World Health Organization

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Public health in an interdependent world: cash commodities, capacities, and conspiracies
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Dr Koplan, Dr Frieden, colleagues in public health, ladies and gentlemen,

The 21st century began well for public health. In 2000, the governments of 189 countries signed the Millennium Declaration and committed themselves to reaching its goals. Taken together, the eight Millennium Development Goals represented the most ambitious attack on human misery in history.

The contribution of health to the overarching goal of poverty reduction was firmly acknowledged, as was the need to address the root causes of ill health that arise in other sectors.

In its concern with fairness and social justice, the Millennium Declaration echoed the values and principles set out in the 1978 Declaration of Alma-Ata, which launched the health for all movement. That document promoted primary health care as a route to fair, rational, and inclusive health care that engaged communities, emphasized prevention as well as cure, and addressed the multiple social, economic, and environmental causes of ill health.

Further international health conferences, declarations, and commitments followed. But an energy crisis hit the world hard in 1979 and the 1980s began with an economic recession. The financial resources needed to act on commitments for better health never materialized.

The 1980s have been described as the “lost decade for development”. In developing countries, structural adjustment programmes, imposed by development banks, shifted national spending away from the social services, including public health. The argument was straightforward. If health care were marketed in the private sector, bought and sold like any other commodity, competition would lower prices, improve efficiency, and increase coverage.

This never happened, of course. Some developing countries have still not recovered from the damage done to their health systems.

The 21st century started differently. This time around, it looked like the international community meant business. World leaders were optimistic, visionary, and determined to see their visions realized. This time around, commitments were backed by substantial financial resources, often from innovative sources.

A host of global health initiatives sprung up, with many designed to deliver life-saving interventions on a massive scale. Presidents and prime ministers launched and funded international programmes for diseases rarely seen within their own borders. Commitments of official development assistance for health rose more than three-fold, from $6.5 billion in 2000 to more than $21 billion in 2007.

As the Millennium Declaration stated, “The central challenge we face today is to ensure that globalization becomes a positive force for all the world’s people. Those who suffer or benefit least deserve help from those who benefit most.”

This principle of greater fairness in distributing the benefits of globalization was readily apparent in a number of specific initiatives. Those who benefit most seemed bent on improving the lives of those who benefit least.

In 2001, the GAVI Alliance, supported by a large grant from the Bill and Melinda Gates Foundation, was launched to reinvigorate the drive to protect children from vaccine-preventable diseases. The Alliance was founded on the principle of fairness.

Poverty, or the place where a child was born, should not determine access to life-saving vaccines, including the newer and more expensive ones. Every child deserves the best that science can offer. The Alliance was also a tribute to the power of innovation to move the human condition a big step forward. A world that can put a computer in every home could surely put vaccines in every child.

The GAVI Alliance provided the prototype for the Global Fund to Fight AIDS, Tuberculosis and Malaria, which began its funding operations the following year. The Global Fund was likewise designed to dramatically expand access to existing interventions. It operated as a major pipeline for the redistribution of wealth to purchase commodities for the prevention and treatment of three diseases with high mortality in the developing world.

Significantly, the new mechanism introduced the principle of funding based on performance and measurable results. By 2006, funds dispersed by the Global Fund accounted for around 20% of all multilateral aid for health.

As the first decade of the 21st century progressed, the determination to seek greater fairness in distributing the benefits of medical and scientific progress looked unshakable. Familiar obstacles were encountered, and some new ones were uncovered, but they were almost immediately met with creative solutions that introduced entirely new mechanisms for international health collaboration.

The need for better tools was recognized early on, and this need confronted a well-established problem. The pharmaceutical industry will not, on its own

initiative, undertake the costly R&D needed to develop products for diseases that largely affect the poor. A profit-driven industry does not invest in products for markets that cannot pay.

Specific unmet needs for better drugs and vaccines drove the creation of a new breed of strategic public-private partnerships for product development. Instead of screening existing compounds for possible new indications, the new strategic R&D partnerships started with an unmet need and set out to produce an ideal product, also in terms of price.

