

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

## Part 2

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

Ladies and gentlemen, not surprisingly, this desire to cooperate internationally for better health, these innovations, these dramatic increases in resources, cash, and reforms toward their more effective use have an impact. The number of people in low- and middle-income countries receiving anti-retroviral therapy for AIDS moved from under 200,000 in late 2002 to 3 million and then beyond 4 million -- an achievement unthinkable just a decade ago.

The number of under-5 deaths dipped below 10 million for the first time in almost 60 years and then dropped again to below 9 million. The yearly number of people newly ill with tuberculosis peaked and then began to drop and decline slowly.

For the first time in decades, it looks like the steadily deteriorating malaria situation might be turned around. These innovations expanded the thinking about public health, as well as its prospects. Every child deserves the best that science can offer. People should not die for want of incentives to develop new products for diseases of the poor. Effective aid honors national priorities and aims for self-reliance. Health initiatives should be purpose-driven. Funding should be results-based. In other words, fairness and efficiency, the dream agenda for public health, the heart and soul of the Declaration of Alma-Ata. But as welcome as they were, these objectives ran counter to the arguments of some development economists, expressed since at least in the mid-1980s, that you cannot have both. If efficiency is the objective, fairness has to take a backseat. The world was aiming high, perhaps very high, and there were some problems. The old debate between the horizontal versus the vertical approach to health resurfaced, this time rephrased as a conflict -- a conflict between the drive to deliver life-saving interventions or commodities and the need to strengthen fundamental capacities.

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

In 2006, the World Health Report documented a stunning worldwide shortage of 4 million doctors, nurses, and other health personnel. With the shortage, most occur in sub-Saharan Africa. Aided by the globalization of the labor market, which favors the highly trained and educated, doctors and nurses were leaving the countries that invested in their training in droves. The alarm was great, as research showed a direct link between low density of healthcare workers and a rise in maternal, infant, and under-5 mortality, and there were other reasons for concern about the dire shortage of health and medical staff.

All around the world, health was being shaped by the same powerful forces -- for example, demographic aging, rapid urbanization, and the globalization of unhealthy lifestyles. Under the

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

This dramatic shift in the disease burden vastly increased the demands on already very weak health systems. It increased the need for healthcare workers and drugs for chronic care and out-of-pocket payments for catastrophic healthcare costs.

These were most unwelcome trends. WHO estimates that out-of-pocket payments for catastrophic care drive an estimated 100 million people below the poverty line each year.

This is a bitter irony, ladies and gentlemen -- a bitter irony at a time when the international community is pursuing better health as a poverty-reduction strategy. As there were other rumblings of trouble, other storms gathering on the horizon that pointed to even bigger problems and bigger questions, a time of unprecedented interdependence among policies, fears, as well as nations, call for unprecedented international collaboration, yet -- yet agreements between rich and poor countries on big-picture issues became increasingly difficult to achieve.

Climate change is arguably the biggest incentive ever for long-range collaborative planning, yet agreement on ways to mitigate the effects of climate change prove elusive. The Doha Round -- The Doha Round of trade negotiations collapsed. A WHO system for the sharing of influenza virus that had functioned seamlessly since 1946 -- and thank you for your contribution to that -- was called into question as biased towards wealthy countries and the profits of the pharmaceutical industry. Negotiations at WHO on issues like patient protection, generic products, and drug prices, though ultimately successful, were extremely intense, divisive, and sometimes almost explosive. In other words, public health was fine when delivering life-saving commodities, but problems arose when health interests and economic concerns crossed paths.

Global issues were increasingly touchy and divisive. A deep mistrust -- A deep mistrust of the international systems seemed to take root, expressed as a suspicion that the rules were somehow rigged to favor the interests of the rich and powerful, while poorer countries were left out and left behind. Some big questions accompany these suspicions. Are factors like poverty, ignorance, social disadvantage, bad nutrition, and filthy environments the true root causes of ill health? Or are these bigger causes located perhaps in the policy sphere, in the international systems that govern the way this world works? Were the MDGs perhaps a corrective strategy, a way of compensating for the fact that the international systems generate benefits but have no rules that guarantee the fair distribution of these benefits?

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

In this lopsided world, with its huge imbalances in health and in wealth, crises of this nature are profoundly unfair. Why do I say that? Developing countries have the greatest vulnerability and the least resilience, and they are hit the hardest and take the longest to recover. Around 1 billion people in this world live on the margins of survival. It does not take much to push them over the brink. In addition, some of these suspicions were substantiated and fully supported by evidence in the final report of the Commission on Social Determinants of Health.

That report, issued just weeks before the financial crisis made headlines, placed a responsibility for inequalities in health squarely on the shoulders of policy makers. As the report argued, the huge gaps in health outcomes are not matters of fate, they are markers of policy failure.

