Transcript of Ilona Kickbusch PhD's lecture:
Tuesday 14 February 2006

Dr Carol Tannahill:
Welcome to everyone. It's very nice to see you here and many thanks to Glasgow Caledonian University for providing us with this venue. We haven't been here before so it's very nice of you.

For those of you who don't know me, I'm Carol Tannahill and I have the pleasure of being the Director of the Glasgow Centre for Population Health. You're obviously aware of the Centre because you have come along today, but we run these seminars every month and we have had such an interesting programme of speakers from a range of different backgrounds and it's an absolute pleasure tonight to welcome Ilona Kickbusch. Ilona's name, I think, will be known to many of you. She has been a leader in the areas of health promotion, international health, health governance, healthy cities, health promoting hospitals, health promoting schools and the list goes on. Indeed Ilona has really been at the forefront of many of the developments that have contributed to improved health and improved partnerships for health across the world over the last two and a bit decades. So we are enormously privileged that Ilona has travelled here today to be with us. Tonight she is going to talk to us about global health, the challenges of improving health globally and the importance of health as a global public good. Ilona will speak for around fifty minutes and then we will have an opportunity for some discussion at the end. So without any further ado, Ilona, I will hand over to you and thanks again for coming along tonight.

Ilona Kickbusch PhD
Well, thank you very much and good afternoon. I've been told that these lectures are think pieces and so I've taken the opportunity to put forward some thoughts and to try to push the envelope a bit about how we might think about global health and global governance. I'll also talk about what that means at the local level because the global is not something that is out there somewhere; the global is something that's very much here. Actually, trying to find our way to this lecture hall and seeing the many students here at this university it was very clear that the global is here; it's not somewhere else.

So, I'll make five points. Some of them I will just touch upon, but I'll try to give you a holistic picture of the elements I think one needs to bring together as one discusses this and you will still find that major points are missing. For example, I'll not be able to say much about global environmental policy, which obviously has a strong impact on health. There will always be bits that you find are missing, but maybe the framework has something to offer.

So firstly I'll say a bit about global health governance dynamics. Just by choosing the word dynamics, I guess, you can hear that I think this is a field that is not stable; we don't know where it's going. There are many different energies and forces at work and I really think at this point we don't know where we will end up. It could be much worse than it is today; it could be a little bit better. I'll then try and speak about the new borderless domains of action that we need to consider in the global health arena. If we take that kind of view of borderless domains that I call 'healthscapes' it means that we need very different policy instruments to deal with them. And I'll say a bit about what is now called global domestic politics and policies and share with you the idea of a global health treaty that was also launched at a recent discussion conference of the WHO in Bangkok.

If we look at the 21st century dynamics in relation to health I think over the last couple of years we have come to realise that it goes in two directions. On the one hand very clearly the processes of globalisation influence health, but particularly over the last couple of years we have come to look at the way health impacts on globalisation. If you wonder what this strange picture at the bottom is *[referring to slideshow]* it's the bird flu virus and that obviously is a very good example of how health impacts globalisation and globalisation impacts health. Initially in the public health arena and still a lot of important work is being done here, there is an analysis of how these processes of restructuring lead to more global inequality and, particularly, to a growing health gap between countries, how the many social determinants of health are affected and, therefore, actually make the health of many people around the world worse than it was perhaps 10, 20 or 30 years ago and that clearly is the case in many parts of Africa.

The return of infectious diseases is something that we are all confronted with. An issue that is frequently neglected but has come into view much more over the last couple of years perhaps is the chronic disease epidemic – tobacco, obesity, diabetes. Globally, at this point, I understand diabetes is probably killing more people than HIV / AIDS is. So we are not as aware of the chronic disease epidemic as we are of the infectious disease epidemic. On the other hand, in terms of health influencing globalisation, there are two very important dynamics there. Initially the thinking was as wealth develops, health develops. I think that was also something that Margaret Thatcher thought a couple of decades ago – with wealth comes health. We now know from many studies – public health people I think, always knew it, but economists sort of had to find this out – that actually health helps create wealth. A very major study, the study of the commission on macroeconomics and health which was initiated by the World Health Organisation made very important arguments about the contribution that health makes to development and to economic growth. Actually, it takes us back to early definitions of health and development in an important WHO document, the Alma Ata Declaration, which said that health means being able to lead a socially and economically productive life. So this idea of health as a determinant of growth and development is important for the developing world, but what is also interesting is that over the last five years or so there've been increasing studies on what health also means for the productivity and wealth in the rich countries in the developed world.

