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CEMI

20 May 2020

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ABSTRACT

The debate between the US and China about the responsibility for the COVID-19 pandemic raises important questions about the obligations of national governments in the global health care domain. Whereas the US attempts to put the blame on China do not have any serious legal or moral justifications, there is certainly a rationale for the establishment of certain minimal standards in the provision of health care for particular countries. Externalities in the global health care protection are too obvious – costs of underinvestment into the national health care system are borne not only by the country in question, but by the whole world.

It is argued that countries should have certain obligations in providing health care services and protecting the population from diseases, especially infectious diseases, similar to the obligations in the framework of the responsibility to protect (R2P) concept that requires countries to protect their citizens from human rights violations. From the point of view of ensuring high life expectancy at a given level of per capita income and spending on health care, China is doing better than many other countries, including the United States that has high per capita income, spends 17% of GDP on health care, but does not provide universal access to health care and lags behind countries with a similar level of economic development in terms of life expectancy (79 years).

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In early 2020 the US and China were blaming each other for spreading the coronavirus. American politicians are seriously talking about taking China to court for the damage it did to the US and/or imposing sanctions intended to punish China and influence its behavior. The US withheld their contribution to the World Health Organization, accusing it in acting in Chinese interests. U.S. President Donald Trump and Secretary of State Mike Pompeo have repeatedly blamed China for the damages caused by the COVID-19, and Missouri Attorney General Mr. Schmitt even filed a lawsuit against China.

"The Chinese government lied to the world about the danger and contagious nature of COVID-19, silenced whistleblowers, and did little to stop the spread of the disease," Mr. Schmitt said. "They must be held accountable for their actions." He believed that Missouri residents have suffered possibly tens of billions of dollars in economic damages[1].

Of course, there is no legal basis for US claims to get compensation and there are no legal ways to force an unwanted policy on a country that is a permanent member of the UN Security Council and enjoys a veto power. The question is, however, whether the world order should be changed in the future, so that such measures become possible?

If the responsibility to protect (*R2P*) concept is extended to public health domain, the performance of the US that does not have the universal health care insurance, spends more than other countries on health care as a % of GDP (17%), but lags in terms of life expectancy, would be considered substandard. The US record in fighting the 2020 coronavirus pandemic poses additional questions about the adequacy of the American health care system. On the contrary, Chinese performance is quite impressive on all these counts.

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[1] Coronavirus: Missouri sues Chinese government over virus handling. BBC News, April 22, 2020 (https://www.bbc.com/news/business-52364797).

Responsibility to protect concept and global health care system

The Responsibility to Protect (R2P) concept is a global political commitment of sovereign countries to protect all populations from mass atrocities, crimes and human rights violations; it was endorsed by all member states of the United Nations at the 2005 World Summit. Should we extend this responsibility beyond cases of genocide, ethnic cleansing, war crimes and crimes against humanity, so that the R2P includes also the commitment to protect the population in case of pandemics and natural disasters? If a country does a poor job in protecting its own population from diseases, tsunamis and earthquakes, should the international community (on the decision of the UN Security Council) have the right and the obligation to intervene?

Consider the current coronavirus pandemic. It is extremely interesting from the scientific point of view to find out from where the virus originated initially, but for establishing a legal and moral responsibility, it does not really matter, whether it came from the wet market, from the bio laboratory in Wuhan, or from elsewhere, as long as the spread was not intentional and the sanitary and safety regulations were not violated. For the future though, it would be good to adopt additional regulations that prevent the uncontrollable spread of the viruses.

In particular, these regulations should be associated with the proper standards for sanitary conditions, for the national health care systems and for the capacity of countries to introduce proper quarantine measures in cases of pandemics. It is widely accepted by experts in public health economics that health care is an area with a lot of externalities – social returns from the investment into health care are greater than private returns, and hence this investment should be financed by the state. The same goes for the national spending on health care – global benefits from spending on health care are greater than the national benefits, whereas the costs of underinvestment into the national health care system are borne not only by the country in question, but by the whole world.