They did so using the same sophisticated technologies that characterize industry-run discovery projects for commercially attractive diseases. These partnerships have already produced tangible results, including a pipeline of new medicines for malaria, with the first one licensed in 2008, and a much better vaccine for epidemic meningitis.

Again, a new principle expanded public health thinking beyond the traditional conviction that people should not die for want of access to existing interventions. In this case, people should not die for want of incentives to develop new products for diseases of the poor. In other words, people should not die for what boils down to market failure.

As another new strategy, an approach using advance financial pledges was put forward in 2006 to encourage industry to move forward with new vaccines to combat pneumonia and diarrhoeal disease, the two biggest killers of young children. Again, the result was swift. GAVI and its partners will soon be introducing pneumococcal and rotavirus vaccines to childhood immunization programmes.

In addition to better products, more money was needed. In 2006, the International Finance Facility for Immunization, supported by GAVI, became operational. By selling blue-ribbon bonds to investors, the facility frontloaded $4 billion to fund the immunization, by 2015, of 500 million children.

2006 saw a second innovation with the launch of UNITAID, a drug purchasing facility that draws funds from a levy on airline tickets. In less than three years, the facility contributed more than $900 million for the purchase of diagnostic tools and drugs for AIDS, TB, and malaria.

These amounts of money are not big when compared with the recent financial bailouts, but for public health, they provided an enormous boost.

More money also needed to be used more effectively. In 2005, high-level officials from more than 90 countries signed the Paris Declaration on Aid Effectiveness. The actions agreed on in the document marked a significant departure from past thinking and practice.

They marked the end of a fashionable scepticism about the value of aid, with blame placed on weak capacities and poor, if not corrupt, governance in recipient countries. This time around, donor policies and practices were also considered at fault.

The Declaration called on donors to harmonize their actions and make funding more predictable and sustainable. They were also asked to channel aid in support of national priorities and in ways that strengthen existing infrastructures and capacities, rather than circumventing them by building parallel structures and services.

Such thinking marked a radical departure from the past in other ways. Under the polarized conditions of the Cold War, foreign aid was often used to purchase a country's loyalty to a political ideology, with the two Superpowers carving up the world into a chessboard of strategic geopolitical interests.
The impact on development, health, or human misery was not the principal concern, and the risk of corrupt use of money was almost built into the bargain.

As this country's Secretary of State, Hillary Clinton, stated earlier this year: "Development was once the province of humanitarians, charities, and governments looking to gain allies in global struggles. Today, it is a strategic, economic, and moral imperative."

Secretary Clinton also stressed the need to break the cycle of dependence that aid can create by helping countries build their own institutions and their own capacity to deliver essential services.

I fully agree. Good aid for health development aims to eliminate the very need for aid. It does so by building the foundation, the capacity, and the infrastructure needed to move towards self-reliance. If aid does not explicitly aim for self-reliance, the need for aid will never end.
Ladies and gentlemen,

Not surprisingly, this desire to cooperate internationally for better health, these innovations, these dramatic increases in resources, and reforms towards their more effective use had an impact.

The number of people in low- and middle-income countries receiving antiretroviral therapy for AIDS moved from under 200,000 in late 2002, to 3 million, then beyond 4 million, an achievement unthinkable just a decade ago. The number of under-five deaths dipped below 10 million for the first time in almost six decades and then dropped again to below 9 million.

The yearly number of people newly ill with tuberculosis peaked and then began a slow but steady decline. For the first time in decades, it looked like the steadily deteriorating malaria situation might be turned around.

These innovations expanded the thinking about public health as well as its prospects. Every child deserves the best that science can offer.
People should not die for want of incentives to develop new products for diseases of the poor. Effective aid honours national priorities and aims for self-reliance. Health initiatives should be purpose-driven. Funding should be results-based.

In other words: fairness and efficiency, the dream agenda for public health, the heart and soul of the Declaration of Alma-Ata.

But as welcome as they were, these objectives ran counter to the arguments of some development economists, expressed since at least the 1980s, that you cannot have both. If efficiency is the objective, fairness has to take a back seat.

The world was aiming high, perhaps implausibly high, and there were some problems.