Now, to some extent we know some of these things from studies in health of the workplace etc, but the really interesting thing is that macroeconomics has taken this up and is starting to discuss health as a form of capital.

So there is a big discussion here about how health contributes to the economy and to quality of life but at the same time there's also increasing realisation in the global world that it costs a hell of a lot if something goes wrong. If you take this cost of when something goes wrong, this cost of course is not just borne somewhere in global outer space. If globally something goes wrong the cost, of course, is frequently a local cost; the burden is carried by the local level. And there have been interesting studies, for example, on the cost of SARS. I've taken the example here of the cost of SARS to Toronto. In Toronto 12,000 people lost their jobs and the local economy had a cost of over 1 billion US dollars in 2003 alone, so a whole range of the follow up costs to the local economy have not even been calculated there. For the Asian cities (Hong Kong, Singapore etc) the figure is really quite extraordinary. The SARS epidemic has cost South East Asia 60 billion US dollars and if you were to calculate that it's a cost per person of 6 million dollars.

So you can see this is truly a phenomenon of globalisation, of greater interdependence, accompanied by an uneven share of risk and of cost. And that is why people speak of a 21st century risk society which is very much based on interdependence. There are two aspects to this: on the one hand global governance needs to respond to the fact that risks are trans-national, for example the spread of SARS throughout the world, but at the same time that local governance needs to respond to this because obviously the global risk production is localised through the globalisation of everyday life. The question at the local level and for local authorities, just as much as for nation states, is: do we know how these things impact on us? How prepared are we for certain impacts? What would our response be? Who should be involved in being prepared? Who should be involved in the planning? And for those of you that are interested in some of this kind of thinking, there was a very interesting follow-up conference in Toronto after the SARS epidemic where the city of Toronto, the public health authorities, came together with the business community and said, you know, this is a joint problem and we don't want to go through this again. What must we do jointly to approach this? What is your responsibility; what is our responsibility? And that's a very interesting approach that is rather new and that brings different actors together in a new way.

Today, of course, we are all discussing the avian influenza and the fact that it's also reached Europe. There are calculations of what a global influenza epidemic of humans would cost the world. Nobody dares say how many deaths it would bring with it, but again the financial calculations are quite extraordinary and the economist sources say this could lead to a major global recession.

So you get this enormous dynamic between health and development and the economy that all of a sudden puts public health into a context and into a debate where it has not been for a very long time. Actually in the 19th century a lot of public discussion was economic – if you just read up all the discussions around quarantine and the start of international health – but I think for us, people in public health, this is sometimes new and because we are interested in humans when people start talking money and economics we say 'well, this is not really what we are about' and we get a bit nervous and say we don't want to be subject to an economic paradigm; we work for health as a human right.

However, I think it is very important to see where those things come together, where they are really different, and also where we need to have our figures at hand because we obviously need to argue very strongly for why we need investments in health and what the outcome, the output, of such investments would be. So you can see here again this point that I'm trying to make: the global and global health is not something that just international organisations do somewhere and that might affect us or not. Global health is not about health in developing countries; it's not overseas aid. It's really how we deal with health here and now in a global society. Also it's not always 'the other' that we feel we can identify, but it's ourselves and that, to some extent, is what this cartoon *[referring to slideshow]* from Canada expresses – we can't really say where the threat comes from, we cannot identify it any more. As one of my friends from CDC used to say, when we're on an aeroplane we have this automatic feeling we don't want to sit next to a person that perhaps doesn't look like us and might be sneezing, whereas the much more dangerous person for health might be the person that looks just like us who sits in first class and is the CEO of a tobacco company. So the threat is something much more unspecific. That is another reason why, in terms of global governance, we cannot say 'you are a threat to us'. In many cases, we are a threat to you and we are a threat to ourselves and that is something, in terms of strategy, that we need to look at.

