SCHOOL OF GLOBAL HEALTH
Faculty of Medicine
Chulalongkorn University

75 YEARS ANNIVERSARY 1947 - 2022
คณะแพทยศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
Faculty of Medicine Chulalongkorn University

2022 SGH LECTURE SERIES #3

Political Economy and its Implications on Global Health

Suwit Wibulpolprasert, M.D.,
Chulalongkorn University

26 July 2022

https://sgh.md.chula.ac.th/ sgh@chula.md

H5N1 – Pandemic Threats in 2004 Until Now

- Spread among Chickens in late 2003 but we covered it up until Prof. Prasert disclosed in the public but was criticized badly by the PM. But a few days after that human case emerged!!! – Chicken export accounted for 5% of the GDP!!
- Should we immunize our chicken – broiler, layer hens, exotic birds?? – legally not but practically yes especially in layer hens
- How are we going to respond to the pandemic – **1st pandemic preparedness plan – now EIDs plan**
- **Should we have a flu vaccine production capacity??**

H5N1 Pandemic – Health Care Provider and Close Collaboration among Countries

- The first Laos' case -12 years old young girl cross the Mekong River to get treatment in Nongkhai
  - Diagnosed after 11 days of illnesses – **private hospital admitted for 7 days??!!! -** Immediately informed Laos
  - **Joint** outbreak investigation started immediately **– trust after long term collaboration**

- In 2006, Indonesian Health Minister declined to share Flu viruses with WHO!!! – WHO PIP mechanism

- Global Program to support developing countries to have Flu Vaccine production capacity – paradox of supply and demand

Virus Sharing!!!

- Indonesian HM decided to stop all sharing of H5N1 viruses with WHO in 2006!!! – story behind
- Spark an real understanding of the Flu viruses surveillance systems which benefit only rich countries
- Start of serious several years discussion on fair share of viruses – the PIP framework
- Industry to pay into a central fund to support developing countries capacity

Flu Vaccine Production Capacity

- Seasonal Flu Vaccine – three strains – global supply of around 700 million doses while the demand is around 4-500 mil. doses – supply over demand and price is now 4 USD/dose
- This can be turned into 2 billion doses in time of pandemic – demand over supply!!!
- Should Thailand have a flu vaccine factory?? Should the national security reason be accepted?? – The issue of technology transfer!!!!

H5N1 Situation Now!!!

- Still 1-2 new cases especially in Egypt!!!
- No news and few people care!!!
- Thailand has the capacity for Live Attenuated H5 vaccine but only 100,000 doses – who would get first???
- We are going to have the Flu vaccine production capacity in 2020?? – technologies changes???

The Government Use of Patent (CL)

- UHC was launched in 2002 and Universal Access to ARVs in 2003 but second line was very expensive and negotiation failed - It is possible to implement Government Use of Patent according to TRIPS but should we do it as the resistance would be very high
- Implemented on two second line ARVs and one blood thinning drugs in 2006-2007, and 4 anticancer drugs in 2008 with extensive consultation with MoC, and government legal
- Huge resistance and threats from powerful countries – USA and EU – trade sanctions

