British International Studies Association

GLOBAL HEALTH EUROPE
A Platform for European Engagement in Global Health

Beyond the Eurozone crisis: New realities for global health

Europe House, London, Thursday 27 September 2012

Conference Report[1,2]

Opening

Welcoming participants, ***Stephen Matlin*** (Co-Chair, Global Health Europe), noted that **'global health'** is used in many different ways: Global Health Europe takes it to refer to **factors transcending national boundaries and governments** that determine health and human security.[3] The European Union (EU) is a significant player in health, as established in the Maastricht[4] and Lisbon[5] treaties. Its role in global health was set out in a 2010 European Commission (EC) Communication.[6]

Current economic conditions have created an opportunity to re-think of Europe's approaches to global health and two aspects of the financial context were of particular relevance to the discussions:

- The 2008 global banking crisis had an immediate effect on the world's economies, and within the advanced economies the Eurozone and related economies have been very badly hit,[7,8] with low or negative growth resulting in deep cuts in health, social protection and international development.
- A major longer-term shift is taking place in the world economic order, with the Gross Domestic Products of "developing and emerging economies" overtaking those of "advanced economies".[9,10]

Over the course of the current decade, many important issues relevant to global health and Europe will be on the international agenda. For example:

- An Open-Ended Meeting of member states of the World Health Organization (WHO) in November 2012 will discuss the report of the WHO Consultative Expert Working Group (CEWG) on Research and Development (R&D): Financing and Coordination, which recommended a global R&D Convention covering financing, coordination and creation of a Global Health Observatory function.
- The EU process is currently under way to create the successor to Framework Programme 7, which is one of the world's largest research programmes. The proposed budget for Framework Programme 8 ('Horizon 2020') is c. €75 billion[11] and health is one of the areas designated for attention. There are major questions about how Horizon 2020 will foster innovation in health in the EU and the extent to which it will address global health issues.[12]
- Consideration is in process for what will follow the Millennium Development Goals (MDGs) after 2015. The EU is the largest provider of official development assistance (ODA) in the world[13] and will play a significant role in the debates. The UK is intimately involved in this process, with PM David Cameron co-chairing a high-level UN group that is preparing for the UN meeting in 2015.[14] Much of the debate is now centring on incorporating global health within a broader set of Sustainable Development Goals.
- The EU is pursuing its growth strategy, **Europe 2020**.[15] To meet the Europe 2020 targets, there are a series of flagship initiatives, one of which is the ***'Innovation Union'*** – aiming to re-focus research, development and innovation policy on major challenges, while closing the gap between science and the market to turn inventions into products.[16]

The combination of short- and long-term economic pressures should be seen as an opportunity to ask how Europe can reposition itself to take advantage of the shifting scene; and how it can realign itself to gain greater coherence between policies, strategies and practices while preserving and promoting values that Europe has cherished, such as equity, fairness and inclusion.

Welcoming participants, the conference chair, ***John Wyn Owen*** (Non-Executive Director, HPA), began by quoting WHO Director-General Margaret Chan: "market forces do not solve social problems". This was an important factor at a time when government was looking at emerging risks and when the economic downturn was leading to civil unrest in many parts of the world, including the Eurozone. At the same time, the old notion of rich countries funding development in poor countries

was no longer appropriate There was a need for a 'realistic attitude' which addresses public health concerns within the broader context of greater efficiency and innovation and with the UK's economy and investment understood in a dual relationship with the EU and the US.

John Wyn Owen introduced ***Andrew Jack*** (Financial Times), who served as the moderator for the two panel sessions, introducing and questioning each of the panellists and moderating the discussion.

