Session Sketch

Addressing Global Health Challenges in an Aging World

Session Two

Introduction

As ageing populations increase and developing countries improve their infrastructure and systems, non-communicable diseases (NCDs) have overtaken infectious diseases as the biggest threat to human health. Because these are not spread through cross-border travel, the challenge is how to construct a global health governance to address them. This issue might be ripe for a trade remedy, such as standardizing and spreading regulations and restrictions on sugary beverages as we have on tobacco. As NCDs rise, the problem of access to affordable medicines is once again becoming a hot issue, as it was immediately after TRIPS was passed and the AIDS crisis resulted in concessions from pharmaceutical companies. However, forcing commercial concessions will be much more difficult because pharmaceutical companies earn the majority of their profits from medicines treating NCDs, not vaccines. Of note is the fact that climate change is poised to bring back many infectious diseases presumed to be eradicated and countries are not prepared for this. There must be some kind of governance structure put into place. Finally, tied to the issue of pharmaceutical costs is the issue of clientelism plaguing healthcare systems throughout the world. The formation of many healthcare systems is fundamentally political in nature, done to appease or at the behest of various interest groups. This must be addressed to provide affordable healthcare to all.

Opening Comments:

Health issues have entered most of the security strategy documents of our countries, and this explains why we as think tankers engaged in foreign security policy discuss global health today. We all are aware in a very general way about the global health challenges. Half of the world's population does not sufficient access to essential medicines and healthcare. For those who can make medical care available, it's often in a way that drives them into poverty because they can't really afford it. As far as the international environment is concerned, there are wider gaps in health financing due to positions taken by the US, the UK and Europe, but we don't yet know the impact of new actors like China on the situation. Of course we always have these general global governance questions of how to coordinate the response when there are emergency situations. Lastly, we also have the effects of climate change and pollution in megacities, the effects of urbanization. So, it makes sense today to talk about global health issues and we should look beyond our nation states when we want to address these issues. In this session we would like to focus more on structural rather than technical issues. I'd like to ask the speakers what they think is the most

demanding issue and maybe also provide one or two policy recommendations. We will begin with the challenge of non-communicable diseases (NCDs).

Presentations

1) Presentation 1

What use is global health governance if it is ineffective in addressing the diseases and health risks that cause the overwhelming majority of death and disability worldwide?

Heart disease, cancers, diabetes, and other non-communicable diseases (NCDs) were responsible for more than two-thirds of all deaths and disability globally in 2016. Despite the high burden of chronic diseases and their surging rates in poorer nations, only 2 percent of global health aid targets NCDs or their associated risk factors, such as tobacco use and obesity. Global institutions have struggled to find an appropriate balance between preserving health and promoting the commercial interests of industries associated with NCDs, such as tobacco, food and beverage, and pharmaceutical. At the same time, the quest at the international level to build quality, affordable and accessible health systems in countries has been ongoing for forty years. It is unclear whether the current movement for universal health care (UHC), the latest incarnation of these efforts, will have greater success.

The Rising Challenge of Non-communicable Diseases[1]

Most countries in the world face the same three challenges: an aging population; a high occurrence of cancers, diabetes, and other NCDs; and an increasing prevalence of risk factors for NCDs, such as unhealthy diets. However, NCDs and their associated risks are now increasing much faster in low- and lower-middle-income countries, in much younger populations, and in settings with limited health systems and regulatory oversight.

In 1990, non-communicable diseases caused about 25 percent of deaths and disabilities in low- and lower-middle-income nations. By 2040, that number is expected to jump to as high as 80 percent in some of those countries (see figure 1). At that point, the burden of NCDs in Bangladesh, Ethiopia, and Myanmar will be about the same as it will be in rich nations such as the United Kingdom and the United States. The difference is that the shift from infectious diseases to NCDs took roughly three to four times as long in those wealthy countries.

[1] Thomas J. Bollyky, Plagues and the Paradox of Progress: Why the World Is Getting Healthier in Worrisome Ways (Cambridge, MA: MIT Press, 2018).

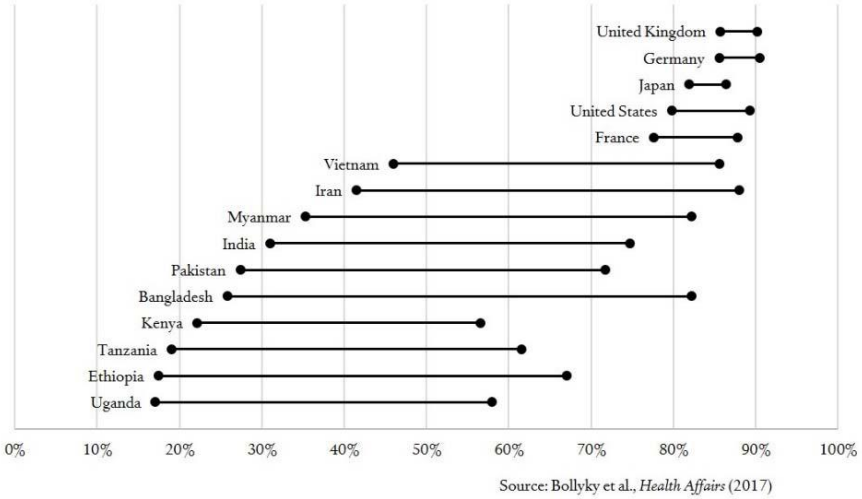

Figure 1. Expected Share of a Country's Health Burden from NCDs, 1990–2004[2]

Much of this dramatic increase in NCDs in poorer nations will be experienced prematurely, by working age people under the age of sixty (see figure 2). Although the rates of death and disability from NCDs are decreasing in every region of the world, those improvements are quite modest in low- and lower middle- income countries and are more than offset by large demographic changes (population aging and growth), increasing the size of the adult population in those nations.

