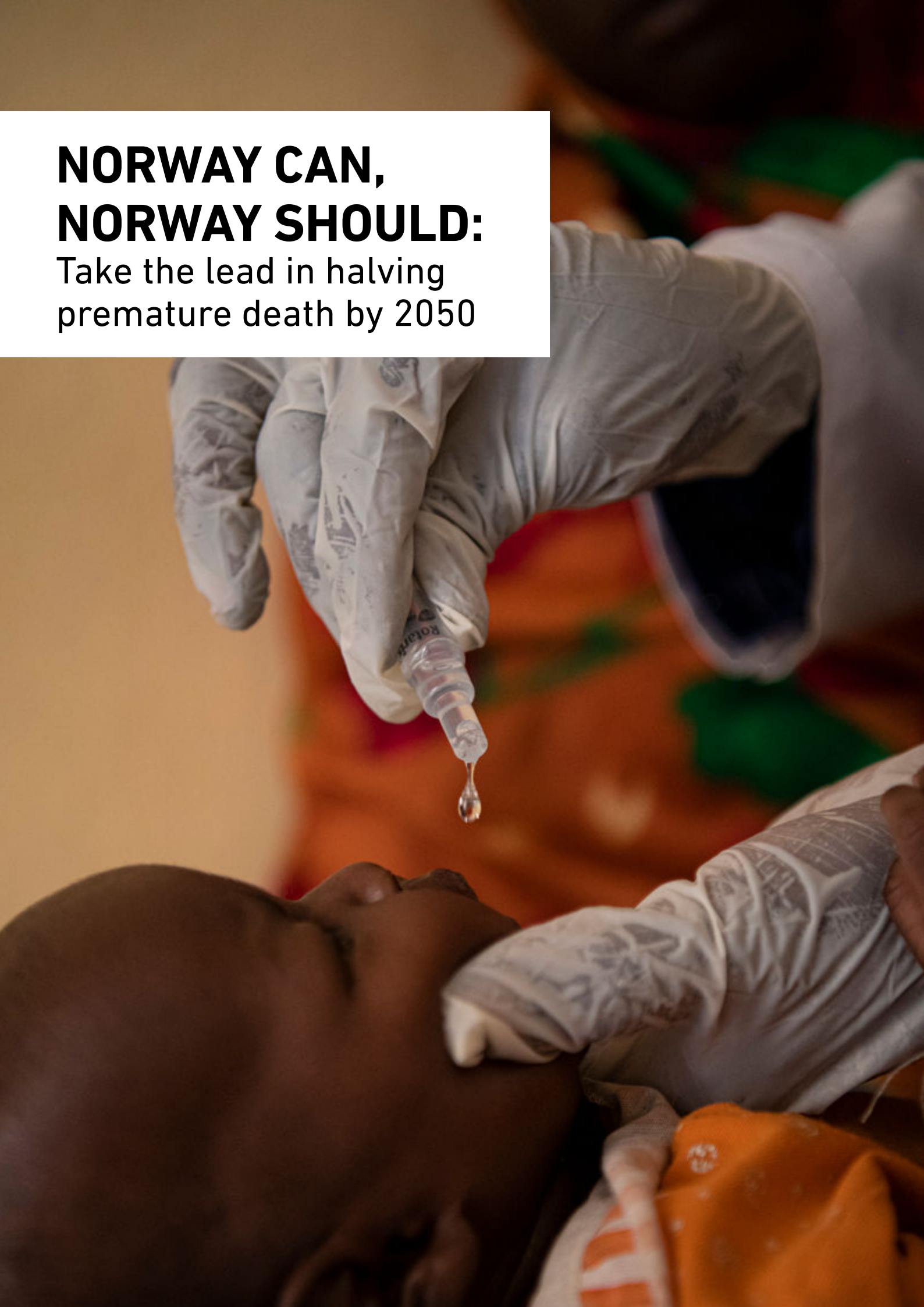
NORWAY CAN, NORWAY SHOULD:

Take the lead in halving premature death by 2050



NORWAY CAN, NORWAY SHOULD:
Take the lead in halving premature death by 2050

Summary of Recommendations

This is a translated and abbreviated version of the recommendations on Norway's global health efforts from the Stoltenberg-expert committee on global health to Norwegian authorities.

The committee recommends that Norway should:

1) Renew Norway's leadership in global health with the goal of halving premature death by 2050.

1.1 Work towards a global goal of reducing premature death by 50 percent by 2050 and ensure that wealthy countries commit to helping poorer nations achieve this target.

1.2 Take initiative at the head-of-state level, in collaboration with other countries, to reform the global health architecture.

1.3 Equip Norway for international leadership across multiple platforms through coordinated efforts by reinstating the position of global health ambassador, establishing a state secretary committee for global health, and engaging more Norwegian institutions.

1.4 Sustain Norway's role as a normative leader in sexual and reproductive health and rights, including maternal and child health, both nationally and in global forums.

2) Invest more in global health – to reduce health inequality and enhance our security.

2.1 Make the reduction of global health inequality a main priority in Norway's development policies and increase Norway's efforts in this area.

2.2 Increase investments in Norwegian and global health security without weakening efforts to reduce global health inequalities and poverty. This should be achieved by increasing the aid budget to more than one percent of gross national income (GNI). Part of this increase can also come from outside the aid budget.

3) Reduce health inequality by prioritizing effective measures and strengthening health systems.

3.1 Focus efforts on a few health conditions that will significantly reduce premature death.

3.2 Increase support for strengthening health systems.

3.3 View health investments in conjunction with other investments in human capital, through continued support for basic education and nutrition.

3.4 Work with multilateral institutions to increase taxes on tobacco, sugar, and alcohol to reduce premature death and boost national resource mobilization.

4) Strengthen coordination and invest in effective measures to enhance global health security.

