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### RESEARCH ON GLOBAL HEALTH SECURITY:

## Influenza pandemic preparedness and response: A review of legal frameworks

The potential of pandemics to cause global destabilization calls for robust pandemic preparedness plans with supportive health legislation; however, few international studies have investigated the national legal preparedness of countries in case of a pandemic. This study reviews India's legal preparedness in the face of an epidemic by reviewing and analyzing seminal publications pertinent to pandemic preparedness and relevant legal frameworks in India. The analyses are presented in matrix formats and reviewed by national experts. It finds that current legal frameworks are largely 'policing' in nature. These provisions seem to be adequate for dealing with small scale emergencies but do not appear to be sufficient for large scale health crises during pandemics. India needs a critical mass of public health legislations to make an impact and not police acts to control epidemics. In addition, it needs a 'public health standards defining agency' which can set standards for these measures and ensure uniformity in implementation of control measures. Technical organization like US CDC's National Institute for Occupational Safety and Health (NIOSH) and UK's National Institute of Health and Clinical Excellence (NICE) are some examples.

Source: [Kakkar, Manish, et al. 2010. Influenza pandemic preparedness and response: A review of legal frameworks in India. Indian Journal of Public Health Vol. 54, Issue 1 \(29 September\).](#)



### GLOBAL HEALTH NEWS:

#### **Global health governance – the response to infectious diseases**

“The burden of disease that affects the developing world has grown from a high prevalence of communicable infectious diseases to new additions of emerging infections plus an increasing problem of non-communicable diseases. Most infectious diseases are largely specific to the world's poorest regions, and sub-Saharan Africa bears a great burden of these diseases. Bilateral and multilateral institutions, followed by organisations and many new initiatives including advocates for health, make up the multiple actors that are responding to the increasing threats of such a crisis in infectious disease. These actors, whose numbers are increasing, endeavour to provide health care to populations and communities, a humanitarian act from which developing countries benefit tremendously [...] However, from a governance perspective, several issues still need to be addressed to increase overall impact. Their focus, plans, and in some cases policies need to be better aligned with those of the recipient country.”

Source: [Leke, Rose Gana Fomban. 2010. Global health governance – the response to infectious diseases. \*The Lancet\* Vol. 376, Issue 9748 \(9 October\)](#)

### RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

#### **A Standardized health information system for refugee settings: Rationale, challenges and the way forward**

Refugee data are of public health importance to ministries of health. However, the unique characteristics of refugee settings prevent host governments using their existing Health Information Systems (HIS) to directly monitor refugee health programmes. Refugee settings require an HIS that is adapted to meet their specific monitoring needs, but that can continue to uphold national reporting requirements and share data with host governments long after they have been established. UNHCR has developed a standardized refugee HIS for its camp-based field operations that is freely available to partners. While this system has several benefits for national information systems, closer collaboration is required between stakeholders to better integrate national and refugee systems. This includes the development of guidance materials, standardization of evaluation methodologies, organization of joint training and evaluation missions, and the dissemination and use of refugee data. At the global level, more concerted efforts are needed to harmonize indicator selection and define common standards for coding data. This will help promote interoperability and integration between national and refugee HIS, and ensure the results can support decision-making at all levels of management and by all partners including refugees, host governments, United Nations agencies and the wider international community.

Source: [Haskew, C, et al. 2010. A standardized health information system for refugee settings: rationale, challenges and the way forward. \*Bulletin of the World Health Organization\* Vol. 88, No. 10 \(October\).](#)

### GLOBAL HEALTH NEWS:

#### **PAHO press briefing on the cholera outbreak in Haiti (25 October 2010)**

On 25 October, Haiti's Ministry of Health reported 3015 cases of cholera and 253 deaths. According to Dr. Jon Andrus, Deputy Director of the Pan American Health Organization, “these numbers [should] continue to increase and be reported from different areas of Haiti. The data is a result of intensive efforts to build capacity in Haiti for early detection and to establish an Early Warning Surveillance System as part of the response to the earthquake on January 12th this year. The MOH is building on those efforts to further strengthen surveillance and reporting of cholera. The official numbers almost certainly under-represent the “true” number of cases, because, in general terms, approximately 75 percent of the people infected with cholera do not exhibit any symptoms, yet they can carry the bacteria and shed them for up to two weeks days after infection back into the environment, especially where good sanitation facilities are lacking, potentially infecting other community members.”

