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EDUCATION

Health challenges for this decade: From international co-operation to the concept of global health. Implications of clinical specialist co-operation☆

Los retos de salud en la década que empieza: de la cooperación internacional al concepto de Salud Global. Implicaciones para la cooperación de especialistas clínicos

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Evolution of health

What is the major health challenge facing the world today? Let us begin by reminding ourselves of the objective that laid the groundwork for the World Health Organization (WHO) 65 years ago: ''The attainment by all peoples of the highest possible level of health''. This inspired its inclusion in the declaration of human rights in the following years. Since then, humanity has increased its mean life expectancy by close to 20 years, almost as much as the estimated amount over the entire prior history of human evolution.

Analyses appear to indicate that the most important factors driving the increase in life expectancy have been food, drinking water, sanitation, living and working in hygienic conditions, and women's liberation. Antibiotics, rehydration serum, and other medical advances also contributed. In its first 20 years, the WHO made strides toward eradicating small pox. It coincided with the last wave of independences and a United Nations Organization, including the WHO, with a global democratic spirit, albeit still constrained by the oligarchy of a Security Council inherited from the world wars. However, during its second 20 years, the WHO's attempts to eradicate malaria failed. At the end of the 1970s, the WHO, UNICEF, and the push of countries from the South, imbued in large measure by social principles in young African democracies, socialist resistance in Asia and America, and the movement of barefoot doctors in China, became excited about the concept of Primary Care at the Alma Ata Conference, spreading health beyond the institutions, mobilizing communities and aspiring to the concept of ''health for all by the year 2000''. But community mobilization lacked truly committed governments to extend health to the communities, limited in part by structural adjustments imposed by international financial institutions (ruled by the North and by capital), putting the brakes on social policies and expenditures. UNICEF, always governed by the United States and its liberal political philosophy, promoted the Bamako initiative during the 1980s in an attempt at self-management of community care; however, that limited it, medicalized it, and ''de-socialized'' it. With health-care systems that did not quite get off the ground and the World Bank dictating efficiency prescriptions in public health interventions (Report

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1993, Investing in Health), the WHO was losing leadership in the final 20 years of the 20th century. Meanwhile, AIDS began to spread, especially where the need for health was greatest and the resources most limited: sub-Saharan Africa. Perhaps another sign that discredited the WHO was that a different agency was founded to fight against a disease. With inequalities growing in a world with pensée unique, a progressively deregulated market, and with weak health-care systems in countries where the economic resources are limited because they gravitated on the fringes of the global economy, dominated by the speculation of central power, AIDS spread and the progress in life expectancy came to a standstill. The decade of the 1980s was known as the lost decade of development and the decade of the 1990s might well be called the lost decade of health. The challenge of ''health for all by the year 2000'' was forgotten about during the 1990s. When its deadline arrived, it was not even given a decent burial.

The last 5 years of the 20th century appeared to transform and all but wipe the entire history of previous commitments off the map: the most important advance in therapy was shown at the International AIDS Conference held in Vancouver in 1996 when David Ho showed how combined therapies could turn AIDS, until then a slowly fatal disease, into a chronic illness. The following years triggered a new, but very different, social mobilization 20 years after Alma Ata: the demand for access to treatment for AIDS. ''Seropositive'' activists from the North demanded access to life-giving treatments and influenced as no grassroots group had ever before at the G8 meetings since Okinawa and the World Trade Organization since Doha, triggering the gestation of a world fund to fight against AIDS and exceptions to patent agreements for drugs against AIDS. The activist AIDS movement did not speak of the right to health in the abstract; it did not demand public health-care systems; it did not represent communities as a whole, it simply demanded access to treatment for AIDS. From grassroots movements to lobbies, from the right to health to emphasis on a disease (later indirectly extended to malaria and tuberculosis), prevention and public health to effective treatments, from services to projects, from public systems to international NGO service providers, from processes to results. All ruled by ''humanitarian'' logic: three million people died of AIDS without access to vital treatments. Projects and results were needed; lives needed to be saved.

