COUNCIL *on* FOREIGN RELATIONS

Independent Task Force Report No. 72

Mitchell E. Daniels Jr. and Thomas E. Donilon, *Chairs*
Thomas J. Bollyky, *Project Director*

The Emerging Global Health Crisis

Noncommunicable Diseases in Low- and Middle-Income Countries

The Emerging Global Health Crisis

Noncommunicable Diseases in Low- and Middle-Income Countries

COUNCIL *on*
FOREIGN
RELATIONS

Independent Task Force Report No. 72

Mitchell E. Daniels Jr. and
Thomas E. Donilon, *Chairs*
Thomas J. Bollyky, *Project Director*

The Emerging Global Health Crisis

Noncommunicable Diseases in Low- and Middle-Income Countries

The Council on Foreign Relations (CFR) is an independent, nonpartisan membership organization, think tank, and publisher dedicated to being a resource for its members, government officials, business executives, journalists, educators and students, civic and religious leaders, and other interested citizens in order to help them better understand the world and the foreign policy choices facing the United States and other countries. Founded in 1921, CFR carries out its mission by maintaining a diverse membership, with special programs to promote interest and develop expertise in the next generation of foreign policy leaders; convening meetings at its headquarters in New York and in Washington, DC, and other cities where senior government officials, members of Congress, global leaders, and prominent thinkers come together with CFR members to discuss and debate major international issues; supporting a Studies Program that fosters independent research, enabling CFR scholars to produce articles, reports, and books and hold roundtables that analyze foreign policy issues and make concrete policy recommendations; publishing *Foreign Affairs*, the preeminent journal on international affairs and U.S. foreign policy; sponsoring Independent Task Forces that produce reports with both findings and policy prescriptions on the most important foreign policy topics; and providing up-to-date information and analysis about world events and American foreign policy on its website, www.cfr.org.

The Council on Foreign Relations takes no institutional positions on policy issues and has no affiliation with the U.S. government. All views expressed in its publications and on its website are the sole responsibility of the author or authors.

The Council on Foreign Relations sponsors Independent Task Forces to assess issues of current and critical importance to U.S. foreign policy and provide policymakers with concrete judgments and recommendations. Diverse in backgrounds and perspectives, Task Force members aim to reach a meaningful consensus on policy through private and nonpartisan deliberations. Once launched, Task Forces are independent of CFR and solely responsible for the content of their reports. Task Force members are asked to join a consensus signifying that they endorse "the general policy thrust and judgments reached by the group, though not necessarily every finding and recommendation." Each Task Force member also has the option of putting forward an additional or dissenting view. Members' affiliations are listed for identification purposes only and do not imply institutional endorsement. Task Force observers participate in discussions, but are not asked to join the consensus.

For further information about CFR or this Task Force, please write to the Council on Foreign Relations, 58 East 68th Street, New York, NY 10065, or call the Communications office at 212.434.9888. Visit CFR's website at www.cfr.org.

This report is printed on paper that is FSC® Chain-of-Custody Certified by a printer who is certified by BM TRADA North America Inc.

Task Force Members

Task Force members are asked to join a consensus signifying that they endorse "the general policy thrust and judgments reached by the group, though not necessarily every finding and recommendation." They participate in the Task Force in their individual, not institutional, capacities.

David B. Agus
University of Southern California

J. Brian Atwood
Humphrey School of Public Affairs

Samuel R. Berger
Albright Stonebridge Group

Karan Bhatia
General Electric Company

Thomas J. Bollyky
Council on Foreign Relations

Nancy G. Brinker
Susan G. Komen

Binta Niambi Brown
Harvard Kennedy School

Barbara Byrne
Barclays

Jean-Paul Chretien
U.S. Navy

Mitchell E. Daniels Jr.
Purdue University

Steve Davis
PATH

Thomas E. Donilon
O'Melveny & Myers

Ezekiel J. Emanuel
University of Pennsylvania

Daniel R. Glickman*
Aspen Institute

Eric P. Goosby
University of California, San Francisco

Vanessa Kerry*
Seed Global Health

Michael J. Klag
Johns Hopkins Bloomberg School of Public Health

*The individual has endorsed the report and signed an additional view.