Source: [Andrus, Jon. 2010. PAHO Press Briefing on the cholera Outbreak in Haiti. \*PAHO online\* \(25 October\).](#)



*RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:*

### **Advancing health equality in the global marketplace: how human rights can help**

The WHO Commission on Social Determinants of Health (CSDH) ascribed health disparities within and between countries to “a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.” This article analyzes the relevance of the international human rights framework (IHRF) to the Commission’s goal of reducing health disparities with reference to both social scientific and legal scholarship. The authors begin with an overview of the IHRF, demonstrating its potential as a challenge to the normative foundations of the emerging global economic order. They then survey the research literature on mechanisms to ensure accountability for realization of health-related rights, emphasizing the potential effectiveness of making human rights enforceable through the courts, and the special need for mechanisms to hold countries and international institutions accountable for obligations related to the human right to health. They conclude by identifying three key directions for further research, policy and advocacy: 1) comparative human rights litigation, specifically the willingness of courts to address broad policy and budgetary issues; 2) the conditions under which governments legislate or constitutionalize economic and social rights; and 3) how rich, powerful countries affect economic and social rights outside their borders.

*Source:* [Schrecker, Ted, et al. 2010. Advancing health equity in the global marketplace: How human rights can help. \*Social Science & Medicine\* Vol. 71, Issue 8 \(October\).](#)

*GLOBAL HEALTH NEWS:*

### **Drug crime and criminalization threaten progress on MDGs**

“International drug crime and the policies intended to tackle it are both threats to progress on health, human rights, and the Millennium Development Goals [...]” In preparation for the UN Millennium Development Goal (MDG) Summit, secretary-general Ban Ki-moon declared on this year’s International Day against Drug Abuse and Illicit Trafficking that “we must recognise the major impediment to development posed by drug abuse and illicit trafficking”, and urged that: “our work to achieve the MDGs and fight drugs must go hand-in-hand”. Antonio Maria Costa, executive-director of the UN Office on Drugs and Crime (UNODC), told *The Lancet* that if the many cross-cutting, multidimensional issues about drugs and crime are not addressed, many MDGs will not be met in various countries. The effect of the illicit drug trade, which constitutes the major part of global organised crime “is high on the international agenda”, Costa notes, and a fundamental concern is the “vicious cycle” of drug production and trafficking, poverty, and instability.”

*Source:* [Morris, Kelly. 2010. Drug crime and criminalization threaten progress on MDGs. \*The Lancet\* Vol. 376, Issue 9747 \(2 October\)](#)



*RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:*

### **Seven challenges in international development assistance for health and ways forward**

This paper outlines seven challenges in development assistance for health, which in the current financial context, have become even more important to address. These include the following: 1) the proliferation of initiatives, focusing on specific diseases or issues; 2) the lack of attention given to reforming the existing focal health institutions (ex. WHO and World Bank); 3) the lack of accountability of donors and their influence on priority-setting; 4) the pragmatic difficulties of financing horizontal interventions; 5) the marginal involvement of developing country governments as aid recipients, 6) the heavy reliance on Northern-based organizations as managers of funds; and 7) the risks of linking health to national security and foreign policy interests. Following an examination of these challenges, the paper provides three suggestions for ways forward: 1) creating new mechanisms to hold donors accountable; 2) developing national plans and strengthening national leadership in health; and 3) studying/learning from South-South collaboration.

Source: [Sridhar, Devi. 2010. Seven challenges in International Development Assistance for Health and Ways Forward. \*Journal of Law, Medicine & Ethics\* Vol. 38, Issue 3 \(Fall\).](#)

*GLOBAL HEALTH NEWS:*

### **Implications of the Adelaide Statement on health in all policies**

“The simultaneous and interrelated challenges of poverty, health, food security, energy, the global economic crisis and climate change should be viewed by the global community as a unique opportunity to develop innovative approaches to achieve sustainable growth without compromising health equity. One such innovative approach is the concept of working across many sectors to improve governance for health and well-being. In April 2010, experts and practitioners from multiple sectors gathered in Adelaide, South Australia, for the International Meeting on Health in All Policies. Their discussions on how the health sector can support broader policy goals related to societal well-being evolved into the Adelaide Statement on Health in All Policies. The Adelaide Statement draws on the increasing body of knowledge on “joined-up” government to propose a new way for governments to engage multiple sectors in the joint goal of improving health and well-being. It starts by stressing the need to examine the management of policies and goals across government. Further, it calls upon the health sector to be involved in the development of policies in other sectors to ensure health equity. This does not necessarily mean a departure from the health sector’s main functions, but rather a broadening of its scope and role within public policy-making.”

