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HEALTH AND THE GOOD SOCIETY  
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Mr. Genaro Borrego Estrada, Dr. Roberto Tapia, Dr. Luis José Martínez Villalba, ladies and gentlemen. I would like to thank Mr. Borrego Estrada and Mr. Martínez Villalba for the opportunity to speak at this Conference. Let me thank you for the invitation to give this lecture. I recall very well my first visit to your excellent installation and have been pleased at the manner in which you have maintained interest in the analysis of the role and functioning of social security systems. Especially in Latin America, the social security systems are important social institutions, that like all significant and successful institutions are changing and it is critical that there be some focus for the study of these changes.

I propose this evening to base my remarks on health status in the Americas, the extent to which that health is an expression of social phenomena and societal values and what kind of health we should equate with a good society. I will deal with some of the contemporary problems as seen through the eyes of the Pan American Health Organization, which has been a partner in many of the activities of this center, and I will also attempt to show that some of the characteristics of a good society are relevant to institutions that have responsibility for social security.

The health of the American people is as varied as the climatic zones of our hemisphere, but in spite of the variability, we can say with certainty that it has improved over the years and continues to improve. The standard approach to measuring health has been through national, subregional and regional averages of conventional indicators. Much of this information can be found in the Basic Health Indicators, which the Pan American Health Organization produces yearly and are probably the most reliable single source of such data in the Americas.

The population of the continent continues to increase although in the last decade the growth rate has declined as the crude birth rate has fallen steadily. Whereas the fertility rate was 3.0 per woman about a decade ago, this has fallen by 20%. Infant mortality rate has fallen from 36.9 per 1000 live births at the beginning of the eighties to a figure of 24.8 at the end of the nineties—an impressive fall of about 30% in this short period. Over the similar period life expectancy at birth has risen by 3.2 years to 72.4 years. One of the consequences of these demographic changes is the increase in the elderly population. Uruguay, for example, has the

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highest percentage of persons over the age of 60 years in the Americas. This brings with it the problems attendant on treating the more chronic degenerative illnesses of that population.

Environmental conditions have improved as measured by such indicators as the percentage of the population with access to drinking water and sewerage facilities. However, there are still problems associated with deficits in this area. Cholera remains endemic in many countries and too many children still die of diarrhea, which is directly related to poor sanitation.

There has been notable increase in coverage in some areas such as immunization where now over 90% of children are covered by the vaccines that are included in the Expanded Program of Immunization. The countries are steadily introducing the new vaccines such as those against meningitis and hepatitis. This attention to child health has resulted in some spectacular successes as now there is no more poliomyelitis, measles is targeted for elimination by the end of this year, and neonatal tetanus is now a rarity.

The pattern of mortality has also changed, partly as a result of the demographic transition and also because of some changes in the social and physical environment. The communicable diseases as a cause of death show a remarkable reduction and we are now observing a relative increase in mortality from the chronic non-communicable diseases such as cancer, diabetes and cardiovascular diseases, which account for over 60% of the mortality and disability in the Americas.

These advances should not blind us to the challenges that remain. We must maintain the programs that have been successful in reducing mortality and morbidity from the communicable diseases. We must adopt the approaches to dealing with the diseases of lifestyle that account for so much of the mortality and chronic morbidity. The most pernicious agent in this category is tobacco as the diseases associated with its use account for approximately 400 deaths daily in the Americas.

But I would cite another challenge that is not disease specific –that is for us is to reduce the inequalities across the Region. Whereas the infant mortality rates for North America is approximately 7.0 per 1000 live births, the figure for Latin America is 35.7. This gap is seen in almost every health statistic. The most alarming and almost disgraceful datum relates to maternal mortality. If we compare the countries with the best and worst figures, the difference is almost one hundred folds. Many of these inequalities should not exist and because we deem them unjust and unfair, we refer to them as manifestations of health inequity in our Region.