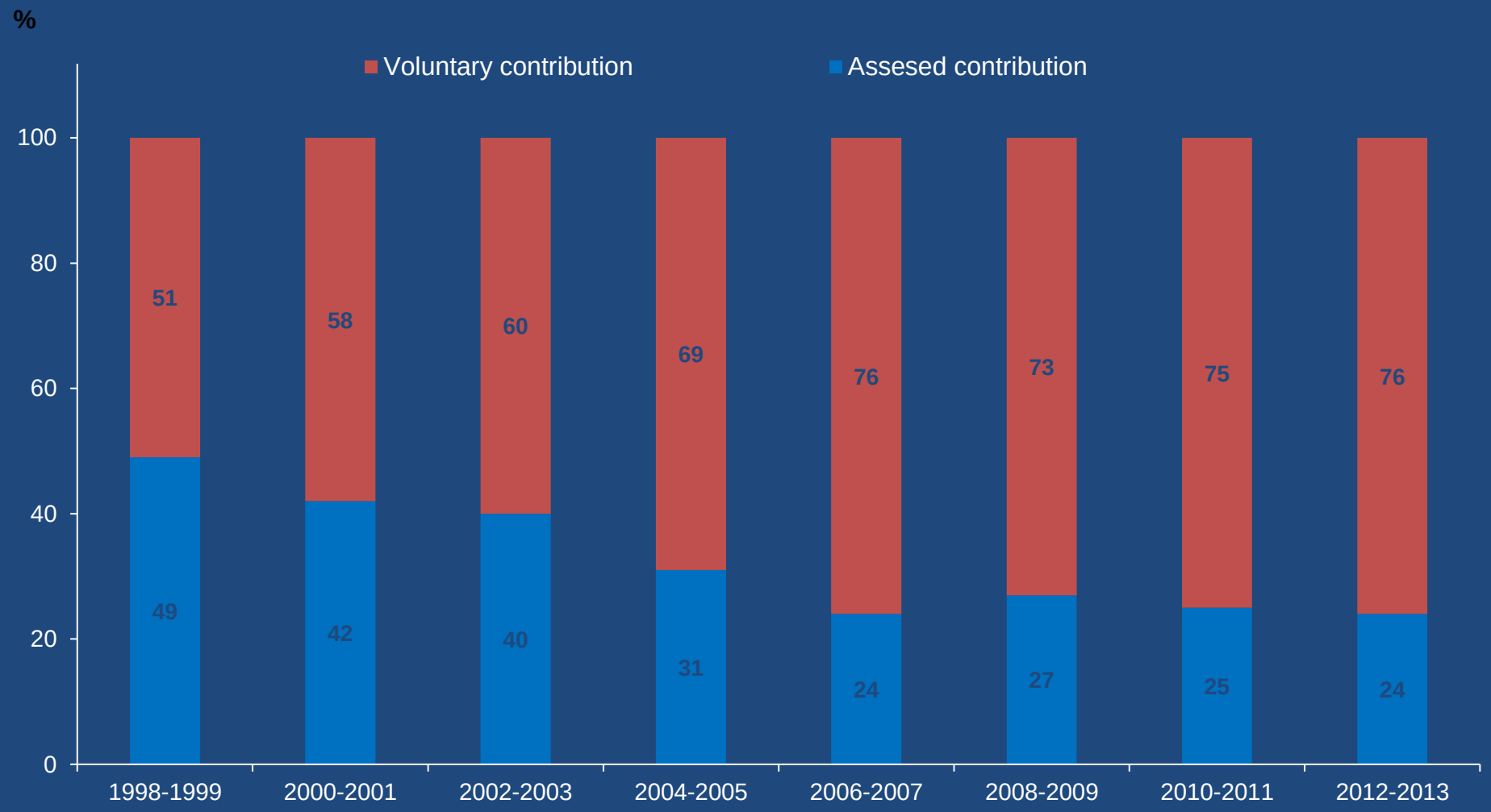
Lessons Learnt

- It’s the MFA (embassies in DC and Europe) that received highest impact but MoPH never realized and never consulted them
- The threats are not real and no implications on exports to US and EU
- Lots of support from INGOs, IGOs and many US congressmen
- The truth about drug companies – how they deceit us – Prof. Macia Angel – Harvard professor and chief editor of New England Journal of Med – Time Magazine put her as one of the top 20 most influential people in the US

The Thai CL and WHO!!!!

- WHO hesitated to support - urged us to negotiate with the companies
- May 2007 - Put a paragraph in the WHA resolution requesting the DG to provide technical support to countries that want to implement TRIPS flexibility - **US added 'based on request'!!!**
- Put an official request to WHO HQ - kicked to RO and nothing happened in 5 months – threat to speak at the EB – WHO moved
- An integrated team from UNDP, WHO, WITO came and **endorsed that what Thailand did was sound according to international rules – strong support for further move in Jan 2008**

