



Hugh R. Leavell Lecture
**“The End of Public Health As We Know It:
Constructing Global Health in the 21st Century¹”**

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INTRODUCTION

The present, says the novelist Carlos Fuentes, is merely the accumulation of the frustrated goals of the past: *“There is no single time: all of our times are alive, all of our pasts are present.”*

There is practically no field for which this sentence applies more at this point in time than the field of global public health. The past is very much alive: just a plane ride away people die of old and new plagues next to fancy tourist resorts and here in the developed countries we fear the next global epidemic that this time around might not spare our part of the world.

Public health rarely works through magic bullets – and public health professionals need what the poet Adrienne Rich has called *“wild patience”* combining ingenuity, evidence, common sense, passion, a sense of urgency and above all a sense of justice. The two public health revolutions that have changed the face of health and disease in the industrialized countries in the 19th and 20th century were the results of often harsh political and ideological battles spread out over decades which always accompanied the professional and scientific progress and discoveries. And of course the two revolutions: the control of infectious disease through health protective measures and the consequent battle against non-communicable disease are both still on going.

But the achievements of these two revolutions in the developed world stand in stark contrast to the situation in the underdeveloped countries, particularly in rural areas, where the predominant pattern is still that of infectious diseases engendered by the natural environment, such as malaria, tuberculosis and infant diarrhoea, as well as AIDS and high rates of maternal deaths. One of the key reasons for his gross injustice is that we have not applied two political and systemic lessons of the past to the developing world:

first the link of progress in public health to a wider context of social reforms and investments (such as redistribution of wealth and access to education) and **second** the lessons of the great sanitary revolution which underlined the need to build strong and sustainable public health systems.

In 1978 the Alma Ata Declaration tried to recapture this historical and systemic understanding of health development but instead the rich offered the poorest people selective primary health care – an approach that indeed turned out to be poor care for poor people. The global AIDS epidemic is one of the prices we are paying for this failure today.

Just a few years ago Lester Breslow stated that we are now in the midst of the third public health revolution. In his view the *Ottawa Charter for Health Promotion* is the document that best captures the key characteristic of this new phase of public health which he terms *“health as a resource”*. Of course I was thrilled that a public health legend of the calibre of Lester Breslow should think so highly of a document that I had been very involved with bringing into this world. And I do believe that the Ottawa Charter has significantly contributed to the rethinking and reshaping of public health concepts and practice around the world. It has been – as its subtitle depicts – a move towards a new public health.

¹ The lecture is dedicated to Joshua Cohen the most important mentor in my life.



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But the challenges to public health are now much larger and even more fundamental. **I believe that we are at a turning point for public health** – therefore the choice of title for this lecture. The changes our societies are facing are as significant as the ones encountered in the “*golden era*” of public health 150 years ago and they are truly global in nature.

In consequence, we need a new conceptual map for public health action that incorporates scientific and technological development, political, social and economic action, as well as domestic and global public health responsibilities in new ways. Geoffrey Rose’s public health dictum is truer than ever:

“the primary determinants of disease are mainly economic and social; therefore its remedies must also be economic and social.”

The major reason why we are facing a global public health crisis today is because we have neglected this dictum. **I believe our choices are stark:**

either we reorient and strengthen public health within both modern and developing societies as a joint endeavour and institute a resilient system of global governance for health or we will face dire consequences in terms of human, social and economic development. At present, it is the poorest countries that are paying the price for this negligence – but we have mounting signals that a new health divide is in the making in the developed world. Indeed it is becoming more and more difficult to define the rich and the poor of this world at the level of the nation state as a large global underclass spreads out around the globe and defies the old definitions of vulnerable groups. HIV/AIDS is only the most visible of the diseases of poverty that undermine the life chances of the poor and in a perverse and unintended consequence – as David Molyneux has shown recently and as the Global Governance Initiative Report also indicates – it might even divert much needed resources from other diseases of poverty that otherwise could be addressed efficiently.

The solutions to this crisis go far beyond the expert based answers (many of which we have). We need not only forceful public health action at nation state level in both the developed and the developing world – we also need nothing less than a **new global social contract on health**. I was delighted to see the use of that phrase also by the British Medical Journal’s Editor Richard Smith in a recent excellent editorial. The drive for such a contract can only be established politically - developed through an ethical and political debate throughout society initiated by outspoken public health professionals, responsible politicians and a concerned civil society at national and global levels of governance. And indeed I was thrilled to see the BMJ take this stance and I believe it should become the clarion call for public health associations around the world.

