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**GLOBALIZACIÓN, SALUD PÚBLICA  
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# INTERNATIONAL AND GLOBAL PUBLIC HEALTH: GOVERNANCE AND ETHICAL ISSUES

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## **Introduction**

The term global health is very much in vogue at this time, and appears to be replacing international health as the framework within which there is debate about governance and to a lesser extent ethical issues related to the health of populations. This paper will examine the origins of the concerns for international health and the reasons for the new predilection for global health and outline some considerations on its governance and ethics. It is not often appreciated how the thinking and practice in international health has evolved over the years along with changes in the relations between states and the enhanced connectivity in all areas, which are captured in the current concept of globalization.

## **The history of International Engagement**

The history and concerns for international health and international health work have been well described in several reviews, and this paper draws heavily on those by Howard-Jones (1950, 1977, 1978) and Goodman (WHO, 1978). The genesis of modern cooperation among states in health can be traced very directly to the concern for infectious diseases and progressive knowledge about their causation. The plague was one of the first great epidemics recorded in the West, and its effect on the economic and other consequences in Europe were nothing short of catastrophic (Herlihy, 1997). The efforts to prevent plague were very much tied to maritime trade, and the system of quarantine as a preventive measure owed its origin to the need to ensure that vessels entering a port were not carriers of infectious diseases. It is of interest that those nations which were least enthusiastic about quarantine based their objections on the fact that such measures served to slow and impede trade. Howard-Jones (1950) cites a British report on quarantine of 1849, which pointed out that “the only real security against epidemic disease is an abundant and constant supply of pure air”. Another citation makes the point more directly.

[:] it is a disputed point whether the plague is even contagious; and the mass of evidence is in favor of its being so occasionally, but that the plague is usually not propagated in this manner. The disappearance of this pest from our own and most other countries of Europe is undoubtedly owing to the much greater attention paid to drainage, ventilation, and the prevention of the accumulation of filth in the streets, etc. When the peculiar atmospheric conditions upon which its diffusion depends are present, quarantine has proved insufficient to prevent its propagation.

Given Britain's position in the world, its dominance in world shipping and its mercantilist posture, this view is not surprising.

Epidemics of cholera, originating in Asia, replaced the plague as the infectious disease of major concern in the latter part of the nineteenth century, and although Koch demonstrated the bacterial basis for cholera in 1884, it took decades before this information could influence the efforts at cooperation to control the disease. In the face of repeated epidemics of cholera and growing apprehension about the difficulty in containing them, the major powers began to meet in conferences to discuss the possibility of collaborative action to reduce the threat of epidemic disease. The history of the International Sanitary Conferences, the first of which was held in Paris in 1851, has been very well described (Goodman, 1971 ; Howard Jones, 1977 ; 1978). They were convened to discuss action by nations to control disease, but it took seven such gatherings before an International Sanitary Convention was signed and it was not until 1903 that the world saw a Convention that introduced some uniformity of approach among the participating nations against the importation of plague and cholera. The agreement over the Sanitary Convention led naturally to the consideration of a permanent body to coordinate the international health work needed.

### **International Health Organizations**

The first of these bodies was the Office International d'Hygiene Publique (OIHP) headquartered in Paris with the prime initial orientation towards systematizing and collating the outputs of the succeeding Sanitary Conventions which eventually came to include typhus and yellow fever as diseases of concern internationally. A separate international health organization was established after World War I under the aegis of the League of Nations. It is a salutary lesson in international power politics to review the

machinations that prevented the logical formation of a single body. For example, the United States was not a member of the League of Nations, but instead was one of the most vocal and effective opponents to establishing a single coordinating body (Goodman, 1971). It is important to realize that the work of these bodies was essentially informational, to report on the presence of disease and advise countries on measures to be taken.

The work of the Rockefeller Foundation's International Health Division, established in 1913, and that of the League of Red Cross Societies, established in 1919, are often cited as examples of international work by non governmental organizations. There is no doubt that their work had a very positive effect on the health of people in many countries. The work of the Rockefeller Foundation in yellow fever in Perú, for example was of critical importance, (Cueto, 2001) and its campaign for hookworm eradication in the USA is said to have played a major role in eradicating the "germ of laziness" and contributing to the economic development of that part of the country (Ettling, 1981). However, in spite of the official title given to the work of these organizations, they are not truly international, because they did not involve any cooperative actions between nations.

After the end of World War II the World Health Organization was formed as a single body responsible for coordinating international health work and it was agreed that it would incorporate the work and mandates of the existing international health organizations. This brief historical overview would not be complete without pointing out that the countries of the Americas had formed their international health coordinating body as early as 1902, the Pan American Sanitary Organization with the explicit objective of coordinating the collection of information and the systematization of practices to prevent the spread of infectious disease in the Americas (Pro Salute Novi Mundi, 1992).

### **The Three phases of International Health Work**

If we restrict our analysis to a period that begins with the twentieth century, the period up until the formation of the World Health Organization can be regarded as the first phase of the growth of interest in international health and the development of any semblance of collaborative international health work. The most important characteristic of this phase is that it represented the effort to control infectious diseases "at the border" (Arhin-Tenkorang, 2003) of the individual countries. All the actions,

beginning with quarantine, were to prevent ingress of disease or prevent diseases from leaving the infected area. This latter was accomplished by standards for inspection of ports to ensure that ships did not become infected or infested there. It has been pointed out that given the relative prevalence of disease in the rich and poor countries, the focus was on preventing the diseases of the poor from affecting the rich. Aginam refers to this as the age of isolationism where the developed world viewed the developing world as a reservoir of pestilence and disease. *“The real politic of nineteenth century public health diplomacy driven by international sanitary conferences was the desire to protect civilized Europe from exotic diseases and pathogens that emanated from the uncivilized non-European societies”* (Aginam, 2004).

The second characteristic was the utilitarian one. The prevention of disease was important not only in terms of the human condition, but also for trade and commerce. Indeed, the Pan American Sanitary Code of 1924, which is the formal treaty that sustains the current Pan American Health Organization, states specifically that its rationale is:

The standardization of the measures employed at places of entry, for the prevention of the introduction and spread of the communicable diseases of man, so that greater protection against them shall be achieved and unnecessary hindrance to international commerce and communication eliminated (Pan American Sanitary Code, 2002).

The third characteristic of this phase is that any health concerns were for those of the individual countries. There was no explicit interest in the health of people globally and therefore the cooperation did not extend to providing any assistance for systematically improving the health of the poorer and unhealthier people of the world. Finally, this phase of international health is characterized by collective agreements between governments as representing nation states. Indeed the first sets of international sanitary conferences were attended by diplomats and the conventions were seen in the same light as other diplomatic treaties between sovereign governments.

