COMMONWEALTH POLICY STUDIES UNIT: 7

2001 Commonwealth Health Ministers' Meeting: Policy Brief

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Policy Brief for the Commonwealth Health Ministers Meeting, 25-29 November, 2001, Christchurch, New Zealand

Executive Summary

The overall theme for the 13th Health Ministers' Meeting (13 CHMM), Priority Setting in Health Systems, was set in Barbados in 1998 at 12CHMM and confirmed by Commonwealth Health Ministers in May 2001. This theme recognises that all countries, regardless of their wealth, demographic composition or epidemiological trends, need to set priorities to ensure that the best use is made of scarce resources. HIV/AIDS will also be given prominence. There is great diversity among Commonwealth countries, but all are grappling with how the health needs of their citizens can be met within the resources available. In recognition of the diversity of Commonwealth nationals, the object of 13 CHMM is to identify those processes and mechanisms which have been successfully used by some countries and which could be applied by others. So, rather than attempting to identify what the actual health service priorities should be for different countries, Ministers will discuss how priorities may best be determined. There will be a parallel Commonwealth Health Symposium and Trade Fair providing a forum for academic, private sector and civil society specialists to discuss health priorities in the Commonwealth. Against the backdrop of a trade exhibition, the symposium will disseminate to governments the views of health-care specialists and other stakeholders in the public, private and non-governmental sectors.

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1 Status, representation, recent meetings

The Commonwealth is an organisation that consists of 54 countries, 17,000 listed companies, 1.7 billion people, US$2 trillion in trade and an alliance that makes up 40 percent of the WTO membership. As a union of both developed and developing countries, it is the largest organisation in the world aside from the United Nations. On a triennial basis, the Health Ministers, Chief Medical Officers and senior civil servants of the Commonwealth meet to discuss best practice and innovations in healthcare from the perspective of the public sector. This year however, the Commonwealth has chosen the 13th Health Ministers Meeting, 25 to 29 November at Christchurch, New Zealand, to begin an open dialogue with the global private sector community in the form of a parallel symposium designed to create a conduit between government and industry. Joint sessions with Ministers are structured to give them a better understanding of current private sector capabilities and views. A meeting of Senior Health Officials will be held on 25 November 2001 to approve the agenda, timetable and other administrative arrangements. A meeting of the Steering Group of the Commonwealth Health Development Programme (CHDP) on 24 November 2001 will precede this.

Health Ministers from member countries are invited to meet to discuss issues which are common to all, and to learn from the experiences of each other. Invitations are issued to all Commonwealth member countries, including special members such as Tuvalu. Self-governing states in association with the Commonwealth are invited to the Commonwealth Ministerial Meetings. Two Commonwealth inter-governmental agencies (the Commonwealth Foundation and the Commonwealth of Learning) are invited to attend, though they may not always be represented.

The Commonwealth Health Ministers' Meeting (CHMM) has been held for the past 39 years. The last CHMM was held in Barbados in November 1998. One hundred and fifty-nine delegates, including 34 Ministers attended and 47 observers from international and regional organisations also participated in the 12CHMM. Participation at the 11CHMM in Cape Town, South Africa in December 1995 was considerably lower. Ninety-seven delegates, including twenty-one Ministers attended that meeting and only 29 observers from 11 international and regional organisations participated.

2 Record for policy

Commonwealth Health Ministers meet at the Pre-World Health Assembly Meeting in Geneva each year. The agenda for the 13CHMM was set at that meeting in May 2001. The record of that meeting is yet to be published which makes it difficult to comment on the precise nature of health policy developments in the Commonwealth. It is ironical that the chosen theme is priority setting in health systems when health itself is a low priority area for the Commonwealth. The Health Programme within the Secretariat is relatively small. It has only 2 full-time staff members. It therefore seems unrealistic to expect them to manage the numerous activities set out by the items on the provisional agenda. Nonetheless, the loose organisational and small structure of the health department has both strengths and weaknesses.

Even within the most conservative trenches of the official Commonwealth there is a grudging acceptance that part of the unique nature and strength of the Commonwealth lies in its multifarious unofficial network. There has been a range of collaborations on health issues between Commonwealth professional associations and the official Commonwealth. An example can be drawn from the lessons of the Para 55 working group. Para 55 is significant

Heads of Government at Durban in 1999 as their personal commitment to fight the pandemic. Para 55 is a group which has been working to create awareness of the Durban communiqué paragraph within other Commonwealth professional associations. It has also implemented a series of activities, including a December 2000 one-day conference on HIV and the Commonwealth, and initiated the Commonwealth Awareness on AIDS.

