Public Health in an Interdependent World: Cash, Commodities, Capacities, and Conspiracies Part 1

[Announcer] This podcast is presented by the Centers for Disease Control and Prevention. CDC – safer, healthier people.

[R. J. Simonds] Good morning, everyone. Everyone here and everyone out in Envision land; it's very nice to see everyone come out. We know you all have busy schedules, and we're very happy to see you here. My name is R.J. Simonds. I'm the Acting Director for the Center for Global Health here for a couple of months until Dr. De Cock comes and really takes over, and one of my pleasures in doing this acting job is to be able to do something like this, which is to help to introduce a really nice program that we have this morning.

This morning, as you know, you're here for the eighth annual Jeffrey Koplan lecture on global health. This is a series that was introduced in order to provide a forum for global health leaders to come and share their wisdom with all of us at CDC so that we can take a moment from our busy, hectic lives to be motivated and inspired by global health leaders. This is part of, you know, our broader mission at CDC to develop the public health capacity workforce of all of you, of all of our partners overseas, and to raise the level of public health capacity in the world.

So, without further ado, I want to introduce our director, Dr. Tom Frieden, who's been a champion of both public health and of public health capacity building, to get our program started.

[Applause]

[Dr. Frieden] Thanks very much. It's really a pleasure to welcome you also to this lecture honoring Jeff Koplan and his leadership in global health and to welcome many of our colleagues here to CDC from not just the World Health Organization, but the Global Health Institute, Rollins School of Public Health, Carter Center, CARE, American Cancer Society, and others. I'm also delighted to welcome here representatives from throughout CDC who work on global health. There's almost no branch, division, or center of CDC that doesn't have a very important global health function in part of their work, both helping to generate knowledge and information that strengthen global health and learning from other countries so that we can do a better job here.

This week we have both World Water Day on Monday, and today is World Tuberculosis Day, and as I'm sure every one of you knows, 128 years ago today, Robert Koch announced the identification of the tubercle bacillus to the widespread surprise, actually, and acclaim.

CDC and the World Health Organization have a long, I think, and very productive history of collaboration and partnership. This goes back to not only well known, successful collaborations

on smallpox eradication and global immunization, SARS, International Health Regulation, and, more recently, H1N1, but also a myriad of ways in which our organizations work together to strengthen each other, to learn from each other, and to figure out how we can most effectively promote global health.

We have dozens of staff members assigned to WHO around the world and are home to some three dozen WHO collaborating centers just here at CDC. I've said from my first time in association with CDC and from my first time as director that global health is a top priority for CDC.

With the leadership of Steve Blount, which I want to recognize in particular, in global health, over many years and more recently culminating in the creation of a Center for Global Health, we now have, for the first time as one of our centers, a Center for Global Health, and this will allow us to work as effectively as we can in the increasingly complex donor and partner environment and the increasingly complex epidemiological context in which we have to work. Partnerships are key to success in that environment. We also look forward to future collaborations to be even more effective in the future.

It's also a pleasure now to welcome Dr. Jeff Koplan, former CDC director, for whom today's lecture is named and who will introduce my friend and our guest lecturer, Dr. Chan. Dr. Koplan has, as many of us do, a passion for global health, for preventing unnecessary illness and death, and I can say that my first meeting with Jeff was in Chennai doing field visits for directly observed treatment and microscopy for tuberculosis when he came to see the work that we were doing there, and he's remained a good friend, model, and mentor since. Dr. Koplan?

[Applause]

[Dr. Koplan] Thank you, Tom. It is a timely day that we celebrate Koch's discovery and our first visit together in Chennai doing DOTS observation -- observing the observers. Thank you both. It's always a pleasure to be back here at CDC, and it's a special pleasure to be here today to introduce my dear friend and long-standing colleague Margaret Chan, Director-General of The World Health Organization. It's a special treat, as well, because I've been seconded innumerable times during my CDC career as both a long-term and a short-term consultant with WHO, and so I feel a special bond and respect and affection for the World Health Organization, as well.

As Tom just said, CDC has a special role to play in global health, and CDC is indeed a pillar of global health in the World Health Organization edifice. This lecture celebrates global health leadership, and this institution has been a feeder for global health leadership for decades.

Many of the people in this room continue to serve that role, but I think I'd be remiss in not seconding what Tom just said, which is thanking Steve Blount for his many years of distinctive leadership here in global health and in praising R.J. for his role in an interim position and prematurely welcoming Kevin De Cock to fill that role, as well. But let me add further that it's a particular delight to have a director of CDC whose passion, experience, and knowledge of global

health runs very deep and ensures that this organization will be playing a major role in global health for years to come.

