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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
at the
Johns Hopkins School of Hygiene and Public Health

"From Cell to Society: Public Health in the Next Millenium"

Baltimore, Maryland
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"Enduring Principles, Practical Lessons and Political Will for the Health for All Revolution"

It is indeed a great honour for me to be with you here today, participating in this important symposium on the occasion of the 75th anniversary of the Johns Hopkins School of Hygiene and Public Health. At this gathering, in this place, one feels — simultaneously — the intellectual effervescence of today's leadership in the field of public health and the rich legacy of wisdom accumulated in this institution over three-quarters of a century of groundbreaking research and action for the health of peoples and nations. Great collective power is concentrated in this room, power of tradition and innovation, power of experience and vision. As the title of this symposium suggests, it is up to each one of us to absorb, channel, harness and multiply that power to meet the new challenges facing us as we approach the new millennium.

I feel a close personal identification with Johns Hopkins. I feel part of the Johns Hopkins family. My father, Dr. John B. Grant, was one of seven who received their Masters of Public Health degrees from this school in 1921 — only the second year of the MPH programme here. John Grant took what he learned at Johns Hopkins with him to China, India, Japan, Europe and the Americas, where over his career he worked with other international and local pioneers in establishing primary health care systems geared to meeting — for the first time — the health needs of entire populations rather than just those of privileged minorities or elites. In recognition of his work, John Grant is honoured as one of the 75 "Heroes of Public Health" for the School's Anniversary.

My own career — first in Third World economic development and then, for the last dozen or so years, working for children's health and well-being as the Executive Director of UNICEF — has continued the family association with the School of Hygiene and Public Health. My own collaboration with the school

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started in the late 1950s and has continued ever since. I had the privilege of serving on Johns Hopkins' Board of Trustees during the 1980s, and continue as an Honorary Trustee. It's been my pleasure to be a member of the Honorary Committee for the 75th anniversary.

From its earliest days, Johns Hopkins adapted the medical concept of the teaching hospital to the needs of public health education, using the Eastern Health District of Baltimore and Washington County, Maryland, as real-world teaching, training and service environments for staff and students. After receiving his degree, John Grant took that model back with him to his birthplace -- China -- where he set up the Peking Union Medical College's Department of Public Health, with the urban area adjacent to the medical school (whose residents made up about one-twentieth of the population of the Chinese capital) serving as a "demonstration health centre". His department then took responsibility for developing health organization in Ting Hsien (today, Ding Xian) county, a rural area of some 400,000 inhabitants about 100 miles west of Beijing. It was there that John Grant most fully applied and built upon what he had learned at Johns Hopkins. There, he helped establish -- for the first time anywhere -- a comprehensive primary health care and family planning system run largely by the community itself, within the cost constraints confronting a poor, underdeveloped nation. That remarkable example of empowerment and self-reliance brought significant health progress to the population at a cost of approximately 12 cents per capita per year -- becoming the prototype of the "barefoot doctor", community and regionally-based health movement that was extended, later on, throughout China, and which was subsequently adapted to the very different circumstances prevailing in Bengal, India at the All-India Institute of Hygiene and Public Health. In one form or another, the model has now been replicated in dozens of countries of the developing world.

Such was his zeal for ensuring equity in health care that some of his colleagues in the Rockefeller Foundation -- with which he was associated for over 40 years -- jokingly took to calling him the "medical Bolshevik". His cause, however, was introducing democracy into the field of health care. He saw it as an imperative for further human and economic progress in the 20th century. It remains so today.

John Grant strongly believed -- as I do today -- in a precept that was later articulated by the historian Arnold Toynbee, who said: "Ours is the first generation in history in which it is possible to think of bringing the benefits of civilization and progress to all people". And, indeed, when we look back to the United States or Western Europe of 100 years ago, we find that infant mortality rates were nearly 200 per 1,000 live births. It was not possible to think, then, of well-being for all people. It has only been in the last 50-60 years that it has been possible, realistically, to consider the possibility of everyone's sharing in a basically decent way of life.

John Grant believed that morality should march in step with changing capacity and that as capacity changes, morality should keep pace. If one lived in a world in which not much could be done about poverty, then doing little or nothing about it would not be a crime. If one lived in a world in which not much could be done about malnutrition and disease, then doing little

or nothing about it would not be a crime. But when experience shows that it is possible to do something about poverty and its ruinous consequences for nutrition and health, then it is clearly immoral not to act. The fact that during the course of this 23rd of April 1992, some 40,000 children are dying -- largely from readily preventable causes -- as occurred yesterday and will again tomorrow...that is an obscene situation. As Primo Levi said: "Once we know how to reduce torment and do not do it, we become the tormentors."