All this had an impact on the agenda of the Millennium Development Goals (MDG): the world was asking for progress and results in the issues that had come to a standstill: stagnated rates of infant mortality (10 million children under the age of five) and maternal mortality (half a million women during pregnancy, childbirth and the postpartum period), and for some headway with respect to AIDS, and indirectly, malaria and tuberculosis.

International co-operation in health

In the first decade of the 21st century now drawing to a close, international co-operation in health has gravitated around the framework of the MDG and the emphasis on projects and results in the areas of specific health issues that have the greatest media impact. This has led to a proliferation of vertical initiatives that are prioritized and designed, no longer in the capital cities removed from the local communities or structures, but as far away as New York, Washington, Geneva or Brussels. These initiatives find their best allies in activist groups, demanding funds from wealthy nations or groups of financial, industrial, or philanthropic power for projects focusing on the health problems to which they are sensitive. This has influenced mobilization of health co-operation funds, in the wake of the commitments to increase development aid agreed on in Monterrey linked to the MDG. Grosso *modo*, the first decade of the 21st century multiplied health co-operation funds by four (from 4 to 16 billion dollars) and the channels of co-operation (some 30 donors from the Development Aid Committee, approximately 140 global health initiatives, about 10,000 NGOs and expert committees from the North dedicated to co-operation in health, hundreds of thousands of reports, missions, evaluations etc.).

But development aid for health is only one small part of health funding: the world spends 10% of its gross world product (some 6 trillion dollars) on health, two-thirds in the private market, one-third in the form of contributions and public funding, theoretically aimed at equality and universal health-care coverage. Of the 2 trillion spent on public health-care expenditures, 80% is concentrated in high-income countries (12% of the world's population, with a mean of $1,500 per inhabitant and year (i/y)), 19% in middle-income countries (two thirds of the world's population, mean $100 i/y), and a mere 1% in low-income countries (12%, with a mean of $20 i/y). Half of all international co-operation funding on health goes to low-income countries where it represents an extra $8 i/y, only one quarter linked to public budgets, accounts, or health programmes; that is to say, 10% of all public funds.

In addition to the limitation in terms of level and consistency with international financial policies, the public and private funding of health services and projects in developing countries is scantly pertinent (or highly ''impertinent''), efficiency, and sustainability. This low pertinence has to do with the distortion in the aid (60% of co-operation in health is concentrated on 20% of the burden of illness in ''developing nations'' (perhaps more accurately denominated, ''peripheral economies''): AIDS, malaria, and tuberculosis. The low efficiency is due to the multiplicity of parallel systems targeting specific health issues that duplicate and squander limited resources. It is difficult to extrapolate the direct relationship between funding and impact on health, but from an approach of projects linked exclusively to one disease such as AIDS, the mean cost-benefit is approximately $2000 per DALY, 40 times more than the recommendation of the World Bank in the 1990s and some 14 times higher than the mean efficiency expected when related to the available resources (national and international) and avoidable burden of illness (at least 200 million DALY) in low-income countries: $140 per DALY. Finally, international co-operation is volatile in its predictability (a mean of 12–18 months, three times lower than the predictability of national public funds) and imbalanced in its contributions in terms of recurring expenditure with respect to investments (ratio of more than 1:1 when health services require at the very least a ratio of 3:1). On the other hand, ''technical'' co-operation accounts for up to one-third of

international co-operation and is often linked to external experts and processes – outsiders – to the ''recipient'' countries. If that were not enough, more than two-thirds of co-operation on health matters lies outside the processes for decision making and public funding of the health system and, consequently, deter the prioritization of health in public budgets. They are ''fungible''.

Paradoxically, the same North that expresses its ''solidarity'', dictates deregulation and neo-liberal prescriptions to the governments of the South by means of the conditions on the loans from the International Monetary Fund and the World Bank, limiting fiscal space and public expenditure on social and health issues. In contrast, bilateral trade agreements try to safeguard patents and strangle the development and accessibility of drugs that are vital for low-income countries. Moreover, the migration policies or specific health strategies of high-income countries foster the emigration of valuable, limited health-care professionals from low-income countries. These inconsistencies have a potential negative impact that is much greater than the impact of international health solidarity co-operation.