These gaps in health status between rich and poor are of course not a new observation and certainly the data of the last two centuries at least bear this out. But I have been fascinated to learn that it might not always have been so, at least in Britain. Fogel in his classic studies on the historical trends in mortality and the effect of nutrition describes the “paradox of the peers.” Until the beginning of the eighteenth century, there was no difference in mortality between the nobility and the general poor population. It appears that while the adult nobility ate well their infant feeding practices were horrible, leading to high infant and young child mortality. In addition the noble ladies ate sparingly during pregnancy and drank enormous quantities of alcohol that no doubt contributed to in utero malnutrition. The high consumption of alcohol probably also contributed to the relatively high mortality among the peers. The gap in mortality

between rich and poor became more evident as the diet of the rich improved and they could in some ways isolate themselves from the environmental conditions that were inimical to the health of the poor.

I am fond of quoting from Rudolf Virchow, the distinguished German physician, who is perhaps known more for his discoveries in pathology than for his burning concern for the health of the poor and his clear articulation of the role of poverty and social deprivation in the causation of disease. In discussing the differences in life expectancy between rich and poor in Germany 150 years ago he quotes as follows:

Or in other words, the average duration of life of the princes and counts amounted to fifty years, that of the receiver of alms only to thirty two years, and chance, which lets a child be born on the cushion of the rich, gives him a present of eighteen more years to live than are allotted to those children who came into the world on the straw pallet of a beggar woman.

Many of these gaps persist and not only are these present gaps an affront to those of us concerned with the public's health, but it is even more alarming to note that over the years we have not succeeded in reducing some of them. The gap in infant mortality between the richest and poorest countries has not decreased over the past forty years. The issue of inequalities in health, their genesis and their reduction has to be one of the central issues of health policy and action in the coming years.

But there are other areas in which there is not cause for the same optimism that is engendered by the overall health data and the results in areas such as the diseases that are prevented by immunization. Other infectious diseases are still very much with us; HIV/AIDS is a major problem and whereas in the north the availability of new drugs has had a dramatic effect on mortality, the same has not occurred in the rest of the Americas, essentially because of the cost and in addition the delivery systems for these regimens is not always present. While we view with alarm the picture of AIDS in Africa we must not forget that the prevalence rate of AIDS in the Caribbean is among the highest in the world. We cannot ignore the presence of malaria and tuberculosis, which still kill large numbers especially in the less developed countries of the Region.

These health conditions do not occur in a vacuum; they are the result of the interplay of social forces. I have been influenced very much by an excellent book *Health and Societies - Changing Perspectives* by Sarah Curtis and Ann Taket, which examines the changes in the perception of the health of populations over time in societies as well as the differences in the cultural expression of health between societies. They explore the extent to which the policies that address health needs are changing in response to the interaction between the various actors such as the professions, the non-governmental organizations, the private sector and the governments themselves. In this process of negotiating roles and identifying a stronger role for the promotion and preventive aspects of medicine, there is much more emphasis on the relationship between health and the society.

Health is very much a social phenomenon, and the varying perceptions of what connotes health, illness and disease are very much determined by the culture of the society. The ancient

Greeks revered health and considered it very much a personal responsibility to maintain the balance or equilibrium that was almost synonymous with health. The historian Sigerist quotes the Greek physician Herophilus:

When health is absent, wisdom cannot reveal itself, art cannot be manifest, strength cannot fight, wealth becomes useless and intelligence cannot be applied.

This view of health as balance and an individual responsibility was overcome by the determinist approach and the reductionist or mechanistic view of health and the disturbances of the body that cause disease. The sixteenth century Cartesian-Newtonian paradigm of nature was applied to health. Determinism meant that natural phenomena have established causal linkages and through the reductionist approach one can unravel complex phenomena such as physiological systems into ever-smaller constituent segments. The body functions as one large machine with predictable responses from its constituent parts to internal and external stimuli.

It was Descartes who emphasized the separation of mind and body, leading to the steady loss of appreciation of the benefit of the folk medicine that had emphasized healing in the context of a close interplay between the body and the soul.

