

AT THE FRONTLINE IN A NEW HEALTH WORLD

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Introduction

I am honored to participate in this meeting of the US-Mexico Border Health Commission. As Americans and world citizens, all of us want to convey our admiration and support to Tommy Thompson, the US Secretary of Health and Human Services, who joined us in the midst of a national health emergency. The anthrax attack is challenging the most basic function of America's national public health system. Our co-chair, the Mexican Health Secretary Dr. Julio Frenk, is a distinguished world health policy-maker, who on the 11 o'clock news tonight said that our biggest danger now is inappropriate and unnecessary "fear." I also want to acknowledge Dr. George Alleyne, the Director – General of the Pan American Health Organization. PAHO is our international health organization of the Americas and the oldest international health organization in the world's major regions.

The Mayor of El Paso and the Governor of the neighboring Mexican State have provided splendid hospitality. These twin cities of El Paso and Juarez straddle the middle of a 2,000-mile US-Mexico border, constituting the heart of the economic and social connections between two nations demarcated by the Rio Bravo or Rio Grand River. Their hospitality will conclude with a formal lunch after this commentary. To do well, speeches after lunch (when post-prandial glucose flows away from the brain to the digestive system resulting in lethargy) require very good jokes. Speeches before lunch, like mine, must be very brief indeed -- to clear the path to lunch!

I will be, therefore, make three brief points. First, we are entering a new global health world; isolationism in health is gone forever. To be effective, national health strategies must adopt global mindsets and transnational strategies. Such strategies must produce more and better "public health goods" and the control the damages of "public health bads." Second, fresh strategies and new institutional arrangements will be needed. This US-Mexico Commission can be at the cutting edge of these new cooperative initiatives for mutual learning and benefit. Third, transnational health strategies, while striving for global health solidarity with equity, perform best with a specific action agenda that is mission-oriented and outcome-driven, demonstrating concrete advances for the people's health. All too many committees manage to say the right things but do preciously little.

Trust and confidence are fundamental in all cooperative ventures. Let me begin with a Rockefeller story that describes how misunderstanding and miscommunications can develop between asymmetric partners. The Rockefeller Foundation began its health work in Mexico in 1920, as its hookworm eradication program in the Southern parts of the US extended across political borders. The Foundation's health work in Mexico gradually expanded to include strengthening disease control, the ministry of public health, and numerous health institutions. In 1933, one of the richest men in the world, John D Rockefeller Junior (son of the Foundation's benefactor) commissioned a mural from Mexican painter Diego Rivera to grace the entrance of his Rockefeller Center in New York City (which recently has received much media attention because of the anthrax attack). Rivera painted a moving mural called "Man at the Crossroads" that depicted the struggles of life by ordinary people. Perhaps encouraged by his political beliefs, he endowed the central figure in the mural with a face (that some said) resembled Vladimir Lenin! Rockefeller was aghast; Rivera refused to budge; neither was willing to yield. Eventually, the mural stayed in Mexico, and Rockefeller's money stayed in New York. Both were poorer -- New York artistically and Rivera financially! I cite this story because although the Foundation has no formal ties to the family (even back in 1933), misunderstanding can be distressingly common in any relationship, especially between asymmetric partners.

Global Health and Public Goods

Secretary Thompson called the US-Mexico border "our neighborhood." The border region, indeed, is at the "frontline" of a new health world. Spurred by globalization in general and NAFTA in particular, this border region has been extremely dynamic -- economically, demographically, and health wise. NAFTA has sparked economic growth by facilitating the rapid flow of goods and services, money and finance, science and technology, and also people and diseases. We need no reminder that just as good things can flow more easily, all sorts of illegal activities (drugs, germs, money, etc.) can also flow more easily. The region 100 km from the border penetrates into four US and six Mexican states containing more than 11 million people. But this is simply the "frontline" of a widely dispersed Mexican-American community of immigrants throughout the United States. Indeed, this border witnesses more than 1 million legal border crossing daily. Even the populations in the border region in both countries are internal migrants from elsewhere in their countries -- for example young, often female Maquiladora workers coming from Southern parts of Mexico.

Dynamism of border health, therefore, should not be surprising. Indeed, people in the region demonstrate all three stages simultaneously of the classical health transition -- common childhood infectious diseases usually related to poverty, chronic diseases like diabetes often linked to changing diet and lifestyles, and a "third wave" of emerging infections (HIV/AIDS), environmental threats (air and water), and behavioral pathologies (trauma, suicides, sexually-transmitted diseases, and mental illness).

Each national government, of course, has responsibility for the health of its citizens. But both countries share the challenge of producing mutually beneficial "public

health goods.” That is because private markets alone cannot produce all necessary or even the most important health goods. Public investments are needed for health infrastructure (water, sanitation), disease control, health promotion, and environmental health. The concept of “public goods” parallels that of a “lighthouse,” which is non-rival (one person’s use does not detract from another user) and “non-excludable” (all benefit and no one can be excluded). Health has some of these powerful public goods properties. The transmissibility of infectious agents, for example, means that every tuberculosis case treated and cured helps reduce the risk of transmission to others. Environmental health is dependent upon the cleanliness of common pool resources like water and air.

