Haggling over viruses: The downside risks of securitizing infectious disease

This article analyses how the ‘securitization’ of highly pathogenic avian influenza (H5N1) contributed to the rise of a protracted international virus-sharing dispute between developing and developed countries. As fear about the threat of a possible human H5N1 pandemic spread across the world, many governments scrambled to stockpile anti-viral medications and vaccines, albeit in a context where there was insufficient global supply to meet such a rapid surge in demand. Realizing that they were the likely ‘losers’ in this international race, some developing countries began to openly question the benefits of maintaining existing forms of international health cooperation, especially the common practice of sharing national virus samples with the rest of the international community. Given that such virus samples were also crucial to the high-level pandemic preparedness efforts of the West, the Indonesian government in particular felt emboldened to use international access to its H5N1 virus samples as a diplomatic ‘bargaining chip’ for negotiating better access to vaccines and other benefits for developing countries. The securitized global response to H5N1 thus ended up unexpectedly entangling the long-standing international virus-sharing mechanism within a wider set of political disputes, as well as prompting governments to subject existing virus-sharing arrangements to much narrower calculations of national interest. In the years ahead, those risks to international health cooperation must be balanced with the policy attractions of the global health security agenda.

http://heapol.oxfordjournals.org/content/25/6/476.abstract
Dilemmas of securitization and health risk management in the People’s Republic of China: The cases of SARS and avian influenza

Since the SARS epidemic in 2003, the international community has urged Chinese leaders to do more to address infectious diseases. This paper looks at two cases in which the Chinese government securitized infectious disease (SARS and avian influenza) and examines the pros and cons of securitization. It is argued that the reactive mobilization involved in a securitizing move runs counter to the preventive risk management strategy needed to address infectious diseases [...] The article begins by examining the contributions of the Copenhagen School and sociological theories of risk to conceptualizing the security challenges that pandemics pose. Although analysis of the cases of SARS and avian influenza gives credence to criticisms of this approach, securitization theory proves useful in outlining the different stages in China’s reaction to epidemics involving reactive mobilization and subsequent efforts to return to politics as usual. The second section examines securitizing and desecuritizing moves in Chinese responses to SARS and avian influenza [...] The reactive mobilization implicit in Chinese securitization moves in the two cases is contrasted with the preventive logic of risk management. A third section draws out the implications of these cases for theories of securitization and risk. It is argued here that when securitization has occurred, risk management has failed.


GLOBAL HEALTH NEWS:

Antimicrobial resistance: Revisiting the “tragedy of the commons”

When the NDM1 enzyme-containing ‘superbugs’ struck in India, Pakistan and the United Kingdom earlier this year, media reports blamed medical tourism for its spread. But in this interview, Professor John Conly argues that the overuse and misuse of antibiotics leading to antimicrobial resistance [...] is the more important topic. NDM1 is an enzyme that confers resistance to one of the most potent classes of antibiotics [...] This new resistance pattern has been reported in many different types of bacteria compared to previously and at least one in 10 of these NDM1-containing strains appears to be pan-resistant, which means that there is no known antibiotic that can treat it. A second concern is that there is no significant new drug development for antimicrobials. Third, this particular resistance pattern is governed by a set of genes that can move easily from one bacterium to another. Fourth, NDM1 has been found in the most commonly encountered bacterium in the human population, E. coli, which is the most common cause of bladder and kidney infections.

RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

Infectious diseases following disasters

Disasters, whether natural or man-made, have the potential to lead to outbreaks of infectious diseases. Despite the common portrayals by the media, outbreaks after a disaster are relatively infrequent and when they do occur, most are caused by endemic organisms as opposed to novel ones. The body of literature pertaining to infectious diseases after disasters has significant limitations, including the frequent lack of baseline data for comparison with postdisaster rates of infections and a lack of documentation of etiologic agents causing outbreaks. The main tools in prevention and treatment remain infection control, epidemiologic analysis, and laboratory diagnostics. By considering the type of disaster, rapidity of onset, endemic organisms, public health infrastructure, and baseline population characteristics, responders should be able to predict with reasonable certainty what infectious agents may pose a threat after a disaster, thereby allowing a tailored response. The recent movement toward including active research agendas in disaster response further solidifies our knowledge and improves the evidence-based foundation for interventions.

