



Making Friends and Saving Lives

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It is a common failure of the imagination to dismiss as a “soft” add-on to foreign policy American efforts to combat pestilence and ill-health elsewhere. In blunt truth, the United States benefits doubly from every victory won abroad, not only in the intangible form of goodwill but also in our own homeland defense against disease. The returns for relatively modest expenditures are enormous. As part of America’s self-examination in the wake of September 11, this overlooked dimension of Washington’s global role cries out for attention. Immediately, an exceptionally promising opportunity is to work with Russia to help arrest a continuing and dismaying decline in fertility and life expectancy.

Foreign health assistance deserves a corresponding rank with other vital elements of diplomacy—security, trade, and development. The humanitarian concerns are obvious. The enormous health and medical resources possessed by the United States—knowledge, pharmaceutical and medical industries, trained personnel, and effective nongovernmental organizations—speak for themselves. Yet the record of the last decade, during which the U.S. government devoted less than 0.1 percent of the country’s gross national product to foreign health programs, and thus ranks behind all other industrialized states, also sadly speaks for itself.

A recent report prepared by the Council on Foreign Relations contends that both “narrow” and “enlightened” self-interest are important in guiding our policies for health assistance as part of our overriding foreign

policy. We are understandably anxious about the specter of infectious disease—HIV/AIDS, tuberculosis, including the drug-resistant form, and other emerging infections—intruding on our shores. The threat is amplified by the mobility of peoples. The tuberculosis epidemic in New York City ten years ago and its lower but still worrying prevalence there now are in part attributable to travel and immigration from other countries, including high-tuberculosis areas of the former Soviet republics.

A broader self-interest argument derives from the relationship between social well-being and health, on the one hand, and political stability and economic development on the other. The conventional wisdom in some quarters is that health status, like boats, will rise with improvement in economic status. In fact, health both influences and is affected by economic development. Health is *both* an economic input *and* an output. High prevalence of disease and disability, and reduced longevity, compromises productivity. Forty-two percent of U.S. trade is with developing nations, and their economic health contributes to ours.

The linkage between health status and a stable civil society has been long recognized. Otto von Bismarck acknowledged this relationship in 1883 by enacting the first national health insurance program precisely to preserve civil order and political stability in Germany. The Carnegie Commission on Preventing Deadly Conflict contended six years ago that “among the most urgent needs for international assistance is to help fund safety net programs....”¹ The authors

of this report argued that this was not charity but an investment in economic reform of countries on behalf of long-term stability. The interplay of humanitarian, economic, and security concerns underlying foreign assistance has been repeatedly noted in successive reviews of foreign aid, beginning with the Marshall Plan.² Historically, in fact, there are some highly successful examples in which health was used explicitly as an instrument of foreign policy. Their scale and creativity contrast sharply with the still-inadequate assistance programs for health in Russia. Among them was the effort to eradicate yellow fever. In 1900, Walter Reed and his collaborators, working in Havana, proved the theory of C. J. Finlay that the disease was caused by a mosquito-borne infection. The sanitation expert W. C. Gorgas shortly thereafter demonstrated (through his work in the Panama Canal Zone and elsewhere in the world) that the disease could be controlled through mosquito eradication measures (which also served to control malaria). The subsequent development of a yellow fever vaccine, along with the application of strict quarantine measures, further aided in the control of the disease.

In 1940, the European war gave new urgency to strengthening ties with Latin America. Many believed that stationing U.S. troops in Latin America would become necessary. This, in turn, gave high priority to reducing threats of malaria and other endemic tropical diseases. In addition, the United States was concerned with gaining access to certain resources such as rubber, protecting the Panama Canal, and luring Argentina and Paraguay away from the Axis camp. Nelson Rockefeller, then a dollar-a-year man in the Roosevelt administration, acting with the strong support of President Roosevelt, established an Institute for Inter-American Affairs as a quasi-governmental corporation devoted to health and medicine assistance for 18 Latin American nations. Members of the staff of the Rockefeller Foundation were heavily involved in this

project and impressed upon Nelson Rockefeller the importance of health as a vital element in Latin American social and economic development. The institute was, in fact, one of a number of extra-governmental groups established with presidential leadership to serve foreign policy concerns in Latin America. Besides health and sanitation, projects centered on nutrition, housing, agriculture, and other public works. The extra- or quasi-governmental form was chosen explicitly to allow for flexibility, to encourage contributions by professionals from the academic and foundation communities, and to avoid normal regulatory restrictions.

