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THE CONTEXT OF REFORM IN THE CARIBBEAN..
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It is a pleasure to be here at this extraordinary meeting of Ministers Responsible for Health in the Caribbean, and I must thank the honorable Minister from Jamaica for the invitation to give this address. Any visit of mine to Jamaica, is pleasant, as it always evokes memories of times past when affairs for me were much less complicated, but I am sure I am not the only one who is nostalgic for the uncomplicated life.

I am also pleased to see so many Ministers present. We know that there had to be a change in the venue of this meeting and on other occasions we have expressed our sympathy for and solidarity with the people of Antigua and Barbuda for the event that led to the change in venue. This, of course, gave Jamaica the opportunity to display its well-known hospitality.

When I thought of being with you, I had intended to spend some time discussing issues that related to the technical cooperation of the Pan American Health Organization with your countries. I had intended to bring to your attention some specific issues related to the Caribbean Cooperation in Health and its future development. I had decided to share with you my disappointment that there is a Dengue epidemic causing you to use several resources for emergency operations, and my frustration that we cannot work together to have a program that effectively controls *Aedes aegypti*, but I will leave such discussion for another occasion - perhaps your regular conference next year, and I intend to concentrate these few remarks on the main purpose of this meeting.

When this Extraordinary Meeting was conceived some three years ago, it was to be concerned primarily with the health services. When definite agreement was reached in the 14th Meeting of Ministers Responsible for Health held in St. Vincent and the Grenadines last year, it was the delivery of services that was the theme that engaged your attention. But during the planning and evolution of this meeting, the focus has been broadened and it is proposed that one of the main objectives is to achieve a clearer understanding of the context of reform in health. The issues of care and rationalization of health service delivery have been subsumed under the general rubric of health reform, and it is this topic that I propose to address.

During this year, many of you have participated in several meetings that have dealt with the issue of health reform, the most recent being the meeting of the PAHO Directing Council

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

.. **Extraordinary Meeting of the Caribbean Ministers Responsible for Health.**

when participants from various sectors opined on the perceptions, practices and pitfalls of reform. This special session of the Directing Council arose as a mandate from the Miami Presidential Summit and is an indication of the importance being accorded to the topic. Since becoming Director, I have participated in at least four major high-level conferences on health reform. As I have said elsewhere, health reform is becoming one of the Region's major growth industries.

Reform in many areas is very much in vogue today and there is increasing appetite for the "re" culture. There is re-engineering of all shapes and form. Reconstruction is now seen in all areas of life - from buildings to businesses to the human body. Sometimes I reflect whether this is not a geometric progression of man's belief that there is nothing in nature that cannot be shaped anew. The mastery of nature that began with Bacon has not ceased and the evidence in the physical environment is one reason for many to be attempting a reevaluation of their "re" culture and trying to achieve some greater sense of balance.

I have never taken any reform lightly and I have been very cautious about considering what is happening in health as the beginning of a reform movement. Reform movements that last have special historical significance, and as I reflected on the possibility that reform in health might persist and have weight in the overall social scheme, I cast my mind back to the reform movement that marked the beginning of modernization and changed the foundations of thought and practice in almost every aspect of society.

Let me dwell on that movement very briefly, perhaps to draw a most presumptuous analogy. When Martin Luther, the humble monk from Wittenberg wrote his 95 theses, he really only set out to question some of the dubious clerical practices of his time. His initial emphasis was on the procedures which in his view were unacceptable. But the ripeness of the time and the more readily availability of information through printing led to such a widening and deepening of the movement that eventually the very essence and pith of religious dogma were being questioned - sometimes modified and sometimes even overturned completely.

Martin Luther's reform had far-reaching effects. It created new ecclesiastical cultures, it eventually led to changes in the face of England's politics. We in the Caribbean can see in the shape of our political and religious organizations many of the consequences of the originally timid efforts of Luther, the monk from Wittenberg, and Gutenberg, the diamond cutter from Mainz, turned printer.

The pale analogy I would draw, as I try to initiate the debate on the context of reform, is that much of the original questioning in health reform, as I will show, was directed and much still is directed towards the change in practice. There is very proper concern about the services, their composition, their roles and how they might serve better the purposes for which they have been and are being designed. I am adventuring the concept that, like Luther's reform, a further step, stimulated by information sharing and interaction, will be the questioning of the role and value of health itself. In parliamentary parlance, I would put the question as to how you Ministers of Health might lead the reform thinking into examining the true value of health to our societies.

