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**The many faces of health
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First, let me thank Dr. Dorothy Powell for the invitation to give this Second Annual Global Health Lecture. I met her first through my friend Dr. Michael Merson and although I know and appreciate the global reach of her Office I am delighted to see her growing involvement in health care in the Caribbean and note the exhibition of the kind of collaboration as well as leadership that can only redound to the benefit of both our institutions.

I confess that when I chose this title for the lecture, I was thinking about a film and book entitled the “The Three faces of Eve” which appeared in 1957-the year I graduated from medical school. This was an outstanding movie about Eve White, a quiet unassuming housewife who had one daughter and suffered from dissociative personality disorder or more simply she had multiple personalities. The three personalities which were brought out by her psychiatrist, Dr. Luther were completely different and the dénouement was when he got the reconciliation or reintegration of the personalities and make Eve whole again as one of them.

In some ways the state of health is similar and I am often amazed at the balkanization of health and the numerous vehement protagonists of one or other perception of what is important and how it should be dealt with. Sometimes, like Janus it shows two faces and the argument grows heated as to the importance of one or the other, with a vehemence that is fuelled by the apparently natural instinct of many of us to be arrested at the level of binary thought. Sometimes they are indeed in opposition but on occasion a bit of rouge and mascara are put on an old face to produce a new visage

I thought I would discuss this evening a few of those faces which have interested me over the years. My essential message will be that we should not see these many faces as being in contradiction or opposition and the best way of bringing them into consonance with one another is through cooperation and partnerships of various kinds. So let me play at being Dr.Luther. I will also try to address the role that nurses and nursing may play in reaching accommodation between the faces or even making a new face more attractive.

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Perhaps the oldest and most dominant of the perceptions is that of health being essentially an individual matter and we can see that clearly today, as much of the polemic that dominates political discussion on health relates almost exclusively to the availability and cost of the individual care. This individual orientation was seen in ancient civilizations and for the Greeks for example the preservation of health and the worship of the healthy body was very much an individual matter and frankly narcissistic. Across all strata and countries and for both sexes, health is the attribute that individuals value most. Prayers for individual health have been prominent from time immemorial and in all cultures and in the religions about which I have read. One of my favorite old prayers comes from an old inn in Lancashire, England which puts the important necessities in perspective;

*Give us Lord a bit o' sun
a bit o' work and a bit o' fun;
give us all in the struggle and splutter,
our daily bread and a bit of butter.
Give us health, our keep to make
an a bit to spare for poor folks sake.*

For physicians and the majority of nurses of my generation, the emphasis in school was on the individual patient, and my own early experience and practice was as a personal care physician. Indeed in my own Caribbean, when social conditions were so poor that riots spread through the region, one of the responses of the colonial power, Great Britain was to establish a university which began with a medical school whose early focus was on personal care medicine. The brightest and best of the young West Indian doctors chose one or other aspect of that medicine. I confess to still recalling the exquisite pleasure derived from treating young adults with a roaring fever, bloody sputum from pneumococcal lobar pneumonia and seeing them walk out of the hospital smiling and cured after a few days of penicillin. And like many of my colleagues, I was prepared to argue for the social merits of such medicine in spite of the salvos of McKeown and Illich who would have had us believe that our curative armamentarium had little to do with improvement in the health status of the public. This is the area of health in which nurses originally shone and in most cases their care was as important as cure and perhaps even more important when there was no cure.

But what time and circumstance have shown me is that one can derive the same endorphin rush from being concerned with the health of groups of varying size, and there need be no conflict between these two faces of health. It is equally critical to be concerned about the conditions that influence the health of populations and the circumstances that have to be changed to effect that improvement. This was of course brought out clearly in the paper that I believe has to be one of the genuine classics of public health. Geoffrey Rose described so clearly the essential difference between the approach to identifying and treating the high risk individuals and the population based approach of reducing the underlying cause of the incidence of the particular condition. He described brilliantly the two different etiological questions which are frequently confused. The cause of cases is different from the cause of incidence. The protection of the health of the individual is seen as different from establishing the cause of the

incidence of a particular disease and putting in place the intervention to reduce the incidence.

My recent experience in the approach to noncommunicable diseases in the Caribbean has brought home very clearly how much easier it is for policy makers to grasp the need for the high-risk approach of identifying the individuals who have one or other of the risk factors and inducing them to change rather than accepting the need to alter the enabling environment or change the accepted social norm. They tend to see two different faces of health. Mention of the polypill as an approach to secondary prevention of cardiovascular disease evokes much more interest than the approach of reducing the population consumption of salt or the provision of cycle paths and organization of facility planning to make physical activity a part of normal living. The pill is seen as providing evident benefit to the individual while the other interventions have very small individual benefit, and are usually of moderate interest to physicians.

