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The challenges for health systems in a globalizing world

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&

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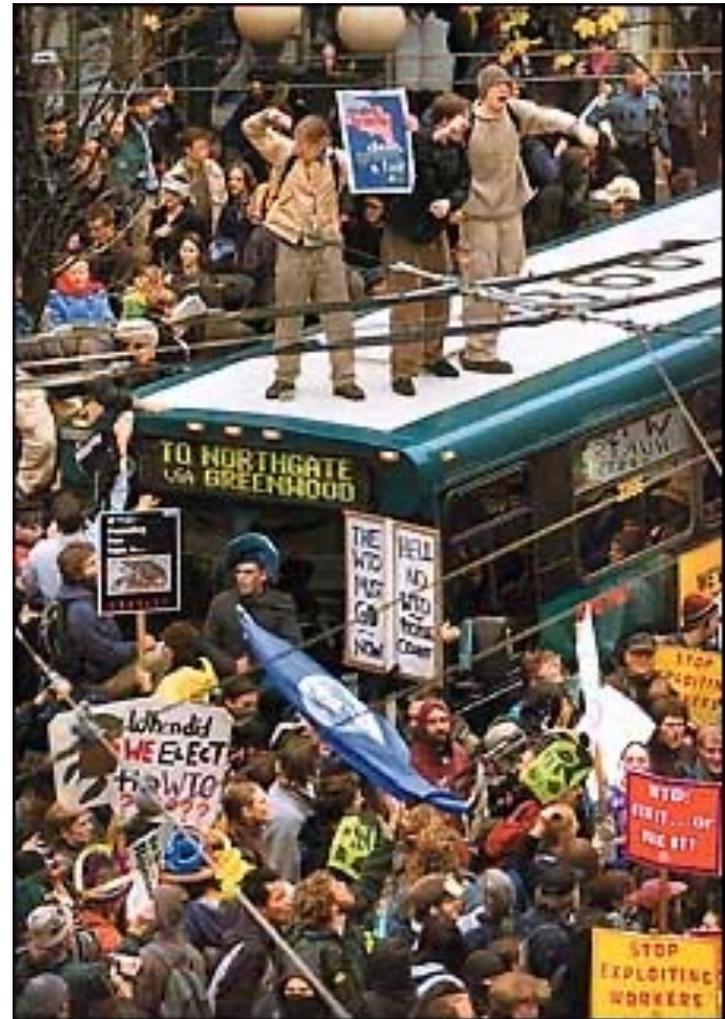
STARBUCKS

10-23.00



Globalization is...

- increasing standards of living
 - “anyone who cares about the poor should favor the growth-enhancing policies of openness to international trade” (Dollar & Kraay, 2000)
- exploitation of the poor
 - “globalization is a new kind of colonialism visited upon poor countries and the poor in rich countries” (Shiva 2000)



Globalization is...



- Nature?
 - Liberal theorists – natural process of allowing market forces to find efficiencies through greater economies of scale within and across countries (“survival of the fittest”)
- Nurture?
 - Non-liberal theorists – process of policy decisions, institutional structures and rules, international agreements and practices to benefit wealthy (globalization embedded within vested interests, driven by ideological principles, creating certain winners)

Globalization is...

- Not new!
 - Trade between societies for centuries (eg silk route)



Globalization is...



- “process and impact of advances in travel & tele-communications which facilitate mixing of people, customs & cultures, and cross-border flows of goods & services, people & capital, ideas & information.”
 - “worldwide integration of humanity and compression of both the temporal and spatial dimensions of human interaction.”
 - “the development of extensive worldwide patterns of economic relationships” (*ie trade*)

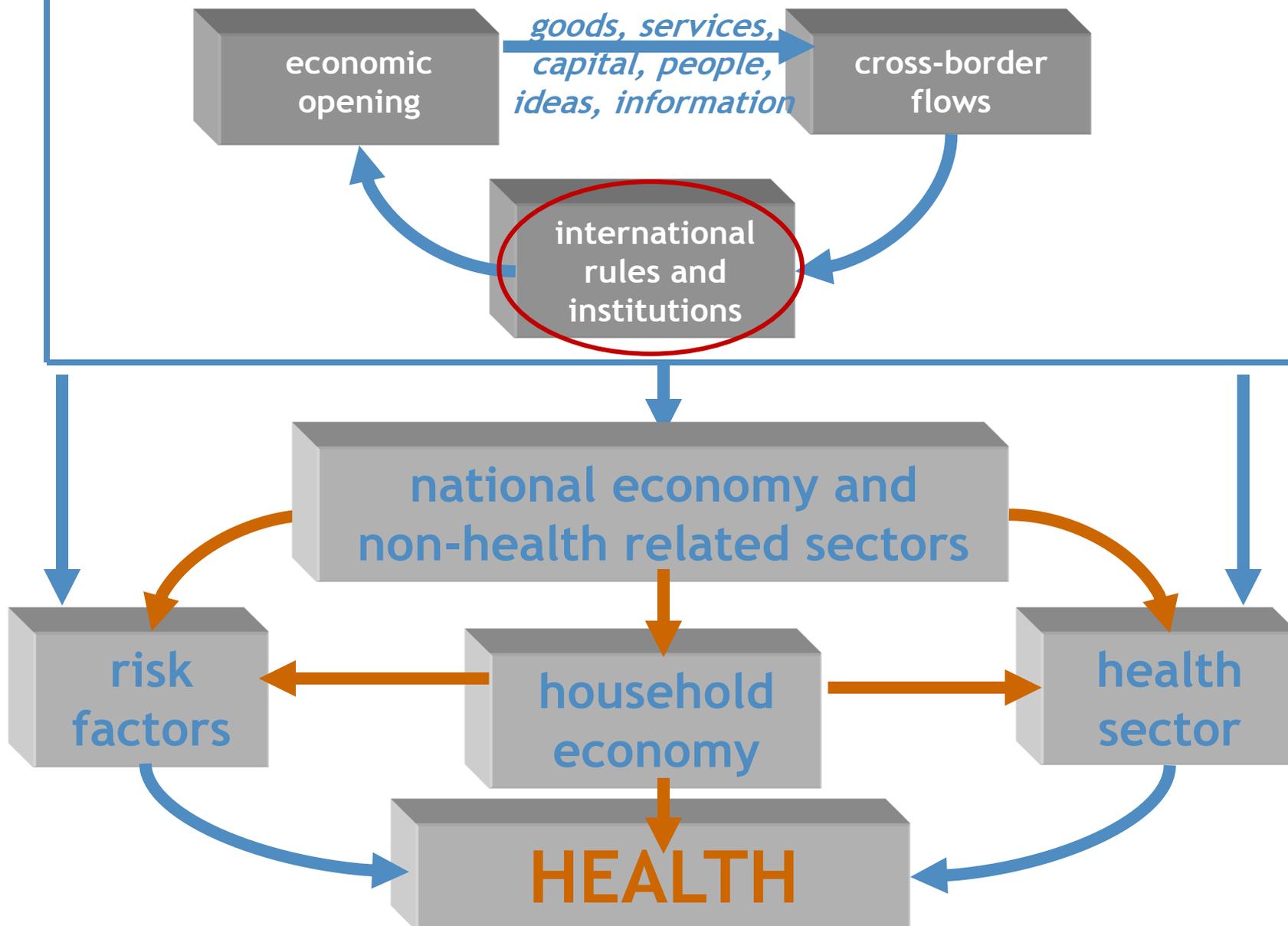
THE LANCET

Trade and Health · January, 2009

www.thelancet.com

“The fact that trade directly and indirectly affects the health of the global population with an unrivalled reach and depth undoubtedly makes it a key health issue that the global health community can no longer ignore.”