The second phase of international health and international health work began after World War II and extends up to the latter decades of the 20<sup>th</sup> century. For the first time serious attention was paid to controlling and preventing disease globally and there is discernible international action specifically for this purpose. The driving forces are essentially humanitarian: self interest and

national security. There is clear evidence of nations cooperating among themselves to achieve common ends for instance, the successful eradication of small pox still remains as one of the beacons of international cooperation for a global health effort. The humanitarian aspect was dominant immediately after World War II, in spite of the fact that much of the debate was colored by the Cold War. The declaration of President Truman in his inaugural address in 1949 gives an idea of this focus, where he declared that:

[w]e must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas. More than half the people of the world are living in conditions approaching misery. Their food is inadequate. They are victims of disease. Their economic life is primitive and stagnant. Their poverty is a handicap and a threat both to them and to more prosperous areas. For the first time in history, humanity possesses the knowledge and skill to relieve the suffering of these people.

As a part of the post-war euphoria for collaboration among nations, there was a strong belief that genuine international cooperation could successfully address the health problems of the world. This was the phase of increasing recognition of what Aginam (2004) refers to as “mutual vulnerability to disease in a globalizing world”. Self interest, however was also evident. A landmark publication by the Institutes of Medicine of the United States set out quite clearly why it was in the interest of that country to address health problems outside its own borders, (Institute of Medicine, 1997), and there was the obvious problem of americans acquiring diseases when they traveled abroad. At its very basic level, widespread disease in the underdeveloped countries could breed discontent and the possibility of social unrest which might spill over into the more developed countries. In addition, unhealthy conditions may be one of the reasons for migration to the more developed and healthier countries. Countries which are unhealthy and poor are usually not considered good markets for the products of healthier ones. According to Walt (2001), states cooperate in health because, although it may prove to be difficult, they recognize the benefit of promoting the international public good that is health. They may also do so because of shortcomings in national health systems which may be strengthened by collaborative action and, finally, although rarely, they may cooperate because of the threat of force. National security has also

come to the fore as a reason for all countries to be interested in health (Alleyne, 1996 & Health and Hemispheric Security, 2002).

The World Health Organization was the unquestioned and unchallenged forum through which countries sought to pool expertise and resources to address health issues. The cooperation through WHO was initially conceived as technical assistance, in that the experts from the various countries employed by WHO give out their expertise in an almost missionary fashion, and the function of the agency and its assistance were the transfer of knowledge and expertise from the developed to the developing world. There was little perception that the work of the agency had major importance in health terms for the developed countries.

The formal relationships between and among states in other fields of course affected their action in health. Panisset (2002) has produced an elegant description of international health as an integral part of international relations and foreign policy. His starting point was the attitude of countries of the Americas to Peru when cholera appeared there in 1992. He describes this second phase of international health as a vindication of the functional theory of politics as espoused by Mitrany, one of the doyens of internationalism. Mitrany was more interested in international politics, but his functionalism is relevant to this phase of international health.

[t]he major principles of functionalism are that man can be weaned away from his loyalty to the nation state by the experience of fruitful international cooperation; that international organization arranged according to the requirements of the task could increase welfare rewards to individuals beyond the level obtainable within the state; that the rewards would be greater if the organization worked where necessary, across national frontiers, which very frequently cut into the organization's ideal working space (Mitrany, 1875).

The third phase of international health work, which started in the latter decades of the twentieth century and extends up to the present, is characterized not so much by a change in the intent of the work, but rather by a fundamental change in the number of actors involved and the plurality of organizations trying to improve health globally. Concern for health is still driven by an appreciation of collective risk, which has been accentuated by globalization. The rapid spread of information in itself contributes to some of the "modern" diseases and there is an ubiquity of vectors of disease that include humans, food and animals; concerns about this may be

seen in the preparations being made globally to confront the possibility of an epidemic of avian flu. Although the focus may be clouded sometimes, altruism and humanitarian concerns still drive some collective action for health.

It is in this third phase that we have seen a shift, with global health tending to replace the notion of international health more frequently, although there should be no confusion about these two substantially different concepts. It is not pedantic or semantic to insist that health is a state of being of people and is addressed individually or in populations which are distributed in some geographical space. One should be able to differentiate between global, national, local and individual health and the commonly used metrics of health reflect these distinctions. International health must imply actions by nations, and the term connotes a specific set of actors. The response to national disasters by collective action of nations is an excellent example of international effort that focuses on a national or sub-national space. International action can focus on a national, a regional or a global health issue. Actions to improve health globally do not necessarily involve cooperation among nations and therefore need not be international. Global health should refer to the state of health of people in the world as a whole, and must have a geographical connotation. Goodman's definition of thirty-five years ago is still the simplest and clearest, (Goodman, 1971) he defined international health as:

“[a]ny or all of those activities for the prevention, diagnosis or treatment of disease which require the combined consideration and action of more than one country”.

He clearly identified country and nation as being synonymous and posited that international health was necessary to improve world health. It has been suggested that the change of terminology with global replacing international was a part of a larger political and historical process that involved a change in the role of WHO and the increasing impact of globalization (Brown, 2006 & Yach 1998). It is still unclear why world health has given way to global health, but perhaps this is simply a preference for grammatical exactitude.

What is perhaps new is the growing appreciation of the fact that the health of the world is everybody's business and not just the concern of the national governments. The health of the world's people is being defined as a global public good and therefore there must be some global architecture for preserving it as such (Chen,

1999). There is the perception that the nation state cannot be the sole actor when so many of the determinants and outcomes of disease depend on influences outside the national boundaries, and it is in that context that concerns about governance arise.

### **Governance in Global Health**

Much of the debate about governance stems from different interpretations of a concept which draws on theories of social science and public policy (Thibault ; Weiss, 2000). Rhodes (1996) for example, identifies six uses of the term, such as “the minimal state”, “corporate governance”, “the new public management”; “good governance”; “socio-cybernetic systems”, and “self-organizing inter-organizational networks”; and proposes that the last “complements markets and hierarchies as governing structures for authoritatively allocating resources and exercising control and coordination”.

Governance in this paper has more of a normative focus and is similar to the concept and definition as could be applied to the complex institution of a University (Gayle, Tewarie). It is taken to mean rather simply: “the structure and processes through which decisions get made that allow for the optimal functioning of the institution” and is fundamentally different from government. Effective governance of the institution or system provides the strategies, identifies the priorities and sets out the modalities for achieving the desired outcomes. This is not very distant from the manner in which the World Bank (1994) uses the term:

Good governance is epitomized by predictable open and enlightened policy making; a bureaucracy imbued with a professional ethos; an executive arm of government accountable for its actions; a strong civil society participating in public affairs; and all behaving under the rule of law.

However, the Commission on Global Governance (1995) defines governance as...

“governance is the sum of the many ways individuals and institutions, public and private, manage their common affairs”.