Since this WFPHA conference takes place in Europe I would also like to underline that I believe that the European Public Health Associations carry a special responsibility to convince European political leaders and parliamentarians to break open the public health stalemate both nationally and globally. Europe needs to take the historical step to make public health a priority within its borders and in terms of its global responsibilities.

I expect no less of a European Union than what it says in the draft of its new constitution – that it aims to “*strive for peace, justice and solidarity throughout the world.*” health a priority within their countries and in terms of their global responsibilities. **A forceful and well funded global health strategy** is the most ethical and forward looking way of paying back what Europe received during a long period of colonialism and empire.

Health lies at the core

Health lies at the core of modernity and development. It has shaped the nature of the modern nation state and its social institutions, it has powered social movements and defined rights of citizenship and it has contributed to the construction of the modern self and its aspirations. Within a very short historical time span – about 100 years - a long and more or less healthy life has become a demographic fact, a societal goal and a personal expectation within developed societies. Within an even shorter time span – about 50 years - universal access to medical care has become a trademark of industrialized welfare states.

The success of public health has changed the very nature of these societies – they have become *health societies*. I suggest they are defined by five major characteristics –

- a high life expectancy and ageing populations,
- an expansive health and medical care system,



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- a rapidly growing private health market,
- health as a dominant theme in social and political discourse and
- health as a major personal goal in life.

Each of these five characteristics (and perhaps even more their synergies) sets a challenge to public health and changes its nature and the extent of its remit - and as in the 19th and 20th centuries the resolution that is adopted will define the progress of 21st century society. How will we treat the old? How will we pay for health? Who has a right to care? To what extent will we enhance our biological capabilities? And all of this could be part of a lecture focusing on public health in post modern societies that I will give another day.

But my focus today is another challenge: **how much are we in the post modern societies prepared to share the benefit of the two public health revolutions?**

Why do we as Richard Smith states redistribute 1/4 of GNP within our own nation states in order to provide education, health care, social services and the like and share less than 1% with the world's poor? Why should our lives be worth more than that of an indigenous mother in Bolivia or a young AIDS patient in Zimbabwe?

Let us compare the characteristics of the post modern health societies with the stark reality of the poorest countries where they will remain unattainable for a long time to come as some of the calculations for the achievement of the Millennium Development Goals show.

- A falling life expectancy in many African countries
- A lack of access to even the most basic services
- An excess of personal expenditures for health of the poorest
- Health as a neglected arena of national and development politics
- Health as a matter of survival

These are the comparative statistics for maternal and child mortality for Canada and Haiti just a plane ride away in the same region of the WHO:

The infant mortality rate is 5.1 in Canada and 97.1 in Haiti, the under five mortality rate is 16.5 times greater in Haiti than in Canada, the rate of maternal deaths is 35 times higher in Latin America and the Caribbean than in North America, the life time risk of death is 1 in 7.700 deliveries in Canada and 1 in 17 in Haiti.

In view of this reality Peter Singer, the ethicist, in his Yale lectures on *"One World" (2002)* challenges us to adopt a radically new mind frame of global ethics, global citizenship and global responsibility that goes beyond health as an issue of the nation state and utilitarianism towards responsible global governance.

"Implicit in the idea of "globalization" rather than "internationalization" is the idea that we are moving beyond the era of growing ties between nations and are beginning to contemplate something beyond the existing conception of the nation state".

How committed is the developed world?

In order to do that, we have a very long way to go. An analysis by the Global Governance Initiative of the World Economic Forum – which brought together leading experts on crucial global governance issues and asked them to focus on the goals of the United Nations Millennium Declaration - came to the conclusion that *"the world is devoting less than half the effort necessary to meet any of the goals"*.

For the three direct health goals

- *stop and begin to reverse the spread of HIV/AIDS, tuberculosis and malaria*
- *reduce by two thirds the under-five mortality rate and*
- *reduce by three quarters the maternal mortality ratio, by 2015*

the Initiative gives the world a score of 4 out of 10 – clearly less than 50%.