Panel Session 1: Europe for Global Health

Opening statements

The panellists were asked to respond to the question "***What should Europe do for global health?***"

Nick Tomlinson (Head of International Affairs, Department of Health: DoH) noted that the UK strategy document[17] "Health is global" in 2008 had been the first of its kind in the world, looking across all of government contributions to the global health agenda. A key component was the recognition that diseases do not have borders and the strategy, which had been updated[18] in 2011, had focused on two dimensions: how the UK could best contribute to developing health systems in Low- an middle-income counties (LMICs); and the trade dimension in global health. The DoH and Department for International Development had collaborated closely on the Health Links Scheme, now the Health Partnership Scheme,[19] drawing on the considerable expertise available in the National Health Service (NHS) and providing UK health professionals to work alongside others in LMICs. Global health security was another area receiving attention, with important outcomes in areas such as emergency preparedness (e.g. working with Brazil in preparation for the next Olympics); health in conflict situations (e..g working with Libya to rebuild the health system) and emerging economies (e.g. working with China and India to strengthen health systems). There were many opportunities for volunteering work, including establishing triangular collaborations with Africa. Noncommunicable diseases (NCDs) were now a major worldwide challenge and it was important to address issues on a large scale beyond individual countries – e.g. international action was needed to reduce fat content in foods and many workforce challenges required global action on human resources for health. There was also need for action regarding global health institutions – e.g. WHO, founded in 1948, was undergoing a much needed reform process including the development of clear work priorities; and the recommendations of the CEWG Report on research and development needed serious discussion to find ways to make progress on research, development and innovation for global health.

Beatrice Nere (Programme Officer, Bill & Melinda Gates Foundation: BMGF) reflected on a number of important advances that had been achieved by some of the large initiatives like the Global Fund to Fight AIDS, TB and Malaria, Global Alliance for Vaccines and Immunization, European and Developing Countries Clinical Trials Partnership (EDCTP), UNITAID, and Advance Market Commitments, where member states or the EU collectively had made major contributions of resources and innovations and where Europe had followed its strong tradition of prioritising social capital. Europe was the global leader in ODA, although lagging behind the USA in research. She pointed to a number of ways in which Europe could further strengthen its contributions to global health, including: continuation of smart investments, which were a small but critical part of Europe's overall budget; ensuring that Horizon 2020 would play a key role; broadly supporting R&D for global health, since this was linked to growth and would generate a natural return on the investments made – EDCTP[20] provided an important example of success when member states and the EU worked together; and address the issue of human resources for health, to ensure that treatments went 'the last mile' to the people who needed them. She also highlighted the important role that triangular collaborations could play and the valuable lessons that could be learned from emerging economies.

Chris Brookes (Director of Programmes and Partnership, Health Action Partnership International: HAPI) began with the observation that in the EC Communication, global health encompassed 'worldwide improvement of health, reduction of disparities, and protection against global health threats'. He quoted former UK Prime Minister Gordon Brown's comment[21] that the global economic crisis is a *"reason to work in partnerships across countries and cannot be an excuse not to"*. Addressing global health and the health of the poorest people of the world was a matter of national self-interest and a series of actions could be taken at European level, including:

- Frame action so it is global rather than European in scope (e.g. research on NCDs).

- Support system-wide approaches and discourage single issue approaches.
- Be prepared to support South- South learning.
- Consider global health in all policies.
- Push for stronger and better delivery of MDGs and a renewal that recognises that health is created outside as well as within the health sector.
- Finance effective research on diseases prevention in low-income countries, and approaches which work in low-income countries.
- Support actions on NCDs, especially in terms of lifestyle risk and balance with trade interests.
- Provide leadership in protecting from health threats (the European Centre for Disease Prevention and Control, ECDC, should work closely with similar bodies for global surveillance)
- Support health systems and not vertical programmes
- Focus on accessibility, affordability, and availability of medicines and medical interventions – Health for All.

Chris Brookes considered that, hitherto, EU action on global health has been weak and it was necessary to fund and resource a global health team adequately to manage an EU programme of work. Member states should also be encouraged to adopt a similar approach, with each having a representative for global health. There would be scope for a European Joint Action on Global Health.