The complexity of governance increases with the numbers of actors and interests involved, but the essential concept remains the same, that there must be structures and processes through which the whole enterprise must be managed. Thus, the main question is what are structures and processes that operate among and within nations to promote health in some defined geographic space which

in the context of global health will be at the world level. It would also seem to be important to frame governance in such a way as to be able to describe what is good governance as the World Bank has done and what is not. Simply to describe it in terms of a myriad of networks and actors and not to be able to define those characteristics that are amenable to change would seem to be inadequate treatment of the issue. It is of interest that in spite of all the challenges that WHO has faced, it would still seem that any structure that seeks to engage the multiple actors and weave some reasonable web from the numerous networks and players involved in global health, gives that organization a prominent place (Kickbusch, 2000).

### **The Role of the State**

We have perforce to examine the nature of the interaction among nations before considering other actors. Right from the beginning with the formation of the International Sanitary Conventions, it was understood that the agreements were between governments representing nation-states. The preamble to the constitution of the World Health Organization begins:

“The States parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of peoples, ...”.

“The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States”.

It is clear that the “parties” to the agreement were nation-states as represented by their official governments. The governance structure of this organization does not admit formal participation and involvement of any entity but governments. To this day there is no recognition of the increased pluralism of actors within the nation state that is advancing rapidly and influencing our understanding of internationalism. The processes through which these international organizations functioned were derived from agreements and resolutions fashioned collectively by governments in various assemblies and translated into their technical work at the level of the country and predominantly, although not exclusively in collaboration with the national authorities. There has been no recognition of the history and subsequent development of the nation-state, nor appreciation that the absolute concentration of

power in the hands of the government as representative of the nation-state is a thing of the past and we are now in a post-Westphalian era. This phenomenon, designated, a “power shift”, has been spurred by interconnectedness that has been accelerated by the growth and speed of communications (Matthews, 1997).

The Treaty of Westphalia of 1648 that marked the end of the Thirty Year War saw the dissolution of the Holy Roman Empire, the demise of feudalism in Europe and the appearance of the nation-state as the entity that would exert authority over a geographically defined space. The nation-state represented the form of social organization through which the lives of the defined population were ordered. That state was characterized by having a system of government responsible for protecting the basic rights of its citizens and the state and the government were virtually one and the same thing. But progressively we have seen the steady growth of pluralism within the nation state and although there is still a government as a central actor within the state, there are also several non-government actors which claim legitimacy in contributing to the ordering of the affairs within the nation-state (Drucker, 1999). Essentially those other actors can be classified loosely as the civil society and the private sector. It is not that the nation-state has disappeared, but there are now several legitimate actors within that state in addition to the government. The persistence and present relevance of the nation-state was captured in a famous editorial of the *Economist* (1995), “The nation-state is dead. Long live the nation-state”.

But to be fair, cognizance must be taken of the state of the world when the current international system was established. As the Commission on Global Governance (1995) points out.

When the United Nations system was created, nation-states, some of them imperial powers, were dominant. Faith in the ability of governments to protect citizens and improve their lives was strong. The world was focused on preventing a third world war and avoiding another global depression. Thus the establishment of a set of international, intergovernmental institutions to ensure peace and prosperity was a logical, welcome development.

It is sometimes also forgotten that at that stage the number of nation states was relatively few. In 1945 there were only 48 members of the United Nations, whereas today there are 192 with consequent increase in the complexity of arrangements, given also the wide variation in size and resources among them.

## **Governance in International Health Organizations**

The main issue of governance in relation to both international and global health is the function of all the interested stakeholders in the nation-state, government as well as non-government ones. In the case of international health, in the sense of health activities carried out by collaborative action among nations, the reality is that for the most part they are inter-governmental. The great question for the near future is how their governance in terms of their structures and processes will be altered to incorporate the plurality of actors that claim legitimacy within the state.

The question of governance in global health then devolves into two separate but related issues. First, how will the new pluralism affect the governance of the organizations that have a mandate for the international work necessary to improve health globally? The second is how governance will evolve in a system in which a plurality of actors is involved.

As we have seen, the World Health Organization is still essentially an inter-governmental organization and its structures and processes do not admit of formal action by any beside governments. Its Governing Bodies are comprised of representatives of governments. It is of interest that initially the members of the Executive Board of WHO were supposed to serve in their personal capacities, as if that would remove the influence of government politics. But it has come to be accepted and formalized that the members do represent their governments. The Head of the Organization is elected by a purely political process in which the weight of the diplomatic efforts of a country counts for more than the intrinsic merit of the candidate. One of the major challenges for this organization will be to so redesign itself to take account of the pluralism that is currently being observed in the nation states. Will WHO allow civil society and the private sector into its councils with voice and vote equal to those of the governments? Will the national governments appreciate the anachronism of the current arrangement and so structure their delegations to reflect the contribution of the non-government state actors? It is easy to determine the locus of authority in a government and thus the lawful representative, but what will be the mechanism for ensuring the legitimacy of the other non-government representation? The multi-interest input into what is an international organization may be seen in the International Labor Organization which from its inception has recognized that the name international did not

preclude the participation of actors outside of formal governments in its governing bodies.

Article 1(International Labour) of its constitution states:

“The Members of the International Labour Organization shall be the States”.

Article 3 sets out its composition as follows:

The meetings of the General Conference of representatives of the Members shall be held from time to time as occasion may require, and at least once in every year. It shall be composed of four representatives of each of the Members, of whom two shall be Government delegates and the two others shall be delegates representing respectively the employers and the workpeople of each of the Members.

Currently there is such a multitude of actors involved in global health that it might be better to follow Frenk and his colleagues and refer to a World Health System (Frenk, 1997). There is a plurality of actors and there is pluralism within those actors as well. There are several agencies of the United Nations beside WHO whose actions affect health globally. Reference is made only to the three main ones although other agencies, such as the Food and Agriculture Organization (FAO) and the United Nations Development Program (UNDP) also carry out activities related to health.

UNICEF. Created by the United Nations General Assembly in 1946 to help children after World War II in Europe, UNICEF was first known as the United Nations International Children's Emergency Fund. In 1953, UNICEF became a permanent part of the United Nations system, its task being to help children living in poverty in developing countries. Its name was shortened to the United Nations Children's Fund, but it retained the acronym "UNICEF," by which it is known to this day. Its governing body consists of representatives of 38 governments.

UNFPA. At the request of the United Nations General Assembly, a modest Trust Fund for Population was established in 1967 to provide training, research and advice in the field of population. In 1969, the fund evolved into the UN Fund for Population Activities. It was officially renamed the United Nations Population Fund (although retaining the acronym UNFPA) in 1987, to reflect its lead role within the UN system: promoting population programmes and coordinating population activities. This agency began with an emphasis on family planning as

important for population control. Its demographic orientation was evident in the series of population conferences that were held. But since 1994 the focus has shifted to sexual and reproductive health with an emphasis on the rights of women in this area. Its executive board comprises government representatives.

UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative joint venture of the United Nations family. UNAIDS brings together the efforts and resources of ten UN system organizations to help the world prevent new HIV infections, care for those already infected, and mitigate the impact of the epidemic. Established in 1994 by a resolution of the UN Economic and Social Council and launched in January 1996, UNAIDS is guided by a Programme Coordinating Board with representatives of 22 governments from all geographic regions, the UNAIDS Cosponsors, and five representatives of nongovernmental organizations (NGOs), including associations of people living with HIV/AIDS. UNAIDS is the first of the UN agencies dealing specifically with health that includes other than government members on its main governing body.

Even within the UN system itself, there is no structure that permits or demands cooperation in health. As Williams has pointed out, there may be open competition between the specialized agencies, producing a crisis in the system (Williams, 1987). It is not evident that there has been much improvement in this area and this has contributed to some of the call for reform of the UN and its agencies. Given the fact that some of the heads of these are elected and some appointed by the Secretary-General, it is difficult to mandate cooperation which depends on the good sense and good will of the head of the agency involved. Also, the different source of funding for the various agencies means that there are different constituencies of influence and interest. The prospect for establishing such structures and processes that will lead to effective and efficient collaboration in these UN agencies is not very promising.

### **Governance in a World Health System**

Are the prospects for good governance in the wider “World Health System” any better than among the formal agencies committed to health? As pointed out earlier, there are numerous actors involved in health. There are the governments, private business and civil society and their interaction and international reach have increased as we have witnessed the increase in

globalization. We have referred before to the phenomenon of globalization which as defined by Giddens (1990) is “the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa”. This process with its intensification of interconnectedness driven inexorably by communication technology makes health a genuine global issue. Infectious disease was once thought to be the sole or main manifestation of this global interconnectedness, but now we know that some of the major determinants of the noncommunicable diseases are due to global influences. There can be no better example of a global phenomenon affecting noncommunicable disease than tobacco use, or more precisely the promotion of tobacco use by the tobacco industry.

The fact that the transfer of health risks is trans-national and their control is beyond the capacity of a single government has led to the view that the nation–state and its government are impotent to be primary actors in global health, hence the need to seek out and stimulate the growth of other actors. But there is a dilemma. While the risks are transnational and the state cannot control them, yet it is the state that has the authority for corrective action within its borders. As Jamison et al, (1998) put it:

The authority of the nation state has been undermined by a combination of supranational forces leading to globalization, and by subnational forces leading to fragmentation and new forms of “tribalism”. Nevertheless, the political structure of the world is such that sovereignty remains vested in individual nation states-one consequence being that national governments retain principal responsibility for the health of their populations.

There are numerous examples of businesses with global reach; trans-national business enterprises clearly influence health. Business coalitions have been formed to address specific health problems as in the case of HIV/AIDS (Global Business). There have been movements to strengthen global civil society by forming networks of diverse “third sector” actors (De Oliveira, Tendon, 1994).

The concept of what civil society and the non-governmental organizations can do in global health has been changed dramatically over the past 10 years by the Bill and Melinda Gates Foundation with assets of US\$29 billion and expenditure on global health in 2005 of US\$844 million (Global Health-Bill and Melinda Gates Foundation). This capacity has been enhanced even further by Warren Buffet’s gift of US\$31 billion and the charge that

US\$1.5 billion is to be spent yearly. This Foundation whose global health mission is “*to help ensure that lifesaving advances in health are created and shared with those who need them most*” does indeed have the capacity to make a difference. Its decisions are shaped by enlightened leadership and its board, and its structures and processes have no formal link to any international health structure. Indeed, it is unlikely that any of the formal structures could accommodate an organization of this size.

But in the final analysis, any system of global governance for global health has to recognize the primacy of the nation state and more specifically the government as the primary actor that has the legal and moral authority to address the health problems within its jurisdiction, even though the determinants may be trans-national and the agreements for collaborative action may be international. It is only the government within the nation state that can pull the policy levers necessary for specific action to address many if not all the social determinants of health, even those which owe their genesis to trans-border spread of vectors. The origin of the risk may transcend national borders, but the corrective solution in most cases lies within the nation state. Much of the discussion on the problem of the plurality of agents and the complexity of achieving cooperation and collaboration loses much of its salience if the fundamental principle is observed, that it is the national program that is the focal point and the framework for action in the individual country. This is not to gainsay the fact that in many occasions there are large programs carried on by non-governmental organizations, including organized religion which provide care to populations. The balkanization of countries with different actors assuming responsibility for care or aspects of care has been seen not infrequently. However, this has to be an unsatisfactory situation and its persistence more often than not perpetuates the weakness of the state apparatus which has the legal and moral responsibility of providing the sanitary and social measures needed to ensure health. This does not mean that NGOs should not and cannot contribute to health outcomes at the country level and we have seen in at least one country-Guatemala, governments accepting the fact of plurality of institutions and contracting with NGOs to provide care under specific conditions.

## **Ethical Issues**

No reflection on the health of individuals or global populations, and the responsibility involved, can escape ethical considerations. There would be general agreement that there must be an ethical code for population health as there is one for the individual care of patients by a physician. There is indeed an accepted code of ethics for public health for the American Public Health system (Thomas, 2002). That code embraces such principles as the need to observe human rights, distributive justice and duty as an ethical motivation, but these deal essentially with the actions of individuals who have the responsibility for public health within a country. It is doubtful if this code can be applied to global health.

Singer explores generally the type of global thinking and practice that have ethical dimensions. The essential question is whether individuals who put the welfare of their kith and kin above the welfare of strangers can be induced to accept that there is a moral, ethical responsibility to care for those who are not within their “circle” and those in proximity or those who are alike tend to be the group to which individuals justify themselves. It is difficult for the individual to be anything but utilitarian with respect to health. While theoretically the individuals may accept that there is a great deal of inequality among humankind and all persons have rights to the measures to protect and preserve health, at a practical level, they see this differently. But Singer argues that all human beings should be the basic unit of ethical concern. The question at the global level is what is the mechanism for achieving a situation in which each person’s health, regardless of geographical location is valued equally and the reduction of inequities is a matter of policy at a higher level and not of individual volition? This can only be done by international cooperation, which may involve actors other than government entities. As noted before, the problem is the structure to achieve that cooperation. Singer posits the ideal of some form of global government, but quickly puts it aside as being unfeasible because of the complexity and rigidity of any such structure, apart from the reluctance especially of all states, large and small to relinquish any part of their sovereignty.

The operationalization of ethical principles at the global level must involve the question of the allocation of resources to address the determinants of inequalities among states as a matter of social justice. Some of these inequalities are socially determined and others may depend on the inadequacy of the local health systems.