Para 55 is an example of how an interdisciplinary Commonwealth grouping can work effectively in a common cause. It has also managed to galvanise broad support beyond the health sector to include actors from the business, social and economic sectors. It provides a forum for sustained formal and informal dialogue among and between its various partners,including the Commonwealth Foundation. The Foundation is the inter-governmental organisation of the Commonwealth with a mandate to work in the non-governmental sector. It has a long-standing commitment to support the work of the citizens of the Commonwealth in health policy-making and delivery. Unlike the Health Department of the Secretariat it has fluid financial resources to carry out workshops on health activities. Over the past three years, its work has focused on: citizens' participation in policy making and service delivery; promoting a multi-disciplinary approach to HIV/AIDS; networking by Commonwealth associations of health professionals; capacity building for NGOs; a Commonwealth working group on traditional medicine; and training of young doctors.

Although there seems to be a lot of emphasis on meetings and workshops among professional Commonwealth associations many of these represent elitist agendas. Even within the framework of Health Ministers' meetings it is almost impossible to ascertain whether any significant steps are taken within the 3-year period that go beyond Ministry of Health officials to promote the ideals of Commonwealth health policy. The media rarely promote any of these activities; a shared website would certainly enhance in-country, regional and global collaboration. The lack of financial resources devoted to health activities in the Commonwealth implies that member states are more likely to place greater emphasis on meetings and policy from other, more prominent international organisations.

3 Agenda for 2001

Following the two opening sessions, the provisional draft agenda, which will be confirmed or amended on the eve of the conference, is:

1 Priority Setting in Health; Processes and Mechanisms

- Prioritising health
- Approaches to priority setting in health
- Successes, failures and lessons learnt

2 Impact of Globalisation on Health

(a) Globalisation, Health and Development

Health: An investment for development

Globalisation and Health Care

- Access to drugs at affordable prices: WTO, TRIPS, patents, parallel imports, biopiracy
- Impact of market forces on health
- Access to research and knowledge: the digital divide: telemedicine, information and communication systems

• Infrastructure, primary health care and appropriate technologies
• Domestic policies and international consensus building

Intersectoral linkages and their impact on countries' capacity to deliver services; sector-wide approaches.

(b)HIV/AIDS: A Commonwealth emergency

3 Resources for health

(a) Financial resources
• Investing in health: health expenditures as a proportion of GDP
• Maximising resources through partnerships
• How could donor resources be used more effectively to meet national health needs?

(b) Human resources
• Management: skills mix; recruitment and retention of skilled personnel, distribution – rural/urban; human resource management information systems, good practices
• Breaking with tradition (multiskilling)
• Commonwealth Code of Practice for International Recruitment of Health Personnel

(c) Increasing the contribution of civil society; NGOs, communities and the private sector

4 Improving efficiency and effectiveness of health systems

(a) Regional co-operation on health priorities including shared services and technical assistance
• Good practices: Organisation of Eastern Caribbean States (OECS)
• PAHO Revolving Fund for Vaccines
• Caribbean co-operation in health initiative
• East, Central and Southern Africa
• The Pacific

(b) Tobacco or health: health systems' response to the consequences of tobacco consumption; FCTC.

(c) Role of international health priorities and programmes in improving efficiency and effectiveness of service delivery

5 Review of action taken on the recommendations of 12CHMM

6 Review of Commonwealth Secretariat's action on Commonwealth health priorities

7 Conclusions and recommendations

8 Any other business

4 Comments on numbered agenda items

Within the ambit of prioritisation ,Ministers have identified three areas for further discussion: impact of globalisation on health, resources for health and improving efficiency and effectiveness of health systems. These three issues impact on either the processes countries will use to set actual service priorities or will help identify areas for further development within health systems.

1 Priority setting in health: processes and mechanisms

Within the main theme of priority setting, HIV/AIDS should be given utmost importance. The pandemic has reached proportions where it threatens all the past gains in development. AIDS is taking a devastating toll in human suffering and death across the Commonwealth. Nine of the most heavily infected HIV/AIDS countries in the world are Commonwealth countries. The Commonwealth includes two of the regions with the highest rates of infection (Africa and the Caribbean); and two of the countries (South Africa and India) with the largest number of people living with HIV/AIDS. At the same time, it can be emphasised that Uganda is one Commonwealth country, which has reversed rising infection rates by means of a well-orchestrated public awareness and condom distribution programme. It can serve as a role model for several countries grappling with the widespread effects of HIV.

