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**HEALTH POLICIES AND MENTAL HEALTH IN  
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Madame Minister, ladies and gentlemen, this is the first opportunity I have had to address a group of senior mental health practitioners and experts. I know from your agenda that the major topic of discussion has been the evaluation of the initiative for the restructuring of psychiatric care. This will have involved examination of some specific issues that are perhaps of particular interest to psychiatrists and mental health experts. However, I wish to take the opportunity to broaden the discussion and describe some of the pressing health problems of our Region and their determinants and initiate a discussion with you on the place of mental health and the role you and your institutions may play.

There are many different approaches to describing health in our Region. The traditional one is to use indicators of mortality as proxies and describe the infant mortality rate, for example, or use the life expectancy of a specific cohort as a measure of its possible exposure to life ending hazards. The infant mortality of virtually every country has been in steady decline and there are developing countries that boast of infant mortality rates as good as those in the more developed countries. Our data show infant mortality rates for Latin America of about 45 per 1000 live births which is certainly lower than that for Asia and Africa. These average figures, impressive though they may seem at first, hide the fact that some half million infants still die every year. In the last ten years the Region of the Americas has had an increase in life expectancy of about 12.5 years — with Latin America having the highest increase followed by the Caribbean and then North America with the least increase.

We might also address the health situation by describing the advances in disease control, focussing mainly on the infectious diseases. Thanks to tremendous efforts on the part of our countries, it is almost five years since there has been no poliomyelitis here. A concerted attack on measles has resulted in significant reductions. Whereas only 5 years ago there were nearly 250,000 cases of measles, in 1995 only 6,300 cases were reported. Neonatal tetanus is disappearing and although cholera seems to be now endemic, case fatality is remarkably low. There have been impressive achievements in a disease that is peculiarly American. As a result of a concerted effort on the part of the Southern Cone countries, there is every prospect that Chagas' disease will be eliminated and already the incidence has fallen 70% in the last five years. In Argentina, for example, sero positivity has fallen to one quarter of the 4.8% reported in 1982.

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

We might also describe achievements in terms of the advanced medical technology that is in use in our countries. In the majority of them one will find the latest imaging equipment and reparative surgery of the most sophisticated type is available in many countries that would be described as developing.

These advances are a tribute to many dedicated health workers, but they hide some of the very grave problems that affect the health systems of our countries and more importantly leave large numbers of our citizens disadvantaged. These problems are the result of accumulated changes and their gravity is compounded by what we can predict with some certainty.

The Americas is a veritable mosaic in terms of the demographic and epidemiologic transitions, but in general we can assume some of the sequential population changes in age and sex structure that the general theory would propose. However, even though we may see the gradual aging of the populations and the health problems that attend the extended life span, in many countries there is still a huge backlog of malnutrition and infectious diseases, particularly in children. But at the same time our countries are having to face new and emerging or resurging diseases such as AIDS and tuberculosis. Rapid travel also brings us potentially closer to the infectious diseases of other continents such as the Ebola virus hemorrhagic syndrome.

Similarly, our health systems have to cope with an accumulated deficit most sharply marked by poor coverage. It is impossible to be precise in our definition and therefore measurement of coverage, but partial evidence shows large numbers of persons without ready access to the most basic health care. The health systems are being further stressed by the aging population, the increased numbers of persons, the consequences of environmental degradation and the greater demand for care by an increasingly vocal population.

All of the accumulated and emerging problems are accentuated by the social panorama of the region, and the most striking feature of that panorama is the inequity that exists. There is inequity among countries and within countries and at every turn there is an increasingly strident cry for equity in health as well as in other areas. It is not only absolute poverty that is a concern, but the inequity between groups is also alarming and the Americas has the dubious distinction of being the world's most inequitable region. Within countries one can show significant differences in health status between rural and urban populations and within cities, major differences between the rich and poor sections.

This search for equity is nothing new. Almost every reform movement in the world has called for equity among population groups. The call for increased citizen participation in the new democracies of the region is another factor that has contributed to the increased awareness of the inequity and social injustice that is manifested in ill health. Parenthetically, it has been very noticeable to me that in these calls for equity and the attempts to measure inequity, scant attention has been paid to mental health.