Now, every year in public health is an adventure, and I think everyone says, after a year in public health, "Ah, there's never been a year like this one before," but this has been an exceptional 12 months for global health, and CDC has, I think, been a key player in these events. We've had an outbreak of a novel strain of influenza, which this organization and the World Health Organization and every ministry of health in the world has engaged in with great effort. It also originated in a part of the world that was somewhat unexpected, placing an additional strain on this institution and on state and local health departments. There's been a resurgence of polio in areas where it was once close to eradication. There's been a recent devastating earthquake that has decimated a fragile public health infrastructure in one of the nation's -- in one of the world's poorest countries. But we're also seeing new commitments in global health from private and public organizations, helping to do what it takes to improve health throughout the world.

Just a couple of examples – the Bill & Melinda Gates Foundation has committed to spend 10 billion dollars in the next decade to work with governments, NGOs, and others to provide research to develop and deliver vaccines for the world's poorest countries.

The Bloomberg Initiative has expanded a concept of global health to include noncommunicable diseases, injury prevention and control -- much needed, for these are the major killers and disablers throughout the world, both poor and middle- and high-income countries. And the U.S. government has initiated a new global health initiative aimed at strengthening the world's health systems, building upon previous success with HIV/AIDS and reducing deaths via the PEPFAR program.

So, it's in this complicated world that our guest speaker leads an operation that touches every part of global health. Dr. Chan received her medical degree from the University of Western Ontario in Canada and then came back to Hong Kong to join the Department of Health in 1978, where her career in public health officially began. In '94, she was appointed Director of Health of Hong Kong and for nine years initiated new creative approaches to disease prevention and promoting health, introduced new initiatives to improve communicable disease surveillance and response, engaged in extensive training of public health professionals in establishing better local and international collaboration. She very effectively managed the outbreak of avian influenza in Hong Kong in 1997 and played a central key and effective role in controlling and managing the response to the Severe Acute Respiratory Syndrome, SARS, when it struck and first appeared in Hong Kong in 2003. That was also the year she joined the World Health Organization as Director of the Department for Protection of the Human Environment. In June 2005, she was appointed Director of Communicable Disease Surveillance and Response, as well as representative of the Director-General for Pandemic Flu. In September 2005, she was named Assistant D.G. for Communicable Diseases and then was appointed as Director-General of WHO in 2006, and her term runs through 2012, although we hope it might extend beyond that. She's a bold and insightful speaker, as you'll soon hear, but she's also a major player, leader, in global health and public health. She embodies the leadership that this lecture series is meant to celebrate and address. She has clear vision, a great intellect, a broad interest and knowledge of the full range of public health and health issues, everything from manpower issues to healthcare reform

-- could have used you the last few weeks and months here -- a wide range of disease-specific issues, both communicable and noncommunicable, and has a passion for all of them. The background she brings to the director-general's role at WHO is unparalleled in director-generals, and you can see it in her performance and on the strength and growth of the organization. She also brings wisdom and common sense, an ability to listen well to others, which ensures that her job is gonna be successful. She herself admits quietly that she's an activist at heart, and that serves us all well in her role at WHO, as well. So, I look forward both because she's a good speaker and a thoughtful person and I always learn from her presentations, but also because the talk includes the words "cash" and "conspiracies" -- familiar words to all of us who work in the area of public health. So, with great pleasure, I introduce my friend and colleague Dr. Margaret Chan.

[Applause]

[Dr. Chan] Let me get a glass of water. Dr. Koplan, Dr. Frieden, colleagues in public health, ladies and gentlemen, give me a couple minutes. Let's put aside the speech. I'm not going to come here without making the following comments. I hope the media friends will excuse this part. It's not on the record.

[Laughter]

I'd like to say, first and foremost, how happy and honored I am to be invited to deliver the eighth annual Jeff Koplan lecture on global leadership in public health. The little thing -- A little story I want to tell you is -- Because when I received that invitation, you know how WHO works. You know, it is important that the D.G. of the organization listens and gets permissions from my colleagues to do the kind of things that I am doing. There is a system in the organization. All invitations to me, they have to be reviewed by a group of people, and normally I'm not allowed to accept lectures. If I do that, I would be out of Geneva 365 days of the year. That's a bit of an exaggeration, but it is pretty close. But when I saw the three letters, "CDC," and the name Jeff Koplan, I was, you know, very agitated when they told me I can't accept this lecture. And I said, "No. Please give me a break."