Discussion

Andrew Jack initiated the discussion by questioning what Europe could do less of in the area of 'bads' as opposed to 'goods', citing the brain drain and migration of skilled human resources for health – both inward to the EU and internally between different sectors. ***Nick Tomlinson*** agreed that this was a very important area and noted that it was a fundamental principle of planning in the UK to sustain an adequate health work force and not be reliant on health staff from other countries, which involved planning 20 years ahead. It was also important to help other countries to train and retain adequate numbers of workers and the Health Partnerships scheme was contributing to this. ***Beatrice Nere*** echoed these comments, citing the long-term planning of the BMGF and the desire of headquarters staff to work in the field in places like Africa. The EU, with its seven-year budgets, was also in a strong position to plan ahead.

Quoting the exhortation to *"do less harm"*, ***Andrew Jack*** asked how Europe could contribute to global health problems in areas such as intellectual property rights, pricing and drug regulation. ***Chris Brookes*** observed that the issues were often complex, especially in relation to NCDs – e.g. tobacco control was strengthening in many high-income countries, with tobacco companies responding by expanding their efforts in LMICs; and relatively little attention was given to alcohol abuse, which also created a large burden of disease. On the issue of quality of drugs, ***Nick Tomlinson*** commented that products not fit for sale in the EU itself could not be exported. Increasingly pharmaceutical ingredients are coming from LMICs (e.g. China) and there are locally produced generic products in many LMICs.

Turning to the economic crisis, ***Andrew Jack*** asked what responses there had been since 2008. ***Beatrice Nere*** replied that it was important that the crisis was being seen, at least in some countries, as an opportunity and that the response needed to include making investments smarter, targeting niche areas and giving aid to catalytic interventions that linked outcomes and access to investments. ***Nick Tomlinson*** said that pharmaceutical budgets were being squeezed and there was an increasing shift to generics and emphasis on trying to make the health sector more efficient. Increasingly, innovation was being found in the emerging economies like India, where many state-of-the art techniques (e.g. in heart surgery) were being practiced. An increased budget for the Health Partnership scheme would enable more collaborations between countries. ***Chris Brookes*** noted that there was now much more emphasis on making Europe competitive, rather than on what Europe could do for the world – a 'cost containment' rather than 'wellbeing' agenda. However, there was also a global movement recognizing that inequalities do exist and some important international opportunities for learning lessons, e.g. in tackling obesity and in the NICE cost-containment model.

During the general discussion with the audience, there was considerable interest in volunteering and the opportunities it offered. ***Sir Tom Hughes-Hallett*** reflected on the experience of Marie Curie Cancer Care, which had encountered strong resistance from health workers to the use of volunteers in the UK but much less in Germany. ***Nick Tomlinson*** felt that it would be valuable to share the German experience with other European countries and ***Beatrice Nere*** commented that there was

interest among health officials in France to accommodate the desire of employees to participate in volunteering. For ***John Wyn Owen***, one important aspect was the interaction of health care and social care, with the latter (often unpaid) lowering the pressure on health care systems. Other audience comments included the observations that more could be invested in informal care internationally; that volunteering presented management challenges and often created a very high emotional strain on the volunteer that was poorly recognized or supported, as well as potentially generating 'care gaps' in the source country. Some volunteering (e.g. in parts of Germany) was undertaken by the unemployed and job-seekers. There were valuable experiences of volunteers working in LMICs (e.g. volunteer surgeons in Africa) and this could be a model for sustainable improvements locally if obstacles were carefully identified and overcome. It was important to recognise that volunteers did not replace the need for a skilled, sustainable workforce.

Stefan Elbe asked the panellists what benefits they saw for their organizations in stronger EU engagement with global health. ***Chris Brookes*** responded that it would make a fundamental difference if there was a coherent global health strategy, encompassing social determinants of health, behaviours and health care. Strong leadership would allow WHO agreements (e.g. on human resources for health) to be better managed. For this to happen, the small EU team on global health needed to be enlarged and strengthened. Learning from other countries could be enhanced, with great benefits for all. ***Nick Tomlinson*** considered that the question of critical mass was important – e.g. where there were large research projects that needed effort extending beyond individual countries, it would be good to have countries joined up and working towards common goals. The EU was not very good at taking priorities forward. A number of public health benefits would accrue with a stronger EU engagement in global health – especially in addressing the innovation agenda. ***Beatrice Nere*** agreed with the value of having a linked-up global health strategy and asked *"what is the trade-off that would be better than a global health agenda?"*.