Globalization



World Trade Organization



WTO Agreements and health



HEALTH ISSUES	WTO RULES			
	SPS	TBT	TRIPS	GATS
• Infectious disease control	*	*		
• Food safety	*			
• Tobacco control		*	*	*
• Environment	*	*		
• Access to drugs			*	
• Health services				*
• Food security	*			
<u><i>Emerging issues</i></u>				
• Biotechnology	*	*	*	
• Information Technology			*	
• Traditional knowledge			*	

Economic vs health governance



WORLD TRADE ORGANIZATION



BILL & MELINDA GATES foundation

- centralised structure
- extensive and expanding membership
- comprehensive scope
- detailed, complex and legally binding agreements
- dispute settlement mechanisms

- fragmented, unstructured, lack of lead institution
- WHO influence from technical expertise and nonbinding recommendations
- lack of broad, deep or binding legal commitments
- lack of dispute or enforcement mechanisms

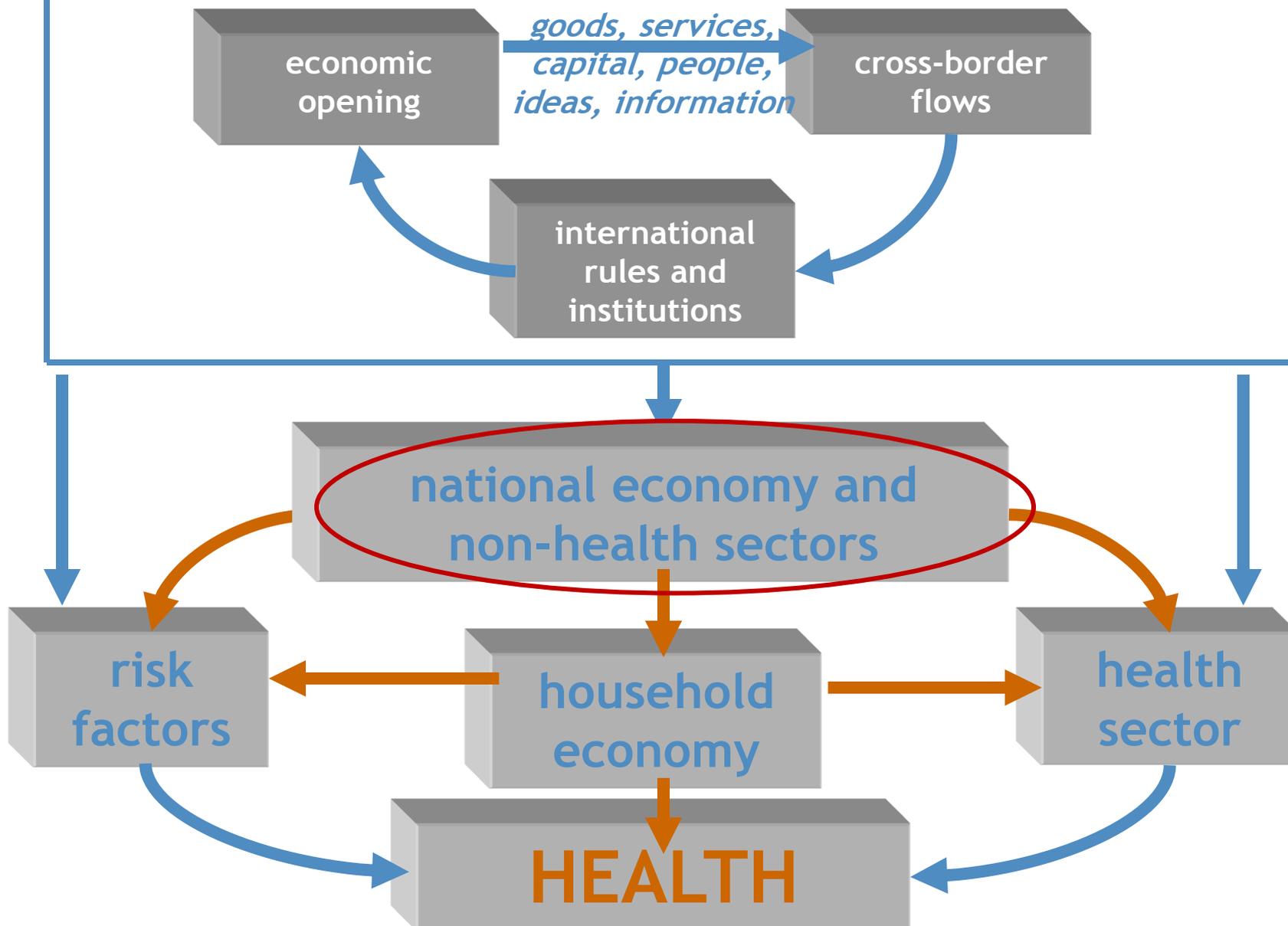
Global Health Diplomacy



- Brings together the disciplines of public health, international affairs, political science, law, economics to focus on *negotiations that shape and manage the global policy environment for health*



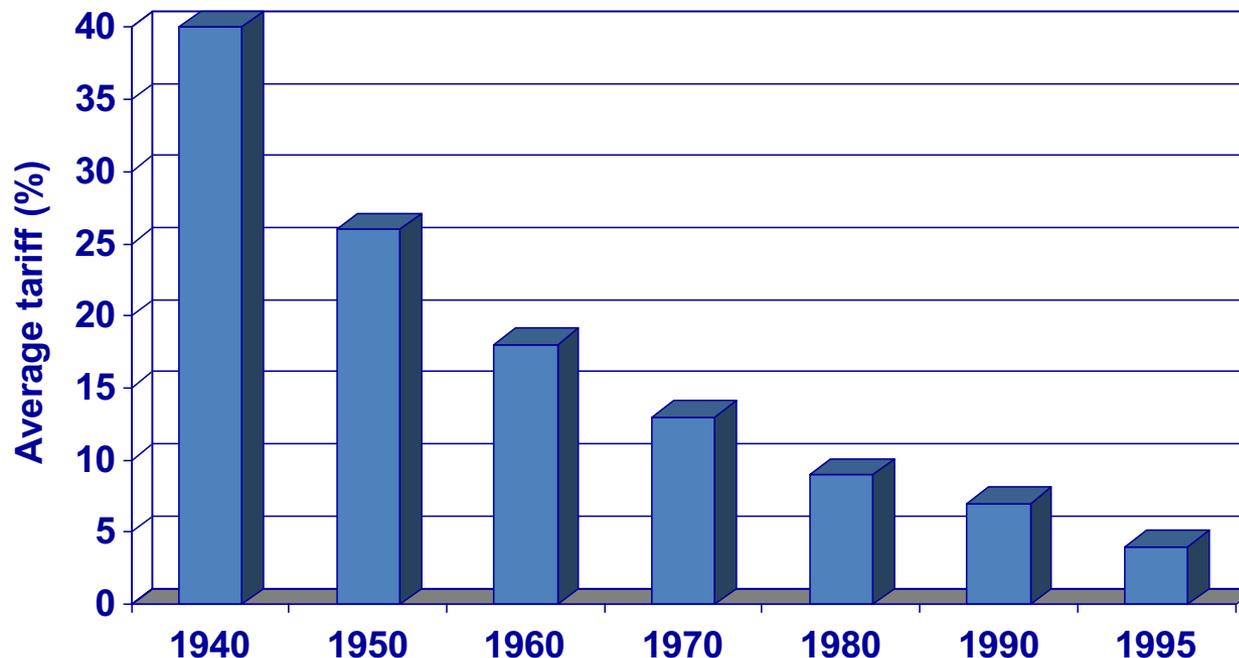
Globalization



National economy and general trade liberalization



- Most countries increasing openness of economy to trade (reducing tariffs, quotas etc)
 - Average tariffs on goods fallen over last 20 years
Brazil 34-12%, China 43-9%, India 83-28%



National economy and general trade liberalization



- Most countries increasing openness of economy to trade (reducing tariffs, quotas etc)
 - Average tariffs on goods fallen over last 20 years
Brazil 34-12%, China 43-9%, India 83-28%
- Often ‘voluntary’, but sometimes a conditional part of structural adjustment lending (IMF, WB)
- Opening the economy may occur through:
 - Bi-lateral trade agreements between two countries
 - Regional trade agreements – EU, NAFTA, ASEAN
 - International trade agreements – WTO