4.1 Invest in a more flexible World Health Organization (WHO) through non-earmarked funding to strengthen capacity and coordination for global health preparedness and response to global health crises.

4.2 Work to establish stronger financing mechanisms for pandemic prevention, preparedness, and response in low- and middle-income countries. This includes financing through insurance, guarantees, or conditional loans that are negotiated before a crisis occurs. Key actors will include the Pandemic Fund, the World Bank, IMF, and regional development banks.

4.3 Support and invest more in innovation and product development, including vaccines, diagnostics, and treatments where there is not a sufficient market, to strengthen global health security.

4.4 Strengthen regional centers for public health initiatives and national institutions and action plans for health security, including building effective early warning systems to stop epidemics and pandemics earlier.

4.5 Support research on the effects of public health and social measures to contain outbreaks and limit the spread of pandemics.

4.6 Play a central role in strengthening global efforts against antimicrobial resistance, including investing more in initiatives to promote innovation and the development of new antibiotics; reducing overuse and improving access to antibiotics for high-priority conditions.

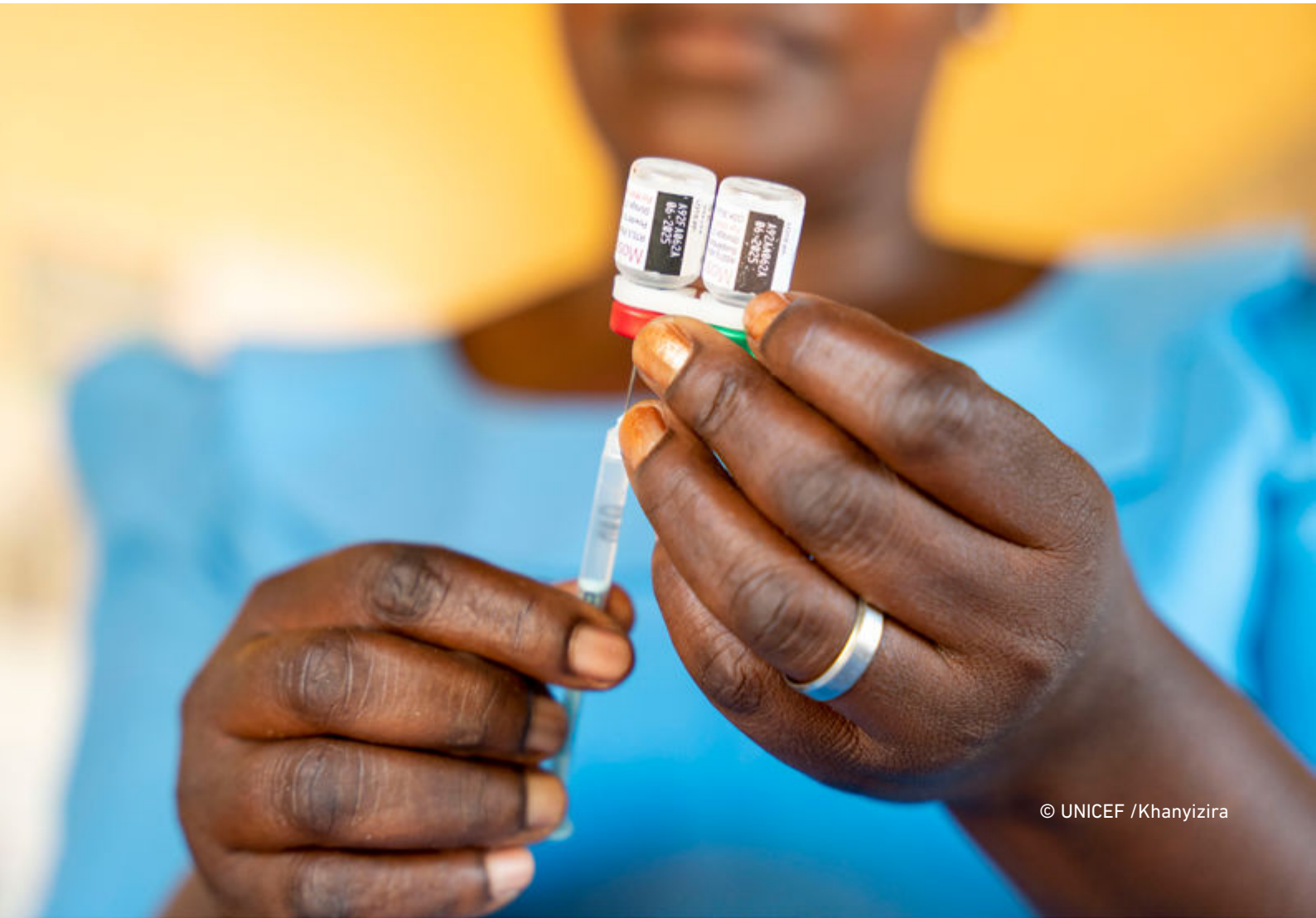
5) Reform global health initiatives.

5.1 Use our influence to reform global health initiatives.
5.2 Work to ensure that resources in global health initiatives are directed to where the needs are greatest.
5.3 Follow up on the Lusaka Agenda.

6) Maintain Norway's efforts in humanitarian aid.

6.1 Continue our efforts in emergency operations where health facilities, infrastructure, and access to healthcare workers are limited due to armed conflict.
6.2 Promote and ensure compliance with international humanitarian law that protects civilians, medical personnel, and health facilities during armed conflict.

See the full list of recommendations and their reasoning in Part D: What should Norway do?



Background for the Expert Committee on Global Health

Good health is crucial for enabling people to live fulfilling lives. Over the past few decades, we have witnessed significant progress. For instance, global child mortality has halved since 2000,[1] the burden of disease has been reduced, life expectancy has increased, and disparities in life expectancy have decreased.