John Wyn Owen referred to the ideas encapsulated in the title of the meeting and wondered what would happen if countries disengaged from the global economy, or whether we can be confident that globalization has been accepted. ***Nick Tomlinson*** responded that this would be a very short-sighted measure and could lead to a downward economic spiral. For ***John Wyn Owen,*** this emphasised the need to keep revisiting globalization as one of the new realities for global health.

Responding to a question about strengthening the EU's role in global health diplomacy, ***Beatrice Nere*** noted that some groups of countries (e.g. in Africa and Latin America) were being seen to very effectively coordinate regional responses on issues and this could be a very powerful effect. ***Nick Tomlinson*** commented that the current UK government would not want to see any increase in EU 'competence' across the board in this area, but there were many opportunities on the international stage for increased EU effectiveness through better coordination in advance on issues, such as in arenas like the World Health Assembly where the EU had direct representation.

Panel Session 2: Global Health for Europe

Opening statements

The panellists were asked "***Why is addressing global health important for Europe?***"

Richard Bergström (Director General, European Federation of Pharmaceutical Industries & Associations) began by observing that the pharmaceutical industry had been around for over 100 years and would be here for much longer, but that *"everything is on fire just now"* and there is an urgent need for long-term thinking. Key points were that research is global in the knowledge it creates (e.g. the results of mapping the human genome and brain circuitry) and communicable diseases travel. Action is needed, for example, to address the empty development pipeline of new antibiotics and one approach now being undertaken is the Innovative Medicines Initiative[22] (IMI), Europe's largest public-private partnership aiming to improve the drug development process by supporting a more efficient discovery and development of better and safer medicines. Pooling knowledge and bringing back old knowledge were essential. Furthermore, to preserve the value of new antibiotics, much better stewardship was required (e.g. in countries where non-prescription access was available): a global compact on the use of new antibiotics needed to be developed. Given the potential health threats, the question *"should we work on global health?"* was not, in fact, an option.

‘Disruptive innovations’ can be important responses to the current global pressures and resource constraints and in times of crisis we can learn how to organize health services in different ways, e.g. Hyderabad hospitals developed round-the-clock deployment of staff and hospital resources, reducing costs and increasing efficiency; Dubai Health City has hospitals for health tourism and attracts the best staff by offering them high quality research facilities; use could be made of leapfrogging technologies such as iPads and the Cloud to reform the health care system.

A more sustainable model for medical development was needed: the current system was not sustainable, one example being that it produced products that many people could not access. The pharmaceutical industry required a business model that was understood and respected – one that, relied on patents to protect inventions and a model in which there was payment for innovation, but according to the individual’s ability to pay, irrespective of where they lived. This meant that there should be tiered pricing operating – not only between countries, but also within them. Establishing this required a global framework that must gain the support of the general public.

Anthony Kessel (Director of Public Health Strategy, Health Protection Agency: HPA) provided the HPA’s perspective on why addressing global health is important for Europe, offering three groups of reasons:

- Policy: The International Health Regulations (IHR) 2005 was an international legal instrument, binding in 194 countries, that requires countries to report certain disease outbreaks/ public health events to WHO; defines county obligations to uphold global public health security; and requires countries to strengthen public health surveillance and response capacity. The HPA has responsibilities to assess, notify and contribute to meeting the IHR.
- Public health: Infectious diseases cross borders and international collaboration is essential to meeting this challenge. HPA was contributing by assisting countries to undertake effective infection surveillance, prevention and control at the source through collaborations and secondments (e.g. in Cambodia, South Africa) as well as working with countries (e.g. Hungary) and organizations (UN, WHO) to respond to environmental emergencies and disasters.
- Moral: Global solidarity and assistance to low income countries was a moral imperative, even in times of financial crisis. The HPA oversees nine WHO collaborating centres that support international efforts.