General trade liberalization and health

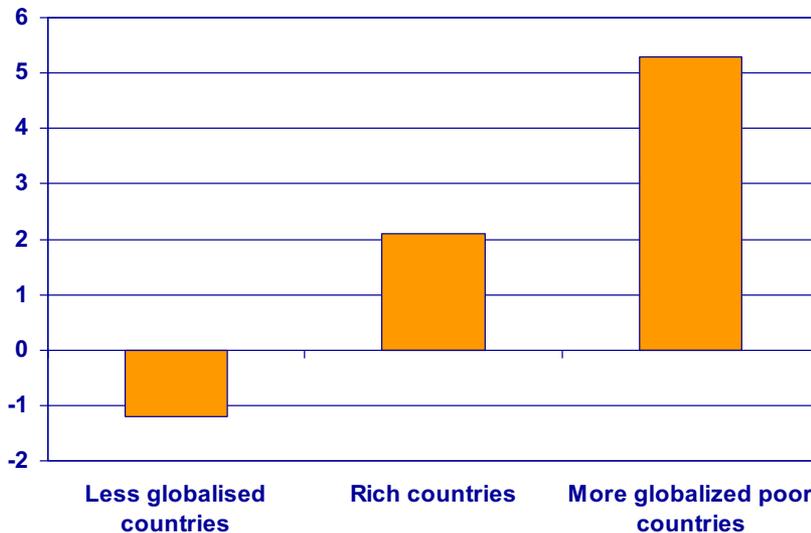


- Increasing trade liberalization impacts *health*
 - changes in income, nutrition, education etc
 - import tax policies concerning tobacco, alcohol, firearms will influence supply & demand for them
- ...and health *system*
 - exchange rate impacts cost imported vaccines etc
 - public expenditure targets determine public HCE
- Two key avenues of impact
 - Economic prosperity and government revenues

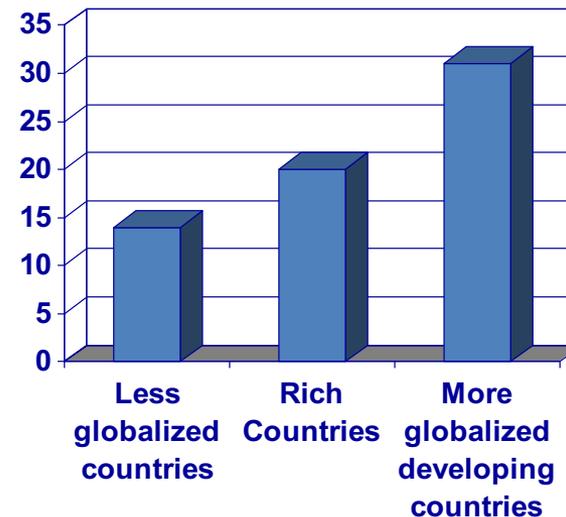


Economic prosperity

- Globalisation improves health
 - Higher GDP = better health (via nutrition, sanitation, water, education, healthcare)
 - Open economies grow faster than restricted ones



GDP growth



Wage growth

■ % growth between 1980s and 1990s

Economic prosperity



- Globalisation improves health
 - Higher GDP = better health (via nutrition, sanitation, water, education, healthcare)
 - Open economies grow faster than restricted ones
- However:
 - ‘outliers’ (openness necessary but not sufficient)
 - enables consumption of goods detrimental to health (eg tobacco, alcohol etc)
 - liberalisation entails adjustment – raise income on *average* in *long-run*, but major caveat is the *distribution* of these benefits



Government revenues

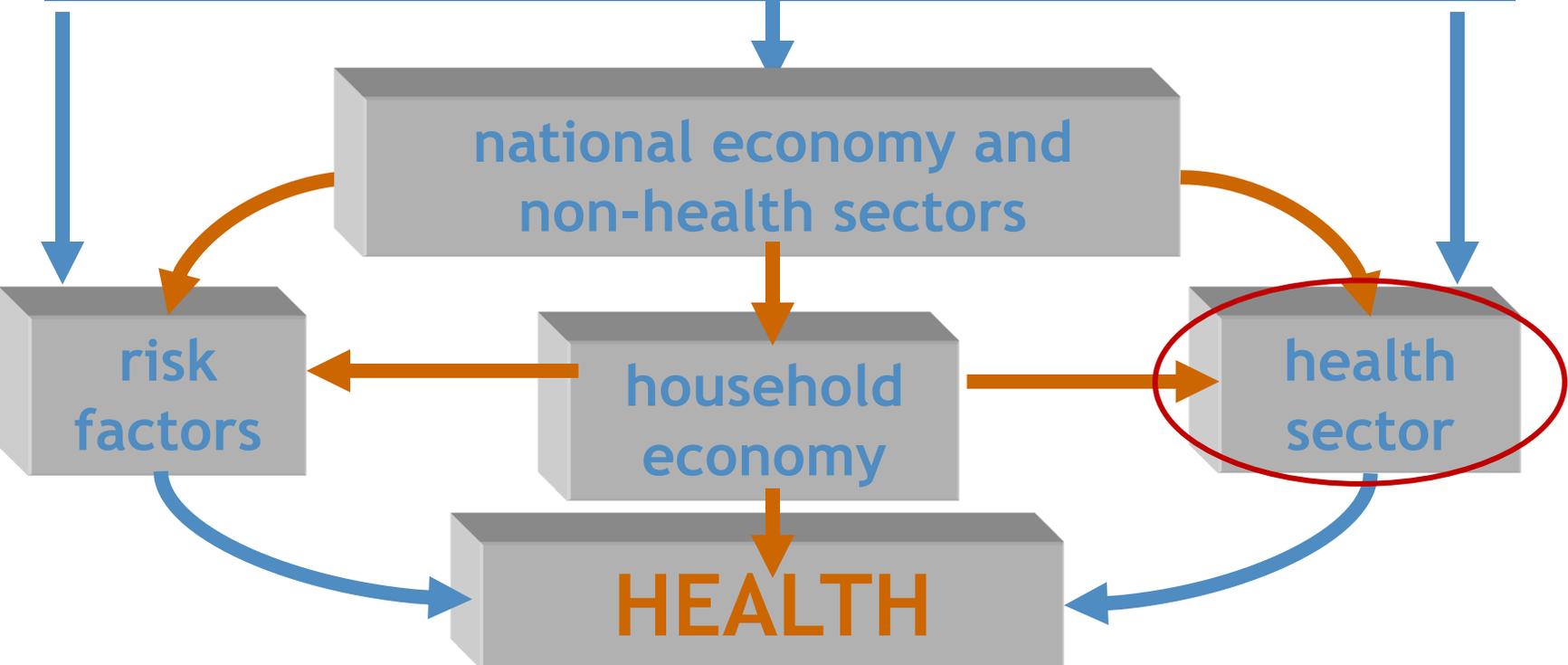
- Trade contributes to govt income via import tariffs (eg <1% OECD, 18% India, 80% Guinea)
 - liberalisation reduces tariffs and government revenues (MICs recover 60%, LICs 30%)
- However:
 - liberalization may increase *volume* of trade to offset reduced tariff rates such that tariff revenues overall may increase
 - tariffs are complex – lower *average* rates may contain various increase and decrease – and can be selective (eg imported raw materials)

General trade liberalization: health system challenge



- Involvement in *economic* (trade) policy making to ensure:
 - liberalization is stable, secure and equitable
 - sustained level of (tariff?) tax revenue for public health system
 - sufficient protection against increased import of harmful products
 - monitoring key indicators to track implementation and impact of trade policy on health and health sector
- Design of proactive, responsive *health* policy

Globalization



Trade and health *care*



- Trade in health care has traditionally been focused on goods – pharmaceuticals & medical devices – which can be stored and transported.



Pharmaceutical trade

- Pharmaceuticals are the most important health-related product traded (55% of all health-related trade, US\$650 billion market)
- Highly concentrated in a few private companies in developed countries (and increasingly so)
- Generates a clear divide between rich and poor countries:
 - generates trade deficit in modern medicines
 - reduces affordability and access, and ‘skews’ R&D
- Reinforced through TRIPS (and ‘TRIPS-plus’)



TRIPS agreement

- TRIPS (1995) established global minimum standards for IP protection, incl. patents
- Provisions for protection within TRIPS but few countries have taken up
 - various exemptions from patentability, limited exceptions to patent owners' exclusive rights, compulsory licensing and parallel importation
- Rather, they have generated circumvention of TRIPS with more stringent standards ('TRIPS+')
 - Bilateral trade agreements where IP protection standards in excess of TRIPS exchanged for trade concessions (eg access to agricultural markets)

Industry lobbying and trade pacts threaten India's role as major supplier of generic drugs



ALAMY/THA/REUTERS IMAGES

Naz Care Home in Delhi was able to look after 45 HIV-positive orphans because of access to cheap drugs

Ganapati Mudur **HNW DELHI**

Indian manufacturers have supplied more than 80% of antiretrovirals to developing countries since 2006, a new study has shown, amid concern that trade negotiations and industry lobbying threaten to restrict this flow of affordable generic drugs.

The study also shows that Indian generic drugs accounted for 91% of all antiretrovirals for children supplied to developing countries in 2008 (*Journal of the International AIDS Society* 2010; 13:35). Of 100 countries surveyed, 96 relied on Indian generic drugs, and 99% of antiretrovirals used by DR Congo, Mozambique, and Namibia came from India.

