Global Health Assistance: *A New Perspective*

Henry M. Greenberg, M.D.,* and Richard G. Farmer, M.D.†

*From the *Columbia University of Physicians and Surgeons, New York, New York, and †Georgetown University School of Medicine, Washington, District of Columbia*

Health care priorities for many emerging economies have undergone a dramatic transition in the recent past because of the rise in chronic illness, increased longevity, and lessened infant mortality. Two additional major societal forces, democratization and the information revolution, will alter the nature of global health assistance. Because of democratization, governments will feel increasing pressure to provide adequate health care. Because of the information revolution, all practitioners will know what is available. The convergence of these three forces will create an enormous financial burden for emerging economies. Adapting to these new realities will be the challenge to donor organizations. What is likely to emerge as a critical health care problem around the world is the need to balance priorities between acute care and prevention or modification of chronic disease. These efforts will be directed at different populations, one manifestly ill and one potentially so, and each will need to be recognized politically as having valid claims on governmental resources. External support will need to include demonstration within the recipient communities that data collection permits an accurate identification of disease burden, that risk factor modification ameliorates the impact of disease, that continuity of care is essential to long term outcomes, and that therapy of developed disease can be rationally carried out utilizing evidence based medicine to insure efficiency and appropriateness. **A.N.E. 2002;7(1):73–77**

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The nature of the need for both aid and advice in international health is dramatically different today from what it was during the post-World War II era when most of the organizations and agencies established for these purposes were founded. The most dramatic change and what has been discussed most broadly is the "health transition" that documents the rise in chronic diseases associated with an increasing longevity and reduction in infant and childhood mortality.[1-4] As the medical demographics of the emerging economies and even developing countries begin to mimic those of the Western democracies, the medical problems of their growing adult and elderly populations will dominate the health care landscape. The data are compelling and cannot be doubted.

The end of the Cold War has prompted many to look anew at the role of international health assistance.[5-9] In fact, even the name has changed. As barriers and boundaries fall away, what was called "international" health is now "global" health.[5] There is broad recognition and growing acceptance that many of the assumptions that sustained global health activity in the past must make way for new realities.[6] These insightful analyses focus on the process of defining the donors and recipients in a new global arena that alters even prior definitions of sovereignty.[7-8] The thrust, primarily, is on the need to redirect the multinational health and financial organizations toward a global concept of health infrastructure. The processes by which health care priorities are defined garner the most attention from these analyses.

There are, however, two additional global facts of life that alter not just the medical priorities in the emerging economies and the processes by which

Dr. Greenberg serves as a consultant to the Eurasian Medical Education Program; Dr. Farmer is the Medical Director of the Eurasian Medical Education Program.

Address for reprints: Henry M. Greenberg, M.D., F.A.C.C., St. Luke's Roosevelt Hospital Center, Division of Cardiology Program, 1000 10th Avenue, New York, NY 10019. Fax: (212) 523-7765; E-mail: hmg1@columbia.edu

help is delivered, but alter the societal milieu into which that help and support must flow from economically advanced countries. The expanding democratization that has taken place in the last decades of the twentieth century and the information technology revolution that is currently sweeping the world both have profound impacts on the expectations and demands of emerging countries and their health care systems.

There has been a rise in democracy around the world in the past 15 years.[10,11] In Russia, Eastern Europe, Latin America, East Asia, the Middle East, and Africa, elected and or representative governments have emerged or been strengthened. As an index of change, the World Bank reports that in the 20 years following 1974, the percentage of the world's governments elected by their citizenry increased from 25% to over 60%.[10] Those governments will have an increased obligation to respond to the expressed needs of their populations and will inevitability have to deliver health care to meet those demands or jeopardize their legitimacy. It has been said that famine does not occur in democratic countries. While diminished access to health care does not call forth the same political response that inadequate food supplies do, the nature of open societies and responsive governments is such that health care needs will enter more and more forcefully into political debates. People will want, and will ask for, improved health care; and their representatives will want to offer it.

The second factor that will accelerate the call for better health care services around the world is the information revolution. Access to the Internet now knows few political barriers and with the emergence of wireless access, it will know none. Education can be a limiting factor but this should diminish as the political transformation matures. The "health transition", in fact, can be attributed in part to rising educational and literacy levels in the emerging economies worldwide.[2] Education, at least insofar as it relates to Internet utilization, will only improve as access gets easier. As a function of Internet use, health care leaders, practicing physicians around the globe, and ancillary health care professionals will have, on-line, current information about the latest developments in health care. Whatever our leading journals publish today will be known, understood, and desired around the world tomorrow. The potential impact of Internet informatics on the American health care system is discussed widely,[12] but its role in defining health care in the developing world is as yet undefined.

