NEW DIRECTIONS FOR HEALTH CARE IN THE AMERICAS

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Most developing countries in the Americas lack the health resources needed to quickly resolve their existing public health problems. Nevertheless, various newer approaches—including integration of health and other development efforts, technical cooperation among developing countries, extension of primary care, and community participation—do offer some opportunities for finding solutions to immediate problems. The following presentation defines these approaches in general terms and describes the role of the Pan American Health Organization in their promotion.

Introduction

The provision of health care to the individual is the result of the interaction of several factors, each with its own set of difficulties. Among the more significant factors are the sociocultural characteristics of the population to be served; the philosophical underpinning that guides national policies in all sectors, including health; the extent and the severity of the diseases that require attention; and, finally, the support provided by the community of nations to each national government—either on a bilateral basis, or through such agencies as the Pan American Health Organization and several others with similar concerns.

Before saying more about these subjects, I would like to tell you something about PAHO and the World Health Organization. The Pan American Health Organization is the oldest international health body in the world. It was established by 11 countries in Washington in 1902 to protect the public health of nations in the Americas. The initial objective of the new organization was "to lend its best aid and experience towards the widest possible protection of the public health of each Latin American republic in order that diseases might be eliminated and that commerce between the said republics might be facilitated."

PAHO entered a new phase of its existence after the Second World War when the United Nations was created, and with it the World Health Organization. At that time, while retaining its separate identity, PAHO also agreed to serve as the World Health Organization's Regional Office for the Americas. It therefore became one of WHO's six regional offices. In this way, the peoples of the Americas are served by a single program embracing the activities of both PAHO and WHO.

1From an address delivered at the Honors Convocation of New York State University's Division of Health, Physical Education, and Recreation at Cortland College in Cortland, New York, on 26 April 1979.
At present PAHO has 29 Member and three Participating Governments and the potential for adding more as new independent countries emerge in its Region.

The philosophy and operating procedures of PAHO have evolved considerably over the years. Originally the approach was philanthropic and paternalistic in nature. For example, medical experts would come into a country and advise their counterparts on the "best possible courses of action," often ignoring the special cultural features and unique circumstances of the developing country involved. Today we have come to realize that the transfer of knowledge is a highly complex endeavor that entails mutual cooperation.

Health and Development

During the last decade the social and political climate within nations and among international organizations has undergone dramatic change. Development goals for the less privileged nations are no longer defined in economic terms alone. The new concept of development is interpreted as a process aimed at promoting human dignity and welfare, and at eliminating poverty as the greatest obstacle to national progress. Development policies and priorities are currently being reformulated so as to meet the basic human needs of all mankind within the shortest possible period.

Among the recognized basic human needs is the fundamental right of each individual to health. This need, recently restated in the Universal Declaration on Human Rights, has been the cornerstone of the World Health Organization's Constitution—that Constitution stating over 35 years ago that each individual is entitled to "the enjoyment of the highest attainable standard of health" and that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

However, today health is seen as more than just a desirable social goal; it is also increasingly recognized as a means, and, indeed, as an indispensable component, or even a prerequisite, for socioeconomic development. Consequently, there is ever-increasing insistence on having health policy and health strategy fully integrated into national and international development plans. Health and development are now viewed as closely interrelated, and their interaction is seen to have far-reaching implications. It has become increasingly clear that health is not the exclusive domain of health professionals alone, but is closely linked with all aspects of socioeconomic development. We have come to slowly realize that the health status of people can be improved as a result of appropriate national efforts and coordinated activities by the health program and the social, cultural, and economic development sectors. Improvements in health both contribute to and result from socioeconomic development. Hence, both elements in this cooperative activity must be well-balanced if lasting progress is to be made.

New Health Policies

National governments, PAHO, and the other international organizations in the field of health and socioeconomic development have been taught by painful experience that health policies must be based on the goals and wishes of the people. We now understand that health programs must be devised to give effect to
new policies of this kind and to attain new goals, rather than being mere extensions of the old existing medical care services.

PAHO, with the guidance of its Member Governments, and with its sister agencies, has been at the forefront of this effort to develop more appropriate tools to keep abreast of the new doctrines built up by the countries. Over the last decade a number of fundamental principles for health development have evolved. Among these is the principle that governments have responsibility for the health of their people and, at the same time, that people should have the right to participate in the development of their own health. This means that governments and the health professions have the duty to provide relevant information and a social framework in health matters so that people can assume greater responsibility for their own health.

These principles have led to the further concept of individual, community, and national self-determination and self-reliance in health matters. Self-reliance implies taking initiatives, determining what can be done without external resources when appropriate, and deciding when to seek external support—for what purposes and from what sources. Such national initiatives in the health field can lead to genuine cooperation between countries rather than dependence on the aid of others. Self-reliance, however, is not synonymous with self-sufficiency, since no community or country can be self-sufficient as far as health is concerned. On the contrary, an important element contributing to recent health policy has been comprehension of the interdependence of individuals, communities, and countries with common health concerns.