Imagine unimaginable today – the world without borders with a democratically elected benevolent social planner fixing the global health care system so as to make it beneficial for all leaving no one

behind. She will probably be following a strategy based on (but not limited to) several general principles.

**Global health care system for all**

First, countries have a responsibility to ensure a certain level of life expectancy of their citizens provided they have a certain level of economic development (per capita income). As fig. 1 suggests, there is a strong correlation between per capita income and life expectancy, but some countries are doing better than the others. China, Japan and many EU countries have higher life expectancy than their income per capita suggests, whereas South Africa, Russia, Saudi Arabia and the US have lower life expectancy than could be predicted given their purchasing power parity (PPP) per capita GDP. Usually this happens when income of the countries is distributed unevenly and access to the healthcare system is not the same for rich and poor. As fig. 2 shows, there is an obvious negative relationship between life expectancy and income inequalities, as measured by Gini coefficient of income distribution, even without control for the level of development.

Figure 1. Life expectancy and PPP GDP per capita in G20 countries in 2017
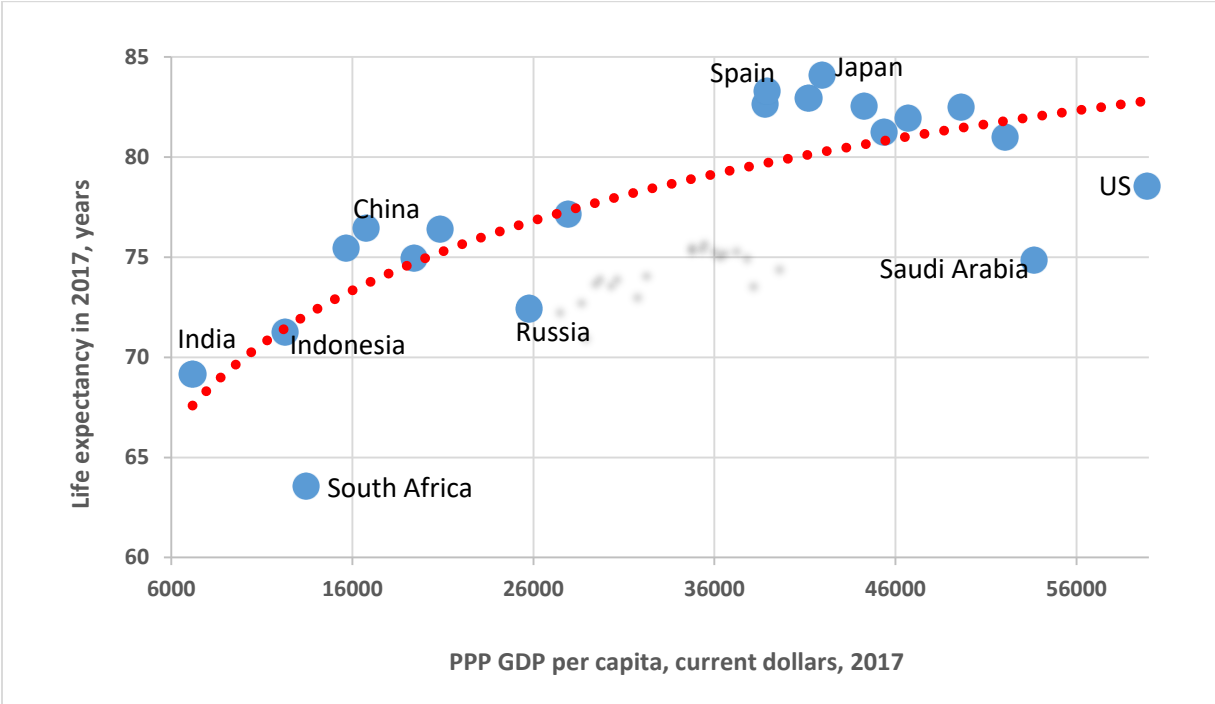
Source: WDI.

