executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

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REPORT OF THE SUBCOMMITTEE ON LONG-TERM PLANNING AND PROGRAMMING ON THE STUDY OF FINANCIAL AND BUDGETARY IMPLICATIONS OF THE REGIONAL STRATEGIES AND THE PLAN OF ACTION FOR ATTAINING THE GOAL OF HEALTH FOR ALL BY THE YEAR 2000

The 86th Meeting of the Executive Committee of the Pan American Health Organization (June 1981) requested that the Director analyze the budgetary and financial implications of the Regional Strategies and of the Plan of Action. It also asked the Director to report to the 88th Meeting of the Executive Committee.

The decision was prompted by the need and concern of the Governments of the Americas to investigate the financial implications of the Regional Strategies which they had approved at the Directing Council of PAHO, and of the Plan of Action--which they later approved and endorsed, respectively, at the XXVIII meeting of the Directing Council, and at the General Assembly of the Organization of American States in Castries, Saint Lucia, in 1981.

The Director has prepared a background document which will assist the Subcommittee on Long-Term Planning and Programming in the discussions at its meeting on 21-22 June 1982. Its recommendations, if any, will subsequently be submitted to the Executive Committee.

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REPORT OF THE SUBCOMMITTEE ON LONG-TERM PLANNING AND PROGRAMMING ON THE STUDY OF THE FINANCIAL AND BUDGETARY IMPLICATIONS OF THE REGIONAL STRATEGIES AND PLAN OF ACTION FOR ATTAINING THE GOAL OF HEALTH FOR ALL BY THE YEAR 2000

At its meeting of 21 June 1982 the Subcommittee on Long-Term Planning and Programming of the Executive Committee examined the preliminary background document on the financial and budgetary implications of the Regional Strategies and the Plan of Action for attaining the goal of health for all by the year 2000 (Annex I).

The Subcommittee made a number of observations which are summarized in Annex II, and submits a proposed resolution (Annex III) to the Executive Committee for its consideration.

Annexes

PRELIMINARY BACKGROUND DOCUMENT ON THE NATIONAL AND INTERNATIONAL FINANCIAL AND BUDGETARY IMPLICATIONS OF THE REGIONAL STRATEGIES AND THE PLAN OF ACTION FOR HFA/2000

(Revision 1)

PREPARED FOR THE MEETING OF THE SUBCOMMITTEE
ON LONG-TERM PLANNING AND PROGRAMMING
OF THE EXECUTIVE COMMITTEE

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EXECUTIVE SUMMARY

Purpose

This background document responds to the request of the Executive Committee at its 86th Meeting in June 1981 that, together with the Director, the Subcommittee on Long-Term Planning and Programming study the financial and budgetary implications of the Regional Strategies and Plan of Action.

The document was prepared with assistance, advice and data provided by the Inter-American Development Bank, the Economic Commission on Latin America, the United Nation's Statistical Office and the International Monetary Fund's Statistical Division. It provides a general perspective on the future costs of achieving the goals of health for all and analyzes the national and external financial and technical resources necessary to meet those costs. It also assesses the implications of the nature and character of existing resource allocations of the health sector for the achievement of the goals of HFA/2000. Finally, it examines the implications for PAHO of the recent pattern of budgetary decisions by its Governing Bodies.

COST ESTIMATES OF HEALTH FOR ALL BY THE YEAR 2000

Cost Factors

1. Goals: The cost estimates relate directly to the regional goals adopted in the Plan of Action. Those goals are more ambitious than the WHO goals, given the significant differences between the Region of the Americas and other developing regions of the world.

2. Health Infrastructure: In the Americas, the infrastructure of the health sector is more modern, complex, and specialized than in other regions. Extension of its coverage is therefore likely to be more expensive than in other regions.

3. Urbanization: Rapid urbanization within the Region will result in more than three-quarters of the population residing in urban areas by the year 2000.

4. Changing Disease Patterns: Countries increasingly are being required to cope with a far broader spectrum of diseases, ranging from parasitic and communicable diseases endemic to earlier stages of development to the chronic and degenerative diseases of later life, which are rising within the Region as primary causes of mortality.

Cost Estimates

Current costs for health within the Region are estimated at approximately $32 billion annually from all sources, and encompass both capital investment and operating costs of health care, or 5 per cent of the Region's GDP.

Between 1981-2000, capital investments for health services, immunization, and malaria control and eradication are estimated at $61 billion and for water and sanitation, $117 billion, with a combined total estimated cost of $178 billion.

By the year 2000, those investments will generate an additional annual recurrent operating cost of $18.75 billion for health care and $17.6 billion for water and sanitation, of which $11.6 billion will be covered by user fees.

The combination of additional costs, existing annual costs and the estimated continuing capital investment requirement of approximately $3 billion will yield a total cost of HFA/2000 of some $60 billion a year.

MEETING THE COSTS OF HEALTH FOR ALL BY THE YEAR 2000

Economic Perspective

Despite the significant amounts estimated to be necessary to fund the costs of health for all by the year 2000, macroeconomic projections offer reasonable expectations that the majority of the countries of the Region will possess sufficient resources to match those costs--and to do so without necessarily increasing the proportion of national resources dedicated to the health sector.

The annual economic growth rate for the Americas in the 1970's averaged more than 6 per cent. In fact, since 1960, the gross domestic product (GDP) in the Americas has been close to 6 per cent.

During the past decade, nations (including private and public sectors) have devoted an average of more than 5 per cent of their GDP to health. A series of projections combining estimates of growth and allocations of GDP to health between 1981 and 2000 present a somewhat reassuring panorama. Even with a low estimate of only a 4 per cent rate of economic growth between 1981 and 2000, and only 4 per cent of the GDP assigned to health, the total estimated costs of $60 billion to achieve health for all by the year 2000 would be available.

A middle range estimate of 5 per cent average GDP growth and 5 per cent assigned to health would produce some $90 billion available to the health sector--significantly more than the estimated costs.

It should be noted that these estimates do not take account of cost savings resulting from the restructuring of the health sector, greater efficiency in the management of services, increased attention to preventive care, and the positive potential impact on health of developments in other sectors during the next two decades.

TRENDS, SOURCES AND IMPLICATIONS OF NATIONAL HEALTH EXPENDITURES

Public Revenues

Governmental spending for health depends on two factors: the total revenues available for government spending and the proportion of government expenditures assigned to health.

Over the past two decades, Latin America and the Caribbean averaged only 13 per cent of GDP devoted to the public sector, a level substantially below the 22 per cent average of a sample number of industrialized countries.

Latin America and the Caribbean show a steady growth in public consumption expenditures over the past two decades: 5.7 per cent annual increase in public spending during the 1960's and 6.2 per cent annual increase in public spending in the 1970's. Both are approximately equal to the rates of GDP growth during the same periods. It is anticipated that faster growth may be needed to finance the basic human needs programs that most countries are planning to implement.

Explanations for the relatively small share of GDP dedicated to public consumption expenditures in most of the Region include the limited nature of overall tax revenues, dependence on indirect rather than direct taxes on individual and corporate incomes, dependence on foreign trade taxes for a significant portion of those indirect taxes, and weak systems of tax collection. One example is that only 25 per cent of central government revenues with the Region are generated by income taxes, compared to more than twice that average in a selected group of industrial countries. In Latin America and the Caribbean interest payments in 1979 represented 11.1 per cent of total central government expenditures, as compared to 5.5 per cent in 1973. Interest payments are likely to account for an even larger share of central government expenditures in the foreseeable future.