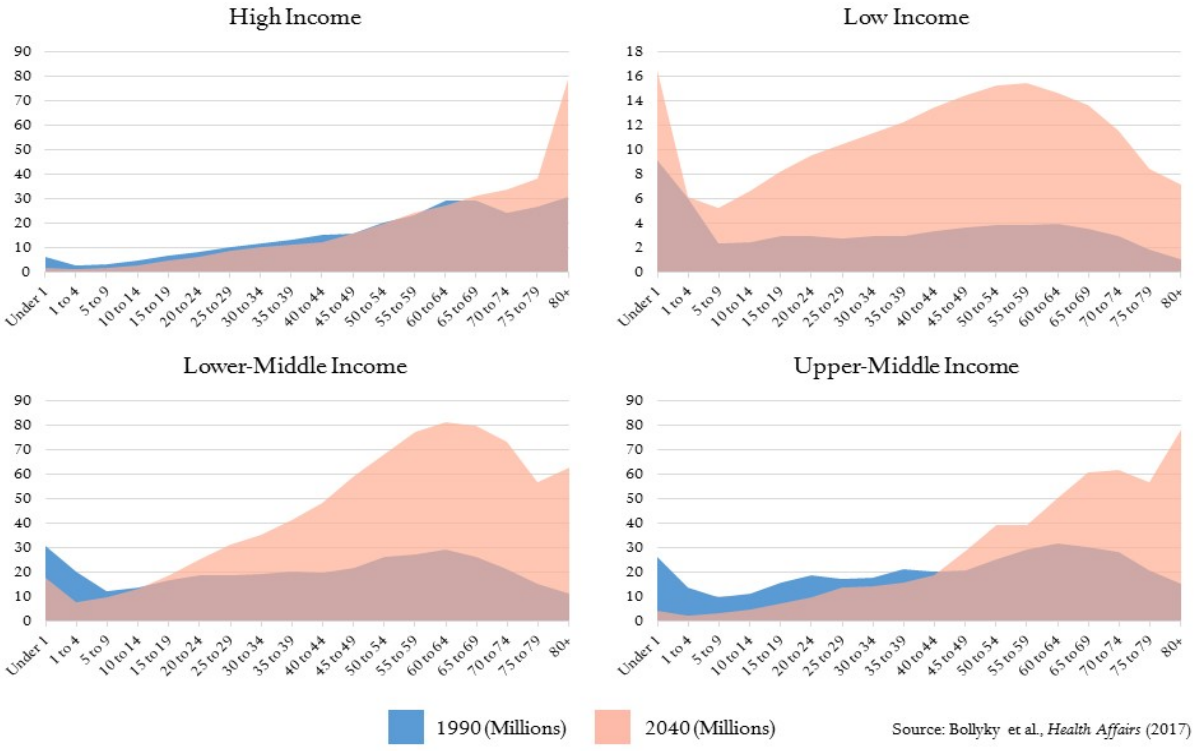

Figure 2. Expected Change in Disability-Adjusted Life Years from NCDs, by Age Group, 1990– 2004

[2] Thomas Bollyky et al., "Lower-Income Countries That Face the Most Rapid Shift in Non-communicable Disease Burden Are Also the Least Prepared," Health Affairs 36, no. 1 (November 2017), http://doi.org/10.1377/hlthaff.2017.0708.

In Bangladesh, for instance, the median age increased from nineteen to twenty-six between 1990 and 2015. Over the same time, its population grew by nearly 50 percent. That means Bangladesh has thirty eight million more adults between the ages of twenty-five and sixty-four than it did twenty-five years ago. This dramatic demographic change is accelerating the shift from the infectious, neonatal, and nutritional diseases that disproportionately affect children to the non-communicable diseases that mostly afflict adults.

The shift to NCDs effectively requires low- and middle-income nations to restructure their health systems, which are currently designed for episodic care. By contrast, non-communicable diseases are largely chronic, require more health-care infrastructure and trained health workers than most infectious diseases, and are costlier to treat.

Health spending is rising in poorer countries, but relative to wealthy nations, it remains low. The government of an average low-income country spends $24 per capita on health care and the average lower-middle-income nation spends $85 per capita.[3] All forty-eight governments in sub-Saharan Africa collectively spent less on health in 2014 ($67 billion) than the government of Australia alone ($68 billion).

The situation may worsen as the consumption of tobacco products, alcohol, and processed food and beverages rises in poorer nations. Many of these countries do not yet have the consumer protections and public health regulations to cope with these changes, especially in small consumer markets. These governments may have limited leverage to demand changes in the labeling and ingredients of products produced for global consumption. Large multinational food and beverage and tobacco corporations often have more resources than the governments that oversee them.

In 2015 alone, everyday diseases—cancers, heart diseases, diabetes, and other NCDs—killed eight million people before their sixtieth birthday in low- and middle-income countries. The World Economic Forum projects that NCDs will inflict $21.3 trillion in losses in developing countries between 2011 and 2030—a cost that is almost equal to the total aggregate economic output of these countries in 2015 ($26 trillion in constant 2010 U.S. dollars).

The Limits (to Date) of Global Health Governance on NCDs

David Fidler defines international governance in health as the "use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively."[4] In the nineteenth century, states began to recognize their interdependence in health in a few areas: outbreaks of infectious diseases, transnational pollution, and trade in potentially health-harming products such as alcohol and opium.[5] With the dramatic increase in trade and travel between nations, that notion of interdependence in health has expanded.

A collective response is required to address NCDs effectively in two ways. First, nations depend on one another to oversee air pollution and the global production, supply, and retailing models for many consumer goods, including tobacco, alcohol, sugar-sweetened beverages, and processed foods. Discordance among countries increases the risk of adulterated and substandard products and illicit trade. Neighboring countries often bear the consequences of unenforced or inadequate clean air standards. Small nations are more likely to have the courage

[3] Institute for Health Metrics and Evaluation (IHME), Financing Global Health Visualization (Seattle: IHME, University of Washington, 2017), http://ihmeuw.org/4l4j.

[4] David P. Fidler, The Challenges of Global Health Governance (New York: Council on Foreign Relations, 2010).

[5] David P. Fidler, "The Globalization of Public Health: The First 100 Years of International Health Diplomacy," Bulletin of the World Health Organization 79, no. 9 (2001): 842–49.

and capacity to regulate when acting in concert with other countries.

