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THE FACES OF HEALTH REFORM**
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I am sure that during the last two days you have heard all there is to know about health reform, the various approaches to be taken and in some cases the early effects of these approaches. I will have to repeat some of this to give the context of much of my major proposition — that we must go further than considering health sector reform if we are to achieve the goals universally agreed upon for improved health of our people.

There is considerable admiration in this hemisphere for the Canadian system and I was pleased to read the Honourable Minister's presentation on Sunday when she spoke of the need for renewal rather than any drastic reform.

But the current interest in health reform is intense — it is almost a new growth industry and most of the debate is not about health systems or sector reform, it is about health care reform and we always have to examine the context or background to that interest. The economic and political developments of the last two decades give the relevant backdrop.

The decade of the seventies saw marked economic growth in Latin America and the Caribbean as measured by their rates of increase of gross national products, and there was significant improvement of many indicators that derived from this economic well-being. This economic growth never actually addressed some of the basic structural problems of the society and there continued to be marked social duality — increased wealth with poverty — urbanization with rural pauperization. This period of expansion was followed in the eighties by the most severe economic crisis of recent times, and one that affected all countries. The solution to this crisis was sought through fairly standard models of stabilization and restructuring which have indeed produced a reversal of the trend and with the widespread adoption of free market policies, in the last five years the region as a whole has begun to show economic growth again. The sustainability of this growth is a source of great concern because of the social instability and tension that are widely acknowledged to exist. But in spite of the growth in national wealth, in terms of absolute numbers and as a percentage of the total population there is now more poverty. The absolute figures vary very much according to the definitions used, but there are around 170 million persons living in poverty and the mode of economic development that has been embraced continues to accentuate the situation. But not only is poverty increasing; the more worrying situation is the increasing income

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inequality or disparity. The degree of income distribution inequality in Latin America and the Caribbean is higher than would be expected for the region's level of economic development.

It is rather difficult to attribute social decline to either of the two major possible phenomena mentioned above and perhaps it is irrelevant. The poverty and income inequality which existed before the crisis, were made worse by the crisis and this trend has continued into recovery. It may be postulated that the persistence of this problem is temporary and will be corrected as wealth increases, but the concern is that the social tension produced will in and of itself prejudice the possible economic development. This concern sees the major agencies that have traditionally been labelled development agencies more and more concerned with the social agenda and focussing on the very thorny issue of how their investment strategies might correct the situation.

The growth of income inequality is not restricted to the countries of Latin America and the Caribbean. Various economists have recently described very clearly a similar situation in the United States of America and the social consequences are equally alarming. Perhaps this does nothing more than point out the known fact that the laissez-faire free market has never and perhaps will never be good at distribution.

The changing political climate is the other major factor to be taken into consideration and it is evident that these changes cannot be dissociated from the macroeconomic scenarios. Democracy is now almost universal in the hemisphere and there is no argument about the value of this system of government. The change is within the democratic system — how the State apparatus is to be reformed to be more efficient. I am struck always with the thinking that one of the major concepts of efficiency in the State relates to the possibility of maintaining the economic growth and containing the social tensions that arise.

This is not the place to go into detail on the types of State reform being practiced or discussed. Basically they are those that see State reform as a form of circumscribing government action — removing the heavy hand of government from the market. They are those who wish to see State reform as a means of distributing more equitably the results or fruits of economic growth, and ensuring that all citizens lead a decent life. This calls for more but different intervention. Then, a third perception is one of controlling the State apparatus through measures that essentially imply more citizen participation.

Health as an area of social concern figures in the discussions of the need for and effects of the economic and political changes I have mentioned, and health reform itself has perhaps become one of the hottest debates as you may have gathered from the presentations made. However, it must be clear to you now that much of the interest centers not so much in organization or reform of the system, but basically on the care for the individual.