The ability to measure the differences in health status as well as the weight of the determinants, is an essential pre-requisite to any effort to reduce the inequalities within and among countries. Thus, it becomes almost a matter of ethical necessity that systems be established to measure the state of individual and population health. It is unhelpful to report the state of health of countries as simply national averages, as such data hide the differences between groups within the country characterized by their geographical or social location and therefore make it impossible to show where the inequities lie or craft measures to address them. The approach to measurement of health thus has an ethical dimension and should not be grounded in the utilitarian approach which sees improvement of the average as being the goal to be achieved.

The efforts to improve health globally must include consideration of the research that is necessary. Much of the improvement of the recent past in developing countries has been due to the diffusion of the information and technology that has been derived from research, most of which has been carried out in the developed world (Jamison, Sandbu, Wang). Genuine international cooperation in health does take place as was the case for the sequencing of the human genome. However, most of the health research that is called international, as with many things in health called international are really “extra-national” and relate to activities carried out in developing countries by actors from developed countries.

Bhutta (2002) has outlined from the perspective of the developing world many of the ethical aspects of this “international” research which have come under increasing scrutiny recently, particularly with regard to the trials of anti-retroviral drugs in developing countries (Angell, 1997). As Bhutta points out, much of the controversy stems for the fact that some wish to see the issue solely in terms of guidelines and regulations and are not sensitive to the complexities involved in community participation and the prior and subsequent standards of care. The health research should not only focus on producing specific answers to questions, but also be concerned with the issue of equity and the extent to which the research and its results will result in reducing the inequities that are so evident. The ideal should be a partnership between the developing and developed country researchers which is based on mutual trust and decision making, national ownership, the early planning to translate findings into policy and practice and the commitment to develop local capacity in research (Costello, 2000).

## **Conclusions**

Global health connotes the health of the world's people, and it can best be assured by collective international effort. The governance of that effort remains a challenge, especially in our highly interconnected world, but the best hope of efficient organization of the system lies in the international health organization, representing the collective will and effort of the nation-states in their post-Westphalian pluralist configuration. A recent paper from the UK Department for International Development argues for reform of the international development system if governance is going to work for the poor (UKDID, 2006).

Effective international organizations are needed now more than ever to balance competing national interests and find solutions to problems that cannot be solved by individual countries alone. Only by working multilaterally will it be possible to: act when states fail to protect their people; enforce rules-based trade; tackle epidemics like AIDS or Avian flu that threaten us all; and manage the climate, forests, fisheries and water we all share. There is no alternative. Without an effective international system, the world would be a more unequal, dangerous and divided place.

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# GLOBALIZACIÓN Y SALUD: RETOS PARA LOS SISTEMAS DE SALUD EN UN MUNDO INTERDEPENDIENTE\*

*Julio Frenk*

*Octavio Gómez-Dantés*

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El desplazamiento de los asuntos humanos del marco restringido de la nación-estado al vasto escenario del planeta Tierra está afectando no solo el comercio, las finanzas, la ciencia, el medio ambiente, el crimen y el terrorismo; también está influyendo en la salud (Valaskakis, 2001). En 1997, un importante informe publicado por el Instituto de Medicina de los Estados Unidos de América señaló: “Las distinciones entre los problemas de salud domésticos e internacionales están perdiendo utilidad y en ocasiones generan confusión”.<sup>1</sup> Esto se debe a lo que el gran historiador europeo Eric Hobsbawm (1994) denominó la virtual aniquilación del tiempo y la distancia.

No se quiere con esto sugerir que los contactos internacionales intensos son una novedad. Desde tiempos inmemoriales las fuerzas del comercio, la migración, la guerra y la conquista han unido a personas de lugares distantes. Después de todo, la expresión “ciudadano del mundo” fue acuñada por el filósofo Diógenes en el siglo IV antes de nuestra era. Lo novedoso es el ritmo, amplitud y profundidad de la integración. Como nunca antes, las consecuencias de las acciones que suceden en lugares lejanos se manifiestan, literalmente, en las puertas de nuestros hogares.

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\*Parte de las reflexiones sobre globalización y salud que aquí se presentan se basan, con modificaciones, en el siguiente artículo: Frenk, J. y Gómez-Dantés, O. 2002. Globalization and the Challenges to Health Systems. *Health Affairs* 21, 3:160-165.

El grado de proximidad en nuestro mundo se puede ilustrar con el número de viajeros internacionales, que se triplicó de 1980 a la fecha y hoy asciende a tres millones de personas diarias. Además, hace dos años, el tráfico telefónico alcanzó por primera vez en la historia los 100 mil millones de llamadas (Kearny, 2001). El mismo movimiento anti-globalización se globalizó en 2001 cuando activistas de todo el mundo se reunieron en el primer Foro Social Mundial en Porto Alegre, Brasil. No podemos subestimar las implicaciones de estos cambios para la salud. Además de atender los problemas domésticos, todos los países del mundo tienen ahora que enfrentar la transferencia internacional de riesgos y oportunidades para la salud.<sup>2</sup>

El caso más obvio de la desaparición de las fronteras de la salud es la diseminación de enfermedades transmisibles. De nuevo, no se trata de un fenómeno novedoso *per se*. El primer caso documentado de epidemia transnacional fue la plaga ateniense del 430 de nuestra era. Habiéndose originado probablemente en África, se diseminó en barcos que comerciaban con granos, a través de Persia, a la Grecia antigua (Porter, 1996). La Muerte Negra de 1347, que acabó con una tercera parte de la población europea, fue resultado directo del comercio internacional. En el siglo XVI, la conquista de los imperios azteca e inca constituyó un ejemplo temprano de guerra bacteriológica involuntaria a través de la introducción de la viruela y el sarampión en poblaciones que no se habían expuesto a estos padecimientos. La colonización del Caribe y Brasil casi condujo a la exterminación de las poblaciones indígenas, situación que obligó a la importación de esclavos de África occidental. Este tráfico, a su vez, llevó el paludismo y la fiebre amarilla al Nuevo Mundo, creando desastres adicionales (Porter, 1999). En este intercambio microbiano, es posible que Cristóbal Colón haya llevado una grave enfermedad de las Américas a Europa, la sífilis (Porter, 2004).

Otro ejemplo de la ininterrumpida historia de la transferencia transnacional de infecciones es la pandemia de cólera de 1829, que se originó en Asia, pasó a Egipto y el Norte de África, entró en Rusia y cruzó a Europa. Tres años después llegó a la costa este de Estados Unidos. Más recientemente, la pandemia de influenza de principios del siglo XX, la mal llamada influenza española, produjo más decesos que la Primera Guerra Mundial.