John Grant felt it imperative to close the gap between knowledge and its use in the community, that there is a powerful obligation to put the knowledge that is available to the use of all and not just to a handful. Within this framework, John Grant articulated, beginning in the late 1920s and early 1930s, a series of valid principles that were to be embraced, half a century later, at the WHO/UNICEF-sponsored conference at Alma Ata, with its endorsement of the goal of Health For All by the Year 2000 through primary health care. Since these principles are many, and I get to bend your ear only so long today, I've taken the liberty of attaching the full list to the distribution copy of these remarks. But I would like to mention five of them now, since they directly impact on the "Babies of the Future" — our theme today.

First principle: the use made of medical knowledge depends on social organization. Many examples abound. Yesterday 7,000 children died of dehydration from diarrhoea because their parents did not know how to use a little six cent packet of oral rehydration salts (ORS) mixed with a litre of water, or the home brew equivalent. In 1980, only one per cent of the mothers of the world were aware of what Lancet called potentially the biggest single medical breakthrough of this century. Today, about half of the world's mothers know to use oral rehydration therapy (ORT) when the need arises. The key to this dramatic increase is obviously social organization. In Peru, women's organizations armed with ORS packets played a central role in keeping the fatality rate from the latest cholera epidemic under one per cent — in past epidemics, between 10 and 30 per cent of cholera patients were lost due to dehydrating diarrhoea. We already have the basic tools and knowledge we need to end the mass child death and disability associated with poverty in today's world, but only in the 1980s have we seriously begun to put together the social organization — best exemplified by the successful universal child immunization effort now saving the lives of more than 10,000 children a day -- to decisively cope with the ongoing waste of children's lives.

Second principle: a vertical medical system cannot be truly effective or ever stand by itself unless it is integrated into other activities of a society, in a concerted attack on the problems of health. In an economy rife with joblessness, one that has no social security and poor education -- the best medical science will make relatively little difference against the negative influences of malnutrition, of ignorance and the like. Health programmes need to be integrated with other social services: education, nutrition, and adequate employment opportunities. Is it reasonable to think of dealing with the problems of diarrhoea without also addressing the problems of clean water and adequate sanitation? Is it reasonable to think of dealing with the problems of drugs in modern society without addressing the root causes of substance abuse in society? The health system must always be

multisectoral; this is perhaps more important to the health of the world's people than even the specific medical expertise of doctors themselves. As important as they are in their own rights, I have always thought of UCI and ORT — in fact, all the components of UNICEF's GOBI strategy and the Child Survival and Development Revolution — as really the first and foremost "Trojan horses" for mobilizing multisectoral support and getting resources into primary health care, into the health system as a whole. While these low-cost/high-impact interventions are often implemented, initially, in a vertical manner, they are in fact cutting edges for building sustainable, horizontal infrastructures and on-going grass-roots participation.

Third principle: successful organization implies reliance upon economically practical strategies for serving the entire population rather than just the elite or a relatively affluent minority. In low income societies and communities this means that the majority of the community and of its members must be participants in the health system. We see in the United States today a health system that serves well, in terms of results, perhaps half or two-thirds of the population. It is, however, an economically inadequate programme for the rest of society, leaving some 90 million Americans unserved or underserved. So we steadily become an increasingly unjust society, with adequate health care for fewer and fewer people -- unless we develop a new organizational pattern that will incorporate all of the population into health services. I will return to the U.S. health system in a moment, but first allow me to complete this short-list of John Grant's principles.

Fourth principle: the education of a health professional requires not only a teaching hospital but also a demonstration health center based in the community. Throughout his career, John Grant emphasized the need for real-world, field station and district work as part of the educational process. After a period of decline, the concept is now being rediscovered and we all should help schools of public health sink roots into communities so that services to living, breathing populations become the vital core of the curriculum. "Community-side" teaching (as it's been called) is as vital to public health as "bedside" teaching is to medical education. Only recently I became aware of the PHS-WOW — public health schools without walls — initiative, coming out of the Rockefeller Foundation...an initiative that certainly merits our enthusiastic support.

The fifth and last principle I'll cite is that a health system has to function within a regional frame. John Grant always felt that there had to be primary units that interfaced with the individual, working the way up through different referral layers to a hospital with high skills and supervisory capacity. There had to be at least a population of a quarter of a million or half a million — a significant population — in order to develop a total, effective health system for a community.

