

# Yes we can! The Raffles Dialogue on Human Wellbeing and Security



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## Summary

The future of human wellbeing and security depends on our ability to deal with the multiple effects of globalisation and on adoption of a new paradigm and philosophy for living and for health that emphasises people's wellbeing and social justice. Such was the topic of the inaugural Raffles Dialogue on Human Wellbeing and Security held in Singapore on Feb 2–3, 2015. Participants agreed that, to achieve these goals, four conditions must be met. First, equity must be integral to the implementation of technology. Second, there is an urgent need for innovations within our global institutions to make them “fit for purpose” in a rapidly changing world. Third, we must find the right balance between the roles of government and markets so that all those in need can access affordable medicine and health care. Finally, we must realise that we live in a small and interdependent “global village”, where Asian countries need to assume greater leadership of our global village councils. This is the great imperative of our times.

The well known electoral promise from a prominent political figure, “Yes we can”, captured the mood of optimism and hope that followed the inaugural Raffles Dialogue on Human Wellbeing and Security<sup>1</sup> held in Singapore on Feb 2–3, 2015. Two overarching themes informed the deliberations.

First, that it is important to be aware of the key megatrends of globalisation that will affect future human wellbeing:<sup>2</sup> ageing populations, environmental degradation, the increasing role of technology accompanied by diminution of the importance of nation states, growing inequality, urbanisation, and, importantly, the gap that continues to exist between the knowledge that we have and our ability to use it effectively.

Second, and as captured in the notion of planetary health,<sup>3</sup> we need a new paradigm and philosophy for living and for health which places people's wellbeing and social justice, rather than diseases and survival, at the centre of the value chain. The future health of civilisations depends on humanity embracing this concept of planetary health which, in turn, strongly emphasises the interdependence and interconnectedness of the risks we collectively face. Achievement of sustainable human development will require a strong social movement based on collective action at every level of society.

If we are to deal with the challenges thrown at us by these megatrends, if we are to take a more holistic view of the health of the whole planet, and if we are to “press the right buttons”, we need to consider carefully the four dimensions of the role of technology, the relevance and capacity of global institutions, the role of governments and markets, and the reality that we all live in a global village which needs to be managed effectively and equitably.

## Equity must be integral to the implementation of technology

As technology rapidly advances the ways we interconnect, gaps in accessibility increase for resource-poor

communities already challenged by ineffective systems and structures, reducing meaningful technology uptake. Too often, decision-making power does not shift to where implementation takes place, and technologies introduced in a relatively top-down manner often impose unsustainable solutions. Thus, *how* technology is implemented is just as important as *what* is implemented.

Effective and sustainable action requires a convergence of technology, human and social capital, and the essential core values of equity. Implementation of technology must be supported by local decision making, bottom-up approaches, respectful partnerships, long-term commitment, trust, and local ownership. Numerous real-world examples exist that illustrate how integration of core values of equity have led to effective action across diverse disciplines, as described below.

Local training and implementation of new techniques in the area of infectious diseases provide one such example. The Sustainable Sciences Institute, an international non-governmental organisation that focuses on building on-the-ground scientific capacity, has successfully generated a cadre of more than 1900 scientists in over 27 developing countries, strengthening in-country capacity to respond to dengue, influenza, and chikungunya infections, among others.<sup>4</sup> Innovative technologies such as the development of low-cost diagnostics and reagents, adaptation and routine application of molecular typing methods, and establishment of laboratory-based surveillance systems enable countries such as Nicaragua to have autochthonous capacity to respond to outbreaks and pandemics and to do locally relevant infectious disease research.<sup>4</sup>

A second example is that of mobilising local populations for widespread, grassroots public health impact. BRAC—a Bangladeshi organisation dedicated to alleviating poverty that serves tens of millions—exemplifies this approach. In the 1970s, BRAC's scale-up of oral rehydration therapy, a simple solution that can be prepared at home to treat diarrhoea, showed the world how implementation of