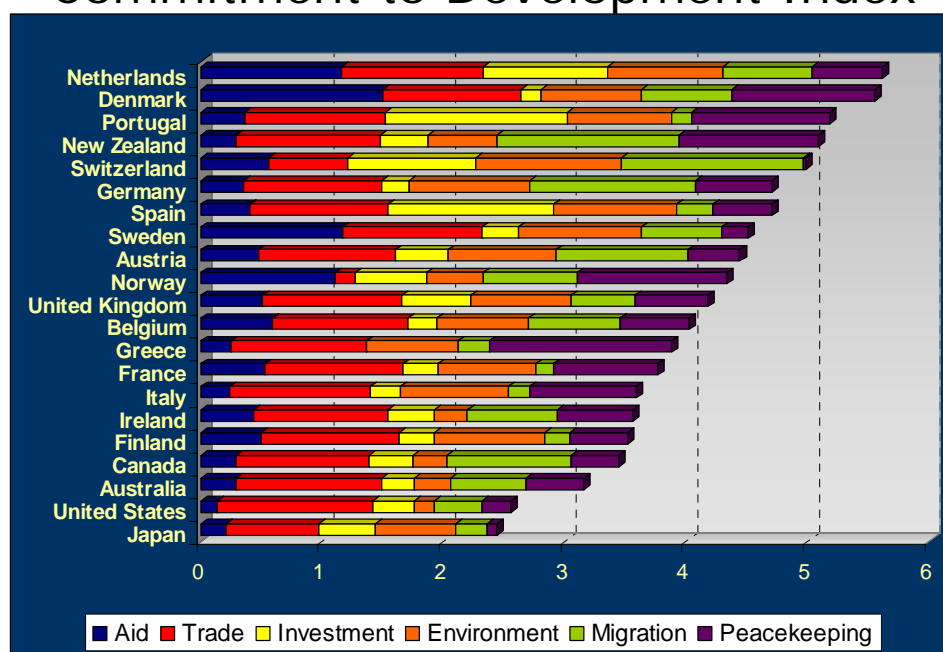
The Goal 8 on partnerships between the developed and the developing world is also far from being approached with the necessary effort. The goal 8 reads: *Develop further a global partnership for development-* it includes 7 targets

focusing on the **means** to achieve the first seven.

Many of the poorest countries will need **additional assistance** and must look to the rich countries to provide it. Countries that are poor and heavily indebted will need further help in **reducing their debt burdens**. And all countries will benefit if trade barriers are lowered, allowing a freer exchange of goods and services.

Most of the developed nations have still not lived up to the target of 0.7% of GNP for development aid. And we are always quick to point to the United States of America that is particularly reticent in this regard. But a recent analysis on commitment of the developed nations to the Millennium Development Goal 8 shows clearly that in order to affect change overseas aid is necessary but totally insufficient. An index developed by the Center for Global Development, which ranks the OECD countries in terms of their commitment to the Millennium Development Compact shows that of 21 countries only 5 reach a score of 5 out of 10. The index brings together six issues: aid, trade, investment, migration, peacekeeping and environment.

Commitment to Development Index



Clearly this is not a pretty picture.

Meanwhile in Africa only 2% of the 4,400,000 million people who would need treatment do not have access to drug therapy despite the fall in prices, despite the creation of a new agency UNAIDS and despite the creation of a new Global Fund on AIDS, Tuberculosis and Malaria.

But despite the lack of international commitment and despite the negative effects of globalization on health in many countries we cannot avoid to point out that in a world of nation states it is not only the international community that is at fault.

In relation to HIV/AIDS the Global Governance Report puts the blame squarely at the door of *"the lack of support and leadership from the governments of affected countries"* and amongst the most tragic examples of this statement is South Africa one decade after apartheid and Zimbabwe under the iron grip of the Mugabe regime.

A recent report by the Washington Post on South Africa underlines: *"for a whole generation it is now too late"*. Business opportunities lie in death: spaces for cemeteries, funeral parlors and hearses – coffins for babies are the best sellers and one coffin wholesaler calls his business *"Caskets Galore"*. But the most worrying dimension of the HIV AIDS epidemic say some South African academics are its social, economic and political consequences. What impact will the wave of death and dying have on the future of democracy in South Africa? Why indeed was the fight against AIDS not instituted as one of the key initiatives of building a new democracy – as participation in health is often a step towards wider societal involvement?



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No wonder that the United States Central Intelligence Agency now regularly issues a report that draws attention to the impact of disease on political instability and that there is a health advisor in the state department.

There is no us and them any more – it is all US.