All of these principles remain valid today. Our failure to fully observe them and to adequately overcome the lag between health knowledge and its use is vividly demonstrated by the fact that some 50,000 people die in the world each day from readily preventable causes, more than two-thirds of them children under five. Among the children, some 7,000 fall victim to

dehydration from diarrhoeal diseases; another 6,000 from vaccine preventable causes -- well down from the 15,000 who succumbed daily in the early 1980s, but still tragically unacceptable. Six thousand to 8,000 are taken from us by acute respiratory infections. And among adults, we have more than 8,000 deaths every day just from causes related to smoking!

It is not my place, as Executive Director of an international agency, to take sides in the great debate now underway in the United States regarding the type of health care system the country needs to replace the current arrangement universally deemed inadequate and outmoded. But I ask you to permit me, in the context of my remarks concerning John Grant's thinking, to refer to a blueprint for providing health care to all Americans which embodied most if not all of his principles: the 1952 "Magnuson Report", prepared by President Truman's Commission on the Health Needs of the Nation, and which John Grant helped draft. The Magnuson Report underscored (and I quote) "the broadening concept of health and the corresponding enlargement of the scope of health services ... Just as health means more than freedom from disease -- the Report continued -- so health progress requires more than the services of physician, dentist and nurse -- important as they are. Health progress depends in large part upon better housing, better nutrition, better education, and related measures which promote the well-being of people..."

The Report argued that the United States could easily afford -- at the time, they put a mere one billion dollar price tag on their proposal -- "a well-equipped system of health facilities adequate to meet every community need, [offering] well-rounded preventive, diagnostic, treatment, rehabilitative and home care services to the entire community". It went on to say that "the cost of providing these facilities throughout the breadth of this land cannot be borne solely by those who are hospitalized, nor can the large-scale support necessary be derived entirely from private sources or from the immediate locality itself. Expenditures for these facilities would, in the long run, represent a net national economy".

As all of you are aware, the Magnuson Report -- although well-received by President Truman, who was then about to leave office -- was not adopted. Bits and pieces of it subsequently made their way into the system, but the essence of the Report remains unapplied today -- a fate shared by many other excellent reports prepared by "blue-ribbon" commissions before and since. This country continues deadlocked on admittedly thorny issues of health system financing, structure and equity, with unacceptable infant mortality rates. Washington D.C. has an infant mortality rate of more than 20 per 1,000 live births -- double the national average and higher than rates in such Third World countries as Cuba or Jamaica. We have national levels of immunization for one-year-olds lower than those of Zimbabwe and Bangladesh. Inner city malnutrition and illness surpass levels in a number of developing countries. In the United States, more children live in poverty than any other age group: 20 per cent nationally in 1990, up from 16 per cent in 1979.

Just the other day, the Baltimore Sun quoted Johns Hopkins sociologist, Dr. Thomas A. LaVeist, in terms strikingly reminiscent of the Magnuson Report. He stressed that poverty, segregation in housing and a lack of political empowerment are key factors leading to high U.S. infant mortality

rates. If the nation is serious about addressing its high rates of infant mortality, Dr. LaVeist said, it must address "economic development, job creation, reductions in poverty, the quality of housing" and political empowerment, even more than access to health care.

The Hopkins Declaration of Health Rights -- which I have the honour of signing today -- reflects, not coincidentally, the ethical underpinning of the Magnuson Report. If John Grant were alive today, I'm certain he would dust off its five volumes and proclaim to the four winds the Report's vibrant relevancy to today's debate.

But 1992 is not 1952. The debate now raging in the United States is part of a worldwide search for new paradigms for financing health systems that effectively ensure coverage of all people. There is increasing appreciation of prevention of ill health and of the role that individuals and families must play in preserving their own health, vitality and productivity. One of the few encouraging signs of late is Mayor David Dinkins announcement the other day that New York City, despite its terrible budget constraints, would establish twenty new community health centers to provide primary preventive care to poor people...on a "family doctor" basis. The logic of this trend is impeccable. I remember that Bill Foege, when he was head of the CDC in the early 1980s, used to point out that medical interventions to add a single year to the life expectancy of the average American male would cost more than US$10 billion annually. But, he said, you could add eleven years -- today it would be somewhat less -- if we would do four cost-free things: stop smoking, moderate alcohol intake, watch the quality and quantity of food intake, and do a moderate amount of exercise. And today we would add, "practice safe sex".

