

Charting a Future for Health in the Americas

*They that go down to the sea in ships, that do business in great waters:
these see the works of the Lord, and his wonders of the deep.*

—Psalm 107



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I was born and grew up in the parish of St. Philip on the island of Barbados. Two of the country's 11 parishes, St. Thomas and St. George, do not have a coastline. As children, we rather pitied the people from those parishes for their lack of contact with the sea. The sea played an important part in our lives and inspired many of the images of our childhood. On our vacations we did not go to the beach, we went to the sea. Many of the poems we learned had to do with the sea—John Masefield's "Sea Fever" that begins "I must go down to the seas again, to the lonely sea and the sky" and Samuel Coleridge's "Rime of the Ancient Mariner" with its memorable verse:

*Water, water, every where
And all the boards did shrink;
Water, water, every where,
Ne any drop to drink.*

We had great respect for those who went down to the sea in ships—a respect heightened by the vivid memory of some who never returned. So now, as I write my last report as the Director of the Pan American Sanitary Bureau/Pan American Health Organization, allow me to envision the Bureau as the "Good Ship PAHO" and reflect on where we have voyaged in the past and what course we might chart for the future.

This is the year of our Centennial. Much has been written of this institutional odyssey of 100 years. The countries have chronicled experiences in health as they bear witness to, and celebrate, the history of the Organization. Indeed, our work together has borne rich fruit: sustained progress in health throughout the Americas. Major contributors to that progress have been an appreciation of the value of health at the highest political levels in all the member countries and the application of appropriate technologies to secure it. Above all, the dedication of countless hundreds of thousands, if not millions, of health workers in the countries has made the difference. I never tire of saluting them as heroes of health in the Americas.

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This report will offer some measure of retrospection on the work of the Bureau in recent years. It will attempt to do so expressing neither the triumphalism derived of accomplishment nor defensiveness regarding things left undone. It will describe achievements that have resulted from the partnership between the Bureau and the countries of the Americas. It will attempt to project a representative picture of the many facets of an institution committed to responding to the various mandates and aspirations of those who have guided it over a century. And it will demonstrate the results of the emphasis I have given to information from the beginning of my administration.

In this introductory essay, however, I will pay more attention to forecasting the challenges that will face Good Ship PAHO, the shoals and the rocks she will encounter, and the winds that will buffet her. I will focus on the strong currents—the great “transitions”—that are occurring in our world and that are conditioning pursuit of the public’s health. These transitions have affected, and will continue to affect, both the charting and the steering of our course.



Much has been written of the “health transition”—a composite term to express changes in the pattern of disease that result mainly from demographic and epidemiological transitions as well as the ever-changing exposure to environmental risks (1, 2). Omran, in his seminal work (3), focused on the causes of mortality and described the epidemiological transition in terms of three major phases characterized, respectively, by pestilence and famine, receding pandemics, and man-made health problems resulting in chronic and degenerative diseases. Three decades later, he modified this concept—which he saw as too simple, too related to the history of industrialized countries—and introduced intermediate phases that depended on a country’s stage of development (4). Clearly, countries and populations do not move irrevocably and discretely from a stage in which they are concerned uniquely with great infectious disease epidemics to one in which such epidemics are replaced by concern with diseases associated with longer life spans and individual behavior.

In the Americas, all the countries are contending with an epidemiological mosaic comprised of a wide range of diseases and health problems. So it is not a question of one stage of the transition ending and another beginning. What matters are the nature of the change underway

and its pace. Infectious diseases have always been, and will always be, with us. The major contributor to the most fundamental demographic shift in the Americas has been the conquest of the main causes of early childhood mortality. Improvements in nutrition and public health successes in combating infectious diseases of the young have figured prominently in reducing child mortality, followed by a decline in female fertility. This decline in fertility, subsequent to a fall in child mortality with varying lag periods, is a universally observed phenomenon (5). I have always had difficulty, however, in accepting that the former is caused by the latter, as a host of intervening factors influences both trends, independently.

One aspect of the health transition that has not been given sufficient prominence is the change in the determinants or vectors of the various diseases or health problems and, consequently, the different approaches required to deal with them. Pasteur made it easy for us to understand the microbial cause of disease. Less discernible is the insidious nature of information when it is used inappropriately or, in its vulgar form, propaganda, as the vector or agent of modern diseases shaping the epidemiological picture. The three most egregious examples are modern epidemics related to changes in behavior (a term I prefer to “lifestyle,” since behavior can be modified)—namely smoking, alcoholism, and obesity. While the litigation and related large sums of money involved in the debate about tobacco use are giving the smoking epidemic tremendous prominence, the obesity epidemic has crept silently upon the world, attracting far less attention.