Physicians and sanitary engineers were deployed from the Public Health Service to the military. Close cooperation with host governments was fostered in each country, usually through the Ministries of Health. The entire operation was directed by Brig. Gen. George Dunham, a highly respected authority on tropical medicine and a member of the U.S. Army Medical Corps with extensive experience in Panama and the Philippines. The United States committed itself to a specific funding level, usually above half of the initial expense. The understanding in all cases was that the host country would eventually assume the entire cost.

Looking back, the Institute for Inter-American Affairs and its health and medical program blazed a promising path. From the beginning, the effort was closely collaborative with host governments. It enjoyed substantial continuity and longevity, coming to an end only in 1958. In collaboration with the Rockefeller Foundation, the program built hospitals, nursing schools, and health clinics. It supported training programs for visiting nurses and health education for the general public. It combined service, expert advice, and training of over 1,500 physicians. By 1945, three hundred Latin Americans had received scholarships and travel grants to the United States.³

A second example was the health program that rose from the rubble of civil war

in Greece. The country had barely begun to rebuild after the Second World War. In 1947, Greece was heavily in debt, threatened with economic collapse and famine. In February 1947, a straitened Britain secretly informed the United States that it could no longer provide military assistance to Greece and Turkey. Within weeks President Truman announced a major aid program for both countries, to cost \$400 million, of which \$250 million was earmarked for Greece. The aim was to help the Athens government defeat the leftist Greek guerrillas, who were being supported by Communist Yugoslavia, and thus halt the spread of communism in the Near East.

The Truman Doctrine resulted in the dispatching, in July 1947, of a combined military and civilian mission to Greece. By November, the American Mission had developed a strategy that combined military and physical security, including specific measures to improve health and social welfare, based in part on the success of the earlier Institute for Inter-American Affairs.⁴ The effort succeeded. Over a seven-year period, specialists developed potable water supplies in rural areas and put in place programs to reduce malaria and to modernize hospitals and clinics.

The United States also spearheaded the programs to eliminate smallpox and polio. The impetus to eliminate smallpox, which killed more people in the first three-quarters of the twentieth century than all wars combined, came from the Soviet Union in 1958. Close cooperation between the U.S. Centers for Disease Control, the World Health Organization, and the Soviet scientific establishment led to the eradication of the disease in 1977. Polio Plus, an initiative of Rotary International in connection with the U.S. Centers for Disease Control, the United Nations Children's Fund (UNICEF), and the World Health Organization to vaccinate every child against polio has been operating since the mid-1980s. Rotary International, which has raised \$2.5 billion for the fight,

expects to see the eradication of the disease in the next two or three years.

Russia and Other Transition Societies

In the early 1990s, a group of American economists proposed a \$27 billion assistance fund for Russia to stabilize the Russian economy, ease the burden of internal and external debt, and promote economic and social stability.⁵ The proposal included an \$8 billion "social fund" designed to tide over the nation during an expected difficult transition period. The proposal, regrettably, was not adopted. An opportunity was lost for consolidating the nascent Russian democracy during a period of devastating hyperinflation and unemployment.⁶

Nor was Western assistance for health and social support for Russia afforded a high priority. Instead, U.S. foreign assistance centered on democracy building, economic development, and fostering a market economy. U.S. government programs for health were episodic, with little systematic effort toward attracting the best private as well as governmental talent and advice.

This vacuum of official leadership was partially filled by unconnected private efforts by church groups, individuals, institutions, and service organizations. Although the number and variety of these projects was large, there was no coordination. For example, Rotary International and individual Rotary clubs provided \$12 million in aid to communities in Russia between 1993 and 2001, of which 76 percent was devoted to health.⁷ These uncoordinated efforts, while well-intentioned, certainly did not represent a coherent program. Recent studies have underscored their meager results. A review of U.S.-Russian relations by the Carnegie Corporation of New York noted the fragility of economic progress and the disillusionment among Russians who feel let down by unfulfilled expectations of market-based systems and democracy.⁸

One coordinated effort that is yielding results is the Eurasian Medical Educa-

tion Program (EMEP), a partnership between the American College of Physicians (ACP) and the Institute of Health Policy Analysis. Through its Continuing Medical Education Program, it is introducing Russian physicians to advances in Western medicine. Western internal medicine experts share their experience and knowledge with their Russian colleagues at Russian regional academic centers. The program concentrates on those diseases that are most responsible for Russia's devastating premature death statistics. In a little over three years, 3,500 Russian physicians have participated in the program.

