George A. O. Alleyne
Director, PAHO*
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THE RATIONALE OF HEALTH SECTOR REFORM**
(Washington, D.C.)

During the course of the next one and a half days you will have the opportunity to hear from many experts about their experiences, perceptions and recommendations on health sector reform. You will no doubt come to appreciate the magnitude of the task given to us by the Presidential Summit of last December. It would be fatuous to expect that you will leave here with a unified concept of what does constitute health sector reform but it is my hope that you do go away with a sense of the importance and complexity of the issues. But even more importantly you should have some appreciation of the experiences in various countries of the Americas and some ideas of those experiences or experiments that might guide your own efforts.

It is refreshing also to see several sectors represented. This was the spirit of the Miami Plan and the reality of the experience in the various countries — that sectoral reform was definitely not unisectoral in terms of involvement.

Health sector reform is quickly becoming another growth industry and perhaps the urge to modify the sector is part of the general frenzy for change. We seek to reform, restructure, repair or reengineer all parts of modern life which perhaps is nothing more than an acceleration of the quest for material goods and happiness on earth that was one of the products of the industrial revolution.

In these few minutes I will not address the essential technical aspects of the reform process, but will give my perception of some of the rationale for health sector reform and the prospects for technical cooperation from the Pan American Health Organization.

The reasons for the rash of interest in health sector reform stem from factors that are extrinsic and intrinsic to the sector. The most powerful extrinsic factor is that health sector reform is caught up in the wave of interest in reform of the State in our countries. This reform is itself open to different interpretations. Some of a more conservative bent wish to see the State bureaucracy reduced, its role circumscribed to some basic functions that are truly essential and cannot be executed by other social partners. Others would view State reform as implying an enhancement of the functions of a physically smaller State, with those functions being concentrated in the provision and distribution of essential public goods and performing certain key regulatory tasks. Others regard the state reform as focussing on political maturation in a democratic mode, incorporating

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* **Pan American Health Organization, Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization.**

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elements such as decentralization and deliberate involvement of all of civil society. Many of you will see many aspects of State reform reflected in the approaches to health sector reform.

However, there are certain factors intrinsic to the health sector itself. There is the perception that the health sector is a single identifiable entity that can be changed to increase productivity in a manner analogous to the other sectors. There is the assumption that increased productivity will lead to improved health. If we accept this thesis, it is natural to ask what are the main determinants of that health status that the health sector is expected to improve.

It is very clear now that the major determinants of individual and population health are the social and physical ecology, collective and individual behaviour, our food, our biology and the care services provided for us. If we were to really address health sector reform comprehensively with the assumption that all those determinants of health status fall within the purview of the health sector, we would in theory pay scant attention to the care services, since they are not the major determinants of our state of health.

However, in this forum, we have elected to address mainly the services and particularly equitable access to those services and it is reasonable to question why. It is a fact that it is the rising costs of the health care services that is driving most of health care reform.

There are essentially two reasons for this — changes in health care demand and enhanced supply of health funds. The increased demand derives from the demographic changes, advancing technology and communication driven expectations.

The availability of funds — strange as it may seem to many of you is also growing. The fraction of national wealth available for care is increasing as the economic prospects of the Americas improve. In Latin America and the Caribbean at least, the slowing inflation and steady economic growth of the first half of this decade is likely to continue. In spite of increasing poverty, mean per capita income is rising and as income rises more is spent on health care. I have been told that studies in this region from Harvard University show that income elasticity for public sector expenditure is greater than unity and it is probable that public expenditure on health will rise. The opportunity costs of paying the rising health care costs are becoming too high for most of our countries. The countries of the Americas spend some 800 billion dollars per year in the health sector and in Latin America and in the Caribbean approximately 6% of the GDP goes to health. The magnitude of this expenditure is not lost on those who hold the national purse strings.

The concern for equity in health care is vital for us, and we believe that it should be a basic principle behind any movement for reform. At its most elemental level, equity represents fairness and while easily understood, intellectually and conceptually, may be difficult to measure. It is probably easier to translate it into equality of access, of utilization and of outcome. Equality of access which is our main concern here implies that all persons should pay the same costs for satisfying their needs. It is important to stress needs since it is clear that no concept of equity can turn around health care demands. One of the major pitfalls of those who seek to reform services is the effort to satisfy health care demands. No country in the world has ever been or will ever be able to plumb the bottomless pit of the health care demands of its citizens.

Another reason for reform which you will doubtlessly address is the popular dissatisfaction with the care services. Health care, especially acute care, is a sensitive political issue and the complaints about services ulcerated by inefficiencies and scarred by deficiencies are never lost on political ears. The clamor in this area is particularly noticeable when it comes from the powerful medical establishment, aided and abetted by the media.

The interest of the Pan American Health Organization in Health Sector Reform is not new and in a sense antedates the Summit Conference and our technical cooperation in this field is guided by some basic tenets. In 1978, the countries of the Americas, flushed with their efforts at regional cooperation went to Alma Ata and participated in what has been described to me as one of the most moving moments in the modern history of health cooperation. They agreed that they would be ambitious enough to issue a call for Health For All by the Year 2000, and put in place the strategies to do so. No matter the impossibility of this as an absolute — it caught the attention of the health workers and fired many with enthusiasm that they might see in their lifetime a decrease in social injustice, an increase in social equity, with health being one of the main markers.

Much has been done but there is still the feeling abroad that many of our countries have lost some interest. For a multitude of reasons, which you know very well, many of the specific goals that were used to characterize HFA have not been fully realized. But many of us, many of you, are feeling that there is a need to burnish that broad goal so we have launched a process of renewing the call for Health for All. We are convinced that the basic ethic behind the consensus of Alma Ata is alive today.

Within this context we view the main Strategic and Programmatic Orientations that the Governing Bodies of PAHO have established to guide the work of the Organization as a whole in the next four years. These Orientations shape our technical cooperation and are particularly relevant to the reform process.

There is no single simple model or recipe for sectoral reform. Our technical cooperation has to adjust to the local reality. We insist, however, in the primacy of the Minister of Health in the reform process and will continue to support them to lead the debate discussion and implementation of the health reform. Other sectors are clearly involved but we will continue to insist that the leadership role must be within the Ministry of Health which should be supported to coordinate the various inputs that the process needs. I have said that our technical cooperation will embrace, in general terms, two major aspects of sectoral reform. Those are the organization of the systems and services and the financing of such. These will be discussed here further, but I would insist that one cannot be considered without the other.

I am sure your debate and discussions will be lively if not heated and if they are heated I hope the energy generated will help to drive the reform process in the Americas. History has seen many reformations, some have stuttered and died and others have persisted to change the way we worship, the way we govern and are governed. I hope the reform process in the health sector has the durability of some of the efforts that have gone before.