I have had the experience of a Head of State putting forward vigorously to me the thesis that he was not in the business of creating a nanny-state that removed from the individual the responsibility for his or her health. It was the life styles adopted by the individual that were responsible for the high prevalence of cardiovascular disease and the solution had to come from persuasion or coercion of the individual to change. He was not disposed to use the regulatory and legislative power of government to alter the social environment that affected the health of the population negatively.

However, when in my own mind the balance between the individual and the population approach had settled nicely, this was somewhat upset as I became very conscious of the challenge posed by the advances in the understanding of the human genome. There is concern for what is described as “boutique medicine” in which the focus will be on the individual’s genetic susceptibility to specific risks and the possibility of developing specially tailored responses. It is clear that this approach will enhance the inequity in health as it will almost certainly be the province of the rich and not the poor. On reflection I have been comforted by realizing that the interaction between genetic predisposition and the environment is so complex that this possibility is very far away and the research on the genetic characteristics of large groups may also lead to population based approaches to disease prevention.

The intrinsic value of health itself has been another subject with at least two faces. There have been strong proponents of the view that health is important in its own right and it borders on the obscene to attempt to value health in economic terms. Health is a personal good and the wholeness or health of the temple of the body is regarded almost as a matter of religious faith. Fortunately, the argument is less heated now and there is currently wide acceptance of the view that health can be instrumental and expenditure to keep a population healthy should be seen as an investment with calculable returns.

The economic returns to health take place through many channels. There is increased productivity irrespective of the dominant form of production. In countries in which the production is mainly through manual labor as well as those in which there is

more knowledge work, the better nourished and healthier workers are more productive and earn. Better health and increased life expectancy make for a longer period in which there is return to investment in education for example. Increased longevity is also associated with higher savings rates which can boost investment nationally. Healthier children miss less school and learn better. As Jamison notes in relation to health;

“Evidence from cross –country growth regressions suggests the contribution is consistently substantial. Indeed, the initial health of a population has been identified as one of the most robust and potent drivers of economic growth-among such well-established influences as the initial level of income, geographic location, institutional environment, economic policy, initial level of education and investments in education.”

Conversely, ill health can wreak havoc with countries’ economies as has been shown in the case of AIDS in sub-Saharan Africa. This acceptance of the instrumental as well as the constitutive roles of health is important when making the case for investment in health. Unfortunately too few of our policy-makers in health are sufficiently conversant with this instrumental aspect of health or the concept of health being one of the capabilities necessary for overall development and tend often to make the case for health purely on the politically expedient grounds of satisfying individual needs for illness care.

There are now different faces to the health problems of the world as a whole. We have progressed beyond the simplistic notion of an epidemiological or health transition in which countries passed from the stage of pestilence and epidemics through one marked by infectious, communicable diseases to one in which there is a predominance of the more chronic, degenerative diseases. There is no longer such a demarcation and all countries face pressure to deal with the whole gamut. In most of the developing world, there is still the unfinished agenda of the infectious diseases while the epidemic of the noncommunicable diseases is very much upon us. It is estimated that just over 50% of all the deaths in the developing countries are now due to the noncommunicable diseases and the burden of these exceeds that of the infectious diseases in all regions except South Asia and sub-Saharan Africa. It must be stressed that this double burden of health is a global phenomenon.

There is now such a globalization of risks that the differences between the causes of incidence are becoming blurred. The ubiquity and cross border penetration of information or propaganda as one of the main vectors of the kinds of life styles that predispose to disease makes for increasing uniformity of disease patterns. Bob Marley was not referring to health risks, but he was prescient when he sang;

Remember that, when the rain fall, it don’t fall on one man’s housetop.

In other words we are all increasingly subject to the globalization of risks

We have been made acutely aware of this in the Caribbean where economic improvement, increased longevity and cultural imperialism have produced what I have called a tsunami of chronic diseases. My country Barbados with an adult prevalence of diabetes of about 15% has been referred to as the amputation capital of the world. In the past six years there have been just over 1000 amputations carried out because of diabetes.

And yet at the same time the Caribbean as a whole has a prevalence of HIV second only to that in sub-Saharan Africa.

To compound the confusion, there is doubt as to whether the old division into communicable or noncommunicable is still pertinent and whether it is still appropriate to speak of infectious diseases as acute and the non-infectious ones as chronic. There is increasing evidence of the role of inflammation in the genesis of the diseases formerly referred to as noncommunicable.

But perhaps the most intriguing change of face has been that related to how the nations of the world address health problems globally and try to preserve the health of their citizens. I can discern about four phases to national involvement and cooperation, or perhaps I should I refer to the changes in the face of national involvement. I have described much of this in detail elsewhere and will give only a summary here.