Central Government Health Expenditures

Latin America and the Caribbean show a relatively high share of central government expenditures devoted to health (6.1% and 10% respectively) compared with other developing regions of the world. Also, since the countries of Latin America with social security systems finance a substantial portion through the central government and devote a large

percentage of those resources to health care, the overall allocation of central government expenditures devoted to health in Latin America is closer to the Caribbean level.

The percentage of central government expenditures assigned to health by industrialized countries, excluding social security, is 11%. However, in recent years, only 10 of 26 countries showed any real per capita increase in the portion of central government spending for health. The majority either remained unchanged or dropped--some by significant amounts.

Equally important for the goal of health for all, the percentage of central government health expenditures destined for hospitals and clinics has increased in recent years in the Region.

Social Security and Health

Social security expenditures for medical care for most Latin American and some Caribbean countries are not considered part of government-financed health services despite generally high levels of governmental financing in many countries. Social security accounts for an ever-increasing portion of GDP, and a significant portion of the social security benefits involves health care. Also, the general orientation of most social security health care systems is curative rather than preventive.

These factors combine to make evident the need for far closer collaboration between ministries of health and social security institutions in order to engender greater equality in access to health care, decrease duplication of efforts, and promote more effective utilization of available resources.

To accomplish closer coordination between those institutions will require clearly defined policy decisions by the national government, particularly in those countries where the independence of the social security institution is provided by law.

Social Security, Financing, Coverage and Equality

The study notes the limited portion of population covered by social security systems and the partial subsidization by the national population of the employer share of the cost through higher prices paid for many goods and services. The result is that some groups of the population, particularly in rural areas and among the urban poor, do not receive benefits but help to finance the costs of those services. To promote greater equality, social security systems would have to expand their coverage rapidly or restructure their financing schemes.

Private Health Expenditures

Most of the Region appears to show a tendency for private health expenditures to decline as a percentage both of total private consumption expenditures and of GDP. The study notes that people are spending less for health while at the same time they are spending more for alcohol and tobacco. In some countries expenditures for alcohol alone are greater than expenditures for health.

Study Implications

The study points out the fragmentation of authority and responsibility, both legal and de facto, within the health sector, both among competing levels and agencies of government and in the private sector. Serving different groups and with different philosophies, the study finds duplication of effort and less than optimum use of resources. At the same time, the study finds evidence of countries attempting to promote coherence through granting of new authority to the Ministry of Health or to national coordinating councils, or through a combination of the two. Similarly, coordination between sectors can be a potential mechanism for achieving more coherence in overall socioeconomic development, avoid unnecessary additional costs--for instance, by avoiding environmental pollution--and offer possible new resources to the health sector itself.

Study Recommendations

- Greater equity in income distribution.
- Generation of additional public revenues.
- Greater intrasectoral coordination and collaboration.
- Expansion in the coverage of the organized sector.
- Improved control and management.
- Increased efficiency in the utilization of existing resources.
- Improvements in the organization and delivery of care.
- Improvements in cost accounting.

EXTERNAL RESOURCES FOR HEALTH

Past Pattern and Future Perspective of Official External Resource Flows to Developing Countries

Between 1970 and 1978, development assistance (in constant dollars) increased from $48 billion to $88 billion. In 1979 and 1980, external resources declined to $80 billion, of which some $30 billion was on concessional terms.

Future trends, given the general economic climate, are likely to see the pattern of slight declines in overall resources flows continue, with the greatest reduction in the levels of concessional lending.

Pattern and Perspective of External Financial Aid to Latin America and the Caribbean

Latin America and the Caribbean receive some 92% of development assistance on non-concessionary terms. Terms are likely to harden even further.

The reasons for the virtual exclusion of Latin American and the Caribbean countries from the concessionary arena relate to the Region's relatively high per capita national income, which has increasingly become a major determinant for multilateral lending institutions and for bilateral donor agencies.

The utility of this measure has been questioned since it fails to account for the nearly 150 million individuals living in absolute poverty within the Region and because it does nost accurately reflect "poverty" by failing to account for the far higher cost of meeting basic needs within the Region.

External Aid to Health Sector within the Region

Currently only about 1 per cent of the Region's total expenditure on health care and rural water and sanitation systems is externally financed. External resources, nevertheless, continue to be available. The potential for increasing the flow to health is unclear.

- The World Bank funded five health care components of other sector projects for $42 million in 1981.
- The IDB approved a $20 million loan for health alone, and one component loan. Its total in the area of health care, water and sanitation, reached $208 million.
- OECD bilateral commitments to health have averaged some 7 per cent of overall development assistance.

Reasons for the Limited Flow of External Resources for Health

- Emphasis of donor agencies, particularly lending institutions, on projects with higher economic rates of return.

- Overall heavy indebtedness of Member Governments, growing from $25 billion in 1971 to $165 billion in 1980 (some 38% of the total external debt of the developing world).

- Hardening terms of assistance.

- Relatively high ratio of recurrent costs associated with many investments in health services.

- Inability of countries to expand health services without creating increasing inflationary pressures within the health sector.

- Long-term benefit return in health investments is unattractive to governments, which must show an almost immediate return on investments.

Alternative Options to Generate More External Resources for Health

- Countries including requests for health component loans in a larger number of agricultural, industrial and other proposals.

- Countries to request funds to help cover recurrent costs.

- Restructuring health care delivery systems to make them more cost-effective.

- Expansion of social security system coverage.

- Reorganization of the health sector.

- Increased integration of unorganized private sector.

ROLE OF PAHO

PAHO undertook reorganization efforts to enhance its capacity to meet rising demands for cooperation. Over the past six years, its Members have risen from 27 to 32, costs have increased because of inflation throughout the Region, and budgets in real terms have declined. Relative to other UN agencies, PAHO budget increases have been the smallest and, therefore, the least responsive to those inflation-boosted costs of providing services. Population growth rates in Latin America and the Caribbean also have reduced the per capita benefit of the PAHO budget from 8 cents in 1976 to 6 cents in 1981.

PAHO reorganization and internal management improvement have sought to reduce costs without reducing services. Creation of the Office of Resource Mobilization has also been a direct response to the need to maximize the flow of external resources to Member Governments and help them identify, mobilize and more effectively utilize national resources.

PAHO is also intent on insuring that the outcome of the monitoring and evaluation system will provide information that will enable PAHO to respond more quickly and directly to Member Governments as they adjust their systems in accordance with the Plan of Action. This process, linked to AMPES, will be aimed at assuring that the Organization is responding to priorities identified by the countries, thereby using available resources in the most effective manner. Nevertheless, if the budgetary trend of recent years continues, the failure to match the rising levels of inflation will inevitably affect the capacity of the Organization to meet the changing demands of the Member Governments for technical cooperation.

I. INTRODUCTION

Over the past few years, concerns have been raised regarding trends in the financial resources devoted to health in the developing countries of the Americas, and their implications for the attainment of HFA/2000. Concerns range from the severe financial constraints which confront the Pan American Health Organization in the light of its role in the attainment of HFA/2000, to the downward trends in the amounts of real resources being allocated to the health sector.