Sir Tom Hughes-Hallett (Executive Chair, Institute of Global Health Innovation, Imperial College London) stressed the importance of a global perspective on health, since diseases do not recognise national boundaries. He was new to the scene of global health and observed that talking about it was becoming an industry and there was a need to turn talk into action. Europe must address global health, as many innovations were now taking place in LMICs – examples being cited from countries around the world of innovations in technology, healthier foods, improved methods for health workers and better self-management of conditions by patients. Development of the ‘polypill’, a combination of drugs to reduce heart disease in older populations, provided a further example – one where there had been considerable interest in India, but much less likelihood of adoption in Europe because of resistance by the medical profession and regulatory demands that would make it uneconomic.

Discussion

Andrew Jack began the discussion by asking whether there was evidence of the economic pressure on global health trends. ***Anthony Kessel*** reported that from his perspective the picture was mixed: the public health system in England was undergoing reform (HPA will become Public Health England in 213) and was in “reasonably good shape”, while the financial crisis was hitting the NHS much harder. One thing that could be done better was to connect the UK’s work with that in other countries in Europe and elsewhere. ***Richard Bergström*** found encouragement in the widespread realization that the pipeline of innovation could not simply be turned off and re-started and that there needed to be a protection of budgets. However, spending a lot of time with ministers, he found that not all were well equipped to stand up to ministers of economy and finance who were determined to make cuts without understanding where the impacts would fall. A much better ‘reverse engineering’ of evidence on effectiveness of health interventions was needed to strengthen the arguments. In ***Sir Tom Hughes-Hallett*****’s** experience, banks that did well were the ones that had ignored the crisis and there was now a real opportunity for innovation where it should have happened a long time ago and for Europe to work together. But against this aspiration, he set the reality that politicians were reluctant to

act on health without evidence and we needed to be brave enough to trial change and encourage policy makers to be brave. ***Anthony Kessel*** added that it was important to enhance creativity in implementing evidence – the examples cited earlier by Sir Tom Hughes-Hallett all having involved innovative implementation– and ***Richard Bergström*** referred to the phenomenon of 'regulatory capture' which, in cases like the polypill, inhibited implementation of low-cost solutions.

Andrew Jack enquired whether there was too much regulation in Europe, or whether tighter control of WHO, the Centres for Disease Control, regulators, etc was the solution. For ***Anthony Kessel***, more regulation would be better, but there was a question of medical and clinical stifling of innovation. ***Sir Tom Hughes-Hallett*** wondered whether government statutory bodies are the right people to coordinate or whether governments should encourage others to be involved. Incentives were often more effective than instructions in achieving innovation and progress. ***Richard Bergström*** felt that Europe's collective size (1/4 that of China;1/3 that of India) was important, as it was still manageable to do things well together and there were initiatives beginning to establish virtual organizations working with academia, industry and 'open innovation', drawing on learning between the public and private sectors. Governments could nudge this along with relatively modest resources.

During the general discussion, a member of the audience asked whether learning was taking place from innovative strategies in middle-income countries. ***Richard Bergström*** reported that many of his organization's member companies were moving investments, e.g. to Singapore, China and potentially India (subject to a better legal approach there), as these had put in place good policies for innovation. Lessons could also be learned from the USA (e..g. Boston's approach as a city, which included weekly meetings between the mayor and heads of hospitals and companies). It was vital to share information and also important for there to be good academic studies of systems of innovation.

