Until recently, health was the most domestic of national issues. Although of huge concern to any country’s population, its stewardship challenge in industrialised countries was mainly a tug-of-war between public expectations and limited budgets. In developing countries, many economists saw investments in health as an add-on which these countries could only afford after having reached a higher income level. In both cases, health rarely concerned anyone within the government beyond the health minister (facing a tremendous challenge of doing too much with too little) and the finance minister (who found it to be a constant drag on resources).

Over the past few years, however, foreign affairs departments, trade departments, development assistance agencies and even ministries of defence, have found that health issues have been steadily creeping onto their own turf.

Health has become a global issue. In a time of globalization, the separation between domestic and international health problems is no longer useful. Over two million people cross international borders every single day. The trade in goods means that any meal we eat may be made from ingredients from half a dozen or more countries. The globalization of information means that inequities in health are glaringly visible to all. The health of people in far-away places affects our own lives in a number of different ways.

Health is now an economic issue, a security issue, a development issue, and – as increasingly only purchasing power separates the healthy from the dying – a moral issue.

But so is globalization itself. What started out as a series of – often unforeseen – economic consequences from advances in communications technology and
The liberalization of financial and economic rules, has become an unstoppable force that is affecting the lives of everybody living on our planet. While many thought that globalization was a tide which rose all ships, there has been a thorough backlash which views globalization as a force that increases inequity and produces more losers than winners. Moreover, many argue that globalization robs nations and communities of their ability to shape their future according to their people’s will.

I believe that globalization carries an immense potential for good. Despite what the critics may say, it is not inevitable that globalization will lead to inequity. If it does, it is a sign of failure. Our challenge is to make certain that the forces of globalization contribute to a more just and inclusive global society.

Health is a key factor here. If we understand better how health and globalization interact, it will be possible to see how we can improve health through influencing the globalization process as well as how we can create a more equitable and sustainable globalization process through improvements in health.

Failed states function as breading grounds for disease.

The main food safety problems are not, for the most part, the spectacular outbreaks that make their way into the media. The biggest food safety problems are made up of the vast number of sporadic cases, which not only fail to reach the headlines but fail to make it into national reporting systems.

We have the resources and experience to make valuable contributions towards global food safety. There is no reason why developing countries should not be able to leapfrog over the past fifty years of development up to modern, globally acceptable food safety standards.

This is important for three key reasons. First, because of the devastating human and economic cost of food scares. As the trade in food and farm products goes global, the costs involved in each food scare rise sharply. We are talking about sums so large that they could be devastating to the budgets of many countries. The United Kingdom has alone spent more than six billion dollars in sorting out its BSE crisis not including job losses, and the economic effects could stretch for years.

Second, as the movement of people and trade of foods – including ingredients and animal feed – is becoming increasingly global, it is becoming increasingly difficult to solve food safety problems without international collaboration and a consolidated strategy to combat problems. The only real way of ensuring food safety is to make certain that what is produced at a farm on the other side of the globe is also safe.

Third, food-borne diseases amount to an enormous global health problem. It is believed that in industrialized countries less than ten per cent of the cases are reported, while in developing countries reported cases probably account for less than one per cent of the total.

Worldwide, almost two million children die every year from diarrhoea, most of this caused by microbiologically contaminated food and water. Even in industrialised countries it is estimated that one-third of the population suffers from food-borne disease every year and, out of these, up to 20 per million die. When you add to these figures the potential of chemical contamination of food, the situation becomes even more serious.

Third, modern technologies such as biotechnology must be thoroughly evaluated if they are to become a true improvement in our way of producing food. Public health can benefit enormously from biotechnology’s potential to increase the nutrient content of foods, decrease their allergenicity and improve the efficiency of food production.

But some governments and large
populations have not been impressed by arguments that they should eat modified maize and beans because these new varieties are cheaper to produce and therefore increase profits for the farmers.

The possible health and environmental effects of genetically-modified organisms need to be examined for safety, nutritional and environmental impacts, as well as efficiency and socio-economic considerations.