So, as I said, in public health we are used to seeing health as a human right, something we absolutely need to insist on. We need to see health as a resource, but we also need to see health truly as a driving force in modern societies, as an investment and as a determinant of our quality of life. And increasingly in a number of countries there is what is called a vital interest in global health. That was also the title of an important study of the institute of medicine that said 'why must we, in developed countries, be interested in global health?'. It's not only that we should do good for developing countries or we should be committed to social justice, but also that there is a very clear self interest, an enlightened self interest, that we jointly need to create a healthier world. If we go back to one of the important public health documents, the Ottawa Charter, it expressed very clearly that health is something local. "Health is created in the context of everyday life", said the Ottawa Charter, very poetically, "where people live, love, work and play". We formulated this before the AIDS epidemic and it actually shows how much these elements are integrated.

I just want to highlight, very rapidly, three components of change that influence this understanding of 'health is local'. One, as I said, is the globalisation of everyday life. The global is here, we are much more global. Kelly Lee has identified these three elements of globalisation that we deal with: one, that our mind frame changes; the cognitive dimension. Think of the media, think of our information about other parts of the world, think about the fact that everything we do and say is also heard in other parts of the world as a conflict at present shows very clearly. So there is a strong cognitive dimension to this. There is obviously a spatial dimension. Borders seem to disappear in some cases; the world seems both smaller and larger at the same time. And there is a temporal dimension – speed becomes incredibly important – and the combination between the spatial and the temporal is, of course, that there is significant people movement, a significant movement of goods throughout the globe. All this brings with it new possibilities but also new risks.

In the health arena one of the big global movements is what one could call the privatisation of health. We, in public health and as people from European welfare states, tend to think that health and health care are things that one has a right to access. That, of course, is not the case in many, many parts of the globe and it is actually the poorest people on this planet that need to pay the highest proportion of their income for their health services. For many of the poorest people on this planet health is a private responsibility and they have to go and buy health out there in the market, something that we are only starting to experience in some of the western countries right now. I've lived in the United States for six years so it's a bit different there. But then, of course, there have been very strong movements from global governance and from international organisations to push privatisation of health. I just want to mention the structural adjustment policies of the IMF and partly the World Bank, the agreements of the World Trade Organisation, intellectual property agreements, the growth of the pharmaceutical sector… So there is a big range of privatisation of health, of investment in hospitals and, of course, part of this privatisation of health is the insurance industry that is increasingly going global. So we have a major trend. Health is one of the largest markets in the world. Actually some economists say that after arms and after illegal drugs, health is the largest global market and that obviously means that there is an enormous dynamic that is underway in this area.

And the third big driving force, in a sense, and which is very much the driving force of the public health movement, of the social movements, of people with an interest in social justice, of the international organisations, many of the donor organisations, is this increasing gap between what we know and what we do. Obviously if we look at many of the global health issues – the infectious diseases, the children's deaths, maternal deaths, HIV/AIDS – in many cases we know what to do, in many cases the solutions are even relatively cheap (a vaccine against measles, you know, costs a couple of cents if you don't count all the infrastructures) but over the last 20 years we have not done it. That is what people call the political commitment gap and the governance gap.

So one of the reasons there is an increasing discussion about governance in the international health and the global health arena is that we are in a situation that there is an ongoing global health crisis. Many people, including myself, would actually say that this crisis is getting worse and that, despite the fact that we have tangible solutions at hand, we are not doing what should be done. Therefore, if we talk of a global health crisis we should look at it not as a disease crisis by, for example, quoting the numbers of AIDS deaths or measles deaths or maternal deaths, as important as they are, but to do an analysis of the elements of the governance crisis, the weakening of public policy and the weakening of many of the international organisations – what you could call the interstate mechanisms. This is a process that has been ongoing over the last 30 years within countries; the weakening of public policy in general and public health in particular. I don't think there is a single western country that would dare, at this point in time, to say that our public health structures are up to par to respond adequately to a global influenza crisis. None. And if the richest countries in the world can't do it, then we don't even want to start thinking about what this means in a country like Indonesia. The probability is that if there were to be a human influenza epidemic it would come to us from one of these populous countries in Asia with a very weak public health infrastructure.

