The Changing Landscape of Global Public Health
Evening Reception
Kaiser Family Foundation
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FEMALE SPEAKER: We are Notes and Keys, and we will be singing one more song for you this evening. Thank you so much.

LINDA P. FRIED: Thank you so much for that fabulous singing. You made our evening. So for everybody here, I'd like to not interrupt the evening, but add a little something to it if I may. We have two people here who are joining us to comment on our goals. I'm going to ask you if you could join us for a minute.

I invite you to come and join us for a few minutes after the wonderful singing. We've had, I think, a wonderful – actually very exciting day trying to both meet each other, understand each other's frameworks, think across sectors and disciplines and about how to create the next generation of public good in terms of health at a global level.

We've talked about – this is very challenging. We've talked at many levels today about how the world is changing, about how knowledge may position us to really address the changing health needs of now and the next decades. How to anticipate the needs of the future so that we can be proactive in terms of solving them and not wait until they're emergent or not soluble any more?

And the level of discussion that, from my perception, we've had has been extremely high level and has indicated a great deal of creativity and willingness to step out into

unchartered territory. Not bad for the first six hours of a meeting.

So I'm very pleased as part of our trying to really chart how public health should lead in a changing world based on knowledge and aligned with the greatest good globally to introduce two people who are engaged in the same enterprise. And I'm going to introduce first my colleague from Columbia University, Jeff Sachs, who will introduce our special guest.

Jeff, I think, is well known to – probably to everyone in this room. Even after wine, Jeff. Jeff is a professor at Columbia University and he is the director of the Earth Institute, and I'm very pleased to say, a faculty member in Columbia University's Mailman School of Public Health as well as many other roles.

So, Jeff, I'm delighted and we're all honored that you're here and thrilled to have you be in the mix on this set of conversations and to try and really create a vision for future leadership of public health [applause].

JEFFREY SACHS: Thank you so much, Linda. Could I ask people to come a little closer? It looks like – that would be good so we can have a little bit of a conversation together with a lot of people in this room whom I admire phenomenally and have learned from over the years. It's a real privilege to have the chance to share a few ideas with you this evening.

I know that the whole purpose of these days of reflection are to look forward, but I find myself always looking backward at public health because for me there are three milestones or pivotal moments in history that we haven't fulfilled, and I think we can only go forward by finishing the agenda that we started.

And so it's going to be a particular pleasure for me to introduce our special guest in a moment, who is in charge of the first of these primarily and that is honoring the universal declaration on human rights which declared that the right to health is a universal right. That was 62 years ago, and we're not there yet, and we're stuck until we get there.

It's a feasible agenda. It's a compelling agenda. It's an agenda that the world fervently wants in most cases, and it's a goal that we can't say that we have met when 9 million children die every year before their fifth birthday of preventable and treatable causes. That to me is a pretty basic single metric to keep our eye on.

We could also keep our eye on the 350 to 400,000 mothers who die in childbirth each year, of which challenge nobody did more to advance that Allen Rosenfield. We could look to the billion people infected with worms and with other neglected diseases that would be so easy to treat if we cared to put our mind to it.

But we don't have health for all. We don't have it in this country, in the United States, and we certainly don't have it in the world. And that for me is the first touchstone, 1948.

The second is 1978. I don't want to give up Alma-Ata even if we didn't achieve health for all by the year 2000. I think Alma-Ata stated something that is profoundly correct. And the failure to achieve it doesn't diminish its force or validity and the attacks on its insight in my view have been wrong for the 32 years since the Alma-Ata declaration.

What Alma-Ata said, you remember, is not only health for all by the year 2000, but with a focus on primary healthcare through the public sector. I am a public sector guy. I believe we're talking about public health, and I mean that not only in the sense of population wide health, but I mean it in the sense of the public sector health. Sorry, this is someone correcting me [laughter].

I will turn that off once I – and all of this continuing ideological attempt to put the private sector into the lives of poor people's healthcare in my view, remains a mistake. And remains a barrier, but there isn't a day that goes by that I don't hear of a new scheme to bring market based primary healthcare to impoverished people. I'm against it.