Norway has played a central role in making this happen. For more than 25 years, Norway has contributed to establishing several global health-focused mechanisms, initiatives, and organizations. This has yielded significant results.

However, the COVID-19 pandemic, increased geopolitical tensions, and climate change have resulted in setbacks in global health. This has serious implications for the lives and health of many people, especially in poorer countries, and poses a heightened risk of new pandemics.

Far too many people today die due to lack of healthcare services, even though they suffer from preventable and treatable diseases. There are medicines, vaccines, and knowledge that could help many if more people had better access to cost-effective and affordable healthcare.

In the spring of 2024, seven Norwegian humanitarian and development organizations and think tanks came together to establish an expert committee to provide advice on Norway's efforts in global health going forward. The committee was tasked with the following mandate:

What are the biggest challenges and opportunities in global health leading up to 2050, and how can Norway best contribute internationally in this field, both economically and politically, with the aim of contributing to global development and Norway's own interests? What does Norway have the best conditions to contribute with?

The commissioning organizations are: Red Cross Norway, Norwegian Church Aid, Save the Children Norway, UNICEF Norway, Civita, Agenda, and Langsikt.

The committee has based its work on relevant knowledge sources, including the Lancet Commission on Investing in Health 3.0: Global Health 2050: The Path to Halving Premature Death by Mid-Century, hereafter referred to as Lancet CIH3.0, which was presented at the World Health Summit on October 14, 2024.

The commissioning organizations specifically requested the committee to:

- Extract findings of particular relevance for Norway's international efforts in global health
- Evaluate the Lancet Commission's recommendations and adapt them to the Norwegian political context where applicable.
- Present concrete recommendations for political actions

The committee held six meetings from August to October and consisted of the following ten members:

Camilla Stoltenberg, CEO of NORCE and Professor at the Institute of Global Health and Community Medicine at the University of Bergen (Chair of the Committee)

Amanda Hylland Spjeldnæs, Leader of Norwegian People's Aid Solidarity Youth and former representative for Norwegian youth at the World Health Assembly in WHO

Anne-Marie Helland, Direct or of International Development at PwC

Bent Høie, County Governor of Rogaland, former Minister of Health and Care Services, and Chair of the Standing Committee on Health and Care Services in Parliament

John-Arne Røttingen, CEO of Wellcome Trust

Karoline M. Linde, CEO of Laerdal Global Health

Lumbwe Chola, Associate Professor at UiO in Health Management and Health Economics

Ole Frithjof Norheim, Professor at the Institute of Global Health and Community Medicine at UiB, and Director of the Bergen Centre for Ethics and Priority Setting, UiB

Ottar Mæstad, Researcher at the Chr. Michelsen Institute and Leader of the Development Learning Lab (DLL)

Trygve Ottersen, Director at the Directorate for Medical Products (DMP) and Associate Professor in the Department of Community Medicine and Global Health at the University of Oslo

Expert Committee, August 2024:
From left to right: Bent Høie, Trygve Ottersen, Lumbwe Chola, Ole Frithjof Norheim, Camilla Stoltenberg, Ottar Mæstad, Anne-Marie Helland, John-Arne Røttingen, Karoline M. Linde, and Amanda Hylland Spjeldnæs.

The committee was supported by a secretariat with representatives from each commissioning organization: Kaia Vedlog Kveen (Red Cross Norway), Henrik Hvaal (Save the Children Norway), Camilla Faarlund Øksenvåg (Norgwegian Church Aid), Kyrre Lind (UNICEF Norway), Trine Østereng (Agenda), Maria Bakken (Civita), Fride Nordstrand Nilsen (Langsikt), and Eirik Mofoss (Langsikt).

This translated version of the report does not include Part A, and Part B of the original report*, because they are of a descriptive art and not essential in understanding the recommendations. Part A provides background information on the importance of investing in global health and the historical progress that has been made in global health. Part B outlines the need for new directions in global health with regards to global health initiatives, investments in both health systems and health security, public health measures, sexual and reproductive health and rights, humanitarian aid, and an overview of the current financing situation for global health.*

Part C: A Framework for Investements in Global health

Norway should increase its efforts for global health to halve premature death by 2050, reduce health inequalities, and enhance safety and economic stability both globally and in Norway. The rationale is twofold: solidarity and self-interest. The committee believes that this dual rationale for Norway's efforts in global health should be reflected in a dual objective for the work. The most effective measures to reduce global health inequalities are often not the same measures that most effectively strengthen Norwegian and international health security. To ensure that global health efforts yield the best possible results, the goals should be clarified, and the measures sharpened, although some initiatives may contribute to both objectives.

The committee believes that the goals for Norwegian investments in global health should be:

a) To reduce global health inequalities both within and between countries.
b) To strengthen health security in Norway and other countries.

In light of this, the committee proposes a new framework for investments in global health (see Table A). **To reduce global health inequality**, cost-effective measures should be supported in the countries bearing the greatest disease burden and lacking sufficient financial resources (i.e., low-income or lower-middle-income countries), with particular attention to the segments of the population facing the greatest health challenges. At the supranational level, investments should be made in research, technology, products, and other common goods that effectively contribute to reducing global health inequalities (e.g., the development of vaccines for neglected diseases).

Certain measures aimed at improving health in poorer countries can also impact Norwegian health security. As long as the primary goal of the measure is to reduce global health inequality, it still falls under objective a). **To strengthen health security** in Norway and other countries, investments should be made at the supranational level to promote health collaboration between countries, enhance preparedness and response to pandemics and other infectious diseases affecting all nations. Investments can also be made in individual countries where this is an effective way to enhance global health security. Investments can be made in all countries, including high-income countries.