There is an increasing discussion in the global health arena about the political determinants of health and what that means. Now if we talk about governance, what would global governance for health imply? We would probably say that good global governance for health would produce good results, it would be effective and efficient, it would ensure that the results are delivered with fairness, that they would reduce poverty and increase equity, and that good governance would address imbalances of power in the global arena and particularly give the developing world and much of civil society a stronger voice in setting the priority. What we have today, and I'll just give you some indications of what is happening, is what in political science is now called unstructured plurality which basically means there is a heck of a lot of different people doing different things in an uncoordinated way and not necessarily in a way that the whole really contributes to the common good.

So if we look at all these political determinants we have a move, as I said, from very few clearly defined international actors to a very large and fragmented group and a movement from what I would call is, or was, the centre – this *[referring to slideshow]* is the flag of the World Health Organisation, The United Nations Specialised Agency for Health – to what you can call a very fragmented political ecosystem. You can see here just a number of the organisations and the individuals that are playing a very key role in global health, and that also indicates where health is being discussed. You see here for example, health / HIV/AIDS was discussed at the UN Security Council – the very first time that a health issue was discussed at the Security Council. You see here a gentleman giving a vaccine. Normally you would see that picture being the Director of the World Health Organisation giving a vaccine, in this case it is Bill Gates giving a vaccine. The amount of money that the Bill and Melinda Gates Foundation is able, or is willing, to spend on global health is somewhere around $800million a year: that is roughly equivalent to the regular annual budget of the World Health Organisation. So you can see that the power balance within this global system is shifting and changing. Many of these new initiatives which are in parallel and sometimes coordinated with the World Health Organisation, are also financed by the Bill and Melinda Gates Foundation. The AIDS vaccine network, for example, the International Vaccine Initiative, a whole range of supports given by this organisation that can, of course, be much more flexible and much more creative than a heavy body of 191 member states having to decide something such as the World Health Organisation. And you can also see, I have just hinted at it, that other agencies like the World Bank are more and more active in health and that fora that never discussed health before like the World Economic Forum now dedicate a significant amount of their discussions to health issues as was the case also this year. And in the centre, of course, you have one of the most well known global health actors right now – that is Bono – who is incredibly active in relation to health in Africa.

So what you see, therefore, on the one hand, from an identified agency you have this multitude of actors and no coordination or cooperation mechanism between them and a total imbalance of power. You also, because health, as I said at the beginning, is gaining a new importance to countries and to the international finance sector, to the private sector and, of course, is a driving force for many of the social movements, you can see that health moves into a totally new political space. A little bit like in the 19th century when – some of you will know this story – when the first meetings for an international sanitary agreement came together and initially the countries sent a health specialist, whatever was a health specialist at the time, and diplomats. At a certain point the diplomats threw out the health specialists because they couldn't agree on the causes of cholera and they said, you know, these guys are just disorienting us, we will set the international health policy, without them. And to some extent you have a very similar situation. Health is discussed as security policy by people with no public health background, health is discussed as foreign policy, obviously as economic and trade policy, and increasingly it is part of discussions around demographics and geopolitical issues. And, as I said, part of the health dimension, and I always underline that, is critical in terms of social movements in what people call the inter-human ethics like, you know, Make Poverty History etc. Death, dying, illness drives a call for social justice because we have the feeling something can be done, you know, we can immunise those kids, those 500,000 mothers don't need to die every year and we feel that, you know, things we have access to need to be shared more globally. You can see here, for example, one of the discussions at the World Economic Forum with four of the global health actors, Kofi Annan, Bill Gates, Bill Clinton and Bono. I was at the WEF in January and one of the most overcrowded sessions was the session on Africa and on trying to invest there.