As the economists told us, the financial crisis represented a failure of corporate governance and risk management at every level of the financial system. The crisis hit the world like a sudden jolt and hit the world where it hurts the most -- money.

Almost within days, ladies and gentlemen -- Almost within days, a world mindframe of prosperity turned to one of austerity. The thinking of the 1990s in financial and corporate circles that greed is good came home to roost. Many working for health development, myself included, immediately asked the obvious question -- Will this usher in another lost decade for development? Will a crisis seeded by greed kill our best chance ever to give this lopsided world a greater degree of balance? Will all those innovations that marked the start of this century, all this good determination to improve health be defeated by bad policies made in other sectors?

Ladies and gentlemen, in a sense -- in a sense, the multiple crises facing the world today are nothing new. Floods, droughts, famine, war, pestilence, plagues, and economic booms and busts are familiar companions in the up-and-down cycle of human history, but today's crises are different. Today's crises are different. They have some unprecedented dimensions. They are highly contagious and profoundly unfair. They are revealing in ominous ways what it means to live in a closely interdependent world.

Viewed in the context of an unprecedented drive for greater fairness, I can personally understand many of the questions, concerns, and frank suspicions. Collectively, we have failed to give the systems that govern international relations a moral dimension. The values and concerns of society rarely shape the way these international systems operate. Equity is almost never an explicit policy objective in the international systems that govern financial markets, economic relations, trade, commerce, and foreign affairs, and health suffers as a result.

Too many models for development assume that living conditions and health status would somehow automatically improve as countries modernize, liberalize their trade, and experience rapid economic growth.

This did not happen. Instead, the differences within and between countries in income levels, opportunities, life expectancies, health outcomes, and access to care are greater today than at any time in recent years. Clearly, globalization has not been the rising tide that lifts all boats. Clearly, globalization has not become a positive force for all the world's people. Decades of experience tell us that this world will not become a fair place for health all by itself. Health systems will not

automatically gravitate towards greater equity or naturally evolve towards universal coverage. Economic decisions within a country will not automatically protect the poor or promote their health, and globalization will not self-regulate in ways that ensure fair distribution of benefits.

International trade agreements will not by themselves guarantee food security or job security or health security or access to affordable medicines. All of these outcomes require deliberate policy decisions. Let me be very clear. I'm not against trade liberalization. I'm not against globalization, and I certainly favor economic growth. I'm fully aware of the close links between greater prosperity at household and national levels and better health. But I do need to say this. Market forces all by themselves will not solve social problems, and this is why public health needs to be concerned. And I'm not arguing that public health has and will ever have the power to change the way this world works, but I do believe -- I do believe we have a duty -- a duty to point out that some genuine reasons why an apparently smooth road to progress for public health in a century that began so well has, in reality, so many speed bumps along the way.

And let me be very frank. Changing human behaviors is harder than delivering commodities. Both are critical for better health. Securing funds to strengthen fundamental health capacities is harder than securing funds to buy Band-Aids, pills, condoms, and vaccines. Public health needs both. Working for health in a country riddled by conflict and corruption is much harder than seeking health gains in a stable country with good governance. But this is no excuse -- no excuse for ignoring unmet health needs or turning a blind eye on human misery. But the hardest thing of all is persuading world leaders or ministers in other government sectors that health concerns can, in some instances, be more important than economic interests, that economic growth is not, after all, the be-all, end-all cure for all. In my view, the net result of all our international policies should be to improve the quality of life for as many of the world's people as possible. Greater equity in health status of populations within and among countries should be regarded as a key measure of how we, as a civilized society, are making progress.

Ladies and gentlemen, the past decade brought mixed news for public health, but for me and, I expect, many others, the best news is the fact that the long-overdue influenza pandemic has been so moderate in its impact.

Had the virus mutated to a more virulent form, much of the progress I have just described would have stalled or suffered serious setbacks. We have been fortunate on many counts, from the beginning on. The virus initially spread in countries with good surveillance systems. The honesty and speed of early reporting set the standard for the international response. The sharing of information, expertise, and viruses was admirable. The virus caused mild illness in the overwhelming majority of cases but caused severe or fatal disease in some, including relatively young and healthy people. Sporadic resistance to oseltamivir emerged but did not spread. Vaccines were available within six months following virus detection. They remained a good match with the circulating viruses and show an excellent safety profile. Things could have gone tragically wrong in any of these areas.

Let me take this opportunity to personally thank CDC. I thank you for the major role you have played in supporting the international response to this pandemic. Let me thank you for so quickly preparing reagents and diagnostic kits and shipping these around the world, for the thousands of

viruses analyzed in your laboratories, for your participation in countless teleconferences and international meetings, and for so many rapid reports in the *MMWR* and elsewhere.

