Interview

An economist's view of health

In January 2000, WHO Director-General Dr Gro Harlem Brundtland set up a commission on macroeconomics and health to clarify the links between health and economic development. The commission comprised 18 leading economists and health experts and was chaired by macroeconomist Professor Jeffrey Sachs, who heads the Center for International Development at Harvard University. On 20 December last, Sachs presented Brundtland with the commission's report. He talks here with the *Bulletin*'s John Maurice about key elements of the report and some of its implications.

Q. What is the report's main message?

A. Without question, its most important message is that the world community could make a profound difference for the good of the world's poor by investing seriously in disease control and improved health. The technologies exist, the knowledge base exists and we know, at least in general terms, how to proceed. What we need to find now are the political will and the financial resources.

Q. Regarding financial resources, the report seems to suggest that a lot of new money will be needed. Given the constraints that many countries are facing, particularly after the 11 September events, what reassurance can you give governments that new money will produce real improvements in health?

A. The evidence is overwhelming that investments in health pay off. They pay off in controlling disease, in improving productivity of the workforce, in speeding up economic growth, and in fostering social and political stability. We have seen these benefits whenever the global community has invested in health, particularly in the health of the poor. Examples include the campaigns to eradicate smallpox and more recently polio; to control river blindness, leprosy, and trachoma; and to expand immunization coverage generally. The problem is that the poor have not benefited from these interventions to anywhere like the extent needed or to the extent possible, given the available resources in the world. The interventions work when we apply them, and yet every year millions of people die tragic, needless and socially costly deaths because they cannot access these interventions.

Jeffrey Sachs

Q. The commission's report calls for major investments from both poor and rich countries. What makes you think that the countries will respond to this appeal?

A. We are making a recommendation about what should be done. We are not predicting what is going to follow. Indeed, we say in the report that it is a vision of how a more peaceful, healthier, more prosperous world could be created. But we don't guarantee that either the donor countries or the poor countries will take advantage of the opportunity to turn that vision into reality. We are asking for a scaling up of donor funding to only one tenth of one per cent of the incomes of rich countries and we show that this modest amount would translate into about

eight million lives saved by the end of this decade. We are hoping that, more than reading the report and finding it convincing, policy-makers around the world will take up our recommendations to begin acting on them in 2002. We are calling upon poor countries to establish national commissions of macroeconomics and health and to chart out a strategy for scaling up efforts to implement our recommendations. We are calling on the donor world in every forum, from the World Health Assembly to meetings of the International Monetary Fund, the World Bank, the Organisation for Economic Co-operation and Development, and elsewhere, to prepare to make major increases in financing just as soon as the recipient countries can demonstrate feasible and realistic approaches to tackling their health problems. And we believe that this process can start early and should start in 2002.

Q. To what extent are the commission's recommendations unprecedented? Has any call ever been made before to the world's rich and poor communities on a scale as great as this?

A. I think what is unprecedented is the care the commission has taken to provide solid scientific underpinnings for its recommendations. Many people have long sensed that vastly more could be done to improve the lot of the poor for the mutual and common benefit of all peoples of the world. The notion of health for all has been around for a couple of decades. What we are offering is clear and, I believe, powerful evidence of how to accomplish the goals and how to achieve so much through significant, yet for rich countries modest, efforts. This approach follows closely upon the millennium summit of September 2000 when 180 world leaders committed the international community to a common set of development objectives for improving health, reducing poverty, and protecting the physical environment. This is the first comprehensive report since the millennium summit that shows how to accomplish an important subset of the millennium development goals. I believe that the approach will be adopted in other areas, such as education, environmental management, and so on.

Q. In a recent comment in the *Washington Post,* you denounced "the virtual disappearance of US foreign assistance". Are you optimistic that, thanks to the commission's report, the US and other rich countries that haven't been playing their full part in global aid will become more generous?

A. There has been a divergent trend in recent years, where many European governments have been raising their financial assistance to poor countries, as measured as a percentage of a donor country's gross national product, while the US has been on a long-term trend of cutting its level of donor assistance and is now essentially at the bottom of the world roster. That trend has to change. I believe that it is in US self-interest to reverse it, because, through the events of 11 September, the US has discovered the interconnectedness of the world and how underdevelopment can contribute to threats on US security. As an American who travels widely within the US, I also believe that the American people are generous and will back specific recommendations that are realistic, even if ambitious. I believe that the US will be re-thinking its development assistance strategy and will realize that it needs to be more in line with the rest of the donor world both for its own security and for its role in developing a world of shared prosperity.

Q. Assuming the new money will be forthcoming and that your hopes will be fulfilled, how will the poorest countries, which are most in need of support but which often have very shaky infrastructures and perhaps inefficient or even corrupt governments, manage to absorb the influx of funds?

A. What we are recommending is a scaling up of the health services and health interventions available in very poor countries. In some countries there is only one doctor for tens of thousands of people and large segments of the population have no access to medical care. So there needs to be a major investment in training, in building physical infrastructure, and in developing new systems of oversight and governance. What we are urging is that the process be started as soon as possible. But we recognize that it is a long-term process. We are talking about a generation-long effort, a phased effort, where investments are scaled up over time, commensurate with recipient countries' capacity to absorb funds. We in the commission have reflected on this capacity constraint, and we call on the donors to provide financing to ease the constraint. We also show in the report that while there are countries with extreme capacity constraints related to profound political instability and poor governance, the majority of people in very poor countries live in circumstances where the constraints are not so severe as to bar very significant progress. Places like China and India, for example, have more resources and would be more likely to find ways of reaching hundreds of millions of people through health interventions.

