries. OECD reported to us that, based on a 2006 survey, “there is progress across the donor community but a lot more needs to be done” (Q 1032). One of the main objectives of the International Health Partnership²¹ is to address this situation. The Global Fund has initiated Country Coordinating Mechanisms (CCMs) in a number of countries, bringing together representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, non-governmental organisations, academic institutions, private businesses and people living with the diseases²². Diane Stewart, from the Global Fund, described CCMs this way:

“Wherever there are players that go beyond government ... the Coordinating Mechanism then takes all of those stakeholders at the country level and they discuss what the priorities will be. It is very much a joint process ... Often it is chaired by the State, the Minister of Health, or in some cases the Deputy President. It is often quite a high-level organisation but it is not owned by the State and it is certainly not supposed to be. It is supposed to be a partnership” (Q 628).

How effective are CCMs? Dr Sylvia Meek, Technical Director of the Malaria Consortium, had mixed feelings. “There are efforts in most countries”, she told us, “to try to have some mechanisms of coordination among the different technical agencies. They work quite well in some countries. In others they do not” (Q 478). Professor Walt expressed similar reservations (Q 98).

We were also told of Sector-Wide Approaches (SWAs), in which a number of donors agree to pool their funding in order to achieve agreed common objectives (Q 653).

How Can It Be Done?

152. Seeing a need for rationalisation of effort is one thing: knowing how to bring it about is another. There is a wide variety of bodies engaged in global disease control. Some are governments, others are IGOs, yet others are

²¹ See Paragraphs 154–158 below

²² See www.theglobalfund.org/en/apply/mechanisms

NGOs, Public-Private Partnerships or Private Foundations. Each has its own objectives, constitution, management structure, funding stream and reporting system. The term ‘international health architecture’, which we have heard used to describe the interaction of the various bodies engaged in global disease control, is perhaps a misnomer as architecture implies order and planning. The reality is more like a house which has been—and is being—continually extended in response to *ad hoc* pressures by individuals and groups. The fact is that, however unsatisfactory the present situation may be, the actors involved cannot be compelled to operate in a particular way or to fund specific projects which they may see as being outside their stated objectives. As Professor Borriello put it, “the bodies, many of whom are independent, need to agree that there is value in them being coordinated” (Q 194). In this section therefore we have the limited objective of sketching out, from the evidence that has been given to us, where global health governance should be going and how it might perhaps get there.

153. A number of possible ways forward have been suggested to us, of which we shall examine just three—the formation of International Health Partnerships (IHPs), the establishment of a Global Compact for Infectious Diseases or the promotion of what has been called “networked governance” to reflect the political situation of the post-Cold War world.

International Health Partnership (IHP)

154. The IHP was launched in London in 2007. It brings together a first wave of donor²³ and recipient²⁴ countries together with a wide range of health-related IGOs and NGOs²⁵, whose objective is to make health-related aid work better for poorer countries by:

- focusing on improving health systems as a whole rather than on individual diseases or issues;
- bringing about better coordination of effort among donors;
- developing and supporting the health plans of recipient countries.

155. Dr Tyson described the IHP as “an accelerated effort ... to try and apply the principles of aid effectiveness signed up to in Paris in 2005 and to apply that to the health sector.” The aim is that all the participants—donors, recipients and implementers—should sign up to mutually-compatible obligations and should align their support with the national planning processes of recipient countries in order to improve health care. Dr Tyson described the IHP as “a joint process of mutual accountability” (Q 2). He continued:

“The International Health Partnership, we should not forget, builds on 15 years of experience in trying to get all partners, donors, civil society and the private sector working behind the national plan. It has not come out of the blue. We do have quite a lot of positive experience to build on” (Q 12)

Gillian Merron, Parliamentary Under-Secretary of State at DFID, believed that “the launch of the IHP was something of an important political

²³ UK, Norway, Germany, Canada, Italy, The Netherlands, France and Portugal

²⁴ Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal and Zambia

²⁵ WHO, European Union, World Bank, UNAIDS, UNFPA, GAVI, UNICEF, Gates Foundation, African Development Bank and the Global fund to Fight AIDS, TB and Malaria

milestone ... It is the first time the global health community have come together with a clear signal that we cannot go on as we are” (Q 1145)

156. The IHP may grow to encompass more donors, recipients and implementers; and, if that should happen, it may progressively take over coordination of external support to health care provision in many developing countries. In this respect it could be regarded as complementing WHO’s activities by providing an implementing arm to parallel WHO’s role of setting global health standards, conducting disease surveillance and providing in-country technical support. Dr Silberschmidt, while welcoming the launch of the IHP, appeared to have some reservations over its transparency and sustainability, and he drew to our attention an alternative proposal, still at an informal stage, that there might be a special committee (he referred to it as Committee C) of the World Health Assembly through which the various other players on the international health stage could be associated with the WHO. “One of the challenges of the coming years”, he said, “is to find a governance mechanism which keeps the momentum, keeps the independence of the organisation, but assures coordination between all the global health players” (Q 595).

157. Dr Lob-Levyt took a rather different view. He told us:

“I think the World Health Organisation’s strength is to its normative agendas, setting normative standards, and less on the implementation side. On the normative areas, yes. In terms of coordination, it is national governments that should be put in charge through the frameworks. There is a huge risk in putting one institution in charge of all coordination” (Q832).

Professor Fidler felt that “we are in early stages with regard to seeing how many of these informal partnerships operate”. He drew favourable attention to one of their notable features—namely, that they had sought to achieve their objectives, at this stage at any rate, through informal agreements rather than formal treaties. “There is a sense”, he said, “particularly in this initial innovative stage of finding some new alternative approaches, that a little bit more flexibility is better at the moment than trying to walk this into international law” (Q 964).

158. **Our assessment of the International Health Partnership concept is that it represents an interesting and innovative project which has the potential for bringing about considerable improvement in the coordination of global health efforts, particularly at the all-important country level. We shall, however, have to wait and see how the concept develops—whether other countries and implementing organisations join and whether the mutual obligations which participants undertake prove sustainable and really do result in the increased efficiency of health-related aid which is envisaged. We are pleased to hear the Minister’s affirmation of the importance of the IHP. We therefore recommend that the Government should throw its weight behind development of the concept in order to turn it into a reality as soon as possible. We recommend also that the IHP should be developed in a way which simplifies and avoids complicating further the already complex global health governance picture.**

A Global Compact for Infectious Diseases

159. The Global Compact concept has been advanced by Professor Harvey Rubin of the University of Pennsylvania. It is described in detail in written evidence submitted by him (pp 375–379). Briefly, Professor Rubin envisages that his Global Compact would have four main components:

- a shared international data and knowledge base, including information resulting from bio-surveillance and research;
- an international network of research centres to support fundamental research on threats from infectious diseases;
- an expansion of the production of drugs and vaccines;
- harmonisation of national standards, best laboratory practices and regulatory standards through the promotion of best practice.