We should, therefore, examine with serious humility and a spirit of self-criticism the effect of international co-operation on health. However, this should not lead to cynicism or a defeatist attitude. First of all because the challenge of millions of avoidable deaths still prevails, as shall be seen later on. Second, because the citizens in high-income countries expect their governments to manifest their solidarity with ''developing countries'', even in times of crisis. Third, because international co-operation with the necessary reforms can have a direct impact on health and an indirect effect on the awareness of citizens and governments of both high- and low-income countries and act as a revulsive for fairer and more humane international trade, economic, and migratory policies.

The reform of international co-operation in health: the concept of Global Health

Aware of the challenges of inequality in health in the world and of the limitations on co-operation in health, based on vertical and disease-based approaches, the European Union (EU) adopted a historic Global Health policy in May 2010, under the leadership of the Spanish presidency. The European Global Health policy identifies challenges and specific actions in four key areas for better Global Health: governance, equality, consistency and knowledge.

Health governance demands democratic and effective leadership. At the national level, it requires democratic governments, dynamic parliaments, and an organized, active civil society. These factors make it possible to design and implement participatory strategies that are pertinent to top-priority problems and effective, given the resources available and the additional demands on necessary resources at the national and international level. These factors and virtues are not common in many countries, independently of their income. Worldwide, the democratic process is seated theoretically in the World Health Assembly, which brings together 198 countries in the discussion of international health priorities and actions. These agreements should be led by the WHO. In practice, most of the agreements are non-binding resolutions and almost 80% of the WHO's budget targets the priorities dictated by those who fund them, i.e. high-income countries and private trade or the philanthropic sector. The EU has committed to buttressing participative processes at the national level and to increment the proportion (up to a minimum of 50%) of their contributions to the WHO by means of integral, non-earmarked funding, thereby respecting the democratic process and leadership of the WHO in its primary function.

The world is suffering growing inequalities in health. As previously pointed out, public health funding is 100 times less in low-income countries than it is in high-income nations and life expectancy is 20 years less, with 15 times higher child mortality rates and maternal mortality that is 60 times greater. The European principles for health policies – equality, universality, quality, and solidarity – should be applied to all national and European policies with third-party countries and international organizations. This should give priority to countries having fewer potential resources by means of systems aimed at achieving egalitarian universal coverage. Hence, the principles of effectiveness of aid, agreed upon in Paris in 2005 and ratified in Accra in 2009, should be applied to a health sector, as previously described, that is highly distorted/biased; fragmented/inefficient, and ''projectized''/unsustainable. This requires a new approach to co-operation, oriented more to aligning funding through transparent, public accounting and participation in the dialogue and monitoring of effective national strategies based on equality. Excluding emergencies and eradication (where vertical interventions have been considered orthodox since the 1950s), partial interventions that do not totally support indivisible, integrated health services must be called into question. These principles are listed in the International Health Partnership, which requires more consistent, honourable, and coherent adherence by its members, especially donors and multilateral organizations, as yet dependent on vertical, partial dynamics.

Insofar as consistency is concerned, the European health principles of equality, universality, quality, and solidarity should be applied to the internal and external policies that have an impact on international health. The EU has identified five key areas for consistency in health: economic and trade policies; policies on migration, food safety, climate change, and policies aimed at peace and security. In all these areas the above principles will have to be applied and guarantees will be needed that their effects will not undermine the efforts of solidarity, but rather will strengthen them. Emphasis has initially been put on guaranteeing that bilateral trade agreements and policies regarding migration toward the EU will not affect the availability of human and material resources that are of key importance for health in third-party countries, in particular low-income third-party countries.

International health knowledge suffers from similar biases and weaknesses as international co-operation does. The level of public funding, including co-operation efforts, is still more limited in comparison with trade considerations; hence the bias against top-priority health problems for the lowest-income communities and countries, less attractive in terms of private economic profit. Furthermore, co-operation in research is also biased toward certain health issues and is not linked closely enough to mechanisms giving more

priority to development and access to vital drugs or impact on health than to commercial benefits. The EU has also committed to adding its efforts in international health research more effectively to the health priorities in low-income countries through new models of innovation and by bolstering the national research processes in each country.

