



THE CENTRE  
FOR THE STUDY OF  
GLOBAL  
GOVERNANCE

## **Public Lecture**

**Gro Harlem Brundtland**

*Globalization as a Force for Better Health*

**Public lecture presented on 16 March 2001 as part of the 'Global Dimensions'  
Programme**

Public Lecture (2001)  
Gro Harlem Brundtland, 'Globalisation as a Force for Better Health'

Centre for the Study of Global Governance  
London School of Economics and Political Science  
Houghton Street, London WC2A 2AE  
<http://www.lse.ac.uk/Depts/global>

This is a transcript of *Globalisation as a Force for Better Health* given by Dr Gro Harlem Brundtland. Dr Gro Harlem Brundtland is Director-General of the World Health Organisation

## **Lecture text**

Ladies and Gentlemen,

My key message today is uncompromising: it is high time to expand our ideas about what determines economic growth.

The new evidence gathered over recent years concludes that health must be seen as a central factor not only in social development, but also in countries' ability to compete on the global economic stage and achieve sustainable economic progress. Health, therefore, must no longer be seen as an expenditure only the rich countries can afford, but as a necessary investment by the poorest countries of this world. I will also argue that this is an investment we cannot leave to these countries to shoulder on their own.

Simply, enlightened self interest compels both industrialized country governments and private corporations to do what it takes to drastically reduce the current burden of disease in the developing world. To do so will be good for economic growth, be good for health and be good for the environment. Not only for the three billion people who have yet to benefit from the technological and economic revolution of the past fifty years - but for us all.

At the beginning of this new century, I see two critically important forces shaping the world we live in: the revolution that is taking place in information and biotechnology, and the growing momentum of globalization.

Both of these forces carry with them immense potential for good. But, as we are all aware, they carry risks. Between them, they can help to transform the lives of millions. But they will not do so just because we want it to happen.

Let us start with globalization. Despite what the critics may say, it is not inevitable that it will lead to inequity. If it does, it is a sign of failure. Our challenge is to make positive things happen. To shape the world. To make certain that the forces of globalization contribute to a more just and inclusive global society.

A world in which the divide between the rich and the poor continues to deepen; a world in which only a privileged few have access to the fruits of the technological revolution, is a world which will become ever more insecure. In the past, desperate conditions on another continent might cynically be written out of one's memory. The process of globalization has already made such an option impossible.

In the modern world, bacteria and viruses travel almost as fast as money. With globalization, a single microbial sea washes all of humankind. There are no health sanctuaries.

The separation between domestic and international health problems is no longer useful. Millions of people cross international borders every single day. A tenth of humanity each year.

It is not only the infectious diseases that spread with globalization. Changes in lifestyle and diet can prompt an increase in heart disease, diabetes and cancer. More than anything, tobacco is sweeping the globe as it is criss-crossed by market forces. Only weeks after the old socialist economies in Europe and Asia opened up to Western goods and capital, camels and cowboys began to appear on buildings and billboards.

If the growth in tobacco use goes unchecked, the numbers of deaths related to its use will nearly triple, from four million each year today, to 10 million each year in thirty years time. Practically the entire growth in tobacco-related mortality, more than 70% of these ten million deaths, will take place in developing countries.

Differences in health status dramatically illustrate the divide between the rich and the poor in today's world.

We know, for instance, that the poor - those living on less than \$ 2 dollars a day - suffer disproportionately from the ravages of communicable diseases. In 1998, communicable diseases were responsible for about 34% of the total burden of disease world-wide, but nearly twice that - 64% - among the fifth of the global population living in countries with the lowest per capita income. Most of these diseases can be prevented or easily cured with available vaccines and drugs, but poor countries and poor people do not have access to them.

We know too that communicable diseases - particularly HIV/AIDS, TB and malaria are themselves major causes of poverty. The success or failure of our collective response to these threats is critical. It holds the key to the economic and physical security - not just of individuals and communities - but of nations and continents.

Health is not just one of the most potent symbols of a divided world, it is an integral part of the remedy for healing that divide.

A good year into its work, WHO's Commission on Macroeconomics and Health, which I formed to provide a solid evidence-base for future action, has already assembled some powerful evidence for saying that we have massively underestimated the devastating effect of ill health on the economic prospects of the world's poor communities.

HIV prevalence rates of 10-15% - which are no longer uncommon - can translate into a reduction in growth rate of GDP per capita of up to 1% per year. TB, which is made worse by HIV, takes an economic toll equivalent to \$ 12 billion dollars from the incomes of poor communities.