Risa Lavizzo-Mourey
Robert Wood Johnson Foundation

Christopher J.L. Murray
University of Washington

Elizabeth G. Nabel
Brigham and Women's Hospital

David Satcher
Morehouse School of Medicine

Donna E. Shalala
University of Miami

Ira S. Shapiro
Ira Shapiro Global Strategies LLC

Tommy G. Thompson
Thompson Family Holdings

Contents

Acronyms

ACE	angiotensin-converting-enzyme
DAH	development assistance for health
DALY	disability-adjusted life year
FCTC	Framework Convention on Tobacco Control
FDA	Food and Drug Administration
FY	fiscal year
GAVI	Global Alliance for Vaccines and Immunization
GBD	Global Burden of Disease
GDP	gross domestic product
GHI	U.S. Global Health Initiative
GTSS	Global Tobacco Surveillance System
HBV	hepatitis B virus
HIV/AIDS	human immunodeficiency virus infection and acquired immune deficiency syndrome
HPV	human papillomavirus
IHME	Institute for Health Metrics and Evaluation
IMF	International Monetary Fund
MNCH	maternal, newborn, and child health
NCD	noncommunicable disease
NCI	National Cancer Institute
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief

R&D	research and development
TB	tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

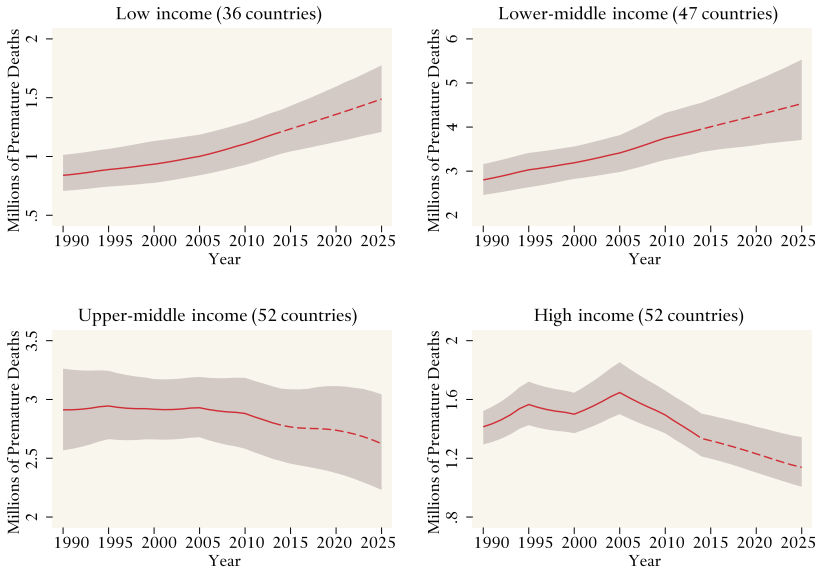
Executive Summary

The biggest global health crisis in low- and middle-income countries is not the one you might think. It is not the exotic parasites, bacterial blights, or obscure tropical viruses that have long occupied international health initiatives and media attention. It is cancer, cardiovascular disease, diabetes, and other noncommunicable diseases (NCDs), which killed more than eight million people before their sixtieth birthdays in low- and middle-income countries in 2013 alone. Unless urgent action is taken, the NCD crisis emerging in developing countries will worsen and become harder to address with each passing year.

The rise of NCDs in low- and middle-income countries is not merely the byproduct of success—increasing incomes, reductions in infectious diseases such as HIV/AIDS, or greater adoption of unhealthy western lifestyles. Recent improvements in life expectancy explain why more people in developing countries get NCDs. They do not, however, explain why so many people in these countries are developing NCDs so much younger and with such worse outcomes than in wealthier nations. Rates of obesity, consumption of fatty foods, and physical inactivity are rising in low- and middle-income countries, but they remain much lower than in most high-income countries. Premature death and disability from NCDs are increasingly associated with poverty in emerging nations, just as they are in wealthier countries.

The factors fueling the emergence of NCDs are the combination of dramatic changes in urbanization, global trade and consumer markets, and longevity that occurred over decades in wealthy nations but are happening much faster in still-poor countries. These changes are outpacing the ability of developing-country governments to establish the health and regulatory systems necessary to adjust. With these trends expected to persist or accelerate, the toll of NCDs on working-age populations will increase in these countries (Figure 1).