So what you get are also new constellations of power and I've already indicated them. On the one hand, new financial resources, (this is the headquarters of the Bill and Melinda Gates Foundation), the Foreign policy movements on geopolitical issues with a very strong health focus like the Commission for Africa and, of course, peoples' movement, people who go into the streets, and part of the reason for the unrest in Latin America, for example, is very clearly based in health and the non access to health and, of course, globalisation itself, the information technology, the easier access and cheaper travel makes it possible for social movements to come together. So obviously there is not only the World Economic Forum, there is the World Social Forum, there are meetings of the Peoples' Health Movement, there is a tremendous ground swell of people, of citizens, for health that has also really changed health policy. We would not have access to antiretroviral treatment in Africa today without the global health movement, without the social movements pushing for it very much under the leadership of Medecins Sans Frontieres. The WHO at the time said this is impossible, we cannot go down this road, we need to concentrate on prevention and social movements said, with a social justice starting point, this is not acceptable, we as human beings cannot accept this, and the prices tumbled down. So it is possible to affect change and increasingly also international organisations are dependent on these social movements to push change forward.

Now, of course, even in global health there is a range of ideologies and ways of approaching it. Again I can just hint at those. When we talk about global health or we read about global health and discuss it we should always try and see where does someone come from. Do we see this as a threat? And, of course, a threat then mainly to ourselves? In the United States the discussion is mainly of global health as a national security threat. There are regular CIA, National Intelligence Reports etc on global health. What does this mean for our national security? There is the risk approach, which is obviously more the public health approach. There is, as I said, the social movement approach with social justice and there is the push and the pressure of the global health market. So just to keep that in mind again, risks are trans-national and we are faced with this globalisation of everyday life.

So how could we structure the issues that we should deal with then? I was very intrigued by the work of the ethnologist Arjun Appadurai who developed the notion of 'scapes'. You can see here on the slide the different kind of scapes that he speaks about and that they are all borderless, they're all trans-national: the techno-scapes, the media-scapes, the finance-scapes. Many of them are also a mix of virtual and real movements and I thought it would actually be quite interesting… we mentioned in the introduction the settings approach, the healthy hospitals, the healthy this, the healthy the other. What would it mean to try and grapple with problems in a new way? And I just want to throw this out as an idea: what does it mean if we start looking at health-scapes? If we start looking at health-scapes under a certain heading, under a certain grouping, under a certain pattern, we can also start to identify the kind of initiatives and policies that we need in order to address a problem. Of course, if you look at the recent WHO document trying to address the global obesity epidemic the amount of complex policy interventions you need is nearly endless in order to address a problem of that nature. You can look at the health-scape 'infectious disease' where you need to have the cooperation between the large travel and tourism industry, trade, ecological issues, migration issues. You can look at issues of food security and you can see the enormous interface of different policy arenas at different levels that emerge. You can take critical social issues like migration and the increased mobility of women and what that means for women's health worldwide, particularly because, you know, this is a non-visible side of globalisation and frequently we talk too little about this dark underbelly. We can look at this new type of health marketplace that also, of course, creates images of health and beauty that are going round the world. We can look at how intimacy changes. How HIV/AIDS has changed notions of sexuality around the world, but also what I thought was interesting was this piece of art [*referring to slideshow]* from I think it was China on the SARS epidemic that, you know, how you needed to protect yourself from HIV/AIDS now you even have to protect yourself when kissing. Whether this works, I don't know, but it sort of shows how these globalisation processes, these risks, become very, very personal and actually change the way we interact in the most intimate situations. That also relates to the health-scape of sex itself as a market and as a product. So possibly in thinking of this notion of health-scapes further we can integrate in a new way the global and the local.