[Laughter]

The reason being, I benefited in my previous life a great deal because of the work of this institution. How can I say no to CDC? And to Jeff? Jeff, we'd better not tell them how long we've been friends, okay? I still recall, you know, he came and visited one of the programs we did in Hong Kong. It's in the context of school health. We visited, you know, a clinic where we bring schoolchildren in to do prevention and promotion. And, of course, you have been a frequent visitor and mentor to not just myself, but to the group of young people that are working in Hong Kong. So, eventually, I present a very convincing argument. So, that's why I'm here.

[Laughter]

So, on that, I want to once again appreciate this opportunity, Jeff. And Jeff is an old friend --

old, old friend. In Chinese sort of culture, that means very good friend, and it doesn't mean age, okay?

[Laughter]

Ladies and gentlemen, let us -- Let me get back to the purpose I'm here. The 21st century began very well for public health. In the year 2000, the governments of 189 countries signed the Millennium Declaration and committed themselves to reaching its goals. Taken together, the eight Millennium Development Goals, the MDGs, represented perhaps 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 Development Goals under the Millennium Declaration echoed the values and principles set out in 1978, the Declaration of Alma-Ata, which launched the Health for All movement. That document, ladies and gentlemen, promoted primary healthcare as a root to fair, rational, and inclusive healthcare 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 -- Sounds familiar, doesn't it? An energy crisis hit the world very 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, structure-adjustment programs imposed by development banks shifted national spending away from social services, including public health. The argument was straightforward. If healthcare 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 fully recovered from the damage done to their health systems.

The 21st century started very differently. This time around, it looked like the international community meant business. World leaders were optimistic, visionary, and determined to see their visions materialized. This time around, commitments were backed by substantial financial resources, often from innovative funding mechanisms. A host of global initiatives sprung up, with many designed to deliver life-saving interventions on a massive scale. Presidents and prime ministers launched and funded international programs for diseases rarely seen within their own bodies.

Commitments of Official Development Assistance, ODA, for health rose more than threefold, from 6.5 billion dollars in 2000, to more than 21 billion dollars in 2007. As the MDGs said -- or rather the Millennium Declaration stated, let me quote -- "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." End of quote.

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 the year 2001, the GAVI Alliance, supported by a large grant from the Bill & Melinda Gates Foundation, was launched to reinvigorate the drive to protect children -- 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 in a big way forward. A world that can put a computer in every home, ladies and gentlemen, could surely put vaccines in every child.

The GAVI Alliance provided the prototype for the Global Fund to fight AIDS, TB, and malaria, which began its funding operations in 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 these diseases with high mortality in the developing world. Significantly, the new mechanism introduced the pipeline of funding based on performance and measurable results.

By the year 2006, funds dispersed by the Global Fund accounted for about 20 percent of all multilateral aid for health. As the first decade of 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 -- 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.

What's the 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 with 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 pipeline 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 – 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 advanced financial prejudice was put forward in the year 2006 to encourage industry to move forward with new vaccines to combat pneumonia and diarrheal disease, the two biggest killers for young children. Again, the result was swift.

GAVI and its partners will soon be introducing pneumococcal and rotavirus vaccines to childhood immunization programs. In addition to better products, more money was needed, and as Jeff says to me, he has never heard anybody saying that they don't need money, and this is our challenge, isn't it?

In addition to better products, more money was needed. In 2006, the International Financing Facility for Immunization, the short-term IFFIm, I-F-F-I-m, supported by GAVI, became operational. By selling blue-ribbon bonds to investors, the facility front-loaded about 4 billion dollars to fund the immunization of 500 million children by 2015.

2006 saw a second innovation with the launch of UNITAID. It is a drug-purchasing facility that draws funds from a levy on airline tickets. Thank you for your contribution. In less than three years, the facility contributed more than 900 billion dollars 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 for more than 90 countries signed the Paris Declaration on Aid Effectiveness. The actions agreed on in the document mark a significant departure from past thinking and practice. They marked the end of a fashionable skepticism 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 principle 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, let me quote -- "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." End of quote.

Secretary Clinton also stressed a need to break the cycle of dependence that AIDS 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 only 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. Do you want to pay for that? Of course the answer is no.

[Announcer] For the most accurate health information, visit www.cdc.gov or call 1-800-CDC-INFO, 24/7.