WHO Budget:
assessed and voluntary contribution 1998-2013



Top Ten WHO Donors (voluntary contribution) 2010-2011

Donors	Non earmarked	%	Earmarked	%	Total
1. Gates	0	0%	446,161,801	100%	446,161,801
2. USA	0	0%	438,285,683	100%	438,285,683
3. UK	41,009,718	14%	247,942,675	86%	288,952,393
4. Canada	0	0%	154,147,294	100%	154,147,294
5. Rotary	0	0%	116,565,898	100%	116,565,898
6. Norway	***47,925,896***	***42%***	65,963,666	58%	113,889,562
7. UNDP	0	0%	109,890,218	100%	109,890,218
8. GAVI	0	0%	98,782,852	100%	98,782,852
9. Australia	28,717,115	31%	63,097,757	69%	91,814,872
10. UN CERF	0	0%	90,809,419	100%	90,809,419

Strengths and Weaknesses of WHO

Strengths

1. Social Credit as Global Normative Bodies
2. Unlimited access to the best global experts
3. Extensive networks of WHO Regional and country offices

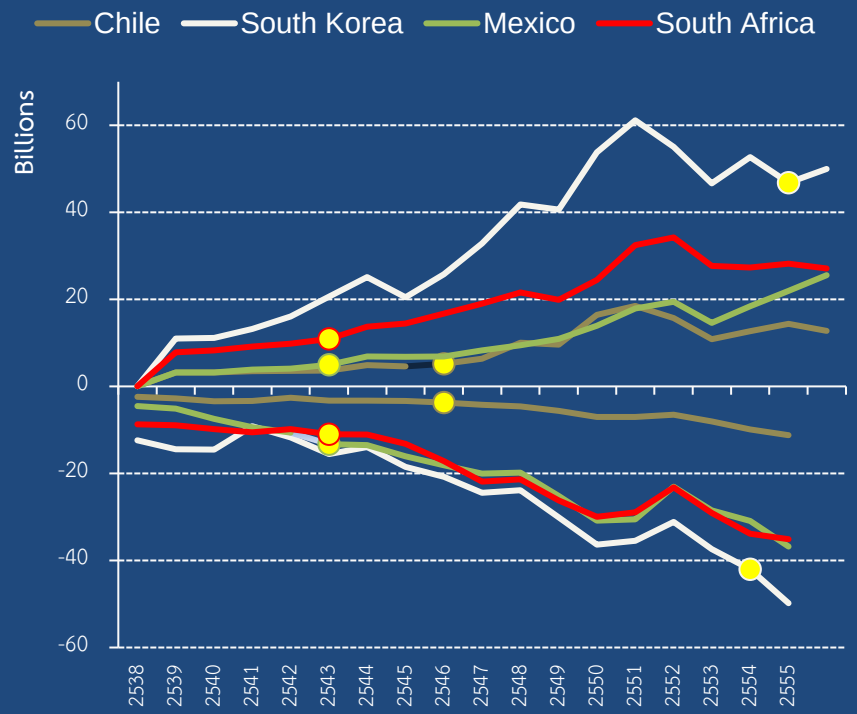
Weaknesses

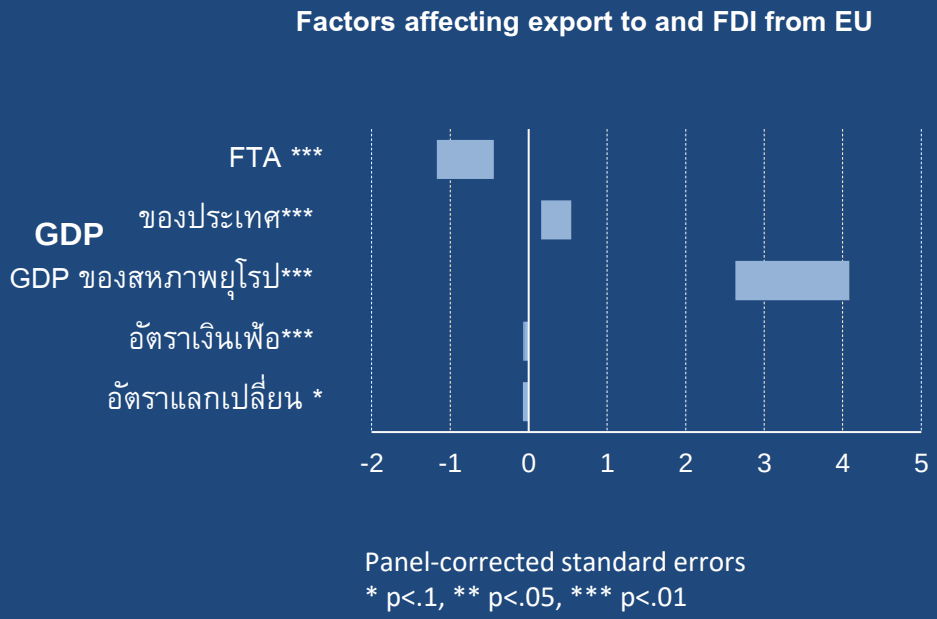
1. Bureaucratic Systems – vertically and inefficient
2. Increasingly politicized
3. Outdated regional structures
4. Changing budgetary structures
5. Loss of global PH spirits – loss of good people