Second, collective action is needed to scale up affordable access to essential medicines, to research and develop new diagnostics and treatments appropriate for use in low-resource settings, and to enable pro-poor integrated care models.

Lack of adequate donor and member state support has limited those international institutions with an explicit health mandate from taking these collective responses to NCDs. Over the last fifteen years, the World Health Organization (WHO) has concluded an international treaty on tobacco control, produced numerous strategy papers on NCD prevention and treatment, and launched a department dedicated to addressing NCDs on a global level. The United Nations has convened three high-level General Assembly meetings on NCDs and included a target among its Sustainable Development Goals to reduce premature mortality from NCDs by one-third in 2030. Despite these efforts, NCDs today represent roughly the same share of development assistance (1 to 2 percent) that they did in 2004.[6] Even with the success of the WHO's Framework Convention on Tobacco Control, advocates have been unable to gain much traction for using treaties or other soft law tools to address alcohol or promoting access to medicines. Outcry over the involvement of alcohol and food and beverage companies roiled the Global Fund to Fight AIDS, Tuberculosis, and Malaria (and the Pan American Health Organization several years earlier).

The institutions without explicit health mandates but that have a direct and indirect effect on NCDs and their risk factors—such as the World Trade Organization (WTO), the World Intellectual Property Organization, and the International Labor Organization—have struggled. The WTO has been pulled into several disputes involving oversight of tobacco. Access to medicines is a perennial sore spot for trade and investment-related bodies and liberalization.

Recommendations

WHO and others are largely banking on NCDs being addressed as part of the overall push for quality universal health-care coverage. The arguments for UHC are unassailable, but it remains to be seen whether collective efforts can successfully encourage national governments to make the hard political economic choices needed for such systems to emerge.

In the interim, certain measures can improve the global governance response to NCDs. First, opening pooled procurement platforms for essential medicines and medicine patent pools to NCDs, even on an unsubsidized basis, would help governments to respond to the needs of the poor. Second, one of the best ways to assist poorer nations is to stop obstructing them from undertaking the same regulatory measures that wealthy nations have implemented to confront tobacco use or rising obesity. Third, promoting international regulatory cooperation on NCD-related matters would advance commerce and health alike.

2) Presentation 2

Brazil's system of health care is currently facing a major crisis. While Brazilians have long been concerned with stagnating or worsening health-care indicators, problems with the country's health-care system have been evident. During the 2016 Olympics in Rio de Janeiro, the Zika epidemic threatened the viability of one of the world's major

[6] IHME, Financing Global Health Visualization. Panelist

sporting events, with at least three athletes canceling their appearances because of health concerns.

Why is it that Brazil's health-care system appears fragile and unable to cope with major challenges, despite investments of hundreds of billions of dollars in taxpayers' money over the last decade?

Health Care in Brazil

Health care has been a long-standing public policy challenge in Brazil. The current health-care system evolved over a long period and reached its current form with the promulgation of the 1988 constitution. The first organized health-care initiatives in the country came about in the early twentieth century, when the Getulio Vargas government organized the first health-care plans for the emerging national civil service bureaucracy and for some vital private careers in the urban formal economy. Although this system represented a first step toward organized health care, it left the vast majority of poor Brazilians in the informal economy with no coverage.

As the country modernized and underwent a period of urbanization, health-care coverage improved but not enough to keep up with the growing economy. Estimates of infant mortality in Brazil in 1960 were as high as 115 per one thousand births. Although gross domestic product (GDP) rose at an annual rate of 4.8 percent between 1960 and 1980, infant mortality only fell at an annual rate of 2.5 percent during the same period.

Significant efforts to broaden coverage and turn health care into a universal public policy issue came about with democratization in 1985 and the constitution of 1988. Anticipating how the creation of universal voting rights for the first time in Brazilian history would require the state to take a more active role in the provision of social services, the framers of Brazil's democratic constitution created the Unified Health-Care System (SUS). Modeled after the British National Health Service, the SUS offers universal and free health care to any Brazilian residents at the point of delivery.

Crucially, the SUS is not funded from employee pay deductions like previous initiatives but from general taxation. This, for the first time, eliminated any access discrepancies between employees in the formal and informal sectors, providing the latter with public health care for the first time.[7]

The Political Economy of the SUS

While the SUS looks like a progressive initiative designed to provide health care as a public good available to all, politics often gets in the way, which fundamentally undermines the quality of health care.

The main challenges are clientelism and interest-group dominance, and each one needs to be tackled one at a time. As a critical component of Brazil's fragile welfare state, the SUS is often used as a tool for politicians to provide clients with privileged access to state resources in exchange for political support[8]

Control over scarce health-care services allows these patron-client relationships to thrive. Because of the way SUS hospitals are managed, local political leaders have significant discretion to manipulate patient lists and priorities. As a result, they often use their influence to reward those that support them and punish voters who do

[7] James W. McGuire, Wealth, Health, and Democracy in East Asia and Latin America (Cambridge: Cambridge University Press, 2010).

[8] Alberto Diaz-Cayeros and Beatriz Magaloni, "Aiding Latin America's Poor," Journal of Democracy 20, no 4 (October 2009): 36–49, http://doi.org/10.1353/jod.0.0115.

not.[9] This not only serves as a mechanism of perverse accountability, whereby politicians punish voters for their decisions, but also creates an incentive for strategic scarcity in health care.[10]

A second political issue with the SUS is that it is vulnerable to the whims of private interest groups that have influence in Brasilia. Because the system's budget is often one of the largest federal accounts, private actors have an incentive to seek opportunities to sell goods and services to the health ministry. The structure of the political system also allows politicians in the legislature to award lucrative contracts in exchange for campaign contributions and personal gifts.[11]

These two political economic mechanisms undermine the effectiveness of the SUS, creating an understaffed bureaucracy in which funds are allocated based on party-political priorities at the expense of effective governance.