The old debate about horizontal versus vertical approaches to health resurfaced, this time rephrased as a conflict between the drive to deliver life-saving commodities and the need to strengthen fundamental capacities.

By mid-decade, it was clear that the goal set for reducing maternal mortality, the goal that depends absolutely on a well-functioning health system, was the least likely to be met, of all the eight goals, in every region of the world.

In 2006, the World Health Report documented a stunning worldwide shortage of 4 million doctors, nurses, and other health personnel, with the shortage most acute in sub-Saharan Africa.

Aided by the globalization of the labour market, which favours the highly trained and educated, doctors and nurses were leaving the countries that invested in their training, in droves. The alarm was great, as research showed a direct link between low density of health care workers and a rise in maternal, infant, and under-five mortality.

And there were other reasons for concern about the dire shortage of health and medical staff. All around the world, health was being shaped by the same powerful forces: demographic ageing, rapid urbanization, and the globalization of unhealthy lifestyles.

Under the twin pressures of globalization and modernization, chronic diseases, long considered the close companions of affluent societies, changed places. As the decade progressed, WHO data showed that 70%, then 80% of the burden of conditions like heart disease, stroke, cancers, diabetes, and asthma were concentrated in the developing world. The diseases of abundance had become the diseases of disadvantage.

This dramatic shift in the disease burden vastly increased the demands on already weak health systems. It increased the need for health workers and drugs for chronic care, and out-of-pocket payments for catastrophic health care costs. These were most unwelcome trends.

WHO estimates that out-of-pocket payments for catastrophic care drive an estimated 100 million people below the poverty line each year. This is a bitter irony at a time when the international community is pursuing better health as a poverty-reduction strategy.

And there were other rumblings of trouble, other storms gathering on the horizon that pointed to even bigger problems and questions.

A time of unprecedented interdependence, among policy spheres as well as nations, called for unprecedented international collaboration. Yet agreements between rich and poor countries on big-picture issues became increasingly difficult to achieve.

Climate change is arguably the biggest incentive ever for long-range collaborative planning. Yet agreement on ways to mitigate the effects of climate change proved elusive. The Doha round of trade negotiations collapsed. A WHO system for the sharing of influenza viruses, that had functioned seamlessly since 1946, was called into question as biased towards wealthy countries and the profits of the pharmaceutical industry.

Negotiations at WHO on the issues of patent protection, generic products, and drug prices, though ultimately successful, were extremely intense, divisive, and sometimes almost explosive.

In other words, public health was fine when delivering life-saving commodities, but problems arose when health interests and economic concerns crossed paths.

Global issues were increasingly touchy and divisive. A deep mistrust of the international systems seemed to take root, expressed as a suspicion that the rules were somehow rigged to favour the interests of the rich and powerful, while poorer countries were left out and left behind.

Some big questions accompanied these suspicions. Are factors, like poverty, ignorance, social disadvantage, bad nutrition, and filthy environments the true root causes of ill health? Or are there bigger causes, located, perhaps, in the policy sphere, in the international systems that govern the way this world works?

Were the Millennium Development Goals perhaps a corrective strategy, a way of compensating for the fact that the international systems generate benefits, but have no rules that guarantee the fair distribution of these benefits?

These suspicions were significantly sharpened in 2008, when the world experienced a fuel crisis, a food crisis, and the worst financial crisis since the Great Depression began in 1929. In a world of radically increased interdependence, crises of this nature are highly contagious, moving rapidly from one country to another, and from one sector of the economy to many others.

In this lopsided world with its huge imbalances in wealth and health, crises of this nature are profoundly unfair. Developing countries have the greatest vulnerability and the least resilience. They are hit the hardest and take the longest to recover.

Around one billion people live on the margins of survival. It does not take much to push them over the brink.

In addition, some of these suspicions were substantiated, and fully supported by evidence, in the final report of the Commission on Social Determinants of Health. That report, issued just weeks before the financial crisis made headlines, placed the responsibility for inequities in health squarely on the shoulders of policymakers. As the report argued, the huge gaps in health outcomes are not matters of fate. They are markers of policy failure.