International Trade and Health

- Trade of Bads – **Alcohol, Tobacco, sugar, salt and Ultra-processed foods** – limited countries' capacity to regulate and help our people
- TPP/FTAs - TRIPs plus – longer patent term, data exclusivity – **access to essential medicines limited**
- Mutual Recognition Arrangements – Health Professional migration after AC 2015 – Is it real???
- Investment Clauses - ISDS which may hide many things in them

Global Health – FTAs and Health





มูลค่าการส่งออกระหว่างปี พ.ศ. 2539-2555 ของประเทศที่ความตกลงเขตการค้าเสรีมีผลบังคับใช้

หมายเหตุ: ● คือปีที่เริ่มมีผลบังคับใช้

- After FTA there is an increasing trend of trade
- After controlling all factors - FTA has negative implications on exports to and FDI from EU

Why Building Capacity on GH

- Protect National Interest (defensive)
- Move global agenda to contribute to global development (proactive as good citizens)
- Build good national image through active and constructive involvement (image)

Definition : Capacity

- The ability of **people**, **organizations** and **society** to manage their affairs successfully [OECD 2006]

- Skills, knowledge, resources needed to perform a function

  http://mirror.undp.org/magnet/policy/glossary.htm

Enabling environment

- Institutional context
- Sociopolitical context
- Economical context
- Environmental context

Interrelationships of groups and organizations (Network)

Individual learning

- Participation/access to information
- Understanding of roles
- Training
- Incentives
- Accountability and feedback

Organization (Node)

- Mission/vision/strategy/policy
- Values/norms
- Competencies & structure
- Processes and systems
- Resources

INNE model of Sustainable Capacity Building (UNDP/Wasi)

What Kind of Capacity for GH?

Type of capacity	Roles of BIH/DIH	Roles of Technical units
Systems, mechanism, process	+++++	+++
Communications including language	+++++	++++
Negotiation	+++++	+++
Technical contents	++	+++++
Networking and building social capital	+++++	++++

What have We Done So Far?

- Started with IH Scholars project in 1998 and turned into IHPP in 2001
- Now become GHD CB (MUGH and MoPH) in 2009
- Build new generation GH leaders, in all partners agencies, based on learning by doing from real life experience – WHO EB, WHA, RC, GF, PCB, ASEAN, etc.
- Thailand Global Health Strategies – MFA/MoPH plus partners (public and private)

What Capacity have We Achieved?

- Constructively intervene and propose evidence based recommendations to proposed draft resolutions
- Capacity to table and agenda, draft resolutions, chairing GH forum, negotiation including in the FTAs
- Networks with regional and global institutes
- Successful PMAC – not just another conference but global health policy movements

What should Thailand Do as UMIC?

- Sharing these capitals for capacity building in other developing countries – INNE model – VN, Bangladesh, Maldives, Sri Lanka, Indonesia, China, etc.

- Contribute more actively to Global Health - Financial contribution as UMICs??

  - UNGA 0.7% GDP on ODA – HICs

  - US/Japan – 0.2%, Nordic ~ 1%

  - Thailand?? - 0.02% of GDP on ODA – mil USD 100?

