Oxford Heath Alliance

Draft Report

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Working Group 2 : Overview of the current framing of chronic diseases in the key international agenda. How to get chronic disease on the Global Health Agenda.

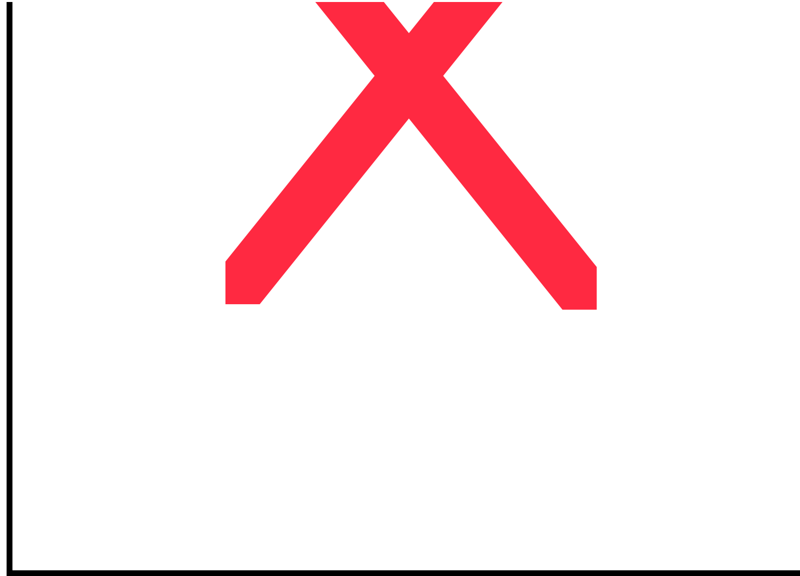
The Challenge: Health experts are not alone in defining the global health agenda – politics, economics, business and star power all play a role.

Introduction:

Chronic disease is being excluded from the global health agenda. Advocates, researchers, policy-makers, medical professionals, civil society and intergovernmental organizations dedicated to the prevention and control of these diseases are concerned that heart disease; stroke; diabetes; chronic respiratory disease and cancer do not feature in discussions about global health priorities. This is particularly true in the case of low and middle-income countries where the incidence of such disease is growing. The lack of awareness about the prevalence and impacts of chronic disease is likely to result in limited investment in research, programs and policies that could help prevent them from overwhelming already overstretched health budgets, negatively impacting developing economies and resulting in millions of unnecessary premature deaths.

In 2005, chronic diseases are projected to account for 35 million deaths or 60% of global mortality. Cardiovascular diseases account for half of that burden or an estimated 17.5 million deaths, 80% of which occur in low and middle-income countries[1,2] (see fig. 1).

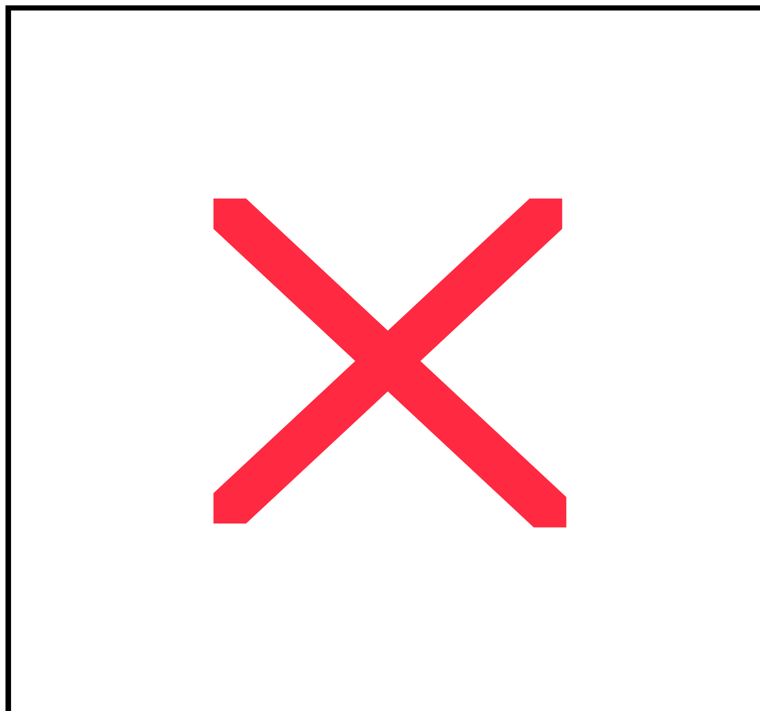
Figure 1



Source: WHO, Preventing Chronic Diseases: A Vital Investment

Chronic disease is already the leading cause of death in all regions of the world with the exception of the lowest income countries including Sub-Saharan Africa, and even there it is on the rise[3]. Yet this reality is not informing the priorities of the global health agenda (see fig. 2).