It is clear that we have not done enough – as countries, as professionals and as citizens. In global health we have failed not only the poor but ourselves – in every moral and ethical sense of the word. And as a global community we are all accountable. I am reminded of the question that haunted my generation of Germans:

Daddy, what did you do in the war?

Please do not misunderstand me. I do not question the professionalism and the well meaning approach of each and everyone of us and of all the dedicated public health professionals and organizations throughout the world - **but I think we have reached a point in time where the public health profession needs to make a choice** about the extent to which it wishes to become a more relevant (and louder) voice in the global debate – and that means entering the realm of advocacy and politics to a much larger extent than has been the case so far.

“In modernity – so Foucault - the sharpest discourse on difference always takes its starting point from the body”. These are as The Lancet editor Richard Horton has said *“the health wars”* and we must begin to see them as such. We can no longer accept forty years of difference between the average life expectancy in Somalia and in Japan. We need to frame this human neglect in new terms – and in some cases it might well qualify as a crime against humanity.

What kind of model of global public health do we want to promote?

We have reached a point where we need to make a choice of what kind of model of global public health the public health community wants to promote. It was one of the characteristics of modernity to take health out of the confines of religion and charity and make it a key element of the action of the state and the rights of citizenship. This process, initially within the context of the constitution of the nation state, today needs to go global as a key dimension of global justice.

The present global drive for access to AIDS medicines for developing nations is not just about health, it is the spearhead of a global citizenship movement that has recognized that global health needs to move out of the charity mode into the realm of rights, citizenship and a global contract.

In a similar vein the proposal by Gordon Brown the British Chancellor of the Exchequer for an *International Finance Facility* which would double annual aid to poor countries is aiming to move to a new premise of financing through collateral bonds issued in the international capital market – but this is not supported by Germany and the USA. So I hope that the American and the German Public Health Associations join forces to move this agenda ahead.

The public health community needs to voice its preference for financing models that are based on rights of global citizens. It needs to support the stand stated in clear language by Stephen Lewis the special United Nations envoy on HIV/AIDS in view of the lack of funds to fight HIV/AIDS be it through the Global Fund or the WHO 3x5 program. Comparing this lack of commitment to the expenditures for the wars in Afghanistan and Iraq Lewis stays:

“There are no excuses left, no rationalizations to hide behind, no murky slanders to justify indifference – there will only be the mass graves of the betrayed.”

It is not just a question of money it is a question of paradigm

Of course this is not just a question of money - it is a question of paradigm. *“The pervasiveness of today’s crises suggests that they might all suffer from a common cause, such as a common flaw in policy making, rather than issue specific problems. If so, issue specific responses typical to date, would be insufficient – allowing global crises to persist and even multiply”* states Inge Kaul in her work on Global Public Goods.

The AIDS epidemic is only the most visible expression of three great failures:

- *the failure to invest in social reform and education,*
- *the failure to build primary health care systems in the developing countries and*
- *the systems failure to continue to be wedded to a global charity model*



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which is increasingly discriminating between the deserving and the undeserving poor. It is as if in the context of the industrial revolution of the 19th century we had decided to make the building of the sewers under the city of London an enterprise of charity without the state.

I personally believe it is a scandal of global health governance that the governments of the world – at present 191 of them – would allow a situation to arise that a private philanthropy such as the Bill and Melinda Gates Foundation has more money to spend on global health than the regular budget of their own organization the World Health Organization.

In a *March of Folly* – as the historian Barbara Tuchman would say - nation states are giving up their major instrument to drive health policy and ensure health security in an ever more interdependent world. Rather than focus and pool sovereignty as would be appropriate in an interdependent world, nation states are cutting up global health responsibility in ever more institutions – as one member state representative said at a recent WHO meeting: they are systematically supporting the “*Balkanization*” (my apologies to colleagues from that part of the world) of global public health. Where is the loud voice of the public health community in response?

Is it really that bad?

Why am I so negative at a time when health has clearly made it “up there” to be a critical issue of the global agenda. Indeed our friends in the environmental movement are now sometimes very jealous of us. Global health is now part of many agendas from foreign policy to security, it has made it to the UN Security Council, health has the richest foundation in the world on its side, in the World Health Organization it has an intergovernmental agency encompassing nearly all countries of the world – a type of institution that the environmentalists most dearly would like to establish. Health also has a multitude of institutions, partnerships and alliances and it has spearheaded new ways for the public and private sector to work together.