One step further: toward an international framework or convention for Global Health?

The second part of 2010 led the EU's Global Health policy to dialogue with key players about new issues in governance, co-operation, and consistency. The same month of its adoption, during the World Health Assembly, the United States presented its Global Health Initiative. This caused Brazil, which occupied the vice-presidency of the Executive Board (a group of 38 countries representing the entire World Assembly), to propose an alliance between these new visions with the growing South-South co-operation in the area of health. The following month, the dialogue surrounding these common challenges brought together a large international community at the International Global Health Conference in Brussels, where the key points for joint work were once again hammered out. The following months were intense as regards discussions of the G8 (still focused on vertical priority menus) and the review in September of the MDG at the United Nations summit meeting that, for the first time, included a joint chapter on health-care systems introducing each of the three partial MDG. December saw a new meeting of world leaders in Brussels, at the ''European Development Days'', and Brazil once again proposed a more specific idea for an international global health framework, very probably under debate at the January 2011 meeting of the WHO's Executive Board.

In this context, what is the challenge at the present time?

Let us once again take a look at the WHO's objective, stated in the human rights declaration: to achieve the best state of health possible, for all. The standard of health has been improving: the rates of child and adult mortality have been going down. It is not so clear that today's psychological and social welfare is also better than it was 65 years ago. Be that as it may, depression and suicide rates have not gone down. While objective, comparative indicators of ''happiness'' are being developed (if such a thing is possible for different cultures and different concepts of life), let us take a closer look at how the ''quantity'' (expectancy) of life has gone up. Over the last 20 years for which we have statistics that are comparable across countries and regions, and for health problems and care capacities, at least half of the impact on greater life expectancy is due to the influence of statistics for China, where one-sixth of the world's population has lowered its infant mortality to at least sixfold and its adult mortality by a factor of more than three. Life expectancy has also increased by more than the mean in other economies that now enjoy medium-income levels in Latin America, Northern Africa, and Asia. The effect of India has also been important in the last decade. On the other side of the coin we find sub-Saharan Africa, with the odd exception, where the increase in life expectancy has been more modest, to the point of being all but non-existent in Central and Western Africa, and even negative in southern Africa, hard hit by AIDS. In 2000, if the infant and adult mortality rates (from 15 to 60 years of age) of high-income countries (in regional terms, the ''best standard'' of health) were to be applied to the rest of the world, the number of ''avoidable'' deaths would have been around 20 million. Clearly, the implication of the last two words in the world health objective (''for all'') represent an unacceptable situation and a high-priority, measurable challenge.

What has happened in the last decade? If we were to apply the mean infant and adult mortality rates for the year 2000 to the current world population in 2010, there would be 7 million more deaths, which the progress made during this decade has managed to avoid. Half of these ''avoided deaths'' in 2010 have been thanks to access to AIDS treatment, almost non-existent in low-income nations in 2000. Let us also analyze the distribution and equality of health in the world today: the number of ''avoidable deaths'': following the same inference previously estimated for 2000, if the infant and adult mortality rates of high-income countries were applied to the rest of the world today, the number of ''avoidable'' deaths would also be some 20 million. In conclusion, while the world continues to advance (although we do not know the proportion of its technological and social potential) in ''the best standard of health possible'' (at the rate of around 4 months of life expectancy every year; it is not clear in terms of ''quality of life''), this progress is not ''for all'' and the differences in health, i.e. the ''avoidable deaths'' have remained constant over the last decade. Getting back to the analysis of the end of the 20th century, the 1980s were a ''lost'' decade for development, the 1990s for health, and the 2000s for equality in health.

The most ''precise'' analysis of inequities came out of the work by the Commission on social determinants of health, which also mapped these inequalities within countries. In fact, one half of the ''avoidable deaths'' previously mentioned occur in low-income countries, whereas the other half is due to intranational inequalities, predominantly in middle-income countries.

