

Rebuilding Global Health Governance — Recommendations for the G7

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The tide of globalization has turned health into a global issue, one that must be considered when seeking solutions to today's global challenges, including the international movement of people in refugee crises, climate change and its impact on the spread of infectious diseases and the threat of terrorists using biological weapons. At the Ise-Shima Summit in Japan this spring, the Group of Seven (G7) must recognize global health as a priority issue. A key to assuring 'human security,' health is the subject of one of the Sustainable Development Goals (SDG3: Good Health and Well-Being)¹ adopted last year, and it relates closely to national security.

The Ebola epidemic in 2014 highlighted several problems in global health governance^{2,3,4,5,6}, namely, insufficient health surveillance in fragile states; lack of any multi-stage decision-making mechanism; inadequate coordination between the WHO and development/humanitarian organizations, necessitating the establishment of the UN Mission for Ebola Emergency Response (UNMEER); and insufficient funding for complex health emergencies. Reforming the governance system to remedy these problems is important in order to develop an enabling environment for collaboration among actors at the field level. Given the G7's technical expertise, resources and political clout, their commitment is critical for the realization of the reforms that are needed in global health.

As members of the Complex Risk Governance Unit of the Policy Alternative Research Institute at the University of Tokyo⁷, and members of the Global Health Working Group for the 2016 G7 Summit⁸, the authors have engaged in an analysis of the challenges facing global health governance. This paper presents the outcome of these activities with a focus on four issues that have been identified in the response to the Ebola epidemic and recommendations for the G7 countries to contribute to solving those problems.

Making Global Health Surveillance Systems Work

The information base for grasping conditions that may escalate into health crises is insufficient. Many developing countries do not have the core capacities needed to implement the International Health Regulations (IHR)⁹ and cannot fully identify the status of their health risks. Even when information is available, some countries fail to file reports out of concern that doing so could result in trade and travel restrictions¹⁰. This concern is understandable when one considers that about forty countries took additional measures, such as quarantine and border closures, that goes beyond the IHR

emergency committee's temporary recommendations in the case of Ebola¹¹.

The WHO must urge member states to comply with the IHR and report on their progress^{2,3,4,5,6}, and the G7 should push this effort. This should be carried out under a more horizontal UN-led framework, through collaboration with other initiatives, such as the Global Health Security Agenda (GHSA)¹² initiated by the United States. More specifically, an expert committee for IHR compliance monitoring should be established at the WHO to scrutinize governments' self-assessments and issue recommendations for further improvement. The committee should also invite reference reports from NGOs and other non-governmental actors.

G7 countries should revamp their bilateral aid, especially to vulnerable countries, to support them in implementing the core capacities of the IHR. Efforts toward IHR compliance could be included as a requirement in development cooperation agreements in the health field.

Internal organizational restructuring may be needed to facilitate the WHO's contribution to the strengthening of the IHR core capacity of developing countries. Merging of the department handling emergency response with the department of health security to boost the WHO's operational capacity at the field level has been proposed^{2,3,4,5,6}, and the WHO is already embarking on other structural reforms³. However, it is also important to note that building surveillance capacity and strengthening health systems so that they can operate effectively in emergencies also requires linkages with the department in charge of health systems and innovation under normal, non-crisis conditions.

Further, to remove disincentives for sharing information, there should be a mechanism for protecting countries that fulfill IHR reporting obligations from unnecessary trade and travel restrictions^{2,4,5,6}. For that purpose, the WHO's recommendation to rectify such restrictions should be reinforced within the framework of the IHR. Collaboration with the World Trade Organization's^{2,5,6} Sanitary and Phytosanitary Agreement should also be considered.

Putting a Multi-stage Decision-Making Mechanism in Place

The key question that global health decision-making mechanisms have to address pertains to how a Public Health Emergency of International Concern (PHEIC) should be handled. Specific problems include the failure to implement a multi-stage response at the pre-PHEIC stage and the reliance on the WHO Director-General's (DG) judgment in initiating a determination of PHEIC to convene the IHR Emergency Committee. Since the decision-making authority is concentrated in the DG, there could be a delay in responding to PHEIC if the DG hesitates to convene the IHR Committee due to political considerations regarding the countries involved^{2,4}.