Como podemos ver, las enfermedades infecciosas tienen un viejo expediente de presencia cosmopolita. Lo novedoso, como se mencionó anteriormente, es la escala de lo que se ha dado en

llamar “tráfico microbiano”. El incremento explosivo del comercio y los viajes internacionales produce miles de contactos potencialmente infecciosos, y los *jets* han reducido el tiempo incluso de los viajes intercontinentales más largos, a menos del periodo de incubación de cualquier enfermedad infecciosa humana. Así, el “mosquito tigre”, un potente vector del virus del dengue, se introdujo en Estados Unidos en los años ochenta en un cargamento de neumáticos usados provenientes del norte de Asia. De la misma manera, el brote peruano de cólera que se inició en enero de 1991, se convirtió en una epidemia continental en cuestión de semanas.

La tuberculosis es otro problema re-emergente. En el mundo hay alrededor de 9 millones de personas que sufren de esta enfermedad y más de 2 millones mueren por esta causa anualmente. Varias razones explican su regreso; una de ellas es la fragilidad de las personas inmuno-suprimidas. Frecuentemente la tuberculosis es uno de los primeros signos de infección con VIH. Otras variables que influyen en el desarrollo de esta enfermedad son el hacinamiento, la mala nutrición y la falta de atención a la salud, factores todos ellos comunes entre los socialmente marginados.

Las últimas adiciones a la lista de epidemias globales son el síndrome respiratorio agudo severo o SARS y la influenza aviar. Esta última es todavía un peligro regional, pero hay especialistas que anticipan una pandemia de este tipo de influenza (Osterholm, 2005). Al respecto, confrontamos dos grandes retos. En primer lugar, existe la necesidad de diseñar medicamentos más efectivos contra las enfermedades virales en general y, más en específico, contra la influenza. El *oseltamivir*, un inhibidor de neuraminidasa, puede reducir los síntomas y prevenir la transmisión de la gripe, pero sus verdaderos beneficios todavía están por demostrarse. El otro reto es la necesidad de nuevas tecnologías para producir vacunas contra la influenza, más económicas y de manera más rápida. Éste es un reto enorme, dada la demanda que se produciría en caso de una pandemia de esta naturaleza (Garret, 2005). Además, se necesita expandir la capacidad de producción de estas vacunas mediante el fortalecimiento de la infraestructura, la capacitación de los recursos humanos y la transferencia de tecnología a un mayor número de países que los nueve que están en condiciones de producirla.

La aceleración de la diseminación de las enfermedades infecciosas se relaciona con cambios radicales en nuestro ambiente y estilos de vida, lo cual ha llevado a Arno Karlen (1995) a hablar

de una nueva era bio-cultural. En efecto, para complicar aún más las cosas, no son solamente la gente y los microbios los que viajan de un país a otro; también lo hacen las ideas y los estilos de vida. El tabaquismo y la obesidad son los mejores ejemplos de los riesgos a la salud ligados a la globalización que están imponiendo una doble carga a los sistemas de salud en el mundo, complicando aún más las inequidades existentes. De hecho, los problemas que afectan **únicamente** a los pobres, como la malaria, no son los **únicos** problemas de los pobres. Las muertes relacionadas con el consumo de tabaco se están concentrando de manera creciente en los países en vías de desarrollo, que carecen de las estructuras legales y regulatorias para contrarrestar el enorme poder de las corporaciones multinacionales. La única manera de contrarrestar ese poder es acoplando las políticas nacionales con instrumentos globales, como la Convención Marco de la OMS para el Control del Tabaco, el primer tratado internacional de salud pública. México fue el primer país en firmar dicho tratado en la región de las Américas.

Pero la globalización de la salud va más allá de las enfermedades y los riesgos para incluir también a los productos para la salud. Por mencionar un ejemplo, las regulaciones sobre el acceso a medicamentos que requieren de prescripción en un país pueden ser subvertidas cuando un país vecino permite la compra indiscriminada de antibióticos, estimulando así la aparición de microbios resistentes en ambos países.

Otro desarrollo reciente con implicaciones potenciales para la prescripción irracional de medicamentos y la consecuente diseminación de resistencias microbianas es el creciente comercio de servicios y medicamentos a través de la Internet. El hecho de que no se trata ya de un fenómeno marginal queda demostrado con los esfuerzos recientes de la Organización Mundial de la Salud para controlarlo.<sup>3</sup>

Todos estos son factores contextuales que limitan el impacto final de los productos para la salud, particularmente los medicamentos y las vacunas, ya que, al final del día, todas las innovaciones tecnológicas tienen que proveerse a través de sistemas de salud concretos. Como lo hemos experimentado en el caso de los amargos debates alrededor del acceso a los medicamentos contra el VIH/SIDA, el desarrollo de fármacos efectivos en ausencia de mecanismos adecuados para hacerlos llegar a los pacientes puede crear dilemas éticos y políticos muy serios.

Por fortuna, ésta es una de las áreas en donde la interdependencia ha abierto nuevas avenidas para la acción colectiva internacional. Así, los esfuerzos iniciales de los años noventa por reducir el costo de los medicamentos contra el SIDA generaron resultados muy modestos. Hace unos años, sin embargo, una fuerte movilización internacional persuadió a varias compañías farmacéuticas multinacionales a establecer acuerdos con países en vías de desarrollo para ofrecer descuentos significativos en los precios de los medicamentos. México se benefició de estos acuerdos, y gracias a ello hoy se cuenta en nuestro país con acceso universal a los anti-retrovirales.

Fuerzas relacionadas con la globalización también posibilitaron la organización en 2001 de una Sesión Especial de la Asamblea General de la ONU dedicada al VIH/SIDA, que aprobó una histórica Declaración de Compromiso. Ésta fue la primera vez en la historia que la Asamblea General dedica una sesión a un tema de salud, lo que subraya el creciente vínculo entre las pandemias como el SIDA, el desarrollo económico y la seguridad global.

La creciente complejidad de los sistemas de salud ha incrementado como nunca el valor de las comparaciones internacionales sobre este particular. Dado el enorme impacto económico y social de las decisiones de política, los países se pueden beneficiar de un proceso de aprendizaje compartido. Éste es el significado del esfuerzo que llevó a cabo en el año 2000 la Organización Mundial de la Salud para evaluar el desempeño de los sistemas de salud de todo el mundo.<sup>4</sup> El análisis comparativo tiene el potencial de promover la diseminación internacional de las mejores prácticas existentes.

Este tipo de bienes públicos globales relacionados con el conocimiento será clave para alcanzar mejoras adicionales en la salud.<sup>5</sup> De hecho, ahora sabemos que la mayor parte de los progresos en salud que se produjeron en el siglo XX pueden atribuirse al avance del conocimiento, a través de tres mecanismos. En primer lugar, el conocimiento genera nuevas y mejores tecnologías para el desarrollo de medicamentos, vacunas y procedimientos diagnósticos. En segundo lugar, el conocimiento científico, al ser interiorizado por las personas, estructura su comportamiento cotidiano en asuntos tan importantes como la higiene personal, los hábitos alimenticios, la sexualidad y la crianza de los niños. De esta manera el conocimiento ayuda a que las personas modifiquen sus estilos de vida para el beneficio de su salud. En tercer lugar, el conocimiento puede mejorar la toma de

decisiones de los gobiernos, tanto en la prestación de los servicios de salud como en la formulación de las políticas públicas.

