Globalization and Sustainable Development

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Today, public health challenges are no longer just local, national or regional. They are global.

They are no longer just within the domain of public health specialists. They are among the key challenges to our societies. They are political, economical and cross-sectoral. They are intimately linked to environment and development. They are key to national, regional and global security.

Which is why, more than ever, health threats, the costs, the risks and the potential instabilities involved, are on the minds of investors and the professions advising them, not just on the minds of responsible governments.

So is the case with some of the major threats to the environment. There is little doubt that the process of human-induced Global Warming has begun. Meanwhile, the process of reducing greenhouse gas emissions has hardly started. Global carbon dioxide emissions climbed by 22 % between 1980 and 2000. And increasingly, developing countries including India and China are adding relatively more to the total impact.

I know this issue is a very controversial one in the US, Canada's neighbour towards the south. But, hopefully, the experiences such as hurricane Katrina will shift more emphasis towards taking action, and less on continued denial.

In fact, before the November elections a debate is raging in California about the proposed legislation to impose caps on greenhouse gases both for industries and carmakers, the first such regulations in the US.

Today the US National Academy of Sciences report in 2002 seems prophetical: "Recent scientific evidence shows that major and widespread climate changes have occurred with startling speed"—"Greenhouse warming and other human alterations of the earth system may increase the possibility of large, abrupt and unwelcome regional and global events." The perspectives are scary. Scientists with (IPCC) indicate that the global mean temperature may rise by 1.4 – 5.8 degrees Celsius by the end of this century, depending on technological, economic and demographic developments. Should the higher end of this spectrum come through, humanity is in for a major disaster. For comparison, it is

worth noting that a cooling of 5 degrees Celsius would be enough to trigger a new ice age!

Based on our analysis in 'Our Common Future' almost 20 years back, we also warned strongly about climate change, which at that time was largely unknown.

Following our report in 1987, we saw a dramatic shift in public opinion. This was driven by concerned NGOs, policymakers and experts, extreme climate events and then a masterly crafted scientific consensus process under the auspices of IPCC (Inter-governmental Panel on Climate Change).

A dramatic change was taking place. Five years after Our Common Future, we had a global framework. The climate convention was established. That was surely beyond our dreams. Then the 1990s saw an impressive series of global summits, tough negotiations and new scientific reports leading up to the Kyoto meeting in December 1997. Crucially, Kyoto established the basis for legal commitments to reduce emissions of greenhouse gases.

This is impressive, but, unfortunately, it is by no means enough! Vested interests continuously mobilise against progress and global emissions are increasing almost as if nothing has happened. Why?

First, we have to realise that global warming is a uniquely demanding task to face. Not only is it the ultimate environmental problem of the world, it is as much a pressing geopolitical- and economic challenge. Any effective global action is bound to challenge individual lifestyles, vested interests of major corporations and key national interests of key nation states.

Second, even with the solid scientific consensus established by IPCC, uncertainties remain, both on the nature of the problem and on what are the most promising response to opt for. Moreover, while the benefits of climate action are long term, uncertain and span generations, costs prove themselves immediately to political decision-makers and key economic players.

Third, we have to deal with very explicit North/South asymmetries. While economic activities in the Western world so far are largely to blame for the problem, developing country action is part and parcel of any realistic plan to halt global warming. This has pressing distributional implications, and requires unprecedented political will and extremely creative global bargaining in order to find lasting solutions.

So why am I still basically optimistic? Why do I still believe that we can be up to this task? I will answer that question with some highlights from my experience as Director General of the World Health Organisation (WHO).

A key feature of our policy in WHO was harnessing science and knowledge for the global good. This implies backing up our key messages with solid evidence, drawing on

the very best of global expertise. Our recent successes in addressing SARS, tobacco and our progress in addressing Aids and other communicable diseases owe much to this strategy of evidence-based advocacy and decision-making.

The parallel to climate change is obvious: probably the most striking success in addressing global warming policy so far is the unique scientific consensus process under the auspices of the IPCC. Given the complex uncertainties I mentioned, and the incentives by vested interests to exploit this uncertainty—IPCC, even if still controversial in some quarters, is nothing but a true UN success story.

Our next lesson was that we had to communicate very clearly the key links between human health, poverty and economic development. We needed to develop a message that could persuade presidents, prime ministers and finance ministers that indeed they are health ministers themselves. I asked Professor Jeffrey Sachs, now at Columbia University, to lead a group of 18 distinguished economists and health experts, to make sense of the links between health and development. And I think we succeeded in merging scholarly evidence and political advocacy: the Sachs Commission has presented a definitive argument for the need to invest in health as part of a basic human development strategy.

