Delivering Health: Clinical, Management Delivery, and Policy Challenges

Lecture 2: What are the biggest challenges in global health and what needs to be done?
January 30, 2017; 6:00pm-7:20pm

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What is global health?
- Human and population health
- Variation in disease and death between countries
- Conditions of death are easily preventable
- “First world problems” are now global problems
  - What’s killing people today – heart disease, strokes, lung disease, Alzheimer’s, lung infections – associated with affluence
  - Disability- heart disease, strokes, lung infections, back pain, premature birth

How did we arrive here?
- Public health needs to step back and see the bigger picture
- 10,000 years ago the agricultural revolution brought huge changes to the global burden of disease, which meant that people were tied to plots of land, worked longer hours, experienced a large rise in interpersonal violence, and large food surpluses fuelled a population boom, the rise of elites, and the emergence of large-scale socioeconomic inequalities (wealth distributed to fewer in the population)
- Industrial revolution: 200 years ago, jobs became more sedentary, poor sanitation, overcrowding, poor hygiene and living conditions
- Technological revolution: 50 years ago, more urban populations, increasingly sedentary, poor diet
- The massive change seen in the last 10,000 years is extremely recent in comparison to the entire course of human history

In the context of astounding success and a 20 year increase in life expectancy, how do we build societies that promote health alongside comfort and choice?

Power
- Humans used to live on the land with society organised under monarchs
- In the past 200 years we are seeing power move back to the hands of the people
- Democracies are good for health; autocracies don’t need health systems
- Leaders have a vested interest in listening to those who voted for them; but the health of those who are marginalised will only improve if their vote is heard
- Ill health is disproportionately concentrated amongst the socially marginalised who are two-times less likely to vote compared to richer groups.
• This can lead to the further marginalisation of groups who already lie on the margins. Ex: cutting disability benefits while maintaining triple-lock pensions
• The health conditions we face require long term investment and planning, but four-year electoral cycles incentivize focusing on quick wins and disincentives long-term investment

**Liberty**
• Almost all countries are becoming obese; this is not a result of laziness, our environment has changed – can do most activities from the comfort of one’s bed
• In place of talking about “poor people,” should think of “people in the condition of poverty”
• Scarcity and poverty constrains our ability to trade off short-term pleasure for long-term gains – there’s a social gradient, people from lower SES backgrounds are more likely to focus on simply surviving “now”
• There are structural social determinants in one’s environment that make it hard to “choose” health (e.g. be exposed to tobacco and alcohol in the womb, lack nutrition knowledge, fewer areas to exercise in safely)
• Does the state have a responsibility in limiting personal freedoms?
• We already allow the state to curtail our freedom to murder, steal private property, and use slaves… Should we cede other areas to increase population health?
• More restrictive interventions are more effective, and they disproportionately benefit those with worst health
• The challenge that liberty poses to global health is that humans are programmed to use it in a way that is self-destructive in this new environment of choice
• We don’t have to have “Spartan” health policies, we can make smaller bans like prohibiting smoking in playgrounds that will improve population health

**Sex**
• The world is getting bigger and living longer
• As countries get richer they go through demographic transition
• In the North: our success in reducing infectious diseases, injuries, and childhood mortality means that people live long enough to develop expensive chronic conditions
• The global old age dependency ratio is growing; but we’re not good at making older people healthy
• In the UK disability free life expectancy is only 62 while retirement age is 65
• High rates of population growth make it hard to extend health services
• Once fertility rates fall, countries need to formalise the economy, import migrants, and keep older people healthy

**Money**
• 6-7 groups (i.e. Bill and Melinda Gates Foundation, WHO, UNICEF) give 50% of all money to global health so they dictate the agenda
• Funding is not distributed according to need, but by personal agendas and the interests of an unrepresentative clutch of Western powers
• Non-communicable diseases get less than 2% of the funding but kill 70% of the world
• Overseas aid is falling, but global real median household income is rising and extreme poverty is falling as a result of capitalism
• Huge variation in life expectancy within income bands and across the world—need more convergence
• Rich people have better health than poor people; evidence that more unequal societies experience more health and social problems. Think of the US vs. the Scandinavian countries
• More expensive medical treatment is putting strains on finance ministers and ordinary individuals as health insurance premiums rise and the basic basket of services is slowly restricted
• The global health community has used the concept of Universal Health Coverage to frame the problem of increasing the number of services on offer, extending access to the entire population, and reducing costs
• The solution is advocacy, political agitation and Universal Health Coverage
• Is there a way of reconciling free trade and the bountiful gains of globalization with fair, inclusive trade that works for all?

Conclusion
• Countless die as a result of living in the new ecosystem we have created in the last 200 years
• Challenges of democracy – focus on prevention and primary health care, decrease birth rates in developing countries
• Challenges of money – mismatch in global financing and economic inequalities
• Solutions include increasing education and health care, cross-party consensus on long-term issues

Discussion led by Dr. Trish Greenhalgh

A lot of NCD research is done in the global North, how do we translate to low and middle income countries?
• Have interventions that work but don’t know what works in poor countries. We’re not sure what evidence base is in poor countries. There is no proof aspirin works for heart attacks in developing countries. Do we have to go back to do all those trials again? Important to have evidence in these countries and get on with things that do work. Do stuff where have good evidence

Aren’t cognizant of culture.
• We have lots of indices and metrics, but they aren’t conveying what it’s like to be poor, have low health literacy, in a particular setting because metrics are in abstraction. There is a tradition in healthcare to explore experiences of the individual through ethnographies, narratives. Using narratives would illuminate metrics that were presented, but it is hard to spot rigorous narrative research. The WHO is recognising that we need narratives in health research, but they are still discussing how to make this research rigorous
Health care costs are spiralling, partially due to increasing age, system is a victim of its own success. How do we make it sustainable?

- People are getting older, most costs are applied at last 5 years of life. The demands for health care are rising and the expectations for what health systems should do for us and prescribing costs have gone up. What can be done? Preventive agenda and keeping people healthy in the first place.

How do we reconcile the benefits of health care when these benefits are often hard to quantify?

- We have lost idea that health is a value in and of itself. It’s outside of the realm of numbers, soft changes. Need to advocate for bringing people together and talking about numbers.

Question to group: how do you want to take the global health movement forward at GTC?

- Continue cross pollination of students and ideas
- How to set up collaborations between students in different departments, get funding for different initiatives
- How use expertise and influence of GTC to motivate policy shift in NHS? Lots of preventive effort, but it’s a narrow effort and it’s at an individual level. Have to shift from individual education as way to change lifestyles that will kill people to a broader public health informed approach. Not just movement of treatment to prevention, but the KIND of prevention. Can’t stay in the ivory tower, have to get into the political discourse. Write for the Daily Mail, the Conversation, petitions, get on a select committee

Look at multi-morbidity conditions

- If we address the structure of society that addresses making people want to drink alcohol, we address all NCDs. Move the focus upstream. Gates has looked at vertical disease systems but key donors have to think differently, not about eradicating disease, but about strengthening health systems and primary care health systems. Requires a conceptual shift. Language and theories are no longer focusing on epidemiology, but about health systems. Now Gates is funding Alliance for Health Policy and Systems.