In a seminal article published in the medical journal, the Lancet, Secretary Julio Frenk succinctly summarized the situation: “Whereas health is a national responsibility, the determinants and risks of health are increasingly transnational.” This is why isolationism in health is obsolescent. The traditional demarcation between domestic versus international health also is less useful. Mutuality of health interests is too strong for absolute national sovereignty in health. Rather, the future of national health must incorporate a global mindset and transnational strategies to achieve benefits beyond the capabilities of any single nation state.

Fresh Strategies

The US-Mexico Border Health Commission has two mandates. The first is to enhance domestic priority to border health issues on a sustainable basis beyond political vicissitudes. The second is to address commonly-shared border health problems. In its first year, the Commission has prioritized health problems reflective of all three stages of the health transition – for example, immunization of all children, prevention and treatment of diabetes, and control of HIV/AIDS.

Transnational health cooperation may be considered in three phases. The first is recognition and awareness. The second is cooperation among sovereign states, usually involving information exchange, harmonization and standardization of practices, and mutual learning. The third and most advanced phase is joint action for mutual benefit.

The Commission’s workplan already has activated the first two phases. Recognition and awareness are central mandates of the Commission. These could be strengthened through more and better public information, press and media engagement, and political participation. Cooperative activities thus far have focused on data and information exchanges and developing parallel goals for existing national health programs. The targets and health systems respect autonomy on both sides of the border.

I believe that cooperation can be strengthened through mutual pursuit of learning. Take for example the public health infrastructure required to combat bioterrorism that so pre-occupies us today. Prevention, control and response to bioterrorism depend on public health information, surveillance, preventive immunization, and emergency drug supplies – all based on a strong public health infrastructure. Epidemiology training in the United States has been linked to Mexico for 75 years. Secretary Frenk’s TV comment last night

about the strength of Mexico's health surveillance system was based in part on an ongoing collaboration between Mexico's Department of Health with the US Center for Disease Control. For nearly two decades, both countries have collaborated in the Field Epidemiology and Training Program (FETP) program. For 75 years, Mexico's public health workers have been trained by its Institute of Public Health in Cuernavaca, headed by Dr. Jaime Sepulveda, an institution that was established with the help of the Rockefeller Foundation.

Although the United States has triple the population and manifold the income of Mexico, there are many Mexican lessons that could benefit the United States. The Human Development Report of the UNDP reports that measles immunization coverage in Mexico (98%) is superior to that of the United States (91%). When I inquired why from Dr Jaime Sepulveda, he described Mexico's social mobilization approach to galvanize community participation through "national health weeks" for accelerating the immunization of all children. Mexico also registers all births, accords each child with an individual ID number, and issues all mothers a child health card that tracks immunizations, nutritional growth, and other health developments. These key health events and processes are linked and computerized. The US public health system could benefit from such a comprehensive system that tracks the health of all children. Such a system, no doubt would be even more important at times of a national health crisis.

Action Agenda

Ultimately, the challenge for this Commission is to move to the third phase -- joint action for mutual benefit. Governmentally-sponsored commissions have the advantage of legitimacy and usually do well in medical diplomacy. Doctors (like each of us) often have our own "favorite diseases," presenting obstacles to focused priorities for action. The challenge is to move beyond diplomacy to identify critical gaps and to exploit unique opportunities.

Secretary Thompson called for "activism." Beyond information sharing and coordination, can the Commission select health priorities that are mission-oriented and results-driven? A host of key health problems could be prioritized for joint solutions – children's immunization coverage, tuberculosis control, reproductive and sexual health among high risk youth, and interrupting the transmission of HIV/AIDS. Specific aspects of the public health infrastructure could be identified for mutual strengthening – worker training, border data and surveillance system, health policy development. In each of these joint ventures, collaboration with corporations and with non-profit organizations like private foundations should be fashioned. As many of you are aware, the Rockefeller foundation has joined The California Endowment to launch a new US-Mexico transnational health program that looks forward to full collaboration with the Commission.

Conclusion

In entering a new health world, let the principles of solidarity with equity (as articulated by Secretary Frenk) guide our work. Earlier, I described the Mexican national health weeks. The one that we observed today in Juarez is celebrated as “Dias de Raza” recognizing the first encounter of Europeans with the New World. In the United States last week, we enjoyed a Columbus Day holiday, which President Bush celebrated in recognition of America’s Hispanic heritage. These common celebrations commemorate the so-called “age of discovery” 500 years ago when Europeans reached the Americas. That contact 500 years ago set off a process of transnational health, marked by crisis (for example smallpox and measles epidemics among indigenous peoples) as well as significant sustained benefits (such as the sharing of food, culture, economy).

The US-Mexico Border Health Commission is the most recent manifestation of that historical process. We have accomplished much, but much more needs to be done. The Commission’s cutting edge work on border health points the way of transnational health into the 21st century. Thank you.