http://www.dmphp.org/cgi/content/abstract/4/3/232

GLOBAL HEALTH NEWS:

Cholera outbreak in Haiti reaches 1523 deaths (as of 24 November 2010)

PAHO is posting online up-to-date research, briefings and press reports describing the public health situation in Haiti. In one of its latest postings, it reported that “Forty tons of essential medicines and health promotion materials were distributed throughout the country [on 19 November 2010] in a partnership among the Ministry Health (MSPP), the Health Cluster, and the Logistics Cluster. This was the first of a three-day operation based on the government strategy to send essential medicines and supplies to areas hardest hit by cholera, as well as to preposition supplies in remote locations. Shipments left PROMESS, the PAHO/WHO medical warehouse, using five WFP. Four helicopter missions headed to Port de Paix and Fort Liberte with essential medicines such IV fluids, ORS, and antibiotics, health promotion posters, and technical guidelines.” For up-to-date information, see: http://new.paho.org/hai/index.php?lang=en

http://new.paho.org/hai/index.php?option=com_content&task=view&id=7056&Itemid=1
Are drug companies living up to their human rights responsibilities? The perspective of the former United Nations Special Rapporteur

The apparent noncompliance of pharmaceutical companies with their human rights responsibilities underscores the vital importance of accountability mechanisms. Such mechanisms can serve to check whether or not these allegations are well founded and can make public, balanced, sensible determinations with practical recommendations for all parties. Both the [Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines] Guidelines and the GSK [GlaxoSmithKline] report highlight the critical role of internal and external mechanisms that [...] hold companies accountable for their right-to-health responsibilities. If a company is serious about its responsibilities to society, why not establish, for example, a corporate Ombuds with oversight of its right-to-health responsibilities relating to access to medicines? If courts are unable or unwilling to play this role, and if neither states nor companies have the appetite to establish effective right-to-health accountability mechanisms, then civil society must take the initiative, as it always has in the implementation of human rights. In short, if others fail to act, a consortium of civil society organisations should appoint a panel of well-respected global leaders, supported by a small but properly resourced secretariat, to monitor the policies and practices of pharmaceutical companies and hold them publicly accountable for the discharge of their right-to-health responsibilities.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946950/?tool=pubmed

Are drug companies living up to their human rights responsibilities? The Merck perspective

While States must continue to bear primary responsibility for the realization of the right to health, its attainment requires a multi-stakeholder approach. Everyone has a role to play and everyone can do more. Pharmaceutical companies could better assess their role and monitor their contributions to advancing the achievement of the right to health. To this end, more companies could document their contributions to the health-related UN Millennium Development Goals. Several companies are working with the Danish Institute for Human Rights to develop a sector-specific human rights assessment tool that will examine core activities—including research and development, registration, pricing, licensing, and donations—that are fundamental to improving access both to medicines and health care overall. Such efforts should continue. Increasing transparency is another area where notable progress has been made by the industry but opportunities for improvement still exist. Progress is possible, but it will require the international community coming together to support States’ obligations and committing to meaningful dialogue on the true barriers and drivers for realizing the right to health.

Research on Global Health Governance & Institutions:

Addressing global health governance challenges through a new mechanism: The proposal for a Committee C of the World Health Assembly

The field of global health has reached a critical juncture, where both its visibility and the complexity of its challenges are unprecedented. The World Health Organization, as the only global health actor possessing both democratic and formal legal legitimacy, is best positioned to capitalize on this new, precarious situation in public health and respond with the governance innovation that is needed to bring the increasingly chaotic network of activities and entities affecting health outcomes under the fold of a centralized, standard-setting agency. One such proposed innovation to guide normative and strategic coordination in global health is the creation of a Committee C of the World Health Assembly that would promote consensus building and multi-stakeholder decision-making within the unique convening power of the World Health Organization. Committee C would be a workable mechanism to improve consistency of global health action and coordination between many partners while respecting their independence and decision-making structure. [It is intended to] provide mechanisms and instruments which let [WHO] achieve the following: link the new global health actors to the system of multilateral intergovernmental institutions [...] engage in new ways with the many non-health actors that can influence health both positively and negatively; perform its coordination function in relation to the development of legal instruments with a broader range of players.