- Reform of GH structures – MoPH, MFA, universities, private foundations – coordination and joint effort

Reform of GH Structures – MoPH, MFA & University

- MoPH's unit – division, bureau, department?
- Chief of MoH unit from DDG level of the MFA - Brazil
- Health attache and Health Ambassadors' – donors
- Division of Global Health in DIO/MFA – Japan
- Global Health Strategies by MFA – Jap, UK, Sw, **Thailand??**
- Global Health Institutes in universities and private foundations – MUGH, Thammasat, PMGHI in PMAF, CSOs

Roles of Thai Technocratic Leaders

- Build up capacity on GH – technical, languages, mechanisms/processes - INNE
- Play active roles in GH/RH/BH activities as a ‘Team Thailand’ to contribute to global public benefits
- Link the GH/RH/BH into national health and development systems – house cleaning!!!
- Vigilant and Surveillance – understand the world, the region and home country

What is Global Health?

"Health issues where the ***determinants*** circumvent, undermine, or are oblivious to ***the territorial boundaries of states***, and are thus beyond the capacity of individual countries to address through domestic institutions. It focuses on ***people across the whole planet.*** It recognizes that health is determined by problems, issues and concerns that transcend national boundaries."

Global Health ***involves all partners from government***, ***communities, to foundations, NGOs and private sectors***.

Global Health and International Health

	International	Global Health
Scope	Conventional health care issues	Extend to social determinants of health, trade, climate change, security, foreign policy
Actors	Government health sector technocrats	Extend to other sectors, private Sector, NGOs, GHPs foundations, academia
Influencing Instruments	Constitutions, regulations, conventions	Other soft laws, financial and trade, social and intellectual capital

4 Big Global Health Threats – 4 Big Tsunamis

- **Emerging infectious diseases and pandemic** – HIV/AIDS, TB and Malaria, **AMR**, pandemic,
- **Socio-economic and environmental changes** – international trade, climate change, industrial wastes, social inequity from neoliberalism, advance technologies – rising health expense
- **Demographic change** – ageing, urbanization and movements/migration
- **CCIs** – chronic conditions (NCDs) and injuries

Health Issues from Different Concerns

- **GH as public health** – maximize health effect – FCTC, pandemic/IHR, UHC, HR migration, AMR, MDR TB, HIV, etc.
- **GH as foreign policy** – trade/economy, democracy, human right, biosecurity, country image
- **GH as security** – bioterrorism, pandemic, AMR, MDR, HIV
- **GH as charity** – fight poverty, philanthropy
- **GH as investment** – economic development – IP, Medical tourisms, infectious diseases
- **More Health issues at UNGA – MDGs, RS, HIV, NCDs, UHC**

Global Development Paradigm

- Neoclassic economic concept:

"Resources are finite, but people has unlimited wants, thus we must design a system that can use the finite resources to best serve the unlimited human wants, in the most efficient and equitable way"

- *However, equity is usually forgotten and we mainly go for 'efficiency' and 'competitiveness'*

- *Neo-liberal concept of development:* ***liberalization, deregulation and privatization***

Why the Current Development Model Fails?

- Economic growth not social targets as its primary objective
- Focuses on export led growth – limit in global consumption and depends on a few rich countries
- Based on competition between countries in the global markets – gainers and losers
- Depends only on 'representative democracy'

Failure of the Current Development Paradigm: Poverty and Inequity

- Pure capitalistic market driven development resulted in shift of limited resources towards the rich – more wealth disparity
- Although poverty is gradually decreasing but 1 billion live under USD 1 per day, 2.5 billion below USD 2 per day, and 3.5 billions below USD 3 per day
- Unsustainable and unrealistic – current environmental, financial, political and social crisis

Climate Changes

- To limit the increase in global temperature to 2 degree C needs 60% reduction of carbon emission from 1990 to 2050, but *we are increasing our emission !!*

- With continuing economic growth rate, there will be more emission and no hope to get near the target emission reduction

Excessive Use of Resources and Energy

- The richest country in the world, with only 5% of the population, uses more than 40% of the world resources
- Environmental deterioration
- Severe climate changes
- Move towards more polluted and more dangerous energy sources