Cada uno de estos mecanismos se ve limitado por una serie de brechas que debemos superar. Por lo que se refiere al uso del conocimiento para generar nuevas soluciones, nuestro principal reto es enfrentar “la brecha 10/90”, que implica que apenas 10% de los recursos globales para la investigación en salud se destinan a los problemas que afectan a 90% de la población mundial. Por lo que toca al uso del conocimiento para mejorar los estilos de vida, el reto consiste en ampliar el acceso a él por parte de todas las personas, particularmente las más pobres. Democratizar el conocimiento es esencial para que las personas desarrollen el poder de enfrentar los riesgos añejos y emergentes. Este poder les permite asimismo ser usuarios informados de los servicios de salud y ciudadanos exigentes de sus derechos. Finalmente, la tercera brecha se refiere a la distancia que aún separa el conocer y el hacer, debido a una deficiente traducción de la investigación en decisiones para la acción inmediata. Aquí el gran reto es lograr que el **poder de las ideas** oriente las **ideas del poder**, es decir, las ideas de aquéllos que tienen el poder para diseñar e implantar las políticas de salud.

Diversos desarrollos recientes en nuestro país pueden servir para ilustrar este último punto. Gracias a la colaboración de varias organizaciones académicas e internacionales, el armamento analítico de las políticas de salud se ha visto considerablemente enriquecido durante los últimos años con herramientas como la medición de la carga de enfermedad, el análisis de costo-efectividad, las cuentas nacionales de salud y las encuestas estandarizadas. La aplicación rigurosa de estos bienes públicos globales relacionados con el conocimiento, aunada a la existencia de excelentes bases de datos nacionales, ayudó a catalizar una reforma estructural del sistema mexicano de salud.

Se trata posiblemente de un caso de libro de texto en lo que se refiere a políticas basadas en evidencias. En efecto, el análisis riguroso hizo posible que tanto los tomadores de decisiones como el público en general cobraran conciencia de diversas realidades críticas que requerían de una solución. Así, el cálculo cuidadoso de las cuentas nacionales de salud reveló que más de la mitad del gasto total en salud en México era gasto de bolsillo. Esto se debía al hecho de que aproximadamente la mitad de la población carecía de seguro de salud. Estos hallazgos resultaron inesperados, ya que había la creencia generalizada de que el sistema mexicano de salud

se financiaba básicamente con recursos públicos. En contraste, el análisis reveló la existencia de una paradoja inaceptable. Sabemos que la atención de la salud es una de las maneras más efectivas para luchar en contra de la pobreza. Sin embargo, la propia atención médica se convierte en un factor de empobrecimiento de los hogares cuando no se cuenta con los mecanismos sociales para garantizar un financiamiento justo que proteja a toda la población.

La conciencia del hecho de que millones de hogares habían estado pagando sumas catastróficas de sus bolsillos, generó una perspectiva diferente sobre la operación del sistema de salud. Los diseñadores de las políticas públicas ampliaron su enfoque para tomar en consideración diversos temas financieros que demostraron tener un enorme impacto sobre la prestación de servicios de salud y los niveles de pobreza de los hogares mexicanos. Otro bien público global que contribuyó a la reforma fue el marco de la Organización Mundial de la Salud (OMS) para la evaluación del desempeño de los sistemas de salud. Este marco, publicado en el año 2000 como parte del *Informe sobre la Salud en el Mundo*, puso énfasis en el financiamiento justo como uno de los objetivos intrínsecos de los sistemas de salud.<sup>6</sup>

Como consecuencia directa de los altos niveles de gasto de bolsillo, México mostró un desempeño muy pobre en la comparación internacional sobre justicia financiera. En lugar de generar una reacción defensiva, la constatación de este resultado echó a andar en 2001 un análisis detallado a nivel nacional, el cual demostró que los gastos catastróficos se concentraban en los hogares pobres y no asegurados. Este análisis fue llevado a cabo de manera conjunta por la Secretaría de Salud de México, la OMS y la Fundación Mexicana para la Salud, lo que constituye ejemplo de la forma en que los gobiernos nacionales, los organismos internacionales y las instituciones no gubernamentales pueden unir esfuerzos. El análisis a nivel nacional se basó en datos de las encuestas de ingreso y gasto para México, otro bien público global. Estas encuestas son producidas por muchos países del mundo y generan bases de datos homogéneas que son clave para las comparaciones internacionales.

El uso cuidadoso de los análisis nacionales e internacionales generó las herramientas necesarias para promover una profunda reforma legislativa que fue aprobada en el 2003 por una amplia mayoría en el Congreso de México, estableciendo un sistema de protección social en salud. Este sistema está reorganizando e incrementando el financiamiento público hasta en un punto

porcentual del PIB durante un periodo de siete años. El objetivo es ofrecer un seguro universal de salud que beneficiará a 50 millones de mexicanos, pobres en su mayoría, que hasta ahora habían quedado excluidos de los esquemas formales de aseguramiento por ser auto-empleados, estar fuera del mercado de trabajo, o trabajar en el sector informal de la economía.

Uno de los sellos distintivos de la experiencia mexicana ha sido la inversión en investigación para el diseño de la reforma, el seguimiento de su implantación, y la evaluación de sus resultados. Éste es un claro ejemplo de la posibilidad de armonizar dos valores centrales de la investigación en salud: la **excelencia científica** y la **pertinencia a la toma de decisiones**.

La necesidad de contar con investigación sólida para iluminar la toma de decisiones se acentúa en estos tiempos, cuando todos estamos buscando mejores maneras de fortalecer los sistemas de salud. Debido a los vacíos en nuestro conocimiento actual, cada iniciativa de reforma debe ser vista como un experimento cuyos efectos deben ser documentados en beneficio de cualquier otra iniciativa, presente o futura. Ello requiere de una sólida inversión en la investigación de sistemas de salud. Cada innovación es una oportunidad de aprendizaje. No aprovecharla nos condena a redescubrir, con un enorme costo, lo que ya se sabía o, peor aún, a repetir los errores del pasado. Para **reformar** es indispensable **informar**, o de lo contrario se corre el peligro de **deformar**.

El caso mexicano también demuestra que el dilema entre la investigación local y la global es falso. Como hemos visto, la globalización permite convertir al conocimiento en un bien público internacional que puede llevarse al centro de las agendas nacionales con el fin de hacer frente a algún problema local. Esta aplicación, por su parte, retroalimenta el acervo global de experiencias, generando así un proceso de aprendizaje compartido entre las naciones.

