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The Globalization of Health

by Gro Harlem Brundtland

The outbreak probably began in Guangdong, China in November 2002. Within four months the virus had travelled as far afield as Vietnam, Toronto, and Frankfurt. Around the world, thousands were infected, and several hundred were dead. If the chains of transmission, and thus the virus, were to be stopped, an unprecedented level of coordination and cooperation by research teams, medical practitioners, health officials, and governments around the world was required. An unprecedented global effort has indeed, at time of writing, stopped the outbreak in Vietnam, and shown rapidly decreasing figures in Singapore and Toronto. But the virus is still spreading in China, and thus continues to threaten the world. We continue to work to defeat it. This is the short history of Severe Acute Respiratory Syndrome, the SARS virus. But it could be the story of any number of health crises in an increasingly interconnected world.

The reality is that public health is, as never before, a priority on the global agenda, for the simple reason that so many of the challenges we face now have a global impact, requiring global solutions and a global response. In an interconnected and interdependent world, bacteria and viruses travel almost as fast as email messages and money flows. There are no health sanctuaries. No impregnable walls between the world that is healthy, well-fed, and well-off, and another world that is sick, malnourished, and impoverished. Globalization has shrunk distances, broken down old barriers, and linked people together. It has also made problems half way around the world everyone's problem—the tenacity of the SARS virus and the public health and economic uncertainty it brings underscores this too well. Countries trying to grapple with new epidemics or collapsing under the weight of disease and malnutrition can now have a devastating impact on economies and societies around the globe. The way that we, as an international community, work to address current crises and prevent future ones will determine whether we succeed or fail in our shared efforts to advance global development, growth, and peace.

These global transformations must lead to a profound change in the way we think about health policy—locally, nationally, and internationally. We need to cooperate and coordinate much more effectively across borders, sharing information, expertise, and resources to a degree that would have been unthinkable even a decade ago. We need to focus much more on the plight of failed or failing states, recognizing

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that poverty is far and away the greatest cause of disease. We need to reassess the role of international organizations and their ability to coordinate global action, set standards and guidelines, deploy resources, and reach inside borders to head off crises before they happen. Above all, we need to move health security to the center of the international agenda.

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Borderless Crises

There is nothing new in the idea that health issues transcend borders. One has only to think of the scourges of history—plague, smallpox, influenza—and the devastation they have wrought over the centuries to realize that disease rarely respects national frontiers. What is new today is our degree of interdependence. More than two million people cross international borders every day, about a tenth of humanity each year. And of these, more than a million people travel from developing to industrialized countries each week. Trade flows of raw materials, goods, and services have increased fifteen-fold since 1945. Investment flows have multiplied more dramatically still, fundamentally changing the way that economies and societies interact.

The line separating domestic and international health problems is fast losing its meaning. As people and goods travel across continents more rapidly and in far greater numbers than ever before, there is no such thing as "foreign" diseases. Suddenly Dengue Fever, West Nile virus, and now SARS are everyone's problem. Shortcomings or delays in international cooperation can have immediate and devastating effects. One country's failure to adequately address a health crisis can now compromise the security of the global community as a whole.

But our world is also interdependent in less direct—but no less important—ways. Countries that are impoverished, in crisis and conflict, and are failing and weak can have an increasingly crucial influence on the prosperity, security, and ultimately the health of the rest of the planet. In many parts of Africa, some parts of the Middle East, and some countries in South America, people have seen decades, in some places more than a generation, of stagnation. They are not progressing; sometimes, they are even moving backwards. It is not a small number. Between 1990 and 2000, the human development index declined in nearly thirty countries. Well over a billion people—more than one-fifth of the world's population—are unable to meet their daily minimum needs. Almost one-third of children are undernourished. Although the UN last year stated that access to clean water is a human right, 1.1 billion people still go without it.

