The global healthcare system after the coronavirus: Who has the responsibility to protect?

Posted on May 12, 2020

Vladimir Popov

Tokyo, Japan, in the third week of a nationwide Covid-19 lockdown. (Credit: Carl Court/Getty Images AsiaPac/Getty Images News)

The US and China are blaming each other for the spread of the coronavirus. American politicians are seriously talking about taking China to court for the damage it has done to the US and/or imposing sanctions intended to punish China and influence its behaviour.

Of course, there are no legal mechanisms to force China to pay ‘compensation’ to the US and there are no legal ways to force an unwanted policy on a country that is a permanent, veto-possessing member of the UN Security Council. The question is, however, should the world order be changed in future so that such measures become possible?

The global healthcare system and the responsibility to protect

Something that does already exist is the concept of the 'responsibility to protect' ('R2P'), a global political commitment from sovereign countries to protect all populations from mass atrocities and human rights violations; this 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 also includes the commitment to protect populations in cases of pandemics and natural disasters? If a country does a poor job of protecting its own population from diseases, tsunamis, and earthquakes, should the international community, as decided by the UN Security Council, have the right and the obligation to intervene?

Consider the current coronavirus pandemic. From a scientific point of view, finding out where the virus originated is extremely interesting, but when establishing legal and moral responsibility, it does not really matter whether it came from a wet market, from a bio laboratory in Wuhan, or elsewhere, as long as its spread was unintentional and sanitary regulations were not violated.

The adoption of additional regulations to prevent the uncontrollable spread of viruses is, however, important. These regulations should provide standards for national healthcare systems, including standards for capacities to fight the spread of infectious diseases, and obligations to introduce proper quarantine measures in cases of pandemics.

Experts in public-health economics broadly affirm the idea that healthcare is an area with lots of externalities; social returns from investment in healthcare are greater than private returns and, hence, this investment should be financed by the state. The same goes for national spending on healthcare; the global benefits from healthcare spending are greater than the national benefits, whereas the costs of underinvestment in a national healthcare system are borne not only by the country in question but by the whole world.

Imagine the unimaginable today: a world without borders, “all the people living life in peace” with a benevolent, democratically elected social planner to fix the global healthcare system, making it beneficial for all with no one left behind. Such a planner would probably strategise using several general principles.

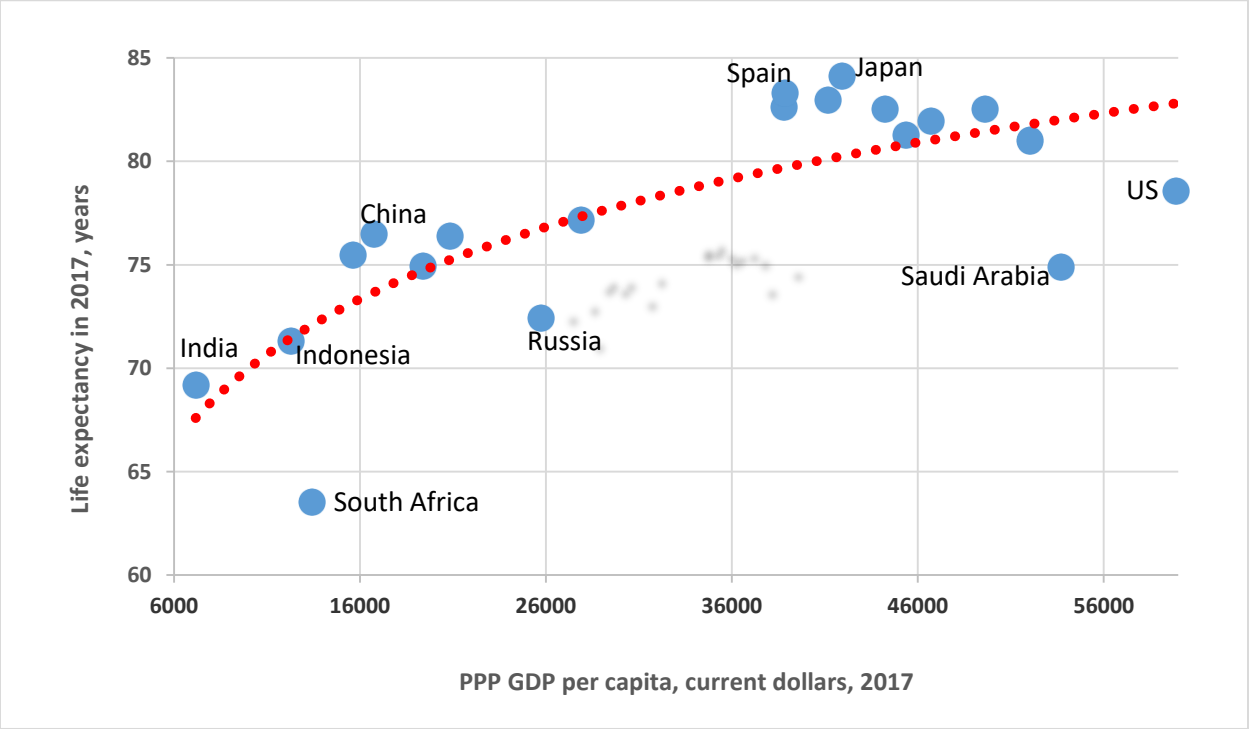
Life expectancy and economic development