The Compact would include States, who would enter into it as a treaty, and IGOs, NGOs, Academia and the private sector, who would be part of it under a system of pledges. The system would operate on the principle that the benefits of the Compact would be shared out among the players in proportion to their contributions to it. As Professor Rubin put it to us, “if you report your data, you will be high in the queue to get the vaccine; if you do this harmonisation, your scientists will be part of the governing body of the research centres” (Q 935).

160. Professor Rubin cited a topical example of a problem which would have been avoided if a Global Compact had been in existence at the time—namely, the reluctance of Indonesia to share H5N1 virus samples to facilitate the development and manufacture of avian influenza vaccines. In Professor Rubin’s view:

“This whole Indonesia H5N1 issue, I believe, never would have come to the table if we had linked the idea of receiving vaccines and drugs as part of contributing surveillance data. If we had understood that fundamental idea from the beginning, the Indonesians’ resistance to sharing sequence data, I do not believe it would ever have become a problem” (Q 918).

161. Professor Rubin felt that a Global Compact would promote adherence to the International Health Regulations, whose enforcement he described as “a major problem” (Q 934). Under a Compact, “the IHR would be an integral part of the Compact” (Q 936).

162. We see some potential benefits in the concept of mutuality underlying a Global Compact. If global disease control is to be effective, it must move away from the notion that it is something which developed countries do for developing ones and be seen as an activity in which each has something to give and something to gain. Thus, for example, while many of the treatment resources lie with developed countries, effective disease surveillance, let alone treatment and prevention, cannot be carried out without investment in and the cooperation of many developing ones. On the other hand, the Global Compact concept does not appear to have attracted widespread support to date among governments, IGOs or NGOs (QQ 929–933) and it is not clear to us how, even if the concept could be agreed internationally, it could be enforced. It is, however, early days and it is certainly possible that the GCID initiative may begin to attract support outside the relatively narrow circle in which it is operating at present.

Networked Governance

163. This model was described to us in evidence by Professor Fidler, who believed that the current situation of global health governance was the result of two developments within the last 10 years—namely, the end of Cold War superpower confrontation and the growth of non-State influences on the way in which international issues are addressed. Professor Fidler suggested to us that, with the ending of the Cold War, the foreign policy of the United States—and, by extension, of many other countries—had been released from a straitjacket of East-versus-West confrontation to engage in other issues of global concern, including health. “The political prominence we have of health today”, he told us, “is the result of the very specific political conditions that have developed in the post-Cold War period” (Q 986). He continued:

“There is no question that health as a foreign policy issue is now more important today than it has ever been in history ... There has been global realisation but, more importantly, realisation on the part of the rich developed countries, the great powers, that emerging and re-emerging infectious diseases are a threat to us and our interests directly and indirectly. That is part of the reason why it has arisen on all these various agendas” (QQ 994, 995).

164. Professor Fidler believed, however, that this situation could change if other issues of higher priority to foreign policy makers—he instanced developments in Iraq and the spread of Chinese influence in Africa—were to come to the fore. “Unless health gets embedded in all these areas of foreign policy”, he warned, “and gets deeply embedded, if we have big systemic changes, where we have great power rivalries coming back to the surface again, this will disappear. We will not be talking about health as a foreign policy issue in the way we do today” (Q 986).

165. Professor Fidler described the existing situation of global health governance as “open-source anarchy”. As a result of a variety of factors, including the arrival of global information technology and the emergence of non-State actors with substantial material resources, the governance of global health could now be accessed by a wide range of players who were not susceptible to governmental or intergovernmental control. Using the analogy of computer software, he told us:

“You have a source code that runs the software, runs the programmes for global health. That source code is now accessible and influenced by a range of actors. Via people in this networked context, they are following what is going on. The source code is open-source, it gets iteratively defined by the participation of the range of actors” (Q 979)

“The governance task”, said Professor Fidler in written evidence, “now extends beyond getting IGOs to function more effectively because non-State actors play significant, and increasingly influential, roles in global health, and especially with communicable disease issues” (p 379). He cited the involvement of The Gates Foundation as an example:

“Many people now believe that The Gates Foundation is becoming the *de facto* center of gravity for global health policy and funding, eclipsing the traditional lead role of the WHO and even the historically influential US CDC. This example constitutes just one feature of a rapidly changing context for addressing global health problems, a context that is

increasingly posing more and more difficult challenges for IGOs” (p 379).

For this reason Professor Fidler did not believe that any rationalisation of global disease control efforts which was based on the imposition of a formal structure was likely to succeed:

“I think architecture is the wrong model, because I do not think you are going to be able to control the behaviour of either States or the big powerful NGOs like The Gates Foundation. If you think it is hard to get the United States and George Bush to toe the line of the United Nations, try getting Bill Gates to toe the line of the WHO. He does not have to. Increasingly, The Gates Foundation is the first place people will pick up the phone to call, not the WHO” (Q 968).

166. So, if one accepts Professor Fidler’s analysis, what conclusions can we draw? He saw it as the evolution of what he called “networked governance”, which he defined as “networks of State, intergovernmental and non-State actors”. He regarded the new IHRs as an example of this process. “The way they build non-State actors directly into a global surveillance system is a very different model of global governance from what we saw before”. It was “an innovative way of trying to integrate the new actors” (Q 962). It represented a move away from the old State-centred approach and from formal treaty-based mechanisms. What was needed, in Professor Fidler’s view, was “a combination of existing mechanisms/processes but building in some of these innovative features, particularly to harness and take advantage of what non-State actors could bring to the table” (Q 963). At the moment, he believed, “we are in a political and institutional transitional period” (Q 966). What we were seeing was “a competition of ideas. The survival of the fittest is taking place right now. To some extent that is a necessary part of this transition” (Q 971). It was necessary to monitor the process, to see which ideas succeeded and which fell by the wayside and to build on the results. “You will then start to see the nodes of the networked governance become a little bit smaller, so you begin to get more coherency, and you begin to get more consensus” (Q 979).
167. Above all, Professor Fidler believed, there was a need for States to recognise that in the globalised world of the post-Cold War era the traditional patterns of inter-State diplomacy had changed and to adjust their operating practices accordingly. “We are chasing the whirlwind of 21st century diplomacy”, he wrote to us, “with an international system still tethered to 19th century patterns of State behaviour and cooperation. Caught in the middle are IGOs, such as WHO, which appreciate the disease trends but remain accountable to sovereign States and their interests” (p 375).
168. A similar analysis was given to us by Dr Iain Gillespie from OECD. He told us:
- “There is a great demand from the individual actors, whether they be PDPs or whatever, to develop a better system. That need not necessarily be a top-down issue imposed on them. What we need is space for them to come together to develop these kinds of networks” (Q 1035).

