First of all, my gratitude to the organizers of this meeting, The Open Society Institute, Mike Borowitz, Head of Public Health Program, Sam Avrett, Distinguished Facilitator and Virginia Ambrazeviciene, Gentle Lady and Effective Executive Secretary.

After this first day, I hope most of you have solved the discussion on Governance and Government, if not, many of us will not sleep tonight.

Talking to others while they are eating was established as a ritual in the monasteries during the middle ages. Maybe not far from here, in the Salzburg Benedictine Monastery. But this is not the case, none of you is a nun nor a monk, and I am supposed to entertain, not to annoy.

So my words will be Pro-digestive and Non-dyspeptic.

Also, in my case I understand this opportunity as a privilege of seniority, I hope not of senility.

For this reason I have entitled these paragraphs as

“ANECDOTES FROM EXPERIENCE AND CONCLUSIONS FROM ADVANCED WISDOM”

A little bit pretentious, but appealing. Don’t you think so?

Although I am 60, I have more than 50 years of experience in Public Health. During my childhood years, in the late forties and early fifties, my father was a District Health Officer in the suburbs of Santiago. There I learned most of the important things in community based medicine, those that matter most. I have perceived overtime.

Safe water and sanitation, immunization campaigns, waist disposal sites, community participation, prompt reaction to accidents and emergencies. Frequent visits to the slums, to the potable water plants, charities to raise money for healthy purposes, frantic races to care for patients injured in accidents in the nearby roads, are part of my early memories.
There was no TV or video games in those years, and the only distraction was going with papa, the local doctor, to visit the poor in their shanty towns, or helping with candid enthusiasm in the anti-smallpox campaign vaccine effort, immunizing other children like myself, drawing the simple leaflets for health education and so on.

This was a privilege that culminated when my father was appointed Minister of Health in 1970 by the late President Salvador Allende.

By that time I was starting my own career. First as a generalist treating TB patients, afterwards as a social paediatrician. Later as a clinician with political libertarian feelings, standing against dictatorship, and finally as Minister of Health in 1990, in pace with democratic restoration in Chile.

My personal history in relation to public health is the basis for life experience based evidence as one might say nowadays. I believe it’s important because it carries the message and strength of what I shall call “Assertions” or conclusions.

**Assertion 1: Memory is weak, History is strong**

As a young doctor, my first assignment in 1968 was treating tuberculosis patients. Each treatment course would last at least two years. Streptomycin injections were painful, PAS tablets were not pleasant to the stomach, INH would provoke invalidating peripheral neuropathies. Most of our patients were street beggars, alcoholics, poorest among the poor. Compliance was difficult if not impossible.

In those days, the World Health Organization had developed a community based strategy for treating persons with TB. Karl Styblo, Wallace Fox and others gave one month seminars in Bratislava, in the former Czech Republic. Many Chilean doctors went there and back in the country applied successfully this model in the out patient network of our National Health Service. There was team-work, nurses were critical, paramedics essential, laboratories and good registration present, algorithms and clinical guidelines with standardized protocols. All the essential components of an effective “disease management” strategy inside an established public primary healthcare network.

Thirty years after, therapy for TB is much shorter, only six months long, drugs are very affordable and it’s community based, planners have called it Direct Observed TB Strategy DOTS.WHO has reinvented its own wheel successfully.

With the AIDS epidemic, the same trend should happen. Drug prices are falling thanks to Brazil and other countries commitment and an effective vaccine should be with us in a reasonable future. But for that to happen, we need strong Primary Healthcare Networks and the necessary cultural change and community involvement. I ask myself, why is it that Latin America and the Caribbean Region has 64% coverage for AIDS therapy, while others reach less than 15%? It’s not only money. It’s energy, organization and culturally unbiased confrontation of disease.
Assertion 2: Time is needed to have results

The seminal idea for the National Health Service of Chile appeared after the 1939 earthquake of Chillan. There, officers observed, unified services for the emergency achieved much more outputs than non-unified ones. Wisely they concluded that unity was a powerful force. In 1940 an amendment to the Social Security Act of 1924 was sent to Congress. Lengthy discussions took place, vested interests and political indifference impeded its approval until 1952. Twelve years of political futility, or unavoidable maturation. Whatever you like, but time. Then, implementation was also another critical path. Program design, experimenting with new approaches to prevalent diseases, maternal and child, immune preventable diseases, TB control, institutional development, human resources formation and training were the main concerns and took almost twenty years to show improvement in impact indicators, basically mortality decreases. By the year 1975, while in full repression of dictatorship, numbers improved. It was an unbelievable paradox few accepted in the midst of economic depression. By the year 2000, we had a single digit infant mortality of 8.9 and a life expectancy of 74 years.

Assertion 3: Leadership and Networks are critical for success

During my life I’ve had the opportunity to meet and interact with unforgettable leaders and high personalities in global health. In 1954 I met Fred Soper, then Director of Pan American Health Organization, previously head of the Rockefeller Infectious diseases effort to control yellow fever in South America. I was ten, and Dr Soper told me about his adventurous life in the tropics and the chase of “Typhoid Mary” in the US when he was a Public Health officer. Fascinating stories I have kept in my mind since.