Source: [Krech, Rüdiger, et al. 2010. Implications of the Adelaide Statement on Health in All Policies. \*Bulletin of the World Health Organization\* Vol. 88, No. 2 \(October\)](#)



*RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:*

### **Reforming health care: Why we need to learn from international experience**

How best to ensure decent health care for the population is a key challenge for every nation. For developed nations with universal coverage the goals are to maintain equitable access to care and ensure public satisfaction, provide sufficient quality of care and achieve greater efficiency while controlling costs. Emerging economies face the tough challenge of how to deliver high-quality care at an affordable price to their new middle classes, while in low income countries the priorities are more profound: how to provide basic health care across as much of the population as possible, for little money. On one reading, western democracies with well established health systems have little to learn from countries with less developed systems, and *vice versa*. But most developed nations are facing a growth in health care consumption, fuelled by individual demand and by suppliers of care. Middle- and low-income countries have never had the resources to support this 'medical- industrial complex'. Instead they have had to develop low-cost, innovative approaches to improve basic health that include a strong orientation around community based, public health, which can be instructive to wealthier countries.

Source: [Dixon, Jennifer, and Vidhya Alakeson. 2010. Reforming health care: why we need to learn from international experience. Nuffield Trust online \(September\).](#)

*GLOBAL HEALTH NEWS:*

### **Achieving the health MDGs: Country ownership in four steps**

"There has been much debate in the global health community on how best to accelerate positive health outcomes. The notion of country ownership has surfaced in many of these conversations. Country ownership is the surest way for developing countries to chart their own course of development and overcome the challenges they face in building effective and productive states." Drawing on experiences in Ethiopia, the author points to four steps for making country ownership a reality. 1) Planning: countries must start with a clear vision and a detailed roadmap for realizing it; 2) Resourcing the plan: countries must take the lead and ensure careful prioritization of resources; 3) Implementation: partners should strengthen existing national capacities rather than replace them; 4) Monitoring and evaluation: partners should help build the capacities of recipient countries to track performance.

Source: [Ghebreyesus, Tedros Adhanom. 2010. Achieving the health MDGs: country ownership in four steps. The Lancet Vol. 376, Issue 9747 \(2 October\).](#)



*RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:*

### **Workforce resources for health in developing countries**

In response to the challenge of inadequate health workforce numbers and distribution, there is a trend to consider alternative cadres who can deal effectively with common health problems and improve access to services in both rich and poor countries. The authors focus on two alternatives to professional medical and nursing practitioners: community health and midlevel workers as essential primary healthcare providers. The decline in enthusiasm for community health workers programs in the 1980s was due to problems, such as “unrealistic expectations, poor initial planning, problems of sustainability, and the difficulties of maintaining quality” experienced by large-scale and national programs. Yet CHW programmes have re-emerged globally, mainly to address shortages in qualified health workers in many countries. In sub-Saharan countries, this is mainly due to the increased needs (diagnosis, treatment and care) generated by HIV/AIDS. Mid-level workers (MLWs) are certificated individuals who are not doctors but have been trained to “diagnose and treat common health problems, to manage emergencies, to refer appropriately and to transfer the seriously ill or injured for further care. For many low resource countries, mid-level health workers are the backbone of the health service. Research into the contribution of mid-level providers indicates that they do indeed improve access to care for underserved populations in both developed and developing countries. MLWs have made trauma care more accessible in the US and increased access to reproductive health services, in particular abortion services, in a number of countries in the developed and developing world. Wide access to HIV treatment in Africa was achieved through the use of MLWs and in some instances, people with even less formal training.