FIGURE 1: PREMATURE (UNDER AGE SIXTY) DEATHS FROM NCDS



Underlying Data Source: Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2013.[1]

U.S. interests will be affected by the rise of NCDs in low- and middle-income countries because of their human, economic, and strategic consequences. More patients will get sick, suffer longer, require more medical care, and die young. Given the scale of these trends, the results will reverberate. At the household level, it will mean less income, catastrophic health expenditures, and potential impoverishment. At the national level, it will mean lower productivity and competitiveness, higher health and welfare expenditures, and a potential missed opportunity for the demographic dividend that lifted the fortunes of many higher-income countries. At the global level, the World Economic Forum projects that the NCD epidemic will inflict $21.3 trillion in losses in developing countries over the next two decades—a cost nearly equal to the total aggregate economic output ($24.5 trillion) of these countries in 2013. These economic consequences will undercut potential U.S. trade partners and allies, and may reduce domestic support for foreign governments of strategic interest to the United States.

This outcome is not inevitable. Despite much higher rates of obesity and physical inactivity, premature death and disability from NCDs have

declined dramatically in the United States and other high-income countries. The difference? Mostly cheap and effective prevention, management, and treatment tools and policies that are not widely implemented in developing countries, but could be by using well-established global health strategies. Yet the international community has struggled to act.

The urgency of this situation has led the Council on Foreign Relations (CFR) to convene an Independent Task Force on Noncommunicable Diseases in Low- and Middle-Income Countries—its first ever devoted to a global health matter. The charge of this Task Force is to assess the case for greater U.S. engagement on the NCD crisis in developing countries and recommend a practical and scalable strategy for intervention.

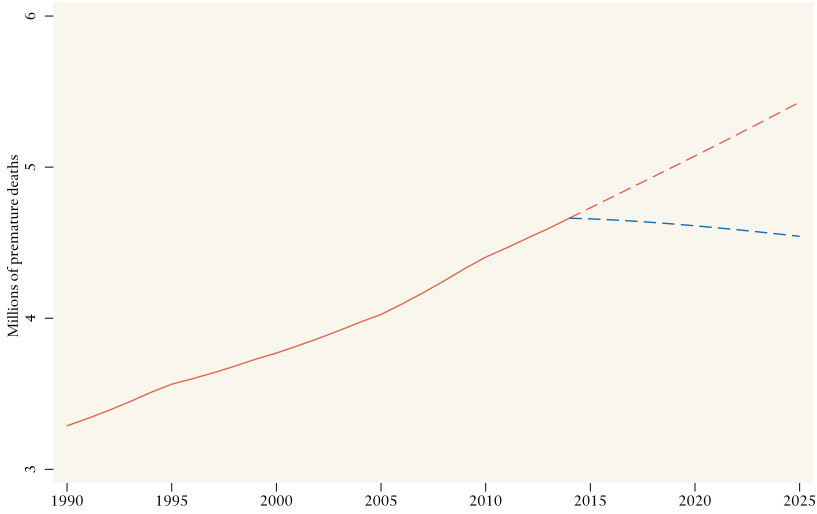
The last time that the world confronted a global health challenge that caused such a large number of premature adult deaths and so disproportionately affected low- and middle-income countries was HIV/AIDS. The United States led the global response to that disease, and the world rallied to its side. The U.S. government launched the President's Emergency Plan for AIDS Relief (PEPFAR) and worked with other donors and partners to establish the Global Fund to Fight AIDS, Tuberculosis, and Malaria. These programs have delivered treatment to millions, saved many lives, and inspired a dramatic increase in international support for addressing other global health challenges from malaria to family planning to maternal and child health. It is an accomplishment of which every American may feel deeply proud.

This Task Force finds that leadership on the new emerging global health crisis of NCDs in low- and middle-income countries is vital to U.S. interests—in improved global health, increased trade and development, and U.S. standing in the world. The means by which that leadership is demonstrated, however, must be different from U.S. interventions on HIV/AIDS.