The Commonwealth has been, and continues to be, a strong proponent of international efforts to address the multitude of problems associated with the pandemic. Ministers will discuss the HIV/AIDS emergency at 13CHMM in the context of globalisation. This is a timely opportunity for Ministers to discuss the implications of the recent resolution of the United Nations General Assembly special session on HIV/AIDS. Commonwealth countries represent approximately 29 percent of the world's population, but as much as 60 percent of those infected by AIDS. Paragraph 55 of the 1999 Durban CHOGM Communiqué reads as follows: "Heads of Government expressed grave concern over the devastating social and economic impact of HIV/AIDS, particularly in sub-Saharan Africa. They agreed that this constituted a Global Emergency, and pledged personally to lead the fight against HIV/AIDS within their countries and internationally. They urged all sectors in government, international agencies and the private sector to cooperate in increased efforts to tackle the problem."

HIV infection these days is almost entirely a sexually transmitted disease. It is, therefore, preventable in theory. The hunt for an AIDS vaccine is built on the depressing, if realistic, notion that human behaviour in sexual matters is not easy to alter, not by active intervention anyway. Vaccines are not immune to the emergence of resistant strains of the HIV virus, but they are one-shot treatments and so are not subject to the whims of patient compliance with complex drug regimes. An HIV-1 vaccine offers the best long-term hope to control the AIDS pandemic, especially in developing countries. It is generally recognised that vaccines are among the most cost-effective health interventions. Unfortunately, few people seem to appreciate the intense research needed for the development of vaccines, including multiple clinical trials. The same lack of understanding exists among many international agencies, donors, and foundations, since they have been hesitant to adopt HIV-1 vaccine development as one of their priorities.

Recent advances in the management of the HIV virus go a long way to dispelling the gloom caused by the deadly epidemic. But the vital question now concerns the affordability and availability of the new drugs that have proved effective against the virus. It is estimated that a patient requires around US$10,000 per year for highly active antiretroviral therapy. The high cost of this treatment keeps it beyond the reach of the poor. Unfortunately, the majority of

AIDS victims fall into this category. Price is however not the only factor that may keep antiretroviral drugs away from AIDS sufferers in developing countries. The poorly developed health infrastructure in these countries is inadequate to deliver the drugs, even if they were to be made available at no cost. Apart from putting money aside for the purchase of drugs, countries have to spend on the mechanisms and systems which ensure the drugs are used correctly and efficiently.

2 Impact of globalisation on health

Interactions between countries are becoming more frequent, rapid, sophisticated and inexpensive. Countries do not operate, socially, technologically or economically, in isolation from each other and health issues do not respect national boundaries. At 13 CHMM, Ministers will have, following a keynote address, the opportunity to consider the implications of globalisation for health and development. In particular, they will consider access to drugs at affordable prices, the impact of market forces on health, the digital divide, primary health care and domestic policies and the global governance of health.

In June 2001 trade negotiators from developing and industrialised countries met at the World Trade Organisation to discuss intellectual property rights and access to essential medicines for the poor. Several delegations included Ministry of Health officials and other public health professionals. At about the same time, at the WHO, governments, businesses and NGOs were discussing plans for a global health fund, launched earlier this year by Kofi Annan, Secretary General of the United Nations. This fund may become the basis of a new collective approach to controlling diseases of the poor, particularly AIDS, malaria and tuberculosis. These two examples from a growing number of initiatives reflect widespread awareness of the need for domestic action within the health sector to be complemented by cross-sector and cross-border action. Only with complementary strategies of this nature will it be possible to protect and improve the health of poor populations. In a world of increased interconnection and interdependence there is an urgent need to scale up combined activities to improve the health of those who have been left behind. It requires a new kind public health workforce, with the shared knowledge and skills to maximise the beneficial effects of globalisation on population health status, and minimise the adverse ones.

It is already evident that policy measures are required to rectify the adverse effects of globalisation on health and strengthen the positive ones. Policy should be guided by the following principles: (i) growth needs to be inclusive, equitable, and sustainable, and this requires policy coherence between political, economic, social and environmental sectors; (ii) opening of borders should be gradual and preceded by appropriate protective conditions; (iii) international rules and institutions should promote the production of global public goods and the control of global public “bads”; (iv) special attention is needed to increase the transfer of financial and technical resources to those lagging behind in the development process; (v) strong national health policies, institutions, regulations and programmes are essential; (vi) the public health workforce must be equipped with the knowledge and skills to engage with partners across the sectors and across borders to achieve health and other social goals.