But it was in the nineteenth century that we saw the rise of what has come to be known as modern scientific medicine based on the biomedical model. Progress in the understanding of the biological phenomena was enhanced by new technology and led to even closer attention being paid to the mechanistic view of the human body in its healthy and non-healthy state. The understanding of the molecular basis of many biological processes contributed to the perpetuation of the Cartesian paradigm.

But slowly and surely this view and practice has been complemented by a more systemic view of health, less rigidity in terms of concentrating on the physical aspect to the detriment of the psychosocial and over the last 100 years we have seen a socio-ecological model of health steadily coming into its own. This view of the interrelationship of all things and the constant ebb and flow of opposites is more akin to the Eastern philosophical approaches to nature and life in general that western medicine is only slowly beginning to appreciate.

The adoption of this socio-ecological model of health makes it easier to understand the relationship of health and society. The views on those societal determinants that influence health were crystallized in the famous Lalonde Report on the health of Canadians and are now well accepted. We acknowledge that such factors as education, the work environment, living and working conditions, housing, employment, and the economic situation—all of which fall under the rubric of social conditions—are major determinants of health. As Evans and his colleagues point out "major shifts in the health status of whole populations over time do not necessarily depend on the implementation of public health or medical control measures against specific diseases." They point instead to a profound linkage between health and the social environment, including the levels and distribution of prosperity in a society.

If health is socially determined it is not too inappropriate to question whether society as a whole or the state as an agent of society has some basic responsibility to provide or facilitate that health. It is fashionable to speak in terms of the right to health and indeed many of our

constitutions enshrine that right and affirm that it is the responsibility of the state to ensure that right. I prefer to say that the right is to those sanitary and social measures that make for good health, and would certainly include those determinants mentioned above.

It would seem logical that if much of health is socially determined, then good societies should be associated with good health. My first encounter with a concept of a good society goes back almost fifty years when I had to struggle with Plato's Republic. Socrates pointed out that the goodness of the city and its happiness depended on equal division of material goods: the extremes of wealth and poverty were equally pernicious and were to be avoided. There was to be a meritocracy and there should be wisdom in the guardians as well as temperance—the mastery of certain pleasures and desires and courage. There must be justice but the concept of justice was strange to me in that it enjoined that “each one must practice that one thing, of all in the city, for which his nature was best fitted.” Several other philosophers must have similarly espoused other versions of the good society.

I will turn to more recent thinking. The distinguished economist, Galbraith, in a recent book "The Good Society—the humane agenda," makes the point that we must in practical terms distinguish between the utopian society and the extent of good that is politically and economically feasible and takes account of the "institutional structure and the human characteristics that are fixed, immutable." He defines the good society as one in which "all citizens must have personal liberty, basic well being, racial and ethnic equality and the opportunity for a rewarding life." One might wonder how far we have advanced from the thinking of Socrates. One could also say that this is so broad as to be unattainable and almost utopian. But indeed these are really no different from the idea that the good society must be one which enhances the possibility of human development—the possibility that all persons should enjoy to the fullest the options that life offers or as Amartya Sen would postulate, the expansion of the real freedoms. Sen sees the expansion of the freedoms as being either the primary end of development or a principal means of development, in the sense that one freedom enhances the others, and more specifically the possibility of economic advancement.

I must restate Galbraith's point that there must be a difference between what is a practical description of a good society and the utopian ideal. Human nature is such that "we will always see men striving to better their condition" as Adam Smith puts it, and this leads to rather narrow selfish behaviour in the area of economics. But there has to be another moral or ethical dimension, which sees human beings demonstrating some obligation to others. Thus, the good society may not achieve a priori the equal distribution of economic goods —indeed the evidence is that this is impossible, undesirable or at least impractical. I must add a parenthesis here and point out that it is no longer believed that income inequality and economic growth are incompatible. Indeed, inequality may be an impediment to economic growth and the reduction of poverty.