These concerns were voiced at the 86th Meeting of the Executive Committee and, as a result the Executive Committee requested:

a) That the Subcommittee on Long-Term Planning and Programming study the financial and budgetary implications of the regional strategies and Plan of Action together with the Director;

b) That the Director enlist the cooperation and participation of specialized personnel from other international agencies;

c) That a report on the above be submitted to the 88th Meeting of the Executive Committee.

In response to this specific request the Secretariat has prepared this background document which presents in summary fashion the general economic conditions faced by the countries in the coming years and their implications for HFA/2000. Section VI outlines some of the steps undertaken by PAHO in response to the challenge.

Achievement of HFA/2000 will most likely require a substantial increase in resources for the health sector. However, as was pointed out in the Regional Strategies of HFA/2000 adopted in 1981, the national accounts and other financial data for a number of countries show that during the 1970's there were declines in the real per capita resources being allocated to finance publicly organized health services. These declines are also apparent in PAHO's real financial resources, as reflected in both its regular and extra-budgetary receipts. If this decline continues, PAHO will face very significant difficulties before HFA/2000 is attained.

Other international organizations have been experiencing, sometimes relatively low, but nevertheless real rates of growth in their regular and other budgetary resources over the past few years. However, PAHO has seen its resources, in real terms, decreasing at an alarming rate and, if this trend continues, it inevitably will affect PAHO's role in cooperating in the attainment of HFA/2000.

At the international level, we do not foresee any improvements in the near future in the flow of resources, in real terms, being channeled to the developing countries of the Americas. In fact, this Region's largest bilateral provider of international cooperation plans to drastically cut back its health sector and other financial cooperation activities. In FY 1983, the health sector is projected to receive 6% of that agency's total foreign aid to Latin America and the Caribbean as compared to 15% in FY 1980. Similar trends are visible in the aid programs of many other bilateral and multilateral cooperation agencies.

This shrinking of international resources for health seems somewhat paradoxical if one considers that very often the major beneficiaries are the industrialized countries themselves. Taking smallpox, for example, which this Region was the first to eradicate, calculations indicate that in 1981 one country alone saved an estimated $500 million in avoided direct health costs, and almost a similar amount in related costs, such as lost working time, border health inspections and other associated costs. Similar savings also accrue to the countries resulting from the control of other diseases in humans and in animals. The savings which result from increasing control and even eradication of foot-and-mouth disease is another example. The US Department of Agriculture estimated in 1980 that if "foot-and-mouth disease were to enter the United States of America today it would mean reduced livestock productivity; over one thousand million US dollars in eradication costs and losses; and reduced, or lost, foreign markets for US livestock products." Improvements in animal health are shared by the populations in the meat-producing developing countries as well as by importing countries, through lower prices. In fact, better health and increased productivity lead to lower prices for many of the goods imported by industrialized nations and favorable changes in their terms of trade. Many other examples could be given of how the well-being of both developing and developed countries are linked through improvements in health and the lessening of social inequities.

In many respects, however, most of the developing countries of this Region are less reliant on foreign financial cooperation for health purposes than are developing countries of other Regions. In 1980, for example, external cooperation, excluding aid for large scale urban water and sanitation projects, provided only about 1% of the total financial resources devoted to health in the developing countries of the Americas. To a certain extent, the relatively low level of external financial cooperation received by virtually all of the countries of this Region is due to the fact that they are not considered by most donors as low-income countries, but rather as middle-income countries. This means that not only do these countries receive little external cooperation, but even the cooperation which they do get is usually on hard terms, and not the soft, concessionary terms enjoyed by many other developing countries. Foreign debt servicing is therefore becoming a very salient issue.

In the framework of the guidelines established by the 86th Meeting of the Executive Committee, this document has been prepared with the assistance, advice and data provided by IDB and ECLA. This is a first step in the close cooperation that PAHO is seeking with the economic sector. The Organization anticipates that it will be possible to work even more closely with those institutions in the future. We have, in this document, refrained from making any recommendations or drawing any conclusions except those which are virtually self-evident. We believe these should more appropriately emanate from the deliberations of the Governing Bodies.

Fragmentary data available from a number of disparate sources concerning national health expenditures in this Region have not been used, as such data can be very misleading. Instead, only comparable trend data from official international sources which cover a spread of several years--ranging from a minimum of three years to a maximum of twenty--have been used.

II. TRENDS IN NATIONAL HEALTH EXPENDITURES IN LATIN AMERICA AND THE CARIBBEAN BY SOURCE OF FINANCE

One of the problems faced by many Latin American and Caribbean countries in their efforts to expand the coverage and scope of their health and other programs in the area of basic human needs is the relatively restricted nature of overall government revenues and thus their capacity to finance such programs.

Over the past two decades public consumption expenditures have, for the Region as a whole, been increasing at almost the same rate as the gross domestic product (GDP). The average annual rate of growth in public consumption expenditure in the 1960's was 5.7% and between 1970 and 1979 the average annual growth was 6.2%. It is anticipated that the rate of growth in public consumption over the next two decades will have to be considerably higher to adequately finance the basic human needs programs that most countries are planning to implement.

As Table 1 indicates, although over the past two decades the proportion of GDP which is consumed by the public, as opposed to the private, sector has tended to increase in most Latin American countries, it is still relatively small as compared to other more industrialized countries. In 1979, on the average only 13 per cent of each country's gross domestic product (GDP) was allocated to meeting public consumption needs. This 13 per cent of GDP, besides having to cover the salaries of all public employees, also had to defray the costs of a host of other activities ranging from health, education and welfare programs to defense, justice and foreign affairs. By way of contrast, the United States of America, Canada, Sweden and the United Kingdom were, on the average, able to devote 22 per cent of their much larger GDP's to public consumption. Private consumption expenditures in these latter four countries accounted for an average of only 58 per cent of their GDP in 1977,

TABLE 1

PUBLIC AND PRIVATE CONSUMPTION, AND INCOME TAX IN LATIN AMERICA

Country	Public Consumption as a Percentage of GDP		Private Consumption as a Percentage of GDP		Income Tax as a Percentage of Total Central Government Tax Revenue, 1977
	1960	1979	1960	1979	
Haiti	...	8	...	81	16
Honduras	11	12	77	64	...
El Salvador	10	12	79	68	13
Bolivia	7	12	86	76	39
Colombia	6	7	73	67	37
Paraguay	8	6	76	74	14 1/
Ecuador	10	12	74	61	25 1/
Guatemala	8	7	84	79	13 1/
Nicaragua	9	17	79	71	13
Dominican Republic	13	6	68	80	21 2/
Peru	9	10	64	66	...
Mexico	6	12	76	62	...
Jamaica	7	20	67	63	40
Chile	11	14	75	71	35 2/
Panama	11	18	78	63	34 1/
Costa Rica	10	18	77	69	26 1/
Brazil	12	10	67	69	...
Uruguay	9	13	79	76	...
Argentina	9	24	70	41	...
Trinidad and Tobago	9	16	61	43	57
Venezuela	14	14	53	52	13 1/
Average (unweighted)	9	13	73	66	25
Canada	14	19	65	56	54
United States of America	17	18	64	64	59
Sweden	16	30	60	53	44 1/
United Kingdom	17	20	66	60	60 4/
Average (unweighted)	16	22	64	58	54

Sources: IBRD, World Development Indicators, 1980
United Nations Statistical Yearbook, 1978-1979

1/ Taxes on income and wealth
2/ 1976
3/ Taxes on income and wealth do not include direct taxation of oil and mining companies, which would increase this figure to 64%
4/ Includes social security and similar charges

as compared to an average of 66 per cent in Latin America. Given the relatively small proportion of GDP allocated to meeting all public consumption needs in Latin America, it is not difficult to understand the severe financial constraints under which most publicly financed social development programs operate, including those for health purposes.