I see the same happening in the area of climate change. At local and national levels, initiatives abound in visualising the benefits of action and dangers of inaction on climate change.

In an interconnected and interdependent world, bacteria and viruses travel almost as fast as email messages and money flows. There are no health sanctuaries. No impregnable walls between the world that is healthy, well fed, and well off, and another world, which is, sick, malnourished and impoverished. Globalization has shrunk distances, broken down old barriers, and linked people together. It has also made problems half way around the world everyone’s problem. And we know that, like a stone thrown on the waters, a difficult social or economic situation in one community can ripple and resonate around the world.

Now, there are solutions for those diseases, which plagued the explorers, soldiers and colonialists of historical times. We know how to prevent and treat malaria. There are vaccines for yellow fever. There are treatments for TB. The striking feature is, while we diligently take anti-malarials and top up our vaccinations when we travel to developing countries—the people living there, those threatened most by these diseases—don’t have this access. 3,000 children in Africa die each day from malaria. They die of vaccine preventable diseases—like measles, by the hundreds of thousands. And, people are dying, by the millions every year, of HIV/AIDS.

Twenty years ago, HIV was a spectre, all but invisible on the horizon. It was considered a disease, which affected specific minorities—gay men and intravenous drug users. Science was slow to respond. The rare cancer, Kaposi's sarcoma, was a marker, and a sentence to die a painful, slow and often lonely death.

The world took more notice with the realization that the human immunodeficiency virus knew no borders. By 1990 in wealthy countries, we were screening blood donors and teaching our kids how to protect themselves against HIV. Condom use had increased. Incidence declined. And then anti-retrovirals were made available to those who could afford them. People in countries with health insurance gained access, giving tremendous hope for a longer, healthier life. In short, HIV diminished—for those in rich countries—as an urgent public health problem.

Today, more than 40 million people are HIV positive. 30 million of them are living in sub-Saharan Africa. They are trying to survive in some of the poorest countries and conditions—with no access to the most basic health care—much less sophisticated and expensive treatment. They are mothers and fathers, teachers, and nurses and other health professionals, civil servants, miners, and soldiers. They are leaving a huge social and professional gap—an imminent threat to countries struggling to develop. They are leaving orphans, penniless grandmothers caring for their children's children, family members and communities frightened, hurt, stigmatized. Health systems stretched well beyond their often-frail capacities. We will see the effects of this unfolding tragedy for decades to come.

Many places in Africa we see a downward spiral, making countries increasingly weak. The important challenge is to address the underlying causes and arrest the descent, before we are forced to deal with the ultimate consequences—famine, unrest and human suffering.

Let us think of other areas where HIV is creeping in—China, India, the Central Asian Republics. Knowing the impact in so many other areas, we cannot stand on the sidelines, only to see another HIV crisis unfold before our eyes with the economic, social, and political devastation it will bring.

In 2003 we experienced the shortest, sharpest shock of all – an outbreak which captured imaginations, often more column inches than the war in Iraq, and always more headlines than Aids, TB or malaria. Severe Acute Respiratory Syndrome put the world on high alert, and drove unprecedented cooperation to stop a disease, which had an immediate and negative impact on markets, on tourism, on trade. And, on hospitals, even in the most well developed countries with the most advanced health systems.

One person infected, staying at an international hotel, put the world at risk. And unlike other diseases which we can prevent or treat, SARS was undiagnosable, untreatable, and, for one of every ten people, fatal.

The way the world responded to SARS was global cooperation at its best. Scientists put aside their differences and drives to be the first, and came together, to share sequencing and study results. Doctors from around the world came together in virtual conferences, to share advice on how best to treat patients. Public health authorities from opposite sides of the globe flew to Geneva, to share their experiences with SARS, their success and

failures with 192 member states at the World Health Assembly. And as a result, in just four short months, we had identified a new disease and contained a global outbreak, which could have become a global catastrophe.

The short sharp shock made us all stand up and pay attention. Due to the speed of science and using the best evidence, we quickly knew that SARS could infect anyone. Governments were committed. Resources made available. People made aware. Health workers given tools for action. Information shared across borders. In short, there was global mobilization to fight a global threat. The result—we probably won't find ourselves 10 years down the road with SARS also endemic in the countries, which can least afford it—devastating lives and economies. Because we acted to make sure that wouldn't happen.