Let us address some of the possible solutions, but before doing so it is relevant to be clearer about the conceptual aspects of equity as applied to health. I have accepted as a first approximation that it is more understandable to deal with equity in relation to services offered or rendered. In that sense, one can discern three possible scenarios in which equity is defined in terms of equality.

There may be equality of provision of services or equality of access, and such equality is really a function of the services and less so of the population using them. There may be equality of utilization in that there should be no social block to use of services. Finally, there may be equality of outcome in that the services can assure similar outcomes for persons with similar needs. The latter is very difficult to ensure since outcome depends so much on the innate characteristics of the user of the services.

The search for equity is behind almost all the efforts at reform of the health system that are in progress both here and elsewhere and we see almost every country in the Americas undertaking some kind of reform of the health system. Even though there are varying models extant, it is remarkable that a basic framework is evolving for achieving a system that is equitable. One should note that in spite of affirmations that the health system should address all the health needs of the individual — promotive, preventive, curative or rehabilitative, by far the greatest emphasis is being placed on the curative personal care services.

One can discern two major approaches to the reform process. First it is accepted that there needs to be a clearer definition of the mode of organization of the services. By organization I refer to definition of the principal actors and their roles and competencies. Thus, it is envisaged, for example, that a reorganized system will see a Ministry of Health involved in system development, policy formulation and regulation of the nature and reach of the services in a broad sense and decreasingly responsible for direct service delivery. In the more advanced adventurous proposals, the actual services delivery is in the hands of groups that may compete for provision of such services. It will, however, remain a Ministry's responsibility to ensure that every citizen has access to a certain basic minimum set of services that should resolve the commonest problems to be faced.

The second approach is that of financing of the service and here there are a variety of mechanisms which in essence see funds coming from the public purse or from individual specific expenditures. These individuals may represent the person or someone who contributes on his behalf, such as his employer. The above is a rather simplified version of the often very complicated description of the health reform process in the Americas.

If at this stage I should try to describe the broad trends of public policy in the light of the above, I would say that the general direction is to maintain sectoral integrity and to focus on those aspects of health that deal mainly with care services. Public policy is being driven by the general tendency to revisit the role of the State and the public sector, and consciousness of the cost of providing the care services. The policies are also sensitive to the perceptions policy makers have of the demands of a public that is responsible for their election or appointment. It is therefore not surprising that much of policy is driven by the perceived needs of the more vocal sections of the population and there is a great dilemma in some instances about how these needs might be satisfied while at the same time the services are oriented towards a greater degree of equity. This dilemma is often played out in the approaches to reform of the health system.

But perhaps even more important than a reform of the health system is the need for there to be a difference perception in the mind of the public of the role and importance of health. The general public has been conditioned to think of health in its absence. Ill health is what triggers public concern and even though there may be some vague perception of the positive value of health as a

state of being this is never crystallized into anything that sparks or sustains public debate and has impact on public policy.

More recently, however, there has been a growing movement to place health in the context of human development. We believe and have argued that if by human development we mean the possibility that human beings will have the opportunity to enjoy the best life options, then there are five basic areas that contribute to that development. They are health, economic growth, a safe environment, education, and a set of social arrangements that I call *people freedoms*. In other fora I have described in some detail the nature of these areas.

The public and the politicians they choose need to understand that their well-being and ultimately the well-being of the State depends on the interaction of these five areas. Health contributes to economic growth and viceversa. Education and health are linked and there is no longer any dispute over the interaction between a people's health and the physical environment.

It is equally important that there be a clearer understanding of the determinants of that health and the loci of production of health. The pioneering work of Lalonde and his associates established the concept of health fields with which you are all familiar. He did not address, however, the importance of the spaces in which persons interact for health. The role of the family has been paramount, but I contend that the family, important though it may be, is not the only space. Recently, the Pan American Health Organization has been promoting the concept of healthy municipalities as another one of the important spaces and identifying others such as schools and work places.

The healthy municipality, for example, represents the politically defined space in which the various political actors come together to define the approaches to the problems that impact negatively on health, and in the best of cases to promote actively those actions that make for positive health outcomes. Intersectoral actions take place in this setting, often without the appreciation that it is intersectoral, and the focus is on the problem rather than on the means. It is here that there is communal appreciation of the various inputs into promoting and preserving the healthy state.