One of the reasons for the relatively small share of public as opposed to private consumption expenditures in most Latin American countries is the limited nature of overall government tax revenues. In contrast to the majority of highly industrialized countries, most Latin American countries generate the bulk of their revenues from indirect taxes rather than direct taxes on individual and corporate incomes, and the buoyancy of their tax systems is sometimes low. One of the reasons for the relatively low buoyancy of tax revenues in many countries throughout the Region is the substantial dependence on foreign trade taxes, which tend to make these countries' revenues very vulnerable to changes in external markets.

In the long run, as their economies expand and as many Latin American countries restructure their sources of revenues and as their tax collection systems become more effective, the resources needed to support a wide range of programs aimed at meeting basic needs should be generated. In the short run, however, administrators will be constantly aware of the need to develop alternative sources of financial support for health programs.

Central Government Health Expenditures

As will be seen from Table 2, in many Latin American and Caribbean countries there are marked fluctuations in central government health expenditures, and one can well imagine the frustrations of many of the agencies involved in trying to implement long-term health plans. With the exception of a few countries, which maintained a fairly steady upward growth throughout the entire decade, in real per capita terms the central governments' health expenditures appear to have peaked out in a number of countries before the end of the decade. Thus, excluding Trinidad and Tobago, in only nine out of the other 25 countries shown did per capita health expenditures, when expressed in constant prices, attain their highest level in the last year shown. Moreover, as pointed out in the footnote, the deflator used for developing the data at constant prices was the overall national inflation rate (CPI), whereas it is well known that throughout virtually the entire Region health costs were rising far more rapidly than the overall national rate of inflation. It is believed that later this year, when data for 1980 become available, very few central governments will have increased their real per capita health expenditures. Moreover, it is believed that in 1981 and 1982 the deepening of the economic recession throughout most of Latin America and the Caribbean may have taken a heavy toll on real per capita health expenditures by agencies of the central government. Generally in times of financial and fiscal turmoil it is invariably the social sectors that are cut back the most.

TABLE 2

TRENDS IN CENTRAL GOVERNMENT HEALTH EXPENDITURES
AT CURRENT AND CONSTANT PRICES 1/

COUNTRY	1971	1972	1973	1974	1975	1976	1977	1978	1979
Argentina									
1,000 million current pesos	.8	1.1	2.2	2.4	7.3	55.3	86.9	207.9	430.3
At 1971 constant prices	.8	.82	1.03	.70	1.72	4.60	1.33	1.15	.87
Per capita at 1971 constant prices	33.0	33.6	41.66	27.94	67.77	178.85	51.04	43.58	32.55
Bahamas									
Millions of current dollars	-	-	15.3	17.1	17.8	22.1	24.3	27.5	29.1
At 1973 constant prices	-	-	15.3	16.2	15.0	16.7	17.7	19.4	19.4
Per capita at 1973 constant prices	-	-	80.95	82.65	75.00	79.52	81.57	86.22	86.61
Barbados									
Millions of current dollars	-	19.7	26.0	25.3	27.1	32.2	34.8	37.3	40.9
At 1972 constant prices	-	19.7	24.3	20.2	15.6	15.4	15.9	15.7	15.7
Per capita at 1972 constant prices	-	81.41	100.00	82.79	63.67	62.60	64.11	62.80	62.55
Bolivia									
Millions of current pesos	-	134	192	413	469	570	662	835.	1 018
At 1972 constant prices	-	134	180.3	294.9	205.8	231.6	257.4	300.4	331.7
Per capita at 1972 constant prices	-	28.879	38.608	62.084	42.086	46.044	49.884	56.679	60.862

TABLE 2 (cont.)

COUNTRY	1971	1972	1973	1974	1975	1976	1977	1978	1979
Brazil									
Billions of current cruzeiros	3.0	3.9	5.4	8.1	11.9	21.7	36.1	55.1	88.1
At 1971 constant prices	3.0	3.2	3.9	5.1	5.9	8.3	9.8	10.4	12.0
Per capita at 1971 constant prices	31.52	32.70	38.78	49.35	55.54	76.02	87.31	90.12	101.14
Canada									
Millions of current dollars	1 687	--	--	2 296	2 782	3 305	3 129	3 849	4 202
At 1971 constant prices	1 687	--	--	1 979	2 157	2 311	2 032	2 319	2 322
Per capita at 1971 constant prices	78.14	--	--	88.35	94.90	100.39	87.29	98.76	98.2
Chile									
Millions of current pesos	--	8	32	226	853	2 691	6 316	10 623	--
At 1972 constant prices	--	8	17.87	27.94	17.39	11.57	8.71	7.63	--
Per capita at 1972 constant prices	--	.83	1.81	2.79	1.71	1.12	.83	.71	--
Costa Rica									
Millions of current colones	--	56.8	61.2	103.3	144.7	209.1	168.5	266.2	207.9
At 1972 constant prices	--	56.8	58.5	85.4	92.2	113.6	88.7	134.4	99.0
Per capita at 1972 constant prices	--	30.87	31.28	44.48	47.04	56.52	42.85	63.40	45.62

TABLE 2 (cont.)

COUNTRY	1971	1972	1973	1974	1975	1976	1977	1978	1979
Dominican Republic Millions of current pesos	--	--	48.3	59.6	42.8	55.3	--	--	--
At 1973 constant prices	--	--	48.3	51.8	32.9	37.1	--	--	--
Per capita at 1973 constant prices	--	--	10.90	11.36	7.00	7.67	--	--	--
Ecuador Millions of current sucres	--	--	356	811	952	1 204	1 493	1 759	2 066
At 1973 constant prices	--	--	356.0	717.7	684.9	752.5	843.5	879.5	926.5
Per capita at 1973 constant prices	--	--	53.94	105.08	97.01	102.94	111.57	112.61	114.67
El Salvador Millions of current colones	37.1	40.0	42.7	50.8	49.2	77.2	97.7	99.2	110.6
At 1972 constant prices	37.1	39.8	41.9	46.6	38.7	51.1	60.3	54.8	54.0
Per capita at 1972 constant prices	10.45	10.85	11.11	11.98	9.65	12.40	14.16	12.60	12.16
Guatemala Millions of current quetzales	--	19.39	22.55	26.75	30.09	36.26	44.93	47.02	60.00
At 1972 constant prices	--	19.4	22.4	23.5	22.6	24.2	27.1	25.1	29.7
Per capita at 1972 constant prices	--	3.48	3.90	3.88	3.62	3.76	4.09	3.67	4.21

TABLE 2 (cont.)