Dr Benedicte Callan, of OECD’s Directorate for Science, Technology and Industry, added:

“We are struggling with the question of where the gaps are in the network, where do they fail and what do they fail to do. There are these multiple communities of practice. There is an incredible—and in large part this is thanks to the Bill and Melinda Gates Foundation—renaissance of ideas and groups that are trying to fill in the various gaps” (Q 1035).

Discussion

169. We are attracted by elements of all three models. The International Health Partnership has the considerable advantage of being already in existence and of having influential participants. It is, in effect, a ‘coalition of the willing’ which is trying to bring greater rationality and synergy into the management of global health, especially at the all-important country level. Such self-help initiatives can often be successful where other, more top-down structures are difficult to bring about. As observed above, we believe the principle of mutuality underlying the Global Compact concept has much to commend it. It recognises that effective global control of infectious disease depends crucially on all countries, whatever their circumstances, cooperating for the common good, whether that takes the form of developing affordable vaccines and medicines, building up good disease surveillance or supplying virus samples, and that that is more likely to be achieved if each of the many actors perceives that it has a vested interest in actively participating.
170. Networked governance, in our view, represents the most accurate analysis of the problem which global health management now faces—in particular, the rise of powerful non-State actors and the rapid dissemination of knowledge around the globe. We note Professor Fidler’s view that top-down imposition of a new global health order is simply not realistic and that there is at the moment a process of natural selection taking place from which we can expect to see emerge in due course greater coherence. What concerns us is whether this process, left to itself, will necessarily lead in the direction of more synergetic and generally more effective global infectious disease control. While we recognise that a new order cannot be imposed, we cannot help feeling that the present situation cannot responsibly be left simply to work itself out in a *laissez faire* manner and that the future will be safer if there is a shared vision of where we are going and a body that is recognised as having responsibility for overseeing what is happening, promoting integrated or collaborative working and alerting the global community if the system shows signs of malfunctioning.
171. In our view, and indeed in that of most of those who gave evidence to us, the natural choice of organisation to exercise such a role is WHO. Its mandated functions of health policy formulation, standard-setting and technical support have recently been enhanced by a more proactive role in the crucial field of global infectious disease surveillance and response. WHO is therefore now well-placed to prepare, with the agreement of its Member States, a strategy for the future governance of global health and to encourage the many players on the global health stage to move towards it. On the basis of the evidence we have received, there should be broad support for WHO to assume such a role.
172. If, however, such an initiative is to succeed in bringing greater rationality and synergy to global disease control, it must be supported by resources as well as words. We have drawn attention above to WHO’s budgetary structure, in

which only a small proportion of total resources is available for investment in programmes which, from WHO's centrally-placed perspective, are essential to strengthen global disease control capacity. In the world in which we now live, where effective surveillance and response is crucial to disease control, we regard this situation as unacceptable and we have recommended above that WHO's budget should be re-balanced and increased. We would not wish to be misunderstood. We are not suggesting that Member States should sign a blank cheque and leave it to WHO to decide how much of its total resources should be spent on programmes to which it attached importance. What we are suggesting is that there should be some re-balancing, based on evidence of need from WHO, of the organisation's budget between Assessed and Voluntary Contributions in favour of the former. A management initiative currently being undertaken by the Department of Health in relation to funding of WHO, to which we refer below,²⁶ may provide a model.

173. **We therefore recommend that the Government should take the initiative, within the global health community, to promote a strengthening of WHO's role in two principal respects. First, Member States should be asked to agree, at the 2009 World Health Assembly, on a new Mission Statement which would give WHO a role of preparing a strategy for global health governance and promoting, through negotiation, an increase of collaborative working among the various actors, State and non-State, in the field of infectious disease control. Second, Member States should be asked to agree, on the basis of evidence of need presented to them by WHO, a re-balancing of the WHO budget between Assessed and Voluntary Contributions.**
174. Moving health governance forward at the global level is essential, but it is by no means the whole story. It is at the country level where the real problems of unintegrated working make themselves felt and where they have the potential to do most damage—for example, if health aid does not reach the sick people for whom it is intended or if host governments are so burdened with responding to a multiplicity of donors that they cannot do their work effectively. There was consensus among all those who gave evidence to us that the most appropriate way of promoting collaborative working among donors at country level was to align such efforts behind the health strategy and planning of the country concerned. Dr Lob-Levyt, from GAVI, told us that “the priorities should be set by the countries themselves and we should try and work behind those priorities, no question” (Q 824). Dr Getahun, from Stop TB, agreed that “an important line should be to work under the national government, under the national plan” (Q 748). We were encouraged to hear, from Diane Stewart of the Global Fund, that these principles are now being acted upon in some areas. Ms Stewart told us that “we are trying to move towards the approval of national strategies for funding, so countries will be able to develop their national strategies, say which piece of it they do not have the funds for, what is the gap, and submit that to the Global Fund for funding” (Q 641).
175. It is important to recognise, however, that in some countries the preparation and implementation of sound national plans cannot be carried out without external support. The Centre for Global Development wrote to us that, “where a host country's plan is weak or has gaps, donors should coordinate

²⁶ See Paragraph 183

efforts to assist the government and other country stakeholders to strengthen it” (p 470), and Dr Lob-Levyt commented that “in some areas, in order to ensure that there is informed decision-making and priority-setting, information is needed, and I think we rely on the normative role of agencies, such as WHO and others, to ensure that the correct information is available to the country to make those decisions” (Q 824). In other words, it is not enough simply for donors to align themselves with in-country health plans: they must, in many cases, support the development of sound plans which reflect real priorities and are capable of being implemented efficiently.

176. **We therefore recommend that the Government, working with other donors and with recipients, should aim to lighten the administrative burden of health aid on developing countries and to strengthen the capacity of those countries to manage health programmes. The aim should be to secure the alignment of donor inputs to disease control programmes within the national health programmes of recipient countries and to simplify the procedures for their management and reporting.**

CHAPTER 4: ACCOUNTABILITY AND MANAGEMENT

177. As will be seen from Table 1, the British Government invests substantial sums of taxpayers' money in IGOs in order to help curb the spread of infectious diseases, mainly in the developing world. We do not argue with the principle—or, indeed, the magnitude—of this investment, which serves the dual purpose, if successful, of relieving suffering in other parts of the world and at the same time keeping infectious diseases away from these shores. What concerns us is whether the investment is being managed in such a way as to maximise the effectiveness of the sums being spent and to ensure that its objectives are being achieved. Dawn Primarolo, Minister of State for Public Health at the Department of Health, endorsed this view. “We have to be accountable”, she told us, “for the resources that have been spent and to explain why that happened” (Q 1148).