Potential Solutions

Brazil's health-care issues are mainly political, so the response also needs to be political. The lack of bureaucratic capacity within the system for effective health-care policy planning needs to be addressed. Because hiring and promotion decisions are often politically motivated at the higher levels, the system suffers from a chronic capacity issue. Institutions outside the system therefore need to work to improve the local management capacity and best practices.

Structural reforms should first and foremost change the way the SUS is connected with the political system. Current laws give politicians significant discretion to intervene in the management of SUS hospitals by nominating its management bodies and controlling budgets and salaries. Legal reforms should focus on eliminating these discretionary powers while creating market-like incentives for public hospitals to compete with one another to provide better quality health care.

Brazilian decision-makers also need to consider restructuring the way the public health-care system connects with the private sector. The SUS should work to implement rigorous anticorruption and anti-bribery regulations, and to better audit contracts with private firms. There should be tough regulations eliminating campaign contributions for persons connected with firms holding large contracts with the SUS. Such measures would begin to reshape the relationship between politicians and the SUS and, hopefully, improve the quality of health-care provision.

3) Presentation 3

The greatest impetus for commitment to global health is the concept of human security.[12] Human security is an emerging paradigm for understanding global vulnerabilities, based on the assumption that the suitable beneficiary of security should be the individual rather than the state. According to the United Nations' 1994 Human Development Report, health security is one of the seven areas that define human security. Health security is the

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[9] Eduardo Mello, "Explaining Success and Failure of Rules-Based Distributive Policies" (unpublished PhD diss., London School of Economics and Political Science, 2017).

[10] Susan C. Stokes, "Perverse Accountability: A Formal Model of Machine Politics with Evidence from Argentina," American Political Science Review 99, no. 3 (2005): 315–325, http://doi.org/10.1017/S0003055405051683.

[11] Eduardo Mello and Matias Spektor, "Brazil: The Costs of Multiparty Presidentialism," Journal of Democracy 29, no. 2 (April 2018): 113–127, http://doi.org/10.1353/jod.2018.0031.

[12] UN General Assembly, "Follow-Up to Paragraph 143 on Human Security of the 2005 World Summit Outcome" (A/RES/66/290), October 25, 2012, http://dag.un.org/handle/11176/298492.

assurance of a minimum protection for an individual from disease and unhealthy lifestyle. Global health recognizes that beyond nation-to-nation relations, the individual must be protected.

The world's poor no longer live in low-income countries (LICs). Today, up to a billion of the world's poorest people—70 percent of the total—live in middle-income countries (MICs), most of them in stable, nonfragile countries.[13] This new distribution of poverty is detailed in monetary, nutritional, and other multidimensional poverty measurements. In 2008, an estimated 75 percent of the world's approximately 1.3 billion poor lived in MICs. About 25 percent—about 370 million people—lived in thirty-nine LICs, principally in sub-Saharan Africa. Politically fragile LICs account for just 12 percent of the world's poor. Poverty, not countries, thus explains a large proportion of disease burden.

According to the sociodemographic index (SDI), middle and high-middle SDI countries account for more than 33 percent of the disability-adjusted life years worldwide.[14] These facts argue in favor of a more individual-centered definition of global health. Even though poor nations deserve most of the assistance, given their lack of capacity to face certain global health challenges, the wide distribution of global poverty and health burdens raises question of the current management of aid. Ignoring diseases concentrated in middle and high-middle SDI countries would effectively disengage major forms of official aid from the bulk of global health problems.[15]

Therefore, foreign aid should be planned on a country basis, to include middle-income countries and to consider the real distribution of vulnerable populations and disease burden.

Governance in the health field transcends the country-based international order, requiring institutional arrangements involving state and non-state actors committed to set goals.[16] The first global health challenge is today's global governance crisis. Governments and multilateral institutions should promote equality and social development through universal health care, which is a long-lasting way to promote human security and dignity. Data openness is another prerequisite for good global health governance. In collecting data and making it transparent, governments could use health-related data to measure the effect of specific health policies. Data transparency would greatly help policymakers accurately target specific health insecurities.

Health-related data should be open to both public and international scrutiny. An international standard for death certificates and population's specific mortality database is also recommended, as is including periodic accountable health indicators in other transnational interactions that affect potential health security.

Social dumping—when companies use cheaper labor—enables companies or governments to be more competitive at the expense of social standards and welfare.[17] In light of evidence linking economic policy measures

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[13] Andy Sumner, "Global Poverty and the New Bottom Billion: What if Three-Quarters of the World's Poor Live in Middle-Income Countries?," Institute of Development Studies, November 24, 2010, http://doi.org/10.1111/j.2040-0209.2010.00349_2.x.

[14] Institute for Health Metrics and Evaluation, University of Washington, Health Data Exchange, "GBD Results Tool," 2018, http://ghdx.healthdata.org/gbd-results-tool.

[15] Ravi Kanbur and Andy Sumner, "Poor Countries or Poor People? Development Assistance and the New Geography of Global Poverty," VOX: CEPR Policy Portal, November 8, 2011, http://voxeu.org/article/poor - countries-or-poor-people-new-geography-global-poverty.

[16] Kelley Lee and Adam Kamradt-Scott, "The Multiple Meanings of Global Health Governance: A Call for Conceptual Clarity," BMC Globalization and Health 10, no. 28 (April 28, 2014), https://doi.org/10.1186/1744-8603-10-28.

[17] Guillermo de la Dehesa, "Are Developing Countries Engaging in 'Social Dumping'?," VOX: CEPR Policy Portal, May 24, 2007, http://voxeu.org/article/social-dumping-misconceptions.

and the health outcomes of populations, it is important to understand the biological costs of modifying social standards. Countries and societies should embrace the goal of improving wages and working conditions of workers without embracing protectionism.

Countries and international institutions should include a human health security clause in international interventions or negotiations to protect health data, individuals, and health-care workers and facilities.

Some international interventions, such as programs by the International Monetary Fund (IMF), have proved to have adverse effects on the health of the residents in target countries. Other trends, such as innovation and trade, have also been proved a source of distress.

Bretton Woods institutions, especially the IMF, should cooperate with international programs designed to promote global health and collect data to detect aspects of health security that could be affected either positively or negatively by IMF programs.