This simple prescription for vastly improving people's health used to apply, mainly, to the rich countries, where chronic diseases -- the so-called diseases of affluence -- account for the bulk of premature deaths and illness. But today, as you know, numerous countries of the developing world are making the demographic-epidemiological transition, leaving them with the double burden of transmissible and chronic disease -- without having attained the affluence that would help them ease the burden.

What we have learned in our work for children's well-being in the poor world in the past decade is that we now have the capacity to reach entire populations with simple, low-cost, life-saving technologies and knowledge if we harness together the triple engines of political will, social mobilization and mass communications.

Last October, at the United Nations, Dr. Nakajima and I certified to the Secretary General achievement of the great demonstration of this truth in our times: by the end of 1990, the world had met its goal of immunizing 80 per cent of all one-year-olds against the six major childhood killer and crippler diseases. That's 100 million infants vaccinated between three and five times during their first year of life -- some half a billion contacts between families and organized health delivery systems, which now extend even further than the ostensibly "universal" postal service in many countries. Since the EPI effort was intensified a decade ago, some 15 million lives have been saved -- thanks to the vaccines, yes, but thanks even more to the extraordinary

mobilization of political will, popular participation and effective communications that create the demand for them at the family and community level and which make their delivery possible. Lessons learned in this greatest global peacetime collaboration can and must be applied across the board, to our struggle for primary education and literacy...our efforts to win gender equity...to family planning...to nutrition programmes...to our efforts to prevent the spread of the AIDS pandemic...to economic development and even to our work to protect and preserve the environment.

The time is right -- the time is now -- to push for application of these lessons and the principles I've touched on today. It is no accident that the first-ever summit meeting of leaders of North and South, East and West, the first global summit of the post-Cold War world, was the World Summit for Children, held at the UN in September 1990. It embodied the recognition that children provide a privileged entry for tackling most of the critical problems that vex and challenge the world on the threshold of the 21st century. Priviledged because consensus around meeting children's needs goes further and deeper than what can be achieved on any other issue confronting humanity.

Agreement reached at the World Summit to recognize children's basic needs as rights and give them a "first call" on society's resources, in bad as well as in good times, represents a major ethical breakthrough, a global leap in terms of human progress. I know that making such a sweeping assertion to a largely American audience during a presidential election campaign is risky, given the plethora of lofty rhetoric and the surfeit of promises from politicians we have all learned to take with a grain of salt. But what happened at the World Summit is that the leaders took the unusual step of committing themselves and their governments to meeting a series of measurable goals within a specific time-frame and provided for periodic international reviews and monitoring mechanisms along the way. As we meet here today, National Programmes of Action are being prepared and issued in over 125 countries to implement programmes to "keep the promise" by the year 2000.

Past experience with internationally-set social goals naturally engenders healthy scepticism. But I suggest that the 1990s offer something new -- county-by-county experience as well as country-by-country commitments -- all opening a new window of opportunity for making the quantum leap of human progress needed to meet our goals. As I said before, 1992 is not 1952. There is no longer a Cold War splitting the world into opposing camps, distorting the global economy and siphoning off endless resources needed for development. Today, with the changes that are extending democracy and market-oriented economic systems to virtually every corner of the globe, and with military establishments in rich and poor nations alike beginning to shrink, we have a better chance than ever before to address human goals in a serious, concerted way. To the extent that politicians are increasingly answerable to electorates, it will become "good politics" -- and good economics, too -- to face -- once and for all -- the central problem of poverty in society, and to invest in high-return programmes of human development. Recognition of the essential interdependence of all nations, of all economies, in today's shrinking world, is being forced upon us by events and, if we are wise, we can deploy the many mechanisms of international co-operation we have developed for the solution of global problems.

UNICEF is one such mechanism and I promise you that we will do everything in our power to deploy it to seize the opportunity before us. The Johns Hopkins School of Public Health and Hygiene is also an important international mechanism for co-operation, a powerful mechanism that has done, these three-quarters of a century, much good in the world...and continues to do so today. If we continue our work together, as part of the growing Grand Alliance for Children, I am convinced the goals of the 1990s will be reached and that humankind will be able to start off the third millennium, the 21st century, from a platform of dignity, as envisioned by John Grant and his fellow "Heroes", and all the fathers, and all the mothers who love their children.

Appendix

JOHN GRANT'S PRINCIPLES

1. The use made of medical knowledge and efficiency of health protection depend chiefly upon social organization.

2. A vertical medical system cannot stand by itself unless it is integrated with other social activities in a joint horizontal attack upon the problem of social reconstruction.