The many NGOs in health are visibly active in the global arena and health has made it to the top of the anti globalization agenda. How can there be a crisis? Have we not made systematic progress as the World Health Report tells us every year?

For many of us, and for the general public and the media a global public health crisis is an outbreak: Ebola or SARS. Luckily and with excellent work done by the WHO these have been contained. But in my mind there is a global health crisis every minute that a woman dies unnecessarily in childbirth around the world. There is a global health crisis every moment a child that could be immunized does not have access to the simplest of prevention measures. There is a global public health crisis every time a sane regulatory approach to tobacco or obesity is defeated in the halls of WHO because of economic interests. There is a global public health crisis every time a woman has no access to safe contraception or safe abortion or a young man dies of AIDS because he has had no access to life saving drugs.

From the perspective of the rich health societies of the 21st century we have chosen to forget in a form of collective amnesia what laid the basis for our health and life expectancy and in many cases our development agencies and lending institutions have not been willing to support those very tenants of success in the developing world:

a strong state, laws and regulation, public health and public education and the understanding that health is part and parcel of a citizen's right.

The key challenges in health in the world during the next ten years: the perfect storm

You will have gathered that my view is that the glass is not half full but half empty – my starting point is the 4 out of 10 figure of the Global Governance Report quoted earlier. The glass is less than half full. **We are in the midst of a global public health crisis which plays out at ALL levels of governance** – a significant weakening of public health has taken place in the last 30 years throughout the world in both developed and developing countries and in international institutions. Laurie Garrett's excellent book “*The Coming Plague*” in 1996 was a first clarion cry in this direction – but not heeded to the extent it should have been.

The crisis has 6 dimensions and there is no need to go into detail on any of them to a professional public health audience such as the one present in this room. What we have not done sufficiently though is to realize that while each of these dimensions is in itself worrying enough, the combination of the 6 dimensions is creating a perfect storm.



Dimension 1: The growth of epidemics

AIDS, SARS etc

Global obesity/tobacco epidemics
Increasing Global risk factors
Unhealthy consumption
The threat of bio terrorism

Dimension 2: The lack of sustainable health systems

Lack of health care coverage of the poor
Insufficient national capacities for public health in rich and poor countries
The dramatic fall of investment in universal health systems.
Lack of human resources //export and brain drain

Dimension 3: The socio-economic-political context

Unstable world
New emerging poverty
People movement: 1 billion on the move
Negative impacts of globalization

Dimension 4: The values

Lack of value attached to human lives in the south
Lack of support for strong public systems
Lack of support for new global financing mechanisms

Dimension 5: The international actors

An ever denser network of actors with lack of transparency
Increasing lack of accountability
"Balkanization" of global public health and unintended consequences

Dimension 6: Systems default:

Focus on disease
A world of vertical programs and quick fix solutions
A tendency to invest in technologies and drugs and not in social protection, health systems and people

Three processes of expansion that are changing the face of public health

This perfect storm and the subsequent weakening of public health means that public health is not prepared to deal with major seminal trends occurring in relation to health and society. I would like to suggest that *three processes of expansion* are changing the nature of public health:

- the **expansion of the territory of health** into an increasing array of personal, social and political spaces
- the **expansion of risk** and a changing nature of risk
- the **expansion of the do-ability of health.**

Time does not allow a detailed presentation of each of these expansion but let me just highlight a few points.

In terms of **expansion** simply put health is everywhere in modern life and it is defined by the notion that it can be "managed", "produced" and now also "enhanced". Just as health becomes an ever more dominant goal – so a dominant risk in the modern world becomes the health risk. It is potentially everywhere: in food, in the air, at home, at work, in the street – it reaches deep into the intimacy of our lives and the exploration of our sexuality. The non-communicable health risk is at present everywhere today as the infectious disease risk was in times past (and continues to be in the developing countries).

Ulrich Beck has coined the term "*risk society*". In risk societies risk stems not from nature but is man made and in the 21st century it is frequently global in its effects. Health is – as the Ottawa Charter for Health Promotion says – *created in the context of everyday life where people live, love work and play.* The determinants of health have



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expanded from those of the first public health revolution to those at the very core of our consumer society: for example food, drink and mobility. This has consequences for how we govern risk, or in other words, what type of public health policies we develop and where the primary focus of risk management should lie.