COUNTRY	1971	1972	1973	1974	1975	1976	1977	1978	1979
Guyana									
Millions of current dollars	--	--	17.0	18.9	26.6	28.5	29.9	30.2	--
At 1973 constant prices	--	--	17.0	17.6	21.1	21.0	20.2	18.9	--
Per capita at 1973 constant prices	--	--	22.25	22.86	27.05	26.58	24.94	22.97	--
Honduras									
Millions of current lempiras	--	25.4	29.3	45.6	47.6	66.4	49.6	65.1	69.6
At 1972 constant prices	--	25.4	27.8	41.5	38.1	49.9	35.4	42.8	43.2
Per capita at 1972 constant prices	--	9.4	9.59	13.88	12.33	15.59	10.66	12.44	12.14
Jamaica									
Millions of current dollars	--	--	--	--	74.6	77.7	83.3	--	--
At 1975 constant prices	--	--	--	--	74.6	66.2	64.6	--	--
Per capita at 1975 constant prices	--	--	--	--	95.64	83.80	79.75	--	--
Mexico									
Billions of current pesos	--	3.41	4.33	4.77	6.85	8.78	12.43	14.57	19.71
At 1972 constant prices	--	3.4	4.1	4.0	4.7	5.2	6.4	5.8	6.7
Per capita at 1972 constant prices	--	62.65	73.01	68.82	78.14	83.43	99.09	86.65	96.57

TABLE 2 (cont.)

COUNTRY	1971	1972	1973	1974	1975	1976	1977	1978	1979
Netherlands Antilles									
Millions of current guilders	--	--	14.1	15.1	13.6	11.6	16.7	19.6	20.1
At 1973 constant prices	--	--	14.1	14.0	10.5	7.8	10.6	11.9	11.2
Per capita at 1973 constant prices	--	--	61.30	59.32	43.57	31.84	42.40	47.22	43.41
Nicaragua									
Millions of current córdobas	56.1	36.5	54.9	101.8	161.5	83.9	--	--	--
N.A.	--	--	--	--	--	--	--	--	--
At current prices	29.68	18.72	27.31	48.94	74.77	37.46	--	--	--
Paraguay									
Millions of current guaraníes	--	434	433	484	586	698	798	994	1 670
At 1972 constant prices	--	434.0	396.5	393.5	380.5	425.6	466.7	531.6	806.8
Per capita at 1972 constant prices	--	178.60	158.60	153.11	143.59	156.47	166.68	183.95	271.65
Panama									
Millions of current balboas	--	--	58.6	69.3	84.3	82.7	94.2	111.1	129.5
At 1973 constant prices	--	--	58.6	64.8	67.4	62.7	68.8	77.7	86.9
Per capita at 1973 constant prices	--	--	37.33	40.00	40.12	36.45	38.87	42.46	46.22

TABLE 2 (cont.)

COUNTRY	1971	1972	1973	1974	1975	1976	1977	1978	1979
Peru									
Billions of current soles	--	3.44	3.53	4.38	5.45	8.45	11.59	16.29	29.85
At 1972 constant prices	--	3.4	3.3	3.7	4.0	5.0	5.1	5.2	6.1
Per capita at 1972 constant prices	--	239.10	225.56	246.01	258.57	314.27	311.74	309.16	352.81
Suriname									
Millions of current guilders	15.60	17.18	20.40	22.10	27.54	36.69	--	--	--
At 1971 constant prices	15.6	17.1	19.6	18.9	20.1	24.6	--	--	--
Per capita at 1971 constant prices	42.16	46.22	53.12	51.36	55.83	67.40	--	--	--
Trinidad and Tobago									
Millions of current dollars	--	--	--	--	--	--	--	--	232.3
At 1979 constant prices	--	--	--	--	--	--	--	--	232.3
Per capita at 1979 constant prices	--	--	--	--	--	--	--	--	206.12
United States									
Millions of current dollars	--	19.80	21.45	24.82	31.12	36.37	41.52	46.65	53.19
At 1972 constant prices	--	19.8	20.8	22.6	25.5	27.4	29.5	31.1	33.0
Per capita at 1972 constant prices	--	95.09	99.11	106.91	119.40	127.35	136.02	142.51	149.93

TABLE 2 (cont.)

COUNTRY	1971	1972	1973	1974	1975	1976	1977	1978	1979
Uruguay									
Millions of current new pesos	--	5	28	62	74	118	177	356	545
At 1972 constant prices	--	5.0	15.9	17.8	12.0	10.6	10.5	13.4	14.3
Per capita at 1972 constant prices	--	1.82	5.76	6.43	4.24	3.73	3.67	4.67	4.97
Venezuela									
Millions of bolívares	1 338	1 484	1 662	2 007	2 536	3 019	3 438	3 799	3 989
At 1971 constant prices	1 338.0	1 436.6	1 567.9	1 824.6	2 131.1	2 304.6	2 438.3	2 499.3	2 447.2
Per capita at 1971 constant prices	126.11	131.32	139.00	156.89	177.74	186.46	191.39	190.50	181.01

Source: IMF Government Finance Statistics Yearbook, Volume V, 1981.

1/ Constant prices relate to total CPI (Consumer Price Index) and not solely to health expenditures. In virtually all the countries shown, health sector expenditures have risen at a faster rate than the total CPI. The source of the CPI data was IMF's 1981 International Financial Statistics Yearbook.

In 18 out of the 23 countries shown in Table 3, health as a percentage of total central government expenditures accounted for a smaller share in the last year shown than in the first year shown. The unweighted average for the first year shown for all 23 countries was 8.4 per cent. The corresponding average for the last year shown was 6.8 per cent, or an average decrease of 19 per cent over the six years. In the Bahamas the percentages for the first and last years shown were the same, but there was a substantial decline between 1978 and 1979.

TABLE 3

CENTRAL GOVERNMENT EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL CENTRAL GOVERNMENT EXPENDITURES

Country	1973	1974	1975	1976	1977	1978	1979
Argentina	3.8	2.5	2.6	4.1	2.7	2.2	1.7
Bahamas	13.9	14.1	13.5	14.6	15.3	15.6	13.9
Barbados	15.5	12.8	11.8	11.2	10.6	11.5	10.3
Bolivia	7.8	8.9	8.4	8.0	8.0	8.3	8.6
Brazil	6.8	6.9	6.5	7.5	8.1	7.8	8.5
Chile	8.0	7.3	6.9	6.5	6.4	6.4	...
Costa Rica	3.1	4.0	4.3	4.6	3.2	3.7	2.4
Dominica	...	...	...	10.6	12.7	9.6	8.8
Dominican Republic	11.7	10.9	6.8	8.7	...	...	...
El Salvador	10.4	10.3	8.2	9.2	9.8	8.9	8.7
Grenada	...	14.1	14.6	12.7	15.6	...	...
Guatemala	9.2	8.4	8.6	8.3	7.6	7.1	7.6
Guyana	6.1	5.7	4.8	4.2	5.8	5.7	...
Honduras	...	11.7	15.7	12.8	14.7	8.5	8.0
Jamaica	...	...	9.3	8.2	7.8	...	...
Mexico	4.9	3.9	4.2	4.2	4.4	4.0	3.9
Netherlands Antilles	8.4	9.2	8.5	8.2	9.7	8.0	7.9
Nicaragua	5.7	6.2	8.4	4.1	...	...	...
Panama	15.1	13.8	14.5	13.2	14.5	15.1	12.3
Peru	3.3	3.0	2.8	2.8	2.7	2.6	3.7
Suriname	5.5	5.7	5.1	5.8	5.9	5.6	4.5
Uruguay	4.8	5.7	3.9	3.9	3.8	5.0	4.7
Venezuela	10.8	7.5	7.6	7.2	7.3	8.0	9.1

Source: IMF Government Finance Statistics Yearbook, Vol. 5, 1981

During the 1970's it would appear from data published by the International Monetary Fund (IMF) that there has been an increasing tendency by many of the central governments throughout Latin America, but not necessarily the Caribbean, to allocate a growing proportion of their health expenditures to hospitals and clinics. The data below tend to highlight this trend.