Bilateral Funding

178. There was general agreement among those who gave evidence to us that a key underlying principle of UK Government aid in this field was that funding should go to governments in order to confer ownership of and support the implementation of national health plans rather than as donations earmarked for specific projects or purposes. In Dr Tyson's view, “money going to the government and being used effectively is not a great problem. In many, if not most, of DFID's African partners we have moved a large part of our resources into budget support. We have confidence that the policy environment is good, the practice is good, and the audits tell the same story” (Q 16). Others endorsed DFID's approach. Dr Bates, from the Royal College of Pathologists, told us that “DFID are one of the only organisations which are very far-thinking; they have pro-poor indicators on their programmes and programmes are not disease-specific. They are very much about strengthening systems ... DFID is a very good example of the sort of innovative thinking that you can have around building systems and structures” (Q 309). Dr Billo, from the International Union against Tuberculosis and Lung Diseases, was making a similar point when he told us that “when you fund programmes in an isolated way, you may run the danger that they only look at their area of interest and not look in a lateral way. DFID has quite a good reputation in addressing that issue and not just funding programmes, they like to have a more holistic approach” (Q 1078).

TABLE 1

**UK Government contributions to Intergovernmental Organisations
involved in Infectious Disease Control**

Organisation	DH	DFID
	£m	£m
WHO	13.6	18.0
UNICEF		21.0
UNICEF (Children with AIDS) (2004)		44.0
UNDP		55.0
UNAIDS		10.0

UNFPA		20.0
UNFPA Global Programme to Enhance Reproductive Health		17.0*
UNFPA (RHCS in Fragile States)		5.0
Global Fund to Fight AIDS, TB and Malaria		110.0*
Roll-Back Malaria Partnership		5.0*
Stop TB Partnership		1.0*
UNITAID		38.0*
Medicines for Malaria Venture		2.0*
Drugs for Neglected Diseases		1.5*
Global Alliance for TB Drug Development		1.5*
WHO Tropical Disease Research		1.0
WHO Global Pandemic Influenza Action Programme		2.0
WHO Pledge to fight Avian and Pandemic Influenza		35.0
Other		1.0
Totals	51.6	350.0
Grand Total		401.6

See HM Government Evidence, Volume II, Page 16. Unless otherwise indicated, figures refer to 2007. Figures marked with an asterisk are annual averages of multi-annual commitments

179. On the other hand, we have heard from many sources that, while alignment of health aid behind a recipient's national programme is the proper way to proceed, its ability to deliver results commensurate with the resources invested is crucially dependent on the existence of good in-country governance, meaning that there are systems in place both to manage donor funding efficiently and to preclude misappropriation of funds for other purposes. Dr Conlon, from the Royal College of Physicians, referred to non-evidence-based local management and to the need "to start educating people about responsibility for decision-making and the use of governance" (Q 315). Dr Lob-Levyt, from GAVI, told us:

"In those countries where you can rely less on the government financial systems, we would be looking more to intermediaries to provide some of that function. For example, the World Bank would take on much more of a financial stewardship role at the country level and transfer the finances to the programmes until the capacity in those countries has been built to operate through national budgetary systems" (Q 802).

Indeed, Dr Tyson had already suggested to us²⁷ that DFID followed such a case-by-case approach.

180. Gillian Merron, Parliamentary Under-Secretary of State at DFID, described to us her Department's arrangements for oversight of bilateral funding. "We identify with our partner governments", she told us, "what we expect for that [funding] and we monitor progress to make sure it is going to the right place". Continuing, she said:

²⁷ See Q 27

“We assess the risk before we commit ourselves to budget support and we audit the use of the funds afterwards. The main assessment is the fiduciary risk assessment, a very detailed investigation and analysis of the public financial management and accountability system of the partner government. It assesses the risk, it makes sure that funds will be used for the intended purposes, that they will be accounted for and that they will achieve value for money. Then we use a whole variety of mechanisms to check on the use of funds during project implementation. We do not just give the money and go away” (Q 1161).

The Minister added that “audits are undertaken by the partner government, international agencies and directly by DFID, including by the UK National Audit Office ... We take action if funds are not used properly. In 2007–08 we did reduce budget support to three countries—Sierra Leone, Ghana and Rwanda—because of issues that were related to public financial management and we also delayed budget support to Malawi and Sierra Leone pending receipt of Audit reports”²⁸. She concluded by saying that “we only use budget support where there is a commitment by the partner government to reduce poverty, respect human rights, improve their financial management and their good governance” (Q 1161).

181. **We are pleased to hear that the Government is alert to the need to operate effective control mechanisms. In view of this and of the generally favourable comments which have been made to us in the course of our inquiry by IGOs and other organisations concerned with infectious disease control as to the competence and effectiveness of DFID support to developing countries in the health field, we do not believe it appropriate or necessary to make any further observations on the management of UK bilateral aid programmes in this field.**

Multilateral Funding

182. As regards multilateral aid (UK Government funds provided through intergovernmental organisations), securing accountability and value for money is obviously more complex as there are other contributors whose perspectives have to be accommodated as well as our own, and ultimately accountability has to rely on the effectiveness of the control mechanisms of the IGOs themselves. Gillian Merron stated that “we are working hard to improve our assessment of multilateral effectiveness, first of all to provide the evidence that is necessary to have the discussions with multilaterals on their performance and also to inform our own decisions about where we allocate our own aid”. She told us that “we are developing a common approach to multilateral effectiveness with ten other donors through a system called MOPAN. We are developing a set of indicators and we will be piloting it at the end of the year”. MOPAN (Multilateral Organisations Performance Assessment Network) is a network of like-minded donor countries²⁹ founded in 2002 following a recognition that it would be more productive to monitor the performance of IGOs collectively rather than individually. MOPAN produces an annual survey looking at multilateral partnership behaviour. Ms

²⁸ In the time available we were unable to examine the audit reports referred to, but we have asked the Department to place copies in the Library.

²⁹ Current members are Austria, Canada, Denmark, Finland, France, Ireland, The Netherlands, Norway, Sweden, Switzerland and the UK.

Merron drew attention also to the Global Fund's system of performance-based measurement. As an example, she said, "as of December 2007, Global Fund support meant that we had 1.4 million people on ARV treatment, 3.3 million on TB treatment and 46 million insecticide-treated bed nets being distributed. So there are very clear indicators of what is coming out of the efforts rather than just what is going in". Nonetheless there were problems: it was often difficult to attribute overall benefits to individual funding contributions and there was "a need for agencies to be improving the quality of their evaluation and the rigour and consistency with which they are reporting results" (Q 1165).