As the economists tell us, the financial crisis represented a failure of corporate governance and risk management at every level of the financial system. The crisis hit the world like a sudden jolt, and hit the world where it hurts the most: money. Almost within days, a world mind-frame of prosperity turned to one of austerity. The thinking of the 1990s, in financial and corporate circles, that “greed is good” came home to roost.

Many working for health development, myself included, immediately asked the obvious question. Will this usher in another “lost decade for development”?

Will a crisis, seeded by greed, kill our best chance ever to give this lopsided world a greater degree of balance? Will all those innovations that marked the start of this century, all this great determination to improve health, be defeated by bad policies made in other sectors?

Ladies and gentlemen,

In a sense, the multiple crises facing the world today are nothing new. Floods, droughts, famine, war, pestilence, plagues, and economic booms and busts are familiar companions in the up-and-down cycle of human history.

But today’s crises are different. They have some unprecedented dimensions. They are highly contagious and profoundly unfair. They are revealing, in ominous ways, what it means to live in a closely interdependent world.

Viewed in the context of an unprecedented drive for greater fairness, I can personally understand many of the questions, concerns, and frank suspicions.

Collectively, we have failed to give the systems that govern international relations a moral dimension. The values and concerns of society rarely shape the way these international systems operate. Equity is almost never an explicit policy objective in the international systems that govern financial markets, economic relations, trade, commerce, and foreign affairs. And health suffers as a result.

Too many models for development assumed that living conditions and health status would somehow automatically improve as countries modernized, liberalized their trade, and experienced rapid economic growth.

This did not happen. Instead, the differences, within and between countries, in income levels, opportunities, life expectancy, health outcomes, and access to care are greater today than at any time in recent years.

Clearly, globalization has not been the rising tide that lifts all boats. Clearly, globalization has not become "a positive force for all the world's people."

Decades of experience tell us that this world will not become a fair place for health all by itself. Health systems will not automatically gravitate towards greater equity or naturally evolve towards universal coverage.

Economic decisions within a country will not automatically protect the poor or promote their health. Globalization will not self-regulate in ways that ensure fair distribution of benefits. International trade agreements will not, by themselves, guarantee food security, or job security, or health security, or access to affordable medicines.

All of these outcomes require deliberate policy decisions.

Let me be very clear. I am not against trade liberalization. I am not against globalization and I certainly favour economic growth. I am fully aware of the close links between greater prosperity, at household and national levels, and better health. But I do need to say this: market forces, all by themselves, will not solve social problems, and this is why public health needs to be concerned.

And I am not arguing that public health has, or will ever have, the power to change the way this world works. But I do believe we have a duty to point out some genuine reasons why an apparently smooth road to progress for public health, in a century that began so well, has, in reality, so many speed bumps along the way.

And let me be very frank. Changing human behaviours is harder than delivering commodities. Both are critical for better health. Securing funds to

strengthen fundamental health capacities is harder than securing funds to buy bednets, pills, condoms, and vaccines. Public health needs both.

Working for health in a country riddled by conflict and corruption is much harder than seeking health gains in a stable country with good governance. This is no excuse for ignoring unmet health needs or turning a blind eye on human misery.

But the hardest thing of all is persuading world leaders or ministers in other government sectors that health concerns can, in some instances, be more important than economic interests. That economic growth is not, after all, the be-all, end-all, cure-for all.

In my view, the net result of all our international policies should be to improve the quality of life for as many of the world's people as possible. Greater equity in the health status of populations, within and among countries, should be regarded as a key measure of how we, as a civilised society, are making progress.

Ladies and gentlemen,

The past decade brought mixed news for public health. But for me, and I expect many others, the best news is the fact that the long overdue influenza pandemic has been so moderate in its impact. Had the virus mutated to a more virulent form, much of the progress I have just described would have stalled or suffered serious setbacks.

We have been fortunate on many counts, from the beginning on. The virus initially spread in countries with good surveillance systems. The honesty and speed of early reporting set the standard for the international response. The sharing of information, expertise, and viruses was admirable.
The virus caused mild illness in the overwhelming majority of cases, but caused severe or fatal disease in some, including relatively young and healthy people.