Figure 2



Source: WHO, Preventing Chronic Diseases: A Vital Investment

A recent set of confidential interviews[4] with Development Aid agencies in the US, Sweden, Canada and the Netherlands reinforced the hypothesis that chronic disease in low and middle-income countries is not on the "global health agenda."

"There is an overwhelming lack of knowledge of the magnitude of the chronic disease problem and the level of mortality in the developing world. It always comes as a complete shock to people".

"Policy-makers are beginning to realize the double burden, but deaths from infectious disease are not letting up. Up until now, chronic disease has not been seen as a major issue".

"Our development program has narrowed its focus and chronic disease got left out. The government wants to focus on results and only a small number of priorities. You cannot do it all".

"We would address many other problems in developing/low income countries before CVD such as communicable diseases (HIV/AIDS) health systems, infant and maternal mortality".

As the above interviews suggest, this report will argue that chronic diseases are not yet on the agenda. To prove that, first, we will determine who sets the global health agenda, what is their mandate, and how long they have been involved in health. Then, we will identify what issues are on the agenda today and hypothesize about why. What is the "real" interest of the organization/individuals in question? These interests can range from political to economic, from good business practice to exercising star power. The last section will suggest creative pathways for those concerned with chronic disease to move forward and build on the experience gained in infectious diseases and the global momentum behind better health as a key component of any poverty reduction strategy.

I. Who sets the global health agenda and what is their mandate?

The World Health Organization, the United Nations specialized agency for health, has for decades had a clear mandate when it comes to setting and implementing the global agenda, in particular through the annual World Heath Assembly meetings and publication of its World Health Report. However, today the WHO itself only controls the budget allocation decisions on 30% of the total annual budget, which is referred to as the regular budget. 70% of the budget, referred to as extra-budgetary allocations is largely donor driven, and therefore increasingly subject to donor agency preferences. [5] The WHO, then, is not fully in charge of setting its own priorities. In the past five years this agenda has been boosted by interest from a range of public and private initiatives aimed at improving health as a prerequisite for development.

Two important developments within the UN system have contributed to the growing awareness of the economic and social impacts of poor health and poor health systems. The Millennium Development Goals were agreed in 2000, stating that the 189 signatories "will spare no effort to free our fellow men,

women and children from the abject and dehumanizing conditions of extreme poverty, to which more than one billion of them are currently subjected"[6] Three of the eight goals identify health issues as critical to the achievement of the Millennium Declaration first signed in September 2000 by 189 world leaders.

The second important development was the establishment also in 2000, of the WHO Commission on MacroEconomics and Health (CMH). The creation of the then Director General Gro Harlem Brundtland under the chairmanship of Jeffrey Sachs, this commission has played a pivotal role in linking health and poverty reduction by arguing that investments in health stimulate economic development. It would appear that the clear linkage between health and development is relatively new. Health issues, independent of the environment, were not at all prominent in Johannesburg in 2002 at the World Summit on Sustainable Development and virtually absent at the Earth Summit in Rio in 1992.

A series of relative newcomers have joined the global health debate expanding from their core strength in economic issues. The World Bank has elected to play an increasing role in health through its Health, Nutrition and Population Strategy.

Health has also made its way onto the agenda of other multilateral fora. The World Economic Forum formally established its first Global Health Initiative at the January 2002 annual meeting held in New York City. At that meeting, UN Secretary General Kofi Annan proposed the establishment of that initiative to engage the 1,000 plus private sector members of the World Economic Forum in the fight against HIV/AIDS, TB and malaria.

Two years later, the Organization for Economic Cooperation and Development (OECD) which "groups 30 member countries sharing a commitment to democratic government and the market economy"[7] brought health ministers together for the first time in 2004 to discuss ways to improve the performance of health systems[8] and to issue its first health report. Entitled "The Health of Nations"[9] the report was the culmination of three years of work and was followed by the creation of a new health division in 2005.