The United States cannot solve the NCD crisis emerging in developing countries. Determining health priorities and allocating resources in the face of this crisis are decisions for national governments. Yet, working with like-minded partners, the United States can slow the rise of this epidemic, lessen its worst effects, and help provide national governments with the time and technical assistance needed to tackle this emerging crisis sustainably on their own.

Figure 2 depicts two projections. The first (red line) is the expected increase in premature (defined in this report as under age sixty) deaths from NCDs in the forty-nine countries where the United States

FIGURE 2: PROJECTED PREMATURE NCD DEATHS IN FORTY-NINE U.S. PRIORITY COUNTRIES, 2014–2025



Underlying Data Source: Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2013.

currently has significant global health investments. The second (blue line) is the decrease in premature mortality that would occur if those countries improved NCD prevention and treatment at the same rate that the average high-income country did between 2000 and 2013. The difference between those projections is 5,166,984 lives over the next eleven years. If this outcome could be achieved or even approached, the results would be comparable to other successful U.S.-supported initiatives on childhood immunization and HIV.[2]

The Task Force recommends that U.S. investments in NCDs focus initially on the specific diseases and risk factors that are (a) especially prevalent among the working-age poor in developing countries and for which (b) effective and low-cost interventions exist that are (c) amenable to collective action and (d) can leverage existing U.S. global health programs and platforms. The Task Force applied these criteria to the NCDs that are causing large numbers of premature deaths in low- and middle-income countries but far fewer in high-income countries. That assessment provides the basis for our recommendations in three areas.

- *Challenges on which U.S. leadership would make a tremendous difference now*: primary and secondary prevention of cardiovascular disease; tobacco control; hepatitis B vaccination to prevent liver cancer; and human papillomavirus (HPV) vaccination and screening programs to prevent cervical cancer
- *Challenges on which U.S. leadership would make a tremendous difference soon*: frugal diagnostic and curative care strategies for treatable and curable cancers such as leukemia and breast cancer; and better diabetes management for low-resource settings
- *Shared challenges on which U.S. collaboration with developing countries and the private sector could help*: population-based strategies to reduce poor diets and nutrition, physical inactivity, and obesity; integration of mental health into primary care; and low-cost chronic care programs and technologies

The recommendation to increase U.S. engagement on NCDs is not one to which this Task Force comes lightly. The United States already does much to address global health, and its resources are not infinite. Yet given strong U.S. interests in addressing the rising NCD epidemic in developing countries and the availability of proven, cost-effective interventions, our conclusion is unavoidable. The time to act is now.

This report proceeds as follows. Sections one and two examine the emerging crisis of NCDs in developing countries and the factors behind its rise. Section three assesses U.S. interests in increased engagement on NCDs internationally. Section four presents a practical, data-driven set of recommendations for that engagement. Each recommendation is accompanied by a case for U.S. investment.

The report concludes with two immediate steps that the United States should take. First, the U.S. government should undertake a serious examination of its global health priorities and spending and act to ensure their continued effectiveness in advancing U.S. interests. In the forty-nine countries with the most U.S. global health investment, the U.S. government spent $44.17 in aid for each year of life lost to disability and early death from HIV/AIDS in 2010 (as measured in disability-adjusted life years, or DALYs), $4.21 per DALY lost to malaria, and $1.82 per DALY lost to tuberculosis, but only $0.02 per DALY lost to NCDs. If the United States devoted the same resources it spends at the lower end of this range—$236 million on tuberculosis in fiscal year (FY) 2014—to NCDs, it would go a long way toward implementing the

recommendations outlined in this report. The United States should consider the potential for additional funds to respond to the changing needs of these countries and the feasibility of building on the positive legacy of PEPFAR-funded programs by expanding their mandate from disease-focused goals to more outcome-oriented measures for improving health.

The costs and the burden of action on NCDs should not be borne by the United States alone. The second step that the United States should take is to convene the leading actors and potential partners for addressing NCDs—national governments, intergovernmental and international institutions, philanthropic foundations, nongovernmental organizations (NGOs), and private companies, especially large-scale employers operating in heavily affected countries. The purpose of this convening should be to develop a practical, well-prioritized, and sustainable plan for collective action on the global health crisis of NCDs in low- and middle-income countries.