Indian generic formulations accounted for 65% of the \$463m (£295m; €353m) purchases of

antiretrovirals in 2008, while non-Indian generics made up 13% and brand name drugs made up 22%, the study found.

Suzette Moon, from the Harvard Kennedy School of Government in Cambridge, Massachusetts, and one of the study's authors, said, "Indian generic antiretrovirals have cost consistently and significantly less than other generics."

The most common first line regimen of generic antiretrovirals from India for adults cost \$74 per person per year in 2008, while brand name regimens reported to the agency *Médecins Sans Frontières* cost up to eight times this amount.

However, the study warns that the free trade agreements that India is currently negotiating with the European Union may create new obligations that will increase the prices of antiretrovirals

and delay access to new and improved versions of generic formulations.

The closed door negotiations have sparked concerns about India accepting fresh restrictions that may block progress in generics. "When India introduced product patents on medicines in 2005, the space for generic production was seriously curtailed. Any further restrictions would add insult to injury," Ms Moon said.

Leaked documents released by non-government health organisations in India last week suggest that multinational drug companies have contacted the top echelons of the Indian government bureaucracy in their attempts to seek fresh changes in intellectual property rules. The documents show that senior officials from five companies met bureaucrats in the office of the Indian prime minister earlier this year to make a presentation on intellectual property enforcement and data protection.

The prime minister's office had subsequently forwarded notes from the Organisation of Pharmaceutical Producers of India, a group seen as representing foreign drug companies, with suggestions relating to intellectual property rights to the Indian health ministry seeking its comments.

Anand Grover, director of Mumbai's Lawyers Collective, who has campaigned for the rights of people with HIV for two decades, said, "This suggests that sections of the multinational pharmaceutical industry are trying to change Indian laws in an insidious, non-transparent manner."



Trade and health care

- Increasingly, advances in telecommunications and travel have seen increase in trade in services, such as:
 - E-health (service crosses border)
 - Health tourism (consumer crosses border)
 - *Foreign investment (capital crosses border)*
 - Migration of health worker (supplier crosses border)



E-health

- E-health is application of ICT across whole range of functions that affect health sector
 - remote provision of a service where the recipient is not in the same country as the provider
 - direct provision (eg tele-radiology) and treatment (eg remote surgery) and indirect, such as communication (eg tele-conferencing) and administration (eg claims processing)
- Global market US\$1 billion – US\$1 trillion
- India, the Philippines and Cuba export leaders, USA import leader – medical transcription and diagnostics



India e-health revenue

	2000	2005
Customer-interaction centres	60	2250
Medical transcription	28	800
Financial and accounting services	50	375
Medical billing and collection	3	75
Medical claims processing	13	30
Pre-press and digital pre-media	45	200
Geographic information systems	..	50
Distance learning	60	150
Human resources services	..	115
Litigation support services	3	27
Total	264	4072

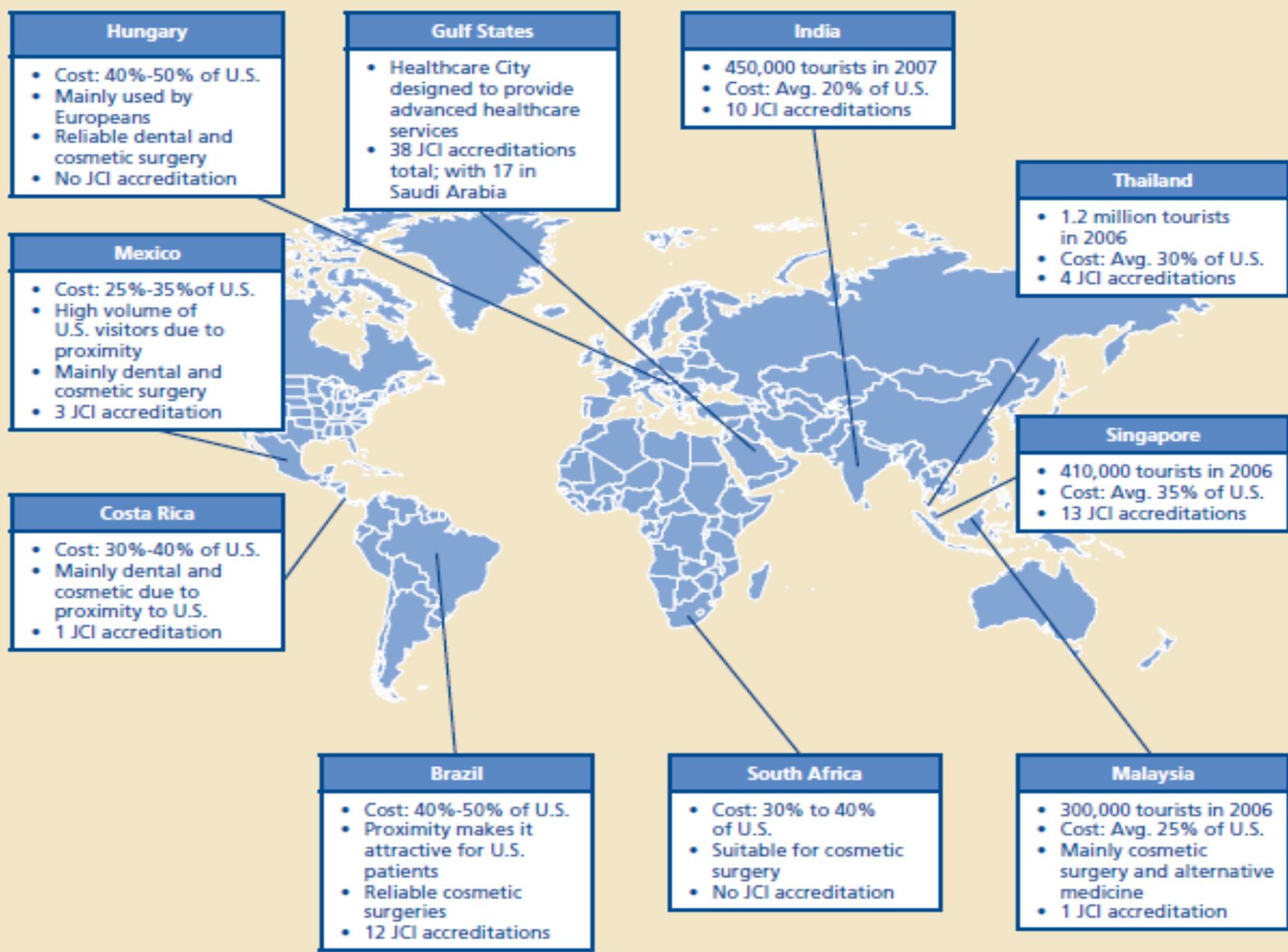
Data are revenue (US\$ million).

Table 1: Revenue of the BPO (business process outsourcing) industry estimates (by service type) by Electronics and Computer Software Exports Promotions Council

Health (medical) tourism



- > 4 million foreign patients per year
- Global market \$30-50 billion
- Social, cultural and linguistic factors generate strong regional dimension, especially among bordering countries
 - Singapore/Malaysia patients mostly from ASEAN
 - Cuban patients mostly from Caribbean and Central America
 - Jordanian patients mostly from Yemen, Bahrain, Sudan, Syria, Libya, Palestine and Saudi Arabia



Hungary

- Cost: 40%-50% of U.S.
- Mainly used by Europeans
- Reliable dental and cosmetic surgery
- No JCI accreditation

Gulf States

- Healthcare City designed to provide advanced healthcare services
- 38 JCI accreditations total; with 17 in Saudi Arabia

India

- 450,000 tourists in 2007
- Cost: Avg. 20% of U.S.
- 10 JCI accreditations

Thailand

- 1.2 million tourists in 2006
- Cost: Avg. 30% of U.S.
- 4 JCI accreditations

Mexico

- Cost: 25%-35% of U.S.
- High volume of U.S. visitors due to proximity
- Mainly dental and cosmetic surgery
- 3 JCI accreditation

Singapore

- 410,000 tourists in 2006
- Cost: Avg. 35% of U.S.
- 13 JCI accreditations

Costa Rica

- Cost: 30%-40% of U.S.
- Mainly dental and cosmetic due to proximity to U.S.
- 1 JCI accreditation

Brazil

- Cost: 40%-50% of U.S.
- Proximity makes it attractive for U.S. patients
- Reliable cosmetic surgeries
- 12 JCI accreditations