The G8 meeting held in Scotland in July 2005, under the Presidency of UK Prime Minister, Tony Blair, featured health as a key component of poverty reduction in Africa.[10] G8 member Heads of State had first recognized the importance of health to poverty reduction at their summit in 2000. At that meeting, the creation of the Global Fund for HIV/AIDS, TB and malaria was first discussed[11]. This health focus represented a marked change. As recently as 1998, the G8 focus was on sustainable economic growth and development including environmental and trade issues but not health.[12] Now, G8 and the massive string of global rock concerts, Live8-Liveaid under the leadership of Bob Geldof and with strong support of rockstar Bono, adds an emotional input to the global aid and health debate.

In the private philanthropy sector too, a boost to health programs, particularly those focusing on infectious disease can be discerned. This is highly significant because of the profile the leadership of such organizations and their founders can bring to the cause and also because the leaders among them have

contributed a hugely significant injection of funding into global health programmes: The Bill and Melinda Gates Foundation's recent global health grants (past five years) have totalled over US$4bn, compared to US$4bn contributed by the World Bank to reproductive health over the past two decades, and an annual WHO regular budget of US$880 million in 2004/5 or approximately US$4 billion over 5 years. Gates nearly matches WHO in health spending levels.

A number of public-private partnerships (PPPs) have also raised the profile of health and developed innovative means of bringing private sector skills to the arena. In this field too there has been a strong focus on infectious diseases. The Medicines for Malaria Venture was set up in 1999 to promote the development of new medicines to treat resistant malaria strains. It was followed by a similar initiative to research new medicines for TB in 2001. In acknowledgement of the difficulties of obtaining adequate funding for health the Global Fund to Fight AIDS, TB and Malaria (GFAMT) set up a year later and now receives substantial ODA. At the same time the Global Alliance for Vaccines and Immunization (GAVI) was working to advance the prevention side of the problem. Many pharmaceutical companies have contributed to these initiatives with in-kind research capacity, commercial know-how and funds.

It is clear then that health has moved beyond the traditional borders of the health ministry and the WHO into the UN and international systems as a whole, touching finance ministries, foreign affairs and heads of state as well as corporate boardrooms, corporate foundations even reaching the younger generation via rock concerts. This move has taken place in the last 10 years, accelerating since the year 2000. The result seems to be increased focus on global health by more and more groups that do not come from the health sector and do not define their priorities based on the latest data from the World Health Report. The increased focus on health as an integral part of the development agenda has been immensely positive with redoubled efforts to tackle some of the most pernicious infectious diseases which have a devastating effect on individuals, families, communities and nations. However, the way the agenda has evolved is ad hoc and in the desire to focus, there is a danger that priorities have been determined emotionally, politically or for financial expediency, without looking at the overall health situation and its causes. The result has been a strong focus on some areas of acute medical need at the great expense of other priorities.

II. What is on the global health agenda today and why?

The overwhelming focus of what can loosely be described as the global health agenda at present is infectious disease. There are clear and good reasons to address the pain and suffering caused by malaria, TB and HIV/AIDS. The problem appears to be that policy-makers, business leaders and celebrities approach this as a zero sum game. Priorities are set at the exclusion of other concerns. Chronic diseases have lost out massively in this equation, despite their dominance of global morbidity and mortality.

The link between health and poverty eradication is an important one. The UN Millennium Development goals explicitly devoted to health are numbers four, five and six read as follows:

4) Reducing child mortality by two thirds.

5) Reducing maternal mortality by three quarters.

6) Reversing the spread of HIV/AIDS, malaria and other major diseases.

While "other diseases" are mentioned in goal 6, they have never been clearly articulated and over time they are disappearing from the literature. In the face of the likelihood of failing to meet the majority of the MDGs, the health goals are being narrowed. The Millennium Project Report to the UN Secretary General issued in 2005 and entitled "Investing in Development" recommends a series of Quick Win actions "to save and improve millions of lives and to promote economic growth".[13] These actions as they relate to health include free mass distribution of malaria bed nets and successful completion of the 3 by 5 HIV/AIDS treatment campaign. Chronic disease receives no mention anywhere in this report. Likewise, the Millennium Project fast facts about the Faces of Poverty only mention HIV/AIDS, TB and malaria[14]. This was perhaps unsurprising, given that the preparation of this report involved five taskforces on health, none of which addressed "other diseases". The authors of the Millennium Project Report are intentionally narrowing their focus to the problems of the poorest of the poor, with many described as resident in rural Africa. One of the primary goals of the report authors is, in fact, to increase government aid specifically to Africa. This may help explain, but not justify, the near total focus on infectious disease.