The question having been put, I must give first some more of the context of health reform as it is traditionally described and discussed. The political and economic climates have to be considered here, and I will be hemispheric first before focussing down on the Caribbean.

The Caribbean is often oblivious to the major political changes that have taken place in the hemisphere, and democracy is taken so much as a "given" that there is often no feel for the emotions stirred by discussions on the spread of democracy in the hemisphere and the need for eternal vigilance if it is to be preserved. The search for the change in the State apparatus here is reviewed primarily as an indication of a need for enhanced managerial efficiency. But all governments are having to analyse whether the State apparatus is efficient and whether there needs to be a rethinking, not only of the role of the State but also of the State apparatus. The discussions and decisions on the extent of privatization must be seen in this light.

There are those who will see state reform as a process of removing the main *loci* of production from the hands of the State with the idea that certain goods and services can be produced more efficiently by the private sector. This is not in opposition to the view that the State, while divesting itself of certain activities, must retain the responsibility for ensuring, through instruments that only it wields, that the wealth of the nation is distributed more equitably. Every Caribbean government is going through this exercise. State reform also is applied to the concept and practice of opening government, broadly defined, to participation by many other social actors. Much of this thinking is reflected in the call by the West Indian Commission for a Charter of Civil Society. Indeed the Port-of-Spain Consensus of the Regional Economic Conference of 1991 emphasized social partnership in the democratization process. That Consensus specified the role of social partners saying:

Public participation by the social partners should be facilitated by systematic arrangements which mobilize the specific characteristics and concerns of the various groups constituting the membership.

These movements in the perception of and governance of the State must of necessity have repercussions in the health sector, as I will mention later.

The economic developments of recent times must also be considered. Let us look at the Americas first - or more particularly, Latin America. The decade of the seventies was a period of boom, followed in the eighties by a severe economic crisis, which was to some extent predicted by Sir Arthur Lewis in his Nobel Lecture on "The Slowing Down of the Engines of Growth". The Caribbean was not immune from these global and regional currents. The decade of the eighties saw the economic crisis affecting all countries which had to undergo in lesser or greater manner severe structural adjustment programs. The nineties give reason for hope. There has been real growth in GDP for Latin America and the Caribbean, and the figure for 1994 was 4.1 percent. I have seen data for an average growth rate of about 1.5 percent in the CARICOM countries for the first years of this decade and there is good evidence in most countries that this positive growth will continue.

But I am sure that many of you, like myself, have agonized over when the effects of this recovery will be seen where it counts - i.e., in improving the overall lot of people. There is evidence in the Americas as a whole that the number of poor is increasing and there is every

indication that this is so for the Caribbean, where it is estimated that 20-30 percent of the population live in poverty. This is a manifestation not only of historical structural problems but also of the pattern of growth without equity.

The issue of poverty and income inequality is vital for us in health, but it is important for us to realize that this phenomenon of growing income inequality, with resultant increase in social tension and often distortion of the demand and delivery of social services, is not restricted to the Caribbean. It is being seen in every country that has based its economic development on the magical myth of the market. The possible consequences of this development for us were expressed almost lyrically by Kari Levitt in an Eric Williams lecture when she said,

The market magic paradigm has proven to be remarkably seductive because it combines the logical coherence of neoclassical economics with the structure of power in the real world. It is appealing because it appears to offer a personal and individual solution to economic pressure. This is a tragic illusion. In reality, it is an instrument whereby the rich and the powerful impose on whole societies a set of values and rules of the game which reinforce inequality and injustice and dismantle the capacity for social solidarity. Governments are disempowered and become the unwilling debt collectors for international capital, while millions of people are condemned to misery without end.

It is in this political and economic climate that you have to consider health reform.

We must distinguish between health reform and health sector or health services reform and, unfortunately or fortunately, it is the latter that occupies most attention and is often contemplated within the economic and political context I have described above. The driving force in most countries has derived essentially from the following considerations.

There are those who are concerned with the cost of the services or rather the rapidly increasing cost, as in this Region as in many others, the cost to the public purse of health services is rising more rapidly than many of the aspects of social spending. There are countries in the Caribbean that devote almost nine percent of GDP to health - a not inconsiderable sum, and there is a cry from the public sector to find some relief from this economic burden.

There is also the wish to ensure universal access to services. The Caribbean has a tradition of providing public services of high quality, and embedded in all the political and social thinking is the concept that the State, if not actually providing, has the responsibility to ensure universal access to services for its citizens.