One participant emphasised the importance of investments being in the right place and contributing to action that was helpful, citing the case of support for anti-retroviral therapy which had enabled some 50% of HIV-positive patients to be treated but with a 3-month interruption when one project ended. It was noted that Nigeria itself was not helping to fund anti-retroviral therapy and ***Sir Tom Hughes-Hallett*** affirmed his view that organizations must learn to raise funds independently and not be totally reliant on sources such as governments and para-statals. Leveraging support was vital and the EU would be acting irresponsibly if there was not clear sustainability in its programmes. ***Anthony Kessel*** considered the comment on the right kind of action very apt. For the HPA, which often worked through invitation from a host, action was not top-down but in partnership and there was always strong emphasis on capacity building and a on clear outcome of raising further funds at the end of the project. ***Richard Bergström*** pointed to the importance of good governance by countries over the question of making medicines available to all the population.

A further round of comments from the audience included an argument for much more attention to complexity, highlighting the mismatch that sometimes occurred between assumptions, evidence and responses, with data on what works not being implemented long-term and population averages being used that masked complex distributions within the country; and a questioning of who really is leading on 'coordination' as there did not seem to be any body tasked with this.

Wrapping up the panel discussion, ***Sir Tom Hughes-Hallett*** welcomed a question about where the 'public' came into the discussions and argued for strong public involvement, which he had found very valuable in changing practices in end-of-life care. ***Anthony Kessel's*** final comments included wondering whether we had yet achieved the right balance between proximal and distal determinants of health or were still giving too much emphasis to the proximal ones; reflecting that there was indeed much more that could be done on coordination and that ECDC could do more in the area of global health coordination; and that HPA strongly encouraged public participation, for example through its 'people's panel', although there had been less public engagement in the HPA's global health work either at home or abroad. ***Richard Bergström*** noted the anger that the public had shown over cuts in health care spending and the lack of sensitivity that some politicians seemed to have to this. However, he was optimistic regarding leadership for global health and pointed to the way that charismatic leadership could change the picture and rally everyone together, as the BMGF had done. Closing the panel, ***Andrew Jack*** summarised three key sets of issues that had been raised in the discussion: the importance to global health of the public and non-institutional actors; the shift from the old 'support' model to one of sustainability and partnerships; and the universalizing of health problems which meant that Europe must both contribute and be open to innovation from elsewhere.

John Wyn Owen thanked Andrew Jack for moderating the discussions and the panellists and audience for their contributions. His final comment, in the aftermath of the sovereign debt crisis and the Eurozone crisis, was to wonder how much solidarity there really was in the Eurozone.

Concluding remarks

Concluding the meeting, **Stefan Elbe** (Director, Centre for Global Health Policy, Sussex University) noted that the BISA Global Health Working Group had identified Europe's role in global health as an under-studied area and would be taking forward work on papers and reports from the meeting. Reflecting on the discussions, he recalled the regret that Nelson Mandela had later expressed for not giving more attention to HIV/AIDS while in office, which had cost many South African lives – an example of what happens when governments drop the ball on critical global health issues. But there was a real risk of this happening in Europe as a result of the current financial crisis, which was in effect presenting a 'triple whammy' – displacing all other issues from attention and pressuring both health spending in Europe and official development assistance.

A deeper story was contained in the two background papers that had been provided by Alexia Duten and Sonja Kittelsen. These demonstrated the history of cooperation on global health in Europe, which had predominantly focused on communicable diseases and had unfolded through a series of pragmatic crises due to HIV/AIDS, SARS, H5N1 and HIN1 that had created a 'crisis model' that was now exhausted.

For solutions, we need 'SMART 'political proposals and a number of points had emerged in the meeting:

- **S**ee the big picture - health is a crucial value for most people and an end in itself, unlike finance.
- **M**ake the business case for global health – working for global health can have employment and economic benefits and ensure a healthy work force.
- **A**ppreciate resourcefulness and innovation – as a two-way street with economic processes, health innovation can help to make the best use of existing resources.
- **R**ealign contradictory policies – reducing inefficiencies and imbalances such as those created by the brain drain of health workers .
- **T**he Diplomatic side – identify how Europe can retain diplomatic influence on the world stage.