In the nineties I had the chance to work with Halfdan Mahler, the Danish born head of WHO that promoted the “Health for All” and primary health care revolution of Alma Atta in the seventies. Rich and wise conversations took place among us while we were evaluating the INCLEN, (International Clinical Epidemiology Network) for the Rockefeller Foundation. Halfdan said, among many other straightforward judgements: “If Chinese clinicians have accepted this methodology, with all their background of mistrust to western initiatives, then INCLEN is a good thing. Few proposals from the west succeed in this region” His sympathy and energy took my heart forever.

In 1990 I met for the first time James Grant, Director of UNICEF and one of the founding fathers of the Child Survival effort in the eighties. We immediately connected during the annual meeting of UNICEF in New York. When I was telling my young kid’s anecdotes with the small-pox immunization campaign, he started shouting his enthusiasm from the presidium of the hall. He came to me and invited me to lunch to exchange further on our common concerns for the children around the world. A couple of years later he went to Chile, and was part of the launching of our measles eradication campaign. His presence solemnized and gave strengthen to our initiative. This was culminated by success. The circulation of the virus was interrupted, no native cases have occurred ever since.

Leadership is a contagious condition, but it requires the presence of networks and illuminated elites.
Some foundations have been extremely successful in this idea. Rockefeller maybe the most with its Schools of Public Health and the Clinical Epidemiology Network (INCLEN). This last initiative was the antecedent to the much in fashion Evidence Based Medicine and the Cochrane Collaboration that is critical to promote the necessary link of medical care with science and good practice.

Networks today may function very well with the omnipresent information technologies and the facilitated international transportation. Nevertheless, the spirit of a network continuous to be the key driver.

**Assertion 4: Institutional interfaces are critical, but human nature and conflicts remain**

We need the interface, we need to see each other face to face and interact in different fora. There is no substitute for institutions and their governance is sometimes complex and difficult. I’ve had some experience of WHO when being member and the chairman of its board in 1998-2001.

In those years, as it is now, HIV-AIDS was the hottest issue and the drafting of an agreement should take many hours and efforts. I presided the drafting committee in the World Health Assembly for two years. It was an impressive experience. There I could perceive the dramatic gap between countries and regions, the differences between the poor and the powerful. Even the language schisms among groups became part of the problem. When meetings extended overtime, interpreters would leave and one of us should have to keep chairing and translating from English to French to avoid the withdraw of francophone delegations from West Africa because of the language barrier.

The World Health Organization Report of 2000 on “Health Systems Performance Assessment” was another issue in my knowledge of how far persons may go to impose their point of view. Good or bad, the proposal to develop a methodology to evaluate health systems became an expensive and not very successful effort that finally provoked several incidents between high level specialists in public health. Those who, for technical and ethical reasons opposed to some conclusions of the report, were simply wiped out of the scenario. Some articles have been published on this succession of debates, but you can trust me that for me it was the final evidence that power and intelligence not always go in hand with respect to the other.

**Assertion 5: It’s not only money**

When dealing with global and local health problems, especially if we deal with poverty areas, of course money is needed to pay for medicines, instruments, and other commodities. But this does is no substitute for health systems development. In fact, you may conclude from my experience, which is common to many, that the organization of good institutions and its sustainability overtime are the most critical factor to succeed in health goals. Health Systems need commitment of its members and leaders, good conditions for their human resources in every sense, training, payment, incentives. Good planning and evaluation to tackle the challenges of its environment and time.
With the generous efforts of many initiatives, countries are being literally flooded by money for HIV-AIDS drugs and consequently paralyzed. Purchasing and form filling for these much needed medicines have made that agencies and ministries have forgotten to buy routine materials such as ampicillin or surgical needles.

It is never enough to insist on the issue of the non financial aspects of health.

**Assertion 6: Don’t forget middle class countries**

My last assertion relates to the present situation of Latin America in general, and Chile in particular. We live in what one might call “the middle class of nations”. Many of our countries have “graduated” according to ODA standards because their income has surpassed the barrier of one thousand dollars per capita income. Nevertheless, we have deep inequities in social and economic indicators, and pockets of extreme poverty that continues to be a huge challenge.

But on the other hand many LAC countries have achieved interesting outcomes in its health levels. The average Infant Mortality rate is close to 20 per thousand live births, many problems are being successfully tackled and the continent is facing an epidemiological transition to non communicable diseases but with remaining Infectious conditions in many sections of its population. There is a lot of interesting lessons learned in maternal and child health care, in TB control and the before mentioned HIV AIDS battle in Brazil.

Middle class countries face these challenges most of the time on their own, without access to communication of their good achievements in the international literature with the evident risk of being ignored by the rest of the world. Good strategies therefore become lost for others in need and the countries have difficulties in facing its dual agenda.

**Final words**

We shall be judged finally by our capacity to understand ourselves mutually in a peaceful and productive manner. For this to happen, we have to listen each other, and this is why I think that initiatives like the present seminar has a big potential when it puts people to exchange in an open mode. OSI deserves the credit.