Initially the tendency was to lay the responsibility clearly at the door of the individual consumer and their health behaviors - increasingly though it is becoming clear that it needs strong state action at national and global level to respond to the great new epidemics. The activities around the most recent World Health Day on road traffic injury prevention are a case in point

The global obesity epidemic is exemplar and WHO must be commended for taking the lead in this charge. Obesity is not a simple cause and effect relationship but the sum of many small everyday decisions, behaviors, products, policies and environments throughout a lifespan and many levels of activity.

In consequence public health action is needed in many areas of society and polity – obesity does not lend itself (even less than smoking) to one public health strategy or intervention. It involves taxation, regulation, education, responsible industry behavior, responsible personal behavior, and support by the media - indeed all the 5 action areas of the Ottawa Charter. I believe firmly that the state must set sugar and salt levels for bottled and tinned goods just as it sets safety levels for air and water. And as a consequence we need to consider whether these issues are well placed in the weak ministries of health or should not be part and parcel of new types of ministries of consumer affairs, agriculture, industry and commerce.

The public health community must be insistent that as a population health issue obesity belongs in the realm of public policy and not merely on personal behavior. WHO has developed nine strategies for its program and shown that it needs action not only at the national but increasingly at the international level given the complex nature of food and agriculture in a global world.

Nation states should be supporting the World Health Organization in this approach rather than obstructing the road to agreements on global access to safe consumer products.

In the first public health revolution it became clear that health and disease were no longer natural states and increasingly health was understood in its social ramifications. Public health became part of the big social reform project of the first wave of modernity – focusing on the key health determinants of the industrial revolution: water and sanitation, air, housing, education, safe work, better food, shorter work days, maternal care, access to family planning.

In the next wave of modernity that now sweeps the globe – all of the above continues to apply (*indeed all of our pasts are present*) and is reinforced through rapid globalization. As many recent analyses have shown we need to redress the balance from a focus on the global public goods necessary to the expansion of commerce to the global public goods needed to speed social progress and social justice. This is exactly where we are challenged as a public health community today.

Solidarity and empowerment

Our lesson lies in history. In the 19th century with the social conflict around health and citizen's rights a new principle entered health governance: *the concept of solidarity* as an integrative force for both social movements and for identity and cohesion within the nation state. Public health was understood to be a social enterprise. The best quote I could find that expresses this is in French:

“L'hygiène publique est l'art de conserver la santé aux hommes réunis en société”.

This notion of health as a social and common enterprise is still captured in the famous definition by C.E.O. Winslow of Yale University: *public health is a collective community effort*. Paradigmatic for this shift is the development in Imperial Germany where 1883 saw the first law on health insurance. But I feel that frequently this collective and societal orientation has been lost in the turmoil of public health practice.

In these historical health wars health also became a means of empowerment for the individual citizen. For groups such as women and workers for example health became part of a program of individual emancipation, of participation in society and the dream of a better life.



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Increasingly the right to health became part of citizenship and identity in national constitutions and was finally codified as a human right in 1948. The early health definitions of the enlightenment still echo 250 years later in the WHO definition of health as *a complete state of physical, mental and social well being and not just the absence of disease and infirmity*. Women's health has remained an exemplary area of the interface between health rights and civil, political and social rights to this day.

Just as health drove the construction of the modern welfare state it now plays a similar central role in the developing forms of a new global solidarity.

Why health? Because it is tangible – because it is do-able.

The Do-ability of health finds two very different expressions both of which are deeply steeped in a debate about *ethics and the rights of citizens* and both of which interface in global health policy.

One approach to do-ability is driven by individualization and a new mix between the driving forces of science and the private market. Increasingly the do-ability of health translates not into government action but into a product or service that can be bought on the market.

In the developed world this means that the citizen becomes a health consumer and/or client – in the developing world it means that the poorest have to use their meager income to access health on the market place rather than be supported by a public health system. In countries with high inequalities this leads to many perverse effects – using amniocentesis to identify and abort girl children, developing a market for health enhancement while the poorest lack the access to the simplest antibiotics. This close link between health as a product in the face of weak legislation of course explains why much of the conflict in the international health arena is about the access to drugs – and it indicates that we will need to change our thinking about access to essential medicines in a very basic way.

The approach to do-ability dominant in the development community is not sufficient even though it has a clear ethical focus on addressing the health of the poorest. At present it is mainly characterized by a broad mix of strategies which are steeped in a charity and loan conditionalities that foster dependency - not a policy model of a global social contract.