The World Health Organization published its report entitled *Preventing Chronic Diseases: A Vital Investment* in October 2005. This is an important step. The balance of the organization's work, however, is firmly in favour of infectious diseases which dominate the agenda and receives 97% of the regular budget[15]. In his first speech to the World Health Assembly, Director General Lee Jong-Wook defined the major objectives of the organization for the next five years as HIV/AIDS, TB and malaria as well as new challenges such as SARS, although he did mention that "non-communicable diseases are taking a heavier toll."[16]. He does not mention that they account for the majority of deaths already today. In his speech to the World Health Assembly in May 2004, the focus is again on the MDG's and HIV/AIDS, tuberculosis and malaria as well as SARS first. However, he does include mention of the Framework Convention on Tobacco Control (FCTC) and states that "1.3 billion people smoke, exposing themselves to illness and premature death".[17] Clearly, chronic disease is recognized but does not receive attention commensurate with the disease burden, even at the WHO. One possible explanation is the leadership's relative lack of control of budgetary decisions.

The report of the Commission on Macro-Economics and Health acknowledged the importance of NCDs, but (with the notable exception of tobacco) did not go into the problem in any depth. Since the publication of the report of the Commission on Macro-Economics and Health, a Coordination of

Macroeconomics and Health program has been established by the WHO to implement the findings of the report on a country by country basis. In many countries macroeconomic commissions have been set up to do so. A generic plan of action has been designed by the WHO to help countries in this process. Governments are nominally free to define their own health priorities, the combination of the CMH report's focus on infectious diseases and subsequent link to the Millennium Development Goals (MDGs) means that chronic diseases will have to fight hard to compete.

A brief ray of hope for the chronic disease agenda was seen in the publication of a follow-up to the CMH report. *"A Race against Time",*[18] by Steve Leeder and his team, contained an introduction by Jeffrey Sachs and called for CVD control strategies to be developed. Nevertheless, disappointingly, the Ten Recommendations of the Commission on Macroeconomics and Health of the WHO include no mention of chronic disease, not even tobacco-related diseases.[19]

Other UN bodies reflect this failure to understand the impact of chronic diseases. The Human Development Report, for example, will not mention chronic diseases in its 2005 report and nor will either of the projected issues for the next edition provide an opportunity to do so.

Unsurprisingly, this consensus focus amongst decision-makers and continuing concerns about poverty, influence the activities of others. The World Economic Forum's Global Health Initiatives reflects these priorities. Its mission is "to increase the breadth and depth of business activities tackling HIV/AIDS malaria and tuberculosis".[20] Responding to the UN Secretary General's challenge and engaging the business community in positive social change is a clear motivator, infectious disease the clear entry point.

This situation is replicated amongst foundations with strong global health programs and in the philanthropic activities of pharmaceutical companies which are exclusively focused on infectious diseases. Indeed, to read the annual reports of some it would be possible to conclude that chronic diseases are not a problem in developing countries. This is unsurprising. Chronic disease therapies are vital to the success of the pharma industry and unlike treatments for malaria or TB where the vast majority of sufferers live in developing countries, the most important markets are in the developed world. To make chronic disease medication available to poor people in developing countries would be highly complicated as most such countries also have a significant middle class customer base. Distributing chronic disease medications "at cost" in low income countries be financial suicide.

The focus on the population subsisting on 1$ per day has led to agenda shifts toward infectious disease. Agenda setters for the most part are not talking about low and middle-income country needs, but rather only the poorest of the poor. There is an increasing momentum to address development in Africa only, despite the fact that Asia is the home to the largest number of poor people and, as such, the largest disease burden. Bono has added a tremendous push for attention to Africa. The emotional impact of HIV/Aids orphans and children dying from

malaria is clearly a factor. There is a danger that this important collective push to meet targets in some of the poorest countries has a negative influence in determining what health priorities should be in other countries, how budgets should be spent and importantly, in determining long-term strategies for national health systems and services.

Clearly, each agenda setting body has been influenced by the other. The MDGs and the Commission on Macro-Economics and Health share leadership and have played a major role in defining infectious disease as the key agenda item. The degree of focus on infectious disease appears to be increasing, not decreasing. This may be explained partly by the parlous state of many developing country health systems, partly because health budgets are so lamentably small due to poverty and lack of prioritization and partly because overseas development aid is insufficient. However, it makes little sense if morbidity and mortality rates are determinants of what should set priorities.

Who is doing what in chronic disease?

The majority of global organizations and individuals working on chronic disease prevention and control are directly involved in health and/or are focused on developed country programs.