Norwegian efforts for global health are currently mainly financed through the development aid budget, within a framework of 1 percent of Gross National Income (GNI). The committee believes that the one-percent target is no longer sufficient to meet both Norway's solidarity responsibilities and our own security. The positive development of the Norwegian economy, combined with significant unmet global needs, indicates that our solidarity responsibility is at least as great as before. At the same time, it is necessary to increase investments in pandemic preparedness, climate, and other public goods that are important for both our own and others' safety and welfare. The percentage target now appears as an inappropriate "cap" that hinders necessary investments.

Therefore, the committee believes that the necessary increase in investments to promote health security in Norway and other countries must come in the form of allocations beyond 1 percent of GNI. The increase can occur partially through a larger development aid budget and partially through allocations for initiatives that are not classified as aid.

Increased efforts to reduce global health inequality can be financed within the current aid framework by increasing the proportion of aid directed towards poverty alleviation and emergency assistance. In 2022, 68 percent of aid went to poverty alleviation and emergency assistance, while the remainder was allocated to various types of global public goods with varying relevance for development.[2]

Table A: A Framework for Increased Investments in Global Health.

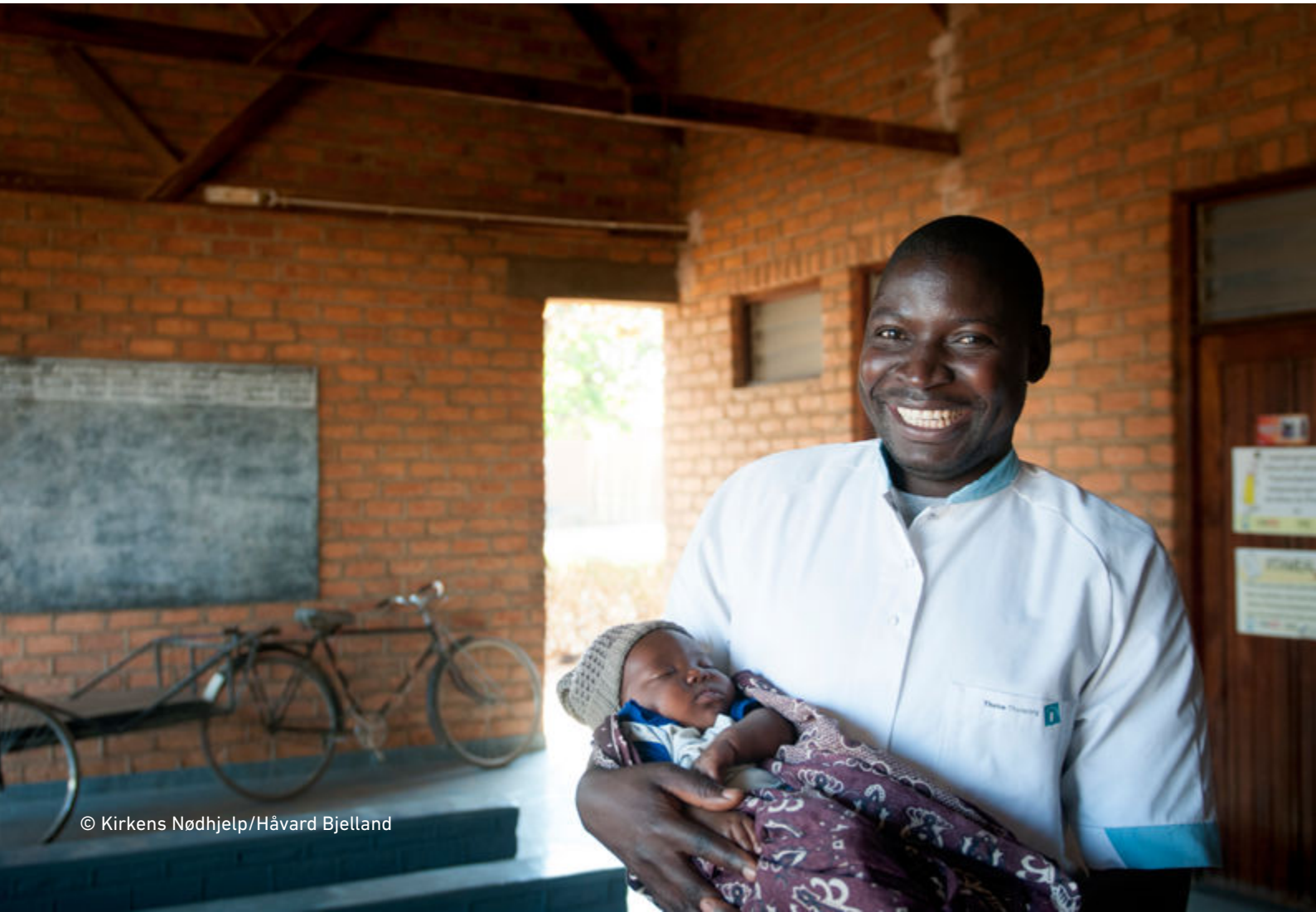
Goal	Interventions in spesific countries	Supranational interventions	Financing of increased investements
Reduce global health inequality	*In low income and lower middle income countries:* Effective interventions to reduce burden of disease and early death, including strenghtening health systems	Investements in technology and products that are important to reduce global health inequality (f.ex. vaccines against neglected diseases)	Aid (increase share of aid that goes to poverty reduction)
Strengthen health security in Norway and other countries	*In countries across all income levels:* Effective interventions for global health security, country	International health cooperation (f.ex. WHO) Pandemic-surveillance and international response Investements in research, technology, and products that strengthen health security in Norway and other countries (f.ex. covid-vaccine and antibiotic resistance)	Allocations beyond 1 percent of GNI *Some measures will be approved as aid, while others will not*

The budgets must clearly indicate how much is allocated to each of the two objectives. This is important to ensure an informed debate on priorities and to follow up on the committee's recommendation that increased investments in global health security should come as an allocation beyond 1 percent of GNI. In cases where a measure effectively contributes to both objectives, the measure can be co-financed by the two allocations. The framework is inspired by the Sending Committee, which emphasized the importance of clarifying the objectives in development policy and recommended that any further increase in investments in global public goods should occur outside the framework of 1 percent of GNI.