Initially, the major concern of countries, at least the more developed ones was with the entry of the infectious diseases into the country and the most dreaded of these were plague and then cholera, particularly in the latter part of the nineteenth century. The initial efforts at international cooperation to address the impact of cholera were spurred by its potential to interrupt maritime trade which was growing rapidly and bringing the world together as one of the instruments for intensifying globalization. This international cooperation produced a series of Sanitary Conventions and eventually led to the founding of the Pan American Health Organization. The emphasis was on reporting or notifying communicable diseases and quarantine to keep them out of the uninfected country. One only has to read Gabriel Garcia Marquez's "Love in the time of cholera" to appreciate the power of the yellow flag-the yellow jack-signifying cholera on board a ship to keep people away.

This phase was succeeded by one in which the nations appreciated that there was merit in controlling disease globally and not just preventing it from entering their countries. This saw the creation of the World Health Organization and a post war euphoria with dreams of a better world in which there would be cooperation in making and keeping all the world's people healthy. Disease in one part of the world was an affront to all.

The third phase was marked not so much by a different perception of the need for cooperation, but by the change in the actors in that cooperation. Over the past twenty or thirty years, involvement of non-governmental organizations and the private commercial sector in addressing health issues cooperatively has grown remarkably. It is striking to me that for the duration of phases two and three, there was a steady growth of the view that international action in health was equivalent to action to address the problems of the developing countries. The numerous departments of international health, especially in this country pursued with messianic zeal efforts to control predominantly infectious disease in the developing countries-particularly Africa and Asia. Unfortunately, we still see international and global used interchangeably in relation to health. I have often referred to this approach as extra national health, since in the main health workers from

the developed countries pursued health projects extra nationally and there was very little appreciation of the fact that international by definition referred to action between nations.

The fourth phase which is only about a decade old has seen international health take on a different face and morph into the new fashionable field of global health and sometimes I wonder if it does not represent old wine in new wine skins. However, there are exceptions and Duke is one of them and there is a genuine attempt by some to define global health as a new approach. My concept of global health is that it is a multidisciplinary field of research and practice dedicated uniquely to improving the health of all the people of the world and more specifically reducing the health disparities which continue to shame us all. I also contend that there cannot be improvement in global health without genuine international action. This is not semantic. Advance and improvement will come only when there is cooperation among nation-states mediated through their various constituent actors, both government and non-government. This makes it imperative that there be strong, credible, effective intergovernmental Organizations such as the World Health Organization.

There are many institutions in the nation state, including academic ones that can play a role. Naturally, academia has been led by health, although the growth of disciplinary pluralism is one of the realities of modern cooperation. The role of the traditional medical establishment is well recognized, but I wish to explore here a possible role for the nursing part of the health academia.

It should not have come as a surprise to me that one of the movements to involve nurses in the concern for global health should bear the name of Florence Nightingale. There is a Nightingale Initiative for Global Health which is conceived as a grass roots, nurse inspired movement to increase global public awareness about the global health priorities and propose solutions. It recognizes that by the sheer weight of their numbers-there are some 15 million nurses world wide, they can be a massive collective voice for global health. I have always been struck by the attributes that are almost peculiar to the nursing branch of the health professions. There is the recognized attribute of presence and also that of advocacy. Even though public health nursing has had a long and glorious tradition, more commonly these attributes have had echo in personal care, but there is the growing perception that they are equally applicable at the population and global level. The numbers of voices that are available for advocacy and the credibility they bring because of their constancy of presence make a powerful force for improving health globally.

My friend Marla Salmon sent me her book entitled “Nurses-a world of care” which is appropriately described as “a moving tapestry of words and photographs that documents and celebrates the vital and often invisible work of nurses throughout the globe”. I warmed to the view that nursing was “critical to delivering health care in every corner of the world”, and if I needed convincing, the beautiful pictures and words would have convinced me that nursing is inseparable from our concern for global health.

Improvements in global health will also be facilitated by partnerships between and among the various actors in the nation state. Thus, I welcome the effort of institutions like this to form partnerships with their homologues in other parts of the world and naturally I am pleased that one of these partnerships will be between you and my own institution. The only advice I would give is born out of experience of the essential ingredients of successful cooperation through partnerships. There must be mutuality of interest, specificity of purpose and clear indication of the resources the partners bring to the enterprise. I do hope that you ensure that these are present from the very outset of your intention to establish any partnership.

Ladies and gentlemen, I hope I have set out some of the faces of health that have intrigued me over the years. Undoubtedly many of you can think of several others but I think these have been the ones most appropriate to the institutions represented here and the prospects for them acting to improve the health of at least some of the world's people. It was the beautiful face of Helen of Troy which was credited with having launched a thousand ships. Perhaps we can hope that this beautiful face of global health will similarly launch more than a thousand initiatives to reduce the differences in an area in which our common humanity urges us to reject not only differences in health, but such differences that are unjust and constitute inequities.