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HEALTH SECTOR REFORM: ITS BASES AND THE CHALLENGES FOR TECHNICAL COOPERATION
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First let me thank you for the opportunity to address this subject here at this forum and before such a distinguished audience of persons who have themselves been architects of a reform that has made Chile famous throughout our Region. The timing of this forum is opportune as it comes four weeks after a special session of the XXXVIII Directing Council of the Pan American Health Organization dedicated much time and effort to examining the processes of health sector reform in the Americas.

This special session was held as a result of the mandate given to the Pan American Health Organization by the Summit of American Heads of State held one year ago in Miami. En esta Cumbre los mandatarios americanos confirmaron su compromiso para la preservación y el fortalecimiento de la comunidad de democracias de las Américas, la promoción de la prosperidad mediante la integración económica y el libre comercio; la erradicación de la pobreza y la discriminación en nuestro hemisferio y la garantía del desarrollo sostenible y la conservación de nuestro medio ambiente para las generaciones futuras.

Dentro del plan para la erradicación de la pobreza se destacó el acceso equitativo a los servicios básicos de salud y se instó la convocación de una reunión especial de los gobiernos del hemisferio con los donantes y los organismos técnicos internacionales interesados, patrocinado por el Banco Interamericano de Desarrollo, el Banco Mundial y la OPS con el fin de establecer el marco de los mecanismos para la reforma de los sistemas de salud.

The discussion in the Directing Council made it clear that almost every country in our Region is involved in a process of health sector reform and although each one is developing its reform in accordance with its particular reality, it is clear that there are some common threads. I believe that PAHO in addition to supporting them has the responsibility to provide the opportunity for countries to share their experiences and cooperate technically among themselves so that through mutual interchange all might benefit.

It was obvious from the material presented and the other reports I have received that the process in Chile is well advanced. This is no surprise, as over the years Chile has demonstrated its leadership in many aspects of health. The health indicators of this country are the envy of many

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

countries that have more national wealth. As Dr. Carlos Massad Abud, Minister of Health, said recently in his ponencia "Principios orientadores para la reforma de la salud", - "Chile ha hecho bien las cosas". But in spite of this affirmation he still saw the need to examine the present reality and propose a program based on the principles of equidad, descentralización y participación.

The documents produced by our Member States have made me reflect on the purposes of health sector reform and the needs as well as the challenges for technical cooperation. No one will disagree with the basic thesis that the purpose of health sector reform is to maintain and improve the health and well-being of all citizens.

This purpose is grounded in a moral imperative that sees human well-being as the real reason for most of human activity and that well-being as almost synonymous with human development. The health of our people is not only a manifestation of their well-being, but also one of the most powerful instruments to achieve it. There are fewer goals that are more noble for the world as a whole or for the nations that make it up, and we who have some responsibility directly or indirectly for ensuring that health or providing the means through which health is maintained or restored have a most sacred trust.

But the issue of health cannot and should not be dealt with in the abstract. Implied in the efforts of all countries undertaking reform is the postulate that health represents a production function of some set of resources that we can define. These resources are multiple and it is ever clearer that the modification or manipulation of these resources in a systemic fashion is the way to improve health at the population level. These resources can also be cast as the determinants of health and some are more easily modified than others. It is a remarkable fact that the expenditure is not proportional to the power of the production function of the various resources that produce health. Thus, although it is known that individual and collective behaviour play an important role in determining health and well being, these figure very weakly in our schemes for resource allocation. It has been estimated in one large country that no more than 2% of health expenditures is dedicated to changing in a positive manner those behaviour patterns that impact negatively in health. We will examine later why the care services consume such a large portion of expenditure and are so central to the health sector reform processes when the might of their production function is relatively low.

The need for reform is not new and some would say that all health services are in a constant state of reform, but the interest is heightened at this stage and we might ask why. There may be variations in the ranking of reasons but I believe that the most important ones are the change in the social climate, the change in the perception of the role of the State and a concomitant drive to be more efficient in the use of resources in the public sector as a whole.

The dominant change in the social climate is the evolution of the Latin American economy as well as the form of governmental organization. There is every indication that the stabilization and adjustment economic programs have had their effect and in spite of transitory difficulties in some countries, the prospects are good. The growth rate of 3.5% in 1993 was remarkable and there has been an increase in domestic consumption and investment. On the whole the trend is towards inflows of investment capital and inflation rates are a fraction of those seen in the dark days of the seventies. The possibility of subregional blocs gives hope for further economic improvement and the reduction of global interest rates has reduced the burden of debt repayment.

There are therefore grounds for optimism, but at the same time there is considerable concern that the extent of poverty has increased. The progress such as it has been in the early 1990s has been due to the growth in household income and the gross disparities in income have remained unchanged or have got worse. Recent studies show an excess of income inequality for the region as a whole and several other studies dramatize the presence of poverty in our countries in spite of the favourable economic progress.

Poor health is among the more prominent aspects of this economic and social inequity. Repeated studies show the differential in life chances between the rich and poor parts of countries and between rich and poor countries. Calculations done by PAHO show that around 1990 reducible gaps in mortality in many countries have not declined or in some cases increased. It was estimated that each year, the deaths of 1.5 million persons under the age of 65 years could have been avoided: indicators such as infant mortality rate and life expectancy also show vast differentials between groups. This relation between poverty and ill health is complex and probably represents a combination of individual and structural effects. Whatever the relationship, the consensus is that this state of ill health is a major driving force for the search for equity in the health systems. The inequity in the health systems also has its ethical dimensions. Historically, it has been the medical profession that has accepted or been entrusted with the moral responsibility for health issues. This derives from its original focus on the individual, but the scope of ethics or its applications in the health field - bioethics - has expanded, and now it is not only the healer, but other actors in society that are being called upon to make ethical decisions about resource allocation. In the health sector, where by definition resources are limited and demands infinite, the allocation of such resources is not only an economic issue, but also an ethical one. These social ethical issues related to reform have received little attention. Every country involved in health sector reform seeks this equity and all find it easy to conceptualize but difficult to measure. I believe as do many others that there are three manifestations of equity that are quantifiable. These are equality of utilization of services, equality of access, and equality of outcome.