Global Health News:

Substantial progress on health in Syria, but more needs to be done, says UN expert

The UN Special Rapporteur on the right to health, Mr Anand Grover, has commended the Syrian Arab Republic’s commitment to realizing the right to health, but said more needs to be done to ensure delivery of quality services, particularly in rural areas. In his statement, Mr. Grover congratulated the Republic for explicit provision of the right to health in its constitution, and referred to Syria’s ‘commendable work in the last three decades’ in improving the country’s health system in its entirety. ‘Admirable advances have been made amongst nearly all key health indicators’ said the Special Rapporteur. ‘Coverage rates are extremely high – upwards of 90 per cent – and the centres in Syria that I visited were well staffed and well maintained.’

**GLOBAL HEALTH NEWS:**

**The new age of global health governance holds promise**

In an era of rapid globalization, the world faces serious global threats to human health, including infectious and chronic diseases, antimicrobial resistance and inequitable access to medicines. Fortunately, since the mid-1990s, recognition of a need for action on global health has led to the creation of many new initiatives and mobilization of unprecedented resources. Diseases do not recognize national boundaries, so tackling such illnesses requires collective action through effective global health governance (GHG), defined as the formal and informal institutions, norms and processes that govern or directly influence health policy and outcomes worldwide. To date, the institutional structures for collective action have mostly evolved in an ad hoc, rather than systematic, manner. [...] Whether there should be a single global health authority to allocate responsibilities and resources is debatable. Notwithstanding the existence of the 2005 Paris Declaration, in which governments pledged harmonization and alignment of the aid they provide, some would consider the idea of such a GHG authority an illusion. But there is no doubt that an absence of effective GHG will exacerbate the current fragmentation of objectives and poor coordination of supported activities, as well as the narrow focus on short-term results, large transaction costs on recipients and the lack of accountability.


[http://www.nature.com/nm/journal/v16/n11/full/nm1110-1181.html](http://www.nature.com/nm/journal/v16/n11/full/nm1110-1181.html)

**RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:**

**The World Wealth Report: Health systems financing: The path to universal coverage**

The ‘circumstances in which people grow, live, work, and age’ strongly influence how people live and die. Education, housing, food and employment all impact on health. Redressing inequalities in these will reduce inequalities in health. But timely access to health services – a mix of promotion, prevention, treatment and rehabilitation – is also critical. This cannot be achieved, except for a small minority of the population, without a well-functioning health financing system [...] Recognizing this, Member States of the World Health Organization (WHO) committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them. This goal was defined as universal coverage [...] In striving for this goal, governments face three fundamental questions: 1) How is such a health system to be financed? How can they protect people from the financial consequences of ill-health and paying for health services? How can they encourage the optimum use of available resources? [...] In this report, WHO outlines how countries can modify their financing systems to move more quickly towards universal coverage and to sustain those achievements.


RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

Evaluation of international recruitment of health professionals in England

[This paper explores] whether a period of intensive international recruitment by the English National Health Service (NHS) achieved its objectives of boosting workforce numbers and to set this against the wider costs, longer-term challenges and questions arising. A postal survey of all pre-2006 NHS providers, Strategic Health Authorities and Deans of Postgraduate Medical Education obtained information on 284 (45%) organizations (142 completed questionnaires). Eight subsequent case studies (74 interviews) covered medical consultant, general practitioner, nurse, midwife and allied health professional recruitment. Most respondents had undertaken or facilitated international recruitment between 2001 and 2006 and believed that it had enabled them to address immediate staff shortages. Views on longer-term implications, such as recruit retention, were more equivocal. Most organizations had made only a limited value-for-money assessment, balancing direct expenditure on overseas recruitment against savings on temporary staff. Other short and long-term transaction and opportunity costs arose from pressures on existing staff, time spent on induction [...] support, and human resource management and workforce planning challenges. Though recognized, these extensive ‘hidden costs’ for NHS organizations were harder to assess as were the implications for source countries and migrant staff. The main achievement of the intensive international recruitment period from a UK viewpoint was that such a major undertaking was seen through without major disruption to NHS services. The wider costs and challenges meant, however, that large-scale international recruitment was not sustainable as a solution to workforce shortages.