So, global domestic politics is therefore what people are calling for which basically means to say we cannot separate anymore what is national and local policy and what is global policy because the interface is much too strong. What I do at a national level obviously in health has influence on others; what others do or don't do has influence on the health in my country. It was interesting for me talking to Swedish colleagues recently. Sweden has produced one of the most forward looking health policies in the recent years, very much focused on social determinants of health… really brilliant piece of work. They have done the first review and first analysis of this work and one of the major outcomes was that they said we under-estimated the amount of impact that globalisation, global decisions, global developments have on our national policy and if we were to write this policy again we would need to take into account many of these factors to a much, much larger extent; we were not prepared for that. And that is quite aside from, you know, Sweden as a member of the European Union and the influences there, for example, on their alcohol policy.

So global domestic policy to some extent means what we've been used to, in looking in terms of the nation state, we have to try and start to understand 'what does that mean at a global level'? What does it mean for global governance? And I've listed here the four key areas we usually talk about when we look at what the nation state should be doing. To ensure security for its citizens it should ensure the rule of law. Many nation states, well a number of them, can't even do that, but at least the minimum of what a nation state would be doing are the first two. There was a development, particularly in Europe, starting in the 19th century and then particularly after the Second World War to increase social welfare and also to increase social participation, to increase the democratisation of the nation state. So you get those four elements and the question is what would that mean at the global level? What would it mean in terms of human security and human rights? A global rule of law, fairness in global distribution in terms of the social welfare and, of course, is there such a thing as a global citizen? Could we imagine being that? How would that come together with our national identity? Or, as many people say, you know, now it's much more a local identity and maybe a European identity and less of a national identity, but something seems to be changing. I remind you of that cognitive dimension of globalisation: we see ourselves differently in the world. We cannot see ourselves any more like we might have 20 years ago.

So what we see coming together in this global governance discussion is on the one hand to say we need to ensure that certain global public goods that we believe are essential for wellbeing are not only produced in the nation states of the rich world, but are made more available step-by-step globally. That we need to identify such global public goods and that we need to find new mechanisms for financing them. And that again because in a global world the actors are not only the nation states, but other actors like civil society, like the private sector, we need to find mechanisms that bind these actors in the global arena just as in some cases they now bind nation states. We do have some of these global public goods – the rule of law, for example, in the world trade arena. A rule of law that is not very equitable in terms of global justice, but it is a rule of law. We have practically no rules of law in the social arena and so social movements, but also the international labour organisation and many other UN organisations, were saying we need to establish a rule of law for human rights and for social issues. So the UNDP in the year 2000 put together those shifts of thinking that are needed in order to move toward such global governance and you can see again these issues: multi-actor accountability, a global accountability (I'm not only responsible for what I do in my country, but what it means globally – but also the other way round: I'm responsible globally for what I do to my citizens) and a major shift in global governance has been individual rights and things such as an international court of justice and recognition of people's rights. That somebody that has harmed their own citizens can be called to account – a total shift in international law. Originally international law was just about nation states and you were not to interfere with what happened within a nation state. That has changed. People have rights and that is a very, very significant movement.

How do we move to a whole range of rights, to move to inclusive models of decision making and to not just look at poverty reduction as a kind of charity undertaking, but really to be driven by notions of social justice? There is this thinking about what kind of regulations and treaties we would need to bind countries in new ways – because nation states do exist and they need to be made more responsible – but also to bind the other actors. And the areas in which this is developing is obviously in a range of trans-border issues and I've listed some of them here for you: Terrorism; Crime; Environment; Infectious Disease; Intellectual Property; Disaster Response; Trade. If you were to go on the United Nations website you would find a plethora of agreements where the world is trying to order its behaviour. For us in global health the new international health regulations are absolutely critical as a movement forward that bind nation states in new ways in terms of reporting and responding to disease outbreaks. International health law is becoming more important and the WHO did a highly relevant and revolutionary thing a couple of years ago. It actually did what its treaty, its constitution allowed it to do. It created a global health treaty on tobacco, the framework convention on tobacco control. Actually when I was in WHO and there was a discussion about revising the constitution of WHO, some WHO lawyers suggested one could drop that part about the potential rights to have conventions or treaties because WHO had never used it any how, but this did not happen and the result was really a revolutionary public health law. Definitely not as strong as many of us would have liked it to be. It's a framework convention, it needs many follow through regimes, but it's a breakthrough in saying we will have a convention on a major disease and health challenge and in this case not an infectious disease challenge, but really one of a different nature that's linked with industry with enormous amounts of money, with global marketing and with millions and millions of deaths every year.