I want to be clear about it. I absolutely don't see any reason why a well-functioning, publicly financed and

publicly provided system cannot be put in place and why we need to constantly improvise on what is essentially an excuse for rich people not to help pay for poor people's health.

I think it's wrong from a systems point of view, it's wrong from an equity point of view, it's wrong from an economic point of view. Because everybody wants the private sector efficiency, but the contracting between the public and the private sector when the goal is universal access is dreadfully complicated and inevitably a failure.

If you want to get healthcare to poor people, provide it. And pay for it, and stop pretending that poor people can pay for their own healthcare, especially impoverished people. They die when they don't have access. And in our projects in the millennium villages, every time we drop the user fees, the use of the clinics triples or quadruples and the access to lifesaving care rises dramatically.

And it's basically true in the United States also. It's a shame here and it's a shame internationally, but when we're dealing with the poorest of the poor people in the world, it's absolutely startling how many times the U.S. government and the World Bank and others have gone to peddle disastrous private sector solutions to things that should be a public collective moral as well as science based effort.

So that's the second date that I'm stuck on is 1978 because we need health for all, and if it isn't going to be by

2000, it should be by 2010. And if it's not going to be now, it should be by 2015 or 2020, but I don't want to let go of that.

Of course, the third date for me is the year 2000 which is the date of the Millennium Development goals. And I've been at this for a decade now for Gro Brundtland, Kofi Annan, and Ban Ki-moon. And it's been a decade of advances. There has been real progress in many areas. A decade ago there was no global fund to fight AIDS, TB, and malaria. There was no GAVI. There were no programs, really, for the aggregate of the neglected tropical diseases, though there were individual initiatives for ONKO [misspelled?] and for some of the others.

There's been a very big advance. And there are the numbers to show it because child mortality has declined significantly. Maternal mortality has come down to a lesser extent, but it has come down. And there have been huge advances in the capacity to deliver primary health services at very low cost to very poor people.

Malaria, which was almost abandoned by the world as a cause between the 1970's and the year 2000, is not only back on the agenda, but is seeing marked programmatic success during the last decade by the invention of long-lasting insecticide treated nets, the development of rapid diagnostic kits, the empowerment of community health workers, and the creation of

these subsystems for community based delivery of anti-malaria care.

And, as everybody remembers, 10 years ago there was literally not one human being in Africa on antiretroviral therapy due to an officially sponsored program. Literally, not one. The epidemic was already reaching 25 million prevalence, and the U.S. government, the World Bank, DFID, and everyone else had as their implicit or explicit policy that it was too expensive to treat an African for AIDS. That was 10 years ago. I recall every day of the fights to have a change of that concept and it came. And now several million people are alive because of that. So there are advances.

But we're also seeing the limits of our rationality and our morality in the world. We had the MDG summit last month and then two weeks later we had the replenishment of the Global Fund. So let me just describe that and then close and introduce our guest.

The Global Fund has saved millions of lives, and it has been the most effective way to pool donor resources of any organization during the last 10 years on major global public health challenges. It's got a lot of design features which are extremely powerful. In a very rational way, the Global Fund staff documented what the needs would be for the continuing scale up of AIDS, TB, and malaria during the years 2011 to 2013.

They put three scenarios on the table. Twelve billion dollars over the three years would be the most minimal acceptable to barely hold the line on the existing programs. Seventeen billion dollars a year would allow for a little bit of natural -- $17 billion over three years – sorry – would allow for a little bit of scale up. And $20 billion would allow for an MDG trajectory.

None of these numbers is very much, to a macroeconomist at least. I have the distinction of being the only macroeconomist in the world that still deals with a few billion dollars here and there. My colleagues think I'm chump change and that I've abandoned all serious economics because I don't deal in trillions except when I put it in the denominator.

So what we have is a need for $6.66 billion a year. That's three days of Pentagon spending for example. That's all. It's a third of Wall Street bonuses at the lowest conceivable count. Probably a fifth of the Wall Street bonuses. So what happened actually. The idea was that the U.S. should give one-third of the total, so it would be about $6.6 billion a year. I'm sorry, one-third of that would be about $2.2 billion. The base is $1 billion right now.