But let me return to the moral aspect of human action and say that it is possible that human nature will condone or even foster deliberately more equal distribution of other goods that are a part of the good society; health and the means to ensure it being one such good. I suggest that the competitive drive or primal urge that makes human beings strive to acquire more material goods than their neighbor does not exist in the case of health. My hope has been that

this drive might be harnessed for addressing those health problems that have to be addressed through joint effort.

I must admit that this latter view is being challenged or perhaps modified in the context of the inexorable increase in the cost of health care as seen in countries such as the USA. The point is made that individuals do not only wish to maximize their utility function in an economic sense, but wish to maximize their lives at all costs. As expensive technology become more widely available, human beings grasp at it as a means of extending life and we find that what might be thought of as extraordinary demands are now being cast as needs. This is done not in the sense of competition with others, but as a rejection of the inevitability of mortality: a view that is fostered by human conquest over much of nature that was thought to be invincible and immutable. Without some societal brake on this expansion and some mechanism for putting the common good before the individual demand masked as a need, there seems to be no limit to the increase in the costs of health care.

Although Galbraith speaks of well being, he does not mention health as being included in those things that the good society should ensure, but Sen specifically refers to health as one of the primary freedoms people should enjoy. In the context of the inequalities in health that I described before, it is interesting to note the emphasis on some aspects of social equality in the good society. There is good evidence that there are ethnic differences in health in those countries in which it has been studied. Such differences are a reflection fundamentally of the social and economic differences, are not innate and indeed represent inequity. The most pernicious differences relate to gender discrimination, which manifests itself in much of the ill health of women, and the manner in which such ill health is addressed in the normal health services.

I have said that there are certain characteristics or features of the good society that can be equated with Sen's real freedoms. But there must be some forms of social organization or some social characteristics that facilitate the availability of these freedoms or contribute to them. We are becoming more aware that one of the essential ingredients for the acquisition of at least some of these freedoms is the accumulation of human and social capital. Indeed, for any society to be optimally functional there is need for construction and maintenance of the social capital. There are several examples of societal deterioration with the erosion of that capital. There is still some debate or criticism, particularly from economists about the relevance or even existence of social capital, but there are eminent socialists who insist that the relations among people are as critical an element in production as the tangible physical capital that has occupied so much of our attention.

The essential feature of that social capital is trust and as Fukuyama puts it:

One of the most important lessons we can learn from an examination of economic life is that a nation's well-being as well as its ability to compete, is conditioned by a single pervasive cultural characteristic: the level of trust inherent in the society.

I wish to extend this concept further to health and more specifically to health and social security. I wish to posit that the whole notion of solidarity that is inherent in the development of social security systems is another manifestation of the kind of trust that should characterize the

good society. Whereas life insurance developed in the context of the replacement value of a human being, social insurance and certainly social health insurance that is a key aspect of social security in Latin America had its origins more in the need to share the costs of illness. There is the explicit notion of solidarity with others who may be from time to time in situations of need. The Bismarkian model upon which the systems of Latin America are based have this concept of solidarity among the insured as a cardinal point of their operation and in general, the assurance of this solidarity is not within state control. This is of course in contrast with other systems in which the sharing of the health risks and costs is ensured through deliberate action by the state.

Let us examine this solidarity in the context of health expenditure and coverage by the social security systems. It has been difficult to collect complete data, but we estimate that in 1995 total spending on health by social security systems in Latin America was US\$19,500 million or 1.3% GDP. The total spending on health in Latin America at that time was 6.8% of GDP. However, this expenditure provides coverage for about 112 million people. The extent of the coverage varies, being as low as 7% of the population in the Dominican Republic and over 60% in Argentina, Chile and Panama. We estimated that approximately half of Mexico's population is covered by social security. As far as I know, only in Costa Rica is the social security responsible for the health care across the whole spectrum of the population. In several countries of the Americas we are faced with large numbers of persons in the informal sector —as high as 50%, and it is estimated that the vast majority of the new jobs created recently have been in the that sector. Indeed, informal work may be the norm in many countries and the tragedy of the exclusion of this class is heightened or compounded by the fact that they are usually poor and are mostly women. If the good society is to ensure these basic freedoms to all, one must question how this solidarity might be extended to those who, because of their situation of work do not fall within that group of persons, which is eligible to be covered by the health benefits of the social security system.