South Africa

- Cost: 30% to 40% of U.S.
- Suitable for cosmetic surgery
- No JCI accreditation

Malaysia

- 300,000 tourists in 2006
- Cost: Avg. 25% of U.S.
- Mainly cosmetic surgery and alternative medicine
- 1 JCI accreditation

Costs of selected procedures in selected countries (US\$)



Procedure	Thailand	India	Singapore	US	UK
Heart bypass graft surgery	7,894	6,000	10,417	23,938	19,700
Heart valve replacement	10,000	8,000	12,500	200,000	90,000
Angioplasty	13,000	11,000	13,000	31,000–70,000	---
Hip replacement	12,000	9,000	12,000	22,000-53,000	---
Hysterectomy	10,000	---	13,000	---	---
Bone marrow transplant	----	30,000	---	250,000-400,000	150,000
Liver transplant	----	40,000-69,000	---	300,000-500,000	200,000
Neurosurgery	----	800	---	29,000	
Knee surgery	8,000	2,000-4,500	---	16,000-20,000	12,000
Cosmetic surgery	3,500	2,000	---	20,000	10,000

Live Kidney Donor Transplant in the Philippines

+ [Information about Kidney Transplants](#)

+ [24-7 private nursing](#)

+ [Comfortable environment](#)

+ [Contact Us](#)



Transplant Package

The Living Donor Transplant package includes the following:

1. Transportation from the airport on the day of the arrival and to the airport on the day of departure
2. Transport, accompanying, and translation by the Company staff during all medical treatments
3. 25 days stay in a clean, respectable, and pleasant three star hotel located in the center of the city five minutes travel from the medical center including breakfast for the patient and the accompanying person of his/her choice. (The room is equipped with a television, mini-bar, and DVD.)
4. As many dialysis treatments as required
5. Hospitalization in the hospital in a large private room including television, DVD, kitchen, refrigerator, and microwave oven.
6. Living donor kidney transplant including drugs
7. Round the clock assigned nurse during the entire hospitalization
8. Anti-rejection drugs for seven days on the departure day

The total price is \$85,000 USD.

The package does not include:

1. Flights
2. Medical treatments not related to the kidney transplant and disease, such as heart and other problems

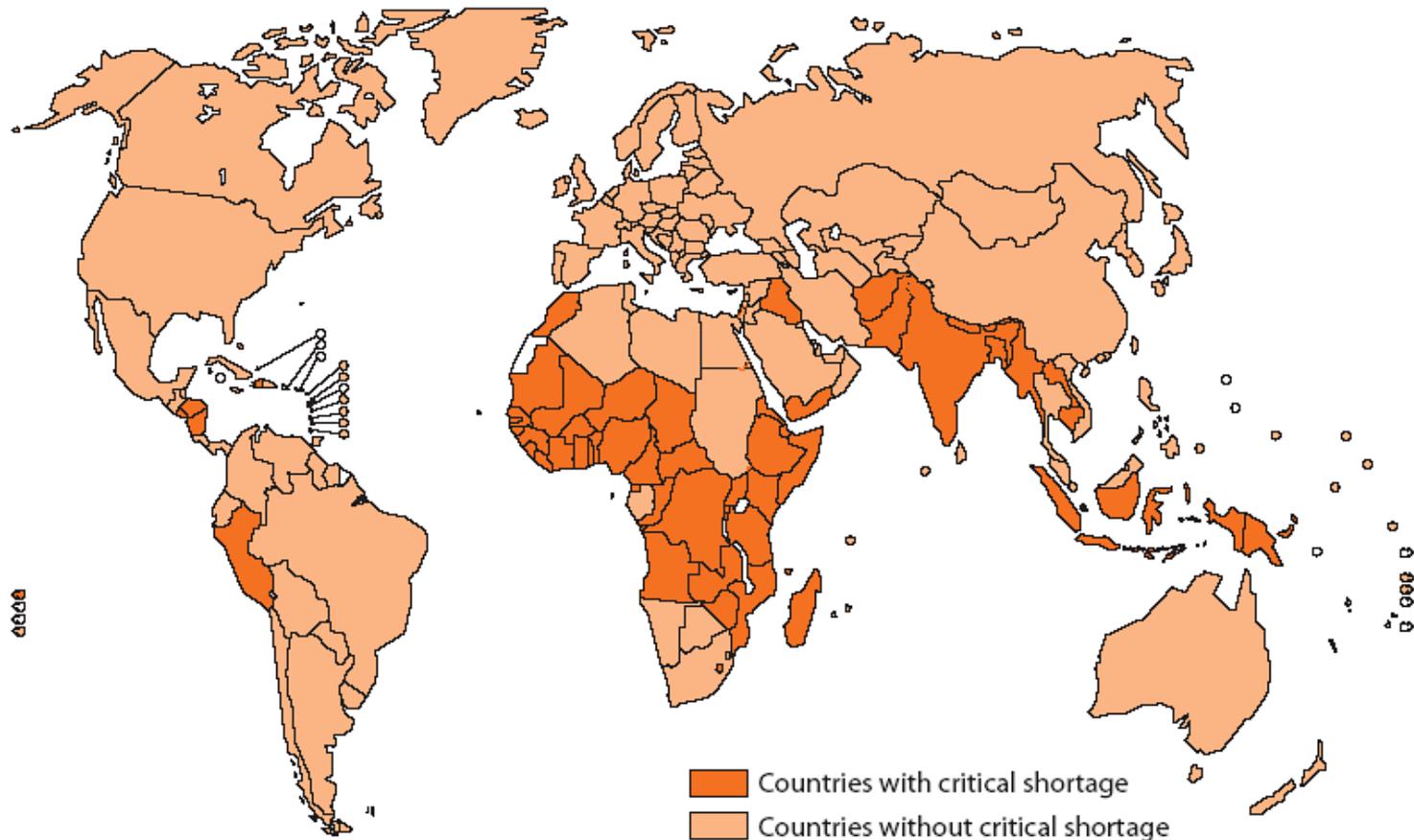
For your convenience, the following is attached: [Engagement Agreement for Kidney Transplant](#)

Philippine Medical Centre Ltd.
28/F, Tower 2,
The Enterprise Centre,
6766 Ayala Ave, cor Paseo de Roxas
Mactay City 1226, Philippines
Tel: +63-2-8493953
Fax: +63-2-8865008

Health worker migration



Countries with a critical shortage of health service providers
(doctors, nurses and midwives)



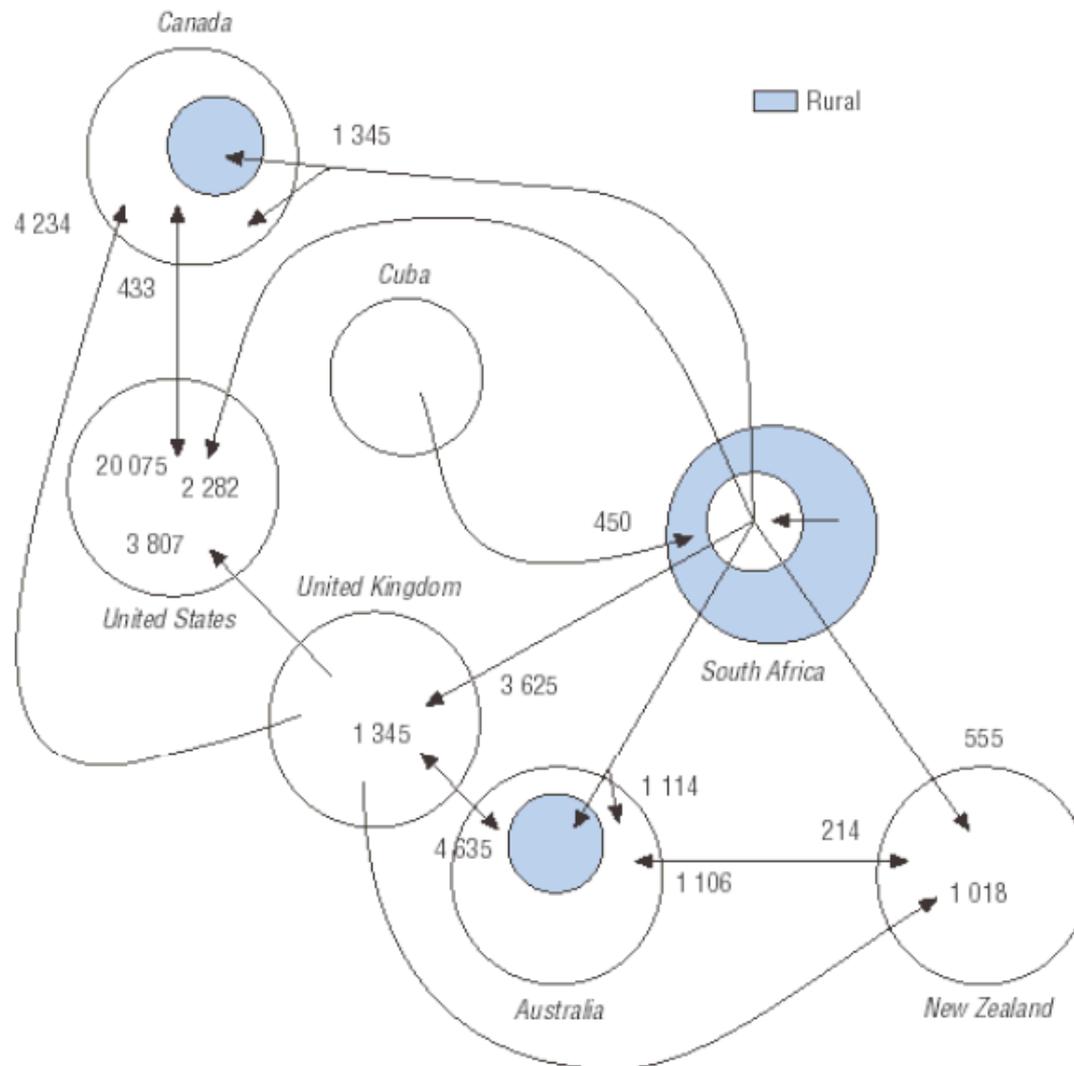
Data source: World Health Organization. Global Atlas of the Health Workforce (<http://www.who.int/globalatlas/default.asp>).