And you can't believe that it took eight months of heated inter-agency, mind-boggling argumentation to get the U.S. to raise its budget from $1 billion to $1.3 billion. It couldn't even take the evidence one week after pledging to the

Millennium Development goals and make a rational process for allocating an extra $1 billion which, by the way, is one-hundredth, if you want another denominator, of what we're absolutely wasting disastrously in Afghanistan this year.

And then we're told, but it's a tough budget year Professor Sachs. It's not a tough budget year if you're down on Wall Street. It's not a tough budget year if you're the Pentagon. You have the all-time high budget ever conceivable, and your budget is half of the total world's military spending.

It's only a hard budget if it's poor and dying people. This time it wasn't even a fight about whether the system works, whether there's corruption, everybody acknowledged it's a good organization, it's good mechanisms. Nobody argued over the costing. They just said no.

So that's, in my view, where we really stand right now. Now, of course, we're all skilled and trained to do the best we can. And people in this room have done marvelous things, saved millions and millions and millions of lives among you with your advances. And I don't want to take away, for an iota, that issue.

But I can tell you, without question, maybe my one comparative advantage in this room is that I can count bucks. How much it costs to deliver healthcare. How much poor people cannot pay. What are feasible budgets for impoverished countries. And how rich we are in the United States. And I can

tell you this does not add up to a sensible, responsible, rational or moral world right now. Not even close.

So I want us to develop the best systems. I want us to use the latest technologies, mobile phones, rapid diagnostic tests, new training for community health workers, health managers.

I want us to put the full panoply of our tools at the disposal of the world's poor people to end the kind of misery that they face because there is not technological systems or economic reason why millions of children should die every year. But it ain't for free. And we've got a real struggle with our voices and our honesty and our rationality.

I don't know, I'm getting old and very cranky, and I just don't like the politicians. I like them less and less. This world is not arranged for the convenience of the politicians. They treat themselves like the kings and queens of old. Who cares about their photo ops or about their elections or their re-elections.

I could care less any more, honestly. We need to tell the truth. The truth is that health is a human right. The truth is we can provide primary healthcare for the whole world. The truth is the Millennium Development goals are achievable. And the truth is that our political leadership does not care to look at the evidence now. And we need to overcome that.

And we need to help our country understand the stakes as well. And decide from their security and the practicality, it's our souls at this point. The world cannot go on, and we are crumbling in my view out of our immorality at this point. I don't mean to preach, but I mean that if we're not attentive to the importance of life, how are we going to get any of our own act together. And that's where we stand right now.

So I believe that this agenda is not only the most marvelous agenda, I think it's a miraculous field. I absolutely adore public health of all of the things that I've been able to dabble in in my life. It's the point of nexus of science and people and ethics and systems delivery. It's a brilliant field with brilliant accomplishment and brilliant and powerful tools. And you are the crowd that can make this happen. Let's look forward, but look forward by remembering the past, our legacies, and our promises.

Now we're lucky that our speaker this evening – that was an introduction [laughter] – our speaker this evening is the person charged in the world community with making this happen, and he is one of the great advocates of India, and one of the great advocates in the world. Because I like what he does too, which is he takes people to court.

And he defines and defends these rights. Not only in speeches and in talks, but fortunately in India's sometimes miraculous judicial system, which has had a public policy

dimension to it, which is almost unique in global jurisprudence because it's India's high court which has revolutionized the environment and public health and many other areas, way ahead of governments, I might say, of elected governments.

And our speaker this evening, Anand Grover, is one of India's great lawyers. He is the director of the Lawyers Collective on HIV/AIDS. He has championed the cause of the rights to health in India and the rights to a safe physical environment. And because of this illustrious achievement and his compelling voice, he was appointed by the Human Rights Council as the U.N.'s special rapporteur for the right to health. We're very lucky to have you this evening [applause].

ANAND GROVER: Thank you, Jeffrey. I think he remembers my advocacy when I defended him in the internecine warfare which occurs in the U.N. agencies. And I was quite successful at that. And perhaps he remembers that. But I think this adulation is really, you know, difficult to match up when I have to speak to a very illustrious audience.