183. The Minister of State for Health (Dawn Primarolo) outlined to us an initiative which the UK was taking with WHO in an effort to secure greater accountability. This involved negotiating with WHO mutually-agreed goals and objectives as a basis for providing funding on a more flexible basis than at present. She described this as "a sort of contract agreement with WHO" and "a framework that is transparent for the UK, hopefully a model for others, in terms of accountability of resources" (Q 1168). It seems to us that such a contractual relationship offers the promise of improved accountability by multilateral organisations, especially if pursued by other Member States as well as the UK and if applied not only to WHO but to other IGOs.
184. **We therefore recommend that the initiatives described to us—MOPAN and what might be termed a Service Level Agreement approach—should form the basis for new accountability arrangements between the UK—and, we suggest, other Member States—and IGOs operating in the field of infectious disease control.**

A Comprehensive Approach

185. In 2007 the Government published its proposals for a government-wide Global Health Strategy³⁰. In his foreword, the UK Chief Medical Officer spoke of the need for "concerted action on global health and for developing a global health strategy, one that will benefit the health of the UK population and those of the rest of the world". Professor Harper described this initiative as being "very much a cross-Whitehall, cross-agency strategy" whose purpose was "to try to brigade the interests so that we have a more efficient system" (Q 11). He told us:

"There is a Ministerial group that is chaired by the Minister of State for Public Health, Dawn Primarolo. She chairs a top-level group of Ministers from various Departments, including of course DFID, FCO, Treasury, Ministry of Defence, Defra, what is now DBERR and others—the Devolved Administrations, for example. There is a shadow group of officials who are working to pull together the strategy" (Q 24).

186. Dawn Primarolo told us that, while the Department of Health (DH) was the lead department for developing the Global Health Strategy, "it is not only about health and should not only be left to health. It is important that we look for the policy synergies in other departments as well": she instanced DFID and the Foreign and Commonwealth Office (FCO) as having particular interests (QQ 1150–1151). The Minister gave "a very specific assurance to the Committee that our departments—the Department of

³⁰ "Health is Global", Department of Health, 2007

Health, DFID and the FCO—are working together on the institutional strategy. We are finalising that, and it is the UK’s engagement with the World Health Organisation, which of course the Department of Health takes the lead on” (Q 1144).

187. While we applaud the initiative which the Government is taking in developing a Global Health Strategy, we would place a question mark over whether the lead should necessarily lie with DH. The answer to this question depends, to a large extent, on what the strategy is meant to achieve. Though the Minister suggested to us that it was “about how the whole of government should be interacting and working with the WHO”, the Government’s *Health is Global* report takes a rather wider view, including international development and interaction with a range of IGOs. There is no doubt that, with its responsibility for formulating health policy for this country and for representing the UK at the WHO, DH is a substantial stakeholder in the Strategy. However, it is arguable that, from the point of view of global infectious disease control, others are equally, if not more, heavily engaged. DFID, as will be apparent from Table 1, provides the lion’s share of UK funding for international disease control and is the department with staff working on the ground in developing countries. Indeed, we have been struck during our inquiry by the *de facto* lead which DFID has assumed in providing evidence and answering our questions. FCO too has a considerable stake in an area of activity which is increasingly becoming focused on the conduct of relations with other countries and with intergovernmental organisations. At a recent symposium in Geneva on “Foreign Policy and Global Health”, Dr Margaret Chan, Director-General of WHO, called for health “to be given a high priority in foreign policy” and for health to be regarded as “a worthy area for foreign diplomacy”³¹.
188. Switzerland has recently given serious consideration to this question of how health policy can best be nationally coordinated in an era when health management is becoming increasingly subject to external drivers. Like the UK, Switzerland has its Health, International Development and Foreign Ministries³². Dr Silberschmidt, of the Swiss Federal Office of Public Health (SFOPH), told us:

“I have had exchanges with many colleagues from other industrialised countries and the tension we most often have is that the Minister of Health is in the lead in the WHO, whereas the Ministry of Development has most resources and is paying most money to WHO. All the time there is the question as to who is really the decision-maker” (Q 588).

This has led the Swiss to develop the concept of a ‘Health Foreign Policy’, in which the Federal Department of Foreign Affairs (in Dr Silberschmidt’s words) acts as broker between the Health and Development Ministries. It has also involved the creation, within the Swiss Federal Department of Foreign Affairs, of a Coordinating Office which is “the contact point for all relevant enquiries from the FOPH and other offices of the federal administration” and which “ensures the coherence of health foreign policy as part of overall Swiss foreign policy”³³.

³¹ Symposium “Foreign Policy and Global Health: working together towards common goals”, 13 June 2008

³² The Swiss Federal Office of Public Health, the Swiss Agency for Development and Cooperation, and the Swiss Federal Department of Foreign Affairs, respectively.

³³ “Swiss Health Foreign Policy”, Page 18

189. **We do not suggest that the UK should simply replicate the Swiss arrangements. Nor do we have a ready-made solution to the problem to offer. We do, however, recommend that the Government should take another look at the machinery for coordinating UK policies with a view to ensuring that the interests of those Whitehall departments who are closely involved with the international dimension of global health are given their due weight and that this is reflected in the arrangements for leadership of the Global Health Strategy.**

CHAPTER 5: SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Infectious Diseases

190. We recommend that at the High Level meeting called by the UN Secretary-General for September 2008 the Government not only re-affirm the MDGs but give a lead in ensuring that adequate resources are committed and targeted in particular on those areas where progress is lagging (including health). (Paragraph 28)
191. We recommend that the Government support and contribute to an increase in resources being allocated to family planning throughout the developing world and back other consensual programmes designed to slow world population growth. (Paragraph 29)
192. We recommend that the Government in its own aid programmes should aim to achieve an effective balance between 'vertical' and 'horizontal' health programmes and should encourage other donors and the World Health Organisation to do likewise. In this context the Government may wish to explore whether an appropriate percentage of health aid provided through IGOs should be earmarked for the strengthening of health systems. (Paragraph 43)
193. We recommend that the Government should press the issue of investment in health care infrastructures within the World Bank with a view to bringing about an increase in such investment within the framework of sensibly streamlined application procedures and appropriate safeguards in relation to in-country governance. (Paragraph 44)
194. We believe that it is an integral part of Britain's own defences against the spread of pandemic outbreaks of disease that warning and preventive systems in developing countries be strengthened and that, where necessary, the resources and skills to effect this are provided. We therefore recommend that the Government should consider urgently how greater priority can be accorded, both in its bilateral funding of developing countries and in the resources which are provided through organisations of which the UK is a member, to bringing infectious disease surveillance and response systems up to an effective level. (Paragraph 56)
195. We recommend that, in achieving an appropriate balance of investment, both of UK bilateral aid and of funding provided through IGOs, and in using its influence within the World Bank to encourage increased investment in health care infrastructure, the Government should regard the building up of in-country surveillance and diagnostic capabilities for antimicrobial resistance as a high priority component. (Paragraph 65)
196. We recommend that the Government should support, within WHO and other relevant IGOs, the development of health diplomacy training to enable developing countries to make the fullest use of the flexibilities in the WTO's Doha Declaration on TRIPS. (Paragraph 75)
197. We recommend that the Government should consider whether the UK might provide a lead either by establishing relevant training courses in this country, perhaps under the auspices of DFID, for suitable officials from developing countries or by sponsoring officials from developing countries to attend

existing courses, such as the Summer Programme on Global Health Diplomacy at the Graduate Institute of International Studies in Geneva, or by seconding suitably-trained UK officials to support selected developing countries in their negotiation of individual agreements. (Paragraph 76)