Health worker migration

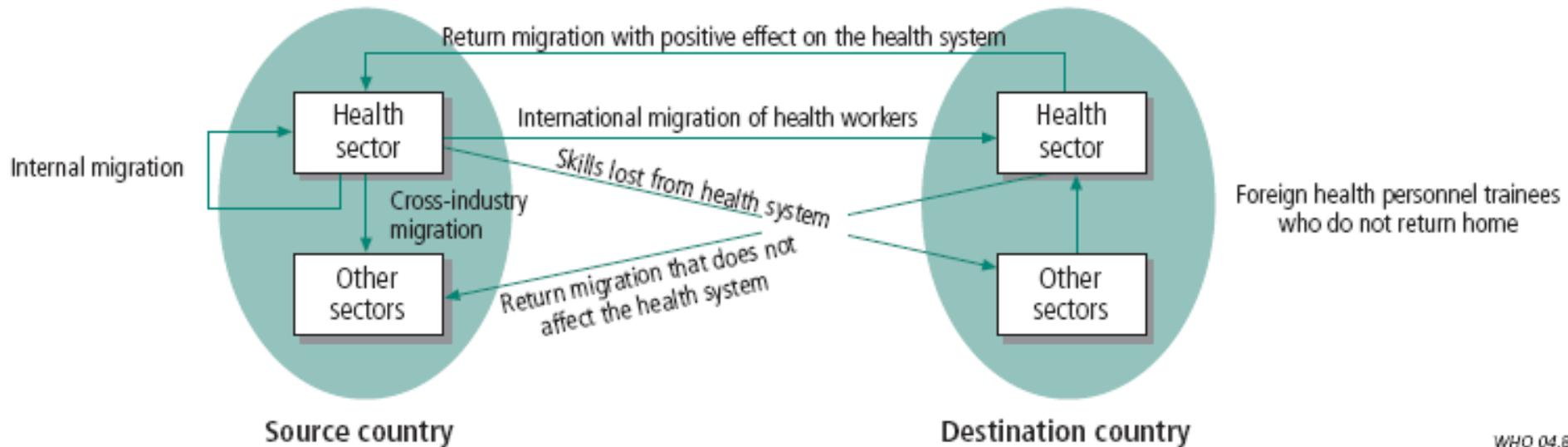


- Migration is neither new nor unique to health
 - Workers migrate (*usually* from poorer to richer countries)
- Migration historical mainstay of health services trade
 - 1970's 6% of world's physicians & 4% of nurses worked outside country of origin – 86% in Australia, Canada, Germany, UK, USA
 - Pattern reflects colonial and linguistic ties (eg India to UK)
- Economic literature shows global welfare gains, **but:**
 - Driven by manufacturing, unskilled temporary migration – health is *skilled service* sector and often migration is permanent
 - Ignores distribution – developed world may benefit ~\$4,000, but developing world lose ~£1-3,000, per-migrant
 - Some countries voluntarily send HCW abroad (eg Cuba, India, Egypt, the Philippines) but for others migration is involuntarily (eg Africa and Caribbean)

Complexity of HCW migration



Complexity of HCW migration





Opportunities vs risks

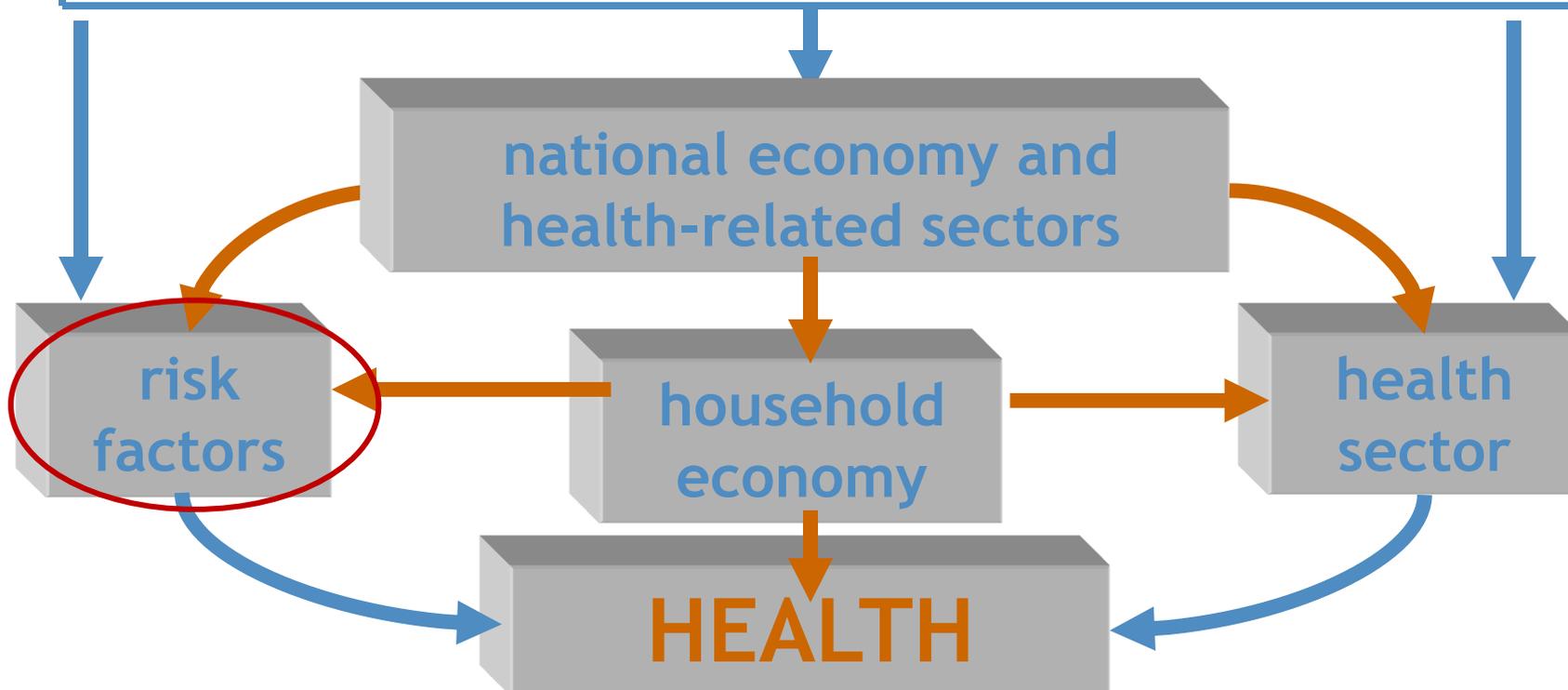
	Opportunity	Risk
E-health	Increased care to remote and under served areas	Diversion of resources from other health services
Health tourism	Generates foreign exchange earnings for health services of importing country	Crowding out of local population and diversion of resources to service foreign nationals
Foreign investment	Creates opportunities for new employment and access to new technologies	Development of two tiered health system with an internal brain drain
HCW migration	Economic gains from remittances of health care personnel working overseas	Permanent outflows of health personnel, with loss investment in educating and training such personnel