EMEP is working on a "swords to plowshares" initiative that would employ former Soviet bio-warfare scientists to redirect their expertise toward fighting infectious diseases. The Soviet Biopreparat program once employed 50,000 scientists, technicians, and support staff in 47 biological warfare laboratories and testing sites. EMEP is working with the U.S. National Institutes of Health and the Nuclear Threat Initiative (begun by former senator Sam Nunn and funded by Ted Turner) to explore ways of using some of these former biological warfare labs as diagnostic laboratories for tuberculosis (which is epidemic in Russia, especially in the prison system), HIV, and other infectious diseases, and to employ these scientists constructively.

A New Opportunity

Immediately following September 11, the U.S. administration began to forge a coalition in the struggle against terrorism, of which Russia is a key member. For the first time since 1941, Moscow and Washington are united by a common enemy. This seismic change favors collaborations that were once deemed impossible, such as stationing U.S. troops on former Soviet soil (in Uzbekistan). An important security issue for Russia is a relentless decline in population of 0.4 to 0.6 percent per year. Russia sustained a net *loss* of 750,000 persons last year. The

major contributors are falling fertility rates and, more important, increased mortality. This decline in population, unprecedented in time of peace, is most striking among those who should be among the most productive citizens, young and middle-aged males. Life expectancy for males, which reached a nadir of 57 years in 1994, had only risen to 59 in 2000.⁹

"The most acute problem facing Russia is its declining population," President Vladimir Putin said in his first presidential address to the Russian people in July 2000. Unless reversed, "the very survival of the nation will be endangered," he warned.¹⁰ The principal contributors to premature death are cardiovascular disease and the effects of violence. More than half of the deaths of males are due to heart attacks and strokes. This reflects self-imposed risk factors (principally smoking and drinking) and widespread undetected and untreated high blood pressure. The prevalence of high blood pressure in Russia is essentially the same as it is in the United States—25 to 27 percent of the adult population. However, in Russia only 8 percent of hypertensives are recognized and appropriately treated.

In the United States, a marked decrease in cardiovascular mortality occurred beginning in the late 1960s and early 1970s, thanks to the recognition of the importance of treating what had formerly been interpreted as normal or "borderline" blood pressure. Effective treatment depended on basic, inexpensive drugs (principally diuretics). This reinterpretation of what was thought of as normal blood pressure, and its aggressive treatment, saved many American lives. Even a modest replication in Russia would bring substantial increase in longevity.

In brief, there are clear contributions that can be made to health in Russia that do not depend on technologically complex interventions. In general, these contributions are entirely consonant with our other foreign policy goals. Health and medicine are neutral, noncontroversial subjects and coop-

erative assistance is almost always welcomed. Cooperative assistance builds on existing strengths, recognizes the accomplishments of the host, and is offered in the spirit of partnership. The Russian admonition throughout the 1990s has been to “limit humanitarian assistance and help us help ourselves.”

Assistance in the health sector characteristically involves professional exchanges. Excellent examples of programs of this sort have included the Hospital Partnership Program, administered by the American International Health Alliance, and the Eurasian Medical Education Program—in partnership with the American College of Physicians. These exchange efforts are in harmony with the spirit of the Russian Leadership Program of the Library of Congress and encourage the development of new, young Russian leadership.

What are the principles we need to observe in designing a program of health assistance for Russia?

First, health assistance should be considered a vital element of our foreign policy. Emphasis should be placed on life-threatening diseases. Tuberculosis and HIV are clearly priorities. However, increased attention to chronic ailments, such as cardiovascular disease, is necessary to prevent the serious complications that are responsible for the devastating decline in Russian male and female longevity. This is also the least expensive route. The epidemiological transition from infectious disease to chronic disease, which has occurred in all countries as they have become more prosperous, means that populations will demand increasingly expensive, technically complex medical treatments for life-threatening events. This, in turn, places impossible budgetary pressures on governments. Far less expensive will be early and basic medical interventions (such as treatment of uncontrolled hypertension or diabetes) combined with public education to reduce lifestyle risks to health.