Africa's GDP would probably be about \$ 100 billion more now if malaria had been tackled 30 years ago, when effective control measures first became available.

Globalization does not have to lead to human insecurity because of the spread of illness. Inequities in health are not inevitable. Better health will result in major economic benefits - for families and for nations. All this is now quite clear. But to reap those benefits there is a need for a completely different approach to investment. There is an increasing recognition of the sheer difficulty faced by developing nations

as they seek to counter these health threats. Poor countries cannot reduce the burden of diseases associated with poverty if they can only spend \$ 5?10 per person on health each year. It is becoming clear that health systems which spend less than \$ 60 or so per capita are not able to even deliver a reasonable minimum of services, even through extensive internal reform. It doesn't matter how good the structure is - as long as you can't afford to pay your doctors and nurses proper salaries and fill the shelves with essential medicines and vaccines, a health system will not be performing at a reasonable level.

It should not be like this. A number of health interventions can dramatically reduce mortality from the main killers. Supervised medication regimes for TB; nets impregnated with insecticide against mosquitoes, and wide distribution of malaria treatment among children and pregnant women; prevention programmes for HIV/AIDS - or access to care programmes that can substantially slow the mortality among those living with HIV. There are many more interventions, proven to be effective on a local or national level.

Quite simply, if we can take these intervention to scale - and by that I mean to a global scale - we have in our hands a concrete, result-oriented, and measurable way of starting to reduce poverty.

We estimate that to reach agreed targets for malaria in Africa will require an additional 1 billion dollars a year. For TB, around half a billion dollars per year in high burden countries. For HIV/AIDS the gap is even larger - probably in the order of 3 billion dollars for expanded prevention and support in Africa alone. Add in the use of antiretroviral drugs and the costs rise even more dramatically.

To achieve the targets that national leaders have set means we must go to scale. Matching new ambitions with realistic levels of resources. Business as usual is no longer an option.

Ladies and Gentlemen,

Let me then briefly turn to the power of modern science.

Here too globalization is at work. It is quite clear, for instance, that the development, marketing and sales of genetically modified agricultural products might have taken a very different course in the absence of a global debate about their value and safety.

But let me keep the focus on health. No matter where they are - in Rio, in Lusaka, in Mumbai or Moscow - people living with HIV know that now there are drugs available which can effectively prolong their lives. They can read news articles describing what they are called and how they work. And they know that only the most privileged among them can afford to buy them. This widespread knowledge, a consequence in part of globalization, radically changes the social and economic context in which these drugs are developed and sold.

There is no doubt that these changes add to the pressures placed on the global pharmaceutical and health technology sector, which is among the most competitive and profitable in the modern economy.

We cannot ignore the fact that essential drugs are not an ordinary commodity. Access to health care is a human right and governments and international agencies have an obligation to see that this right is progressively realized. Access to essential drugs is part of this obligation.

We have been witnessing an unprecedented effort, driven by committed people from governments, nongovernmental organizations, UN agencies and the private sector, to dismantle the obstacles that are preventing essential drugs from reaching the millions who need them.

Popular outrage, political will, market forces and the best science are enabling the pursuit of a fundamental principle of public health: the supply of essential medicines on the basis of need rather than on the ability to pay.

A year ago, when WHO, UNAIDS and other UN Agencies, embarked on a joint effort with 5 leading pharmaceutical companies, the prices of medicines needed to slow the progression of AIDS were far beyond what most Africans, Latin Americans and Asians, or their governments, could afford. At a cost of \$ 10,000 to \$15,000 per person per year the drugs were out of reach.

Today, antiretroviral combination drug therapies have become available to African countries for around \$ 1000 dollars per patient per year - a tenth of what they used to be.

True, such prices are still beyond what almost any African health system and most patients are able to spend. But it must not stop here. We must ensure that not only HIV/AIDS drugs but all essential medicines and vaccines are accessible to all. It will take time, but we must make sure that no moment is wasted.

All of us would take the view that an effective regime for international trade is one which allows countries to implement workable systems that secures people's basic needs - including their health needs - while respecting intellectual property. We can only make this happen through political negotiation and legal process. That is what is happening, now: I welcome the increased public attention being given to the limited access to health care to prevent and treat priority conditions within Africa.