First, countries have a responsibility to ensure a certain level of life expectancy for their citizens, provided they have a certain level of economic development (per capita income). As figure 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 would suggest, 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 the income of a country is distributed unevenly and access to the healthcare system is not the same for rich and poor.

Generally, income inequalities in former communist countries were low and access to healthcare was free and near-universal. Even after the mortality crisis in the 1990s, life expectancy in former communist countries was, on average, five years higher than in other countries with the same level of development (per capita income). In China, the universal access to healthcare that existed before the market liberalisation of the 1979 reforms was weakened in the 1980-90s but strengthened afterwards with the creation of a national health insurance system, which was further strengthened after the 2003 SARS epidemics. In the USSR, life expectancy in the 1960s reached 70 years – almost the same as in much richer developed countries – but during the mortality crisis associated with the market transition in the 1990s life expectancy fell by over five years.

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

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

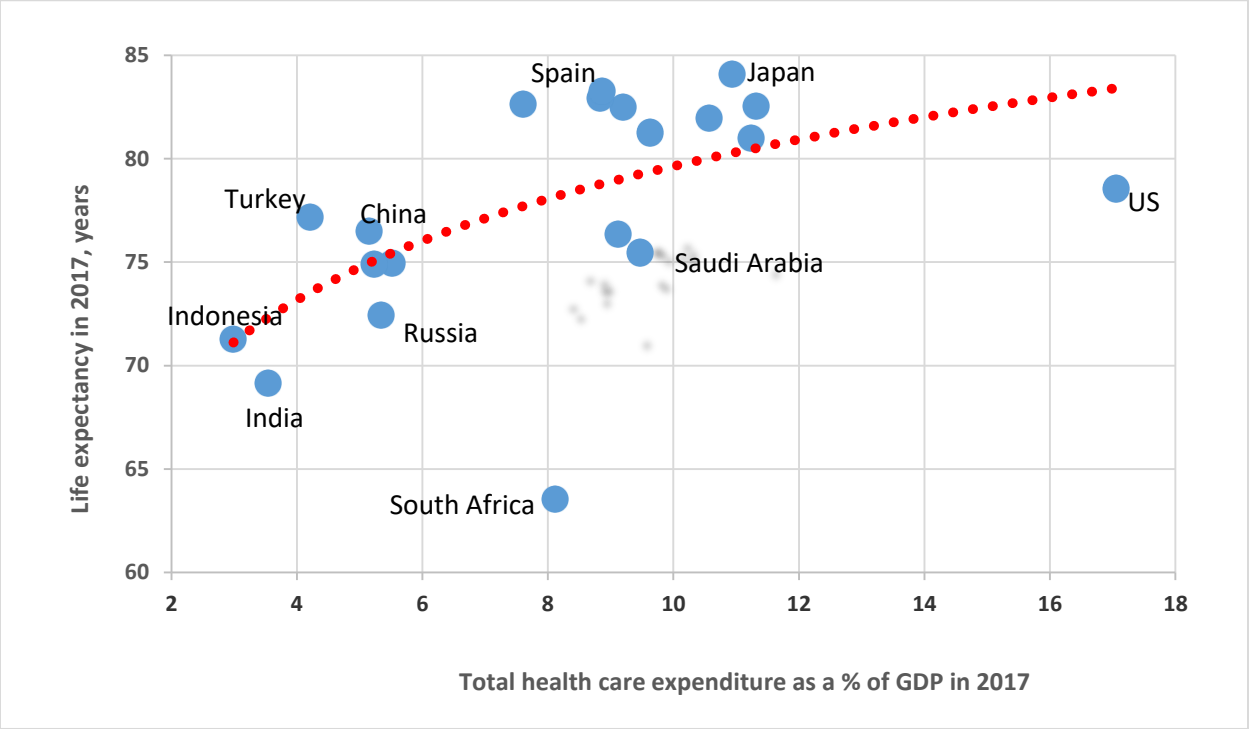


Source: World Development Indicators

Efficiency and healthcare systems

Second, countries have a responsibility to ensure that their healthcare systems are efficient, i.e., that a certain level of healthcare spending results in commensurate life expectancy. As figure 2 shows, there is a correlation between total healthcare spending as a percentage of GDP and life expectancy, but South Africa, Saudi Arabia, and the US are below the regression line, i.e., their healthcare spending produces results that are inferior to other countries in terms of life expectancy. The reason is usually the same: healthcare spending is distributed unevenly; the rich have better access to healthcare than the poor.