Figure 2. Life expectancy and Gini coefficient of income distribution in G20 countries in 2017
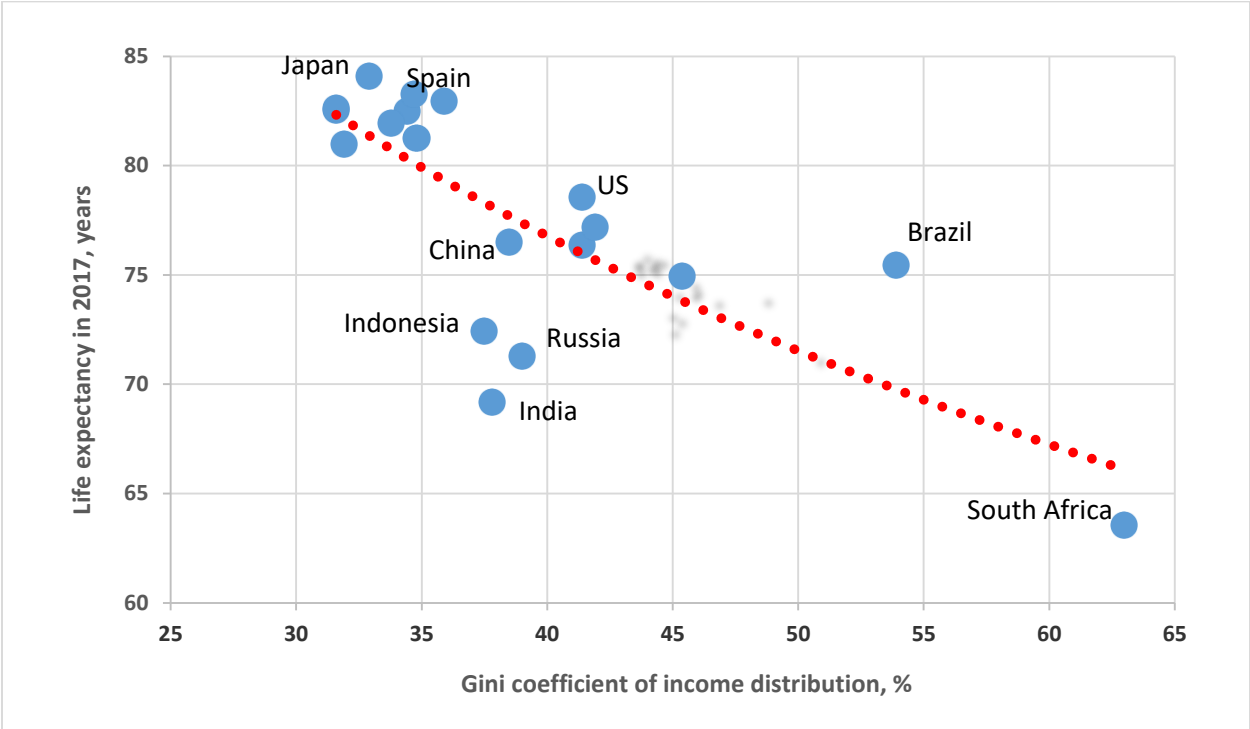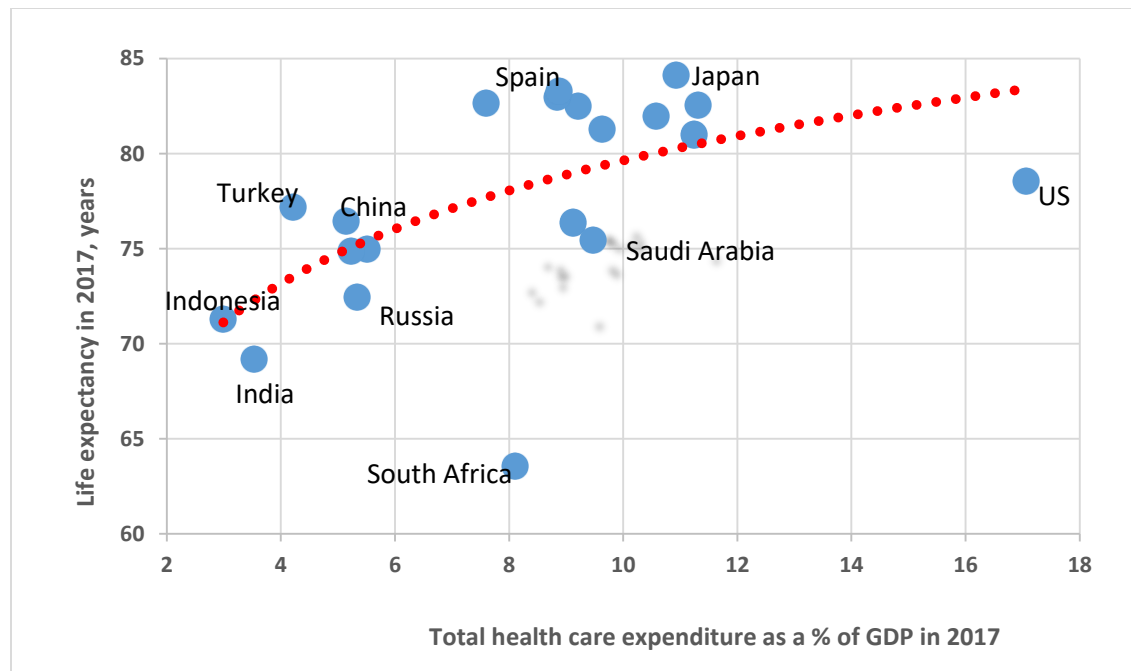