Yes, the process is difficult. Along the road, there will be disputes about how trade agreements are to be interpreted. There will be challenges to those national drug policies which seek to change the ways in which patent rights are applied. These can only be solved by testing their limits through a legal process: this is costly and frustrating to all concerned, but the stakes are very high indeed.

Over the past weeks, we have seen the beginnings of just one such legal process - in South Africa.

The World Health Organization strongly supports the 1996 South African National Drug Policy, whose objectives are "to ensure an adequate and reliable supply of safe, cost-effective drugs of acceptable quality to all citizens of South Africa and the rational use of drugs by prescribers, dispensers and consumers."

WHO worked closely with the South African Government in the formulation of this policy and has actively assisted South Africa in implementing the policy. The policy is consistent with long-standing WHO views on national drug policies, access to essential drugs, drug quality, safety and efficiency, and rational use of drugs. WHO fully supports the intent of the 1997 Medicines Act 90, which is to operationalize key elements of the National Drug Policy, including generic substitution, greater competition in public drug procurement, improved drug quality, and more rational use of medicines. We recognize that language within parts of the act is seen as a challenge by some companies. During the past few years we have worked with the different interests involved as numerous attempts have been made to find a way forward that is acceptable to all.

Unfortunately, negotiations have so far failed to achieve any agreement. 39 pharmaceutical companies have challenged parts of the 1997 Medicines Act 90, contending that the law would destroy patent protections by giving the health minister overly broad powers to produce, or import more cheaply, versions of drugs still under patent.

At the request of the South African Department of Health, WHO has assisted in identifying relevant international legal expertise to support, and report to, the Government of South Africa.

The court case as you know is now temporarily suspended. We hope that renewed efforts will be made to resolve the dispute, and that they will succeed quickly. The only acceptable result is that all parties work together for a rapid expansion in equitable access to essential medicines for all South Africans who need them.

We need to act at the global level too. The new political environment makes it essential for WTO and WHO to start developing principles for improving access to essential drugs through differential pricing along with increased international finance. In April, the two organizations will host a meeting of an international group of experts in Norway to further develop these principles and possible solutions.

It would be naive, however, to think that reducing the prices of medicines is enough to bring all people's access to health care up to the desired standard. For example, 25 million persons in Africa are thought to be infected with HIV. 5 million of them are estimated to need health care that includes anti-retroviral medication. Currently, only about 10,000 are thought to be receiving this care. This calls for scaling up access by a factor of 500, using medicines that cost around \$ 600 per person per year. Similar calculations suggest the need for a 30-fold scale up in the number of Africans that use insecticide-treated mosquito netting, and are able to access effective treatment for malarial illness.

Some, however, are pessimistic, in particular when it comes to the issue of wider access to antiretrovirals. They claim that bringing complicated HIV/AIDS treatment regimes to poor settings is impossible. Such positions miss the point. We cannot deem a task too difficult and then abandon it. Our job is to push the limits of what is possible, making use of the best science and the dedication that health workers already have shown in abundance.

True, work is needed before we can effectively administer combination therapy without the elaborate laboratory monitoring which is routine in industrialized countries. Clinicians and researchers must work together to define essential components for diagnosis, laboratory support, and effective care. Finding a minimum standard that ensures safe use of quality drugs in poor countries is a challenge we cannot shrink away from.

Ladies and Gentlemen,

I have focused so far on the present: how to make the technologies that we have today accessible to a greater proportion of the world's population. But let me now turn to the future.

To sustain our efforts to reduce human suffering and promote equitable development, we will need better tools - the best that science can offer. New vaccines, new drugs and new diagnostics - designed, developed and priced to respond to the health needs of the poorest countries.

We need to ask ourselves: which essential global public goods are unlikely to be developed or distributed at a reasonable price through normal market forces alone? We need to think about how we structure incentives to promote the necessary changes. We need to decide who should pay the cost of R&D for diseases that drive poverty. These, I believe, are policy questions for which we need urgent answers.

We also need to look ahead and think about the implications of knowledge resulting from new advances in genomics and other areas of biotechnology.

The basic knowledge on the human genome is, of course already in the public domain.

Today, most biotechnology research is carried out in the developed world, and is primarily market-driven. It is inevitable therefore, if this pattern continues unchanged, that the knowledge and technology gap between developed and developing countries will widen, and that the health needs of poor nations will fail to get the attention they deserve.

