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POLICIES FOR SUSTAINABILITY OF HEALTH PROGRAMS ALONG THE US-MEXICO BORDER THE EQUITY FACTOR (Hermosillo, Sonora, México) **

First, let me thank you for the invitation to address the 58th Annual Meeting of the US-Mexico Border Health Association. Any association that has managed to sustain interest and commitment from the health officials along the Border for this length of time must be fulfilling a purpose and responding to a need. In my 17 years of association with this part of the Americas, I have come to appreciate its unique characteristics and the extent to which it has grown in size and continues to grow in importance. The enhanced communication and strong linkages between these two great countries make for a focus of attention on the area where they meet geographically. Since both have constantly highlighted the importance of the well-being of their people as essential elements of their national development, it is no surprise that health concerns should figure prominently in discussions about this area of the Border.

After all, 20% of the population of the two countries live in the 10 border states, and we should note that population growth in the Border is higher than in either country. We have an area of increasing population and one that is growing in strategic importance.

Although there is merit to the claim that this area is unique in its ecology, we cannot ignore the differences that exist between the two sides of the Border. The Pan American Health Organization, in cooperation with the "Dirección General de Estadística e Informática" of the "Secretaría de Salud de México" and the National Center for Health Statistics of the USA, has produced Mortality Profiles of the Sister Communities on the United States-Mexico Border –first for the period 1992-1994 and recently for 1995-1997. These profiles cover 4 pairs of sister communities that account for about 95% of the population of the Border.

You will hear much more about this excellent collection of health data during the Conference. It shows, for example, that heart disease is the first leading cause of death along the Border and you will also find categorization by age and sex of the different

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mortality patterns. One of the unique features of this publication is that it shows the spatial distribution in the Sister Cities of the various causes of mortality. These data are complemented by other epidemiological information that point out other major health problems. These include tuberculosis, acute respiratory infections, AIDS, chronic diseases such as diabetes, environmental health, and the problem of diseases transmitted by foods.

When we analyze these data, it is inevitable that we ask the question as to which of the problems show gross inequalities in terms of geography, sex, or some other determinant to such an extent that they can be described as inequities. Is equity a factor to be considered in this area, and should the policies for sustaining health programs take it into account?

There are many differences in terms of health between the populations on both sides of the Border, but it is interesting to me, that the closer one gets to the actual Border, the smaller these differences become. There are differences also within the Border states themselves. The trap we must avoid is to adjudge all of these differences as inequities. It is easy to stir moral indignation at inequalities or disparities that really do not represent inequities. Inequity represents disparities that are unjust or unfair.

The equity issue is one of fundamental importance to PAHO and to me personally. It is a matter of concern that while the health situation of the Americas as a whole is improving, there are growing disparities that we feel are unwarranted and unjust and therefore represent inequity. We must be clear that there are differences in health outcomes that represent inequities. But of equal relevance, or perhaps of greater relevance is to examine the determinants of individual or population health to see whether disparities in the determinants themselves contribute to the disparities in health outcomes. Thus, the differences or disparities in health outcomes or health status are important, but it is even more important to look for the causes of these differences or disparities if we are going to find means to reduce them.

In assessing whether those determinants of health are distributed unequally in such a way that they constitute inequity, I always examine whether or not they are avoidable. Some differences in determinants are not avoidable. Differences in health status that derive from our biology or our genetic make up are not avoidable and therefore, do not constitute inequity. But we must be careful in attributing any difference to a genetic cause, as we know that as we look further into so many things that were said to be biologically or genetic determined, we find that the social environment plays an important if not a dominant role. In addition, there is now good evidence that presumably inherited or genetically characteristics may be determined by intra-uterine conditions such as level of nutrition.

We may look at whether some of the distributions of these determinants are avoidable from a financial point of view. When we see societies with sufficient wealth available to make a positive impact on the health of all citizens, and yet see so much illness and suffering, we have to call this inequity. Unfortunately, the form of social

organization and the dominant pattern of economic organization creates a steady pressure for increasing the social and economic differences within our societies, and this can only lead to the widening of health differences or disparities, since social and economic status impact on health. It is very true that the economic gaps are widening in all countries and this is marked in the USA. This gap itself, in addition to poverty is a cause of ill health. I would be naïve to propose that it is within our grasp to reduce these gaps without waiting for economic equality.

It is often difficult to separate technical from financial measures that should be available so that health differences do not occur. Usually, the application of the technology necessary to reduce the differences in health status is driven by the resources available to pay for it. But again, much of the technology is within the grasp of both sides of the border. The use of community health aides represents one such technology.

When we speak of inequity in terms of the distribution of determinants, we should be clear that any differences must be beyond the volition of choice of the individual or group if we are to see them as representing inequity. We know that there are great differences in living conditions among groups along the Border that contribute to ill health, but I am positive that persons do not usually live in substandard conditions because they voluntarily choose to do so. There are circumstances beyond their immediate control that force them to do so. Thus, we have no difficulty in framing these health differences or disparities as a result of social inequity.

I have mentioned living conditions or the environment as a determinant of health and certainly there is no good, unavoidable, or technically insurmountable reason for there to be such differences in environmental conditions as to lead to wide differences in health along the Border. Yet, we do see vastly differing environmental conditions, both between the two sides and within the states themselves. I have been particularly impressed by the efforts to address some of these environmental problems in a binational manner that seeks as it were, to level the environmental playing field.