198. We recommend that the Government should throw its weight against the inclusion, in bilateral or regional trading agreements, of proposals inhibiting the use by developing countries of the Doha flexibilities. (Paragraph 77)
199. We recommend that the Government should support, both bilaterally and multilaterally, the development of sound long-term funding mechanisms which are able to offer incentives to pharmaceutical companies to develop new medicines at prices which can be afforded by poorer countries. (Paragraph 81)
200. We have concluded that, so far as controlling the spread of infectious diseases is concerned, the deliberate release of toxic organisms should not be considered as in a separate category from the normal arrangements for controlling natural outbreaks. We recommend that the Government should support, both nationally and intergovernmentally, generic surveillance and response systems which are capable of addressing both deliberate and naturally-occurring outbreaks of infectious diseases. (Paragraph 87)

International Health: The Institutional Labyrinth

201. Reforming WHO's internal structure is an essential, though challenging, prerequisite of improving global health governance. While it is true that some progress has been made and that the Regional and Country Offices are now more willing to cooperate following the SARS experience, a more fundamental overhaul of the relationship between headquarters and regions and a review of the current procedures by which Regional Directors are appointed seems overdue. Given the threats to global health which we face from newly emerging infectious diseases, a dysfunctional organisational structure within the world's principal policy-making, standard-setting and surveillance body simply cannot be afforded. We therefore recommend that the Government should bring its influence to bear, along with that of other like-minded Member States, to ensure that a fundamental review is initiated of the inter-relationship between WHO Headquarters and its Regional and Country Offices and of the system of appointment of Regional Directors so that WHO as a whole is better structured to meet the contemporary challenges of global health management. (Paragraph 111)
202. We recommend that, when budgetary negotiations for the next biennium get under way, the Government should support a re-balancing of WHO's budget in order to make more funds available for the core budget. (Paragraph 113)
203. Infectious diseases pose a major threat both to this country and to the wider world, and we believe that WHO will need additional funding if it is to be able to respond effectively to these threats on behalf of the international community. The UK is already a major funder of WHO and we are mindful of current budgetary constraints. We recommend however that the Government, in concert with other Member States, should work towards an increase in financial contributions to WHO. (Paragraph 114)
204. As regards ECDC, we believe that it will be important that duplication and overlap does not occur and that ECDC does not become a further

complicating factor in an already complex system of global disease management. (Paragraph 119)

205. We recommend that the Government should pursue, as a matter of urgency, through its membership of the relevant IGOs the creation of an event-reporting system for animal diseases along the same lines as the new IHRs relating to human health and should encourage the building up of much stronger systems of cooperation between the bodies dealing with human and animal health in sharing information and handling reports of disease outbreaks. (Paragraph 128)
206. We recommend that the Government should continue to encourage the development of integrated strategies for combating TB and HIV and should satisfy itself, before committing funds to fight one or both of these two diseases in developing countries, that there is adequate local recognition of the problem of TB-HIV co-infection and that there are sound programmes in place to address it. (Paragraph 137)
207. We recommend that the Government should, via its representatives in the relevant UN agencies, seek to ensure that instances of non-collaborative working are highlighted and remedied. We recommend also that the Government should urge the UN Secretary-General to give WHO a clearer lead role. (Paragraph 147)
208. Our assessment of the International Health Partnership concept is that it represents an interesting and innovative project which has the potential for bringing about considerable improvement in the coordination of global health efforts, particularly at the all-important country level. We shall, however, have to wait and see how the concept develops—whether other countries and implementing organisations join and whether the mutual obligations which participants undertake prove sustainable and really do result in the increased efficiency of health-related aid which is envisaged. We are pleased to hear the Minister's affirmation of the importance of the IHP. We therefore recommend that the Government should throw its weight behind development of the concept in order to turn it into a reality as soon as possible. We recommend also that the IHP should be developed in a way which simplifies and avoids complicating further the already complex global health governance picture. (Paragraph 158)
209. We recommend that the Government should take the initiative, within the global health community, to promote a strengthening of WHO's role in two principal respects. First, Member States should be asked to agree, at the 2009 World Health Assembly, on a new Mission Statement which would give WHO a role of preparing a strategy for global health governance and promoting, through negotiation, an increase of collaborative working among the various actors, State and non-State, in the field of infectious disease control. Second, Member States should be asked to agree, on the basis of evidence of need presented to them by WHO, a re-balancing of the WHO budget between Assessed and Voluntary Contributions. (Paragraph 173)
210. We recommend that the Government, working with other donors and with recipients, should aim to lighten the administrative burden of health aid on developing countries and to strengthen the capacity of those countries to manage health programmes. The aim should be to secure the alignment of donor inputs to disease control programmes within the national health

programmes of recipient countries and to simplify the procedures for their management and reporting. (Paragraph 176)

Accountability and Management

211. We are pleased to hear that the Government is alert to the need to operate effective control mechanisms. In view of this and of the generally favourable comments which have been made to us in the course of our inquiry by IGOs and other organisations concerned with infectious disease control as to the competence and effectiveness of DFID support to developing countries in the health field, we do not believe it appropriate or necessary to make any further observations on the management of UK bilateral aid programmes in this field. (Paragraph 181)
212. We recommend that the initiatives described to us—MOPAN and what might be termed a Service Level Agreement approach—should form the basis for new accountability arrangements between the UK—and, we suggest, other Member States—and IGOs operating in the field of infectious disease control. (Paragraph 184)
213. We do not suggest that the UK should simply replicate the Swiss arrangements for global health policy formulation. Nor do we have a ready-made solution to the problem to offer. We do, however, recommend that the Government should take another look at the machinery for coordinating UK policies with a view to ensuring that the interests of those Whitehall departments who are closely involved with the international dimension of global health are given their due weight and that this is reflected in the arrangements for leadership of the Global Health Strategy. (Paragraph 189)