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Footnotes and references

1. Report prepared by SA Matlin, Co-Chair, Global Health Europe. Institute of Global Health Innovation, Imperial College London. s.matlin@imperial.ac.uk
2. An editorial based on this meeting was published in The Lancet 2012, 380 (9849) 1204; doi:10.1016/S0140-6736(12)61695-X. www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2961695-X/fulltext?elsca1=ETOC-LANCET&elsca2=email&elsca3=E24A35F
3. I Kickbusch, G Lister (Eds), *European Perspectives on Global Health: A Policy Glossary.* European Foundations Centre, Brussels, 2008, 72pp. www.ilonakickbusch.com/kickbusch-wAssets/docs/EFC_EPGH.pdf
4. *Maastricht Treaty*, European Union, 7 February 1992. www.eurotreaties.com/maastrichtext.html
5. Treaty of Lisbon, 13 December 200. http://bookshop.europa.eu/is-bin/INTERSHOP.enfinity/WFS/EU-Bookshop-Site/en_GB/-/EUR/ViewPublication-Start?PublicationKey=FXAC07306
6. Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions: *The EU Role in Global Health.* European Commission, Brussels, COM(2010)128 final, 31.3.2010. 11 pp. http://ec.europa.eu/development/icenter/repository/COMM_PDF_COM_2010_0128_EN.PDF
7. *World Economic Outlook Update: New Setbacks, Further Policy Action Needed.* Washington, IMF 16 July 2012, 8pp. www.imf.org/external/pubs/ft/weo/2012/update/02/pdf/0712.pdf
8. CES Ifo Group, Munich, *Weak prospects for the Euro-zone.* Eurozone Economic Outlook 4 July 2012, 2 pp. www.cesifo-group.de/ifoHome/facts/Forecasts/Euro-zone-Economic-Outlook/Archive/2012/eeo-20120704.html
9. M. Eghbal. *Special Report: Developing world to overtake advanced economies in 2013.* Euromonitor, 19 February 2009. http://blog.euromonitor.com/2009/02/special-report-developing-world-to-overtake-advanced-economies-in-2013-.html, accessed 08.02.12.
10. *Top 10 largest economies in 2020.* Euromonitor International, 20 July 2010, http://blog.euromonitor.com/2010/07/special-report-top-10-largest-economies-in-2020.html
11. *The EU Framework Programme for Research and Innovation.* European Commission, 2012. http://ec.europa.eu/research/horizon2020/index_en.cfm?pg=h2020
12. S. Battams, S.A. Matlin, A. Jahn, I. Kickbusch, *The Case for Europe as a Leader in Research and Innovation for Global Health.* Global Health Europe, Nov 2011, 29pp. www.globalhealtheurope.org/images/stories/ghe/GHEResearchPaperFinalNov2011.pdf
13. Eurostat, *Development aid statistics,* Brussels, European Commission, 2012. http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Development_aid_statistics
14. UN Press Briefing, *UN Secretary-General Appoints High-level Panel on Post-2015 Development Agenda.* New York, UN 31 July 2012 www.un.org/sg/offthecuff/?nid=2455
15. European Commission: *Europe 2020.* http://ec.europa.eu/europe2020/index_en.htm
16. European Commission: *Innovation Union.* http://ec.europa.eu/research/innovation-union/index_en.cfm
17. *Health is global: a UK Government strategy 2008-13.* HM Government, 2008, 39pp. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088753.pdf
18. *Health is Global: An outcomes framework for global health 2011-2015.* HM Government, 2011, 20pp. www.dfid.gov.uk/Documents/publications1/health-is-global.pdf
19. *Health Partnership Scheme*. London: Department for International Development, 2011. www.dfid.gov.uk/work-with-us/funding-opportunities/partnerships/health-partnership-scheme/
20. European and Developing Countries Clinical Trials Partnership. www.edctp.org/Home.162.0.html
21. Gordon Brown, then UK Prime Minister , speaking at the launch of the *Report of the Commission on the Social Determinants of Health,* London, 6 November 2008.
22. Innovative Medicines Initiative. www.imi.europa.eu/