Health as a component of human security – The global spread of disease
In public health, there is a saying: “If one person is infected, the whole world is at risk”. This is literally true for polio, which we are on the verge of eradicating. Only when every child in every country is vaccinated and there are no more cases of polio anywhere in the world for three years, can we draw a real sigh of relief. We are in the home stretch for eradicating polio, but there are still very real challenges in conflict-ridden areas.

Yet, polio is only the second disease we will be able to eradicate (the first one was smallpox). Despite enormous economic and technological progress, large populations are still as vulnerable to killer diseases today as they were several centuries ago.

Profound changes in lifestyles, in communication and movement of goods and people affect the way diseases and health risks are spread and contained.

An example is the repeated occurrence of West Nile Fever in Canada and the United States, first in New York City and now in more than 40 states.

There is the recent sharp rise in tuberculosis in countries that for decades had considered the fight against TB as won. This new wave of TB in industrialised countries, often in forms resistant to all normal treatments, is to a large extent a result of the movement of people from endemic countries into Europe and Northern America. In the developing countries, China, India and the former Soviet states, of course, it had never gone away.

The rapid spread of dengue fever and its deadly haemorrhagic strain to large areas of Asia, Africa and Latin America over the past decade is a sign of how increased urbanization and movement of people can provide opportunities for a disease to thrive. Before 1970, only nine countries had experienced epidemics of the deadly haemorrhagic variety. That number has increased to more than 50. WHO currently estimates there may be 50 million cases of dengue infection world-wide every year.

The problem is even greater for malaria. A decline in funding, insect resistance to DDT and environmental concerns related to DDT led to the malaria eradication campaign being abandoned in 1972. Malaria has been rebounding ever since and is now even reappearing in some countries that had previously eliminated it. The number of annual deaths from malaria...

Improving people’s health may be the single most important determinant of development in Africa.
is now 1.1 million, nearly back to 1950s level. Millions of people fall sick every year. The drain on family, community and the economy is enormous.

It is not only infectious diseases that spread with globalization. Changes in lifestyle and diet 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

By substantially scaling up investment in health we could save around eight million lives per year and generate economic benefits of $360 million billion by 2015.

old socialist economies in Europe and Asia opened up to Western goods and capital, camels and cowboys began to appear on buildings and billboards.

Last year’s anthrax incidents in the United States have taught us how vulnerable even the most sophisticated societies are to the deliberate use of chemical and biological agents to cause harm and panic. But we have also seen that this wake-up call has been heeded by a number of countries around the world.

In short, what is emerging today is a new and wider notion of national security, something we perhaps can call – for want of a better word – ‘human security’. The levels of ill-health in countries constituting a majority of the world’s population pose a direct threat to their own national economic and political viability, and therefore to the global economic and political interests of all countries.

Health as a component of human security – Health as a threat to stability

Not only are people vulnerable to diseases that originate on the other side of the globe. Disease is also helping to erode the basic foundations of civilised society in countries which have lost out in the past decade’s race for investments and economic growth.

In many parts of Africa, some parts of the Middle East and some countries in Latin America and Asia, people have seen decades – in some places more than a generation – of stagnation. They are certainly not progressing; in many countries they are even moving backwards.

Many are living in countries where too many people cannot meet their basic daily needs for food, water and shelter. They cannot access services that they need for survival, including essential health care and personal protection. They are vulnerable and insecure.

Between 1990 and 2000, the human development index declined in nearly 30 countries. Today well over a billion people – more than one fifth of the world’s population – are unable to meet their daily minimum needs. Almost one third of all children are undernourished. In many of the countries that have seen economic growth, increasing inequality means that the poorest part of the population has seen little or none of the benefits from this growth. In fact, the average African household consumes 20 per cent less today than it did 25 years ago.
Over the past 15 years, the populations in many of the poorest countries have also become much harder to reach. As the iron hand of the cold war loosened its grip, the result in some areas was armed conflict and seriously weakened states. Of course, this trend is far from universal: Mozambique, Uganda, and Cambodia are only three examples of countries which have seen peace, stability and functional government appear out of the ashes of war during the past 15 years.