The convergence of these three forces–the ascendancy of chronic illness, democratization, and the information revolution–will create an enormous financial burden on emerging democracies. Those governments will feel an increasing pressure to provide adequate health care to the population on whom they are dependent; leaders at every level of society will know exactly what is available; and the cost of prevention and treatment of chronic illness is extraordinarily high. In fact, the costs are so high that they have driven the richest economy the world has ever seen into paroxysms of covert rationing and a seeming willingness to risk the infrastructure of a health system that has been the model for the world.[13]

ROLE OF DONOR COUNTRIES

Given this vision of the future, the role of the Western democracies and the global community of health aid organizations is far from clear. In the past, Western industrial nations could send supplies to manage acute illness, could train and supply local personnel to inaugurate and perpetuate immunization, nutrition, or birth control programs, or could help host countries with sanitation projects and the associated education programs. These did not cost much, had a quickly visible effect, and reflected well on the local government. This will no longer do. China's National Bureau of Statistics recently released census data which reveals that 7% of the population is greater than 65 years of age, meeting the U.N. criteria for an "aging population".[14] In Eastern Europe and Russia, cardiovascular disease and diabetes are the cause of 60% of the mortality and afflict people at a mid-career age.[15-17] In India and China, cardiovascular disease is now a major cause of death.[18-20] Circulatory diseases now account for 30% of all deaths worldwide.[4] To treat these populations the way we do in the United States would devour most health budgets within two weeks of the onset of the fiscal year! Angiography, coronary or peripheral bypass procedures, and contemporary management of myocardial infarction and unstable coronary syndromes for all who might benefit are priced beyond the cost of virtually all economies. Contemporary management of cancer, lung disease, or chronic hepatitis may be less expensive but are no less beyond the budget capacity of many emerging de-

mocracies. When costs attributable to increasing longevity are considered, the fiscal burden of managing chronic illness increases even further.[21]

According to data from the Global Burden of Disease Study,[18] the emergence of chronic and disabling diseases has exceeded expectations in much of the world, including Latin America and China. Even in Sub-Sahara Africa, which has overall mortality rates still driven by communicable diseases, the incidence of chronic diseases in the adult and elderly populations looks more and more like that in the developed world. Projections of chronic disability reflect similar patterns.[22]

Why Should We Help?

The answers to this questions fall into three broad categories. We should help because we can and because it is the right thing to do. This sensibility has sustained global health assistance, particularly nongovernmental efforts for generations and will continue to do so. Recent global health assistance programs have addressed threats such as HIV/AIDS, multi drug resistant tuberculosis, and malignant new viruses because of the proximate risk they represent to all people and all nations. Most importantly, however, looking forward, the emerging democracies and developing world must become desirable addresses for their populations. As such, they will become increasingly essential contributors to the expanding global economy as both consumers and producers. Effective, affordable and appropriate health care is a necessary and mandatory ingredient for a successful societal infrastructure.

How Can We Help?

We can certainly export our insights into prevention and public health, help with smoking cessation, dietary/ agricultural policy recommendations, and pharmacologically based treatment/prevention plans. However, people who are ill will want active therapy, not just prevention, and therapeutic standards will be known, even if prohibitively expensive. While we can supply catheterization laboratories and the latest thrombolytic drugs, there will be few buyers.

What is likely to emerge as a critical health care problem around the world is the need to balance priorities between acute care and intervention for chronic disease and the prevention of the emergence of these same illnesses. These efforts will be directed at different populations, one manifestly ill and one potentially so, and each will need to be recognized politically as having a valid claim on the government's resources. One way of looking at democracy is that it is a social system in which competing, valid claims on public resources are balanced and distributed equitably and acceptably. If intervention is denied to all with symptomatic atherosclerotic vascular and heart disease, most families will feel betrayed by the governments. If only a select few are offered help while others are not, this failure to satisfy the norm of social justice could permit an unfortunate political instability to emerge. The challenge will be to create a balance that is based on socially and culturally accepted values such that a budget-based combination of treatment, prevention, and education can be instituted and accepted. This will not be easy and it has not been the obvious purview of the traditional international health care consultant or agency.