Its history shows that paho has always taken cognizance of the changes implied by the health transitions. The aim of much of our work over the past 100 years has been to reduce the threat of infectious diseases through attention to environmental factors, as well as through introduction of technologies to improve the health of children and reduce childhood mortality. It remains to be seen if we will be similarly effective in assisting countries to deal with newer transitions. Doubtless, new tools will be needed to cope with new epidemics, and new vectors will be found. There will be more emphasis on applying health promotion strategies—as I argued in my report of last year (6). Promulgation of the strategies of health promotion will not, however, suffice. Information must be granted its



proper role as a tool both for monitoring transitions and for effecting the changes that result in better health (7). When the problem lay predominantly in preventing the infections responsible for the great pandemics, information may have been a less essential public health tool. Today, however, the effective management of information is critical to stopping the spread of new pandemics, whether infectious or noninfectious in origin. There is now, for instance, no debate about the power of appropriate information in halting the spread of hiv/aids. In spite of our long history, PAHO and organizations like ours are still neophytes in understanding the application of modern concepts and technologies for using information appropriately to change behavior. I am not sure whether, in the nautical sense, I should cast information as our rudder or our sail.



We are fond of referring to ours as the “Information Age” and forget that every age has been one of information. The changes wrought by Gutenberg’s movable-type printing press in the spread and use of information may have been every bit as profound as the changes we are witnessing now. What is different today is not only the speed at which information is transmitted, but the reduced cost of its transmission. This cheap and rapid dissemination of information has had profound political repercussions in our time. Much of the political power, once centralized, is now decentralized. It has also rendered the borders between nations more porous and permeable to the spread of information—information that in many cases is injurious to health. The modern epidemics that I mentioned above—tobacco, alcohol, and obesity—are spread across borders by the facile dissemination of information in the form of advertisement, making it difficult for individual nations acting alone to deal with them.

Although the concept of global public goods has become popular recently, paho has managed information as a global public good from the moment of its founding. Stiglitz refers to knowledge as a “global public good” and claims that “the efficient production and equitable use of global knowledge require collective action” (8). I would prefer to use the term “information” in this context instead of “knowledge.” Today more than ever, health information fulfills the criteria of a global public good in that it is non-rivalrous (no additional cost incurred with more persons using it) and non-excludable (no one can be excluded from using it). The challenge for paho will be to continue to produce and use information as a global public

good, while demonstrating the value of a voluntary cooperative system that is the basis for our existence.

Another one of the great changes that has influenced us, and will continue to do so, is our form of interaction with the countries: a transition of relations. In the first quarter-century of the Bureau's existence, the main form of our cooperation was the collection of information on the health situation in the countries and its dissemination to the membership. On 2 December 1902, the president of the first meeting of the Bureau, Dr. Walter Wyman, Surgeon General of the United States, summarized this principal role:

We have come together to give one another interesting and necessary information about ourselves, to give encouragement by telling of the good work that is going on in each Republic, and at the same time, in a fraternal manner, to confess the shortcomings of each, with the confident assurance of that sympathy and aid which one member expects confidently of the other members of a family.

The purpose of sharing information was to enable countries to protect their borders. Knowledge of disease elsewhere was essential to preventing its entry into other countries. Thus, proceedings of the Bureau's early governing body meetings dealt largely with the efficacy of quarantine measures and maritime disinfection.

With the appointment of Dr. John D. Long in 1923 as the Bureau's first travelling representative, another transition began: the Bureau took on the role of assisting countries to improve their health status. Long traveled throughout the Americas advising mainly on the application of sanitary measures that could relieve the burden of disease. The institutional emphasis, however, was still very much on preventing disease within the borders of individual countries.