We should also emphasize the importance of professional exchanges between the two countries. Particular attention should be devoted to collaboration not only at the national level but also at the provincial level with local governmental, academic, and clinical leaders. Civic leadership and citizen participation must also be encouraged.

Assistance efforts should be designed with an appropriate long-term commitment in mind. Short-term, episodic projects should be avoided.

We should strive to engage the best professional talent and advice. Successful programs for improving health in the past have enjoyed the solid contribution of physicians and other health workers from universities as well as from foundations.

Such a program would combine complementary skills and resources from the fields of clinical medicine, public health, and public education. Best of all, the joining of community resources with professional medical talent would make for a powerful combination. A current example of just such a combination is a coalition involving Project Hope, the Eurasian Medical Education Program, the American Public Health Association, and Russian Rotarians from Rotary Clubs in 67 cities of Russia.

Financial support should be drawn from a combination of public and private sources, including philanthropic and private business interests. The leadership in international health already shown by the philanthropists Bill Gates, George Soros, and Ted Turner should be further encouraged and honored by others. This effort should proceed with the understanding that financial support should increasingly become the responsibility of the host.

The case for treating foreign assistance in the health sector as a key element of U.S. foreign policy unassailable. Health *is* a security issue. Russia’s case makes this clear. It is unquestionably in our interest that Russia be economically strong and politically

stable. Attending to Russian health and longevity issues should be an important component of any strategy to ensure long-term prosperity and stability.

A recent traveler to Russia post-September 11 tells the story of being approached by an elderly Russian male who asked, "You American?" When the traveler said that he was, the Russian raised clasped hands and, with a big smile, said, "Uncle Joe and FDR partners. Russia and America, partners again." A health partnership between the United States and Russia may be just what the doctor ordered for a thriving U.S.-Russian relationship. ●

Notes

1. Larry Diamond, *Promoting Democracy in the 1990's: Actors and Instruments, Issues and Imperatives*, Carnegie Commission on Preventing Deadly Conflict, Carnegie Corporation of New York, December 1995.
2. See U.S. House of Representatives, *Report of the Task Force on Foreign Assistance to the Committee on Foreign Affairs* (Washington, D.C.: GPO, 1989); U.S. Agency for International Development, *Development and the National Interest. U.S. Economic Assistance into the 21st Century, A Report to the Administrator* (Washington, D.C.: AID, February 17, 1989); U.S. Congress, *The Role of Foreign Aid in Development* (Washington, D.C.: Congressional Budget Office, 1997).
3. Cary Reich, *The Life of Nelson A. Rockefeller* (New York: Doubleday, 1996); C. Erb, "Nelson Rockefeller and U.S.-Latin American Relations, 1940–1945," Ph.D. dissertation, Clark University, Worcester, Massachusetts.
4. J. C. Warren, "Origins of the Greek Economic Miracle: The Truman Doctrine and Marshall Plan Development and Stabilization Programs," in *The Truman Doctrine of Aid to Greece: A Fifty-Year Retrospective*, ed. Eugene T. Rossides (New York: Academy of Political Science, 1998).
5. Jeffrey Sachs and Peter Boone, "Strengthening Western Support for Russia's Economic Reforms," unpublished memorandum, December 28, 1992.
6. Jeffrey Sachs, "Russia's Struggle with Stabilization: Conceptual Issues and Evidence," speech given at the Annual Bank Conference on Development Economics, The World Bank, Washington, D.C., April 28–29, 1994.
7. "Russian Health Initiative," Rotary Activity Report (unpublished), Rotary Foundation, March 3, 2001.
8. *The Russia Initiative*, Carnegie Corporation of New York, 2001.
9. Mark G. Field, "The Health Crisis in the Former Soviet Union: A Report from the 'Post-War' Zone," *Social Science and Medicine*, vol. 41, no. 11, pp. 1469–78 (1995).
10. Quoted in Murray Feshbach, "Russia's Population Meltdown," *Wilson Quarterly*, vol. 25 (winter 2001).