*Lancet Glob Health* 2015; 3: e496–500

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innovative interventions and technology from the ground up catalyses widespread uptake and behavioural change. 13 million illiterate rural mothers in Bangladesh were educated about use of oral rehydration therapy for their children's diarrhoea—as were men and other community leaders—resulting in significant reductions in child mortality from diarrhoea.<sup>5</sup> UNICEF estimate that child deaths from diarrhoeal diseases have dropped from 1.2 million in 2000 to 0.6 million in 2013.<sup>6</sup> BRAC now integrates community engagement throughout their numerous health, education, and social entrepreneurship programmes to improve the lives of those most in need.

In a third example, development and testing of information and communication technologies (ICT) by involving local end-users help create dependable and cost-effective tools that can rapidly streamline health information in response to public health challenges. ICT tools developed at the Sustainable Sciences Institute for infectious disease research, surveillance, and laboratory management were designed and developed iteratively by integrating the input of stakeholders at each stage.<sup>4</sup> Responding to user demand, ICT tools that extend past the laboratory were then developed to track primary health measures such as pregnancies and immunisation and to facilitate provision of health education and collection of data by community health workers using mobile apps. Another illustration is Hesperian Health Guides' HealthWiki and mobile app for safe pregnancy and birth, among other topics, connecting communities with online resources developed in conjunction with local populations. From March, 2014, to March, 2015, alone, Hesperian's HealthWiki reached 3.6 million users in places where there would otherwise be no doctor.<sup>7</sup>

Beyond health, similar success stories exist of engaging local communities to implement sustainable change. In agroecology, the development of diverse and ecologically sustainable farming environments relies on empowering local farmers, who know their land and apply agroecological techniques improved on over centuries. Supporting sustainable farming provides resilient alternatives to industrial monoculture farming by helping diverse ecosystems flourish and strengthen local food production systems.<sup>8</sup> Similarly, microfinance and grassroots entrepreneurship provide essential financial services to those who otherwise cannot access or afford them. Opportunities that are created through organisations such as Ashoka, BRAC, and Kiva are crucial in supporting entrepreneurs in poor rural areas develop small businesses that lift vulnerable households out of poverty.

Although tensions can underlie the implementation of new technologies in resource-limited communities, lessons from successful real-life scenarios have proven that addressing the confluence of systemic and structural failures requires bottom-up approaches to build capacity and advance health equity. Creating and sharing technology using a long-term collaborative approach

ensures a meaningful convergence between high-tech and low-tech, North and South, and novel and traditional—bridging the gap to improve human well-being globally.

### An urgent need for institutional innovation

At the core of our future ability to effectively manage the major megatrends of globalisation are the institutions that shape and govern collective actions. Institutions at all levels are struggling to cope with the pace and reach of change, but it is at the global level that institutional shortcomings are most acute. It is apparent, from our failure to negotiate collective action on climate change, to our inability to redress stark inequalities in life chances between rich and poor, that our existing institutions are sorely inadequate. The world has fundamentally changed and there are three ways that existing global health institutions are out of step.

First, our existing institutions are hardly global. The defining impact of globalisation is its rendering of the world into a single entity. The Treaty of Westphalia of 1648 established the international states system which carved up Europe, and then the rest of the world over the next 350 years, into parcels of land each governed by an independent authority. Today, the planet is divided into 194 sovereign states, with governments exerting exclusive authority and responsibility over their territory and the populations within. Globalisation, however, has been steadily eroding the capacity of governments to rule. The national borders of sovereign states must now compete along new organising logics, such as an increasingly integrated world economy, the power of the internet, and the rise of new ideologies. Governments seeking to manage their domestic economies, for example, cannot control many factors of production and consumption linked to the world economy. Similarly, the capacity of national health systems to protect and promote the health of citizens is eroded by populations, and broad determinants of health, that flow across borders. Truly global health institutions need to recognise the “respatialisation” of the world and the effects of its human inhabitants on it.