Equality of utilization means that individuals with similar problems should have full use of services to address these problems irrespective of the characteristics of those individuals. Equality of access implies that the services should give the same facility and opportunity to individuals without any fear of discrimination. Equality of outcome is more difficult to measure and implies identical results from the required services.

The attention to these problems and the attempts to reduce inequity as manifested by differential health outcome is important not only for ethical and moral reasons, but also on political grounds. The tensions that are derived from patent inequalities in the availability of social goods can produce political instability to such an extent that the very foundations of the State can be shaken.

The form of social organization has changed and is changing in our Region. Democratic forms of government are the norm and I believe that contributes to the quality of life and the possibility of enhanced human development. But there is good evidence of a more active popular participation in public affairs through various actors of the civil society such as the non-governmental organizations.

Wider participation of these various actors has influenced the shape and dynamic of health sector reform.

A great deal has been written about the changing role of the state in Latin America and the Caribbean. There is general agreement that as most governments move towards a more plural society and market-driven liberal democracies, the role of the state must change. There is not, however, consensus on the face of the reformed state. One scenario is consistent with reduction of government involvement in production of goods and services and circumscribing the state's role to one that is minimally regulatory. The other view sees the state smaller, but with a powerful voice in determining the allocation of certain public goods among which are various aspects of health care.

The health sector reform will be influenced significantly by the type of state reform, and there is a growing consensus on the relationship of the state to provision of health goods to ensure equity. There is general agreement that the state should ensure universal access to basic health care. I believe that direct state provision of services should be in proportion to their externality content: the higher the externality content of the services, the greater should be the responsibility of the state. In addition, within the context of universal access and equity, the state should ensure the provision of a basic package of essential clinical services. The composition and cost of that package will vary with the epidemiological profile of the population and the ability of the state to pay. The lower the externality content of services, the greater the possibility of plurality of providers.

The third important factor that has driven or influenced reform is the concern for the efficient use of resources. The care services consume by far the largest fraction of the funds spent in the health sector. We estimate that approximately 800 billion dollars were spent on health in the Americas in 1990 with Latin America and the Caribbean being responsible for 6.8% of that amount - a figure that represents 6.24% of Gross Domestic Product. Countries that spent less than 4% included Ecuador and Paraguay while Argentina, Costa Rica, Guyana and Jamaica spent more than 9%.

The causes of the increase in health care expenditure are complex, but in general are related to demand and of course supply. Increased demand reflects the availability of more expensive technology, the longer life span of our populations which brings with it changes in the disease profile. This country, like all others in our hemisphere is having to deal with chronic diseases and those biological changes related to aging which involve increased expenditures by the health sector. Demand is also driven by the consumerism that derives from the globalization of media coverage in health. The availability of money also increases expenditure and as countries' wealth increases, a higher percentage is spent on health. Reform is not only driven by the absolute expenditures, but also by the perception of inefficient use of public funds.

I have dealt with health sector reform as if it were purely a technical issue driven by a moral principle but relying on instruments and concepts that were technically sound. We must never, however, neglect the political aspects of health sector reform. It is obvious that the political climate must be right to introduce any reform and because of the numerous stakeholders in the process, those persons initiating health sector reform must carefully construct the political alliances necessary. Apart from the fact that any change is threatening, in this case some of the stakeholders are among the most powerful and influential in the community. Just the perception of erosion of

influence or earnings by the health care industry is enough to provoke the kind of reaction that can derail even the best conceived health care reform process. In this context, the role of the mass media is critical, as they are a major force in shaping public opinion.

PAHO is committed to monitoring the process of reform in the countries and offering its technical cooperation where needed. We will follow certain basic principles. We see the reform process as facilitating the progress of countries to that social equity that is the underlying principle of the goal of Health for All. We are inviting all countries to reflect on what has been achieved since they agreed to seek that goal - to examine the adequacy of the strategies that were accepted and hopefully adopted. We are encouraging them to renew their enthusiasm and practices and, yes - their faith in the principles that make Health for All a noble goal. We will continue to press for the primacy of the Minister of Health in the reform process. Even though other action may be involved in the health sector, even though the intersectoral approaches to improving health status are accepted fully, the Ministers of Health must be the primary protagonists.

We will continue to advocate at the highest levels of government for a wider appreciation of the role of health in society. Most political actions are driven by popular perception, therefore, PAHO must assist Ministers of Health in focussing the public debate on health sector reform appropriately.

We will seek to collaborate with other partners in offering appropriate cooperation in relation to the two most important technical aspects of health sector reform - organization of the health systems and services and their financing.

But apart from our own technical cooperation we will foster technical cooperation among countries in this field. The results of the debate in our Directing Council have brought home quite sharply the possibility of beneficial intercountry cooperation. This can be achieved by the interchange of personnel, but also by the interchange of experiences. This forum provided an excellent opportunity for such exchange and I trust that all those who participate leave here not only wiser, but also committed to share the experience with others. I know there will be much for all of us to learn - because as Minister Massad Abud said "Chile ha hecho bien las cosas", and I would add "¡Ojalá siga así!"