

# COUNCIL ON FOREIGN RELATIONS

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Thank you, Lars Thunell. And thanks to the IFC for giving me the opportunity to address you this evening. Your meeting tomorrow promises to be a vitally important one, and I am honored to have the opportunity tonight to set the tone – or at least lay out some of the problems in the current paradigm of this thing we call “global health”.

Until quite recently when we spoke of “global health” we were referring to the provision of *public* health services in poor and some middle income countries. These included: immunization campaigns, improved drinking water and sewer systems, nutritional education, well-baby campaigns, pesticide applications to reduce insect vector populations and all the other mainstays of classic *public health*.

Public health is truly effective when it is a two-way trust between the State and the People: the State guarantees safe water, sewers, effective regulation of food and drug safety, limits on all forms of pollution that could endanger

human health and a battery of preventive medical services such as child immunization. The People, in their half of the trust, agree to cooperate in the State's public health efforts – even if they may be individually onerous -- for the common good.

In parts of the world where the State is weak, corrupt or preoccupied with conflict, this Trust breaks down, disease spreads and life expectancy falls. There is no public health.

Since Bretton Woods the wealthy world has tried to offset this collapse in State public health trust by funding a mélange of United Nations, private sector and direct Ministry of Health support – all in an attempt to somehow improve public health *in the absence of its most defining elements – the responsible State and a cooperative People.*

### **Enter the Treatment Dynamic**

In 1996, the seals were broken on a series of clinical trials involving various combinations of anti-HIV drugs. The results were astounding: Antiretroviral drugs had not cured the patients, but for most of them, the treatments were sufficiently effective that the AIDS patients could look forward to living normal life expectancies. Within days of the announcement, 10s of 1000s of men and women in the wealthy world went on antiretroviral therapy. By 1998, deaths due to AIDS had plummeted in wealthy countries – in the United States the impact was so dramatic that all but a handful of the once-vociferous AIDS activists switched from protesting to portfolio management.

By 2000 a general clamor arose from poor countries, particularly in sub-Saharan Africa, demanding access to these life-sparing medications.

### **The Security Dynamic**

After the fall of the Berlin Wall there was a fair amount of soul-searching in the G-7 and Western nations regarding their national security priorities. That process is an on-going one, and it is doubtful any formula for national security will emerge for the early 21<sup>st</sup> Century that can match the clarity and vision of George Kennan's post-WWII Policy of Containment.

Since the 2001 al Qaeda attacks here on the Pentagon, and in my home town against the World Trade Center -- followed by the anthrax mailings -- many transnational threats have been elevated to national security status, not just here in Washington, but also in London, Paris, Moscow, Beijing, Johannesburg and Santiago: All over the world. The 2003 SARS epidemic fueled security concerns about health threats, demonstrating the acute needs for transparency, surveillance, rapid international response, and collective improvements in health infrastructures – not only for the rich world, but also the poor.

### **Treatment Captures Wealthy World Attention**

This combination of growing security concerns, coupled with pressure from the poor world for access to life-sparing, but enormously expensive, medicines captured the collective imagination of the wealthy world. President George Bush made the links when he announced in his State of the Union Address in 2003 plans to spend \$15 billion to tackle HIV prevention and treatment in 15 countries. Combined efforts by governments, private donors, celebrity-driven campaigns, leading corporations have pushed the global health pot up from a few hundred million dollars in 2000, to more than \$18 billion in 2006.

Without a doubt the primary political push behind this surge in funding has been the drive for access to antiretroviral drugs to treat HIV infection. According to a statement released this week by the World Health Organization, by the close of 2006, 1.3 million people in sub-Saharan Africa were on the medicines, and nearly a third of the 7.1 million people in poor countries that WHO thinks need the drugs, were receiving them. About 85 percent of these people were getting their drugs thanks to support from United States President's Emergency Plan for AIDS Relief or from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

This is all very exciting.

But where is it headed?