Investments in global public goods—goods that everyone can benefit from once they are available—are crucial for promoting global health. Such investments are particularly important for strengthening global health security. Some global public goods are also central to reducing global health inequality, such as technology and knowledge that help combat diseases that particularly affect poor countries. An important question is therefore which public goods should be prioritized and how these investments should be financed.

The framework in the table above helps answer such questions. Not all global public goods are equally important for everyone. An effective malaria vaccine, for instance, is particularly important for populations in poor countries. Such a vaccine would help reduce health inequalities worldwide, thus belonging under objective (a). A Covid vaccine, on the other hand, is important for the entire global population. It does not significantly contribute to reducing health inequalities, but it strengthens our collective health security. Therefore, it is a global common good that falls under objective (b).

The framework we have presented addresses financing for increased investments in global health but does not discuss the financing of current investments. The committee has not deliberated on this issue. However, it notes that over time, an increasing share of the aid budget has been spent on health security and other global common goods that have substantial value for Norway and other wealthy countries. It is reasonable to discuss whether this should have implications for the aid framework, to ensure that Norway's solidarity contributions are maintained.



Part D: What Should Norway Do?

The committee believes that Norway's efforts in global health are based on two main justifications. The first justification is international solidarity. We have a shared responsibility to help reduce health inequalities around the world. Norwegian investments have contributed to more children surviving today than twenty years ago, and to a decline in the differences in life expectancy between poor and rich countries. Investments in health also contribute to poverty reduction and economic development, making health one of the highest priority development areas for those receiving Norwegian aid.[3]

The second justification relates to our own security, welfare, and economic development. Improved health among the global population, stronger and more resilient health systems in all countries, access to basic healthcare services for everyone, increased investment in global health goods, and effective global health cooperation—all these factors significantly impact Norway's own security and economic development. The COVID-19 pandemic revealed how vulnerable we are and underscored the importance of international cooperation and good health security in other countries for our own safety.

Investments in global health have delivered—and are expected to continue delivering—positive results in terms of better lives, welfare, and economic conditions. However, new challenges threaten this progress, and the sector faces an increasing financing gap. This makes it especially important to maintain a strong, effective, and targeted Norwegian effort. Based on this, the committee presents its recommendations to Norwegian policymakers regarding future investments and priorities. The committee also suggests setting an ambitious goal for this effort, inspired by the Lancet CIH3.0 vision: a global target to halve premature mortality by 2050.

1) Renew Norway's Leadership in Global Health with the Aim of Halving Premature Deaths by 2050.

Historically, Norway has played a significant role in global health, notably through its work with GAVI, CEPI, and ACT-A. This has often granted Norway a seat at the table in key global decision-making forums, including G7 and G20 discussions on health initiatives. By combining political will and commitment with expertise and a long-term approach, Norway has established itself as a significant player in global health. However, this position is weakening, partly due to reduced political interest at the government level, and partly due to a weaker krone and lower investments, both as a share of the aid budget and in real terms. A renewal of Norway's leadership is still possible and would bring significant benefits. Norway can leverage its historical role to exert positive influence and raise ambitions in other countries.

The new report from the Lancet Commission, *Investing in Health 3.0* (CIH3.0),[4] provides clear and straightforward recommendations that the committee believes Norway should pursue to achieve more. The committee suggests that Norway should work globally towards a common goal, termed "50-by-50," aimed at reducing the disease burden and halving premature deaths by 2050, based on 2019 levels. However, these recommendations do not depend on a global consensus on this goal and still stand as an independent recommendation for Norway's efforts in global health.

To renew its leadership in global health, Norway will need to engage and commit across ministries. The two justifications for Norway's efforts—reducing health inequalities and strengthening health security—make it relevant for multiple ministries, and their expertise is essential to ensure that the right areas are prioritized. It is also important to heed the expert knowledge available in Norwegian civil society organizations and academic environments focused on global health. Moreover, Norway's efforts in global health will take place in an increasingly complex landscape of challenges and threats.

Norway must continue its value-driven leadership in sexual and reproductive health and rights (SRHR) because access to SRHR services is critical for women's health and societal development. This is especially crucial at a time when SRHR is under growing pressure in many countries. Norway has both a strong historical commitment and an important role as a champion in international forums such as the World Health Organization (WHO) to ensure that SRHR is recognized as a fundamental human right.

The committee recommends that Norway should:

1.1 Work towards a global goal of halving premature deaths by 2050 and ensure that wealthy countries commit to helping poorer countries achieve this.

a) The Lancet CIH3.0 outlines a pathway for all countries to reach this goal, including prioritizing 15 conditions across communicable diseases, maternal health, non-communicable diseases, and injuries. See further details in recommendation 3.1.

1.2 Initiate discussions at the government leadership level with other countries to reform the global health architecture[5].

a) This initiative should aim to increase the influence of recipient countries in line with the Lusaka Agenda, support the strengthening of health systems, and reduce transaction costs.
b) Such an initiative should involve the WHO, the World Bank, and key global health initiatives, alongside important donor and recipient countries and regional organizations. It should be anchored within G20 and G7 frameworks.
c) Donor countries should continue to prioritize and enhance support for global health through multilateral channels.
d) See recommendation 5 for details.