Source: [Bangdiwala, Shrikant I. 2010. Workforce Resources for Health in Developing Countries. Public Health Reviews Vol. 32, No. 1.](#)

*GLOBAL HEALTH NEWS:*

### **Possible shortage of up to two million health care workers by 2020**

Forecasts “predict a shortage of 600,000 workers in nursing alone by 2020 and a shortage of 230,000 physicians [...] The effect of this gap in supply would vary from one individual EU member state to another. The poorer Member States might find it more difficult to retain a sufficient number of health professionals making the shortage of professionals all the more acute in these countries. A number of activities are underway at the European level to address this and the other challenges facing the European health workforce. In 2008 the EU Commission issued its Green Paper on the European Workforce for Health, thus placing the topic on the European agenda. As part of the Europe 2020 Strategy to overcome the crisis and prepare the EU economy for the next decade, one of the flagship initiatives will be to set an agenda for new skills and jobs. Health professions will be included in these efforts.”

Source: [European Health Forum Gastein. 2010. Possible shortage of up to two million health care workers by 2010. European Hospital online \(8 October\).](#)



**RESEARCH ON TRADE POLICY & HEALTH:**

### **Infectious disease movement in a borderless world: Workshop summary**

From 16-17 December 2008, the Institute of Medicine's (IOM's) Forum on Microbial Threats hosted a two-day public workshop in Washington, DC, on *Globalization, Movement of Pathogens (and their hosts), and the revised International Health Regulations (IHRs)*. Chapter 2 of the workshop report, *Travel, Conflict, Trade, and Disease*, includes four essays. In the first essay, Mary Wilson of Harvard University illustrates the profound impact of recent increases in the volume, speed, and reach of global travel. According to Wilson, "Humans can reach almost any part of the earth today within the incubation period for most microbes that cause disease in humans". In the second paper, Bary Levy discusses major causes that contribute to the increased incidence of infectious diseases during wartime: reduced availability of health services, environmental damage, and forced migration. In the third paper, Ann Marie Kimball and co-author Jill Hodges present case studies of several emerging infectious diseases, including H5N1 influenza and bovine spongiform encephalopathy (BSE), and their relationship to "risky" trade practices in food production and medicine. Finally, David Acheson of the Food and Drug Administration (FDA) describes the agency's response to two recent challenges to the security of the U.S. food supply—the 2008 outbreak of Salmonella Saintpaul and the deliberate contamination of imported wheat gluten with melamine. He also discusses changes in FDA's food security efforts to respond to such threats by seeking to understand where and when they arise, to anticipate their potential to spread globally and to use risk-based inspections to detect them before an outbreak occurs in the United States.

Source: [Institute of Medicine \(US\) Forum on Microbial Threats. 2010. Infectious Disease Movement in a Borderless World: Workshop Summary. The National Academies Press.](#)

**GLOBAL HEALTH NEWS:**

### **Court ruling strengthens EU governments' power to demand prior authorization for cross-border healthcare**

"National health authorities are entitled to insist that patients wishing to be reimbursed for specialised medical treatment outside a hospital setting in another European Union country must first receive prior authorisation, says the European Court of Justice in a new ruling. The judgment is a setback for the European Commission, which had taken France to court, arguing that the authorisation requirement violated European law and one of the EU's basic principles: the freedom to provide services. [...] The ruling by the Luxembourg based judges is the latest in a series of cases involving the right of patients to be treated in another member state and be reimbursed for the costs involved. In an attempt to clarify the many complex issues at stake, EU governments and the European parliament are currently negotiating legislation to enshrine certain basic ground rules in law."

Source:

[Watson, Rory. 2010. Court ruling strengthens EU governments' power to demand prior authorisation for cross-border health care. \*BMJ\* 341: c5657 \(11 October\).](#)



RESEARCH ON INTELLECTUAL PROPERTY & HEALTH

### **Nano-microbicides: Challenges in drug delivery, patient ethics and intellectual property in the war against HIV/AIDS**

As we continue to be embroiled in the global battle against the human immunodeficiency virus (HIV), there has been an ongoing evolution in the understanding of the molecular mode of sexual transmission of HIV. This has gone hand-in-hand with a paradigm shift and research focus on the development of microbicides — compounds designed for vaginal (and possibly rectal) administration that are envisaged to put safe, affordable and accessible protection into the hands of women. In this review, advances in the design of innovative microbicide nanocarriers and nano-enabled microbicides, henceforth referred to as ‘nano-microbicides’, are presented; and the unique issues facing the generation of intellectual property relating to nano-microbicides in the ongoing global ‘tug-of-war’ of ‘patients versus patents’ are also explicated. Amongst their findings, the authors’ show that since research and development in this field is ensuing at a rapid pace, the issuance of valid enforceable patents will be the predictors of success and failure for emerging nanotechnological companies. Since nanotechnology is an interdisciplinary convergence of physics, chemistry, biotechnology, electronics and medicine, inventions can only be expected to be of a multidisciplinary nature. Patent offices will thus be expected to face multiple challenges in dealing with patent applications that claim inventions in this field. One of the foremost stated difficulties by law experts is the identification of examiners with sufficient knowledge and experience of the technology to examine applications.