The second half of the century witnessed yet another change: a great shift towards multilateralism, as activities became largely inter- or multicountry. Given the prevailing spirit of Pan Americanism, an appreciation of the intercountry movement of vectors, and the increasing availability of technology, countries began to target the prevention and control of diseases in the Americas as a whole—as in the case of immunization programs as well as of initiatives such as the recent Regional



Commission on Food Safety. In addition to the increase in multicountry activities that are continental in scope, countries began to cooperate with one another, with the Organization acting as facilitator of that cooperation. I am firmly convinced that, today, there are useful experiences and pertinent expertise to be found in all the countries of the Americas, the sharing of which will be of universal benefit. This transition—from within country to multi- and intercountry—has challenged the Organization to adapt the form and focus of its technical cooperation. Henceforth, it will be necessary for paho to identify problems whose solutions can result from continental initiatives and to use its knowledge of and presence in the Region to ensure a symmetry of benefits that will encourage sustained collective endorsement of the hemispheric approach. All the while, we must remain sensitive to the precious sovereignty of nation states, so that our Organization will be perceived to be equally relevant and useful to Belize and Brazil.



A transition underway in the political world—one aggravated by the events of 11 September 2001—can also be expected to affect our work. The nation state as we know it, at least its European version, took definitive shape after the Thirty Years' War with the signing of the Treaty of Westphalia in 1648. This saw the end of the feudal system, the decline of the Holy Roman Empire, the end of religious wars, and the growth of the modern nation state that would assume responsibility for the social arrangements necessary to ensure order and protection of the basic rights of its citizenry. The unitary state was the dominant paradigm for some 300 years. It follows that, when the Bureau was founded in 1902 and when the Pan American Sanitary Code was created in 1924, the participants and the signatories were duly accredited representatives of the governments of the Americas. Even today, participation in our governing bodies is by persons who come duly accredited by their national governments. The multilateral system, with the United Nations as its epicenter, was an arrangement among sovereign states at a time when the state and the government were almost coterminous.

Over the past century, however, the pluralism that marked the Middle Ages has begun to reemerge—what Peter Drucker calls “a congeries of autonomous and semiautonomous institutions,” each concerned with its own cause, values, welfare, and aggrandizement (9). Actors outside of

government are growing in number, making their presence felt, and claiming a voice—often stridently—in decisions that affect the citizenry as a whole. The best recognized of these actors are what is called civil society and the more clearly defined private sector.

This political transition characterized by the growth of pluralism presents a number of challenges. First, there is the issue of governance in entities like ours that are intergovernmental in the sense that a collection of governments representing sovereign states constitutes the membership. Increasingly, nongovernmental actors are seeking to participate in the governance of all international agencies. The day will surely come when our Organization with its current governance structure will have to address the claims of these other actors—commercial enterprises as well as civil society organizations—for meaningful participation. Their claims will be buttressed in part by the argument that they are already “international” as they have allegiances and networks that cross national boundaries. The United Nations and the World Bank have experimented with approaches to consulting various institutions of civil society, taking into account all the caveats about their legitimacy.

The formation of the United Nations in 1945 represented the hope of the world for a multilateral system that would put the common interest and welfare of mankind to the fore. Over time, however, we have seen a slow erosion of interest in multilateralism and a steady growth in the unilateral approach to solving many of the world’s problems. The undisputed world dominance of the United States in so many fields led inevitably to the perception of a predilection for unilateral action. It is a matter of great satisfaction for us, however, that in the case of health and in the Americas, the United States has been a genuine partner in the Pan American approach to the health problems of our continent.

There is general agreement, however, that on the wider scene the terrorist attacks of September threw into sharp relief the need for there to be a re-examination and a re-appreciation of the absolute need for multilateralism in the approach to some of the problems that appear to be the most intractable. Joseph Nye, in his book *The Paradox of American Power—Why the World’s Only Superpower Can’t Go it Alone*, examines the role of the superpower in this new world (10). His analysis has profound relevance for us in a health organization. He traces the growth



and development of social, economic, and military globalization and the effect they have had in polarizing the distribution of power. He says, “power today is distributed among countries in a pattern that resembles a complex three dimensional chess game.” On the top board, military power is largely unipolar, with the United States undoubtedly dominant. In the middle there is economic power, which is multipolar but with the power concentrated in a few countries. “The bottom chessboard is the realm of transnational relations that cross borders outside of government control. On this bottom board, power is widely dispersed.” It is at this third level that influence is wielded through what he calls “soft power”—the power to co-opt rather than to coerce—the power that is derived from shared values and appreciation of genuinely public goods—the power that becomes ever more awesome in a world that is increasingly globalized through the speed and cheapness of the spread of information.