3 Resources for health

The resources available for health will influence the process of setting priorities within health systems. Resources may be financial, human, or relate to infrastructure. In turn, the process of priority setting will highlight resource issues which need to be addressed for priorities to be met. Ministers at 13CHMM will hear a keynote address on human resources for health

systems and will then focus their committee discussion on three areas related to resources for health:

* Financial resources – how best to use donor resources in less developed countries, and how to use partnerships to maximise resources, will be important issues for consideration, as will a discussion on the amount of investment different countries make in their health systems as a proportion of GDP.

* Human resources – the health workforce needed for the delivery of different types of services is an issue of particular importance to Commonwealth countries and Ministers will discuss a Commonwealth code of practice on the recruitment of health professionals from developing countries. Poorer countries have argued that the recruitment of their health professionals by developed countries can be unfair, as they spend large amounts of money training these workers only to lose them to wealthier ones. The code of practice will cover the terms and conditions under which health professionals, including doctors, nurses, midwives and pharmacists, work. It will address the recruitment policies of countries as well as the ethical considerations involved in recruiting health workers.

* Increasing the contribution of the non-public sector – civil society, NGOs and the private sector all have contributions to make to the health of citizens. Ministers will take the opportunity to compare the contributions made within different jurisdictions.

4 Improving efficiency and effectiveness of health systems

In joint sessions with delegates attending the Parallel Symposium, Ministers will address regional co-operation on health priorities including shared services and technical assistance; health systems' response to the consequence of tobacco consumption; and the role of international health priorities and programmes in improving service delivery.

Vaccines

Several mechanisms have been established to assist countries to become self-reliant in financing their vaccines. The two most important and largest are the Revolving Fund run by the Pan American Health Organisation (PAHO), which was established in 1979 and UNICEF's Vaccine Independence Initiative (VII), which began in 1993. Both of these programmes allow countries to obtain high-quality vaccines at extremely low cost taking advantage of bulk purchasing. In the case of the PAHO Revolving Fund, PAHO has set up its own procurement mechanism, while VII allows countries access to UNICEF's procurement services. Both mechanisms facilitate country procurement and financing of vaccines by – helping them plan and forecast their vaccine needs in advance on a yearly basis, based on sound policies and realistic goals, in order to minimise disruptions or shortages in supply or the need for emergency shipments; by allowing them to apply for vaccines in local currency, thereby saving them valuable foreign exchange; and by allowing countries to pay for vaccines only after they are delivered in country. Through a system of bulk purchasing, the PAHO revolving fund for vaccine procurement has secured for the past 20 years a supply of high quality vaccines for national immunisation programs at affordable prices, and it has also allowed for the orderly planning of immunisation activities. Between 1979 and 1999, the dollar value of vaccines purchased through the fund grew from US$2 million to a projected $85million in 1999. Initial contracts were for vaccines against diphtheria, pertussis, tetanus, poliomyelitis, measles and tuberculosis. Currently, the fund is playing an instrumental role in the rapid introduction of new and other vaccines in the Caribbean and Latin America at

affordable prices, such as Haemophilus influenzae type B (Hib), mumps, rubella, hepatitis B, and yellow fever vaccines.

Tobacco control

It is widely recognised that tobacco was a major public health disaster in the 20th century and the spiralling rates of tobacco consumption now harm global health on an unprecedented scale. The extraordinary public health implications of tabacco, long apparent in developed countries, are now obvious throughout the world. In the early 1990s, an estimated 1.1 billion individuals used tobacco worldwide. This figure increased to almost 1.24 billion by 1998. Assuming no change in global prevalence, the number of tobacco users is expected to reach 1.69 billion in the year 2020. In 1990, tobacco use caused as estimated 3 million deaths. In 1998, the annual death toll from tobacco use reached 4 million. The toll is expected to reach 8.4 million deaths by 2020, 70% of which will occur in developing countries. If current growth rates continue, tobacco use will be responsible for about 10 per cent of the global burden of disease by 2020. Of the 100 million projected tobacco-related deaths over the next 20 years, about half will occur during the productive ages of 35-69 years. Tobacco related diseases are the single most important cause of preventable deaths in the world. Smoking causes over 20 major categories of fatal and disabling disease, including lung and other cancers, ischaemic disease, and chronic respiratory diseases. Recent studies point to the importance of tobacco as an important cause of tuberculosis death. Yet in different regions of the world, the tobacco epidemic has taken on different profiles. In India, the widespread use of bidis (cheap cigarettes made using unprocessed tobacco) is associated with a very high rate of oral cancer.