I'm sorry I could not be with you during the day because I had to, as the special rapporteur, present my fourth report on the issue of criminalization of drug use and possession and the right to health. Surprisingly, the U.N. general assembly actually accepted the report. I was really pleasantly surprised [applause].

I want to just take off from what Jeff said. I think the moral imperative that you have, not only in this country but the world over at this juncture, is very, very important to appreciate. To me, the take home message from Jeffrey is there is a moral imperative which used to be Alma-Ata. It exists today, and we have to fulfill it. And that moral imperative is that the right to health is realized by everybody across the world.

Now one of the things that Jeffrey has been emphasizing throughout his last 10 years, ever since I've known him, is the issue of financing. I think he's correctly stressed the fact that the Global Fund is one of the better mechanisms, not the best mechanism, but one of the better mechanisms that we have today.

But let me tell Jeffrey that despite the discussion in the last two months, there are governments who want to go back to the old system, DFID, etcetera. They don't want the Global Fund type of system. They want to go back to the multi-lateral [misspelled?] funding where governments are given money, where governments are told, okay, we are giving it for TB, but if you want to pay your debts with this money, you can service your debts.

So they need not spend the money on TB. And that's what governments have been forced to do with the Global Fund. The Global Fund is an open, transparent system where, in all

decision making, whether the people are affected by the ailment, HIV positive people, TB affected people, or malaria people.

They're sitting on the decision-making bodies at the international level, at the state level, and also responsible for monitoring and implementing. This is a very important system which, for some reason, has been thrown up in the midst of crisis during the HIV rise in the last part of the millennium.

Now I want to go back to that in a minute, but I think the critical issue, as Jeffrey has pointed out, the first critical issue is in fact funding. How do we actually convince not only the United States, but also our developing country governments to abide by the Abuja Declaration formula but they also contribute to the overall funding so that the right to health can be realized for everybody.

And I want to emphasize and actually support this idea. And I hope we can do that in this meeting. I hope you can do that. It should go home as a message to all governments that people who have been concerned with global health consider that primary health and universal care can only be achieved through public health and not through privatization. I think that's a very, very important underlying message for every public health advocate.

The second thing I want to emphasize is that it has to be based on the right to health framework. It's not a purely public health issue. Let me just take issue with you if I've heard Jeffrey correctly. I think the right to health is slightly distinct from a public health approach. We don't have time to go into that, but I hope you'll consider that.

And the right to health approach means certain things at international law and in domestic law. It means that there is the availability, accessibility, and acceptability of all facilities, goods, and services. It means that the states have to respect, protect, and fulfill the obligations. It means, very importantly, participation of those who are affected.

Because without participation, you will not achieve the results that you want to achieve. And if you see in that context which has succeeded to the largest extent in the NDGs, the health NDGs, I would submit that it is the HIV which has been successful and that is precisely because they have been able to follow, fortuitously or otherwise, the right to health approach.

HIV positive people, because of fortuitous circumstances are able to be on the decision-making table. They are able to be on the implementation and monitoring and accountability.

I'll just give you an example from my own country because I have been associated with HIV for a very, very long

time. When ARV rollouts – antiretroviral rollout treatment was first started in India, it was later than other countries but we had the fortunate circumstance of being able to have the lowest prices for ARVs, there was an issue whether HIV positive people should be on the decision-making table.

And the person who was running the show as it were was a very good doctor, like all of you, who said, why do we need all these people discussing. We know what the answers are. I said, look, just have them here to discuss with you. They will tell you what the problems are.

And, indeed, today it is not possible for him to run the program without those people because every time things go wrong, they're the first to point out there are stuck outs, there is this problem, and he is able to set them right.

So it is very important to understand why HIV NDG has been achievable more than other NDGs. Because you have a problem in maternal mortality or even infantile mortality where there is no community participation. A large number of successes have been achieved through other measures. Whether we can sustain them or not is a difficult issue.

The third thing I want to highlight is that there is a political system in the world and there is an economic system in the world which discourages competition. Jeffrey mentioned the fight we had in the late last century to change and turn around the most expensive drugs, ARVs which were available at

that time, at $15,000 per person, per year. Why were they so expensive? It is because of the patent system.