The health profession is also a major participant in the debate on services as, quite properly, it tries to ensure that persons who need care can get it. There is often the tendency to attribute base motive to this desire of health care workers, particularly physicians, to ensure wider access to care. This is most unfortunate, as it is the responsibility of the health care giver to strive to do the best for the individual - it is a societal responsibility to determine how its resources, including those allocated to health, should be distributed.

Of course the public influences profoundly any decisions about health systems and services, as it is often its demands, or the perception of its demands by policymakers that guide resource allocation. More than one system has become caught-up in the impossible task of trying to satisfy the health demands - not needs of a population.

I am sure that it is clear to you that the Pan American Health Organization has more than a passing interest in this topic. To the extent that we have sought to focus our technical cooperation in this field, we have elected to concentrate on two main issues. First, we consider the extent to which the whole health system needs to be restructured -including the health services; and second, the nature of the financing mechanisms that must be employed.

There is general agreement that the endpoint of the restructuring of the system is to secure more equity in that system. We may debate how that equity - how that fairness is to be measured. I am most attracted to a notion of equity as meaning the equalization of net benefits to the individual and similarly equalizing opportunity for enjoyment of an access to such benefits. This in no way runs counter to the needs for the community's health to be maximized. The instruments of restructuring the system include decentralization, the provision of basic packages of services, and appropriate managerial improvement at the various levels and within the various subsystems.

Financing often drives the debate -unfortunately- and the essence of the argument is how much of the health sector costs should be borne by the State. What possible mix is there in terms of financing the system and who should determine that mix? I am sure you will discuss this in some depth.

It is critical that you have the basic data and information to allow you to make decisions. I am confident that the forthcoming PAHO publication *Health Conditions of the Caribbean*, which will be complementary to our quadrennial *Health Conditions of the Americas*, will provide you with this information in a form that is attractive, readable and technically sound.

I am pleased that you will have the opportunity to comment on the early version of a Caribbean Regional Health Study, which is being conducted under the auspices of the Inter-American Development Bank and PAHO. I recommend it to you not only for good solid technical reasons, but also for personal ones. The execution of this study is a realization of one of my ambitions that is now at least four years old, and I am very pleased to see it now coming to fruition. The study will invite you to reflect on the main issues that must be considered for sustaining an agenda for reform and it lists the following:

I hope you are as pleased as I am with the progress made and the calendar for the future work in this Study.

But I wish to move now beyond that aspect of the reformation that deals with procedures and practices and invite you to reflect on what needs to be done to modify the perception of health and the nature of the public debate about health. Luther's reformation went beyond practices.

Health has to be seen beyond health systems and services. Health has to be seen as a vital resource that is an essential part of the human and social capital that all, repeat all, nations need for their further development. Expenditure in health has to be seen as an investment in producing that human and social capital, and let us not be offended by the notion of capital in this context. There is now increasing evidence that investing in health has a positive impact on a country's future economic well-being. I have proposed that the health of its people is important for a country's internal stability and national security. In addition, I have argued that the health of neighbours is also important for national security. I have also traced the relationship between health and the maintenance and stability of the democratic process. The organization of the democratic state as alluded to before, must now take into account the participation of various social partners, and the nongovernmental organizations represent one such partner. There is no doubt about the avidity with which NGOs embrace action in health as certainly one area in which they can work cooperatively with government.

Of equal importance is the popular perception of health and its meaning -a perception which is currently and perhaps has been historically colored by the spectre of illness and the fear of death. To the extent that the public continues to have only this focus, its demands for technology of ever increasing sophistication will increase with resulting pressure on policymakers. If health and the need for its preservation are not seen in these broad terms, we will continue to have public behaviour that leads to recurring epidemics of dengue. This need not be so!

I am not referring to a return to the narcissism that characterized much of the classical approach to health in the slave societies of ancient Greece. I am proposing a better appreciation of the health state of the individual and, by extension, the community and the nation. An appreciation that this healthy state is indispensable for human development might lead to a better understanding of the need for investment in health and a more rational allocation of resources among those factors that are the determinants of the healthy state.

I would be asking too much of you if I said that I expect all of you to try immediately to make operational these latter concepts I have put before you. I leave them with you as ideas with the hope that such ideas may become powerful infectious agents. I also hope that you will not develop antibodies to these ideas or seek from within your services the antibiotic or other medicine that can eliminate the ideas from your systems.

But I really do hope you reflect on what I have said and, as Kahlil Gibran had the Prophet say,

If aught I have said is truth, that truth shall reveal itself in a clearer voice, and in words more kin to your thoughts.

I thank you.