Second, existing institutions are not temporally aligned with the changes brought by globalisation. Collective action is frequently too slow to respond to rapidly unfolding events such as disease outbreaks or major emergencies. Equally disastrous is the failure to act decisively to slow-moving, but significant, events such as the looming pandemic of non-communicable diseases. The lumbering pace of traditional bureaucracies, combined with the political cycles of powerful member states, constrain the timing of their ability and willingness to act.

Third, the reductionist ways in which existing institutions think about global health problems and solutions is incongruent with the need, in a more interconnected world, for more holistic approaches. Most governments now recognise the need to be more joined-

up and integrated because the days of discrete policies on health, agriculture, security, and so on are long gone. Scholarly silos are being called on to come together to generate the new interdisciplinary knowledge we need in today's world.<sup>9</sup> The public health community, as a whole, is being challenged to embrace systems thinking, one health, and the concept of planetary health.<sup>3</sup> The structures and functions of existing institutions, in short, serve as cognitive blinkers to approaches addressing human and planetary wellbeing.

So how can we reinvent our institutions to cope with a changing world? One approach might be to see the problem as one of innovation. Applied to global institutions, innovation can be seen as redefining the rationale for institutions and developing new relationship architectures within and across institutions to break existing performance trade-offs and expand the realm of what is possible—ie, creating smarter institutions that can thrive in a world of exponential change.<sup>10</sup>

But what sort of innovations do we need? Although originating from the business world,<sup>11</sup> innovation thinking has much to offer global health governance. It begins with identifying needs and designing products to meet them. As described, there is a profound disconnect between existing institutions and the spatial-temporal-cognitive changes brought about by globalisation. Global health institutions should begin with a planetary perspective,<sup>3</sup> and be capable of addressing health determinants and outcomes that span political boundaries and manifest in novel geographical ways. They should be temporally nimble, keeping pace with a faster and more volatile world, but also capable of managing long-term problems and solutions. Finally, they would overcome fractured thinking about human health and the world, by connecting dots, building creative and diverse teams, and supporting open-source learning.

A second task is to harness the drivers of global change to create new institutional forms that are driven by a search for scalable efficiency. Global health governance has become central to the new social and technological infrastructures needed to secure our long-term survival. How might digital technologies, for example, redefine how global health institutions operate? How might new forms of social organisation, such as social media, the shared economy, and crowd sourcing, be adapted to drive institutional innovation? Experimentation to date, focused on public-private partnerships, has been limited in scope, ad hoc, and narrowly conceived. New forms of institutional innovation are rapidly emerging, led by collaborative communities such as OpenIDEO, InnoCentive, and Re:Search, which apply open-source design thinking and crowd sourcing science to complex social and environmental challenges.<sup>12</sup> Global health institutions must capture other emerging forms of community to avoid irrelevance.

Collective action on global health has thus reached a critical point. Institutional innovation, and not simply

improvement, is urgently needed. The incrementalism of reform efforts to date has left existing institutions far out of step with the realities of an increasingly globalised world.

### **What is the role of governments and markets?**

The social determinants of health are central to future human wellbeing, yet the political and economic determinants are equally important. What is the role of the state and markets in providing human wellbeing and security?

The central challenge is about finding the right balance and finding the answer to fundamental questions such as letting markets work versus affordable medicine and health care for all. There is also the issue of maximising growth versus the right for human wellbeing for all based on the moral arguments of social justice and human rights.

The basic premise of economics is that free markets will deliver the most efficient outcomes, but that the state still needs to manage markets so there is fair competition. The state also intervenes when there is market failure such as the provision of affordable basic services to ensure wellbeing. Over time and across countries, this economic premise holds true, but with shifting emphasis and lessons learned in terms of the right balance. We went from the unregulated capitalism that led to the Great Depression in the 1930s, to the role of the state in regulating markets and ensuring good societal outcomes such as basic needs and health care in the post-war 1960s–70s. The pendulum swung again in the 1980s Reagan and Thatcher era of neoliberalism, “let the market economy bloom” with Perestroika and Glasnost in Russia, and the fall of the Berlin Wall and the opening up of socialist and communist countries in eastern Europe. This transition was followed by the Washington consensus in the 1980s–90s of getting prices right through opening up of markets, privatisation and private property rights, and incentives for innovation and entrepreneurship. Part of the result was innovation and technologies including patented medicines which are sold at market prices to obtain the return from the research and development investment.