Several new approaches have evolved in recent years. Although all constitutions of the nations of the Americas highlight the duty of governments to provide health care for their citizens, there are still large numbers of people in Latin America and the Caribbean where such services are unavailable or inadequate. To improve this situation, and in an attempt to reach more citizens with health services, governments have incorporated into their regional policies the concept of extension of coverage—a concept that embodies the ideas of universality; geographic, economic, cultural, and functional accessibility; and continuity of services. But, because of resource scarcities, increasing populations, and growing expectations, new strategies had to be found to extend the provision of health care to the remotest places, taking into account serious manpower and economic constraints.

**Extension of Primary Care**

One of the strategies designed to stretch health care delivery is extension of primary health care, which encompasses several activities destined to satisfy basic community needs. Its main focus is on bringing together, at the community level, the cultural and socioeconomic factors necessary to significantly influence the health and well-being of community members. Basically this approach requires acceptance and adaptation, as well as an interlocking between the traditional ways the community has for dealing with health matters and the nation's more formal health systems and institutions. It is also essential that the approach be intersectoral in nature, because many of the conditions affecting the health of
the population depend on factors lying outside the control of the health sector itself. It therefore follows that health programs must be closely related to other community development programs. Only through such a closely integrated multisectoral approach can we expect self-sustaining progress. To achieve this close integration of efforts throughout several complex development sectors requires a carefully thought-out strategy that will get the members of the community deeply involved in solving their own problems, including the problem of health care.

Community Participation

Only by enlisting the support of the people at the grass-roots level can the goal of basic health services for all become a reality in the near future. This principle of community participation in health is so basic that PAHO's Member Governments selected it as the theme for the Pan American Health Organization's 75th Anniversary. Together, this new goal and this new theme have brought forth new concepts to guide our work for the future.

The first concern is thus the role of the community. In the past, experts working on international development in the Americas tended to overlook the community as an important agent of its own change. They believed that rapid economic growth alone would be sufficient to propel society forward. Unfortunately, this forward propulsion did not occur. Hence, they were forced to conclude that all elements of society do not move together. So, if all components are to function in a coordinated fashion, many individuals must be motivated to assume new responsibilities that will help both themselves and their communities.

Similarly, the health programs of the future must acknowledge that change cannot be imposed from outside or from above; it must be generated from within. In this respect, our future approach must depart from previous experience. There are numerous examples—in health as well as in other development areas—where failure has occurred because objectives were pre-established by technical experts in total disregard for the needs and expectations of the communities involved, and where the attitudes and behavior of community members were ignored. At times developing countries adopted models and methods from the developed countries, even though their cultural, political, and socioeconomic conditions were very dissimilar.

If we are to succeed, we must educate and involve people at the community level, so that they identify and solve their own problems and in so doing rely on their own efforts. Such community participation is a process of self-involvement by individuals seeking to satisfy their own needs and those of their community. Its end result should translate into the largest possible number of citizens—together with appropriate health professionals and related institutions—assuming responsibility in health programs and health activities. It is now believed that good health cannot be imposed, but must be attained through the wishes and the efforts of individuals and their communities. Thus individuals, families, and communities must actively participate as much as they are able in identifying their health problems, in searching for possible solutions, and in implementing actual programs.
Yet another change that must take place is in our use of technology. We have become accustomed to regarding technology as an end rather than as a means. In the field of health care it is now time to reemphasize the fact that technology does not exist for its own sake, but rather for the benefit of the people it serves. In the past, the health sectors of the developing countries imported technological models from the more developed countries, even though the high levels of sophistication required to maintain and operate them were frequently unavailable at home. It has taken us time to realize that what is needed is technology adapted to the real needs of each country; that what makes a technology effective is not its sophisticated design or the elegance of its application, but rather its appropriateness to the circumstances and the environment in which it must operate. The increased demands placed on the delivery of health services by the principle of universal coverage, and the fact that poorly educated individuals at the community level were actively involved in the health sector, created a need to develop appropriate technology that was relevant to immediate needs. Both PAHO and the Governments of the Americas are now actively searching for ways to adapt and invent new, cheaper, and simpler ways to provide the tools needed to accomplish their chosen objectives. Once again, experience has indicated that success can only be achieved when the methods employed are in tune with the social and cultural patterns of the consumers of the services involved.

In concluding, I should like to mention another very significant initiative in the health care field—namely, technical cooperation among developing countries. This is a process through which developing countries can share their development capacity, inform one another of their successes and failures, and thereby help each other along the way. It is felt that developing countries may have better insights into the needs of their respective sectors, and that if one of them finds a satisfactory solution to a given health problem, that solution could be more readily applicable to a similar country than a solution derived elsewhere. PAHO has made this transfer of experience between Member Governments an active part of its programs for many years. In the field of health, our Organization has been a forerunner among those espousing this approach, which we believe to be leading in the right direction.

Conclusions

Overall, the health problems facing the developing countries—and even developed countries such as the U.S.—are extremely complex. Their solution will require huge resources in terms of funds, equipment, and manpower, as well as drastic changes in sociocultural patterns. For the developing countries, these constraints will turn out to be insurmountable if they continue to face their problems in the old, traditional way. The new directions that I have mentioned offer the possibility of resolving their immediate problems to some degree. That is why the Pan American Health Organization is actively involved in promoting these promising approaches to health care.