Despite an ever growing range of international actors in health and development aid in the end it does not work: 140 NGOs have worked in Haiti – the result has not been better population health even though each and every one of them was working in good faith in their own little area. William Easterley has provided an excellent analysis of the failures of what he calls *“the cartel of good intentions”*.

Most central to my argument is **that part of global health action where the do-ability of health expands the legal territory of rights and global citizenship**: the litigation cases against the tobacco companies are a case in point as is the debate around TRIPS in the World Trade Organization. Very important is the push by global social movements that aim to change the rules of globalization and use as the most tangible example the access to drugs, in particular for HIV/AIDS treatment. What we need are public health models that take radically different approaches and question the very premise of **what at the global level is a public and what is a private good**.

For the public health community this means being more challenging and ingenious. Take as an example the thinking underway in the information technology area. Nicholas Carr has recently questioned the strategic advantage that IT (information technology) supposedly provides as a proprietary technology. He too takes his example from history and outlines how electricity

“became a revolutionary force in society only when it ceased to be a proprietary technology used by one or two factories here and there and instead became an infrastructure – ubiquitous and shared by all.....once it becomes available to all it becomes a factor of production.”

Similar issues are discussed in the Microsoft monopoly cases or the debate on “open systems” such as Linux.

This is what we are challenged to do in global public health – to protect public health from being subjected to a market model and increasing privatization (directly or through the back door) and indeed become very Victorian and Bismarckian again and develop a policy and financing model for global public goods which at the same time ensures the rights of global citizens. The ethical issue is simple:



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Health in the developing countries is do-able we have no excuse.

The political issue is of course more difficult: what social, political and financial price will we be willing to pay for better health both individually and as a community, both at the local and at the global level? Peter Singer has calculated that it would cost US\$ 100 a year by each middle class citizen in the developed world to finance the achievement of the Millennium Development Goals. Even if that figure were US\$ 500 it would still be do-able. I have not heard of any political party – green, red or black or otherwise – take this serious matter to their constituents.

We need to instill in politicians and business people that we need to build a global system of responsibility that ensures access to basic health even where states fail – and that this has to be linked to a regular flow of funds that is legally binding. Elements of this are part of the Gordon Brown plan. I would hope that the Global Governance Council and/or the Helsinki Initiative on Global Governance would be willing to take this step forward and that the public health community and the WFPHA would advocate strongly for such new solutions.

There are many ideas available including the famous Tobin Tax or George Soros' proposal for issuing special drawing rights to finance development. Others include a form of taxation on global consumer goods (such as airline travel and global tourism) where US\$ 5 for example of each international ticket go to a global health security fund or a new form of taxation at the national level where a separate budget is established for the production of global public goods – as has been proposed by Inge Kaul.

I believe we have no choice but to build a global solidarity system as revolutionary as Bismarck's was in his day to share the cost and the risk of global health. I believe global health leadership means today to develop a social reform model worthy of our historical predecessors but at a global level. The International Labour Organization has made a first such attempt (and promptly been criticized for its idealism by The Economist) – our responsibility is to place health firmly within such a model and be part of the debate in a much more forceful way than has so far been the case.

The third public health revolution

It seems clear: **we cannot continue to do public health as we used to**. The Ottawa Charter spoke of the move towards a new public health – Lester Breslow of the third public health revolution. But this third public health revolution needs to be a global revolution. It is the new interdependence and the new global dynamics which have positioned health as **a defining characteristic of the global society of the 21st century**.

And just as the Ottawa Charter set out 5 action areas for the new public health I would like to propose five action areas for the new global public health:

- *health as a global public good*
- *health as a key component of global security*
- *health a key factor of global governance of interdependence*
- *health as responsible business practice and social responsibility*
- *health as global citizenship.*

The five action areas respond in an integrated way to the systemic challenges I have mentioned above through a matrix:

Dimension 1.	Growth of epidemics – global security,
Dimension 2.	Lack of sustainable systems – health as a key factor in development;
Dimension 3.	Socio-economic-political context - health as a key factor in interdependence,
Dimension 4.	Values – global citizenship; health as a global public good.
Dimension 5.	International actors – global health governance; responsible business practice;
Dimension 6.	Systems default – global health governance.

As such a matrix shows we need to work on no more and no less than on a global social contract for health.



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The positioning of health therefore lies not in the instruments of technical assistance but in the policies of interdependence.