Developing countries in east Asia mostly followed the Washington consensus and experienced unprecedented growth often termed as the East Asia Miracle. Some countries used state intervention to “pick winners” or sectors that got facilitation, protection, and subsidies. There were some successes but also failures where the vested interests “pick” the government. This lack of good governance, including in the banking sector with owners lending to their own groups, and crony capitalism, exposed the vulnerabilities that led the east Asia region into a serious financial and economic crisis beginning in mid 1997. The prescription from Washington was austerity measures and closure of banks, which actually deepened the crisis. The east Asian crisis extracted a high price on human wellbeing and security: the number of

poor and near poor jumped dramatically, with soaring food prices, unemployment, and austerity measures that cut into health care, family planning, and social welfare programmes. The role of the state was absent in providing a social safety net to the poor.

Post crisis there was a great deal of caution regarding the role of the markets and the focus was on getting institutions and governance right, including a sound banking system, transparency, and good corporate governance. After 5–8 years of stabilisation and reforms, the east Asian economies were on an upward trajectory when the 2009 world economic crisis struck. The east Asian economies that followed good economic policies and building of institutions were still hit by the crisis because there were massive capital outflows going back to the USA and Europe where the crisis ensued. Ironically, this time the same people from Washington prescribed the opposite remedy to what they prescribed during the east Asian crisis.

The response to the crisis was very much state-driven, with concerted fiscal stimulus, expansive monetary policy, bailouts of banks and key enterprises, and an agreement to refrain from using protectionist measures even though there were “buy America” and “buy Europe” programmes. Much like what was discussed previously for health, the big learning this time was on how in good times and when markets are allowed to work, we should develop the right institutions for delivery of human wellbeing programmes so that, in crisis, social safety net programmes can be rolled out easily.

Post financial crisis there is now greater distrust of the working of markets alone to deliver growth and the role of the state in managing markets. In the past few years, a lot has been done in terms of multilateral and national reforms to find the right balance between regulations and market to avoid the irrational exuberance that was the fulcrum of the crisis. Just as equity is important for technology, there is also a much greater concern for inequities across income, groups, and sectors, and not just in developing countries, as the Occupy Wall Street movement showed. This movement led to questions of the role of the state and of markets in addressing inequities.

So what have we learned and how should we go forward with regard to the role of states and markets in delivering human wellbeing? The basic premise of economics is still the same, that there has to be growth for there to be distribution. And there are trade-offs when it comes to letting markets work, but also ensuring the goals of equity, human wellbeing, and sustainability, whether through the intervention of state or states (in the case of international agreements) or through incentivising the private sector and innovative public–private cooperation. Global agreements can also provide the norms and standards to make markets work better to achieve human wellbeing.

In the health sector, letting markets work can bring down the cost of medicines, medical equipment, and

health services. Global and regional trade agreements and market opening by countries focus on reduction of tariffs on pharmaceuticals and medical equipment and the opening up of the health service sector. However, whereas markets and incentives lead to innovation, research, and development, the appropriately priced products and services mean that affordability and accessibility is an issue for those who need them most. At the national level, the state can intervene through schemes such as tiered pricing and cross subsidies. At the global level, a good example of an intervention to improve affordability and access to needed medicines for the poor is the agreement to allow “compulsory licensing”, whereby intellectual property rights owned by pharmaceutical companies are waived to allow production of generic medicines needed to deal with urgent public health problems. Furthermore, there are creative ways of using market principles, public–private cooperation, and incentives or disincentives to change the behaviour of the private sector so that we can get the desired outcomes for human wellbeing.