PAHO and the International Labor Organization have begun exploring the feasibility of micro- insurance schemes as a mechanism for extending health insurance to the persons in the informal sector who are excluded from participating in the traditional social security schemes. The nature of the exclusion is complex as it involves the high transactional costs of attending the services even when they are provided, and the hopelessness and desperation of poverty that render the poor so impotent. These approaches to providing some care through micro-insurance schemes are promising, but because of the fragile nature of the economic base of the informal sector are unlikely to prosper for long unless there is state support. They represent ideal mechanisms for displaying the solidarity needed in group based health insurance and indeed are rooted in the concept of local common interest, but they are not enough to ensure sustainability.

We do not have any single recipe for ensuring that health promoting or health maintaining measures is available to the whole population. We do believe, however, that the systems that are predominant in Latin America are not the most equitable. The division of service provision between the Ministry of Health, the private sector and the social security does not ensure the uniformity of access that should be the goal of the good society. The abolition of the segmentation of the system and the allocation of specific functions to each part is in our view

the most logical development. But that requires firm and decided action by the state, which after all must have some guiding or steering role as it seeks to ensure the best for all citizens.

Consideration of distribution of resources for health must enter any discussion of health in the good society. We have seen already that there are major gaps in health outcomes in the Americas and have referred to the need to reduce them. There is bound to be ethical and moral controversy about the measures of health status and the allocation of resources to reduce the gaps. But first there is the problem of measurement. The frequent use of averages hides the disparities that occur, and unless serious attention is given to measures of distribution we are likely to fall into the utilitarian trap of seeking to maximize benefits in the aggregate. PAHO is extending its work on Basic Indicators of health to provide disaggregated data to show the differences that occur geographically or in relation to some other social indicator. In addition, distribution measures of morbid and fatal conditions are being developed to permit a better appreciation of the places for appropriate intervention.

It would be fatuous to assume that a good society is static or that new forms of societal organization will not affect health differently. The current dogma is that the inexorable trend in societal organizations is towards a globalized world in which market forces are dominant and liberal participatory democracy is the preferred form of government. This is not the place to expand on the specific effects of either on health, but we can be sure that there will be effects. It is already clear that the concept of a good society involves relationships that cut across national boundaries. There will be globalization of health risks that call for global responses. Such responses will demand that the societies share appreciation of the risks and are willing to work in concert to reduce them. The communicable diseases are the prototype of such risks, but the information revolution has brought other risks such as tobacco into prominence as being genuinely global. We are at the beginning of this process of adapting to these trends and only time will tell how the results in health will unfold.

The Pan American Health Organization has to be concerned with the extent to which health is seen as a characteristic of a good society and the mechanisms for making it so. The equality of distribution is a central issue for us and we place health equity as one of the fundamental values that guide our work. This search for equity has always been a central point of the goal of Health For All that espoused the principles of distributive justice in health.

I am sure that your Center shares these principles and PAHO will be pleased to continue to work with you in the years ahead. What can we do? We can elevate the debate about health above the discussions on how to reduce the cost of care as an economic measure. This is without prejudice to the legitimate need for fiscal efficiency in health as in any other sphere. We can argue that the good society is not a utopian dream, and some elements of it, if not all are critical for social stability. We can produce the empirical data to show the interrelationship of the freedoms. There is no doubt that wealth is associated with better health, but it is becoming apparent that good health is also a contributor to wealth at the individual, family and national level. We can give more attention to the pressing problem of how the trust and solidarity that are features of social security can be extended to those who are at present excluded. It is not enough to propose here that health is an essential part of a good society. We must have that notion translated into the kind of health policy that was envisaged when the call of Health for All was



raised-a policy that promotes inclusion rather than exclusion-a policy that insists on directing resources to those most in need-a policy that seeks genuine participation of all stakeholders in the noble enterprise of maintaining or restoring health.

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