Let's take a look at the United States, where state-of-the-art antiretroviral treatment has been heavily subsidized by the federal government, for a decade. A recent National Institutes of Health study shows:

- In 1993, before the medicines were available, the average life expectancy from time of HIV diagnosis was 6.8 years. In 2006, thanks to those medicines, this has expanded to 24.2 years – a nearly four-fold increase in survival time.
- In 1993, more than half of the costs of care for people with HIV disease were for hospitalization; only 14 percent was for medicines. Today drug costs account for more than 70 percent of total treatment, and hospitalization has plummeted.
- The projected lifetime treatment costs for HIV care in the U.S. are now about \$620,000 – about \$430,000 of that is for drugs.
- The annual cost for treatment of HIV+ Americans will top \$12 billion by 2010. The bulk of that will be pharmaceutical expenditure, which is guaranteed for uninsured Americans by the federal government.<sup>i</sup>

Pushing the costs steadily upwards is drug resistance. The longer individuals are on antiretroviral drugs, the more likely they are to develop drug-resistant strains of HIV. With each change in treatment that is necessitated by drug resistance, costs soar.

Those nearly 2 million people in poor countries now getting antiretroviral treatment are receiving the cheapest, first line drugs for which volume purchasing schemes, generic manufacture and patent manufacturer discounts have, combined, brought annual treatment costs to around \$200. What will happen to these people as resistant strains of HIV emerge in their bodies?

Brazil is a good place to turn to for insight. Since 1997 antiretroviral treatment has been available to all Brazilians in need of it, at the federal government's

expense. Brazil has cut the AIDS death rate in half, and reduced the numbers of new HIV infections by more than half. More than 170,000 Brazilians are on antiretrovirals, which cost the government about \$400 million in 2005....However, by 2003, drug resistance was so widespread that 14 percent of newly infected Brazilians, who had never taken the medicines, carried resistant strains.<sup>ii</sup> And by 2006 the majority of Brazil's HIV patients had developed resistant strains of HIV, requiring use of secondary and even tertiary drugs. Costs soared. And today about 80% of Brazil's entire drug purchasing fund is spent on purchase of medicine for less than 1 percent of the nation's population.<sup>iii</sup>

This is not sustainable.

By the way, the top choice for second line therapy is an Abbott drug called Kaletra. Not surprisingly, this drug has been the focus of WTO TRIPS disputes this year, with Thailand leading the pack.

There is nothing new about drug resistance, nor its inevitable tendency to drive up treatment costs. Second to HIV in the political pecking order of global charitable interest are tuberculosis and malaria. Here, too, resistance is a theme. Tuberculosis is probably the best indicator of failure in that public health trust I spoke of earlier: Treatment is the key to outbreak control. Untreated individuals are very contagious. But a combination of antibiotics, taken for 6-18 months can completely cleanse the body of TB.

This is a *lot* easier than maintaining HIV patients on combination drug treatment for the rest of their lives.

Yet we see profound failure in the TB fight. Last year a new type of TB emerged in South Africa – XDR-TB. It is resistant to every class of anti-tuberculosis drugs. And recently WHO surveyed the global tuberculosis burden, finding that this deadly XDR was already in circulation on every continent, in rich world and poor.

We are dangerously close to losing our entire armamentarium for fighting bacteria. Drug resistant strains of staphylococcus, streptococcus, clostridium difficile, and a host of other contagious killers have emerged, many of them able to defy virtually all known antibiotics. The microbes are *way* ahead of us: they swap resistance genes across species, and like a giant Google gmail system store resistance capacity in a group-share environment, grabbing what they need to fight off our weapons.

The GlaxoSmithKline pharmaceutical company executed a massive search for new antibiotics – a 7 year, multimillion dollar operation. They screened more than 350 bacterial targets, searching for chemicals that could disable them. They came up with nothing. Between 1996-2004 the 34 biggest pharmaceutical and biotech companies screened more than 125 potential new antibiotics. Not a single viable drug was discovered.

### **Medicalization of Global Health**

The profound increase in global health funding has come as a result of the medicalization of global health. There has not been a profound increase in

funding or attention to classic, preventive *public health*. Rather, it is the notion that pills can stop plagues that has captured the wealthy world's imagination.