1.3 Prepare Norway for international leadership on multiple fronts through coordinated efforts by:

a) Reestablishing the position of Global Health Ambassador as a joint position between the Ministry of Foreign Affairs and the Ministry of Health and Care Services.
b) Creating a secretarial committee for global health, including members from the Prime Minister's Office, the Ministry of Foreign Affairs, the Ministry of Health and Care Services, the Ministry of Finance, the Ministry of Education, the Ministry of Justice and Public Security, and the Ministry of Climate and Environment. The work will be supported by a civil service group led by the Global Health Ambassador.
c) Involve Norwegian organizations and academic environments.

1.4 Continue its value-driven leadership in sexual and reproductive health and rights, including maternal and child health, at the country level and on global platforms.

2) Invest More in Global Health – To Reduce Health Inequality and Enhance Our Security.

The committee believes that the dual justification for Norway's investments in global health should be reflected in a dual goal for this work. The most effective measures to reduce global health inequalities are often not the same measures that most effectively strengthen Norwegian health security. Therefore, to achieve the best possible results, the objectives should be clarified, and the means sharpened, even though many of the initiatives may contribute to both goals.

The committee notes that the government, in the budget proposal for 2025, suggests increasing support for public goods for health preparedness relevant to both high-income and low-income countries "within existing budget frameworks." In the committee's view, this will undermine Norway's solidarity contribution to reducing global health inequality, which the committee warns against. The percentage target now also functions as a "cap" that hinders what would be a necessary increase in Norway's investment in global public

goods, including climate initiatives and pandemic preparedness. Given this context, the committee argues that the percentage target is no longer sufficient to uphold both Norway's solidarity commitments and our own security. There is a need for greater effort to address the global challenges we face.

The committee recommends that Norway should:

2.1 Make the reduction of global health inequality a primary priority in development policy and increase Norway's efforts.

a) In light of the strong arguments for investing in global health, the committee considers Norway's overall investments to reduce global health inequality to be too low and recommends that they be increased. This should be done by raising the overall share of gross national income (GNI) dedicated to combating poverty and global inequality. This share was 0.69 percent in 2022 and 0.72 percent in 2023.[6]

2.2 Increase investments in Norwegian and global health security without undermining efforts to reduce global health inequalities and poverty. This must involve raising the aid budget to more than one percent of gross national income (GNI). Some of the increase may also come outside the aid budget.

3) Reducing Health Inequality by Prioritizing Effective Measures and Strengthening Health Systems.

There are significant differences in health status and access to healthcare services both within and between countries. The largest disparities, however, are between countries. In Western Europe and Canada, the probability of early death is as low as 15 percent, while it remains as high as 52 percent in Sub-Saharan Africa. Over half of the world's population lacks access to basic health services,[7] and many low-income countries lack the financial resources necessary to elevate their healthcare offerings to an acceptable level. Strengthening health systems is, therefore, crucial for reducing global health inequality.

The Lancet CIH3.0 has identified 15 health conditions that account for the majority of the global gap in life expectancy,[8] and recommends prioritizing these to halve the likelihood of early death by 2050. (See Box 2 for details.) Given the modest progress in universal health coverage since 2015,[9] the Lancet CIH3.0 recommends a new, modular approach to health system strengthening. With the goal of comprehensive universal health coverage in the long term, the commission initially advises focusing on modules with cost-effective interventions for the 15 prioritized health conditions. These modules also include measures for health conditions that cause a significant disease burden without leading to early death, such as psychiatric disorders, as well as other needs that all health systems should address (including rehabilitation, child and youth development, and palliative care). In total, the Lancet CIH3.0 recommends initially focusing on 19 modules, before gradually expanding these to achieve universal health coverage over time.[10] This focused approach simultaneously makes an ambitious contribution to health system strengthening.

Norway is known for having one of the best health systems in the world, and we possess expertise in various areas. This expertise should be offered to countries interested in it.

Many factors outside the healthcare system significantly impact health. For instance, education and health are closely linked. Education contributes to increased human capital and promotes good health throughout life by providing knowledge and skills that support healthier lifestyle choices, better quality of life, and increased health literacy. Nutrition is another crucial aspect of enhanced human capital. Malnutrition in early life leads to irreversible reductions in physical growth and cognitive development. Compared to their well-nourished peers, those who experience early malnutrition complete fewer years of schooling, earn lower incomes later in life, and face a higher risk of non-communicable diseases such as cancer, cardiovascular diseases, obesity, and diabetes.[11] A strong base of human capital is essential for training enough local healthcare personnel to build a robust primary healthcare system.

Non-communicable diseases, including cancer and cardiovascular diseases, increasingly account for a significant share of the global disease burden. Targeted interventions addressing common risk factors for non-communicable diseases, such as tobacco, sugar, and alcohol, will prevent substantial health problems and early death worldwide.

As a wealthy and small country, where our welfare is closely tied to a safe world and a stable global economy, Norway has both a solidarity responsibility and a self-interest in reducing health inequality globally.

The committee recommends that Norway should:

3.1 Concentrate efforts on a few health conditions that will lead to a significant reduction in premature death.

a) The Lancet CIH3.0 identifies 15 health conditions that contribute to a large share of premature deaths in all countries: eight communicable diseases and maternal health conditions, seven non-communicable diseases, as well as a few selected needs that all health systems should address. Norway should prioritize the health conditions that most affect low-income countries and contribute in line with the countries' own priorities.
b) Contribute both national resources and through research, innovation, and new technologies targeted at the prioritized health conditions.