Today, nearly a third of the population of Sub-Saharan Africa lives in countries one can define as weak and failed states or states which are ravaged by complex emergencies. Development or humanitarian work in such states is, therefore, a very difficult task. One of the key signs of a failing state is its growing inability to provide even basic services, including primary health care, to its population. A descent into poverty and lawlessness leads to rapid declines in health indicators such as infant mortality and life expectancy.

Southern Africa is a case in point. A number of political, economic and social factors have played a role in creating a situation where more than 14.5 million people in that region are now affected by famine. But there is no sudden event that has caused the crisis. It has been compounded by the AIDS pandemic which has reversed much of the tremendous progress Botswana had achieved and is now becoming a profound burden in South Africa, as well as Zimbabwe, Zambia, and Malawi.

Failed states function as breeding grounds for a number of diseases, like polio, malaria, and sleeping sickness, to mention only a few. Complex emergencies are prime breeding grounds for HIV/AIDS because of population movement and deployment of peacekeepers and other military and police staff. This also holds true for other communicable diseases.

A strong state is needed to sustain public health to prevent disease outbreaks, win battles for eradication, and create conditions that reduce

As disease in the slums of London threatened those living in Mayfair a century ago so the slums of Nairobi threaten those of us lucky enough to live in the rich part of the world today.

disease transmission and promote health for all.

In countries in crisis people get locked in a vicious cycle of poverty and insecurity. Rates of severe illness and death are high and often growing, as is the case with HIV/AIDS. The crises are caused by: violent conflict, often over decades; natural disasters, like drought or flooding; economic collapse; or poor governance. Often these causes work together in a deadly combination.

These underlying causes form a downward spiral, which makes countries increasingly weak. The greatest challenge is to address the underlying causes before we are faced with the ultimate consequences – famine, unrest and human suffering.
Health as a development issue
This downward spiral between poverty and disease is familiar enough. Over the past few years, however, a growing body of research has shown that such a spiral can also be reversed.

For too many years, investments in health were seen by many economists as an add-on which developing countries could only afford after having reached a higher income level. I am convinced this is wrong: a healthy population is a prerequisite for growth as much as a result of it.

In 1999, I asked leading economists and health experts from around the world to come together and consider the links between health and economic development. I wanted them to change old dogmas. In its report two years later, this Commission on Macroeconomics and Health showed how investments in health can be a concrete input to economic development. It also demonstrated how improving people’s health may be the single most important determinant of development in Africa.

Its argument reached wider than merely documenting how diseases are a drain on the economy through the cost of treatment and the reduction in high-quality human resources and productivity. It looked into the lost investments in industry and tourism in areas plagued by malaria or dengue or weakened by HIV/AIDS. The report documents a tremendous potential for developing countries if only the main infectious diseases can be brought under control.

The report highlighted the need for major new injections of resources from high income countries. It called for a major increase in the resources invested in health in the poorest countries over the coming two decades.

It provides the first detailed costing of the resources needed to reach some of the key goals set in the UN’s Millennium Declaration. The report calls for an annual investment of $66 billion from year 2007, over half of which will come from the developing countries’ own resources and just under half that should be contributed from the rich countries in the form of effective, fast and result-oriented development assistance.

The Commission puts forward a global framework for health. By substantially scaling up investment in health, we could save around eight million lives per year and generate economic benefits of more than $360 million billion per year by 2015-2020.

Global health and trade
The 1990s were marked by a strong belief in free-market ideologies, coupled with systematic efforts to ‘roll back’ the power of governments. If there is one lesson from the freewheeling 1990s it must be that better markets do require better government. We have again seen that market forces on their own do not ensure equity and development – this time in a global context.

As we have seen, the costs of this lesson have been high. For most of Africa, large parts of Latin America and the Middle East and some countries in Asia, this decade has been one of stagnation and crisis.