The trends in tobacco use among women and youth are also of concern, since tobacco companies increasingly target this potentially lucrative market. In general, 8 per cent of women in developing countries and about 15 percent in developed countries currently smoke cigarettes; women in India and several other countries chew tobacco. Unless innovative, robust, and sustained initiatives are adopted, these figures are expected to rise to 20 percent by 2025. Similarly, trends in tobacco use by children and teenagers raise alarm. Studies in developed countries show that most people start using tobacco before the age of 18 years. Recent trends show an earlier age of initiation and rising smoking prevalence rates among children and adolescents.

This scale of the tobacco epidemic indicates the inadequacies of traditional forms of governance at national and international levels, given the transborder health risks characteristic of recent globalisation. The progress of tobacco-related deaths and disease reflects the extent to which the industry has been able to thwart the development and implementation of effective control policies at national, regional and international levels. Commonwealth countries such as Canada, Australia, Singapore and South Africa have been able to adopt relatively comprehensive programmes of control measures; their programmes have succeeded in checking or reversing increases in smoking. However, in several other countries, tobacco companies have largely been able to manage the policy process so as to ensure that they are able to continue trading on advantageous terms, with limited hindrance. At one extreme are countries within where tobacco interests have kept all but the most minimal and ineffective control measures off the policy agenda. The paucity of regulation may reflect the importance of domestic interests, particularly in the small number of national economies that depend on tobacco production. In Zimbabwe, for example, tobacco typically accounts for up to one third of foreign currency earnings, contributes substantially to GDP and employs 6 percent of the population, a context in which the close identification of

government with industry, and the minimal nature of existing tobacco control measures, are scarcely surprising.

The Tobacco Free Initiative (TFI) of the World Health Organisation is undertaking an ambitious effort to address the global tobacco epidemic through negotiation of the Framework Convention on Tobacco Control (FCTC). The Commonwealth Secretariat's Health Department has played an advocacy role in support of this initiative. The Health Department, with the Secretariat's Legal and Constitutional Affairs Department, is working with WHO on the use of legal instruments to control tobacco. Other actors may be able variously to lobby, embarrass, educate and support national governments. But the success of the FCTC itself will rely upon states avoiding feeble, lowest common denominator positions, in forthcoming negotiations.

5 Review of action taken on the recommendations of 12CHMM
In the area of health sector reform, which was the theme of 12CHMM, four areas were focused upon: (i) community participation and the development of the needs-led services; (ii) leadership development requirements, particularly of nurses and midwives and also of other health professionals and managers of health services; (iii) improved support for the sharing of experience; (iv) the assessment and evaluation of all interventions. A number of regional meetings were held in the Caribbean, the South Pacific, Europe, Asia and Africa and over the last three years nurses came together to take forward the agenda. A comprehensive survey of the progress made by nursing and midwifery across the Commonwealth has been conducted. There have been many examples of achievement in the development of health and healthcare, of the profession, and of the national action plans. Most notably, progress had been made quite independently of the economic development and status of countries. For example, many countries found that giving a key position to a nurse in government, with real influence had a major policy impact.

6 Review of Commonwealth Secretariat's action on Commonwealth health priorities
The Secretariat has made progress in the areas of health sector reform, HIV/AIDS and human resource development for health. The Commonwealth Health Development Programme (CHDP) steering group has been giving increased priority to HIV/AIDS in its work programme on health sector reform.

The Technical Support Group (TSG) has been strongly commended for its work on models of good practice, the building of databases and establishment of a website, and the attention given to women's health. Indeed women bore the brunt of the responsibilities for the health of their families, while their own health continued to be marginalised. More attention should be focussed on sexual and reproductive health issues; the impact of violence should be given more importance, particularly in the light of HIV/AIDS and increasing maternal mortality.

