George A. O. Alleyne
Director, PAHO*
16 June 1995

THE FUTURE OF THE HEALTH SYSTEMS IN LATIN AMERICA AND THE CARIBBEAN **

(Boston, Massachusetts)

Mr. Chairman, distinguished guests, ladies and gentlemen. First, let me ask your forgiveness for burdening you with this presentation at the end of a week of very intense work and hopefully fruitful discussions. My tendency when speaking after dinner is to be flippant and entertaining rather than trying to be instructive, but it is difficult to be lighthearted when dealing with the topic assigned to me this evening. But in view of the time, I promise I will deal with the subject on a general level and not weigh you down with figures and complicated models.

It is obvious that there will be health systems in the future - they cannot disappear, so I will attempt to look at some possible developments and directions they might take. The assumption is of course, that it is always possible to improve any humanly designed system or rather any humanly operated system, since the characteristics of some of our health systems would make one doubt that they had been actually designed. I say that in a mechanical sense, in that in very few if any countries, has any government had the capability, capacity or luxury of designing a system to meet predetermined specifications.

If one observes the health systems of Latin America and the Caribbean, one is struck immediately by their heterogeneity. There are systems that are highly centralized; systems that are unique in terms of having a single body with formal responsibility, others in which responsibility, if one can use such a term, is shared among a wide variety of actors - the public sector, the private sector, and non governmental organizations of varying hue and capacity. There would be general agreement, however, that all these varying actors have a similar purpose - to improve the health status of the populations.

Perhaps the second striking characteristic, and one that seems more uniform is the inequity in the health system. If one examines the care services as one part of the system, it is clear that the poor are always disadvantaged in terms of access and quality. Regardless of whether one measures equity in these terms or in relation to health outcomes, the poor fare less well. This is shown clearly in mortality differentials between countries and within countries. The urban/rural comparisons in many countries show or accentuate the differences that are essentially those of rich versus poor.

The next characteristic is that of high cost. Every country is concerned with the cost of health care which is increasing because of factors you know well. There is increasingly sophisticated and

---

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

** **The Harvard International Health Leadership Forum.**

expensive technology - the systems themselves - or rather the industry generates demand. There is evidence that whereas in most countries, disease in its original sense, was treated within the home or by folk practices and only a small percentage was dealt with by the formal care systems, the approach is changing. There is increasing pressure to treat more disease as opposed to illness, within the very expensive formal care system. Demographics will also affect cost as our countries deal with ever older populations.

Studies by Harvard, supported by the World Bank and the Pan American Health Organization (PAHO), show that health spending in Latin America and the Caribbean constitutes about 4.0% of the US$1.7 trillion spent in 1990. This was some 36% of spending in the developing world. Spending was about 6.0% of GDP and the differences among countries was huge, having little relation to their level of development. Poor countries like Jamaica and Nicaragua with differing GDP's spent 9.4% and 7.9% respectively of their GDP on health. There is no discernable pattern to this spending over time, but the salient message is that a large portion of national wealth is spent on health and predominantly health care.

The final general characteristic I wish to mention is the popular perception of health. In all countries there is this perception that health is important; health care is also important, but there is rarely if ever satisfaction with the provisions of health services. In most countries, one can hear a long litany of complaints about the health services - their cost, their inefficiencies, their poor coverage and their technological backwardness. The popular perception of the needs for care and for increased expenditure on care is not dissociated from the power and prestige of the health care providers and the relation of the size of the system to the benefits care providers may derive from it.

There are therefore many voices that are calling for changes in the health system, and it is useful to examine some of those forces in society that militate for change and will direct the shape and content of the health systems of the future.

One of the major determinants of change will be the economic situation of the Region. There is almost universal optimism that the world economy is in an expansion phase that is likely to continue for the short and medium-term. In Latin America and the Caribbean, the moderate economic growth and slowing inflation that we saw in the first half of this decade seem likely to continue. In most countries the per capita income is likely to rise even as we continue to see an increase in poverty and the number of the poor.

The studies from Harvard show that the income elasticity for public sector expenditure is greater than unity, or public expenditure as a share of GDP will rise, and in some cases faster, with increasing income. This would imply that we might predict an increase in public expenditure on health in the majority of the countries. The actual quantum of this is unpredictable, although I would doubt that in the near future we will recover the capital deficit that characterized the decade of the eighties. The destination and distribution of this possibly increased public expenditure will be a matter of some importance.

The second of the forces that should affect the system is the change in the social agenda. Every development agency and every country is now conscious of the need to pay attention to what is called the social sector or sectors. The newly appointed President of the World Bank, when asked

about his first priority, unhesitatingly answered, "poverty." The persistence of poverty is likely to frustrate all attempts to produce balanced development. The focus on poverty must engage the attention of the health sector since poverty is not only one of the root causes of ill health, but it is claimed that investment in health is itself anti-poverty.

Poverty per se is anti-development and anti-health, but another face of poverty is the unequal distribution of income that characterizes Latin America and the Caribbean. There is a close correlation between income distribution and health outcomes but even more importantly, investment in health, including nutrition, serves to reduce the income distribution inequality.

Another force that must be mentioned along with poverty is the inequity in access to health goods that I have mentioned already. The attempts to correct this inequity is one of the driving forces of the many efforts at health sector reform that are occurring in our countries. Apart from the ethical or moral reasons for reducing this inequity, there are strong political forces driving the efforts to reform the health systems to be more equitable.