http://jhsrp.rsmjournals.com/cgi/content/abstract/15/4/195

GLOBAL HEALTH NEWS:

Europe develops action plan to address health workforce shortfall

European officials have developed an action plan to resolve an anticipated shortfall of one million health workers among the 27 member states of the European Union (EU) by 2020 [...] The projected workforce shortfall inspired roughly 250 health ministers and health administrators to gather in Belgium in September to address four issues: the assessment of future health workforce needs; finding the right ‘mix’ of skills in groups of health care workers; creating a supportive working environment; and promoting a ‘learning culture’ to improve patient care and safety [...] The plan commits member-states to a series of specific measures. These include: 1) support for a platform to develop countries’ capacity for health workforce data collection/analysis, and for policy development /implementation; 2) structured support for early career workers; 3)use of structural funds for bridging and retraining professionals, (and the possible creation of a health sector council on jobs and skills); 4) equivalency in specialist training; 5) establishment of an EU-wide continuing professional development accreditation equivalency; and 6) use of European core-curricula for patient safety in medical education and training programs.

Source: Villanueva, Tiago. 2010. Europe develops action plan to address health workforce shortfall. CMAJ online (12 November).
http://www.cmaj.ca/earlyreleases/12nov10-europe-develops-action-plan-to-address-health-work-force-shortfall.dtl

RESEARCH ON TRADE POLICY & HEALTH:

**What is known about the effects of medical tourism in destination and departure countries? A scoping review**

Medical tourism involves patients intentionally leaving their home country to access non-emergency health care services abroad. Growth in the popularity of this practice has resulted in a significant amount of attention being given to it from researchers, policy-makers, and the media. Yet, there has been little effort to systematically synthesize what is known about the effects of this phenomenon. [...] The large majority of the 203 sources accepted into the review offer a perspective of medical tourism from the Global North, focusing on the flow of patients from high income nations to lower and middle income countries. This greatly shapes any discussion of the effects of medical tourism on destination and departure countries. Five interrelated themes that characterize existing discussion of the effects of this practice were extracted from the reviewed sources. These themes frame medical tourism as a: 1) user of public resources; 2) solution to health system problems; 3) revenue generating industry; 4) standard of care; and 5) source of inequity. Given its positive and negative effects on the health care systems of departure and destination countries, medical tourism is a highly significant and contested phenomenon. This is especially true given its potential to serve as a powerful force for the inequitable delivery of health care services globally. It is recommended that empirical evidence and other data associated with medical tourism be subjected to clear and coherent definitions, including reports focused on the flows of medical tourists and surgery success rates. Additional primary research on the effects of medical tourism is needed if the industry is to develop in a manner that is beneficial to citizens of both departure and destination countries.


GLOBAL HEALTH NEWS:

**Intellectual property and public health in the EU-CAN FTA**

The relationship between the protection of public health and intellectual property rights (IPRs) was among the most delicate topics in the free trade negotiations recently concluded between the EU, Colombia and Peru. This article analyses the outcome from the public health angle. The negotiations started in September 2007 with the intention of concluding a region-to-region ‘association agreement’ between the Andean Community of Nations (CAN) and the European Union. In February 2010, Peru and Colombia wrapped up the negotiations [...] From the public health angle, the text is [...] better when compared with other treaties negotiated by the EU with developing countries. This improvement can largely be imputed to co-operation between Colombian and Peruvian negotiators, and civil society in both countries. A powerful coalition of national and international NGOs (HAI/AIDS, Misión Salud, RedGe) was formed to monitor the negotiations and influence the text. Importantly, the ministries of health of both Colombia and Peru were present in the negotiations. There are, nevertheless, grey zones and problematic issues. One of them concerns the degree of interconnectivity between TRIPS plus and TRIPS extra standards included in different agreements. Although the TRIPS Agreement allows countries to adopt different stances in this regard, in practical terms the most probable outcome is the adoption of the highest levels of IP protection resulting from each of the agreements.