Populations in many of the poorest countries have also become much harder to reach. As the iron hand of the cold war loosened its grip, some countries enjoyed new freedoms, but in other areas, paradoxically, the result was conflict, marginalization, and collapsing states. In these "disappearing" countries, the work of donors, NGOs, and international agencies is quickly becoming almost impossible. Of course, this trend is not universal: Mozambique, Uganda, and Cambodia are only three examples that have seen relative peace, stability, and functional government appear out of the ashes of war. But there are many other countries where too many people cannot meet their basic daily needs for food, water, and shelter. They cannot access the services they need for survival, including essential health care and personal protection. They are vulnerable and insecure. Worse, trapped in ethnic conflict or civil strife—but beyond the media spotlight—they also risk being forgotten by an international aid community already feeling stretched to the breaking point.

Poverty breeds disease—more than any other single cause—just as disease breeds poverty. In countries in crisis, rates of severe illness and death are high—in some settings the daily death rate is at least double the expected level. One of the key signs of a failing state is its growing inability to provide even basic services to its population. A descent into poverty and lawlessness leads to rapid declines in health indicators such as infant mortality and life expectancy. Southern Africa is a case in point. A number of political, economic, and social factors have played a role in creating a situation where more than twelve million people in that region are now affected by famine. But there is no sudden event which has caused the crisis. Rather, it comes as the result of a long process now compounded by the AIDS pandemic, which has reversed much of the tremendous progress Botswana had achieved and is now becoming a profound burden in South Africa, as well as Zimbabwe, Zambia, and Malawi.

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The experiences over the past year and a half show that we neglect countries in crisis at our peril. Economic crises in distant countries now reverberate in financial markets around the world. Mass migrations from failed states can topple governments and provoke conflict, even genocide. Pandemics, such as AIDS, can cut so deeply into the basic fabric of countries that their social, economic, and political repercussions destabilize whole regions.

Then there are the resentments and hostilities that flow from inequality and deprivation. All over the world, extremists use popular frustration to justify their actions. It is no accident that they take refuge in the debris of failed states, where the consequences of crisis fuel frustration and insecurity. The terrorist attacks on New York and Washington—combined with new fears about the proliferation of weapons of mass destruction—have taught us how much even the most sophisticated societies need to do to face up to the possible deliberate use of chemical and biological agents to cause harm.

The challenge for the international community is to address the underlying causes of crisis and arrest the descent, before we are forced to pay dearly for the ultimate consequences—famine, unrest, and human suffering. To do this, we need to move health to the center of the development agenda.

Borderless Issues

It is not just countries that are more interdependent, but issues as well. Even five years ago, when I first arrived at the WHO, the development agenda was weighed down by old dogmas, long past their sell-by date. The most anachronistic was the notion that investments in health are essentially add-ons—luxuries that developing countries could only afford after having boosted economic growth and achieved higher income levels. Policy was narrowly focused on pro-growth strategies—curtailing deficits, smothering inflation, liberalizing trade, attracting foreign investment, and building infrastructure like hydroelectric dams and roads. "Soft" programmes aimed at promoting basic health, social welfare, and even education were seen at best as a diversion from more pressing issues and at worst as a drain on scarce financial resources.

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This approach was fundamentally flawed. It failed to recognize that a healthy population is as much a prerequisite for growth as a result of it. In 1999, the WHO asked leading economists and health experts from around the world to come together and consider the links between health and economic development. Two years later, under the guidance of Professor Jeffrey Sachs of Harvard University, the Commission on Macroeconomics and Health presented its report. It showed, quite simply, how disease was a drain on societies, and how investments in health could be a concrete input to economic development. It went further, stating that improving people's health may be the single most important determinant of development in many poorer regions, including Africa.

This report has already had a considerable impact. The Commission argues for a comprehensive, global approach to health with concrete goals and specific time frames. It wants to see the forces of globalization harnessed to reduce suffering and to promote well-being. The proposed investments are well-tried interventions that are known to work. Their impact can be measured in terms of reducing the disease burden and improving health system performance. The emphasis throughout is on results, on investing money where it makes a difference.