When seeking the causes of this concern, I refer to what Eli Ginsberg calls the "medical triangle" which the skeptics might refer to as another version of the "eternal triangle." The three poles are the politicians, the physicians and the public. The politicians worry because the cost of health care is rising in all countries and in most, faster than the increase in the cost of living and certainly faster than the increase in GNP. Total health expenditure in the Americas in 1990 was about 800 billion dollars, with Canada spending about 52 billion. Health expenditures represented

just over 6% of GDP in Latin America and the Caribbean which was higher than any other developing region of the world. It is frightening to politicians to see this increasing, especially when such expenditure on care is regarded as nonproductive consumption. Politicians who are also concerned with State reform and the reform of the various sectors of State, see reform also in terms of what fraction of health expenditure should be a charge to the State and what should be left to the market. But as public choice theory would predict, politicians react to the perceived needs or rather demands of the public to whom they owe power and legitimacy. Therefore, reform that is politically driven will not do damage to those sectors that wield most influence.

Parenthetically the politicians who are concerned with cost are not unaware of the contribution that the health care industry makes to GNP. The transactions that result from motor vehicle accidents or result from illnesses caused by unhealthy life practices enter into the national accounts. It is tragic but true that no such accounting is made of the efforts made to prevent illness or promote healthy living.

The physicians are major players partly because of the influence they have nationally. They can advocate for improved personal care very successfully and the increased cost and sophistication of the technology available for care, as well as the changing demographics in all countries is a fool proof recipe for increasing costs. Physicians who are locked into a fee for service health care system clearly have a vested interest in any type of reform that affects their own financial state, although I believe that too much is made of the costs of physicians' services in debates on reform.

The public is the third participant. At present the majority of the Region's people are concerned about health care in the sense of demanding those services that are curative or rehabilitative. Perhaps, I should also add reparative. Man has always feared illness and the power accorded to healers in all societies is a relic of the sacerdotal origins and links of medicine. Modern communication has given most publics an image of the indefinite postponement of death and the magic cures of most illnesses. The public demand for attention is virtually insatiable and unfortunately many systems attempt to cater to these demands. The increase in public demand is not spontaneous. There was a time when only a small fraction of the personal discomforts or illnesses came into the formal care system. They were dealt with domestically or through the dominant folk system, with the latter two being frequently the same. But propaganda of all types — and the health care professionals are not the only culprits — has induced the public to enter the formal care system for attention to more and more problems with consequent increase in costs.

The interaction of these three forces results inevitably in increased costs of health care and naturally of different perceptions of how the care system might be reformed. The interaction also represents the view and concern of those who have access to the system and the constituency of those who do not have access to the system is not equally strong. It is fair to say, however, that much of the political rhetoric about reform has made universal access a prime consideration.

The debate on health sector reform has been a major area of work for the Pan American Health Organization (PAHO) in terms of our technical cooperation with our Member Governments. We concluded recently a major discussion on the issue as a follow up to the Miami Presidential Summit and our approach is along two lines — the reorganization of the health system and the financing of

that system. We consider it illogical to deal with one without the other. Canada has been a very active participant in the committees that have shaped PAHO's action in this field.

The major focus of the reorganization is to provide more equity in the system. The main approaches are to expand coverage with all services, to reformulate the health care models and to foster genuine decentralization with enhanced local participation. The rationale for expansion of health services coverage is obvious in view of the large population that does not have access to adequate services. I state this as a fact, although I have difficulties accepting absolute numbers for this uncovered population since there are many components of service coverage which is not an all or none phenomenon. The reformulation of the models includes the provision of some basic minimum package of services that you have no doubt discussed. I was pleased to learn that IDRC is currently evaluating the effectiveness of these basic packages in Africa and we eagerly await the results of those studies. The managerial changes imply changes in many of the resources in the sector — such as the human and physical ones. Decentralization as a policy is now almost universal and the main interest at this time is the strengthening of the capacity of the local health systems.

The crux of the issue of health financing is which and how much of the costs should be borne by the State and what other mechanisms should be established to bear the costs or to assume the services and be paid from one or other source. I accept the general thesis that the State must be responsible for, if not actually delivering those services that can be genuinely described as public goods and have a high externality context.