The reaction to this increasing gap
between rich and poor has created strong forces working to counter the inequities which may result from unfettered market forces. Increasing development aid is central to this effort. Only a handful of countries live up to the international goal of spending 0.7 per cent of GDP on development assistance. Several countries, notably the United Kingdom, have made efforts to boost their aid budgets. The United States have also promised aid increases, although from such a low base that the net effect is still moderate. Such investments are crucial if we are to achieve any of the ambitious goals the world set itself in the Millennium Declaration, of reducing poverty, pollution and disease and improving education.

The development of new mechanisms to mobilize and channel resources for health, such as the Global Fund Against AIDS, TB and Malaria and the Global Alliance for Vaccines and Immunisation is also an encouraging promise that we will be able to both finance and deliver effective interventions.

Another significant development over the past couple of years has been the growing acceptance of technology and knowledge as public goods. There is now a global cry for equitable access to medicines for the prevention and treatment of HIV/AIDS, as well as other essential medicines, especially those for common childhood diseases, major infectious diseases and chronic conditions such as diabetes, hypertension, epilepsy and mental disorders, which benefit from long-term treatment.

New international agreements, including the WTO TRIPS agreement must be struck in a way that ensures the principle that these medicines become available to those who need them regardless of purchasing power.

This work is absolutely critical. For too many of the world’s poor people, particularly those with an income of one or two dollars a day, the onset of serious illness in the family often leads to death, disability and impoverishment. Out-of-pocket payments – a large proportion of which go on medicines – constitute up to 90 per cent of total health spending in some poor countries. For many the reality is stark: no cash, no cure.

Thirty-eight countries spend less than two dollars per person per year on medicines, and many of these countries have large numbers of people living with AIDS. Overall health expenditure in some countries is as little as 10 to 12 dollars per person.

The same principles of equity and fair access must apply to the next WTO milestone: the negotiations on an agreement for trade in services. The issues here are complex: a freer flow of services and human resources can benefit developing countries through better efficiency and new market opportunities, but again equity and the principle that health issues take precedence over trade must be respected. It will also be necessary to assist development country governments in strengthening their ability to provide effective stewardship in a complex environment where both private and public sector share responsibilities for the health needs of the population.
Health as a tool for a more just and inclusive global society

In Western Europe, we have lived through a century of spectacular economic and social gains for the vast majority of the population. We achieved this through a broad consensus that no-one should be left behind in the development that as a continent made us rich. No matter which government ruled, the basic social-democratic values of inclusion and solidarity dominated Europe during the crucial years between 1945 and 1980 to such an extent that every country has an extensive welfare system and security net for those who need it.

Underlying the progress of the 20th century was a revolution in health and hygiene in the second half of the 19th. As Europe learned about the existence of infectious agents, the importance of hygiene and clean water became apparent. The rich finally began to do something about the dreadful slums that surrounded their wealthy areas. As hygiene and health care improved, the average life expectancy increased by nearly 20 years in many countries. Following this development was the huge industrial push that brought the current wealth and affluence to the West and practically eradicated absolute poverty from most of Europe.

Today, we have to increase our horizon. As the slums of London threatened the health and welfare of those living in Mayfair a century ago, the slums of Nairobi today threaten the stability and welfare of those of us lucky enough to live in the rich part of the world. And in the way that solidarity took root in Europe after the Second World War, we now need a global solidarity.

The world today is too small to accept the enormous differences between rich and poor, between those who live healthy lives far into their 90s and those who see their children die from nothing other than an unfair distribution of our global wealth. A world in which the divide between the have and have-nots 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 health we have a road map. Thanks to the Commission on Macroeconomics and Health, we even have a price tag. We have a number of interventions we know work. We have mapped the key risks to health and we can therefore foresee the needs in the years to come and the actions we need to take today to reduce the future burden of disease.

It is such an eminently possible task. It only requires that we rediscover our roots of inclusion, fairness and equality.

Dr Gro Harlem Brundtland is Director-General of the World Health Organisation.