And, we found that it was in everyone's interest to act. In today's connected societies, there was no choice. It was impossible to hide SARS in a world with the Internet and email. Impossible to pretend it didn't exist, or that it was already contained. The consequences of doing so were mistrust in government, and in economies. Societies have been shaken to their foundation, fundamental questions raised about the handling of disease, of media and information, of constituents.

As you all know, we now face the risk of a new, major influenza pandemic, in the wake of the Avian flu now spreading across the world. Until now, there has been no spread from humans to humans, although more than a hundred people have been infected from animals. Our public health systems are stockpiling medications and preparing for the production of a vaccine, in case such a new situation could be evolving.

The experience with SARS has improved our international network to respond. However, far more needs to be done to reduce the potential impact of a new pandemic. Many poor countries are ill-prepared and have little or no public health capacity. A number of richer countries, too, urgently need to move forward, based on the recommendations made by the WHO to secure continous monitoring, response and mitigation.

Contingency planning is of the essence, to be able to limit the spread and the total damage to lives and societies.

No one is able to quantify this risk, nor to quantify the size of an outbreak in humans. You may have seen hugely different numbers reported about the potential death toll globally. The point is that the difference between "a worst case scenario", repeating the dimensions of the "Spanish Flu" in 1918, and a more moderate assessment, is huge. Representatives of WHO have addressed both scenarios, resulting in a range between 5 to 10 million—and 150 million dead.

If, or when, Avian Flu spreads between humans it would be the first such pandemic since East Asia became integrated into the global economy. What has become one of the greatest sources of strength for the world's financial and commodity markets would become their greatest vulnerability.

Investing in improved surveillance and other key capabilities for health is a way of turning risks into opportunity.

A world where a billion people are deprived, insecure and vulnerable is an unsafe world. The separation between domestic and international health problems is losing its usefulness as people and goods travel across continents. More than two million people cross international borders every single day, about a tenth of humanity each year. And of these, more than a million people travel from developing to industrialized countries each week. Trade flows—of raw materials, goods and services—have increased fifteen-fold since 1945. Investment flows have multiplied more dramatically still, fundamentally changing the way that economies and societies interact.

We also know that, in poor countries where people feel powerless, and watch as much of the world gets richer, they can bundle hatred and channel it in the most devastating ways. A giant construction site where the World Trade Center used to be will always remind us of a world of conflict, a world divided. It exposes a new awareness of our vulnerability.

We must counter this manipulation of despair. We should seek to engage even more strongly to promote the values of democracy, justice and human rights, and help foster sustainable development.

Successes in health have been unevenly distributed: 1.3 billion people have entered the 21st century without having benefited from the health revolution. These are the people who are still living in absolute poverty. That is, living on less than US$ 1 a day.

The health impact of this inequality gap is staggering. Despite the rise in average global life expectancy, in the least developed countries, three out of four people die before the age of 50. Infant mortality is almost seven times higher in a developing country than in industrialized countries. A child born in a developing country today runs a 1.000-fold greater risk of dying from measles than a child born in an industrialized country. Children living in absolute poverty have a five-fold greater probability of dying before their fifth birthday than their wealthier counterparts.

Poverty breeds disease—more than any other single cause—just as disease breeds poverty. In countries in crisis, rates of severe illness and death are high—in some settings the daily death rate is at least double the expected level. One of the key signs of a failing state is its growing inability to provide even basic services to its population. A descent into poverty and lawlessness leads to rapid declines in health indicators such as infant mortality and life expectancy. At CIA, where the analysts used to count warheads and troops they are now paying attention to changing child mortality rates as a telling sign of a state heading for collapse.

In the spring of 2003, the world also came together in the largest act of unity for health. 192 countries adopted the Framework Convention on Tobacco Control—the first truly international health treaty. Implementation of the treaty will see tobacco advertising

banned, increases in the price of tobacco products, efforts to control smuggling and more smoke free places. This will also counter the challenge of second hand smoke, a risk that affects us all, smokers and non-smokers, as your own report recently has confirmed..

The Tobacco Convention had many opponents—many actively fighting to undermine the spirit and the letter. But those who wanted, and needed it most prevailed. Developing countries made the strongest push to see the convention adopted. Through this instrument, they have the power to keep the tobacco industry from encroaching further. And the power to reverse the current trend, which, would kill 10 million people every year by 2020.

That is foresight—for health, development, and for global security. It illustrates the world creating a global public good.