http://ictsd.org/i/news/bridges/84905/
**RESEARCH ON INTELLECTUAL PROPERTY & HEALTH**

**Using market-exclusivity incentives to promote pharmaceutical innovation**

The number of new drugs emerging in the U.S. pharmaceutical market is at a low point. The Food and Drug Administration (FDA) approved an average of 22.6 new drugs and biologics per year from 2005 through 2009, down from 37.2 a decade earlier (1995 through 1999). Paradoxically, this decrease in production has occurred despite billions of dollars in public and private funding for research and development, as well as consistently high revenues reported by the pharmaceutical industry. Meanwhile, demand for innovative therapeutic alternatives has been rising in numerous fields, including antibiotics for multidrug resistant organisms and drugs for tropical diseases prevalent in low-income populations. As a result, policymakers from academia, industry, and government have called for federal initiatives to stimulate drug development. Most proposals target the intellectual property environment, because market-exclusivity periods, usually supported by patents, foster revenue generation in the pharmaceutical market [...] Yet patients (or their insurers) bear the costs by paying higher prices for the products during market-exclusivity periods. These programs may also be subject to misuse if they are implemented in a way that permits the incentives to be earned for marginal innovations or in contexts beyond the intended scope of the legislation. Finally, hidden costs can emerge, such as the public health implications if market exclusivity makes essential drugs prohibitively expensive [...] [The authors conclude that] future legislative efforts aimed at encouraging investment in drug research and development should be more precisely designed to avoid waste and misuse, and they should be linked to demonstration of positive public health outcomes. Without these limitations, making exclusivity incentives available to pharmaceutical manufacturers may not be worth the potential risks to public health.


**GLOBAL HEALTH NEWS:**

**Final ACTA text released**

The United States Trade Representative has released the final text of the Anti-Counterfeiting Trade Agreement, though it is still ‘subject to legal review.’ This text, dated 15 November, is the agreed finalised version, according to a USTR press release. Following a ‘legal verification of the drafting’ the text will go to national governments so they can ‘undertake relevant domestic processes,’ the press release says. The final text reflects a proposed United States/European Union package solution on a few remaining areas of disagreement that was leaked last week [...] Also in last week’s leaks is the scheduled meeting for legal review, to take place 30 November to 3 [...] December in Sydney, Australia.

Preexposure chemoprophylaxis for HIV prevention in men who have sex with men

Antiretroviral chemoprophylaxis before exposure is a promising approach for the prevention of human immunodeficiency virus (HIV) acquisition. [The authors] randomly assigned 2499 HIV-seronegative men or transgender women who have sex with men to receive a combination of two oral antiretroviral drugs, emtricitabine and tenofovir disoproxil fumarate (FTC–TDF), or placebo once daily. All subjects received HIV testing, risk-reduction counseling, condoms, and management of sexually transmitted infections. The study subjects were followed for 3324 person-years (median, 1.2 years; maximum, 2.8 years). Of these subjects, 10 were found to have been infected with HIV at enrollment, and 100 became infected during follow-up (36 in the FTC–TDF group and 64 in the placebo group), indicating a 44% reduction in the incidence of HIV (95% confidence interval, 15 to 63; P=0.005). In the FTC–TDF group, the study drug was detected in 22 of 43 of seronegative subjects (51%) and in 3 of 34 HIV-infected subjects (9%) (P<0.001). Nausea was reported more frequently during the first 4 weeks in the FTC–TDF group than in the placebo group (P<0.001). The two groups had similar rates of serious adverse events (P=0.57). Oral FTC–TDF provided protection against the acquisition of HIV infection among the subjects. Detectable blood levels strongly correlated with the prophylactic effect.