Recent studies from the World Bank have put an interesting face to the issue of financing. Beginning from the base of level of economic performance, it is argued that Latin America and the Caribbean has a health gap, in the sense that there is poorer health than might be expected for the level of national wealth. It is also argued that there is no real resource gap and the major issue is the allocation of already existing resources. Of course, if one alters the dependent variable it may be possible to conclude that the countries economic performance has been extraordinarily good given their level of social development as measured by health indicators.

I have up until now dealt with the reform in the very traditional sense, but at this time I would like to share with you some other ideas. I am positing that the real reform that is necessary is one that changes in the minds of the various publics the fundamental perception of health and until that occurs we will advance very little. The emphasis on the health systems and the health services is essentially a parochial or individual focus and really a zero sum game. For one individual or small group of individuals to gain, there will be some loss by others. In my opinion this has been the classic flaw in many of the very heated and failed debates about reform. Parenthetically, I might add that another, though smaller flaw, was to conceive the problems and their solutions in technocratic terms. Reform in terms of conceptualizing health has a universal rather than a parochial connotation.

The health of the nations or of the region is a production function of a set of inputs or resources — and these inputs are probably the same as eminent Canadian research has shown to be the determinants of health status. But unless we think of health as a resource itself that is of intrinsic value to human kind we will ever be concerned with the wrong debate. I am attracted to the work of the World Bank which examines the capital inputs into the wealth of nations and identifies the man

made, the natural, the human and the social components. It is impressive to note that produced assets, man made capital, accounted for no more than 20% of the wealth of countries, even though the majority of funding for so called development goes into this area. The wealthier the countries, the greater the contribution of human and social capital.

Health is obviously a major aspect of human capital, although hitherto more attention has been paid to the educational component of that capital. It is less clear how health might contribute to the important social capital which represents the form of civil organization and cohesion necessary for any human development. In this context I refer often to the Canadian Government's response to the Recommendations of the Special Joint Parliamentary Committee Reviewing Canadian Foreign Policy. The Government's foreign policy had three objectives: promoting prosperity and employment, protecting Canadian security and projecting Canadian values and culture. There was acceptance that national security should embrace a broader concept that included nonmilitary matters. Serious threats to security derived from certain global trends that included environment, demographics and health. Perhaps the Ministers were thinking of health in terms of disease elsewhere affecting national security. But I would press the point further and argue that it is health as a state and the perception and value of it that are essential for internal stability — is a part of the social capital — that is necessary. Health through contributing to internal stability will also impact on national security and in the future I believe we will also see security defined much more in terms of the individual security and well-being, with health being a major concern.

An important part of the social capital rests with the manner in which society is organized and structured and we have seen that interest in the preservation of health and not only cure of illness is a rallying point for the fastest growing segment of civil society — nongovernmental organizations. Their relations with government and their impact in society are likely to be much more productive in an area such as health that is essentially noble and nonthreatening.

Why should an international health society be concerned about any change in perception of health reform? First, the conventional aspects of health sector and health care reform have international connotations. As the globalization trend continues, reform in one state is bound to affect practice in another. As the Region's interest in various blocs grows, health and health resources are bound to play ever more important roles.

Although most of these alliances and blocs have been formed for commercial and political purposes, it is being realized that common approaches to many issues such as health have to be found. Not only must we entertain the possibility of transborder transmission of illness, we in international health must promote the transnational transmission of ideas and perceptions of the kind of health reform that can really lead to improved human well-being.

The need for a rethinking of the importance of health is not a national affair — it is something that will or should involve all nations large or small, rich or poor. To the extent that health is seen as a resource, as a factor in human and social capital, these considerations about reform of the institutions that deal with it will take on a different colour. Health will be seen as genuinely intersectoral and a necessary consideration whenever and wherever human development issues are being discussed — be they issues related to economics, education or human freedoms. As individuals and as a group interested in the international dimensions of health, we have almost a

fiduciary responsibility to seek to initiate or promote and certainly participate in debates or discussions that seek to redefine the place of health in the public agenda.

I wish us all luck in this kind of reform.

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