Source: [Du Toit, Lisa C, et al. 2010. Nano-microbicides: Challenges in drug delivery, patient ethics and intellectual property in the war against HIV/AIDS. \*Advanced Drug Delivery Reviews\* Vol. 62, Issues 4-5 \(March\).](#)

GLOBAL HEALTH NEWS:

#### **WTO paragraph 6 meeting aims at improved use of health waiver**

The agenda for the upcoming annual World Trade Organization review on 27 October 2010 has been circulated. “The meeting is intended to result in next steps and recommendations. It also will consider alternatives to the use of Paragraph 6, and will include input from UN agencies such as the UN Conference on Trade and Development, the World Health Organization and the World Intellectual Property Organization [...] Paragraph 6 of the Doha Declaration mandated governments to solve the problem of countries lacking pharmaceutical manufacturing capabilities not being able to take advantage of TRIPS flexibilities. In August 2003, WTO members agreed on a paragraph 6 solution, a temporary waiver to TRIPS rules that require predominately all medicines produced under compulsory license be for the domestic market of the country producing them. But the waiver has only been used once, by Rwanda importing from Canada. The waiver was approved by WTO members as the first amendment to TRIPS in December 2005 but so far not enough of the required two-thirds of member countries have ratified it for the amendment to permanently enter into effect so the August 2003 temporary waiver remains in force.”

Source: [New, William. 2010. WTO Paragraph 6 Meeting Aims At Improved Use of Health Waiver. \*IP Watch\* online \(16 October\).](#)



RESEARCH ON RESPONSE TO HIV/AIDS, TUBERCULOSIS & MALARIA:

### **Financing of HIV/AIDS programme scale-up in low-income and middle countries, 2009-31**

The aids2031 project modelled long-term funding needs for HIV/AIDS in developing countries with a range of scenarios and substantial variation in costs: ranging from US\$397 to \$722 billion globally between 2009 and 2031, depending on policy choices adopted by governments and donors. In this paper, the authors examine what these figures mean for individual developing countries, and estimate the proportion of HIV/AIDS funding provided. Scenarios for expanded HIV/AIDS prevention, treatment, and mitigation were analysed for 15 representative countries. They suggest that countries will move in increasingly divergent directions over the next 20 years; middle-income countries with a low burden of HIV/AIDS will gradually be able to take on the modest costs of their HIV/AIDS response, whereas low-income countries with a high burden of disease will remain reliant upon external support for their rapidly expanding costs. A small but important group of middle-income countries with a high prevalence of HIV/AIDS (eg, South Africa) form a third category, in which rapid scale-up in the short term, matched by outside funds, could be phased down within 10 years, assuming strategic investments are made for prevention, and efficiency gains are made in treatment.

Source: [Hecht, Robert, et al. 2010. Financing of HIV/AIDS programme scale-up in low-income and middle-income countries, 2009-31. \*The Lancet\*, Vol. 376, Issue 9748 \(9 October\)](#)

GLOBAL HEALTH NEWS:

#### **The Global Fund: A bleak future ahead**

"In early 2010, [The Global Fund] provided donors with resource need scenarios for 2011—13, which ranged from a minimum of \$13 billion to continue funding existing grants and for funding new programmes but at a substantially lower level than previously, to \$20 billion for full replenishment of the fund to meet the target of universal access [...] On Oct 5, at the third replenishment conference for the Global Fund to Fight AIDS, Tuberculosis and Malaria, donors pledged US\$11.7 billion for 2011-13—a sum that falls badly short of what is needed. The world is backsliding on its commitments, made recently at the Millennium Development Goal Summit in New York, to expand access for millions of people to life-saving interventions [...] The Fund needs \$8.8 billion over 2011—13 for renewing grants, plus paying for round 9 and operating costs. That leaves an insufficient \$2.9 billion for rounds 10, 11, and 12 [...] The funding shortfall partly reflects the effect of the global financial crisis, but more than that it represents a collective failure of international cooperation at a time when the world needs global solidarity. The predicament faced by the Fund therefore bodes badly for other health issues that demand multilateral solutions. [...] why does WHO stay silent? Those close to discussions about the Fund's replenishment have often voiced surprise and sadness that WHO played little part in galvanising donor commitments to the Fund, viewing money going to the Fund as money not going to WHO. Multilateral failures have been matched by failures in the governance of global health."