The fourth force that will provoke change in the health systems is that which seeks to redefine the role of Government in general. As countries contemplate the steady march towards market driven liberal democracies, they are questioning the role of Government and the role of the State. In the decades of the forties, fifties, and sixties, there was considerable political and intellectual support for development that was directed and controlled by the State. But in the eighties and afterwards there has been increasing clamour and criticism, with louder calls for State reform. The critics of both the public interest view as well as those who propose that public choice theory explains how the modern State functions have been attracting increasing attention. While most will agree that the State is essential as an instrument of social solidarity, the prevailing view is that many of its functions should be reduced and perhaps shared with other parts of civil society.

The health systems will inevitably be subject to the reform process that is taking place. The nature of this reform process has been the subject of your discussions for the past week, but let me state my view very briefly. I believe that the crux of the reform process in all our countries will be the reorganization of the health systems and the financing of such systems once they are reorganized. Of course, no government can start from scratch, so we see both processes proceeding pari passu. The final point I would make here is one that is perhaps intuitively obvious. There will not, and cannot be, a single recipe for the reform and the final score will be a variation on those two themes that will depend on the characteristics of each country. It is interesting to look at those countries in Europe that have focussed on cost reduction as a priority in their health care reform process, such as Sweden and the United Kingdom, and see the remarkable convergence of policies. Government intervention is seen as essential in ensuring universal coverage and regulated or managed markets seem to be a common theme in the reorganized system. This approach is being increasingly breached in Latin America and the Caribbean.

The next force that will modify the health systems is the growth of technology. As I mentioned before, newer and sophisticated technology will affect the cost of health care, but apart from the medical hardware, there are other kinds of technology that will shape the systems. Chief among these will be new forms of management and organization and a high degree of dependence on

information. The future health systems will be highly dependent on the appropriate conversion of data into usable information.

Until now I have looked at the whole health system without delving into its various parts or subsystems. I would characterize the health system as comprising all those groups of practices and activities that impact on the health of people, or on population health. Perhaps the most important instrument for change in the nature and relative importance of the various parts of the health system is an appreciation of what are the true determinants of population health. My thinking in this area has been influenced a great deal by Canadian research.

I have found that few political leaders in health have a true grasp of the determinants of their people's health. There is a fixation on health care services as being the most important area of concentration of effort and resources. Health care, its cost, its effectiveness and its universality are occupying center stage when there is clear evidence that individual care services are by far among the least important of the determinants of a population's health. Far less attention is given to the social and physical ecology. Even within the health care system, the attention is almost exclusively on the cure and rehabilitation of the individual. Unfortunately, we are seeing more and more of the preventive care and promotion being brought within the purview of those whose primary avocation is individual care.

As long as this condition persists we will continue to see the pressure for increased spending for more health care being unresisted. There will not be the willingness to grasp the inescapable fact that no health care system can satisfy the demands of its people. And there are indeed many pressures to maintain that position. There is the pressure of the powerful health care industry - there is the power of politically powerful interests. There is also the power that is derived from the political perception of what people wish to have.

If the health systems of the future in Latin American and the Caribbean are to be really reformed and respond to the needs of the people, I would suggest that there are certain prerequisites. I have mentioned already some of the forces that are likely to condition some of that reform and would now go further.

First, there needs to be a clearer understanding at all levels, as to what is the importance of health nationally and the determinants of that health. At the highest levels of government - at the levels of presidents and prime ministers - there must be appreciation that the determinants of national health are such that the whole body politic has to be involved. It is only at Cabinet level that a responsive health system can be designed. A health care system is properly within the responsibility of the Minister of Health, but even so he or she will need firm extra sectoral support.

Perhaps of equal importance is that the public must be brought fully into the debate. If the cost of care - which is among the main concerns of the governments - is to be brought down, then there has to be popular participation. The part of the cost that is driven by technology will not come down if the decisions on choice are the sole responsibility of the health care providers.

I used to wish that items such as health care and the proper organizations of the system be excluded from the political arena. I now doubt that this is possible. What I can hope is that the debate take place around health of the population as a whole and less around the individual care.

The Pan American Health Organization will continue to cooperate technically with countries as they seek to reform their whole health systems. We will continue to press for the primacy of Ministers of Health in the organization of the changes to occur and will not be enthusiastic about the trend we see of making Ministers of Health junior to super ministers of social development. We will continue to engage the attention of the highest political leaders as to the importance of health nationally and the breadth of the systems needed to protect and promote it. We will continue to argue for and assist ministers in interfacing with the various publics through the press, of trying to stimulate a different kind of public debate about health and the health systems of the future. We will also continue to collaborate with the various agencies and institutions that like ourselves see the importance of the health systems of the future structured to respond to the needs of the populations of Latin America and the Caribbean.

We must attempt to supply some of the policy analysis that has been lacking in much of the discussion on health sector reform in the Region. It has been argued that in many developing countries, the scant policy analysis that takes place outside the economic area is focussed more on the content and structure of the reform and less on the context and actors. I believe that some of that has been answered this week.

We do not seek to enter into any competition in supporting our countries. Throughout the ninety-three years of our existence our leitmotif has been to be of service to the countries of the Americas and more particularly to Ministers and Ministries of Health. Our concern with health sector reform in our countries of the Americas is derived from our history and perhaps an unparalled knowledge of the health situation of the Americas.

I hope I have not given the impression of undue pessimism about the health systems of Latin America and the Caribbean. They have in the past responded magnificently to many challenges. Sometimes we forget that most of the major triumphs of public health in the Americas have been due to the health systems and particularly to the men and women in them. I predict that even as they undergo their individual processes of reform they will still be among the most efficient and productive of the systems that support our national aspirations.

R:\SPEECHES\018e-95