3.2 Increase support for strengthening health systems.

a) Prioritize financial support to strengthen health systems in countries that themselves invest in and prioritize this. National ownership is a prerequisite for success.
b) Initially focus health system support on modules that support work on prioritized health conditions** (see point 3.1a), in a coordinated manner, and then build upon these to achieve universal health coverage over time.
c) Offer technical and professional advice, research, and educational collaboration where requested and in areas where Norway has special expertise, such as:**
    - Health information systems, including health monitoring, pandemic preparedness, and cause of death registries.
    - Health legislation and regulation that can contribute to better public health.
    - Implementation research to ensure the best possible implementation of documented effective interventions.
    - Health financing and prioritization for more efficient resource use and reduced national health inequality.
    - Local capacity building through collaboration on higher education.
d) Help address the global health personnel crisis through the exchange of experiences and expertise.** Norway should work to ensure that strengthened access to qualified healthcare personnel is prioritized as part of health system strengthening through new and effective training methods. Additionally, Norway should strive to revitalize the World Health Organization's (WHO) code on international recruitment of healthcare personnel.[12]

3.3 View health investments in conjunction with other investments in increased human capital through continued support for basic education and nutrition.

3.4 Work with multilateral institutions to increase taxes on tobacco, sugar, and alcohol to reduce early death and enhance national resource mobilization.

4) Strengthen Coordination and Invest in Effective Measures to Enhance Global Health Security.

Resilient national health systems are vital for achieving good health security, but they are not sufficient on their own. Therefore, should parts of Norway's health efforts focus on strengthening global health security. To prevent health crises and respond swiftly to acute emergencies, it is crucial to have effective global and regional mechanisms in place. This requires relevant actors in health preparedness to possess the necessary flexibility to coordinate efforts and act quickly when crises arise. The World Health Organization (WHO) plays a key role in this work by leading global coordination of health preparedness and crisis response, thus contributing to our collective health security.

Global health security also relies on strong health preparedness in low-income countries, which can be enhanced through regional and national initiatives. Innovation, product development, adequate production capacity, and equitable distribution of vaccines, along with research on measures to mitigate the consequences of health crises, all play essential roles in health security. Regional and national public health institutions and action plans are equally important. National action plans for health security, aligned with WHO's framework, will ensure better coordination and faster responses, thereby limiting or averting regional and global health crises.

Pandemic prevention and preparedness represent an investment made before a health crisis occurs. Even for a high-income country like Norway, prioritizing such measures has proven challenging,[13] and it is even more difficult for low- and middle-income countries. Another challenge for these countries is that a rapid response to health crises requires readily available financing. It cannot be expected that low- and middle-income countries will fully finance measures for pandemic prevention, preparedness, and response when the benefits also accrue to other countries. Therefore, financial support and appropriate financing arrangements are crucial and must be established and consolidated quickly.

It is not only pandemics that threaten health security globally and in Norway. The World Health Organization ranks antimicrobial resistance (AMR) among the top ten threats to global health.[14] The spread of resistant bacteria threatens health security not only in the countries where they arise but also in Norway. It is essential to invest more in measures that prevent the rise of antimicrobial resistance.

The committee recommends that Norway should:

4.1 Invest in a more flexible World Health Organization (WHO) through unearmarked funding, to strengthen the capacity and coordination of global health preparedness and response to global health crises.

a) Norway should also support WHO's framework for coordinating the "Global Health Emergency Workforce."

4.2 Work to establish stronger financing instruments for pandemic prevention, preparedness, and response in low- and middle-income countries.This would include financing through insurance, guarantees, or conditional loans negotiated before a crisis occurs. Low- and middle-income countries cannot be expected to finance such measures alone when the benefits also accrue to other countries. The Pandemic Fund, the World Bank, the IMF, and regional development banks will be key actors.

4.3 Support and invest more in innovation and product development, including vaccines, diagnostics, and treatments, in areas where the market is insufficient, to enhance global health security.

a) Support the international effort for sustainable production capacity of vaccines, diagnostics, and medicines,** including in low- and middle-income countries, to contribute to equitable distribution of vaccines and other health products.
b) Support CEPI's work on vaccines for diseases with market failures.

4.4 Support stronger regional centers for public health initiatives and national institutions and action plans for health security, including the development of effective early warning systems to halt epidemics and pandemics at an earlier stage.

a) Example institutions include the Africa Centres for Disease Control and Prevention (Africa CDC) and public health functions in individual countries.

4.5 Support research on the effects of various public health and social measures to limit the outbreak and spread of pandemics.

a) An example of such research is the work of the WHO Collaborating Centre for effectiveness research on public health and social measures for health emergencies at the Norwegian Institute of Public Health (FHI).[15]

4.6 Take a central role in contributing to an intensified global effort against antimicrobial resistance,including investing more in measures to increase innovation and development of new antibiotics, reducing overuse, and improving access to antibiotics for high-priority conditions.

a) These measures must be cross-sectoral and include a "one health"[16] approach.
b) Ensure that recommendations from high-level meetings during the UN General Assembly "UNGA 2024" are followed up by all relevant departments in international efforts.[17]

5) Reform Global Health Initiatives

Norway should prioritize the funding channels that are best suited to achieve the goals of global health efforts: reducing health inequality between poor and rich countries and improving health security worldwide and in Norway.

In 2022, only 25 percent of global health assistance went to the least developed countries.[18] This suggests that the countries least able to provide quality health services receive too small a share of the resources.

Recipient countries should have increased influence over the use of health aid. National ownership of health assistance enhances the relevance and sustainability of projects while strengthening accountability and efficiency. This promotes the development of local institutions and reduces dependence on aid over time.

The Lusaka Agenda supports these goals. It emphasizes the importance of locally developed health policy to meet future challenges. The agenda focuses on strengthening health systems by prioritizing primary healthcare, which is key to ensuring basic health services for all. A central component of the Lusaka Agenda is to reduce reliance on fragmented external financing, increase national funding partly through more effective tax systems, and instead build robust health systems that are better adapted to national needs and sustainable in the long term.