This means moving out of the charity model and the focus on the deserving and the undeserving poor as reflected in many of the new modalities and conditionalities of getting access to donor or fund moneys. It means first and foremost that we have to strengthen international organizations – in particular the WHO – in a way that allows them to fulfill new functions in an interdependent world.

Increasingly for WHO this function lies in the policy and normative parts of its Constitution and not in the technical assistance arm it has built up over the years. The issues at stake are binding international treaties for health, not only in the area of disease and medicines but also in such areas as the mobility of health professionals and the brain drain that is hitting developing countries. Health and globalization is not an afterthought but is at the core of this change.

The key aim of the global public health community must be to establish health as a global public good and a right of global citizens. Together with a strategy of empowerment and community involvement such an approach acts as a spearhead to enable and support individual health behaviours.

This means underlining the importance of the state and the public sector; it means translating the do-ability of health into strong public health systems with both a national and a global dimension because they can be separated less and less. Disease maintains poverty and negatively affects growth and security in both developing and developed societies – universal access and efficient managing of health care systems are increasingly important components of good governance.

This shift of perspective is central.

Amartya Sen has always insisted that the understanding of health as an end (the right of citizenship) is as important as the utilitarian principle of health as a means – and the public health community must never lose sight of the interface between the two.

In summary let me do a quick revisiting of the 5 key issues:

- 1. Health as a global public good** implies ensuring the value of health, understanding it as a key dimension of global citizenship and keeping it high on the global political agenda. It implies defining common agendas, increasing the importance of global health treaties and increasing pooling of sovereignty by nation states in the area of health.
- 2. Health as a key component of global security** implies an extensive global health surveillance role and expanded international health regulations with interventionist power for the World Health Organization and sanctions (through other bodies such as the World Trade Organization or the International Court of Justice) for countries that do not comply – the financing of a global surveillance infrastructure, a rapid health response force would be ensured through a new kind of global public goods tax.
- 3. Strengthening global health governance for interdependence** means strengthening the World Health Organization and giving it a new and stronger mandate. It must have the constitutional capability to ensure agenda coherence in global health (also vis a vis the development banks), it must be able to strengthen its convening capabilities and it should be able to ensure transparency and accountability in global health governance through a new kind of reporting system that is requested of all international health actors. Indeed recognition of its coordination and leadership role should significantly reduce the transaction costs for countries and for donors and should include a brokering role in relation to the health impacts of policies of other agencies. It should also be the coordinator of health in crises by acting as the intermediate health authority. Finally it should be able to take countries to the international court for crimes against humanity if they clearly refuse to take action based on the best public health evidence and knowledge.
- 4. Accepting health as a key factor of sound business practice and social responsibility** means increasing the capacity of the WHO to develop a new system of access to drugs based on a global public goods model. For example in the area of pricing, joint negotiations by 10 Latin American Countries (together with PAHO) with global players on antiretroviral drugs led to a 92% price reduction. Clearly legally binding Global Health Conventions such as the Framework Convention on Tobacco Control must be developed and strengthened. Finally there is an enormous scope – as the work on nutrition has shown – for producing and marketing health and safe products to the poor – such new business models should be part of the work of the World Economic Forum.



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But it is even more important to develop a model package of a Bismarckian type of global health insurance together with the insurance industry and perhaps the ILO, the ISSA and the World Bank. We need to work on a model that ensures access to prevention, care and treatment in developing countries – and it cannot be piecemeal any more. Clearly health and social protection cannot be separated - this falls squarely into the Goal 8 on global partnerships of the Millennium Development Goals.

5. Accept the ethical principle of health as global citizenship

I believe firmly that ethical norms apply to international relations – and as Nigel Dower points out –

“If citizens are increasingly motivated by global concerns then cosmopolitan goals enter domestic policy in that way and people can be effective global citizens by being effective global oriented citizens of their own states”

In particular this implies a common notion of social justice and a system of international law where human rights constitute a legal claim. As a German I am very aware that this is the year of the 200th anniversary of Immanuel Kant's death, and I would like to end with his words:

“to act that you treat humanity whether in your own person or any other person never merely as a means but as an end in itself.” (1785)

Kant's thinking leads us beyond the state towards our obligations of citizens in a global world and highlights our obligations to any human being anywhere in the world. **Indeed a guiding phrase for the beginning of a new public health revolution!**

Thank you.



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A final version of this lecture will be published in Public Health – Journal of the Royal Institute of Public Health. It is also accessible on my website: www.ilonakickbusch.com