Health care trade liberalization: health system challenge



- Involvement in *economic* (trade) policy making
 - commitments to health sector trade made with awareness of impact on sector
 - monitor implementation and impact of health sector trade commitments on health *care*
 - optimal positioning in global market (eg India e-health, Philippine nurses)
 - secure health input to other sectoral commitments (eg finance & insurance)
- Design of proactive, responsive health *care* policy

Globalization





Globalization and risk factors

- Trade influences pattern of disease risk...
 - Communicable disease patterns affected by speed of movement of people, animals and goods
 - Non-communicable disease patterns affected by changes in income and marketing/availability
- Increasing levels of disease impacts economy
- Globalization can change pattern of response
 - Speed of identification of emergent disease (eg SARS) and development/distribution of vaccines
 - Other measures, such as travel advisories etc

EMERGING AND RE-EMERGING INFECTIOUS DISEASES: 1996-2004

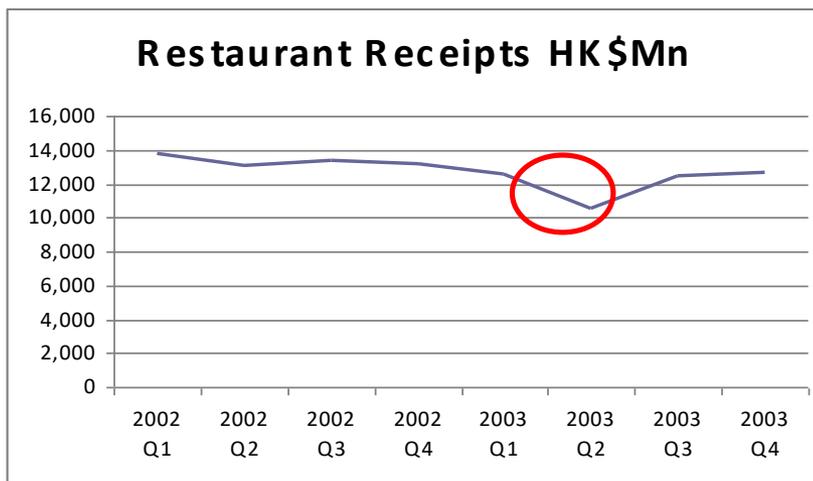
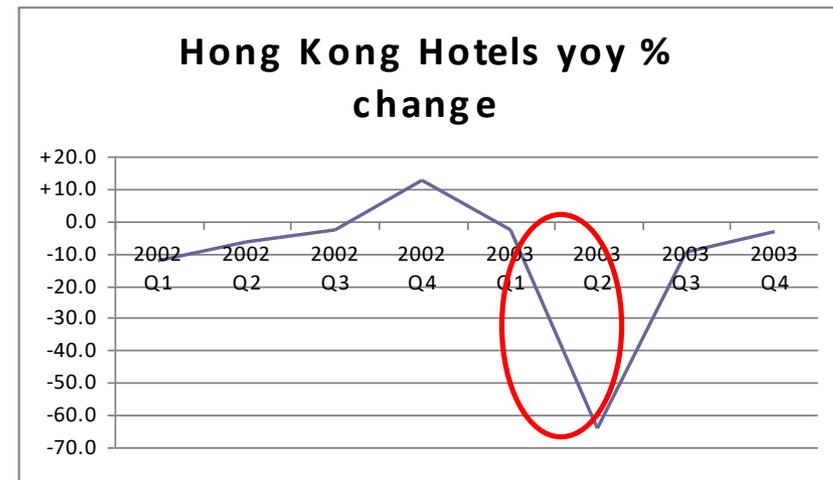


- | | | |
|--|---|----------------------------------|
| ● Ebola and Crimean Congo haemorrhagic fever | ◆ New variant Creutzfeldt-Jakob disease | ▼ Leptospirosis |
| ● Influenza H5N1 | ■ SARS coronavirus | ▼ Lyme borreliosis |
| ● Lassa fever | ■ Venezuelan equine encephalomyelitis | ★ Escherichia coli O157 |
| ◆ Monkeypox | ■ Yellow fever | ★ Multidrug-resistant Salmonella |
| ◆ Nipah Hendra | ■ West Nile fever | ★ Plague |
| ◆ Riftvalley fever | ▼ Cryptosporidiosis | |

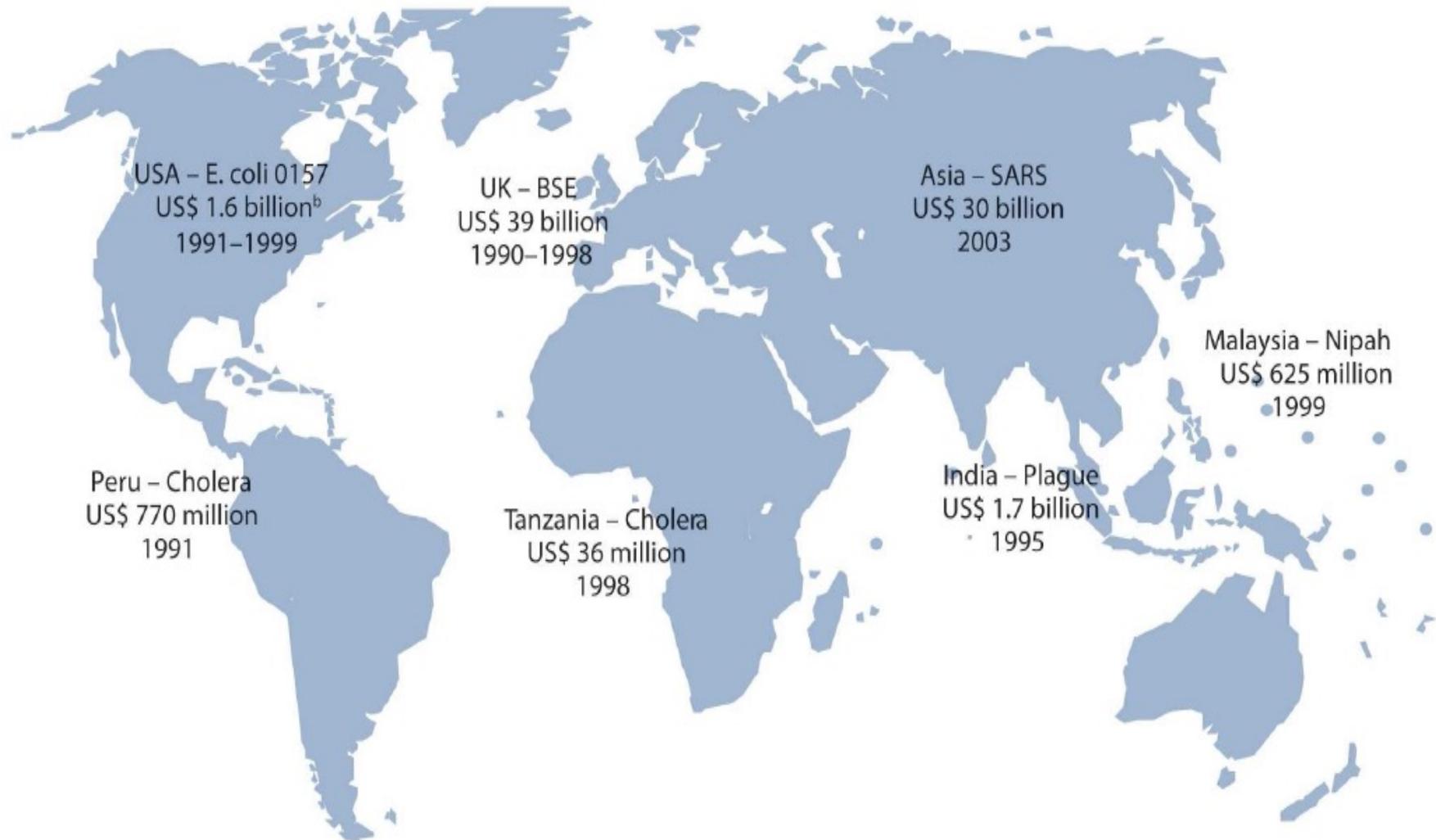


Example of SARS in Hong Kong

- Health (sector) impact small, but impact on other sectors large
 - E.g. Hong Kong retail losses ~ US\$334m



Direct economic impact, selected infectious disease outbreaks, 1990-2003





The economy-wide impact of pandemic influenza on the UK: a computable general equilibrium modelling experiment

Richard D Smith, professor of health system economics,¹ Marcus R Keogh-Brown, research fellow in economic modelling,¹ Tony Barnett, professorial research fellow and honorary professor,^{1,2} Joyce Tait, professor and scientific adviser³

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doi:10.1136/bmj.b4571

ABSTRACT

Objectives To estimate the potential economic impact of pandemic influenza, associated behavioural responses, school closures, and vaccination on the United Kingdom.