TABLE 4

PERCENTAGE FOR HOSPITALS AND CLINICS OF CENTRAL GOVERNMENTS' TOTAL HEALTH EXPENDITURES

Country	1972	1979
Argentina	33.3	78.6
Barbados	75.6	72.1
Bolivia	(1973) 23.1	40.1
Brazil	82.0	85.0
Chile	87.5	92.5
Guatemala	71.0	79.3
Dominica	(1976) 72.1	65.0
Honduras	87.0	49.9
Mexico	59.8	90.7
Panama	(1973) 92.2	(1978) 93.8
USA	85.1	92.9
Canada	(1971) 55.1	59.0
Dominica	72.1	65.0
Guyana	(1973) 93.5	(1978) 95.4
Netherlands Antilles	(1973) 63.1	45.3
Suriname	72.2	(1976) 63.3
Tanzania	86.0	72.7
India	83.0	75.6

Source: IMF Government Finance Statistics Yearbook Vol. V, 1981

This trend towards increasing proportions of total central government health expenditure to hospitals and clinics has serious implications for the strategies of primary health care and HFA/2000. Representatives of Member Governments may wish to check the validity of the data pertaining to their country with the authorities responsible for submitting them to the IMF, because of their implications.

TABLE 5

SOCIAL SECURITY AND WELFARE, AND HEALTH AS PERCENTAGE OF TOTAL CENTRAL GOVERNMENT EXPENDITURES

	1973	1979
Social Security and Welfare		
World	31.7	34.3
Industrialized Countries	34.9	37.9
USA	31.6	33.6
Oil Exporters	3.5	5.2
Africa	5.4	5.3
Asia	4.5	4.0
Middle East	9.1	11.4
Latin America	27.4	28.3
Caribbean (unweighted)	6.0	7.0
Health		
World	9.1	10.0
Industrialized Countries	9.9	11.1
Canada	7.6	7.6
USA	8.3	10.5
Oil Exporters	5.2	4.8
Africa	6.1	5.4
Asia	2.7	2.8
Middle East	3.0	3.5
Latin America[1]	6.0	6.1
Caribbean (unweighted)	11.0	10.0

[1]For most countries the total does not include health care expenditures or social security.

Social Security Systems and the Financing of Medical Care

The social security financial operations presented in ILO's document entitled "The Cost of Social Security" are necessarily included in the various flows recorded in the United Nations System of National Accounts (SNA), although they may not all be classified under the heading "social security" as defined for the purpose of the SNA. For example, in the new SNA, "social security arrangements" are defined as follows:

> The social security arrangements to be included are those which are imposed, controlled or financed by the government. Schemes imposed by the government will involve compulsory contributions by employees and/or employers and cover the whole community or

> particular sections of the community. These arrangements may, in addition, allow certain sections of the community to join the scheme voluntarily. Schemes formulated by the government solely in its role as an employer of personnel, for example schemes which differ significantly from social security arrangements for the community or which are the subject of negotiation with government employees, are not to be included here. Such schemes are considered to be pension arrangements. Even if a scheme does not involve compulsory contributions imposed by the government, it should nevertheless be included as a part of general government services if, by way of public regulation and supervision, or by virtue of the existence of a system of government grants, the scheme clearly forms part of the social policy of the government in respect of the community as a whole.

This definition covers to some extent the schemes classified under "social insurance and assimilated schemes" and "family benefits" in the ILO inquiry. Schemes for public employees (military and civilian) are, as far as pensions are concerned, included under "pension funds and other financial institutions" in the SNA; this category also includes private pension funds which fall outside the scope of the ILO inquiry. Sick leave and other short-term benefits to public employees appear under "wages and salaries" in the SNA.

This means that social security expenditures for medical care for most Latin American and some Caribbean countries are not considered as being part of government-financed health services, although the government may account for the largest share of their financing.

As Table 6 indicates, with the exception of a few of this Region's smaller countries, in the majority of the countries throughout the Western Hemisphere having social security schemes, they are accounting for an ever-increasing proportion of their GDP.

In many of the countries shown in Table 7, e.g., Costa Rica, El Salvador, Nicaragua, United States of America, Uruguay and Venezuela, social security expenditures on medical care are larger than those of the central government health expenditures. In terms of the attainment of HFA/2000, it is becoming increasingly evident that there is an urgent need for far closer collaboration between ministries of health and social security. In most countries this would not only engender greater equality in the access to health care, but would also lead to decreased duplication of efforts and a more effective utilization of available resources.

Moreover, in many countries it appears that a major source of additional funds for supporting health services could stem from expanded social security contributions. There are, however, a number of potential limitations, such as legal caveats, which could restrict funds from such sources being effectively utilized in national programs designed to provide health for all. For example, in many Latin American countries, besides the fact that the ministries of health and their counterparts have little control over the use of such funds, social security health programs are usually oriented towards

TABLE 6

RECEIPTS AND EXPENDITURES OF SOCIAL SECURITY SCHEMES
(as percentage of gross domestic product in purchasers' value[1])