Sporadic resistance to oseltamivir emerged but did not spread. Vaccines were available within six months following virus detection. They remained a good match with circulating viruses and showed an excellent safety profile.

Things could have gone tragically wrong in any of these areas.

Let me thank CDC for the major role it has played in supporting the international response to this pandemic. Let me thank you for so quickly preparing reagents and diagnostic kits and shipping these around the world, for the thousands of viruses analysed in your laboratories, for your participation in countless teleconferences and international meetings, and for so many rapid reports in the MMWR and elsewhere.

I thank you, too, for directly helping so many countries improve their surveillance and laboratory capacities well in advance of the pandemic. The world's defences against the next outbreak are much stronger as a result.

But will the public believe WHO and other health officials when we announce the next public health emergency? And I can assure you: there will be more. This brings me to that last word in the title of my talk: conspiracies.

Though the virus did not deliver any devastating surprises, we faced surprises in other areas. We anticipated problems with producing enough vaccine fast enough, and this did indeed happen. But we did not anticipate that many people would decide not to be vaccinated.

This is the first influenza pandemic to occur following the revolution in communications and information technologies. In today's world, people can draw on a vast range of information sources. People make their own decisions about what information to trust, and base their actions on those decisions. The days when health officials could issue advice, based on the very best medical and scientific evidence, and expect populations to comply, may be fading.

Managing public perceptions has proved especially challenging in other ways. One clear problem arose from the great discrepancy between what was expected and what actually happened. For five long years, the world kept a nervous watch over the highly lethal H5N1 avian influenza virus, which was widely regarded as the virus most likely to ignite the next pandemic.

A pandemic caused by a virus that kills more than 60% of those it infects is strikingly, and fortunately, very different from the reality of the 2009 pandemic. Adjusting public perceptions to suit a far less lethal event has been problematic.

This has been the most closely watched and carefully scrutinized pandemic in history. We will have a wealth of new knowledge as a result. It is natural that every decision and every action that shaped the response will likewise be closely scrutinized.

WHO anticipated close scrutiny of its decisions, but we did not anticipate that we would be accused, by some European politicians, of having declared a fake pandemic on the advice of experts with ties to the pharmaceutical industry and something personal to gain from increased industry profits.

This has been a little hard to take. Though understandable, again given the discrepancy between what was expected and what happened, such accusations have been damaging, as they have undermined confidence in the need for vaccination in a number of countries, including several in the developing world.

We have experienced the impact of conspiracy theories before, and I believe that public perceptions of risks and remedies will be a new source of setbacks for public health for some time to come. And the setbacks can be severe.

In Northern Nigeria, in 2003, rumours emerged that the polio vaccine was linked to HIV, or was part of a Western plot to sterilize Muslim children. People refused immunization. Polio resurged in Nigeria and the virus was reintroduced into at least 12 polio-free countries

In Europe and North America, many parents remain convinced that measles-mumps-rubella vaccine is linked to autism and bowel disease. Findings in the paper that ignited these concerns in 1998 have been soundly refuted. And yet the concerns of many parents linger. Similar to the situation with the 2009 influenza pandemic, some anti-vaccine groups see a conspiracy between paediatricians and the pharmaceutical industry.

Countries in North America, Europe and elsewhere are seeing entirely unnecessary outbreaks of measles at a time when the drive to control measles worldwide has reached unprecedented strength.

Ladies and gentlemen,

Today is World TB Day. Let me thank your Director, Dr Frieden, for his international leadership in this and many other areas of public health.

Since 1995, some 35 million TB patients have been treated and cured and an estimated 6 million deaths have been averted. Yet TB still kills a staggering 1.8 million people each year, making it the second biggest infectious killer of adults worldwide. The emergence of drug-resistant forms of this disease reminds us of the ever-present risk of setbacks.

Much has been achieved. Much remains to be done. New problems have surfaced, but public health is used to setbacks and surprises. Our value system is irreproachable and our optimism and determination are irrepressible.

I look forward to continued collaboration with CDC as one of our most talented and valued partners.

Thank you.