Furthermore, the Lusaka Agenda highlights that global health initiatives (including GAVI, GFF[19], and GF[20]) must change and adapt to new challenges and the new reality with stronger regional and national mechanisms. The agreement recommends that efforts from the global health initiatives should increase, not decrease, but it must be ensured that these initiatives are adaptable and continuously responsive to the needs, priorities, and voices of governments, civil society, and local communities in partner countries implementing programs and measures. Power imbalances and prioritization within the structures and decision-making processes of global health initiatives must be identified and addressed.

The committee recommends that Norway should:

5.1 Use our influence to reform global health initiatives.

a) Norway should lead reforms of global health initiatives aimed at simplification, sustainable financing, cost-effective results, and reduction of transaction costs.
b) Consider targeted global health initiatives in relation to the health investments of global and regional development banks, utilizing fewer funding channels for each recipient country and establishing a common coordination platform for each country where the countries themselves take the lead.

5.2 Ensure that resources in global health initiatives are directed to where needs are greatest.

a) Global health initiatives should prioritize investments in low-income countries and must ensure co-financing from each country transitioning from low- to middle-income status.
b) Grant countries greater decision-making authority over the use of health aid in line with national priorities.
c) The global health initiatives should expand support to include the 15 prioritized conditions that can contribute to reducing premature death.
d) The global health initiatives should procure a larger share of health services through the regular health system in recipient countries, thereby helping to build up health services in these countries rather than relying on international organizations.

5.3 Follow up on the Lusaka Agenda.

a) Contribute to ensuring that global health initiatives adhere to the Lusaka Agenda, which emphasizes the importance of locally developed health policies, strengthening health systems, ensuring basic health services through public health measures and primary healthcare, reducing health inequality, and making countries less dependent on fragmented external financing. This can be achieved, among other ways, through Norway's governance roles.

6) Maintaining Norway's Efforts in Emergency Relief Work.

War and conflict are significant barriers to good health and the development of functional health systems in conflict-affected areas. Today, the world is experiencing the highest number of armed conflicts in 80 years, dramatically impacting people's health. Of the 1.1 billion people living in poverty worldwide, 40 percent also reside in conflict zones.[21] The UN estimates that approximately two billion people, a quarter of the world's population, live in areas affected by conflict.[22]

Many current conflicts are taking place in urban areas, where military targets are in close proximity to civilians and civilian infrastructure.[23] Additionally, critical civilian infrastructure is often severely impacted, affecting health systems and the health of the population. The public power grid no longer supplies hospitals, private households stop receiving clean drinking water, communication networks break down, and damaged transportation infrastructure hinders logistics services. This weakens the community's ability to provide necessary health care. In such situations, the risk of epidemics increases while the capacity to combat disease is drastically reduced. Civilians, healthcare workers, and health facilities suffer greatly in armed conflicts, particularly where international humanitarian law is not respected.

Norway is an important player in emergency relief work,[24] where rapid response during crises is crucial for saving lives and health. This effort must be sustained to ensure that we can assist those in greatest need, when they need it most.

The committee recommends that Norway should:

6.1 Maintain our efforts in emergency operations where health facilities, infrastructure, and access to healthcare workers are limited due to armed conflict.

6.2 Promote and ensure compliance with international humanitarian law that protects civilians, medical personnel, and health facilities during armed conflict.

Endnotes

1 Our World in Data. (16.10.24). Under- five mortality rate.

2 Calculation carried out by Norad on behalf of the Ministry of Foreign Affairs: Assignment 29a-2023 Follow-up to the report 'Investing in a Common Future. A New Framework for Development Policy.' s.4

3 Norad-report. (2024). What are the African people asking from their governments? Norad.

4 Lancet Commission on Investing in Health 3.0.(2024). S.1605-1606. Global Health 2050: the path to halving premature death by mid-century.

5 The global health architecture refers to the entire system of international organizations, including global health initiatives and intergovernmental organizations like WHO, that work toward improving health globally.

6 The figure from 2022, from the response to Assignment 29a from the Ministry of Foreign Affairs to Norad 2023: Assignment 29a-2023 Follow-up to the report 'Investing in a Common Future. A New Framework for Development Policy.' The figure for 2023 is calculated using the same method.

7 WHO. (2023). Billions left behind on the path to universal health coverage

8 Lancet Commission on Investing in Health 3.0.(2024). S.1572. Global Health 2050: the path to halving premature death by mid-century.

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10 Lancet Commission on Investing in Health 3.0.(2024). Tabell 8, s. 1580. Global Health 2050: the path to halving premature death by mid-century.

11 WHO. (2024). Fact Sheet Malnutrition.

12 WHO. (2022). Global Code of Practice on the International Recruitment of Health Personnel: fourth round of national reporting.

13 The Corona Commission Reports from 2021 and 2022.

14 WHO. Ten threats to global health in 2019.

15 WHO Collaborating Centres Global Database. WHO Collaborating Centre for effectiveness research on public health and social measures for health emergencies.

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17 United Nations. (2024). Political Declaration of the High-level Meeting on Antimicrobial Resistance

18 Lancet Commission on Investing in Health 3.0.(2024). S.1601. Global Health 2050: the path to halving premature death by mid-century.

19 GFF is the Global Financing Facility for Women's, Children's, and Adolescents' Health, and it is a global health initiative aimed at combating poverty and inequality by promoting the health and rights of women and children.

20 GF is the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

21 United Nations. (2024). Nearly half the world's 1.1 billion poor live in conflict settings.

22 United Nations. (2023). With Highest Number of Violent Conflicts Since Second World War, United Nations Must Rethink Efforts to Achieve, Sustain Peace, Speakers Tell Security Council.

23 Minister of Foreign Affairs.(2024). Strategy for Norwegian humanitarian 2024–2029.

24 Minister of Foreign Affairs.(2024). Strategy for Norwegian humanitarian 2024–2029.


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