Our challenge will be fourfold:

- to anticipate the consequences of new discoveries rather than reacting to the effects;
- to assess the ethical aspects of this new knowledge;
- to determine which of the downstream products of this discovery are public goods and therefore should enjoy some protection from commercial exploitation; and
- to ensure widest possible access.

Ladies and Gentlemen,

Scaling up our response to the diseases that create and perpetuate poverty. Creating the conditions which will allow more equitable access to the information, services and

technologies that have the potential to transform peoples lives. Pursuing a more inclusive agenda for research and development. These are the challenges as I see them today.

Later this year, the Commission on Macroeconomics and Health will provide a road map setting out what can be done. It is already evident that the sum total of current government, development agency and corporate effort is no where near enough to make a real difference over next decade. A massive increase in finance and human resources is needed.

There are signs that world leaders have grasped the necessity of such investments. Both the European Commission and the G8 leaders have agreed to targets for reducing the mortality caused by malaria, TB and HIV/AIDS. Currently, detailed discussions among these countries' governments focus on how a new flow of money can best be disbursed and invested. I would be surprised if we will not see commitments of substantial amounts of funds by the time the G8 leaders meet again in Genoa in July.

Scaling up involves a level of finance and human effort that is way beyond what the poorest developing countries and their health systems can be expected to deliver. To make matters more complex, the widely reported prospects of cheaper medicines stimulates increased public demand for care. This puts massive pressure on national governments and their health ministers. Fortunately, some of this pressure is beginning to reach the international community.

No matter how low the prices of medicines and commodities fall, a massive increase in funding is needed to improve the poorest people's access to prevention and care for malaria, tuberculosis, HIV, together with childhood and maternal illnesses. Most of this money must come through increased development assistance as well as debt relief. This has to be new money. Early results from WHO's Commission on Macroeconomics and Health suggest that it must be of the order of \$ 10 billion per year. We can't take from the little that is already being spent on other development priorities.

To trigger such a massive increase in funding, WHO is working with officials from developing countries and donor agencies to develop new systems for efficient handling and monitoring the use of resources. For example, we are working with countries to help improve the performance of their health services to prevent and treat those at risk, and their capacity to purchase medicines and other commodities, distribute them and ensure they are well used.

We are talking about a fundamental break from "business as usual". It will mean that governments go beyond their traditional avenues for dealing with bilateral and international questions. By shaping a global response to global health issues, we are exploring new ways to collaborate.

Some times individual countries take a lead and inspire others, such as Brazil's effort to build a comprehensive care system for people living with HIV. Some times the world unites to regulate global negatives, such as the growing sale and marketing of tobacco, through the International Framework Convention for Tobacco Control,

which is currently being negotiated. This break also includes a realization that governments can only do so much.

The private sector and civil society play a crucial role if we are to succeed. New partnerships are formed; partnerships where all parties are out to find the best possible solutions. Partnerships that are driven by enlightened self interest, not charity.

This is the way forward. Often the best partnerships are those that are forged between unorthodox entities. When people with vastly different backgrounds come together with a shared purpose, creativity is released and expertise is used in innovative and constructive ways.

We see such partnerships taking shape in the discussions between countries, international agencies and major pharmaceutical companies to find ways of increasing access to essential drugs and vaccines.

We see them in the shape of the Global Alliance for Vaccines and Immunization, GAVI, which combines contributions from private sources such as the Gates Foundation, with funds from national governments and which is testing out a new model of allocation of funds as countries "compete" for money to improve their vaccination coverage through "bids" that are evaluated for quality and feasibility.

We see them in efforts to provide new purchasing models that will encourage development and production of medicines and vaccines needed for populations too poor to pay for them.

We see them in venture capital funds such as the Medicines for Malaria Venture and the Global Alliance for TB Drug Development, which finance the development of new medicines which normally don't have a market potential that would make pharmaceutical companies invest in them.

This is just the beginning. As it becomes more commonplace to consider health one of the prerequisites for development and economic growth, along such basics as physical infrastructure, good governance and a proper educational system, I expect we will see a wide variety of new interventions and collaborations. Most of them will involve the private sector in one way or the other. Many will present governments with unorthodox challenges, but all - if they are well designed and executed - will yield significant, measurable, returns in terms of better health and reduced poverty.

Better health provides people with an opportunity - both as a good in its own right, and as a means which can enable many of the world's poorest to emerge from poverty. Better health is a duty in the sense that we cannot ignore or condone growing inequity. But the key point I want to leave you with is this: We have an unprecedented opportunity to make a difference.

Thank you.