The developing world is in the midst of a protracted epidemiological transition that involves a dual burden of, on the one hand, non-communicable diseases (NCDs) typically associated with wealthier nations and, on the other, infectious diseases.[18] Communicable, maternal, neonatal, and nutritional diseases accounted for 20 percent of global deaths in 2015. NCDs, such as cardiovascular and chronic respiratory diseases and cancer, accounted for 71.3 percent.[19] Old age and longevity rank first among the new trends influencing human health, followed by urbanization, trade, and pollution. Unfortunately, not all global health systems recognize that NCDs kill more people than communicable diseases.[20]

Even though NCDs account for a larger percentage of deaths, infectious diseases that create epidemics such as Ebola and influenza continue to constantly remind the world of global health challenges. The AIDS epidemics revealed the weaknesses in modern global health mechanisms and organizations. Health challenges can start out local but have global implications.[21] Enormous changes in global demographics such as aging, as well as new political, geoeconomic, and health dynamics, have changed the landscape. These dynamics generate questions and demonstrate the lack of a coherent global health strategy. Who is expected to be in charge of facing global health challenges? What priorities are important and who defines them? What human ethical and moral values should be taken into consideration when discussing global health issues? Achieving sustainable, just, and fiscally rational approaches to global health crises will require global leadership and innovative thinking.[22] Four major types of

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[18] Ala Alwan et al., "Universal Health Coverage and Intersectoral Action for Health: Key Messages from Disease Control Priorities, 3rd Edition," Lancet 391, no. 10125 (November 24, 2017): 1108–1120, http://doi.org/10.1016/S0140-6736(17)32906-9.

[19] GBD 2015 Mortality and Causes of Death Collaborators. "Global, Regional, and National Life Expectancy, All-Cause Mortality, and Cause-Specific Mortality for 249 Causes of Death, 1980–2015: A Systematic Analysis for the Global Burden of Disease Study 2015," Lancet 388, no. 10053 (October 8, 2016): 1459–1544, http://doi.org/10.1016/S0140-6736(16)31012-1.

[20] Mitch Daniels, Tom Bollyky, and Tom Donilon, "A New Direction for Global Health," Project Syndicate, December 15, 2014, http://project-syndicate.org/commentary/developing-countries-noncommunicable-disease-increase-by-mitch-daniels-et-al-2014-12.

[21] Laurie Garrett, "The Challenge of Global Health," Foreign Affairs, January/February 2007, https://www.foreignaffairs.com/articles/2007-01-01/challenge-global-health.

[22] Paul Farmer and Laurie Garrett, "From 'Marvelous Momentum' to Health Care for All: Success Is Possible with the Right Programs," Foreign Affairs, March/April 2007, http://foreignaffairs.com/articles/2007-03-01/marvelous-momentum-health-care-all-success-possible-right-programs.

responses to these challenges have been developed: global health-related governance institutions, such as the World Health Organization (WHO) and the World Bank; foreign aid; international treatises; and the third Sustainable Development Goal of universal health coverage.

Since the first International Sanitary Conference in Paris in 1851 that helped regulate quarantine measures across countries, many international treaties have addressed global health issues. Although the effect of these treaties on global health has yet to be scientifically studied, they are still a valuable tool.[23] Countries should evaluate the effects of such treaties on the health of their populations.

Other international treaties could also have a robust effect on population health. When scientists conducted a comprehensive systematic review of the health effects of trade and investment agreements, for example, they found evidence that trade agreements pose significant health risks.[24] To mitigate these effects, health protections should be explicitly included in treaty language.

One of the major advances in global health is the World Bank's Universal Health Coverage initiative and its Disease Control Priorities in Developing Countries (DCP) project. DCP assesses cost-effectiveness of health interventions to help address major sources of disease burden in developing countries.[25] Its goal is to identify satisfactory responses to disease burdens while considering the resiliency of existing health systems in developing countries. It is grounded on moral principles, legal arguments, conviviality needs, and economics.[26] DCP should be used as a model to improve for global health given that it has identified evidence-based, cost-effective, and meaningful health interventions, which should be integral to all health systems that aim for universal health coverage.

It will be difficult to make global health improvements without a clear, measurable, universal target, however. Appropriate investment in a universal health coverage program, for example, could yield a 40 percent reduction in premature deaths by 2030 that could save near eight million lives, mainly in developing countries. All nations should acquire universal health coverage by that year.[27]

Extreme poverty is the most significant challenge to improving health in developing countries, but the development of management systems and human resources is also important. Political commitment toward universal health is the beginning of any process to improving global health.[28] The role of private financing for universal health coverage strategy is still unclear. The role of public financing is more convoluted: experts debate whether universal health care should cover the entire population or only the lowest socioeconomic classes. The economic growth rate alone not will be enough to finance universal health coverage.

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[23] Steven J. Hoffman, John-Arne Røttingen, and Julio Frenk, "Assessing Proposals for New Global Health Treaties: An Analytic Framework," American Journal of Public Health 105, no. 8 (2015): 1523–1530, http://doi.org/10.2105/AJPH.2015.302726.

[24] Pepita Barlow, Martin McKee, Sanjay Basu, and David Stuckler, "The Health Impact of Trade and Investment Agreements: A Quantitative Systematic Review and Network Co-citation Analysis," Globalization and Health, March 8, 2017, http://doi.org/10.1186/s12992-017-0240-x.

[25] Alwan et al., "Universal Health Coverage."

[26] David E. Bloom, Alexander Khoury, and Ramnath Subbaraman, "The Promise and Peril of Universal Health Care," Science 361, no. 6404 (August 24, 2018), eaat9644, https://doi.org/10.1126/science.aat9644.

[27] Dean T. Jamison, Lawrence H. Summers, et al., "Global Health 2035: A World Converging within a Generation," Lancet 382, no. 9908 (December 7, 2013): 1898–1955, http://dx.doi.org/10.1016/S0140-6736(13) 62105-4.