Design A computable general equilibrium model of the UK economy was specified for various combinations of mortality and morbidity from pandemic influenza, vaccine efficacy, school closures, and prophylactic absenteeism using published data.

Setting The 2004 UK economy (the most up to date available with suitable economic data).

Main outcome measures The economic impact of various scenarios with different pandemic severity, vaccination, school closure, and prophylactic absenteeism specified in terms of gross domestic product, output from different economic sectors, and equivalent variation.

Results The costs related to illness alone ranged between 0.5% and 1.0% of gross domestic product (£8.4bn to £16.8bn) for low fatality scenarios, 3.3% and 4.3% (£5.5-5bn to £7.2-3bn) for high fatality scenarios, and

syndrome (2003), H1N1 subtype of the influenza A virus (2009), and sporadic outbreaks of H5N1 influenza subtype.² In addition to the direct health impacts of a serious outbreak, we should be concerned about the economic impact; especially at a time of global recession.³ Preparedness planning for a pandemic must therefore balance two key policy strands—maintaining “business as usual” to minimise the economic impact of a pandemic, and encouraging “social distancing” to minimise the health related impact of a pandemic⁴—as well as using resources such as antivirals and vaccinations.

This paper considers the tension inherent in these two policy strands. It provides evidence of the economy-wide impact of each approach, as well as the impact that vaccine development may have in reconciling the two objectives of minimising both the health and economic effects of a pandemic. A key consideration in this analysis is the role of public perception and confidence, expressed by “prophylactic absenteeism.”

PERSPECTIVE

GLOBAL NONCOMMUNICABLE DISEASES — WHERE WORLDS MEET

GLOBAL HEALTH

Global Noncommunicable Diseases — Where Worlds Meet

K.M. Venkat Narayan, M.D., Mohammed K. Ali, M.B., Ch.B., and Jeffrey P. Koplan, M.D., M.P.H.

Like climate change, the relentless worldwide spread of noncommunicable diseases offers an opportunity for low-, middle-, and high-income countries to join forces in addressing a major global challenge that threatens health and economies alike. A recent report from the World Health Organization¹ identified six risk factors associated with noncommunicable diseases as the leading global risk factors for death: high blood pressure, tobacco use, high blood glucose levels, physical inactivity, overweight or obesity, and high cholesterol levels. Together, these factors contribute to a large proportion of

situations of individuals, families, and societies. According to the World Economic Forum's 2009 report, noncommunicable diseases are among the most severe threats to global economic development, more likely to be realized and potentially more detrimental than fiscal crises, natural disasters, or pandemic influenza. It is projected that in the next 10 years, China, India, and Britain will lose \$558 billion, \$237 billion, and \$33 billion, respectively, in national income as a result of largely preventable heart disease, strokes, and diabetes.^{2,3} In the United States, cardiovascular disease and diabetes

culosis and community-acquired pneumonias — and therefore to the poorer outcomes associated with these complications. Furthermore, owing to burdensome health care costs, disability, absenteeism, and forgone income, noncommunicable diseases result in poverty, thus contributing to a vicious cycle. Because of their multiple interacting causes and complications, as well as their lifelong nature, noncommunicable diseases challenge current paradigms of health care organization and delivery.

Confronted by the ever-increasing threat of such diseases, high-, middle- and low-income coun-



Globalization and food

- Massive expansion of agricultural trade:
 - 1990-2010 increased from \$243bn to \$467bn
 - 1980-2010, imports into developing countries increased by 115% (45% into developed)
 - 1990-2010, FDI in manufacturing \$73-\$248bn
- Impacts on food availability, prices & safety
- Impacts on health (+ve *and* –ve):
 - Undernutrition (food availability/price)
 - Diet-related chronic diseases
 - Foodborne disease (food safety)



Chronic Diseases: Chronic Diseases and Development 2



Health, agricultural, and economic effects of adoption of healthy diet recommendations

Karen Lock, Richard D Smith, Alan D Dangour, Marcus Keogh-Brown, Gessvir Pigatto, Corinna Hawkes, Regina Mara Fisberg, Zaid Chalabi

Transition to diets that are high in saturated fat and sugar has caused a global public health concern, as the pattern of food consumption is a major modifiable risk factor for chronic non-communicable diseases. Although agri-food systems are intimately associated with this transition, agriculture and health sectors are largely disconnected in their priorities, policy, and analysis, with neither side considering the complex inter-relation between agri-trade, patterns of food consumption, health, and development. We show the importance of connection of these perspectives through estimation of the effect of adopting a healthy diet on population health, agricultural production, trade, the economy, and livelihoods, with a computable general equilibrium approach. On the basis of case-studies from the UK and Brazil, we suggest that benefits of a healthy diet policy will vary substantially between different populations, not only because of population dietary intake but also because of agricultural production, trade, and other economic factors.

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This is the second in a [Series](#) of five papers about chronic diseases

London School of Hygiene and Tropical Medicine, and Leverhulme Centre for Integrative Research on Agriculture and Health, London, UK (K Lock PhD, Prof R D Smith PhD, A D Dangour PhD, M Keogh-Brown PhD, Z Chalabi PhD); Universidade Estadual Paulista Julio de Mesquita Filho, Tupã, Brazil

Introduction

Profound inequalities in access to food exist between the 1 billion people worldwide who are estimated to be undernourished and the many millions who have overabundant access to diets that are rich in calories but low in mineral and vitamin density.¹ Concurrently, a transition to diets high in saturated fat (mainly meat and dairy foodstuffs) and sugar, and low in staple foods such as cereals, fruits, and vegetables, is occurring in all but the very poorest of countries.^{2,3} This transition is causing global public health concern, because patterns of food con-

foods. Indeed, agricultural and health sectors are largely disconnected in their priorities and policy objectives. Typically, agricultural priorities centre on production and processing systems, markets, and livelihoods, with concern for food safety only as it affects trade, rather than on broad public health issues. By contrast, public health traditionally centres on agriculture insofar as it affects food security and food safety, with only recent consideration of agriculture's potential role in prevention of non-communicable diseases.^{7,10} Neither sector considers the complex inter-relation between agri-trade, food

Implications for health systems



- Impact on profile of disease facing health system
 - Non-communicable disease growing issue globally, changing demands on health system; important is 'dual burden' facing developing countries
- Need to be prepared for outbreaks of new or re-emergent infectious disease, which may be quick and severe
 - Human resource implications especially critical, but also aspects related to transport and wider infra-structure, vaccines etc
 - Risk of investing in 'risk'!
- Wider spill-over effects on rest of economy
 - Population behaviour, as well as morbidity/mortality and investor 'confidence' etc affect economy which affects national income available for health system
 - Other affects, such as through agriculture...

Globalization and risk factors: health system challenge



- Secure an integrated global surveillance system for communicable disease (a ‘global public good’)
- Provide (methods to establish) estimates of *economic* and health impact of global communicable and non-communicable diseases
 - Often the economic impact generates interest!
- Persuade trade and other policy makers that this information be linked to compensation for countries notifying communicable disease etc



Conclusion

- Globalization will continue. Increasingly national health (system) is affected by events beyond its boundaries/control: wider economy, health-specific trade, disease risk-factors etc
- Empirical research, conceptual and methodological developments and policy advice can no longer be viewed purely from a national perspective
- Challenge is to understand implications of this to better analyse and evaluate how to strengthen health 'system'

Thank You



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Obrigado!

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Gracias

Vielen
Dank

Hvala



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Dikey



תודה

Grazie



Ευχαριστώ

Köszönettel

Bedankt

धन्यवाद

Teşekkürler

Merci

謝謝您