Source: WDI.

In general, in former communist countries income inequalities were low and the access to health care was free and rather universal. Even after the mortality crisis in the 1990s life expectancy in former communist countries was on average 5 years higher than in other countries with the same level of development (Popov, 2018). In China universal access to health care that existed before the market liberalization 1979 reforms was weakened in 1980-90s, but strengthened afterwards with the creation of the national health care insurance system and especially after the SARS 2003 epidemics. In the USSR in the 1960s life expectancy reached 70 years – nearly the same as in much richer developed countries, but in the 1990s there was a mortality crisis associated with the transition to the market and life expectancy fell by over 5 years (Popov, 2018, 2020).

In any case, it is the responsibility of the national governments to ensure that life expectancy of the citizens is commensurate with the economic potential of the country.

Second, countries have a responsibility to ensure that the health care system is efficient, i.e. that a certain level of health care spending results in the commensurate life expectancy. As fig. 3 shows, there is a correlation between total health care spending as a % of GDP and life expectancy, but South Africa, Saudi Arabia and the US are below the regression line, i.e. their health care spending produce worse results in extending life expectancy than in other countries. The reason is usually the same – health care spending is not distributed evenly among the population, so that the rich have better access to health care than the poor.

Figure 3. Life expectancy in years and total health care expenditure as a % of GDP in 2017 in G20 countries
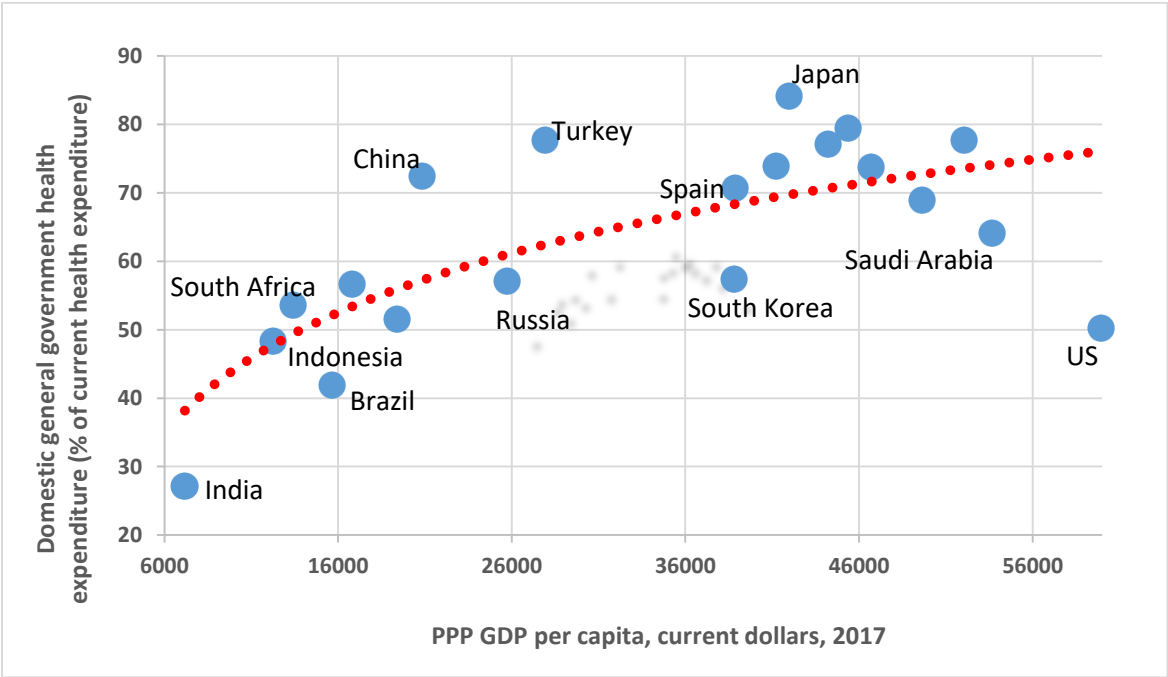

Source: WDI.

Third, national governments have a responsibility to guarantee a certain minimal level of access to the health care system for all citizens irrespective of their income. Fig. 4 shows the relationship between the share of government in total (public and private) health care spending and per capita income – generally the share of the government increases with the rise in per capita

income. But there are some outliers – in India, Brazil, South Korea, Saudi Arabia and the US the share of private financing is higher than in countries with similar level of economic development. For countries with the relatively even income distribution (South Korea, for instance) this pattern cannot not push life expectancy below the trend (fig. 1), but for other countries it decreases the efficiency of health care spending and lowers life expectancy. South Africa with one of the most uneven income distribution in the world (Gini coefficient exceeding 60%) is a case in point: over half of its relatively high (8% of GDP) health care spending comes from the government (fig. 3, 4) – better indicator, that in countries with similar income levels, but this is not enough to raise its life expectancy (only 64 years) to the level of the similar income per capita countries, such as Indonesia with life expectancy of 71 years (fig. 1).

Figure 4. Government health expenditure (% of total health expenditure) and PPP GDP per capita in 2017 in G20 countries

Source: WDI.

Finally, fourth, national governments should be ready and able to introduce quarantine and isolation of the infected individuals in case of epidemics. At the time of writing (May 2020) the coronavirus pandemic is not over**,** the analysis of the relative performance of countries is yet to be completed, the lessons are yet to be derived, but as preliminary statistics suggests, death rates from COVID-19 differ between countries by two orders of magnitude – from several to several hundred per 1 million of inhabitants (fig. 5).