The Human Resource Development Division (HRDD) has organised a series of Health Management Systems (HMS) training workshops for some 50 Commonwealth countries thus far. The seventh workshop held in Uganda in June 2000 enabled eight Commonwealth countries in East and West Africa to develop plans of action for mainstreaming gender in their health systems (Women and Health was the theme of 11CHMM). Participants were encouraged to collect and use gender disaggregated data to analyse health problems and make decisions. The last workshop in the series was held in Cyprus in June 2001. The Health Department also proactively encouraged Commonwealth Ministry of health training institutions to integrate gender into existing courses or develop gender-sensitive ones. Gender

and Health curriculum outlines were distributed to all Commonwealth Universities and higher education institutions.

5 Interactions with other bodies

Traditionally the Health Ministers invite observers from the WHO, PAHO, the United Nations Children's Fund, the World Bank, the United Nations Population Fund, UNAIDS and the International Planned Parent Federation. Several Commonwealth NGOs have also had representation. These include: the Commonwealth Association for Mental Handicap and Development Disabilities, the Commonwealth Dental Association, the Commonwealth Medical Association, the Commonwealth Nurses Federation, the Commonwealth Pharmaceutical Association, the Commonwealth Society for the Deaf, and Sightsavers (previously the Royal Commonwealth Society for the Blind). Essentially the official and unofficial organisations work in symbiosis for advancing Commonwealth values and the welfare of Commonwealth citizens. The unofficial Commonwealth organisations comprise all Commonwealth-wide NGOs which have a pan-Commonwealth or regional presence and are committed to Commonwealth values and priorities as set out in the Harare Commonwealth Declaration. The parallel symposium and trade fair are organised by Kensington Publications Ltd (KPL), a London-based private sector company working in collaboration with the Commonwealth Secretariat.

6 Other issues

Like so many aspects of our lives since 11 September 2001, the writing of this brief is dominated by thoughts of the terrorist attacks on citadels of the United States and the events surrounding their aftermath. No doubt the full consequences of that event will dominate global politics both in the short and long term. While the world looks a very different place through the lens of large-scale and transborder terrorism, clearly most of the world's woes predate the events of September 2001. Without learning broader lessons, including how globalisation must be more inclusive and equitable, we will not tackle the true roots of so many global health risks. Traditionally health is seen as a topic appropriate for the table of 'low politics', a social welfare issue that is primarily dealt with at the national level by the governments of states.

In a bold speech in June 2001 marking the twentieth anniversary of the first report of HIV/AIDS, Kofi Annan called on the private sector as well as donor governments to contribute to a $7-10 billion global trust fund to combat HIV/AIDS, malaria, and tuberculosis. Annan warned that AIDS leaches profits out of economies and businesses, and raises new barriers to human and economic development. The positive correlation between health and income per capita is one of the best-known relationships in international development. This correlation is commonly thought to reflect a causal link, running from income to health. Higher income gives greater command over many of the goods and services that promote health, such as better nutrition and access to safe water, sanitation and quality health services.

While global markets have created unprecedented economic opportunities and growth, the benefits have not been equally distributed. Furthermore the risks – especially health risks – of an increasingly interlinked and interdependent world have not been thoroughly considered. Short-term international efforts should focus on immediate threats and build foundations for long-term efforts.

Commonwealth health ministers could set up internationally recognised and endorsed standard protocols for human vaccine development and testing for HIV/AIDS, malaria, tobacco control, and other killer diseases. They could plan comparative trials of multiple vaccines against these diseases. They should commit themselves to the rapid eradication of diseases that have not yet developed resistance to standard treatments -- including polio, measles, river blindness, and Guinea worm. Public-private partnerships could accelerate development of new disease treatments. Scientists, medical professionals, and disease specialists should have better access to distance learning, training, and exchange programmes to increase understanding of, and the best treatments for diseases.

Winning the fight against disease and protecting the world's health, economies, and food supplies will require coordination, cooperation, resources and above all, political commitment. If the Commonwealth can build that model of cooperation, perhaps there is a chance to win this war – and in the process create the hope of cooperation in other areas as well.

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Preeti Patel is a Research Fellow in Global Health at the Centre on Globalisation, Environmental Change and Health, in the Health Policy Unit of the London School of Hygiene & Tropical Medicine. With a primary research interest in tobacco control, she is participating in a 14-country study for the US National Institute of Health entitled 'Globalization, the tobacco industry and policy influence'. The Commonwealth Policy Studies Unit (CPSU), part of the Institute of Commonwealth Studies, London University, began in 1999 and is working on aspects of globalisation, and on a "Harare programme" for democratisation, civil society and human rights. *The author would like to thank all those who helped her in preparing this document.*