And that would be ok, if we had healthcare workers available to do the job. But we don't. We don't have sufficient nurses, physicians, pharmacists, lab technicians or public health workers in poor or middle income country to handle any major campaign. Each new treatment campaign simply adds to the burden, sapping health care workers from less glamorous, less well funded efforts. In this week's edition of PloS Medicine a team of Belgian physicians call upon global funders to start directly subsidizing the salaries of healthcare workers engaged in HIV treatment, from physicians all the way down to community health attendants.<sup>iv</sup>

But if we pay for workers to distribute HIV medicines, should we not do the same for those who hand out TB drugs, bed nets for malaria, oral rehydration formula for dysentery and cholera? Why stop with AIDS?

Kenya has 14 doctors per 100,000 people. Lesotho has 5 per 100,000. And at a time when their health needs are rising – thanks in large part to HIV and drug resistant TB – the poorest countries in the world are losing doctors and nurses. Over the last five years, for example, Malawi lost 53 percent of its health administrators, 64 percent of its nurses and 85 percent of its physicians.

WHO estimates that the world is short 4.3 million healthcare workers right now. There are no systems in place that would shrink that deficit: On the contrary, the demographic aging of the wealthy world is creating ever greater demand for healthcare workers. By 2020 the United States will have a shortage

of 800,000 nurses and 200,000 physicians. Much of the wealthy world's health talent demand is being met by recruiting personnel from poor and middle income countries.

### **What can be done: Shift from Charity**

For decades global health has been treated as a charity. Billions of people the world over have, for decades, been dependent on the kindness of strangers for their health and survival. While other fields of development may have encouraged capitalist solutions, health has been treated as if it were too sacred to be besmirched by profits. In the wealthy world *every* aspect of health, from record-keeping to pill-making; ambulance driving to hospitalization, is a profit center. We seem to feel that if you are living in France, Denmark, Canada, Japan – in those places it's ok for hundreds of companies and thousands of individuals to realize profits from the health enterprise. We just don't think that is ok in poor countries.

I think it's time to tell truth to power: The charity model of global health is racist. It assumes that the health leaders of the poor nations of the world will endlessly get on bended knee, and with outstretched arms beg for alms. It doesn't matter to whom the begging is directed – the World Bank, USAID, Bill Gates, Bono – it is still begging. The charity model offers no supply or resources guarantees over time. Yet it expects targeted achievements, realized in very short time windows, allowing the donor to brag about the numbers of lives saved, thanks to his beneficence.

I think it's time to get out of the charity model, and get serious about investment. My take-home message is this: Invest in small businesses, even micro-finance approaches to health. Do *not* invest in models that promote health by subsidizing

outside corporate interests. Rather, build local economies and businesses, employ the unemployed, and do so aggressively.

The second piece of this is related to supplies: sterile syringes, medicines, latex gloves, autoclaves --- build global scale supplies procurement and distribution centers. Give the little guy in Malawi a chance to purchase essential supplies as part of an international pool, arguing down unit prices in favor of volume purchasing. Why should a small pharmacist in Lilongwe pay more for aspirin than Wal-Mart?

### **Some business models already exist, and are successful**

The Bangladesh Rural Advancement Committee, or BRAC, was founded in 1972 as a tiny micro-finance NGO. Today BRAC employs 100,000 people, mostly women, and provides services to 80 million Bangladeshis. BRAC covers a wide terrain of issues, among them health. The organization is controlling TB by paying women to find tuberculosis sufferers, bring them in for diagnosis, and monitor their treatment. The volume of TB cases successfully processed is directly related to the community healthcare worker's income. Incentives are in place.

Scojo Foundation has also taken a business approach to its mission to broaden global access to affordable corrective glasses by local women as "Vision Entrepreneurs." The women make money, proportional to the volume of sales, and thousands of people can now read, drive, and work. In El Salvador, Guatemala, and India, the Scojo Foundation has sold over 40,000 pairs of reading glasses, trained more than 560 Vision Entrepreneurs, and referred nearly 65,000 people for advanced eye care.

The Acumen Fund, based in New York, invests in health and development companies all over the world. One of their clients is an Indian venture called Zigitza – popularly known as 1298, their telephone access code. Zigitza is a two year old private ambulance company in Mumbai that offers free emergency transport to the poorest Indians, and uses a unique pricing mechanism to bill other customers according to their means. The average ambulance trip cost patients 500 rupees... about \$12. Last year Zigitza hauled 20,000 patients, using 10 ambulances. With Acumen’s investment, the company will now scale up to 70 ambulances and expand operations to other cities in India.