I thank you, too, for directly helping so many countries improve their surveillance and laboratory capacities well in advance of the pandemic. The world's defenses against the next outbreak are much stronger as a result, but will the public believe WHO and other health officials when we announce the next public-health emergency? And I can assure you, there will be many more to come.

This brings me to the last word in the title of my talk -- conspiracies. I think this will wake up many people.

[Laughter]

Though the virus did not deliver any devastating surprises, we faced surprises in other areas. We anticipated problems with producing enough vaccines fast enough, and this did indeed happen, but we did not anticipate that many people would decide not to be vaccinated. This is the first influenza pandemic to occur following the revolution in communications and information technologies.

In today's world, people can draw on a vast range of information sources. People make their own decisions about what information to trust and base their decisions -- and base their actions on those decisions. Ladies and gentlemen, the days when health officials could issue advice based on the very best medical and scientific evidence and expect the populations in countries to comply may be fading or is already fading. Managing public perceptions has proved especially challenging in other ways. One clear problem arose from the great discrepancy between what was expected and what actually happened.

For five long years, the world kept a nervous watch over the highly lethal H5N1 avian influenza virus, which was widely regarded as the virus most likely to ignite the next pandemic. A pandemic caused by a virus that kills more than 60 percent of those it infects is striking and, fortunately, very different from the reality of the 2009 pandemic. Adjusting public perceptions to suit a far-less-lethal event has been problematic. This has been the most closely watched and carefully scrutinized pandemic in history. We will have a wealth of new knowledge as a result of this. It is natural and fair that every decision and every action that shaped the response will likewise be closely scrutinized.

WHO anticipates close scrutiny of its decisions, but we did not anticipate that we would be accused by some European politicians of having declared a fake pandemic on the advice of experts with ties to the pharmaceutical industry and something personal to gain from increased industry profits. This has been a little bit hard to take, isn't it?

Though understandable. Again, given the discrepancy between what was expected and what happened, such accusations have been damaging, and they have undermined confidence in the need for vaccination in a number of countries and including several in the developing world. We, the world -- We have experienced the impact of conspiracy theories before, and I believe that

public perceptions of risks and remedies will be a new source of setbacks for public health for some time to come, and the setbacks can be very severe.

In northern Nigeria, ladies and gentlemen, in 2003, rumors emerged that the polio vaccine was linked to HIV or was part of a Western plot to sterilize Muslim children. People refused immunization. Polio resurged in Nigeria, and the virus was reintroduced into at least 12 polio-free countries. We are still struggling, working very hard with those countries to eradicate polio.

In Europe and North America, many parents remain convinced that the measles, mumps, rubella vaccine is linked to autism and bowel disease. Findings in the paper that ignited these concerns in 1998 have been soundly refuted, and yet -- and yet the concerns of many parents linger.

Similar to the situation with the 2009 influenza pandemic, some anti-vaccine groups see a conspiracy between pediatricians and the pharmaceutical industry. Countries in North America, Europe, and elsewhere are seeing entirely unnecessary outbreaks of measles at a time when the drive to control measles worldwide has reached unprecedented strength.

Ladies and gentlemen, today is World T.B. Day.

Let me thank your director, Dr. Frieden, for his international leadership in this very important area of work and, of course, in many other areas of public health. Tom, it's a great pleasure to be in CDC when you are the head of this organization. Tom and I also worked together previously, but we better not tell them how long ago that was. But you are much younger than me, so that's okay.

Since 1995, because of the great work and good work of many people—many colleagues in this room and in other parts of the world—some 35 million T.B. patients have been treated and cured and an estimated 6 million deaths have been averted, yet T.B. kills a staggering 1.8 million people each year, making it the second-biggest infectious killer of adults worldwide.

The emergence of drug-resistant forms of this disease reminds us of the ever-present risk of setbacks in public health. Much has been achieved. Much remains to be done. New problems have surfaced, but public health is used to setbacks and surprises. Our values system is irreproachable, and our optimism and determination are irrepressible. I look forward to continuing our very close collaboration with CDC as one of our most talented and valued partners in global health.

Thank you.

[Applause]

[R. J. Simonds] Thank you very much, Dr. Chan, and we especially appreciate your resisting your handlers and allowing you to take the time out of your extremely busy schedule to come and give us such an insightful story about the complexities of global health and how it's not just health, it's a very complicated interplay of many other forces.

And we hope that everyone can digest that, go back to your jobs, and be inspired to carry on your work in ways that are lined up with these great forces in global health.

Thank you very much and we hope to see many of you at the World TB Day talks this afternoon, as well. Thank you.

[Applause]

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