Source:

[The Lancet. 2010. The Global Fund: a bleak future ahead. \*The Lancet\* Vol. 376, Issue 9749 \(16 October\).](#)



### GLOBAL HEALTH NEWS:

#### Trying to follow the trail of missing AIDS patients

“Several years ago, during the rapid international expansion of HIV drug distribution, researchers reported very high rates of adherence to treatment in sub-Saharan Africa — as high as or higher than in the United States. More recently, however, studies have found that 15 to 40 percent of those who start treatment are lost to follow-up within one to three years. This unsettling trend has emerged at a difficult time; financing for treatment from the United States and other donors is not keeping pace with the rate of new infections, which has generated waiting lists for the lifesaving medications in some parts of Africa. [...] HIV programs in Africa are experimenting with various strategies to reduce loss to follow-up — offering a two- or three-month supply of medication per clinic visit, delivering drugs directly to patients’ homes and reimbursing them for transportation costs. Faces [Family AIDS Care and Education Services, a joint program of the Kenya Medical Research Institute and the University of California] is exploring modest projects to raise patients’ income and stabilize their lives, like creating a microfinance system to provide water pumps and other agricultural support to help them grow more crops.”

Source:

[Tuller, David. 2010. Trying to Follow the Trail of Missing AIDS Patients. \*The New York Times\* online \(25 October\).](#)

### RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

#### Obesity and the economics of prevention: Fit not Fat

Obesity is a major health concern for OECD countries. Using a wide range of individual-level and population data from OECD countries, this book presents analyses of trends in obesity, explores the complex causal factors affecting the epidemic and develops an assessment of the impacts interventions to combat the problem. The book provides new information on what prevention strategies are most effective and cost-effective, discussing the respective roles of individuals, social groups, industry and government, and the implications of these findings for the development of policies to address one of the largest public health emergencies of our time. In addition, it presents an economic approach to the prevention of chronic diseases, which recognizes the importance of human goals that are potentially in competition with the pursuit of good health and the social and material constraints which influence individual choice and behaviours. An economic approach aims at identifying possible factors, which limit opportunities for people to make healthy lifestyle choices, and devising suitable strategies to overcome such failures.

Source: [Directorate for Employment, Labour and Social Affairs. 2010. Obesity and the Economics of Prevention: Fit not Fat. OECD \(23 September\).](#)



# HEALTH & FOREIGN POLICY BULLETIN

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[research.policy-net.org/blogs/healthandforeignpolicy](http://research.policy-net.org/blogs/healthandforeignpolicy)

## GLOBAL HEALTH NEWS:

### OECD ministers fear that economic crisis may reduce investment in prevention of chronic disease

“Health ministers and policy makers from 36 countries met in Paris last week to discuss ways to reduce spending on health care in the current economic climate without damaging the quality of care. “The message is loud and clear that some objectives are so central and important that we cannot compromise,” said Anne-Grete Strøm-Erichsen, Norway’s health minister, at the close of the Organisation of Economic Co-operation and Development meeting on 7-8 October, which she chaired. Amid huge financial pressure on OECD countries, whose health spending is on average 9% of gross domestic product (and more than 10% in seven countries), “access, quality, and prevention” are crucial in terms of dealing with future health challenges and ensuring better value for money, Ms Strøm-Erichsen said. Countries around the world could make major savings simply by making their services more efficient, the OECD ministers agreed. If all countries were to become as efficient as the best performers, people would live two extra years on average across OECD countries, for the same level of spending, the OECD has calculated. By contrast, a 10% increase in spending would achieve only a two month increase in life expectancy.”

Source: [Arie, Sophie. 2010. OECD ministers fear that economic crisis may reduce investment in prevention of chronic disease. \*BMJ\* 341: c5655 \(11 October\).](#)

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](mailto:hfp_bulletin@carleton.ca).

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