Figure 5. Death rate from COVID-19 per 1 million inhabitants by May 10, 2020 in G20 countries, log scale
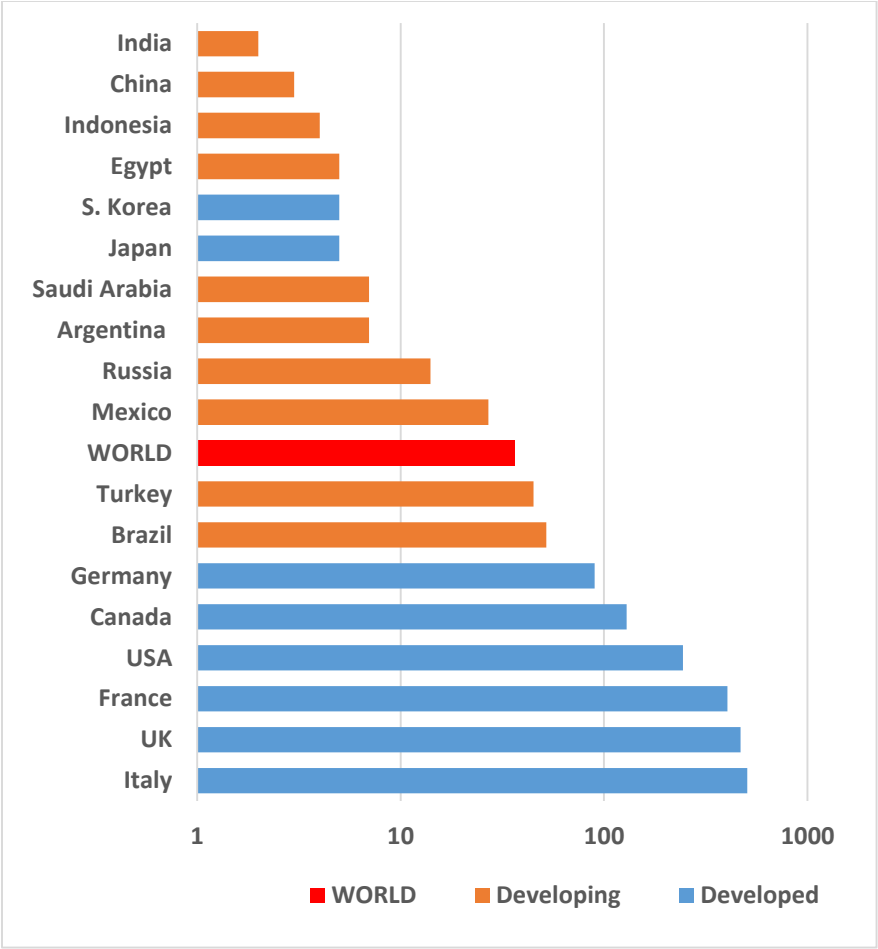
Source: Worldometers (https://www.worldometers.info/coronavirus/).

Partly these differences are explained by statistical deficiencies: the higher the number of tests, the higher the number of infections and the higher the number of registered corona-deaths – that is why developed countries on average have higher corona death rates than developing. The final analysis should be possible when the information of monthly death rates by countries would be available, so that monthly 2020 rates could be compared with the rates for the same months of the previous years to compute excess deaths (MOMO, 2020).

But another likely explanation is the ability to carry out symptomatic tracking (even without testing) and isolation – here East Asian countries and MENA countries performed way better than most developed countries, where strict tracing, isolation, and lock down quarantine measures were often regarded as a violation of human rights.

Conclusion

On all four counts China performed so far way better than the US – its life expectancy is higher than in countries with similar per capita income and similar health care spending as a % of GDP, its government spending on health care is higher than in countries with same level of development, and its ability to contain epidemics via symptomatic tracking and isolation was really miraculous and surprised the whole world.

If there is a global benevolent social planner or even if the international community (UN, WHO) adopts R2P principles with respect to health care systems, China would deserve a lot of praise and a bonus, whereas the US performance would be considered substandard. This kind of comparison of relative performance will not have any legal consequences unless there are new international treaties and new powers are given to the UN and WHO. But it would impose important moral obligations on respective countries.

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