Country	Financial Year	Receipts	Expenditure	Benefits
Argentina	1975[2]	8.0	7.3	7.0
Barbados	1971[4]	6.4	3.6	3.5
	1975	6.7	4.9	4.8
	1976	7.4	5.7	5.6
	1977	7.9	6.2	6.1
Bolivia	1961[2]	4.3	3.6	3.0
	1972	3.3	3.1	2.8
	1975	3.4	3.1	2.8
	1976	3.5	3.1	2.8
Brazil	1965[2]	4.5	4.3	3.4
	1970[2]	5.7	5.7	4.7
	1975[2]	6.1	5.7	4.9
	1976[2]	6.1	6.2	5.2
	1977[2]	6.2	6.2	5.3
Canada	1959-60	9.8	9.2	9.0
	1964-65	10.7	9.4	9.1
	1969-70	14.4	11.8	11.5
	1974-75	16.7	14.7	14.0
	1975-76	17.3	15.2	14.7
	1976-77	16.4	14.5	14.2
Colombia	1961[2]	1.5	1.5	1.4
	1965[2]	1.1	1.1	1.0
	1970	3.1	2.6	2.4
	1975	3.6	3.0	2.8
	1976	4.1	3.4	3.0
	1977	4.5	3.7	3.3
Costa Rica	1961[2]	2.9	1.9	1.6
	1965[2]	3.8	2.3	1.9
	1970[2]	4.8	3.4	2.9
	1975	6.8	5.1	4.6
	1976	7.6	5.9	5.3
	1977	76.4	5.8	5.3
Chile	1965[2]	13.9	12.1	9.8
	1971[2]	19.4	17.2	15.6
	1975[2]	11.7	9.3	8.5
	1976[2]	12.0	9.4	8.8
	1977[2]	13.2	10.1	9.4
Dominican Republic	1970	2.9	2.7	1.8
	1975	2.5	2.4	2.3
	1976	2.7	2.6	2.5
	1977	2.6	2.5	2.4
El Salvador	1960[2]	2.2	2.1	2.0
	1965[2]	2.4	2.2	2.1
	1970[2]	3.7	2.9	2.3
	1975[2]	3.9	3.3	2.4
	1976[2]	3.7	3.2	2.1
	1977[2]	3.4	2.9	2.0
Guatemala	1959-60[5]	2.0	1.9	1.8
	1965[2]	2.0	2.0	1.8
	1970[2]	2.2	2.1	1.9
	1975[2]	2.0	2.0	1.8
	1976[2]	1.9	1.8	1.6
	1977[2]	2.1	1.6	1.5
Guyana	1965	4.3	4.3	4.2
	1972	5.2	3.3	2.8
	1975	3.6	1.9	1.6
	1976	4.0	2.1	1.7
Haiti	1974-75	1.0	0.9	0.8
	1975-76	0.9	0.7	0.7
	1976-77	0.9	0.8	0.7
Jamaica	1964-65[2]	2.9	2.7	2.5
	1969-70	4.0	2.8	2.1
	1974-75	4.1	3.1	2.5
	1975-76	5.2	4.1	3.6
	1976-77	5.9	4.4	3.9
Nicaragua	1960-61	2.3	1.9	1.8
	1965	2.6	2.1	1.9
	1970	3.4	2.8	2.5
	1975	3.4	2.8	2.5
	1976	3.2	2.7	2.4
	1977	2.8	2.3	2.1
Panama	1960[2]	7.7	6.3	6.0
	1965[2]	7.3	6.0	5.6
	1972[2]	8.5	7.4	6.2
	1975[2]	9.2	7.2	6.1
	1976[2]	10.0	7.7	7.0
	1977[2]	9.9	7.9	7.0
Trinidad and Tobago	1965[2]	3.0	2.8	2.8
	1970[2]	3.1	3.1	3.1
	1975[2]	3.2	2.3	2.2
	1976[2]	3.4	2.4	2.3
	1977[2]	3.4	2.5	2.4
United States	1959-60[6]	7.5	6.8	6.3
	1964-65	8.1	7.1	6.5
	1969-70	11.3	9.6	8.9
	1974-75	14.4	13.2	12.4
	1975-76	14.4	13.9	13.1
	1976-77	14.8	13.7	12.9
Uruguay	1975	11.1	10.4	8.2
	1976	12.0	10.1	9.0
	1977	11.3	10.3	9.1
Venezuela	1959-69[2,5]	2.6	2.5	2.1
	1965[2]	3.0	3.1	3.0
	1970	3.4	3.1	2.3
	1975	4.2	3.7	3.5
	1976	4.5	4.0	3.8
	1977	4.5	4.1	3.8

Source: ILO, "The Cost of Social Security," Geneva, 1981.

1 Gross domestic product computed in accordance with the new System of National Accounts adopted by the United Nations in 1968 (unless otherwise indicated).
2 As percentages of the gross domestic product computed in accordance with the old System of National Accounts.
3 Excludes public employees, for whom data are not available.
4 As percentages of gross domestic product at factor cost.
5 Financial year 1 July 1959 to 30 June 1960.
6 As percentages of gross national product at current market prices.

TABLE 7

TRENDS IN SOCIAL SECURITY RECEIPTS AND MEDICAL CARE EXPENDITURES

Country	Years	Total[1] Receipts (in millions of National Currency Units	Total Receipts (in millions of US$)	From Insured Percentage Total Receipts	From Employers Percentage Total Receipts	State Participation Percentage Total Receipts	Medical Care Expenditures In millions of National Currency Units	Medical Care Expenditures In millions of US$	Medical Care Benefits Percentage Total Expenditures
Argentina	1975	107 984.3	2 950.39	22.8	70.4	5.0	17 758.6	485.21	18.2
(Pesos)	1976	555 698.1	3 969.27	28.1	61.2	6.7	124 316.1	887.97	27.0
	1977	1 487 545.7	3 649.52	27.3	57.2	6.8	311 147.8	763.37	24.3
Barbados	1971	19.15	9.70	43.0		48.3	9.29	4.70	87.3
(Dollars)	1975	53.64	26.55	12.2	14.3	62.9	25.56	12.65	64.7
	1976	62.77	31.33	11.7	13.6	65.2	31.06	15.50	64.2
	1977	75.12	37.43	11.3	13.1	67.0	37.31	18.59	63.1
Bolivia	1961	209.97	17.67	15.7	59.2	20.7	71.91	6.05	41.2
(Pesos)	1972	578.7	43.53	25.0	35.9	23.2	345.1	25.96	63.7
	1975	1 692.8	84.64	17.8	43.9	30.6	988.1	49.41	64.5
	1976	2 077.2	103.86	26.7	39.0	27.6	1 171.0	58.55	65.2
	1977	2 198.5	109.93	28.5	47.6	11.8	1 003.9	50.20	57.3
Canada	1959-60	3 426.8	3 564.76	11.5	12.1	34.7	831.9	865.39	26.0
(Dollars)	1964-65	5 468.6	5 075.27	6.7	13.6	33.2	1 546.2	1 435.00	32.3
	1969-70	11 566.8	10 908.99	8.4	13.6	30.0	3 616.5	3 410.83	38.2
	1974-75	24 893.3	24 791.65	6.9	10.5	48.5	7 634.7	7 603.53	34.9
	1975-76	28 836.8	28 802.24	7.4	11.3	46.8	9 272.0	9 260.89	36.6
	1976-77	31 766.4	30 650.71	7.3	11.4	47.2	10 301.1	9 939.79	36.8
Chile	1965	2.64	880.00	19.3	4.2	31.8	0.26	86.67	11.4
(Pesos)	1971	25.09	2 090.83	20.6	37.5	35.3	2.91	242.50	13.1
	1975	4 929.0	1 003.67	16.3	46.5	30.9	541.6	110.28	13.9
	1976	17 532.8	1 343.10	17.0	48.0	27.9	2 178.7	166.90	15.8
	1977	42 330.5	1 966.21	17.5	45.6	29.7	5 321.4	247.17	16.5
Colombia	1961	461.81	68.93	7.9	35.8	56.0	334.04	49.86	74.5
(Pesos)	1965	678.39	64.76	13.9	52.6	33.2	456.84	43.61	68.9
	1970	3 996.84	216.71	14.6	39.5	42.6	2 120.05	114.95	63.6
	1975	14 703.80	475.41	16.6	33.7	39.6	6 498.80	210.12	52.3
	1976	22 071.70	636.18	14.0	33.0	35.2	8 880.70	255.97	48.5
	1977	32 389.10	880.74	12.3	31.3	34.7	12 250.10	333.11	46.5
Costa Rica	1961	85.8	14.42	25.3	38.7	26.5	37.8	6.35	67.1
(Colones)	1965	149.9	22.63	25.1	37.7	26.0	58.8	8.88	65.6
	1970	314.5	47.47	23.2	36.0	28.9	154.4	23.31	69.9
	1975	1 148.8	134.05	23.8	47.8	16.2	615.8	71.86	71.2
	1976	1 566.1	182.74	23.1	45.6	15.7	854.3	99.68	70.4
	1977	1 952.4	227.82	23.5	44.2	10.6	1 094.8	127.75	71.2

TABLE 7 (cont.)