[28] John R. Evans, Karen Lashman Hall, and Jeremy Warford, "Health Care in the Developing World: Problems of Scarcity and Choice (Shattuck Lecture)," New England Journal of Medicine 305, no. 19 (November 5, 1981): 1117–1127, http://dx.doi.org/10.1056/NEJM198111053051904.

Research and management innovation should focus on creating an affordable health-care initiative, designing low-cost, rapid access health-care tools for individuals and governments. This could be achieved by innovative management of patents and licenses. A cost-constrained benefit package for universal health coverage that emphasizes affordable medicines and technologies for disadvantaged people regardless of where they live is essential. This would create an opportunity for the private sector to innovate in health management tools, more affordable platforms of health delivery, and new medical technology to make the global health coverage a reality. A related transnational flow of companies with innovative and cost-containing solutions should be stimulated.

Given changing demographic trends, proper and affordable health technology needs to be a priority. In the current environment, new drugs are expensive and sometimes not affordable. New products are the result of considerable investment, but in many cases, the cost to the consumer is exponentially greater than that to the company. Pharmaceutical companies clearly need a comfortable profit margin if they are to develop new medicines, but they often provide either incomplete or false information and incur costly marketing activities. This underlying business framework affects global health—given the large sums spent on lobbying political actors—has slowed the progress toward making new products affordable.

An initiative should be established—under the leadership of international global health agencies, countries, and aid and development agencies—to save lives through access to innovative medicines. This initiative would create value through innovative health-care access for all, affordable for governments. A multilateral board would be appointed to define research priorities such as diseases that could benefit from funding to develop new medicines, clear-cut indicators of success, a transparent acquisition plan, and a framework for creating value from medicines in health care.

Both corporations and human activity more generally have a significant influence on global health. Selective taxation has been efficient in reducing exposure to specific risk factors. Independent national taxation on imports should be encouraged rather than encompassed in protectionist practices.

Most preventable behavioral and environmental risk factors for health require international cooperation. Mitigation of these factors requires intersectoral policies implemented through international trade agreements or tied to heavy investment open to financial and nonfinancial foreign aid. Countries should include the third edition of the DCP project in all kind of international agreements related to human development or growth.

Q&A Session

Comment 1

I want to make some points with regards to Russia in connection with several emphases you made, especially about silent health challenges and the level of responsibilities of local governments in health.

First of all, as Russia plays a certain role in global health governance, the prospects of its activity has some importance. I want to make a point on two different areas. The first is the role of Russia in global governance. In Russia, there is state capitalism with great authority from the Kremlin and so on, and the private businesses, especially the pharmaceutical sectors, have much less role. The main interest in this issue was stimulated by Russia's participation in G8 and G20. Russia played a prominent role in the 2000s before and during its chairmanship of the G8 in 2014. After that the interest was almost zero. There is some interest in the G20, but the interest of the Kremlin is almost zero.

This has a great impact on public-private partnerships, because the Kremlin does not stimulate the role of private money for health programs, pharmaceutical businesses and so on. My point is that in this situation and now that Russia is out of the G8, there should be some channels for increasing the interest of the Kremlin in this area, particularly in the G20, and also the voice of the UN. The UN channel should be activated in increasing the interest of the government of Russia to stimulate their financial and political resources in global health governance and nationally.

Second, use the consequences of the sanctions. It seems the sanctions will be in place for the foreseeable future. The problem is that everybody (West and East), they focus on the consequences of sanctions on technology, financial systems, energy, and other problems for Russia. But there is almost no attention of the consequences of sanctions on the health situation in Russia, and the interest of the Kremlin in this area. The sanctions play an important role in so-called commercial interests, because now the argument is that it will stimulate local production. Actually Russia has a huge scale production of fake pharmaceuticals, and this is a national problem. You cannot find this data anywhere in Russia; almost nobody pays attention to this. So now people in Russia who leave the country buy two things abroad--hard cheese and medicine. People do not trust Russian medicine, or even German medicines bought in Russia because they could be fake. This problem should be addressed in different channels, international channels, and global governance. If sanctions continue forever, the counter sanctions of Russian authorities, particularly in the pharmaceutical sector, are a problem to the health security and national security of Russia.

Comment 2

I have several questions which are more related to the global governance aspect of this challenge. First, how can we frame it as a global governance challenge? When you think about infectious diseases and biosecurity, it gets a lot easier for traditional foreign policy and national security people to think of it as a global governance issue. You think of the WHO and its binding health resolutions that are obligatory for UN member states. However this seems to be more of a case of coordinating national approaches to NCDs for instance. So I want to think about if there are some aspects of the global governance aspect that we can make some recommendations on.

The first is about the Framework Convention on Tobacco. That's tougher to do when it comes to sugary soft drinks, etc. This sort of sinful aspect that humans are gluttonous, they like to indulge in alcohol and sweets and do things that are bad for them. So one question would be are there any lessons from the FCT and is there any low-hanging fruit?

The second would be access to medicines, particularly trade rules governing access to medicines, but also are there incentive structures that need to be created to come up with the type of medicines that we need. Maybe it's actually easier to tackle than the issue of infectious diseases. One problem there is that there are a lot of relatively obscure infectious diseases that don't bother people in the developed world, so you had to create the global alliance for vaccines and immunizations. Is the issue when it comes to NCDs, are those questions of not having the incentives? We need to have advance commitment for vaccines, for example. Could we promise a market in advance if treatments for NCDs are developed?

Related to development policy, health and development policy, one of the problems with global health assistance in general has been the focus on disease-specific interventions rather than coming up with foreign assistance and pressing countries that are vulnerable to come up with overall global health systems strengthening. At the multilateral level, do you see a role for the multilateral development banks, or the OECD DAC, the big

consortium of donors, to come up to a statement of principles to focus on health systems strengthening? We also need to make sure that the aid we're giving are not crowding out domestic finance mobilization, because some countries aren't living up to their capacity in terms of what they could be spending.

With respect to the WHO, are there any ramifications to the way it should be structured, or how can we shift its focus? Or do we need to? Has it totally embraced this NCD agenda or is there something else it should be doing?