With our experience in public education and making information accessible, health maintenance, outcomes assessment, clinical trials, and public debate, we have much to offer. But simply outlining one or more scenarios in which competing generational needs for treatment or prevention of chronic illnesses are met is not in and of itself effective help. External support will need to include demonstration within the recipient communities that data collection permits an accurate identification of disease burden, that risk factor modification, often in arenas other than health care per se, ameliorates the impact of disease, that continuity of care is essential to long-term outcomes, and that therapy of fully developed disease can be rationally designed and carried out utilizing evidence based medicine to insure efficiency and appropriateness. Concomitantly there will need to be an enhancement of the capacity for acute therapeutic management of those deemed most ill, and all of this must fit into budget guidelines that are agreed to by the majority of stakeholders. Developing models for chronic disease management, including a public health component, and helping to create an environment in which these can be rooted and nurtured will become an important task for donor countries and organizations. Developing, emerging, and "devastated" economies (Russia) will have different needs, priorities, and timetables. One solution will not fit all, but the importance of developing methods to manage chronic illness will be a common theme for all.

Modulating the progression of chronic diseases such as hypertension, atherosclerotic cardiovascular disease, diabetes, and chronic lung disease, and the postponement of their complications are feasible goals. Even tuberculosis, in its recurrent, multidrug resistant form, and HIV/AIDS can be approached by applying the principles of chronic disease management. Tuberculosis control and HIV/AIDS management require effective surveillance, longitudinal case management, and patient and public education for its sustained success, concepts that differ little from managing hypertension or diabetes. These observations do not detract from the unique, devastating communicable consequences of these scourges. But viewing them, at least in part, as chronic diseases permits a wide array of management techniques, teaching programs, and health care delivery organizations to contribute to the efforts to contain and eliminate them. Such chronic disease management programs have multiple components: (1) public education regarding risk factors, individual personal behavior, and the role of and need for medical follow up; (2) screening of high risk populations; (3) reduction of environmental risks; (4) patient counseling regarding risk factor modification; and (5) medical management of disease expression which should include diagnostic testing, drug therapy, and assurance of continuity of care.

Programs for managing chronic disease must engage the host country's medical establishment at multiple levels: governmental, academic, preventive, and clinical. There must be support at all of these levels and the donor organizations and their visiting physicians must recognize the different perspectives represented by these disciplines. Program failure occurs when the various components of the recipient health care system are not involved in the specific program. At the governmental level, those responsible for the community or regional health will need to see that the teaching program inculcates cost-benefit analysis and efficiency. Outcomes analyses designed to show the impact of evidence-based medicine on macromedical indicators such as longevity, reduction in disability and unit cost of service are essential. The academician will want to see his or her faculty engaged in best practices medicine, contemporary risk reduction programs, and possibly even gaining experience which can lead to participation in clinical trials. The public health staffs will need to see their concerns for environmental issues and behavioral risk reduction, compliance, and patient education addressed seriously at each step in the program. And lastly the clinicians, the community-based generalists, who deal with the individual patients, need to understand that they are participants in up-to-date practices and that their data collection efforts and focus on compliance, continuity of care, and clinical outcomes are valued and valuable.

Because management of chronic illness, as varied as tuberculosis and diabetes, is ongoing, long standing, and expensive, all the stakeholders, including the patient, need to understand that the process is sensitive to their needs. The allocation of funds and personnel for risk reduction, medical/pharmacological management, and procedural intervention must be done in an open manner that bespeaks a societal based sense of social justice. Because of limited funds, the competition for resources can become intense. Only if the stakeholders understand the validity of competing claims in a fashion consonant with cultural norms can long-term progress be made. Global health assistance must be governed by such understandings.

CONCLUSIONS

The priorities and characteristics of global health assistance have changed rapidly in the recent past. With emphasis on prevention and management of chronic illness in a world more open and informed, global health assistance will need to address issues centered on cost control, efficiency, public health, and evidence-based medicine. Cardiovascular disease dominates this landscape. Allocating resources between competing valid claims will need to be based on locally derived data which will in turn be dependent upon newly learned capacities in organizing and managing care. Decisions will need to be consonant with local cultural and fiscal realities. In short, the dominant attributes of health care in the emerging economies will more and more resemble those in the United States.

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