The Border XXI Program as I understand it, is designed to achieve a clean environment through such strategies as ensuring public involvement, decentralization of environmental management, and trying to ensure or facilitate inter-agency cooperation. There are several federal agencies active along the Border. The binational workgroups that will actually be implementing this Program will deal with problems related to water, air, hazardous and solid waste, as well as pollution prevention. PAHO has to be an enthusiastic supporter of this initiative which does not necessarily involve the massive injection of new funding.

I am often asked if my concern for equity is simply a moral one and if I see equity in health as some kind of holy grail that can never be reached. I admit that the root causes of the inequities are sometimes so deep that they will be difficult to eradicate. But I do know that in many cases, we have the technology and the knowledge to address the inequities. In addition, I believe that these visible and glaring gaps, especially in social

conditions that lead to inequities, are causes of social unsatisfaction and social instability. It simply is not good for social cohesion that these wide gaps continue to be present.

It is obvious that the intervention programs should address the identified health risks. If risks are purely local, then the programs have to be focused locally. In the case of this area, many of the risks are geographical and local rather than national in scope – they are risks of the Border and not peculiarly of one country or state. The risks posed by vector-borne diseases clearly have to be addressed binationally and this is the case whether the vectors are insects, humans, or food. They all cross the Border with ease. One of the classic examples is tuberculosis –the ready crossing of patients with the possibility of incomplete therapy or follow-up, make for the development of multidrug resistant tuberculosis with all its attendant problems of therapy. And that is why the project of "Ten Against Tuberculosis" deserves much support.

I referred to the Border XXI as an example of a binational initiative, and I would stress the necessity for binational efforts to address many of the problems that exist. But it is a complex issue to mount a genuine binational effort that is sustainable. I learned this some 15 years ago, when I was deeply involved in a project funded by the Carnegie and Pew Foundations to address the problems of maternal and child health along the Border. It was also clear that it was not enough to have the declarations of interest by the various stakeholders; mechanisms had to be found to bring them together around specific projects and sets of activities.

It has become even clearer to me now that one of the first tasks is to identify the various institutions along the Border that have a stake in the health of this area. I am pleased that at last we have been able to develop a directory of these institutions that, if circulated and used, will facilitate exchange and interchange among the institutions themselves. Knowledge of the various actors will not per se eliminate duplication, but will certainly facilitate collaboration. But knowledge of the institutions is not enough, it is ideal for there to be some forum or fora for inter-institutional and indeed interpersonal interaction. I see this as a key role for the US-Mexico Border Health Association. In the past year, under its dynamic President, Ms. Eva Moya, it has tried to do just that. It has sought to show that there can be tangible benefits for the Border if this collaboration is a real one. I hope that the Association continues on its upward trajectory and represents, not only a forum for discussions about the Border but a voice that articulates the opinion of the concerned health professionals about the health problems of the Border.

There are, of course, governmental for a, such as the Border Health Commission, which we expect to be an important force for change here. There are also the formal groupings such as those of state health officers and universities. I would like to pay tribute here to the memory and work of Dr. Wadie Kamel, of the University of Arizona, who was an indefatigable worker for the cause of health along the Border.

It is also fair to suggest that sustainability of binational programs along the Border will depend on the strength of the institutions I have mentioned above. The individual governments are clear that it is in their interest to see the disparities or differences

reduced in the Border and this can only be done through a binational approach. There is no question that national policy for health on both sides of the Border, considers equity as important. It is not only here that reform of the health sector has equity as one of the essential features. It is true that most attention has been paid to equity of access to health services, but there is growing appreciation of the fact that, although health services are important, they are not necessarily the most critical determinant of individual or population health.

Although funding is also important, it is not the only factor that will make for success in reducing these disparities. Institutions are necessary to identify the disparities that represent inequity and to apply the interventions to reduce them.

The Pan American Health Organization ,as one of the involved institutions, is, of course, committed to this area. Our field office in El Paso was one of the first offices established by our Organization outside its Headquarters in Washington, D.C. and continues to be unique in that it responds to the expressed interests of the two federal governments, and seeks to craft its technical cooperation focused on the problems of the Border. I see our role also, as one of a facilitator –enhancing the possibility of binational cooperation and seeking to strengthen local institutions. The US-Mexico Border Health Association is first on that list of local institutions to which we are committed, as I see it, as a powerful mechanism for mobilization of resources along the Border. I also see a major role for us in helping to provide and disseminate the kind of epidemiological information that can be analyzed to show where the health disparities are, and which of the health problems, can only be addressed through the binational approach. We have not and will never work alone. We seek to promote partnerships among national and local institutions and it is therefore natural that we should try to establish partnerships ourselves with the various agencies and foundations that have an interest in health at the Border. We have productive partnerships with federal agencies from both nations.

Let me close by giving another reason for my enthusiasm for Border health. There are many international borders that are the sites of armed conflict or at least tension. I have always had the hope, that in some of these places, the examples of the concern for health being used as a means to draw people together might take root. It may be possible to persuade those who maintain their territorial integrity through war, that it might be more beneficial for the people who live in the area, if some of their efforts could be deployed to change the distribution of those determinants of health that result in the disparities and differences that are unwarranted and represent inequity.