What sort of international cooperation in health 2055?

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In a paper comparing the challenges to international health in 1950 and 2000¹ one of the shifts I lamented was a loss of optimism. In 1950 there were high expectations for global cooperation through the United Nations, whereas in 2000 the UN was troubled, with global policy and cooperation dominated by the G8 nations.² The UN's main health agency, the World Health Organization (WHO), designated to 'direct and coordinate international health work', was increasingly criticized and challenged by other players such as UNAIDS, the Global Fund to Fight AIDS, TB and Malaria, and the Bill and Melinda Gates Foundation, all of which arrived on the health scene only in the past decade. So what will international cooperation in health look like in 2055?

Fifty years on

Of one thing we can be certain: the need for cooperation will not have disappeared. Global trends in trade, travel and communication have highlighted risks that cannot be addressed within traditional national borders. They include new and emerging infectious diseases, international drug smuggling and human trafficking, environmental pollution and global warming, conflict and cross-border population displacement. No one state can by itself resolve these problems. At the end of the twentieth century the priorities for global action were communicable and non-communicable (for example, tobacco-related) diseases, environmental concerns, information and knowledge, trade and the international financial architecture.³

Fifty years hence, the needs of poor countries will not have diminished, but may have changed. Although over the last half of the twentieth century mortality in under-5s decreased from over 17 million to 11 million deaths a year, progress was strikingly uneven. In many countries of Africa health status was worse at the end of the century than in mid-century. The shocking lack of progress was due to a complex interplay between AIDS, weakened public health

systems, as well as conflict, worsening trade conditions and poor governance, resulting in huge inequities within and between countries. In an increasingly interdependent world, where the effects of poverty and ill-health are not confined within country borders, development assistance will be as important in 2055 as it is today (perhaps even more crucial, given global warming and increasing numbers of natural disasters). So what sort of international cooperation in health will meet these needs? Existing trends provide some hints.

At the beginning of the 21st century the global health agenda has been dominated by efforts to address poverty and increase aid. World leaders committed themselves to the eradication of absolute poverty and coordinated action through a set of eight time-bound and measurable goals—the Millennium Development Goals (MDGs). Discussions on how to finance the attainment of the MDGs started formally in 2002. This period was marked by an extraordinary global consensus that world poverty had to be tackled and the rich world must raise resources to assist the less prosperous.

The discourse around increasing aid was positive, with rising pressure to redress a decade of falling development assistance. First, WHO's Commission on Macroeconomics and Health provided evidence of the gap between needs and funds available; it was less knowledge or technology that was missing than sheer resources.⁴ Second, several innovative proposals were made to increase global spending on overseas aid, including the Tobin tax and the International Finance Facility (proposed by the UK Chancellor, Gordon Brown).⁵ These initiatives would double or treble long-term commitments to aid by taxing financial interactions and leveraging additional money from the international capital markets. In 2005 these moves were given a moral boost by the public response to the Asian tsunami, where at times private contributions matched governments' pledges. Intense media interest focused on the vulnerability of the poor and the plight of their governments, contrasting their predicament with the prosperous industrialized world, its wealth, and most countries' poor compliance with the UN's overseas development assistance target of 0.7% of gross national product. The UK promised to raise its aid to 0.7% of GNP by 2013, and if all rich countries followed suit, aid would rise from roughly US\$70 billion a year to US\$210 billion.⁶

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There was also considerable global consensus that aid should be focused on those countries with 'good' policy environments or governance (decision-making governed by the rule of law, with low levels of corruption, open markets, free media and so on), so that aid would be used to good effect.

Looking back, in 1950 development assistance was led by the UN (with health coordinated by its specialized agency, WHO) and by bilateral agencies (providing government-to-government aid). By 2000, that scenario was more complex, with the entry of many new players from civil society and the corporate sector, and new partnership initiatives incorporating old (UN agencies) and new players such as the Gates Foundation. By 2000 there were strong arguments for raising the level of aid, by billions of dollars, but making recipients more accountable for demonstrating responsible performance within good policy environments, and innovative ideas were being floated about different mechanisms for aid. Aid that had in the 1960s and 1970s focused on building up primary health systems, shifted towards technological interventions. This culminated, at the turn of the new century, in the diversion of much development assistance to subsidizing product research (new drugs and vaccines), while the systems for delivering interventions weakened considerably. By 2005 there was a growing call for increased support for health systems.⁷ So, looking ahead, one can take a pessimistic or an optimistic view on prospects for international cooperation in health.

Two visions of 2055

The pessimistic vision is that multilateralism will have diminished and unilateralism increased. The UN will have shrunk, focusing only on coordination in wars, conflicts and natural disasters. Most of its agencies will have disappeared. WHO will address narrow tasks of disease surveillance, and some normative regulation. Many of its policy functions will have been overtaken by global partnerships or other agencies, which will convene expert panels and develop international norms and standards. The power of the G8 will have shifted, with China and India becoming major players (brought to the table partly because of their potential impact on carbon dioxide emissions). Neither country will have great interest in upholding the UN, which they will perceive to have been dominated by the North for its first 50 years. But they will challenge the UN's most powerful agency, the World Trade Organization, ensuring that its rules of trade serve the interests of the fast industrializing countries. While this may favour China, India and Brazil, it could further disadvantage countries unable to compete in global markets. China and India may also follow the example of the USA, providing aid unilaterally in a self-serving manner—emulating such bodies as the US's

Millennium Challenge Corporation. This federal agency is planning to dispense US\$6 billion by 2006 to those poor countries which meet criteria such as political rights, lack of corruption, education expenditures, and days required to start a business. Finally, climate change will be taking such a huge toll on vulnerable populations that some cooperation will be necessary, but it will be narrowly focused (perhaps on regions), and health will no longer be high on the global agenda.

The optimistic view is that people will have begun to see their fortunes more closely tied together, approaching development cooperation from a perspective of enlightened self-interest that eschews unilateralism. In this scenario, development aid will target global public goods (to stop the spread of disease, to control levels of carbon dioxide in the atmosphere) corresponding to regional power groups. Multilateralism will still be a force, but the UN will be smaller, and regional organizations such as the European Union much more powerful. There will be no bilateral aid—government-to-government. All aid will be channelled through public-private partnerships, regional organizations or intergovernmental mechanisms such as the UK's International Finance Facility. Non-government organizations will be actively involved in policy discourse and in dispensing and delivering aid. Individual global health initiatives will have come and gone; for example, the Global Fund to Fight AIDS, TB and Malaria will have metamorphosed to address another set of ills because the global effort on HIV/AIDS will have paid off, just as the population movement of the century before led to a fall in fertility.⁸ Technology will have shifted attention from some diseases to others newly emerging.

Even in the above optimistic scenario, countries will still have to demonstrate good governance to receive assistance. However, they will be able to apply for large amounts of aid to address specific issues (including building up systems for health care delivery or capacity building) which will not leave them indebted. Those countries with weak or failed governments will receive much lower levels of humanitarian aid, channelled through non-government organizations. In those (and other) countries the corporate sector may assist employees and their families, just as in 2000 global companies began to provide antiretroviral drugs for their workers. But in many of these countries these schemes will be oases of care in deserts of neglect and instability.

I started by referring to a paper I had written in 1998, looking back over 50 years of international health. To look forward 50 years is much more difficult, and had I been writing in 1950 I would never have anticipated some of the changes that occurred. Much will depend on the sort of motivation that wins the day—humanitarianism, commercialism or enlightened self-interest.

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