APPENDIX 1: AD HOC COMMITTEE ON INTERGOVERNMENTAL ORGANISATIONS

The members of the Committee which conducted this inquiry were:

Lord Avebury
Lord Bowness*
Lord Desai
Baroness Eccles of Moulton**
Baroness Falkner of Margravine
Baroness Flather†
Lord Geddes
Lord Hannay of Chiswick
Baroness Hooper††
Lord Howarth of Newport
Lord Jay of Ewelme
Lord Soley (Chairman)
Lord Steinberg
Baroness Whitaker

* until 28 January 2008

** since 18 February 2008

† until 17 March 2008

†† since 31 March 2008

Declaration of Interests

A full list of Members' interests can be found in the Register of Lords Interests:

<http://www.publications.parliament.uk/pa/ld/ldreg.htm>

APPENDIX 2: CALL FOR EVIDENCE

The Committee has decided to undertake an inquiry into the effectiveness of action carried out through intergovernmental organisations of which the UK is a member to control the global spread of communicable diseases. You are hereby invited to submit written evidence to the inquiry. The deadline for submissions is Monday 21 January 2008.

About the Committee

This is a new Select Committee of the House of Lords, the Upper Chamber of the British Parliament. It was established in November 2007 with the following remit:

“To consider how contemporary issues of international policy are addressed through United Kingdom membership of intergovernmental organisations (excluding the European Union), including their impact and value for money”.

The Committee’s approach to its work is a thematic one—that is to say, it focuses on specific policy objectives and examines how these are being addressed via action through intergovernmental organisations. The EU exclusion reflects the fact that the House of Lords already has a European Union Committee. However, while scrutiny of EU activity *per se* lies outside the new Committee’s remit, it may examine the interface between activity by the EU and by non-EU intergovernmental bodies. The Committee’s remit is also limited to *intergovernmental* organisations and thereby excludes non-government bodies. However, the Committee is interested to hear non-government as well as government and intergovernmental perspectives and both types of organisation are therefore invited to submit written evidence.

The Members of the Committee are:

Lord Avebury, Lord Bowness, Lord Desai, Baroness Falkner of Margravine, Baroness Flather, Lord Geddes, Lord Hannay of Chiswick, Lord Howarth of Newport, Lord Jay of Ewelme, Lord Soley (Chairman), Lord Steinberg and Baroness Whitaker.

About the Inquiry

Infectious disease knows no national boundaries. The rapid spread of HIV/AIDS during the last 20 years, the more recent outbreak of SARS (Severe Acute Respiratory Syndrome) and now H5N1 Avian Influenza have underlined the importance of international action to control the spread of such diseases before they become pandemics. At the same time other infectious diseases, such as Tuberculosis and Malaria, have become greater threats with the emergence of widespread drug-resistance. Drug-resistant TB has claimed many lives both in the UK and elsewhere, and the death rate from Malaria in infancy and childhood is high in many parts of the world—over 3,000 people die every day from the disease. In addition, with climate change, areas of the world which have hitherto been Malaria-free are becoming threatened by the disease, as the anopheles mosquito shows signs of spreading more widely.

This is not the first time that the House of Lords has addressed the subject of communicable diseases. In 2003 the Science and Technology Committee reported on the impact of infectious diseases in the UK and its report underlined also the importance of international collaboration. In 2005 the same committee conducted an inquiry into Pandemic Influenza. Its report was focused primarily on the measures which the UK Government was taking to deal with an outbreak of the

disease if one should occur, but it noted also that prevention is better than cure and that there is a need for increased collaborative action with source countries in order to arrest the disease before it begins to spread globally. The present inquiry is focused on an in-depth examination of action through intergovernmental organisations to control the global spread infectious diseases generally and of Avian Influenza, HIV/AIDS, Malaria and Tuberculosis in particular. The Committee wishes to assess the overall effectiveness of intergovernmental action in these fields and to explore the synergy with which the various bodies involved are operating.

The Issues

This Call for Evidence is addressed to a wide range of organisations. Some of them are national and others international bodies; some of them fall within government while others are non-government organisations; and some are focused on the control of specific diseases while others are concerned with the field more generally. In responding, therefore, you will need to be selective and to answer those questions in which you consider you have an interest.

The principal issues on which the Committee would welcome your views are:

1. A recent report on Communicable Diseases by the UK Department of Health stated that “post-war optimism that their conquest was near has proved dramatically unfounded”. What is your assessment of the overall position? More specifically, is it simply that not enough progress is being made in reducing the spread of such diseases? Or is the global situation actually deteriorating? Would it be an exaggeration to talk of a crisis?
2. What reliable data exist regarding the numbers of people infected globally with the four diseases³⁴ on which the Committee is focusing particular attention? What trends are discernible in both the numbers infected and the patterns of infection? And what are the main underlying causes of infection and of any changes in its incidence and pattern?
3. What intergovernmental surveillance systems exist to give early warning of outbreaks of infectious diseases? Are these systems adequate? And what improvements might be made?
4. Given the continuance of current or planned intergovernmental programmes to prevent or control the four diseases, what predictions can be made of their likely spread and pattern over the next 10 years?
5. What do you consider to be the principal blockages to achieving progress in the prevention or control of the four diseases? And how might these blockages be removed by more, or better-targeted or better-coordinated intergovernmental action?
6. What role does your organisation play in combating the four diseases? Do you believe that it is correctly configured and adequately resourced to do the job? With which other organisations do you collaborate? How would you assess the degree of synergy?
7. What are the main non-health causes (e.g. global warming, poverty, changes in land use, international travel, lifestyle, population) of the spread of the four diseases? To what extent can intergovernmental action in non-health fields contribute to alleviation of their spread? What action is taking place or planned in these areas? And what more needs to be done? Do you consider that there is sufficient ‘joined-up’ thinking in approaching the problem?