The other issue that's been discussed is how do we move from charity to entitlements? Much of global health work, much of global health support, is through development aid either from governments or from charity and philanthropical organisations and there is a discussion about how we can reach entitlements. How can we move forward so that the poor really have access to health and that health is part of global citizenship? One step in that direction is the global compact, the millennium development goals. I can't go into them in any detail now, but the global community has agreed on eight goals, three of those goals are health goals and many of the other goals, of course, are determinants of health: poverty, environment, education etc. There has been a significant change in the global community over the last five years focusing effort in the direction of these goals and part of that is, of course, addressing global inequality and poverty as a global social justice issue. Important again within all that is that a lot of the organisation here, a lot of the push also for the millennium development goals, comes from community groups, comes from social movements. Either very, very localised groups who are fighting against malaria, who are fighting for women's rights, or globally organised groups. It's interesting to see how even that is globalised. I mentioned that I was at this WHO conference in Bangkok and we walked through the Bangkok market – you know, all those markets stalls and everything – and what you could get… they had these big baskets and in these big baskets they had all these rubber bands so, you know, for every cause that ever a rubber band was produced it was available on the Bangkok market at an extra price. Now I don't know who got the money if you bought the rubber band there, but this identity politics this, you know, 'I stand for a cause and I'll show you that I stand for this cause' – something has changed there, just as people say 'I have this disease and I want that people are better treated'.

So, finally, a global health treaty. At the Bangkok conference of WHO we discussed this and said if all these elements of global health and global governance are out there in a patchwork, how could we bring them together? What should be the elements of it? And we stole a bit from a document recently produced by the European Union. Those of you familiar with the new European Union programme on public health and consumer safety will recognise some of this text. But we said what should a global health treaty do? "It should ensure a common high level of health protection and health rights for all citizens of the world and, we added, wherever they live, love, work and play – and we thought we should be, you know, a bit more global and say travel, buy or Google – from those risks and threats to their health, safety and wellbeing which are beyond the control of individuals and communities and nation states (because that's increasingly the case) and cannot be effectively tackled by nation states alone, but need to be multi-actor" because, obviously, in terms of unsafe product, unfair commercial practices etc you need to be able to act more broadly.

A global health treaty would reform and strengthen global institutions, control unsafe goods and products, address collective human security issues, ensure access to all essential medicines, vaccines and health knowledge. There is an increasing, very interesting discussion around how the open source principle, to which we have become more accustomed in the IT world should actually be applied to global health; should be applied in any case to the sharing of health knowledge and the results of health research, but should also be applied to essential medicines and essential vaccines, that these should be available as an open source, as a global public good.

Obviously jointly, we need to fight major diseases, create the surveillance systems, support public health infrastructures and again, very important, create professional capacity. One of the increasingly important global issues is the brain drain from developing countries to developed countries. Some of the poorest countries are loosing their best health professionals both nurses and doctors because obviously they can find better paid work in the developed countries and with what they earn in the developed countries they can support several members of their family back home. The remittances are extraordinary if you were to look, for example, at the money Philippino nurses sent back to the Philippines, it runs part of the Philippine economy and that is true for a range of other countries. Obviously you could say, well, there's a bit of compensation, but there's very serious discussions in Africa about how the countries should be compensated directly for the loss of these professionals and that ethically, at least, developed countries should not try and actively attract and market professionals from the developing countries which is something they do very, very proactively – particularly a couple of English speaking countries are very proactive in recruiting from the poorest countries.