The world is not well prepared to face this challenge of inequality and for working to achieve the objective set forth 65 years age, as relevant now as it was then: the international framework is that of the MDG, which is clearly insufficient: by categories (infant and maternal deaths, as well as those due to AIDS and malaria), they only cover 55% of all avoidable deaths (11 million deaths: 8 in children under the age of 5; 0.3 million maternal deaths and some 3.5 million due to AIDS and malaria) and by objectives around 40% (reduction – the same for all countries – by two-thirds in infant mortality and three quarters in maternal mortality or, less precisely in the diseases cited). Not only do the MDG account for little more than half of all avoidable deaths, but they also ignore the inequalities between and within countries and the morbidity due to other health issues and in other age groups. During 2011, this fact will be properly analyzed at the world summit on non-communicable chronic diseases. It is clear that the world is in need of a new operational framework in order to progress in the unresolved health issue: equality.

International co-operation in health also requires radical reform. Its low degrees of pertinence, efficiency, and sustainability can no longer continue to be covered up by the marketing of each vertical initiative and its universe of lobbies. Independent cost estimations for partial objectives continue to proliferate, as do analyses of economic deficits to continue in the vertical model, the attributions of avoided deaths (all together they would exceed the seven million previously mentioned several times over). All this in a competitiveness which in no way appears to differentiate itself from that of the detergent or soft drinks markets. Politicians with their need for short-term data without any reference whatsoever to the universality of the right to health or to opportunity costs, and a civil society that is sensitive to isolated stories of diseases and individuals, continue to prioritize fragmented care, due to a lack of information such as this article seeks to remedy. The EU can do much in this reform by applying the principles of equality, universality (in terms of population and health problems), quality, and solidarity. The countries of the EU, even in their diversity of health-care systems, understand that the State is a kind of guarantor of rights, both political and social, including the right to health. They therefore regulate the markets to avoid inequalities in the basic right to life and assign revenue to the funding of a public, universal system of health services. The public fund that cares for all citizens is essential to the right to health and for social cohesion in the EU. The same principle and concept could inspire, at the world level, a Global Solidarity in Health Fund, that helps countries whose current resources, even after boosting tax collection and maximizing economic growth, cannot pay minimum wages to their professionals to keep them from emigrating, or the minimum prices for essential drugs. The market for these universal goods (goods that are indispensable to the universal right to health) must be regulated in terms of coherence, as well as mitigated or compensated by a solidarity fund, for the natural evolution from the multiplicity of current partial funds, and from a project-based to a service-based approach, from disease to right.

This right to health requires three elements: a guarantor, a beneficiary, and a contract. The guarantor, within our nation of the EU, must be the State. The beneficiary must be the citizen, who is also responsible for contributing to this right economically and in other ways (health lifestyle, community participation), and the contract must be clear and must identify which services and in what conditions they must be legally available or, if absent, can be demanded.

This reform requires participatory leadership, a new global governance. The Constitution of the WHO and its current working programme from 2006 to 2015 is based on rules of quality and statistical monitoring, makes scant reference to inequality, and it is certainly in no way at the core of its functions and objectives. The main health problem in the world calls for a reform of the constitution of the WHO, around a global health framework or convention, where the international community regulates the commercial and philanthropic market, and gradually guarantees equality in integrated and essential resources and services (possibly with the definition of a basic universal package of health services) based on the right to health and its universality. In short, it is a matter of ''removing the fences'' surrounding the right to health, which has been fragmented by economic barriers, by partial arbitrary approaches, by population groups, by time-limited projects. It requires a renewed and firm WHO not always trying to please all the funders and executing the democratic resolutions of the World Health Assembly, toward its, our, common objective, the best health possible ''for all''.