³⁴ HIV/AIDS, Tuberculosis, Malaria and Avian Influenza

8. Cases of Tuberculosis fell progressively in the UK until the mid-1980s but started to rise again in the early 1990s. Around 6,500 cases are now reported each year, an increase of about a quarter since the early 1990s. What are the main factors of the revival of Tuberculosis infections in Britain? And how could intergovernmental action help to reverse the trend?
9. Tuberculosis is potentially curable by long-term antimicrobial therapies. Yet the numbers of reported cases worldwide seem to be rising. Are the necessary medicines not getting through to patients? What are the barriers to effective long-term therapy? Are we now seeing infections which stem from other conditions—e.g. HIV/AIDS? Or are there other reasons why a treatable disease should be spreading? How might intergovernmental action help to deal with this situation?
10. To what extent do you believe that the 2004 Stockholm Convention limiting the use of DDT against Malaria-carrying mosquitoes has been a factor of increases in the spread of the disease? Has any risk analysis been carried out comparing the relative dangers to human health posed by DDT and Malaria?
11. What intergovernmental action is planned or in hand for early detection of the transmission of Avian Flu from birds to humans and of human-to-human transmission in potential source countries? Is this proving sufficiently effective to prevent an Influenza pandemic? What more could be done?
12. To what extent do you consider that the rise in infections in the four diseases is attributable to increased microbial resistance to antibiotics? What intergovernmental action is taking place in this area?
13. In a number of countries, including the UK, there is a problem with hospital-acquired infections. What intergovernmental sharing of knowledge is taking place to help bring this problem under control?
14. Are there any difficulties with regard to patents or intellectual property which are impeding the flow of medicines or other control methods to those infected? Is intergovernmental action needed to improve the situation?
15. What interchange exists between States in regard to knowledge of and training in the diagnosis and treatment of the four diseases or regarding preparations for dealing with outbreaks? What improvements might be made through intergovernmental action?
16. The International Health Regulations 2005 are intended to provide a global framework for the rapid identification and containment of public health emergencies. How effective do you consider this response system to be? Do improvements need to be made?
17. What intergovernmental planning has been undertaken to cope with the impact of an outbreak of infectious disease caused by deliberate release of micro-organisms into the environment? Is there adequate liaison between the various agencies involved, including intelligence, law enforcement and health care professionals? How could action by intergovernmental bodies help further?
18. Though our remit is focused specifically on known infectious diseases, we would be interested to know how you view the global threat from new or previously unrecognised ones and from the transmission of infections from animals to humans.
19. What resources (subscriptions, staff, training, medicines etc) does the UK Government commit to intergovernmental bodies to help in the fight against the four diseases listed?
20. Do you wish to provide any other relevant information in addition to what you have said in answer to the above?

APPENDIX 3: LIST OF WITNESSES

The following witnesses gave evidence. Those marked * gave oral evidence.

- Academy of Medical Sciences
- Association of Port Health Authorities
- British Association for Sexual Health and HIV
- British Infection Society
- * Centers for Disease Control and Prevention
- Center for Global Development
- * Dawn Primarolo MP, Minister of State for Public Health
- * Gillian Merron MP, Parliamentary Under-Secretary of State for International Development
- * European Centre for Disease Prevention and Control
- * Professor David Fidler, Indiana University School of Law
- Food and Agriculture Organization of the United Nations (FAO)
- * GAVI Alliance
- GlaxoSmithKline
- * Global Fund to Fight AIDS, Tuberculosis and Malaria
- Global Influenza Surveillance Network
- Health and Safety Executive
- * Health Protection Agency
- * HM Government
- * Imperial College London
- International Civil Aviation Organization (ICAO)
- * International Federation of Pharmaceutical Manufacturers and Associations (IFPMA)
- * International HIV/AIDS Alliance
- International Organization for Migration (IOM)
- International Pharmaceutical Federation (FIP)
- * International Union Against Tuberculosis and Lung Disease
- * Liverpool School of Tropical Medicine
- * London School of Hygiene and Tropical Medicine
- London School of Hygiene and Tropical Medicine—Malaria Centre
- * Malaria Consortium
- * Professor Sir Michael Marmot, University College London
- Medical Research Council
- Merlin
- Nuffield Council on Bioethics

- One to One Children's Fund
- * Organisation for Economic Co-operation and Development (OECD)
- Research Councils UK
- RESULTS UK
- * Royal College of General Practitioners
- * Royal College of Pathologists
- * Royal College of Physicians
- Royal College of Physicians and Surgeons of Glasgow
- * Professor Harvey Rubin, Institute for Strategic Threat Analysis and Response (ISTAR), University of Pennsylvania
- * Stop TB Partnership
- * Swiss Federal Office of Public Health
- * Target Tuberculosis
- * TB Alert
- * Terrence Higgins Trust
- * UNAIDS
- United Nations Association of the UK (UNA-UK)
- United Nations Population Fund (UNFPA)
- United Nations High Commissioner for Refugees
- UNICEF
- * UNITAID
- United Nations System Influenza Coordination (UNSIC)
- * University College London
- * University of Oxford
- Wellcome Trust
- * World Health Organization (WHO)
- * World Intellectual Property Organisation
- * World Organisation for Animal Health (OIE)
- World Trade Organization

APPENDIX 4: PRINCIPAL INTERNATIONAL ORGANISATIONS WHO ARE INVOLVED IN OR WHOSE ACTIVITIES ARE RELEVANT TO CONTROLLING THE SPREAD OF INFECTIOUS DISEASES (NOT EXHAUSTIVE)

Intergovernmental Organisations

Council of Europe (CoE)

European Centre for Disease Prevention and Control (ECDC)³⁵

International Civil Aviation Organization (ICAO)

International Labour Office (ILO)

International Maritime Organization (IMO)

International Organization for Migration (IOM)

Organisation for Economic Co-operation and Development (OECD)

Pan American Health Organisation (PAHO)

UN Children's Fund (UNICEF)

UN Development Programme (UNDP)

UN Food and Agriculture Organisation (FAO)

UN High Commissioner for Refugees (UNHCR)

UN Office on Drugs and Crime (UNODC)

UN Population Fund (UNFPA)

UN System Influenza Coordination (UNSIC)

UNAIDS

World Bank (WB)

World Health Organisation (WHO)

World Intellectual Property Organization (WIPO)

World Organisation for Animal Health (OIE)

World Trade Organization (WTO)

National Governmental Organisations

UK Department for International Development (DFID)

US Centers for Disease Control and Prevention (CDC)

US President's Emergency Plan for AIDS Relief (PEPFAR)

³⁵ ECDC is an Agency of the European Union

Non-Governmental Organisations

Interact Worldwide

International Alliance of Patients' Organizations (IAPO)

International Committee of the Red Cross (ICRC)

International Federation of Pharmaceutical Manufacturers and Associations

International HIV/AIDS Alliance

International Society for Infectious Diseases (ISID)

International Union Against TB and Lung Diseases

Malaria Consortium

Médecins Sans Frontières (MSF)

Merlin

Oxfam

Results UK

Save the Children

Target TB

TB Alert

Terrence Higgins Trust

Tropical Health and Education Trust (THET)

United Nations Association of the UK (UNA-UK)

Public Private Partnerships (PPPs)

Drugs for Neglected Diseases Initiative (DNDI)

GAVI (Formerly the Global Alliance for Vaccines and Immunisation)

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

International AIDS Vaccine Initiative (IAVI)

Medicines for Malaria Venture (MMV)

Roll Back Malaria Partnership

Stop TB Partnership

UNITAID (International Drug Purchase Facility)

Private Foundations

Bill and Melinda Gates Foundation (Gates Foundation)

William J Clinton Foundation (Clinton Foundation)