Comment 3

It's clear that there's a need for a strategy, and you've mapped out where the pain lies, but I am less sure about your policy prescriptions. I wonder whether going the trade, international agreement route, is too starry-eyed or the wrong way around it. Given the complete breakdown of the multilateral trade system, increased fragmentation and bilateral attitudes of states, how certain can we be that there would be mainstreaming of those clauses in those trade agreements? Apart from the WHO, and beyond trade and regulation efforts, I wonder if you'd find any good examples there at the regional level, whether there might be any other ways of addressing global health issues, the low-hanging fruit. What would you prioritize if not trade and regulation?

Presenter

Global governance around global health really only started in the mid-19th century. This happened because through most history, the only way to deal with cholera on trade ships was purely a domestic affair. What really launched this issue of global governance was that countries were taking measures like quarantine in an uncoordinated manner, and this was not only ineffective at curing disease, it also had commercial consequences. So the first set of agreements on global health were primarily about the intersection of trade and health and the response to outbreaks, but a lot was also related to tobacco, alcohol, pollution, and opium. With global health governance, you want to limit the health harm caused but not create undue commercial burden. We are in the same place with many NCD issues.

So, access to medicines is a much worse problem with NCDs than infectious diseases. Access to medicines really blew up after the conclusion of TRIPS in the WTO, but it was really about HIV. For the first time you had a disease that existed in both high and low-income countries, and you had on-patent medications. For the most part, health needs of low income and high income countries were different. Health needs in high income countries were focused on NCDs, and low income countries had problems with infectious diseases. HIV was this rare thing, where it was exploded into the consciousness of rich countries but was causing most of its harm in Sub-Saharan Africa. So you had on-patent drugs, you had this treatment access crisis, and you had a lawsuit against pharma companies from Brazil and South Africa. It was resolved by cutting deals between pharmaceutical companies and countries, because generally they don't make much money on infectious disease treatments anyway.

The shift in health needs in low and middle income countries to NCDs means that now they need access to the drugs where pharma really makes their money; cancer, heart disease, diabetes. India, Brazil, Colombia, and other middle income countries are the markets of the future for pharma companies. The consensus about giving good deals to poor people breaks down when you're talking about NCDs. So that is an enormous challenge in the future.

In general, the tension between health and trade on these issues is the fact that you have existing trade rules that may or may not limit the ability of one to put packaging labeling. What kind of labels can you put on your food? What kind of labels can you put on tobacco? Is it a TBT issue, or an IP issue? Resolving these issues remains a great problem. The positive role for trade is pretty similar as it is for environmental issues, where really, it comes

down to cooperation. We need consistent approaches to facilitate both health and trade. If you think about the environmental goods agreement, when it was primarily about having preferential treatment on environmentally friendly goods, you can imagine something similar on health.

In addition to having a different approach to trying to build health systems, this is about trying to facilitate accountability of national governments for addressing these needs, promoting evidence based approaches and monitoring adoption. One idea put forth by the World Bank was to measure human capital and punish countries financially for not investing in health systems or educational equality. This is about looking for levers to improve accountability.

The last issue for wealthier nations is that there are a set of problems in global governance that are less around cross-border outbreaks and are more about what to do when the drivers of a problem are international but the remedies are domestic. There's an argument that it's a sovereign obligation, it's what governments are responsible for, and I do think whether it's on access to medicines or bullying governments on adoption of health regulations, it may be a remedy.

Presenter

First of all, the coalition between the infectious diseases and NCDs. There is a problem of cost effectiveness, and I will tell you a story about diabetes. 50% of patients in poor countries with diabetes have treatment. Pharmaceutical companies have created medicines for diabetes, but none have them been superior to the previous ones which cost 100 times less. But doctors fly all around the world and pressure governments to use new medicines rather than those that are less expensive and equally effective to the old ones for treating diabetes. It is interesting to listen to the hearings of the US Senate Commission that was studying fraud in information given by companies about medicines. You would be surprised at the frankness with which they speak. If you don't take seriously changing the incentives of the business model for developing medical technology, many are going to die because of simple diseases. Now we know that aspirin is almost useless in healthy people over 65 years old. But we still see ads telling people to take an aspirin a day. That produces death.

The change we could foresee for the World Health Organization is to try to adapt its strategies that many important institutions are fostering in the world, perhaps the Bill and Melinda Gates Foundation. He may be the most enlightened man in the world right now on how to advance a policy for health. Clearly these are political issues. No single law or international agreement will be able to solve the problem that is in terms of human lives and premature death devastating. The promise for the future is that they will get worse.

When you study a country, you see an aggregate of a whole country. It's composed of very successful people and suffering people. 70% of poverty is in middle income countries, but it is hidden. The same is happening with health. It is not true that you have to think about chronic disease as a new separate entity. As soon as the 8th century, people who died of the same things were able to survive and the main thing behind this was nutrition. We have to think about cost-effective treatments. How can we translate cost-effective treatments to international policy?

I have been in a room like this with 28 most powerful health ministries in the world. They all complain they can't afford medicines for cancer. Only 16% of the medicines discovered for cancer in the last 10 years are effective, so we are wasting money, many times because the WTO says that you have to protect that, or you have to go with that, and that is absolutely useless.

Presenter

Health care is a public policy, and like all public policies it is plagued by interest groups. The interest groups in bigger countries have a lot of power in shaping the rules and they can use international regulations to force smaller countries that may be unnecessary and waste money. They design rules that may be flawed and inefficient and we all pay for it. That's a problem of power.

On the other hand, in developing countries, there are interest groups too, and they sometimes design things in a way that is not efficient. One of the things foreign aid can do is to be this exogenous force that can break the grasp of interest groups over local health policy. I'm talking about conditionality Smart conditionality in health might help, but not if they are designed to copy US regulations. They must think why the healthcare system is here not so well designed, what can improve the design, which groups are forcing this government to adopt this substandard design? What can we do to undermine the hold of these groups over policy making? That's one agenda we should be talking about.

