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PUBLIC HEALTH AT THE BEGINNING OF THE MILLENNIUM
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First let me thank the Institute for the opportunity to participate in its biennial conference, and to note, in particular, the growing and firm relationship between the Institute, the Johns Hopkins University, the American Public Health Association, and the Association of Schools of Public Health of the Americas. This relationship can only bring depth to public health thinking and practice in the Americas. The Pan American Health Organization has been a constant supporter of ALESP because of the great potential it has for changing the perception and teaching of public health in our part of the world.

In the short time I have, I wish to pose that there will be three major challenges to be faced by public health and public health practitioners in this new millennium. First, there is the change in interest from local to global. Perhaps we should revisit Rene Dubos' famous statement about thinking globally and acting locally and rephrase it to emphasize that we must both think and act globally. There was a time when the focus was almost exclusively parochial, and I am fond of referring to the Report of the Royal Sanitary Commission in 1871, which, in looking at health in the UK, wrote:

“The importance of the subject cannot be too highly estimated. The constant relation between the health and vigour of the people and the welfare and commercial prosperity of the State requires no argument. Franklin's aphorism ‘public health is public wealth’ is undeniable.”

I shall return later to the aspect of the prosperity of the state, but the report was focussed on local problems. Just over 100 years later, Donald Acheson, in reviewing the state of public health in the UK, would take the same line, and I have always liked his crisp definition of public health as “the science and art of preventing disease, prolonging life and promoting health through organized efforts of society.”

I would like to examine now how we may think of the health of the people of the world in this light, and then see how the organized efforts of society can be seen in a global rather than a parochial context. As I mentioned before, it is only relatively

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recently that issues that might affect the health of the world's people were a subject for debate and discussion. Even in the enthusiasm for multilateralism that saw the birth of the United Nations and its agencies, the prevailing concern for global peace was not evidenced in a similar concern for global health. When health was mentioned in the latter part of the last century, much of the discourse was couched in terms of finding solutions to the health problems of the poor, developing countries. Much of the aid that flowed from the developed countries for health was in a spirit of missionary support. More recently, however, we have seen the birth and growth of the idea that health is indivisible and the health of all is the concern of all. This view is gaining currency in spite of the obvious variations in health status in the various countries of the world.

It is in this context of global action that we should consider the two fundamental changes that have brought public health into the global arena. First, I believe that we are witnessing an upsurge in global humanitarianism. There is abroad the notion of inalienable human rights, and the view that the ill health or other unavoidable deficiency in one set of people, is the concern of all humanity. We are seeing, for example, protests in one country over what are perceived as human rights and environmental abuses in other countries—a movement that has nothing to do with professed solidarity among the various groupings of developing countries.

The second change is perhaps more utilitarian in the sense that it is being appreciated that the health of one part of the world influences health and other aspects of human well-being in other parts, and I see nothing venal in this type of self interest. It is being recognized that the health of a distant country has a possible effect on another country's perception of its national security. The Security Council discusses a health issue and links it to global security; intelligence agencies think not only of armed aggression as security threats, but the health and social conditions in other places take their place along with the environment as crucial non-military security issues. Caging of the nuclear genie is no longer the only or predominant concern in discussions of national or even global security. We see countries shaping their foreign policy on the basis of these kinds of concerns which would have been unmentionable 50 years ago.

The health of others also influences our own wealth. And there is no doubt now of the firm forward connection between health and wealth. To the extent that there is improvement of global health, then there is enhanced opportunity for increased global trade which is one of the principal dogmas of the current economic order.

The second major challenge will be to appreciate that the old form of global organization has changed. This indivisibility of the health of the world's publics has been brought into sharper focus, in my view, by two of these changes. The first, which has been debated almost ad nauseam, is the increased connectivity that is the hallmark of the new globalism. I see the main feature of this as the ability of distant events to influence more proximate ones, and, as everyone here knows, this has been fashioned or accelerated by the enhanced speed of communication of men, materials, and information. This increased connectivity has given rise to the clearer definition of what are truly global health risks with the obvious deduction that such risks have to be dealt with by global

mechanisms. But I must stress that it would be the gravest of errors to believe that it is only when health risks are global that public health should be regarded as a global issue. For reasons given above, even local health risks may be of global concern.

The second change, which affects the public health perception, is the changing role and perception of the state. This has usually been treated from the point of view that global public health risks escape the capability of a single state and, therefore, some form of multi-or interstate arrangement must be found to deal with them. But I think that we in public health must take the phenomenon of the growth of pluralism more seriously. It goes beyond the role of the state. Drucker would point out that the last millennium was marked by the rise, fall, and return of pluralism. The last 100 years have seen the steady erosion of the nation state as the predominant unit of social organization. But, whereas the pluralism of the beginning of the millennium was based on power, the social pluralism of today is based on the functions of the multitude of institutions that form organized society. So when today we revisit the definition of public health in terms of the organized efforts of society, we have to be cognizant of the numerous state and nonstate actors that legitimately have a place in the care for the public's health.

What effect do these phenomena have on academic public health institutions and the practice of public health? Perhaps the most present and profound one relates to the types of disciplines that are brought to bear and that are taught in these institutions. There is no escaping the traditional disciplines, but more and more we have to appreciate that there are several new disciplines that are involved in the care of the public's health. Let me cite one that has been fresh in my mind recently, as I have had cause to look at the spectrum of resource allocation for health in the Americas and note the wide range that occurs in spite of the universal acceptance of the importance of public health. There is a gross ignorance of the manner in which political decisions get made, and such theories as those of rational public choice that are fundamental to the understanding of resource allocation are absent from most of the public health discourse. I find there is still the tendency to think of the profession of public health as a guild, with strenuous efforts to maintain disciplinary purity. The formation of human resources that will occupy themselves with public health in the future will have to be much more catholic in accepting other-than-the-traditional disciplines.

But it is in the area of research that I foresee great possibilities for associations and schools gathered here. We find that in our countries there is a great dearth of research on the fundamental determinants of population health. Many of the examples we have to draw from come from developed countries. One simple example is the lack of data on such an important issue as gender discrimination in our health services. We are all engaged in processes of reform and know very little about how such processes will affect women, apart from when they exercise their reproductive role.

Finally, let me pose the third challenge that will be in center stage in public health for at least the first centuries of this millennium, and one that is central to the thinking and practice of the Pan American Health Organization. The issue of equity will come to occupy us all. This is not the time to expand on this, but I am sure that we will all be

caught up in defining the inequalities that are socially unjust and are, therefore, dubbed inequities. Even more importantly, we will be forced to examine those determinants of health outcomes, not only the health services that are inequitably distributed and contribute to health inequity. Future students of public health will be concerned not only with the state of the health of a determined population, but also with the removable barriers to health equity.

These will certainly be exciting times.