The G7 should take the following measures to enable a multi-stage response: First, they should urge the WHO to adopt a multi-stage approach, instead of the current binary process in which an emerging health threat is either a PHEIC or it isn't, with nothing in between. There is a general consensus that there should be more integration among grading systems^{2,4,6} on health risks from

infectious diseases and risks from humanitarian emergencies, drawing on the WHO's Emergency Response Framework (ERF) and other UN grading systems that rely on triggers in current debates. However, it is also important to recognize the fact that not all health risks from infectious diseases develop into humanitarian emergencies, especially in countries that are not considered vulnerable, as in the case of the current Zika virus outbreak in Latin America, which was declared a PHEIC on February 1. Grading is also required when making decisions on mobilizing the WHO's newly created Contingency Fund for Emergencies (CFE). Second, there should be a process for automatically activating an emergency assessment at the WHO and seamlessly connecting emergency responses with existing schemes on the ground that have been operating under normal conditions. The same department should be responsible for handling information gathering and risk assessments concerning infectious diseases under normal conditions and should have strong links with the IHR Emergency Committee to ensure a graded risk assessment. As part of this process, an international mechanism should be built to systematically process health risk information supplied by non-state actors such as NGOs. While the DG will continue to have the final say on the determination of the declaration of a PHEIC, the risk assessment that forms the basis of the DG's judgment must be carried out by an expert organization that has a certain level of autonomy and is capable of self-management⁵.

Making Coordination Work

The recent Ebola outbreak highlighted the need for a coordinated emergency response^{2,3,4,5,6} among the WHO; other international organizations, such as the UN Office for the Coordination of Humanitarian Affairs (OCHA), the United Nations Development Programme (UNDP) and the United Nations Children's Fund (UNICEF); and NGOs, such as Médecins Sans Frontières (MSF)¹³ and the International Federation of Red Cross and Red Crescent Societies (IFRC), among others, especially in countries with fragile health systems. However, there is still no consensus about which patterns of collaboration are best suited to which conditions. In addition, there are no mechanisms for switching smoothly between patterns of collaboration and assuring "honorable replacements" amongst actors already at work—for example, from Resident Coordinator to Humanitarian Coordinator—without causing anyone to lose face.

To ensure coordination and an effective switching of functions from one actor to another, the G7 should help establish a platform led by the UN Secretary General (UNSG) to examine various patterns of collaboration on global health governance, based on indicators on the severity or magnitude of an infectious disease and the affected countries' ability to respond, as illustrated in the Figure, which was developed by the authors. In response to the Ebola epidemic, UNMEER, the first mission ever to respond to a global threat, was established under the leadership of the UNSG^{14,15} (type 5 in the Figure). There is general consensus that this UNMEER-type body should not be created in future health crisis responses^{2,4,5,6} and the authors agree that rather than creating a new organization, focus should be on

re-strengthening the existing framework, including the UN Development Group / UN Development Assistance Framework (type 3) and the Inter-Agency Standing Committee (IASC) and OCHA (type 4)¹⁶. In some cases, in areas where the capacity to respond to an epidemic is high and severity of the infectious disease is low, responses can be implemented with minimal support from the WHO (types 1 and 2). The WHO should maintain its lead role in mobilizing collaboration in these cases that fall within the scope of the health field. However, when a response beyond the health field is needed, collaboration should be sought with lead agencies of other relevant sectors and clusters. Coordination should be considered in advance³ through a memorandum of understanding (MOU) (similar to the partnership agreement between the WHO as the lead agency on health and the World Food Programme (WFP) as the lead agency on logistics¹⁷) or the establishment of Standard Operating Procedures (SOP). To ensure collaboration, there should be official consultations between the UNSG and WHO DG¹⁸ (involving the UN Security Council as needed). The final authority on coordination that goes beyond the WHO framework should be given to the UNSG on a case-by-case basis, while the WHO should maintain responsibility for making health-related judgments. To secure accountability, the results of such consultations should be reported to the UN General Assembly and the WHO Health Assembly.