GLOBAL HEALTH NEWS:
At least 56 countries have either stabilized or achieved significant declines in rates of new HIV infections

A new report by the Joint United Nations Programme on HIV/AIDS (UNAIDS), released [23 November], shows that the AIDS epidemic is beginning to change course as the number of people newly infected with HIV is declining and AIDS-related deaths are decreasing. Together, this is contributing to the stabilization of the total number of people living with HIV in the world. Data from the 2010 UNAIDS Report on the global AIDS epidemic shows that an estimated 2.6 million (2.3 million–2.8 million) people became newly infected with HIV, nearly 20% fewer than the 3.1 million (2.9 million–3.4 million) people infected in 1999. In 2009, 1.8 million (1.6 million–2.1 million) people died from AIDS-related illnesses, nearly one-fifth lower than the 2.1 million (1.9 million–2.3 million) people who died in 2004. At the end of 2009, 33.3 million (31.4 million–35.3 million) people were estimated to be living with HIV, up slightly from 32.8 million (30.9 million–34.7 million) in 2008. This is in large part due to more people living longer as access to antiretroviral therapy increases.

Source: ________. 2010. Press Release: At least 56 countries have either stabilized or achieved significant declines in rates of new HIV infections. UNAIDS online (23 November).
**Research on Global Action on Non-Communicable Diseases:**

**Health, agriculture, and economic effects of adoption of healthy diet recommendations**

Transition to diets that are high in saturated fat and sugar has caused a global public health concern, as the pattern of food consumption is a major modifiable risk factor for chronic non-communicable diseases. Although agri-food systems are intimately associated with this transition, agriculture and health sectors are largely disconnected in their priorities, policy, and analysis, with neither side considering the complex inter-relation between agri-trade, patterns of food consumption, health, and development. We show the importance of connection of these perspectives through estimation of the effect of adopting a healthy diet on population health, agricultural production, trade, the economy, and livelihoods, with a computable general equilibrium approach. For example, 70,000 premature deaths per year, could be prevented in the UK if diets matched nutritional guidelines set out by WHO; this could save the health services about £20 billion every year. On the basis of case-studies from the UK and Brazil, we suggest that benefits of a healthy diet policy will vary substantially between different populations, not only because of population dietary intake but also because of agricultural production, trade, and other economic factors.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61352-9/abstract

**Global Health News:**

**A made-in-India solution to a tragic health scourge**

Type 1 diabetes -- unlike the more common Type 2 -- frequently presents in childhood. Its incidence worldwide is rising, but no one knows why; lifestyle, exercise and body weight are not to blame [...] In countries such as India, however, the burden of daily insulin injections drives many parents to despair. Some stop treatments altogether, condemning their child to death. With so many mouths to feed, they feel they have no choice [...] What might we do to help? [...] Pressure on Indian authorities to craft a better healthcare system is clearly warranted. This task is one for Indians themselves, but global health advocates can add their voice [...] We can also ask pharmaceutical companies some hard questions: Why aren't they shipping off-patent test strips to poor countries, or providing voluntary licences to generic manufacturers? According to the World Trade Organization, moreover, governments can issue compulsory licences for essential diagnostic tools -- including, arguably, blood test strips -- and exempt them from patent protection.

*Source: Ron, James et al. 2010. A made-in-India solution to a tragic health scourge. Ottawa Citizen online (5 October).*  

**Global Health News:**

**Lancet publishes series on non-communicable diseases**

In September 2011, the UN [held] its first High-level Meeting of the General Assembly on chronic non-communicable diseases. The Lancet’s Series of papers is [its] contribution to preparations for the September meeting. These papers cover a range of diseases -- cardiovascular, diabetes, cancer, and chronic obstructive respiratory diseases -- and present strategies for substantial health gains, monitoring, and scaling up of interventions. [It] also highlight[s] earlier Lancet Series and provide links through to all of the relevant content.

*Source: The Lancet. 2010. Chronic diseases and development series. The Lancet online (September).*  
The Health and Foreign Policy Bulletin is a monthly publication of the Norman Paterson School of International Affairs and the Centre for Trade Policy and Law. Its objective is to promote evidence based policy making by summarizing and disseminating the latest research on the intersection between global health and foreign policy. The Bulletin also identifies key events and developments of importance to policy makers. We are always looking for ways to improve the Health and Foreign Policy Bulletin and to expand its readership. If you have any suggestions or would like to subscribe, please contact us at hfp_bulletin@carleton.ca.

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