If we move down that road, we need new financing mechanisms and the most important thought I'd like to leave you with here is to clearly differentiate between financing development aid and financing global public goods. There is an increasing discussion that we need a totally new mechanism to finance global public goods, that this mechanism must include the private sector and you will remember, perhaps, all the discussion around the airport tax or the air ticket tax that came up also in connection with the Tobin Tax. Everybody thought, you know, this was something the global health movement was asking for and then last year in January President Jacques Chirac spoke at the World Economic Forum and said "I think the rich countries should introduce an airline tax" and we all thought we hadn't heard correctly, but he brought it to the European Union. Not all European countries are willing to do so, but as of June of this year France is introducing a so-called air ticket tax which I think is five euro for an economy ticket and 40 euro or something like that for a business and first class ticket and that money goes to development aid. These are the kind of mechanisms that one is looking at if one says "If we need to finance global surveillance, for example, and a rapid response force for SARS or avian influenza, recompensate the farmers who lose their chickens etc, these are the kind of global funds that we need". They are very different from giving development aid for health and that differentiation is something that is very important because in terms of global health what you need to do is address the weakest link and that needs to be financed in terms of ensuring a secure network.

We need clear accountability and again this is a local issue. You see here (I think this was the health commissioner of the City of Toronto during the SARS outbreak) the first reaction of the City of Toronto during the SARS outbreak when WHO issued a travel advisory was “Who are these guys in Geneva that can tell us what to do?”. And first of all, you know, it showed a certain lack of information, but it also indicates how global policy and local action are becoming more and more interconnected and how local action is part of global responsibility and how a local health commissioner needs to be increasingly aware of global rules and laws and activities and, of course, also be transparent to the global community.

So I will end with five dimensions of what could be the characteristics of good global health governance or, one could say, a new global public health:

- health as a global public good;
- health as a key, an important policy dimension of collective human security; and obviously
- health as a factor of good global governance. That is mentioned separately because it’s not just the health governance, but the governance in other sectors that then takes account of health issues, for example, in relation to trade.
- Health as responsible business practice and social responsibility. You will know that Kofi Annan created the global compact which sets a set of guidelines for global companies to be socially responsible. One can look at that with a number of pinches of salt, but it was the first time that the UN tried to say, look, you have a global responsibility; you’re not just about your business, you’re also about the world. And again it was interesting how that was discussed on occasion of this year’s economic forum and in relation to what are the business responsibilities in SARS, avian flu, not only in terms of pharmaceuticals, of Tamiflu production for example, but in terms of responsibility for the community both where they are physically and who they are responsible for globally.
- And finally, an understanding of health as global citizenship.

Since some of you are aware of the dimensions of the Ottawa Charter and health promotion and its part of my own history, I thought it might just be interesting to put those two dimensions next to each other. A public health document that was produced before we were really aware of globalisation where we thought good national public policy with a strong local base could resolve our health issues and we see now that that is not sufficient, that we need a lot of these other dimensions.

So we need national and local global health strategies and I think it would be interesting to have brainstorming sessions of, you know, how do we respond at the local level to global health threats? How do they directly or indirectly affect the local population? How do we contribute to global problems: pollution, for example? How do we contribute to global solutions and what values would we bring to the global health arena? So we could engage in global local health summits where we should, I believe, also involve citizens and the business community.

I would end with the thought that we need to move towards a new public health. I think the challenge in public health is at least as large, if not larger, than about 100 years ago when we were in what many call the golden era of public health and which, by the way, when we read it up in many ways is very similar in terms of the challenges, strategies, type of approaches: we just lost those along the way. Public health became professionalised and medicalised in a way that it lost its political dimension and what we today call the inter-sectoral dimension. It's fascinating how anybody could afford to build the sewers under the City of London and just as people are suggesting in global health that we need finance facilities and global bonds and, you know, all those kind of things, those were the kind of things that people tested out in the 19th century. So maybe we are also partly going back to the future and just as we worked nationally on social contracts that should at least ensure basic human rights and life to people, we should start to work on that kind of social contract globally.

Thank you.

[Applause]

The views expressed in this paper are those of the speaker and do not necessarily reflect the views of the Glasgow Centre for Population Health.

Transcript prepared by the Glasgow Centre for Population Health.