

In the eye of the storm

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The future performance of OECD health systems will depend on how healthcare is progressing globally. A greater effort, including investment, is needed to improve health systems in other (particularly poorer) countries.

Those of us brought up in wealthy OECD countries since the Second World War have been lulled into a false sense of security by our modern health systems and medicines. We too easily forget the power and virulence of unconquered disease. We forget the "Black Death" of the 1300s in which one-third of Europe's population perished. We forgot that Spain's conquest of Mexico received more than a little help from the smallpox brought by a single infected slave; Mexico's population plummeted from around 20 million in 1520 to just 1.6 million by 1618.

And we forgot that an estimated 95% of the population of the New World was wiped out by diseases the native Americans had never encountered – influenza, measles, smallpox, typhus and tuberculosis. Similar tragedies were played out in Australia, Fiji, Hawaii, Southern Africa and elsewhere.

All this is just ancient history. Or is it? The biggest natural disaster of the last century was not fire or flood, earthquake or drought, but the influenza epidemic of 1918-1919 that killed 25 million people. Now, AIDS is well on the way to surpassing that figure. In the 20 years since it was first reported, AIDS has infected 58 million people and killed 22 million of them, according to UNAIDS.

We, in wealthy OECD countries, have grown up in an unusually fortunate age, where our antibiotics and vaccines have been able to hold many diseases at bay. Smallpox has been vanquished. Polio likewise is within range. But anti-

microbial resistance is spreading. Tuberculosis is making a comeback in major cities in the United States and Europe. The West Nile virus arrived in North America in 1999, infecting 69 people in New York and killing seven. Malaria is still endemic in tropical zones, killing millions.

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In the last couple of years, following the rampant spread of AIDS, the international community seems to have finally woken up to the health crisis facing the world's poorest countries. Several new initiatives have been launched in the last few years. They include Stop TB (www.stoptb.org), Roll Back Malaria (www.RBM.who.int), the International AIDS Vaccine Initiative (www.iavi.org), the Multilateral Initiative for Malaria (www.nih.gov/fic), the International Partnership for AIDS in Africa (www.unaids.org/africapartnership), and the World Health Organisation's Commission on Macroeconomics and Health (www.cmhealth.org).

In May 2001, the UN secretary-general, Kofi Annan, launched a "Global AIDS and Health Fund", aiming to raise US\$7-10 billion to fight HIV/AIDS, malaria and tuberculosis. But by August only about

US\$1.4 billion had been raised and Mr Annan has had to weather criticism from irritated donors that he raised expectations too high.

The trouble is, the UN secretary-general's figure may be just what is needed. Without an assault of that scale, the problem will hardly be dented and the consequences will be unimaginable. Mr Annan is supported by the strong vocal support of a widely respected Harvard economist, Jeffrey Sachs.

Representatives and organisations from around the world want the new Fund to become operational by the end of 2001. UNAIDS executive director, Peter Piot, told a meeting in June that half of the amount Mr Annan aimed to raise to fight AIDS would be needed for sub-Saharan Africa alone. Current spending in developing countries to fight the disease is estimated at just \$1.8 billion.

Yet around 36.1 million people are living with HIV/AIDS, most of them in sub-Saharan Africa, where 3.8 million people became newly infected last year. Of the more than 10.4 million AIDS orphans world-wide, over 90% live in sub-Saharan Africa and it is predicted that by 2010, the 19 worst affected African countries will have produced about 40 million orphans.

But AIDS is not the only problem. There were some 8.4 million new tuberculosis cases in 1999, up from 8 million in 1997. The rise was largely due to a 20% increase in African countries most affected by HIV/AIDS, according to WHO. Alarmingly high rates of multi-drug-resistant TB are

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TB, as seen in an x-ray. The pale pink area shows extensive fibrosis in both lungs, called primary pulmonary tuberculosis. In the post-primary stage cavitation may occur.

occurring not only in Africa, but in Argentina, Estonia, Latvia and Russia. With modern jet travel, the resistant strains can spread quickly. In the early 1990s the US spent nearly \$1 billion treating just 350 cases of multi-drug-resistant TB in New York, from a strain that had migrated from Russia and Asia.

Drug-resistance thrives under poor drug control regimes, caused principally by under-resourced health systems – if patients do not complete a course of treatment, or are given inappropriate antibiotics, the bacteria can develop resistance to the drugs.

Malaria also kills over a million people each year – mainly children – and severely erodes national incomes. According to WHO, it has reduced sub-Saharan Africa's GDP over the past 30 years by around US\$100 billion. There is no vaccine, and again, resistance to current drugs is growing. Some epidemiological models predict that with global warming, by the end of next century, malaria's range will have

increased from the current 45% to around 60% of the world's population. It has already returned to parts of the US, Korea, southern Europe and the former Soviet Union. Even scientists in the UK are preparing risk assessments, to determine whether this "marsh fever", rife from the 16th to 18th centuries, could return.

Can OECD countries afford to ignore these problems? No – and not just for moral reasons. Costs on OECD health systems will come under pressure as diseases and drug-resistance spread. In fact, the evidence points to a stark but simple choice facing OECD countries: invest several billion dollars now, strategically and carefully, in helping developing countries solve their current health crises, or pay hundreds of billions in future years to deal with international humanitarian disasters, collapsing economies (and OECD export markets), waves of stricken refugees and outbreaks of virulent drug-resistant diseases.

The Global Health Fund is an important initiative but is fraught with potential problems, not least the need to ensure that the planning and administrative burdens on developing countries are simplified, not increased. A lack of co-ordination by donors forces developing countries to tie up more of their scarce financial and administrative resources in the red tape of compliance required by their donors. Reform is needed here.

Similarly, control of the new fund requires careful thought: in particular, will it be another donor-driven exercise, or will developing countries and poor people themselves be at least full partners, if not taking the lead in the decision-making processes?

A further matter to be resolved is that of drug prices. The World Trade Organisation's TRIPS agreement on intellectual property rights needs to be revised in a pro-public health way. Yes, incentives for research are vital, but these might well be better provided by an international fund guaranteeing purchase of successful drugs, viewing health as a global public good, rather than an

individual luxury commodity available to those who can afford it. For all its trumpeted importance, the current patent system has resulted in AIDS drugs that have been unaffordable to most of those in need, and has led to virtually no new drugs for tuberculosis and malaria being developed in the past 30 years.

Finally, national health systems in developing countries must be strengthened. This will require significantly more aid, less debt

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repayments and sustained capacity building and technical assistance. In 1999 the global donor effort for all health programmes in sub-Saharan Africa totalled just \$1.30 per person, a figure Jeffrey Sachs described as "tragically insufficient".

Health security strategies can no longer be formulated purely nationally. They must be considered in a global context. An OECD country's health services and public health strategies will be ultimately ineffective if they ignore the interdependency of global health challenges. Today we understand the importance and gravity of these challenges better than ever. We have an historic opportunity to meet them. Will we invest now, or pay later? ■

References

- Diamond, J., *Guns, Germs and Steel: A Short History of Everybody for the Last 13,000 Years*, Vintage, London, 1997.
- Dombo, M., Muwonge, J. and Brandt, D., *HIV/AIDS and Human Development in Africa*, World Vision International, Monrovia, CA, 2001.
- Ford, N. and Hoen, E., "The Global Health Fund: Moral Imperative or Industry Subsidy?", *The Lancet*, August 2001.
- Sachs, J., "The Links of Public Health and Economic Development", Office of Health Economics, 8th Annual Lecture, London, OHE, May 2001.
<http://www.ohe.org/meetings.htm>