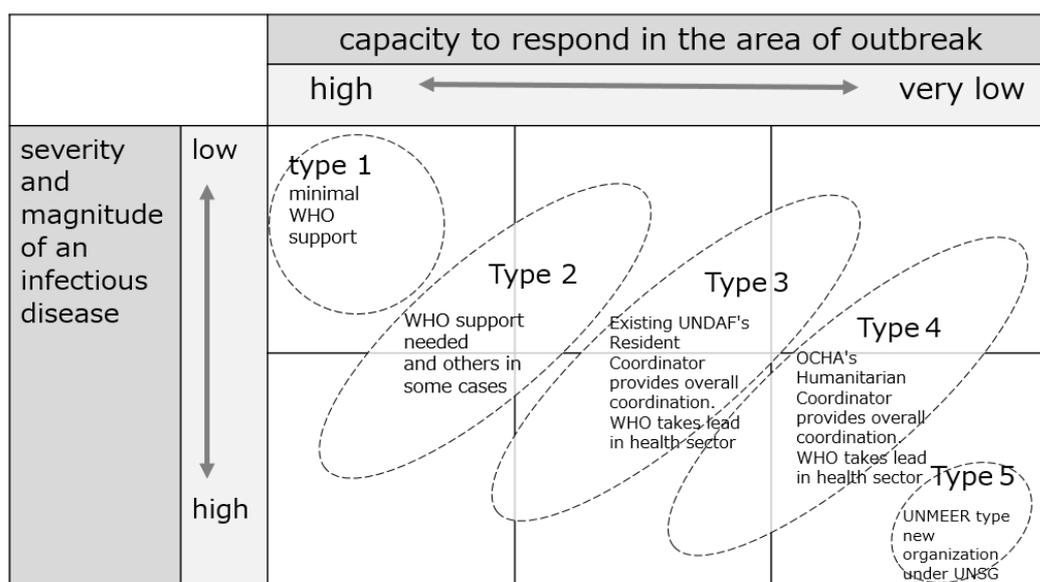


Figure: Different Patterns for Collaboration

Bridge Funding Mechanisms

There is currently not enough mechanism to allow the immediate release of funds in complex health emergencies. In the case of the Ebola crisis, it was difficult to use OCHA's funding process because the main target of the OCHA scheme was natural disasters and armed conflict. Although they do have the Central Emergency Relief Fund (CERF) for humanitarian emergency response, this is not used for emergency responses to infectious diseases. Other funding sources, such as UNICEF or UNDP, were

also unable to be utilized, as their funding consists of voluntary contributions and requires appeals processes that take more time. In addition, strengthening the IHR's core capacity is not clearly prioritized in development cooperation, and there is insufficient funding for emergency response preparations or for long-term health system strengthening (HSS).

To mobilize emergency funding, the G7 should support the WHO's newly created Contingency Fund for Emergencies (CFE)¹⁹ and the Pandemic Emergency Facility (PEF), currently being discussed under the leadership of the World Bank²⁰, and consider collaboration and coherence between these frameworks^{2,6} and the CERF framework for humanitarian crises^{3,4,5}. In addition, a financing mechanism for research and development, for example one to support vaccines development during times of emergency, should also be considered. For that purpose, diverse public-private partnerships (PPP), similar to such efforts as the Global Health Innovative Technology Fund (GHIT Fund), should be encouraged. Furthermore, HSS should be embedded within frameworks for development aid. More specifically, bilateral and multilateral projects for development cooperation should target HSS and make it a condition for disbursement. Vertical funds (e. g. the Global Fund to Fight AIDS, Tuberculosis and Malaria and GAVI, the Vaccine Alliance) should be urged to apply their monitoring systems and other resources—developed through their responses to specific diseases—to other types of diseases as well. The International Health Partnership Plus and other networks for coordination should be strengthened to bridge emergency funding and long-term development cooperation for HSS. The G7 has the resources needed to take the lead in coordinating such holistic approaches to avoid duplication among all these different types of funding mechanisms.

Four recommendations were proposed in this paper: make global health surveillance systems work; put in place multi-stage decision-making mechanisms; ensure a smooth switching function between different patterns of collaboration; and support financing mechanisms for global health. If adopted, these recommendations could lead to improved functionality in global governance as a whole, which will in turn enhance human security and move us toward achievement of the SDGs and improved national security. The G7 should not squander the opportunity it will have when it meets in Japan to provide the necessary political legitimacy to these recommendations, thus convincing the international community to spring into action and take the lead in facilitating funding.

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¹ Goal 3: Ensure healthy lives and promote well-being for all at all ages

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⁷ Hideaki Shiroyama and Makiko Matsuo are members of the Complex Risk Governance Unit of the Policy Alternative Research Institute, University of Tokyo
<http://pari.u-tokyo.ac.jp/unit/crg/> This Unit explores the challenges posed by the complex interrelated nature of risks at global and domestic levels and considers policy options for such issues. Ebola crisis and global health issue are one of such cases.

⁸ A unique platform, consisting of experts from various interdisciplinary backgrounds including those from academia, research institutes and relevant ministries of the Japanese government, was established in Japan to develop and recommend agenda items to be addressed at the G7 Summit. All the authors of this paper are members of this group. A more comprehensive proposal for the G7 Summit by the Japan Global Health Working Group, “Protecting human security: Proposals for the G7 Ise-Shima Summit in Japan” will be published in the *Lancet* (*Lancet* 2016; 387: 2155–62, forthcoming).

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https://www.humanitarianresponse.info/en/system/files/documents/files/integrated_disease_surveillance_quarterly_bulletin_31_may_2015.pdf (accessed Mar 2, 2016)

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¹¹ Statement on the 5th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa

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¹² GHSA Global Health Topics The Global Health Security Agenda
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¹³ MSF. Pushed to the Limit and Beyond A year into the largest ever Ebola outbreak. Geneva: MSF, 2015.

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¹⁵ UN. Security Council Resolution (S/RES/2177) of 18 September 2014, New York: UN, 2014.

¹⁶ While we agree that the UNMEER-type category is undesirable in future responses, it is also true that there may be extreme situations in which UNSG-led initiative is needed. So we do not exclude this option as a last resort.

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