Figure 2: Life expectancy in years and total healthcare expenditure as a percentage of GDP in 2017 in G20 countries



Source: World Development Indicators

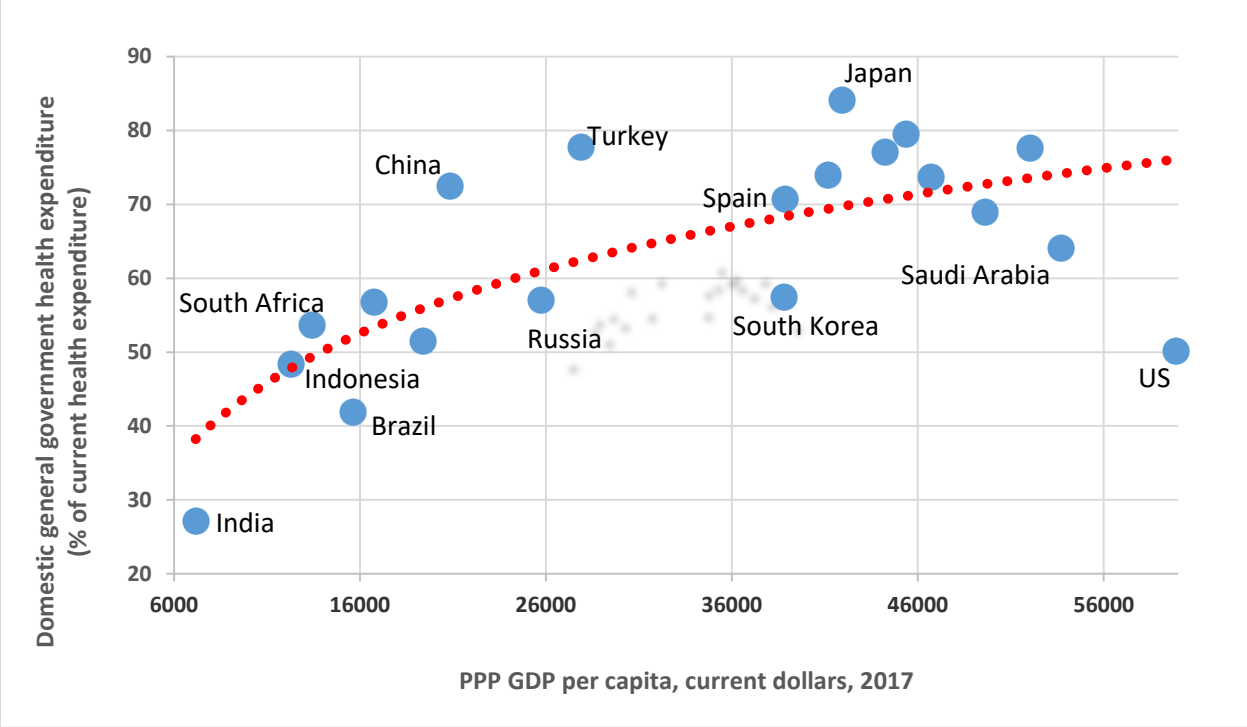
Accessing healthcare is key

Third, national governments have a responsibility to guarantee a minimal level of access to their healthcare systems for all citizens, irrespective of their income. Figure 3 shows the relationship between the share of government spending in total (public and private) healthcare spending and per capita income: generally, the share government spending in total spending increases with rises in per capita income, but there are outliers – in India, Brazil, South Korea, Saudi Arabia, and the US, the share of private financing is higher than in countries with similar levels of economic development.

For countries with a relatively even income distribution (South Korea, for instance), this pattern cannot push life expectancy below the trend (fig. 1), but for other countries, it reduces the efficiency of healthcare spending and lowers life expectancy. South Africa has one of the most uneven income distributions in the world – it has a Gini coefficient exceeding 60% – and is a case in point:

over half of its relatively high (8% of GDP) healthcare spending comes from the government (fig. 2, 3). This is a better indicator than in countries with similar levels of income, but it is not enough to raise life expectancy (64 years) to the level of countries with similar levels of income, such as Indonesia, with a life expectancy of 71 years (fig. 1).