International order is one of those public goods that are of critical importance for all nations, and this is assured in large measure by the exercise of soft power. I have no doubt that international order will be facilitated by the provision of health internationally—the provision of a state of health to all the world’s people such that there is alleviation of the poverty and deprivation that breed dangerous tensions. As the Gallup Millennium International Survey has shown, health is valued above all else by the poor (11). Health organizations like ours must promote appreciation of the value of health as a good in its own right and also as a contributor to international public order. Indeed, in the chessboard taxonomy of Nye, the only power in our hands is soft power. It is our ability to facilitate exchange, provide the information that allows for identification of health patterns and health risks, and promote shared values and principles that are appropriate for an intergovernmental social entity.

The growth of pluralism within the nation states must not blind us to the fact that there are certain responsibilities that devolve on the state and cannot be avoided or delegated. Even though, as I have pointed out above, the borders of nation states are becoming more and more porous, enabling the international spread of propaganda that leads to certain health risks, the state still must discharge its responsibility for countering those risks. While collaborative health protection and promotion efforts within global and regional contexts will always be important, a basic responsibility still falls on

the state. The kind of global governance that arrogates from the state the basic responsibilities for promoting health and combating some health risks is a transition that we are unlikely ever to see.

The last of the great transitions that paho must negotiate is the social transition, which will come in many forms. One of the more important will be the ever-changing role of women. The trend for increasing participation of women in the work force has been adjudged to be one of the causes of disintegration of the traditional family structure with consequent social disruption and increased violence (12). The change has meant that there have to be other arrangements made for the care of children. It has been argued that those aspects of primary care that dealt with child development represented an undue burden for women and were likely to be neglected as more women entered the workforce. The data for the Americas do not seem to bear this out, however, as in all countries child health has continued to improve. Of more significance is the increased attention to the education of women, particularly young girls, with the well established effect of reducing fertility and improving child health (13). Recognition of imperfections in the attention to women in health care services must lead to a greater commitment to respond to the needs of women other than those related to their biology (14). This inappropriate care of women in the health services is but another manifestation of the gender inequity that is so pervasive and goes much beyond the domestic violence that is so common. The health of women apart from their reproductive roles will be one of the challenges for all the countries of the Americas. With increased entry into the workforce, there will be work-related health problems that are not considered at this time, and this is not a problem related to a country's level of economic development.

The changing role of women will have positive implications for our Bureau. We are pleased at the increased incorporation of women into our staff, where currently 45% of professionals are female. This increasing proportion will prompt consideration of different forms of work, so that accommodation can be made for other legitimate roles.

But the most significant of the social transitions taking place results from the apparently inexorable drift towards the liberal market economy—driven in part by economic globalization. Some would contend that the



magnitude of the change we are experiencing is unprecedented. The headlong rush is towards a global cosmopolitan society with hitherto unknown risks and dangers (15). Others will posit that globalization is not a new phenomenon. It was in full bloom at the beginning of the 20th century: in 1913 merchandise trade, as a percentage of global trade, reached a level that was not achieved again until the decade of the 1970s, and a similar phenomenon occurred with international capital flows (10). It is argued that that era of globalization came to a sorry end with the great social disruptions and wars of the mid-20th century, because of the social inequalities that resulted (16). The question is whether this new wave of economic globalization, which is unquestionably producing an increasing social inequality, will suffer the same dismal fate. The optimistic view is that the social safety nets put in place as a result of the first debacle will prevent a similar occurrence of massive social unrest. It is not clear, however, that such nets are the norm in most of the poor countries of the world. This aspect of the social transition will present a major challenge for PAHO. We will have to argue and prove that one of the ways to avoid unrest is to invest appropriately in health as a means of reducing poverty (17, 18). Such investment may also contribute to reducing the social inequality that is a marked phenomenon of our Region. Promoting social inclusion in terms of services will be particularly important in the Americas, where services for the population are so often segmented and so many work in the informal sector. In addition, PAHO should proceed with its path-breaking work on developing core health data and assisting countries in focusing on the distribution of health outcomes as well as their determinants.



I have outlined some of the major transitions that I regard as the currents that the Good Ship PAHO must note and log as it charts its course for the future. The Organization will not be able to avoid them and, indeed, must even take advantage of those that are favorable. Unfortunately, as is the nature of currents, they do not necessarily flow together or in the same direction nor with the same force. The transitions that are driven by technology and many of the aspects of globalization are evolving much more rapidly than the social transitions. Such is their nature. In addition, we often observe a “concertina effect” with many of these changes, as they are apt to be squeezed together and compressed because of other transitions acting upon them.

I have no doubt, however, that the ship will be steady and that those who come after me will do business in great waters, and the wonder they will see will be the ever-improving health of the people of the Americas.

Ave et vale—hail and farewell!



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