#### The bird’s-eye view: managing the global village

The global financial crisis of 2008–09, global warming, global terrorism, and the Ebola threat have confirmed that we live in a small and interdependent world. Indeed, we live in a global village.

If we accept that we live in a global village, we should be strengthening global village councils. Unwisely, we have been doing the opposite. Western governments have had a long-standing policy of weakening global multilateral institutions like the WHO. The USA has led this effort, believing that multilateral institutions act as a check on American power.<sup>13</sup>

These institutions have been weakened via their finances. WHO provides a dramatic example. In 1970–71, it received 62% of its budget from regular budget funds and 18% from extrabudgetary funds. By 2006–07, the ratio had reversed to 28% from regular budget funds and 72% from extrabudgetary funds.<sup>14</sup> Since 1990, WHO’s regular budget, and the proportion of development assistance for health that is directed towards WHO’s core functions, has fallen dramatically.<sup>15</sup> Why is this shift significant?

WHO can only make long-term spending plans (such as recruiting senior long-term personnel) from regular and reliable regular budget funds. By squeezing regular budget funds and increasing extrabudgetary funds, the West has denied WHO the capability to build deep and long-term expertise to deal with outbreaks like Ebola. The West has also been shifting funding for health lending away from WHO to the World Bank. World Bank health lending was US\$0.25 billion in 1984, but exploded to \$2.5 billion in 1996. Meanwhile, the WHO budget rose only \$400 million in the same period, to \$900 million. As a result, “for the WHO, it has meant a substantial bypassing of its role as the lead UN health agency”.<sup>14</sup>

Why did the West shift funding to the World Bank? Because the West dominates the voting shares of the World Bank, it can control and influence the Bank's direction. It cannot do the same with WHO. In theory, this shift of health funding to the World Bank should not damage our ability to deal with global health challenges. In practice, it has.

To understand why, we need to look at global demographics. We have 7 billion people living in our global village. 12% live in the West. 88% live outside the West. Naturally, most of the world's population would prefer working with institutions that reflect global wishes, not the wishes of a small minority. WHO is trusted by the world's population, whereas the World Bank is seen to be an instrument of the Western minority. The G20 meeting in November, 2014, reflected this lack of trust. World Bank President Jim Yong Kim called on the G20 to give more funds to the World Bank to fight Ebola. He also called for a multi-billion-dollar contingency fund for future pandemics. Significantly, the G20, which represents the majority of the world's population, did not support his call. It wants WHO to remain the primary organisation to deal with global health challenges.

Fortunately, there is a long-term solution. The weight of the Asian countries in the global economy has increased significantly. In terms of purchasing-power parity, in 1980, the US share of the global economy was 25% whereas China's was 2.2%. However, by the end of 2014, the US share had fallen below that of China. The Asian Development Bank projects that Asia as a whole could account for 52% of the world's gross domestic product by 2050—nearly double its share in 2010.<sup>16</sup>

As the Asian states gain global economic power, they will also have to take on more global responsibilities. Sadly, most Asian countries show little inclination to do so. They have not woken up to the new reality that Asia will soon become the wealthiest corner of the world, with more middle-class citizens than the entire population of the Western countries. Indeed, the number could be more than double. These middle-class citizens will demand better global health conditions. Hence, the time has come for Asian countries to assume greater leadership of our global village councils. This is the great imperative of our times.

In conclusion, "we can" if we collectively agree to use the positive aspects of globalisation to look after the health of our planet and manage the global village, to reform our global institutions innovatively, to ensure that

technology helps to achieve equity, and to get the right balance between state and market forces. We can, and should, convene future Dialogues to continue and broaden the discourse on this topic which is central to the survival of our civilisation.

#### Declaration of interests

We declare no competing interests.

#### Acknowledgments

HF and EH thank Heather Zornetzer, Miguel Altieri, Sarah Shannon, and Naomi Sager for their thoughtful comments on their contribution.

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