The patent system made them expensive, and the Indian generic companies were able to, without actually producing them, throw a gauntlet to the multinational corporations and say, we can produce them at less than $400. And indeed, the moment they did it, the prices slashed from $15,000 to less than $500. Who was making that unconscionable profit? What is the moral imperative I ask you, about making such an unconscionable profit? And multinational corporations will tell you, we are doing it because we need it for innovation.

I'll give you a very small suggestion which you can take home and maybe persuade your government in the United States and Europe. Today the incentive for what are called new forms of old products is the same as a really new molecular or chemical entity.

So a company which has a therapeutic base converts it into a salt or converts it into a crystalline form, has the same profit as a company which makes a completely new molecule. Why should that be? It's inefficient. There is actually, if you look at the new inventions that have been taking place in the last two or three decades, they are tapering off, because of this system partly.

Not only because of it, but this is largely responsible for actually reducing innovation. I would argue, as public

health specialists, to really persuade the government that this system is not delivery and it has to be changed. And there's an easy way to change it because in the land of money and capitalism, when money talks, incentives must actually be based on real change.

Now in this context, I want to highlight the first report that I made to the Human Rights Council. You know, the TRIPS agreement was entered into as a compromise. Everybody – well, let me just say it very candidly. I'm not a person who hides behind shibboleths.

American Pharmaceutical Manufacturers Association wanted the developing world not only to have Coca-Cola and hamburgers, but also the patent law. Okay? I think you understand what I mean. All of them are bad. Now, the developing countries agreed to it because it was a compromise. There were flexibilities in it. But those flexibilities were an illusion. The Indian government thought, it's all over.

We don't have to do anything. But today they are facing the actual agenda which has been rolled out. The patent system in India has to be the same as the patent system in the United States. So there's pressure by EU, the USDR, to have the same patent system, which would mean that access to medicines will not be possible in the future.

Please appreciate today, because of what happened in 1999 and 2000, Indian generic companies are actually supplying

93-percent of all developing country requirements based on the mutual prequalification and the Global Fund.

If new intellectual property rights are installed by pressure, there is no arms length kind of bargaining, please. This is a real world where if you do what I want, you will have to do what I want. That's how it is. And some people think it's a good thing because liberalization is modern and it's very good.

And I'll give you an example. In Francophone, Africa, the least developing countries, the Bengwe agreement, they were able to thrust in that region, TRIPS-plus measures, which India doesn't have. Even in 2005. Because that was the only way they could do it if they wanted any aid. The reality of aid is not Global Fund, it is the fund which mean that I am corrupt as a developing country and the person who is giving to me is corrupt. It's a modus vivendi based on corruption.

So the moral imperative is today to support an open and transparent system. But if you want to do that, you have to resist all pressures by developed countries, through their multinationals or otherwise, or the other way around, not to insist and pressurize developing countries to go for TRIPS-plus measures.

The final point I want to make is, the fact that, okay, I see really great friends of mine, but I have to make this as a candid observation. Whenever I go on a country mission,

whenever I talk to the U.N. emirates council, I tell them, I'm just a mirror. I'm not criticizing you. If you want to change anything, you have to involve communities.

Whether they're HIV positive people, whether they're TB affected people, whether they're gay people. If you don't involve communities in your fight, you cannot change. The reason is – and I'll tell you I'm very much of a Leninist, not a very attractive and popular thing – but he believed in one thing very strongly, which is, if you want to change things, the abstract must marry the real.

The emotion that we have, what are we? We are so-called intellectuals according to his jargon. We have only abstract knowledge. Experiential knowledge must marry with us. And then only can you change things. We have the abstract knowledge. We have the answers. We can't change it unless we marry with them. That is the success of HIV.

And I would urge you to find good examples as experts in these areas, in the area of TB, in the area of maternal mortality because that is actually really affecting me. How can we get community participation in maternal mortality or child mortality?

Richard told me not to take more than 10 minutes. It's very hot here. I would like to have a cold beer. Thank you very much [applause].

LINDA P. FRIED: So thank you so much to both of our speakers, and thank you to everybody who has been – everyone has been so engaged today. I certainly have learned a tremendous amount and I look forward tomorrow to working with all of you to try and bring all of our great thinking to a stage of fruition [applause].

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