The role of professional associations and clinical specialists in the new context of Global Health

The contrast between our setting in Spain – a high-income context – and the mean of low-income countries implies contrasts of much greater needs (three times the burden of illness, on average, infant mortality rates more than tenfold, life expectancy of 50% less), and much more limited resources (up to 100 times less in public funding per capita). A large proportion of health professionals, in their different specialities and functions, have expressed their desire to collaborate in the area of international co-operation, especially for and in situations of greatest need. Collaboration is channelled from less to greater implication, by sporadic or regular economic collaborations to co-operation groups (for the most part, development NGOs or multilateral co-operation groups such as the United Nations), at times linked to voluntary contribution to debates in assemblies or on-site voluntary work, in a smaller proportion of cases (less than 5% in Spain, more than 10% in the UK) by means of short stays in hospitals (often belonging to religious missions) or projects in low-income countries (beginning with rotations during professional training or residency programmes, followed by periods of time during vacation or personal days off), longer periods of dedication during professional training (less than 1%) or professionals dedicated to international co-operation in health as the number one activity of their professional career (a minority). None of these forms of activity is clearly defined, supported, informed, or acknowledged.

There are clear needs for information about the concepts of Global Health, regarding global and European political frameworks, the different means of training and contribution in different modalities, about the co-ordination of these opportunities and initiatives within the context of the effectiveness of the aid – as described above – with respect to the means by which the said co-operation can be useful for information, awareness, and commitment of remaining professionals, as well as for the health-care system in Spain itself (institutions and society in the Netherlands, for instance, highly value professionals in terms of their management capacities – expenditure efficiency – and the clinical and community approach acquired within the context of limited resources and great needs. All this should lead to the inclusion of global health concepts in undergraduate programmes and in administration, rationalization, and European and world-wide acknowledgement of varying degrees of in-depth training depending on dedication in Global Health (introductory courses, diplomas, master's degrees, specialization).

While that is taking place, what are the specific, short-term aspects that can facilitate and improve sporadic, short-term, international co-operation activity by clinical professionals in Spain?

First of all, a certain ''co-ordination'' would be necessary (there are almost 50 medical specialities recognized in Spain, with their professional associations, co-operation groups, often lacking any kind of mutual co-ordination and all with their European counterparts) for these contributions to take the fullest advantage of their possible impact, avoid duplicities, tend to the greatest and most pertinent needs, and to facilitate greater continuity and sustainability of the actions. The health section of the Spanish International Co-operation Agency (AECI) might be the proper place for inventory and co-ordination, matching the identification of needs with capacities in co-operation, linking to broader (by means of a sectoral approach – ''SWAP'') and longer-term co-operation processes.

Second, from professional practice in Spain, we can contribute to greater ''coherence'' in Global Health. An example: our influence in getting pharmaceutical companies to promote or permit (through manufacturers of generics) the marketing of drugs or essential equipment at affordable prices in low-income countries, could have a much greater impact than sporadic co-operation as a whole. On the other hand, the awareness of migratory flows of professionals from low-income countries toward our public and private system should respect the worldwide voluntary code of the WHO regarding the international hiring of health-care personnel and promoting forms of mobility that are mutually beneficial for the countries of origin, for host countries, and for the professionals themselves, such as circular migrations. Professional associations can promote these types of initiatives.

Third, ''training'' of the professionals involved in co-operation activities is needed at least to a minimum level of knowledge with respect to global health and co-operation policies). This training (while being structured in a broader sense as mentioned earlier) might be co-ordinated and recognized by the AECI in collaboration with the National School of Health-Care and the international health-care institutions present in Spain (among others, the King Charles III Health Institute, the Global Health Institute in Barcelona, or the Andalusian Public Health School). It should include concepts of global health, international and European policies and regulations, concepts of epidemiology in low-income countries, the appropriate technology, anthropology in intercultural relations and health-care systems. Each association of specialists (there are close to 50 in Spain, some 20 with active co-operation groups) could complement this training with aspects that are germane to their speciality.

These suggestions are in no way intended to curb or hinder the praiseworthy and very necessary sensitivity and solidarity of thousands of health-care professionals in the area of co-operation, but rather to bolster it, rationalize it, and increase its pertinence, efficiency, and impact the health of the most needy, within the context of Global Health as described above.

Level of evidence

Level of evidence III.

Protection of human and animal subjects

The authors declare that no experiments were performed on humans or animals for this investigation.

Confidentiality of data

The authors declare that no patient data appears in this article.

Right to privacy and informed consent

The authors declare that no patient data appears in this article.

Conflict of interest

The authors have no conflict of interest to declare.