Comment 4

The statement that we all have aging populations is absolutely true for many developed countries, and for China or Russia, but it's absolutely not true for Africa. When we are thinking about all these issues, we should include the demographic situation in Africa. For example, Niger has 20 million inhabitants right now and will have approximately 60 million people in 2050. We should try to balance our thinking.

My question is related to the pressure of engaging big business in terms of governance. It seems that there is an interesting parallel that can be made. In the collaboration of all the debates and negotiations for the Paris Agreement on climate change, one question was should we to address the companies in the energy sector. Maybe we can raise a similar question about the health companies. Can you go further into detail to map the issue and see what the core industries that can be used for global governance are?

Comment 5

My first point is on the linkage between or advocacy of the global governance architecture today to deliver the competing needs of health care in different parts of the world. In many parts of the world, the challenge today is at the early stage of life, reproductive, maternal, child, nutrition, and healthcare. But the largest amount is being spent on the end of the life infrastructure, how to keep people alive longer. So that is a competing demand. How do you allocate resources to huge youth populations that are unfortunately in developing countries? Is global governance itself going to reorient itself dramatically from the 20th century to the 21st century based on this constituency? Do we need smaller regional or clustered arrangements? An Africa-India partnership? Do we need these new partnerships to be first responders to what the Atlantic system did not deal with? Let's be honest that the Atlantic system has failed in its ability to meet this need. What is the new format of global governance and health when you have an old continent and a young population clamoring for the same resources?

Secondly, at the intersection of climate change and health, there are two challenges here. One is what the WHO is trying to do which is looking at climate-resilient health systems, they are spending a lot of money and resources to make sure that South, Southeast Asia, and so on have climate resilient infrastructure. But I think another problem is that many diseases that we thought were gone are back. I mean cholera coming back to Europe, malaria appearing in parts where the world believed it was safe. The stockpiles of vaccines and responses to old diseases which are likely to appear in new geographies- what is the framework to do that? I don't believe that the

WHO has that capacity or that mandate to do that. How do you coordinate a new grouping, a G20 like gathering of those who are capable of responding? Can we create something useful with the countries that are capable of dealing with it?

Finally, there is the elephant in the room- IP and its implications on affordable healthcare. I think we use the word trade, but let us be honest here. There have been two contradictory trends. The first is that countries are welcoming the public sector becoming increasingly privatized. We are beginning to realize that the private sector has to provide taxis, has to provide mobility, has to provide education, healthcare, has to create multiple things, this is one trend. But the second trend is that the public element of the public service is also dying. The private sector is corporatizing many of these public services. I don't think that was the original idea of including the private sector in this service provision. The original idea was not to remove the public out of the service, but to create a balance between the two. How can we restore the public element in these essential areas?

Comment 6

I have a theoretical question. Turning this into a global governance issue, we have the externality set. Here it seems like it's more about the SDGs, basic rights, and so on that front how will we make the measurement operational? The SDG metrics say to prevent premature deaths. But that's a sliding metric as we figure out ways to prolong life. This is also true for national systems. How do you deal with the upside of health systems and health delivery as a socialized concept? As a national system problem it is there, but on the global scale it's a really serious thing. Who is going to determine these metrics if this will indeed become a basic rights SDG type metric that we'll all have to follow?

Comment 7

The Brazilian problems in healthcare are also present in Mexico. This leads me to believe that this is a common problem between several countries. The problem is structural, and not only related to health. How does global governance help to deal with corruption and structural weakness of our institutions?

Presenter

The reason why you find it similar is that this sort of design in countries, you see many countries that use health care utilizing healthcare as part of clientelist machines. Mexico and Brazil and many such countries design public policies around this. This is something you don't recognize in comparative politics, but clientelism shapes how public policy plays out. How can global governance deal with it? It can't. It's not a global governance issue. What global governance can do is one thing. It's to be an exogenous force that enforces accountability, that takes clientelist machines and forces them to be accountable to the public. And, historically, it hasn't been very successful. It'd benefit health policy a lot if institutions like the World Bank and the Gates Foundation start to think about how health systems in certain countries are designed to mobilize voters, not to deliver the most effective healthcare possible.

Final Words

We put more regulation on money laundering than healthcare transparency. Banks all around the world are established with a strong foundation, but we don't do the same thing with healthcare. It's a worldwide problem. No country is free from corruption in health care. I remember being shown a pair of gloves by a health minister who showed us that the price changes four times when you go to different cities in the same country. When you go to

medicines and look for bribery, the strategies to bribe doctors to provide and prescribe new and useless expensive medicines is incredible and probably has surpassed the global problem of domestic corruption.

The demographic inequality that was mentioned is also present within countries. That is a cost of inequality among countries, but I completely agree that the problem will be of poor and urban residents.

Talking about metrics, metrics in health are probably the most precise in the world. When you talk about premature death, you're talking about a specific measurable metric. Metrics exist, but you have to accomplish them. Regarding end of life care- it is unnatural to live so many years. So it is also expensive. The good news is that there is a physiological characteristic among humans, which is compression of morbidity. If you live longer you don't add years of poor quality life. The problem is financing. What is absolutely unbearable is to work until 65 years of age. That is meaningless in terms of medicine and financial health. I suggested this in my country and they wanted to hang me, because I said people should work into their 70s.

Finally the strategy to provide the incentive to the private sector. In medicine, there is something called chrono-therapy. This is a therapy of letting time pass. We are just applying chronotherapy to the problem of IP and pharmaceutical medicines. We are waiting for the problem to be solved on its own. That is not going to happen. We have to produce cheaper medicines and medical technology. Asia is pioneering that strategy of making the best technology affordable because it is becoming a commodity. Medicines are going to be copied, biosimilars will be easier to produce, and technology is going to be cheaper with new business models. When you're talking about governments, every country is going to be more state dependent in terms of healthcare financing. Healthcare is going to become even more complex as people live longer.

Vaccines are a good example of a state level, private sector level, and innovation level strategy to improve health. We have to stop sending doctors to business class to sell expensive and useless medicines, and we have to start to think again about NCDs in terms of populations, poverty, giving free medicines, giving them massively with various technologies, with doctors again gaining that greed for the well-being of people. ■

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