Figure 3: Government health expenditure (percentage of total health expenditure) and PPP GDP per capita in 2017 in G20 countries

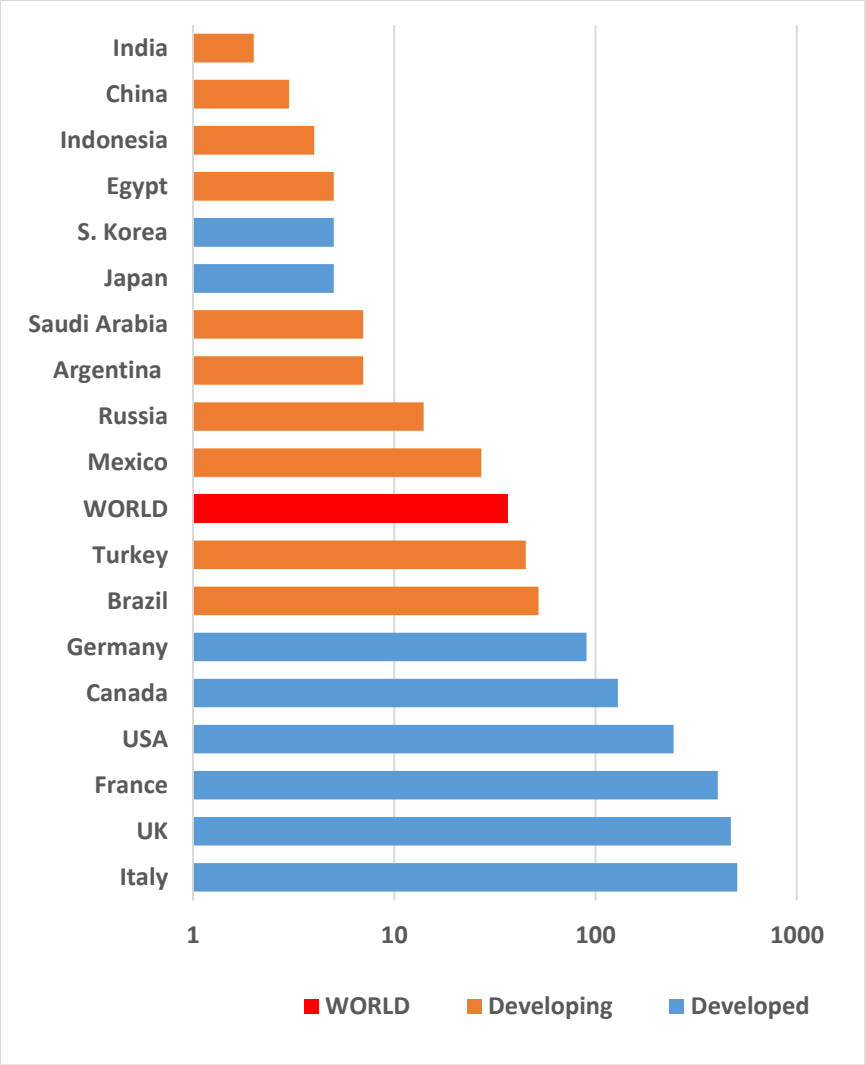


Source: World Development Indicators

Finally, fourth, national governments should be ready and able to introduce quarantine and isolation of infected individuals in the case of epidemics. The current coronavirus pandemic is not over**,** the analysis of countries' relative performance is yet to be completed, and lessons are yet to be derived. However, as preliminary statistics suggest, death rates from COVID-19 differ between countries by two orders of magnitude – from just

several cases per 1 million inhabitants to several hundred cases per 1 million inhabitants (fig. 4).

Figure 4: Death rates from COVID-19 per 1 million inhabitants by 10 May 2020, in G20 countries, log scale



Source: Worldometers.

These differences are partly 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 have higher average corona death rates than developing. But another likely explanation is the ability to carry out symptomatic tracking (without testing) and enforce isolation – here East Asian countries and MENA countries performed way better than most developed countries, where strict tracing, isolation, and lockdown quarantine measures were often regarded as a violation of human rights.

The value of performance comparisons

The bottom line is that on all four counts, China has performed – to date – far better than the US. China's life expectancy is higher than in countries with similar per capita income and similar healthcare spending as a percentage of GDP, its government spending on healthcare is higher than in countries with similar levels of development, and its ability to contain epidemics via symptomatic tracking and isolation has been truly miraculous, surprising the whole world.

If there was such a thing as a benevolent global social planner, or even if the international community via the UN and the WHO were to adopt R2P principles with respect to healthcare systems, China would deserve a lot of praise and a bonus, whereas US behaviour would be considered substandard.

True, this kind of relative-performance comparison can have no legal consequences without new international treaties and new powers for the UN and WHO. However, it could establish important moral responsibilities and create important moral obligations for respective countries.