I believe we are now standing at the threshold of a major shift in thinking among financial officials and economists. Health spending was seen as consumption rather than investment.

Poverty breeds ill-health, and triggers a vicious cycle, hampering economic and social development and contributing to unsustainable resource depletion and environmental degradation.

Now we are learning an even more powerful lesson. Health gains trigger economic growth and, if the benefits of that growth are equitably distributed—this can lead to poverty reduction.

As in Europe at the end of the 19th and beginning of the 20th century, we have seen that developing countries which invest relatively more, and well, in their peoples health are likely to achieve higher economic growth.

In East Asia, for example, life expectancy increased by over 18 years in the two decades that preceded the most dramatic economic take-off in history.

The Asian Development Bank concluded that fully one-third of the phenomenal Asian economic growth between 1965 and 1997 resulted from investment in people's health.

There is now growing recognition that our world is turning into a two speed global society: perhaps a billion people are enjoying unprecedented prosperity and advantage, while nearly half are living on less than $2 per day and have extremely limited prospects for prosperity. This perpetuation of poverty and deprivation also creates an insecure world for us all. There is new evidence on the ways in which frequent and severe illness keeps poor people and their societies poor, and prevents them taking advantage of opportunities to earn, to learn and to have a better life.

Extending the coverage of crucial health services, including a relatively small number of specific interventions, to the world's poor could save millions of lives each year, reduce poverty, spur economic development, and promote global security".

We need to invest in people, in their health and education, not only to promote human rights, but to spur economic growth.

Competition in a global market place will not provide enough incentives for poor countries to move out of poverty. The idea that little help should be given to any country apart from supporting free-market reforms and democracy, is now fortunately being seriously challenged.

Humanitarian aid and development assistance have contributed greatly to reduced suffering and increased security. We should expect even more: after a decade of shrinking resources for international development, donors have become increasingly focused on support for quality programs that promise to yield measurable results. It is a sign of hope that key donors have made commitments to raise, not lower their abysmally low levels of ODA.

Public responsibility, local and national government action is of course indispensable to deal with the human and environmental challenges involved.

Historically speaking, improvements in health and life expectancy were phenomena linked with the dramatic technological and economic changes taking place since the last part of the nineteenth century. Better health and nutritional status were both a result and a cause of higher income levels.

In contrast, the 20th century health revolution has resulted far more substantially from the generation and application of new knowledge.

While life expectancy in England and Wales varied around an average of 40 years during the two centuries preceding 1870, in the subsequent 130 years it almost doubled. Other countries shared this pattern in the 20th century.

As an example: The life expectancy for a Chilean female in 1910 was 33 years. Today it is 78 years, an increase of a remarkable 45 years. From an average of 5,3 children at mid-century, her fertility has dropped to 2,3, barely above replacement level. This is what we call the demographic transition. Typically, following improved health and life expectancy, fertility falls. She will have fewer infections, less anaemia, greater strength and stature, and a quicker mind. Her life is not only much longer; it is much healthier as well.

Other low and middle income countries are undergoing a similar transformation.

Tragically, recent exceptions to these favourable trends are seen in AIDS-ravaged parts of Africa, and for a variety of reasons, among adult males in Central and Eastern Europe.

Increasingly, countries have taken the view that they must base their policies on the right to health and education for all. This has greatly helped generate and apply new knowledge.

Rich countries typically have a well-functioning health system with universal coverage, although there are remarkable exceptions, such as on this continent. They spend 6 – 15 per cent on health care. However, being highest in that range is no guarantee you are the best with regard to total health impact.

Health systems have increasingly been developed that cover the whole population, although we know there still are big gaps between rich and poor countries, as well as within countries.

Health has therefore been centrally placed within the so-called Millennium Development Goals that were reaffirmed at the last Summit of the United Nations.

The importance of good governance and a functioning health system that reaches all, has also been clearly demonstrated by the dramatic developments, in China and also some of the other socialist countries, after their rapid transition towards a market economy.

Dismantling of public services, also in health, has been followed by a reduction in health indicators and large inequities in access to health services.

In China, 71 % of the people were insured in 1981, only 21% by 1993.

A key responsibility of the health system is to narrow health equity gaps, and governments need to play a central role in making that happen.

These are also illustrations of why we need to invest in people, in their health, environment and education, to create a world that is more prosperous, more just and more secure.

The main question is one of taking responsibility, of using our democracies to promote change. This is an obvious choice. It saves lives, millions of lives. It is a basic human right, and a question of social justice. But it will also boost the economy, of poor countries and of the world.