One of my goals as Director-General of WHO has been to deliver this message at the highest political level—at international conferences and summits, in my many meetings with national governments, and in the WHO's day-to-day contacts and collaboration with other international agencies. Three diseases—HIV/AIDS,

tuberculosis, and malaria—are crucially important. HIV/AIDS makes up just over half of the global burden these three diseases represent, both in terms of healthy life-years lost and mortality. Malaria and tuberculosis share the rest on a roughly equal basis. It means that more than ninety million healthy life-years are lost to HIV/AIDS each year, forty million to malaria, and nearly thirty-six million to tuberculosis. More than five and a half million lives are lost every year worldwide to these three diseases. But these are certainly not the only health issues that need to be on the international community's radar screens. Maternal and child conditions, reproductive ill-health, mental illness, violence, injuries, immunizing children against vaccine-preventable diseases, and the health consequences of tobacco, to name but a few, are also global health priorities. Any serious attempt to stimulate global economic and social development, and so to promote human security, must successfully address the burdens caused by these diseases.

Health must be at the center of all of these agendas because what we are really talking about is the interdependence of people—not just markets and multinationals.

Raising political awareness is only the first step. The real challenge is to mobilize the necessary resources and technical expertise to make improved public health a central plank of development policy. The Commission's Report is the first detailed costing of the resources needed to reach some of the key goals set in the Millennium Declaration. We are talking about an annual investment of $66 billion from the year 2007. Most of this will come from the developing countries' own resources. But about half must be contributed by the rich countries of the world—in the form of effective, fast, and result-oriented development assistance. For example, through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), and a number of other alliances and partnerships, we have developed a new set of tools to turn resources into effective action. The common denominators for these new tools are that they respond to the countries' own priorities, they process funds rapidly, they reward results, and they are transparent.

The simple fact is that there can be no real growth without healthy populations. No sustainable development without tackling disease and malnutrition. No international security without assisting crisis-ridden countries. No hope for the spread of freedom and democracy unless we treat health as a basic human right. Health must be at the center of all of these agendas because what we are really talking about is the interdependence of people—not just markets and multinationals.

Weaving the Threads Together

We know that international collaboration in the field of public health can work. Take the agreement amongst 192 Member States, after more than four years of

negotiations, to put the Framework Convention on Tobacco Control to the World Health Assembly in May this year. Tobacco kills 4.9 million people every year. According to best estimates, this number will double in twenty years time—hitting developing countries hardest—if we do nothing to stop it. With the Tobacco Convention, we will have an international agreement with global standards, global rules, and global commitments to effectively contain this major threat to public health. This global health treaty—the first ever under the auspices of WHO—could mark the beginning of a new phase in building an effective rules-based international system for combating the many other global health challenges we face through improved standards, better surveillance and information sharing, more cross-border research, more effective rapid response to crisis, and significantly enhanced financial resources. Such an effort will require the collaboration not only of member governments, but of aid agencies, universities, research institutions, the private sector, and other NGOs as well.

None of this will be easy. There is no one solution to the multiple health challenges facing us. No magic formula that will make our world a healthier, safer, and more secure place. We know that global cooperation is key to the many global challenges facing us, but we also know that global cooperation can be messy, unwieldy, and painfully slow. Take trade: 150 years ago, it was not so difficult for a handful of countries to come to an agreement, and what could not be solved around the negotiating table was often settled by more forceful means. Even when the UN was created, it consisted of only fifty-one nations. Today, nearly 145 members of the World Trade Organization, nearly 200 nations in the UN, are struggling to agree on a growing list of seemingly ever-more complex issues.

But what is the alternative? Leaving each country to try to fight a new disease, like SARS, on its own, without the benefit of shared international support, resources, and expertise? Pretending that Africa's thirty million AIDS sufferers—and their orphans—inhabit another planet? One thing that is crystal clear is that we need effective global cooperation and institutions to pull these disparate threads together. That is what was promised by the international community at the G8 Summit in Kananaskis last year, at the Financing for Development Conference in Monterrey, and again at the World Summit for Sustainable Development in Johannesburg. It was promised, not just by health ministers, but by finance ministers, foreign ministers, prime ministers, and presidents. They were admirable sentiments to which governments must now give real commitment and substance and honor the Millennium Development Goals set by world leaders at the Millennium Summit.