The family as the most durable of all social institutions is another critically important space, given the ranges of age and experience that interact. The movement towards the family as a more democratic institution favours action by members upon one another to promote health. We believe that it is in these spaces that the basic principles of health promotion can be applied and the concept of a healthy public policy given more meaning and context.

But the issue that is of more importance to you is how these various factors that I have described might relate to public policy in the area of mental health. I hope you will pardon my temerity in make some observations to the experts, but I am reassured by the fact that very often practitioners are so caught up in their own disciplines that they do not see the wider relationships.

I have often felt that there are many reasons why mental health is not seen as an integral part of public health. It is not only because of the historical development of public health that was essentially fixed on disease elimination. Perhaps one reason is the lack of specific simple mortality

indicators that can serve as a ready guide to the success of public health interventions. There is no equivalent to infant mortality in mental health and unfortunately the precision of death as an indicator is very difficult to match.

Another possibility is that perhaps the enormity of the problem staggers the mind of the policy makers and there has been no simple point of entry to the problems. When I read the publication on World Mental Health that was presented recently in the United Nations I could not help being awed by the magnitude of the problems, and as we all know, problem size can lead to paralysis of action.

But at a more practical level I have wondered if the area of mental health might not benefit from the kind of approach taken by Lalonde with clearer definition of mental health fields. What Lalonde's thinking did bring into sharp focus was the role of the services and the fact that they were the major consumer of resources while other determinants were more important contributors to health.

Perhaps your appreciation of the role of the services is what led to the initiative for the restructuring of psychiatric care in the first place and I have been led to believe that your Caracas Declaration has been a rallying point that has provided a focus for action in a specific area in which there can be measurable results. I hope that your revision of where you have come after five years shows that the emphasis in care has indeed shifted to the extra mural setting and mental health experts see themselves more and more as not being confined to the traditional psychiatric institutions. This will of necessity entail considerable modification of training and a widening of the net of mental health practitioners.

But above all, if there is going to be a shift in policy direction, there must be strong advocacy from a wide range of institutions. In this sense I will outline very briefly some of the approaches taken and being planned in the Pan American Health Organization. Many of you will have seen the document presented to our Governing Bodies on the program of mental health in PAHO. This policy document outlined the nature of the problems faced in the Region and examined the basis for action.

The purpose of presenting the program was to aumentar la visibilidad de las acciones de promoción y prevención en salud mental por medio de, entre otras medidas, la formulación de políticas y la elaboración de planes nacionales de salud mental incorporados a los de salud y desarrollo social; asegurar la inclusión de la atención de salud mental en la canasta básica de servicios de salud; apoyar la reestructuración de la atención psiquiátrica en todo el conjunto de acciones que ésta implica, incluyendo la reorientación de los servicios, la adecuación legislativa y la capacitación de recursos; fortalecer la capacidad gerencial de las divisiones y departamentos de salud mental, o establecerlos si no existieran; y facilitar el desarrollo de cuadros técnicos líderes y de programas innovadores.

I have been thinking, however, that we have to do more. We will make a greater effort to ensure that World Mental Health Day is marked appropriately, with the kind of material and messages that reach to all levels of our population. We intend to make a concerted effort to address the addiction to noxious substances that have a significant role to play in damaging health — I refer

specifically to tobacco, alcohol and drugs. I am convinced that these have to be addressed as a group and some of the critical approaches have to be in targeting those groups of the population that are most vulnerable, and directing our actions to those spaces to which I referred earlier. The most vulnerable group is the adolescents and we have to learn and use those techniques that involve them in the design of the programs from which they will benefit. I do not presume that these approaches will touch all the other problems in mental health, but I am struck by the enormity of the health damage that occurs in this area and I am optimistic about the possibility of achieving some concrete and useful results.

I will end on the note of the desirability of achieving some results. It is often said that failure to advance in one or other area is due to lack of political will, but increasingly I am becoming disenchanted with this as a rationale for non action. Political will is not some abstract entity — it is a manifest action of the interaction of many complex forces, and we in the health sector have a responsibility to ensure that those who exercise the political will are informed. We must also ensure that there are adequate policies and plans presented to those who make decisions. We must also ensure that there are advocates in strategic places helping to shape the public opinion that in turn influences public policy. This is applicable to mental health as in all other areas of public concern. I am confident from what I have heard of the enthusiasm and dedication of this group of experts that we will not lack for powerful advocates.