3. Organization implies reliance upon tested practicable methods and training institutions designed to meet local needs.

4. Socio-economic progress depends chiefly upon actual demonstration of feasibility and worth.

5. Demonstrations, to be successful, must make use of technical methods which are scientifically efficient and economically practicable.

6. Demonstration units must take into consideration the economic practicability of extending them to the nation as a whole. This implies that the principle of self-help be adopted, as no developing country can as yet afford to make full use of available technical knowledge through tax funds alone. Among the most essential elements of self-help is the development of technical consciousness at the village/community level. Generally speaking, universities are most qualified to undertake demonstration projects.

7. The immediate social problem is to overtake the lag between modern knowledge and its use in the setting of a community. The single outstanding and basic cause of this lag in the health field is the lack of scientific investigation of methods to apply the results of the growing body of scientific knowledge to society. As the principal instruments for generation, utilization and application of new knowledge are the universities, these institutions must be held primarily responsible for the failure to develop effective and scientifically based community health care.

8. Investigation requires a suitable organization to determine the most effective and economical methods of applying the results of basic research to the maintenance of health and the cure of disease through organized community effort. This implies that the investigative organization must control its own experimental community in the same manner that teaching hospitals are available for research in clinical medicine.

9. Public Health administration is effective in proportion to its adherence to the following seven principles:

a) social services are interdependent;
b) health maintenance can be achieved only if the consumers of services themselves are technically aware and practice the knowledge which they possess;
c) the administration of special function (e.g., health, agriculture, education, etc.) should be undertaken only by one governing body;
d) compromise between theory and practicability is necessary in social progress;
e) administrative procedure must be based upon sound economic considerations and practicable financial budgeting;
f) success depends upon the extent of self-participation, directly or indirectly, by the citizen;
g) methodology must be developed inductively through controlled experimental communities administered by personnel who are trained in methods that are scientifically derived.

10. For planning to be effective it must build up from the local unit of organization to the central administration rather than be superimposed from the centre on the periphery.

11. The eventual goal of all administration is to achieve as much decentralization of services as is compatible with efficiency. A major factor in this undertaking is the development of community technical consciousness of health needs among the consumers of the community. This can best be achieved when the health services are established as an integral part of community development designed to raise the welfare level of local inhabitants in all fields through self-help which can look to the technical agencies of government for guidance and support.

12. It is necessary to attempt to clarify the impact which financial investment in health care has upon social, economic and political development in general.

13. A demonstration project, if not conducted at an appropriate financial and technical level and if the mechanism for duplicating or expanding upon it is not readily forthcoming, can be a hindrance in terms of further development.

14. For a community project to succeed the community unit chosen for demonstration must conform to an already existing political unit of the country in question.

15. The first principle of administration is that when a function is to be undertaken by government for the welfare of its people, this function should be discharged by a single agency....The greatest single obstacle to health progress in many countries is the establishment of social insurance which permits the security agency to establish its own institution for the provision of health care.

16. The efficient distribution of health care services requires that they be co-ordinated within a given region in a systematic pattern. The regional system should provide for among other things, continuing education, and periodic evaluation of the system itself.

17. A regionalized area should contain a population large enough to be self-contained in supporting the provision of all branches of health care facilities. This requires a population of between 250,000 and 500,000. This level is needed to render efficient service and supervision and to support the costs of service personnel. Co-ordination is effected by establishing a two-way flow of professional and administrative services between the peripheral units and the base, which preferably should be a teaching medical center.

18. Sound planning of medical education is essential; for it is only through the systematic and continuous application and co-ordination of the techniques and principles of administration, economics, finance, and sociological and public health research that teaching institutions will be enabled to provide professional training in keeping with the needs and resources of any given country or geographical area.

19. The principle purpose of research on health care is to study its organization and administration, the available resources, the staff and the services, with a view to establishing their distribution, effectiveness and cost. The principal aim of research is the dissemination and utilization of these findings to improve the administrative and technical practices of health care.

20. The successful development of health care services, as a social service, requires a suitable national atmosphere and an appropriate economic system with equitable distribution. The prerequisites are satisfactory land tenure and laws, and legislation prohibiting the flight of capital.

21. A teaching hospital should be intimately linked and integrated with an adjacent community field practice area, for teaching purposes, and to provide integration and continuity of care. In addition, this enables the teaching hospital to undertake the epidemiological assessment of its role in the care of at least that proportion of its patients admitted from the practice area and of the practice population as a whole.