The OECD, whose member countries include a majority of high income countries, cover a wide range of topics in their Health of Nations summit. Topics included Obesity and Health, Ageing and Health and Cancer and the Environment as well as Sustainable Development and Health Human Rights and Development.[21] This is a reflection of the fact that the majority of these countries have sophisticated health systems and are well aware of the role of chronic diseases in causing death and disability.

WHO's Non-Communicable Disease and Mental Health Division is dedicated primarily to a common approach to all chronic diseases. Academic groups come from public health and direct patient care, again primarily in developed countries. NGO's, with the exception of parts of the tobacco control community, are mostly disease specific organizations such as the International Diabetes Federation, the World Heart Federation, and the Union Internationale Contre le Cancer headquartered in the western world. Efforts have been made to attract the World Bank and to involve economists but with limited success. Industry involvement is evident within pharmaceuticals, food and beverage, all groups that are directly involved in or affected by the increasing burden of chronic disease. These groups are already knowledgeable about chronic disease and its risk factors.

The William J. Clinton Foundation provides an interesting illustration of where chronic diseases do feature today on the "agenda". Within global health, the Foundation's focal point is the battle against HIV/Aids in the developing world. Within the United States, however, the Clinton Foundation has formed an alliance with the American Heart Association to create a healthier generation by preventing childhood obesity. Clearly, this latter issue is politically hot and emotionally charged. Chronic disease features prominently today primarily in higher income countries.

III. How can the global agenda setters be persuaded to extend their focus to include chronic disease? What arguments and communications strategy must be employed?

1. The global health agenda is being determined without a coherent picture of the greatest causes of disability, morbidity and mortality. We need to get the most basic information about chronic disease into the hands of a wide range of decision–makers including the development aid agencies. They do not have it today. We need to spend more time and resources on communication to those who know little than on those who are already committed to chronic disease prevention and control.

2. The chronic disease community must clearly define its geographic arguments including which regions have which disease burdens and risk factor profiles today. The situation in Africa is different from all other developing regions of the world and must be understood as such. Collectively we must define a compelling and specific strategy for Africa that builds on efforts on infectious disease. Heads of State from Asia, Central and Eastern Europe and Latin America must speak out about the diseases affecting their populations. They know their populations suffer increasingly from chronic disease.

3. We must tap into the world's emotions not just intellect. A focus on women and children could be a way to do that. We need to enlist visible star power in the fight against chronic disease. We need to use the emotional hook of childhood obesity if we wish to get our voices heard.

4. Economic arguments are critical when speaking to economists and business people, and they must include specific descriptions of how much it will cost to do what, by when, and not just the opportunity cost arguments classically used by health economists. We must live within current funding levels while we advocate for growing the investment pool for chronic disease. We need to identify quick hits, and low cost interventions (e.g. smoke-free workplace legislation) and rank the interventions in terms of cost and speed of impact.

5. As a group we must build on existing WHO strategies and treaties including the FCTC and Global Strategy on Diet Physical Activity and Health. Chronic disease activists can leverage global interest in obesity. Tobacco control must remain in front of policy-makers. Policy interventions can be among the most cost effective.

6. We must leverage the knowledge base and commitment in high income countries to the benefit of low and middle-income countries.

7. Health systems cannot be built vertically, disease by disease. We have medical and public health resources to contribute. This argument will help us gain support from other quarters. We need to prepare a coherent argument about how we can work collaboratively with the infectious

disease community to build stronger health systems in the developing world.

8. Working in partnership is critical. The chronic disease community has the unique opportunity to enlist corporate partners who share a common view of the disease burden. Pharmaceutical firms, food & beverage, and eventually sports companies share common concerns. Public private partnerships, e.g. Oxford Health Alliance, WHF-Unilever relationship, IBLF, HEAL initiative, International Diabetes Foundation, are the kind of efforts that need to be scaled up. New partnerships must be created. Joint efforts such as the Prevention Alliance involving the International Obesity Taskforce, International Diabetes Federation, International Pediatricians Association, World Heart Federation, and International Union of Nutrition Sciences are critical to increasing physical activity and improving diets around the world. In tobacco control, the joining together of many NGO's into the Framework Convention Alliance was critical to the treaty's success.

Chronic disease health experts can only begin to influence the global health agenda if we learn to speak the many languages of the new agenda setters. Our arguments must suit their needs and they must include not only death and disability date and risk factor profiles, but credible economic arguments, programs that fit within limited budgets, a willingness to contribute to better health systems and an emotional hook.

We need to refine our communications strategy and get chronic diseases on the "global health agenda" if we are ever going to increase the resource pool devoted to chronic disease, particularly in low and middle-income countries. We must work together to accomplish this task.

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