Q. The report speaks positively of the globalization movement. Not everyone is so sanguine about this movement.

A. I think that in the broadest sense globalization is about increasing economic, social and political interconnections between the world's societies and is a very positive trend because it enables the poorest countries to make use of the technologies, ideas, and capital of rich countries. Globalization has been a major stepping-stone for positive economic development. But its potential is not being realized in practice in a significant number of poor countries. There are many reasons. Some countries are so geographically isolated that globalization has had little impact on them. Some countries are so burdened by debt and disease that they are cut off not so much by physical geography as by financial crises and disease epidemics, and we describe such situations in the report. The anti-globalization protesters are making a valid point when they say that some of the poorest places in the world are not only *not* making progress in closing the gap with the rich countries but are actually falling behind in absolute terms. What we are proposing in the report is a way to help make globalization work for everybody. We are proposing an approach that ensures faster economic growth for the poorest of the poor so that they will have a vastly improved chance of benefiting from the globaliztion process. We believe that control of diseases like malaria and AIDS can facilitate the flow

of capital, technology and investment into these regions because these diseases are blocking countries from enjoying the fruits of globalization.

Q. The commission's report argues for greater access to antiretroviral treatment by people with HIV/AIDS in developing countries. Rumour has it that this was a controversial issue amongst the commissioners.

A. All the commissioners agreed that the AIDS pandemic is a unique, profoundly significant risk to the world and that we have to confront it with our full arsenal of disease control measures and response mechanisms. That means prevention as well as treatment, and not just antiretroviral therapy but also treatment of the opportunistic infections that accompany HIV infection. What we note in the report is that antiretroviral therapy is subject to a real risk. Because the virus mutates so rapidly, poor compliance with these drug regimens can lead to drug resistance and loss of effectiveness of the antiretrovirals themselves. Therefore, the scaling up of the use of these interventions has to be undertaken as a public health strategy with lots of operational research, lots of monitoring, lots of study of what is working and what isn't working, and lots of attempts to find the right protocol. As the report makes clear, this is not something that can be solved from one day to the next. The absence of an effective health infrastructure is certainly a barrier in many places where HIV prevalence is extremely high. We say in the report that this is not a reason for not acting but rather a reason to get started now in building the capacity and the infrastructure needed to support the scaling up of antiretroviral use. And we endorse the goal enunciated by WHO and UNAIDS experts, namely to have five million people on antiretroviral therapy by the end of 2005.

Q. The commission's report is generally positive about WHO and the World Bank as major actors in implementing its recommendations. Public scepticism, however, has been voiced about both of these organizations.

A. We desperately need multilateral institutions like WHO and the World Bank. They are so vital that we have to do everything possible to strengthen them in areas where they have weaknesses. Fighting major epidemics has become increasingly complex over the last decade and AIDS has emerged as the most overwhelming infectious disease epidemic in modern history. Yet, WHO's core budget has remained static in dollar terms year after year after year, just when we need to strengthen this organization's capacity and that of its partner institutions to help countries meet these dramatic challenges. Our report calls for an extra one billion dollars a year for the multilateral agencies charged with oversight and coordination of public health measures, especially the provision of global public goods by the year 2007. That's an important recommendation. These interventions do not reside in the marketplace. While they may use market forces, in some areas they require the provision of public goods at the local, national and international levels by agencies such as WHO.

Q. Advocacy groups, like Médecins Sans Frontières and Oxfam, have become increasingly influential on the international health scene. Do you see this as a positive development?

A. I do, because these groups have not only made contributions through the direct provision of health services, but also have helped to draw the world's attention to the health crisis and to its interlinked nature, such as the linkages between tuberculosis, malaria, and AIDS. I am hoping that we will find a broad commonality of views across the donor community, the recipient community, the pharmaceutical industry, and the advocacy community about the goals and the approaches that the commission recommends. What we have tried to do is forge a set of ideas and proposals that could win broad consensus across the whole spectrum of different and varied stakeholders in this process.

Q. The Brundtland commission on environment and development was spectacularly successful, most people would agree. What are the chances of your commission's recommendations being as influential?

A. I can only hope that Dr Brundtland's magic touch will rub off on this report as well. She is the progenitor and the guiding spirit behind it and not only launched the commission but also gave us critical support all the way through. As chairman of the commission, I can say that she gave me tremendous conceptual and practical help.

Q. What brought you into the health field in the first place?

A. I am a macroeconomist and I spent the first 15 years of my professional career at the university as an economic adviser worrying about issues of hyperinflation, currency stabilization, trade liberalization, and the like. As my macroeconomic work took me more and more into the very poor countries, I sensed with increasing intensity the impact of disease on the very economic objectives that I was trying to help promote. This was of course especially true in Africa, where I perceived the incredible burdens of malaria, AIDS, resurgent tuberculosis, and the general breakdown of public health in many places where I was working. Looking at these life-and-death issues as a macroeconomist, I discovered, first, that the disease burden was impacting on economic development and, second, to my great surprise, that the level of assistance and attention to disease was incommensurate with the scale of disaster that diseases were inflicting on societies. And so I became a scholar and practitioner of health and development economics.

Q. Is this more than just a parenthesis in your career?

A. It is more than a parenthesis because the message of the report that health is central to economic development means that anyone committed to economic development has to put health right at the centre of his or her agenda. As far as my agenda is concerned, that's where it will stay. ■