Por último, la reforma mexicana ilustra la manera en la que los bienes públicos del conocimiento pueden empoderar a los tomadores locales de decisiones para hacer avanzar la agenda de salud en la competencia por atención y recursos públicos. Los responsables de la salud pueden usar las evidencias globales para demostrar que, además de su valor intrínseco, un sistema de salud con un buen desempeño contribuye al bienestar general de la sociedad, al mejorar la productividad, incrementar las capacidades educativas, desarrollar el capital humano, generar empleo, proteger el ahorro, aliviar la pobreza, mejorar la competitividad y estimular

de manera directa el crecimiento económico. Estos argumentos han sido una poderosa herramienta para convencer a los tomadores de decisiones sobre la necesidad de movilizar **más dinero para la salud**. Pero también es necesario garantizar a los ciudadanos que tengamos un sistema de salud eficiente para obtener **más salud por el dinero**.

El desempeño de los sistemas locales de salud también puede incrementarse con uno de los más potentes motores de la globalización: la revolución de las telecomunicaciones. La telemedicina está abriendo enormes perspectivas de mejorar el acceso de las poblaciones marginadas a los beneficios de la innovación, ya que apunta hacia un futuro en donde la distancia física no constituya un obstáculo significativo para la atención de la salud.

El reto, por supuesto, será asegurarse de que las brechas geográficas no sean simplemente sustituidas por las brechas digitales, y que las nuevas tecnologías no generen nuevas formas de exclusión social. La magnitud de este reto resulta clara cuando constatamos que el 80 por ciento de la población mundial, que vive en los países en vías de desarrollo, representa menos del 10 por ciento de los usuarios de la Internet.<sup>7</sup> Las nuevas formas de exclusión social se alimentan de las viejas calamidades de la pobreza y la desigualdad. Los 1,300 millones de personas que sobreviven con un dólar al día nos recuerdan las enormes brechas que aún es necesario superar.

La exclusión y la desigualdad son uno de los lados oscuros de la globalización; la insensibilidad hacia las culturas locales es otro. Juntos pueden explicar una de las paradojas más dolorosas de nuestros días: precisamente cuando la tecnología ha acercado como nunca a los seres humanos, estamos siendo testigos de la reaparición de la intolerancia en la forma de xenofobia, exterminio étnico y opresión.

Y con la intolerancia, como un gemelo siamés, viene el terrorismo, tradicionalmente el instrumento de las minorías fanáticas ofendidas que se resisten a creer en la persuasión. En su esencia, el terrorismo es la peor forma de deshumanización ya que convierte a la gente inocente en un simple blanco de ataque. El arsenal del terrorismo se ha expandido para incluir a las armas químicas y biológicas. De acuerdo con las agencias de inteligencia, en años recientes varios grupos militantes del mundo han tratado de desarrollar o adquirir armas biológicas para fines terroristas. Mucho se ha discutido sobre la viabilidad y posible magnitud de

este tipo de ataques. Lo que parece claro, sin embargo, a la luz de los acontecimientos recientes ocurridos en Nueva York, Madrid y Londres, y el rápido crecimiento del poder de la biotecnología, es la necesidad de fortalecer nuestros sistemas de vigilancia a través de redes internacionales de laboratorios de salud pública, mecanismos eficientes de intercambio de información y programas de capacitación para personal especializado. Independientemente de que se materialice o no un ataque bio-terrorista, estas medidas en sí mismas pueden mejorar el funcionamiento cotidiano de nuestros sistemas de salud para el bien común (Henderson, 2001).

En el largo plazo el mayor reto que enfrentamos es el de construir un orden mundial caracterizado por la paz en medio de la diversidad. En vez de afirmar nuestras identidades rechazando o destruyendo lo que es diferente, nuestra obligación es tratar de suavizar las confrontaciones, equilibrar los reclamos y buscar acuerdos (Berlin, 1992). De esta manera, podremos vivir de acuerdo a lo que Vaclav Havel (1995), ex presidente de la República Checa, denominó un código básico de coexistencia mutua.

La salud puede contribuir a este objetivo porque involucra aquellos fenómenos que unen a todos los seres humanos. Es ahí, en el nacimiento, la enfermedad, la recuperación y finalmente la muerte que todos encontramos nuestra humanidad común. En momentos críticos para el mundo la salud ha sido de manera consistente una de las pocas aspiraciones verdaderamente universales. De hecho, antes de la constitución de las agencias técnicas especializadas, los asuntos de salud eran un bien básico de la diplomacia internacional. Hoy la salud nos ofrece de nueva cuenta la oportunidad concreta de reconciliar el **interés propio** de cada país con el **interés común** de todas las naciones. Hoy, como nunca, la salud es un puente para la paz, un terreno común, una fuente de seguridad compartida.

Si hemos de construir un nuevo orden mundial en el que los valores como la salud sean promovidos en aras de la justicia y la seguridad, será necesario renovar la cooperación internacional. Para concluir, permítanme sugerir tres elementos para esa renovación, tres “e”: intercambio de experiencias, evidencia y empatía.

Los sistemas de salud en todo el mundo están enfrentando retos sin precedentes, muchos de los cuales, como ya se mencionó, están relacionados con la globalización. La revolución de las comunicaciones nos ofrece la oportunidad de intercambiar

**experiencias** sobre las mejores maneras de enfrentar esos retos. Para que el intercambio sea útil, deberá estar basado en **evidencias** sobre las alternativas. Solo así seremos capaces de construir una base sólida de conocimientos sobre lo que verdaderamente funciona y sobre las posibilidades de transferirlo a otros países cuando resulte cultural, política y financieramente razonable.

Pero hay un valor más. El filósofo británico Isaiah Berlín (2001) propuso el estudio comparativo de otras culturas como antídoto contra la intolerancia, los estereotipos y el peligro o engaño por parte de individuos, tribus, estados, ideologías o religiones que se presentan como los poseedores únicos de la verdad. Y esto nos conduce al tercer elemento, la **empatía**, esa característica humana que nos permite participar emocionalmente en una realidad ajena, comprenderla, relacionarnos con ella y, al final de cuentas, valorar aquellos elementos esenciales que nos hacen a todos miembros de la raza humana.

Al involucrarnos en este proceso de renovación, haríamos muy bien en recordar las palabras de un líder universal, el Dr. Martin Luther King Jr. (1968), quien hace casi 40 años escribió lo siguiente:

“En realidad las cosas se reducen a esto: que la vida toda está interrelacionada. Todos nos encontramos atrapados en una red inescapable de reciprocidad, entretejidos en la vestimenta de un destino común. Cualquier cosa que afecta a uno directamente, afecta a todos los demás de manera indirecta”.

Sigamos tejiendo juntos el destino de una mejor salud para la humanidad entera en este mundo interdependiente que tenemos el privilegio de compartir.

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