The entrepreneurial spirit is waiting to be tapped – or financed.

But ambulances and eyeglasses are one thing: medicines are quite another. The free market does not favor the poor world.

Let’s take a look at one of the world’s health and economic success stories: Malaysia. It ranks 31<sup>st</sup> for health achievements under WHO’s assessment. A new drug access study for Malaysia<sup>v</sup> compared prices for essential medicines sold in that country to the International Reference Price, or IRP. The study found, “that, irrespective of the source of medicines, prices were on average much higher than the international reference price, ranging from 2.4 times the IRP for innovator brands accessed through public hospitals, to 16 times the IRP for innovator brands accessed through private pharmacies. The availability of medicines was also very poor, with only 25% of generic medicines available on average through the public sector. The affordability of many of the medicines studied was again very poor. For example, one month's supply of

ranitidine (a drug for stomach ulcers) was equivalent to around three days' wages for a low-paid government worker, and one month's supply of fluoxetine (an antidepressant) would cost around 26 days' wages.”

A separate WHO survey found that drug expenditures may amount to 50%–90% of nonpersonnel costs for most poor and middle income country health budgets.

I urge the IFC to investigate mechanisms for large scale drug, diagnostics and medical equipment purchasing, inventory and distribution. Establishing regional centers of excellence for bulk purchase could greatly facilitate improvements in health delivery, both by the private and public sectors, in poor and middle income countries.

## **CONCLUSION**

The medicalization of global health absolutely cannot be sustained based on charity. None of the magic bullets are genuinely “magic”. It is the biological nature of microbes to mutate, becoming resistant to the drugs that have formed the basis of this enthusiasm for medicalization.

The future cries out for a reordering of priorities. Financial incentives – profits – must be part of the health picture. Global scale purchasing must be part of the picture.

And by all means, the essential tool box of public health -- clean water, disease prevention, nutrition, immunization – must not fall to the side amid this moment of magic bullet zeal.

I thank you very much for your time and attention. May you have a fruitful meeting.

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<sup>i</sup> Schackman, B. and Freedberg, K.A., "The Lifetime Cost of Current HIV Care in the United States," *Medical Care*, November 2006.

<sup>ii</sup> Waleria-Aleixo A, Tanuri A, Cleto SC, Greco DB., Mutations Related to Primary Resistance to Antiretrovirals Among Newly HIV-1 Infected Individuals in Belo Horizonte – Brazil," *Antivir Ther.* 2003; 8 (Suppl.1): abstract no. 242.

See also Brites, C, Bahia, F., Gilbert, M., et al., "Evaluation of viral resistance to Reverse Transcriptase Inhibitors (RTI) in HIV-1-infected patients before and after 6 months of single or double antiretroviral therapy," *Brazilian J Infect Dis* 5:Aug 2001., and d'Adesky, A., "Brazil's AIDS Model: A Global Blueprint?," *The Gully* (2003), [www.thegully.com/essays/brazil/030904\\_brazil\\_AIDS\\_dadesky.com](http://www.thegully.com/essays/brazil/030904_brazil_AIDS_dadesky.com) .

<sup>iii</sup> <http://www.iavireport.org/vax/VAXJuly2005.asp>

<sup>iv</sup> Ooms, G., Van Damme, W., Temmerman, M., "Medicines without Doctors: Why the Global Fund Must Fund Salaries of Health Workers to Expand AIDS Treatment," *PloS Medicine* 4:0001-0004 (2007).

<sup>v</sup> Din Babar, Z. U., Ibrahim, M.I.M., Singh, H., et al, "Evaluating Drug Prices, Availability, Affordability, and Price Components: Implications for Access to Drugs in Malaysia," *PloS Medicine*, March 27, 2007. See also Mendis S. et al (2007). The availability and affordability of selected essential medicines for chronic diseases in six low- and middle-income countries. *Bulletin of the World Health Organization*, 85(4):279-287.