Global Health Governance
- not only WHO and Rich Countries

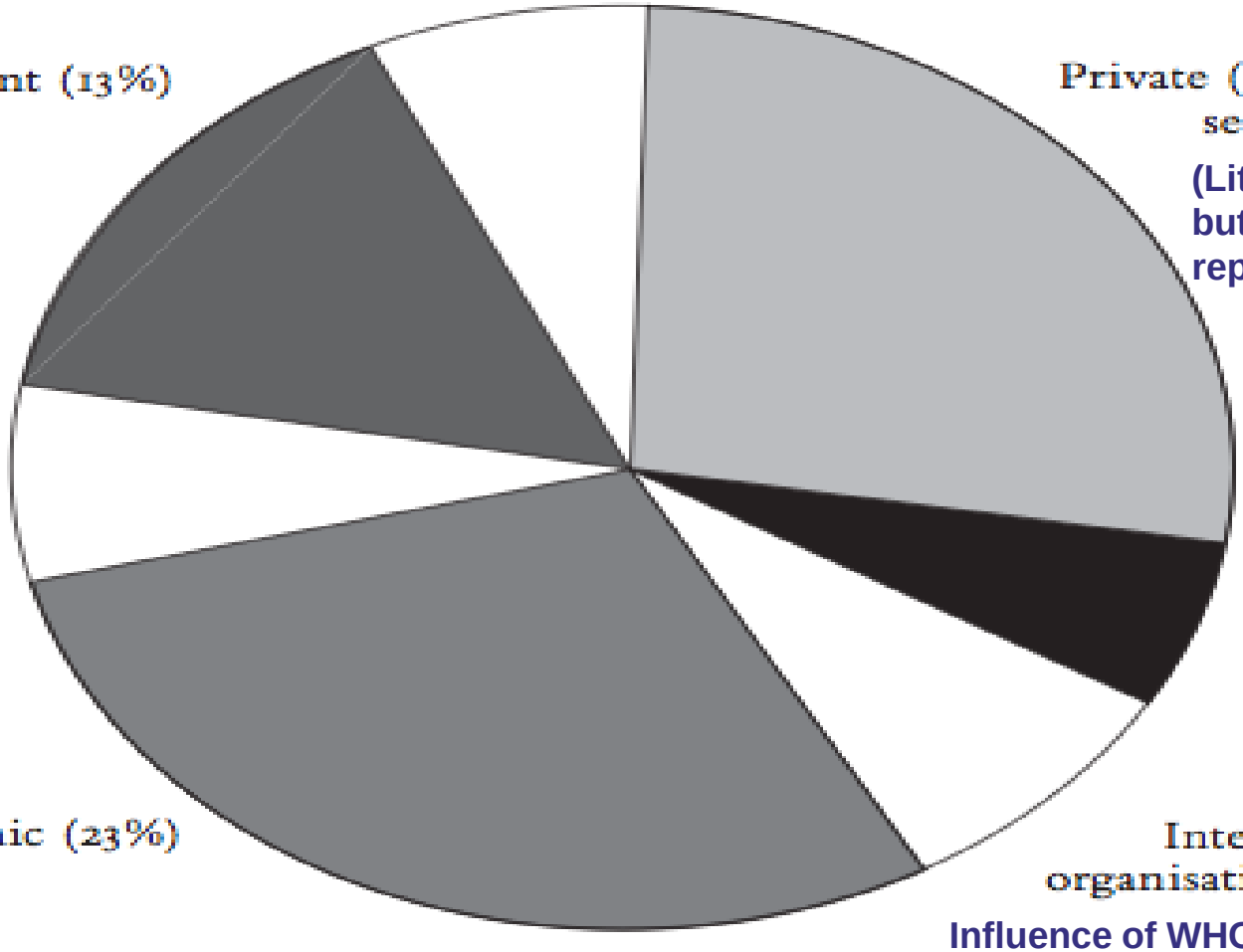
- UN: WHO, ILO, UNICEF, UNFPA, UNAIDs, WTO, WB
- Donors: JICA, USAID n PEPFAR, DFID, EU/EC, G8/G20
- Foundations: BMGF, RF, CMB, Wellcome Trust, …
- New players – Emerging Economies - BRICS
- INGOs: MSF, Oxfam, Clinton foundation, ...
- Global Health Partnerships: GAVI, GF, …
- Private Sector – drugs, foods, tobacco, alcohol, …

Crowded Global Health Landscape

Who influence Global Health Partnerships – Northern Global Actors and private sector??

(analysis of 298 board seats of GHPs)

FIGURE DI.I.2 **GHP board analysis**



Source: Buse and Harmer 2007.

Global Health Financing – Two Decades