TRENDS IN SOCIAL SECURITY RECEIPTS AND MEDICAL CARE EXPENDITURES

Country	Years	Total[1] Receipts (in millions of National Currency Units	Total Receipts (in millions of US$)	From Insured Percentage Total Receipts	From Employers Percentage Total Receipts	State Participation Percentage Total Receipts	Medical Care Expenditures In millions of National Currency Units	Medical Care Expenditures In millions of US$	Medical Care Benefits Percentage Total Expenditures
Dominican	1970	42.394	42.39	10.8	47.4	35.7	14.217	14.22	35.9
Republic	1975	89.578	89.58	...	...	64.3	44.199	44.20	50.8
(Pesos)	1976	105.325	105.33	...	...	66.9	54.089	54.09	52.9
	1977	117.481	117.48	...	...	67.6	61.903	61.90	53.5
El Salvador	1960	30.59	12.24	5.1	32.9	61.8	26.60	10.64	90.7
(Colones)	1965	47.33	18.93	6.0	41.9	51.5	32.08	12.83	74.0
	1970	96.24	38.50	8.5	37.2	53.1	39.49	15.80	53.4
	1975	173.05	69.22	11.0	35.7	50.1	76.16	30.46	50.9
	1976	209.55	83.82	10.9	33.1	52.9	89.44	35.78	49.0
	1977	244.61	97.84	11.0	32.6	52.8	107.26	42.90	51.4
Guatemala	1959-60	20.7	20.70	12.1	32.4	55.1	...	...	...
(Quetzales)	1965	26.9	26.90	20.8	29.4	49.4	17.3	17.30	66.3
	1970	42.5	42.50	23.1	36.9	39.1	26.7	26.70	65.3
	1975	73.2	73.20	23.6	34.0	41.1	47.5	47.50	66.6
	1976	83.3	83.30	24.7	35.3	39.1	49.8	49.80	64.5
	1977	113.2	113.20	26.2	41.2	31.7	53.5	53.50	62.0
Guyana	1965	15.634	9.12	...	23.0	77.1	8.341	4.87	53.4
(Dollars)	1972	31.121	14.91	21.0	27.8	41.2	13.363	6.40	67.5
	1975	42.824	18.18	21.1	28.6	35.7	15.653	6.65	69.1
	1976	45.078	17.68	21.2	28.9	33.9	15.699	6.16	67.3
	1977	48.806	19.14	21.2	29.2	31.3	15.678	6.15	63.1
Haiti	1974-75	43.88	8.78	...	...	71.0	31.49	6.30	83.1
(Gourdes)	1975-76	50.01	10.00	...	...	69.3	35.00	7.00	82.3
	1976-77	60.46	12.09	...	...	69.8	43.52	8.70	83.1
Jamaica	1964-65	17.288	24.20	6.5	21.9	67.6	10.966	15.35	66.1
(Dollars)	1969-70	40.059	48.07	13.5	28.7	50.4	14.411	17.29	52.5
	1974-75	93.222	102.54	10.0	11.7	68.7	34.978	38.45	50.2
	1975-76	137.514	151.26	9.1	10.6	72.0	66.549	73.20	62.3
	1976-77	160.958	177.05	10.6	12.4	67.8	73.322	80.65	61.8
Nicaragua	1960-61	59.3	8.47	30.4		68.1	43.7	6.24	90.0
(Córdobas)	1965	101.8	14.54	11.9	29.6	23.4	65.1	9.30	76.8
	1970	187.0	26.71	14.0	34.1	24.1	114.2	16.31	75.6
	1975	377.7	53.76	13.4	32.9	24.0	234.2	33.33	76.1
	1976	417.9	59.48	13.8	34.0	23.4	260.4	37.06	75.1
	1977	444.5	63.27	14.8	36.3	23.8	271.5	38.64	75.4

TABLE 7 (cont.)

TRENDS IN SOCIAL SECURITY RECEIPTS AND MEDICAL CARE EXPENDITURES

Country	Years	Total[1] Receipts (in millions of National Currency Units	Total Receipts (in millions of US$)	From Insured Percentage Total Receipts	From Employers Percentage Total Receipts	State Participation Percentage Total Receipts	Medical Care Expenditures In millions of National Currency Units	Medical Care Expenditures In millions of US$	Medical Care Benefits Percentage Total Expenditures
Panama	1960	31.82	31.82	13.6	21.7	55.9	...	...	...
(Balboas)	1965	48.35	48.35	18.5	31.7	37.6	...	...	...
	1972	110.17	110.17	20.3	45.0	24.3	44.93	44.93	46.8
	1975	177.87	177.87	22.8	49.8	20.1	65.74	65.74	47.5
	1976	200.85	200.85	24.0	50.8	17.3	79.02	79.02	51.0
	1977	213.32	213.32	23.9	49.7	17.8	83.40	83.40	49.2
Trinidad and Tobago	1965	37.41	21.82	8.0	17.6	64.7	23.70	13.82	67.7
(Dollars)	1970	54.27	27.14	4.3	15.0	72.1	37.70	18.85	71.1
	1975	182.26	84.00	11.2	23.2	60.5	83.00	38.25	63.0
	1976	227.56	93.35	10.9	22.6	61.0	100.20	41.11	61.4
	1977	284.23	118.43	9.7	20.3	64.1	137.30	57.21	65.1
United States	1959-60	38 137	38 137	21.8	34.9	24.2	5 405	5 405	15.7
	1964-65	55 892	55 892	22.3	35.9	23.6	7 682	7 682	15.7
(Dollars)	1969-70	110 932	110 932	24.3	33.3	24.1	21 938	21 938	23.4
	1974-75	219 900	219 900	22.7	34.1	25.7	45 311	45 311	22.4
	1975-76	244 664	244 664	21.5	34.2	26.9	51 471	51 471	21.8
	1976-77	280 460	280 460	21.4	35.5	26.5	59 797	59 797	23.0
Uruguay	1975	925.70	402.65		68.0	25.2	100.14	47.91	12.6
(Pesos)	1976	1 557.00	458.62	22.9	45.2	26.5	172.92	50.93	13.1
	1977	2 252.19	474.15	24.6	49.4	18.6	266.28	56.06	13.0
Venezuela	1959-60	655.2	195.61	8.5	16.2	74.8	430.2	128.43	66.0
(Bolivares)	1965	1 149.8	255.52	7.4	12.8	79.5	1 080.4	240.10	93.2
	1970	1 755.7	390.30	13.6	26.3	57.3	1 079.5	240.00	67.3
	1975	5 323.7	1 242.40	9.5	19.1	66.5	3 883.3	906.36	83.7
	1976	5 898.9	1 375.07	9.6	19.2	66.4	4 463.6	1 040.49	83.2
	1977	6 953.2	1 619.84	9.2	18.4	67.8	5 178.1	1 206.31	83.2

Source: ILO, The Cost of Social Security, Geneva, 1981.

[1]The total percentage breakdown of the three sources of receipts shown in the table may not equal 100.0% because of receipts from such other sources as (1) special tables allocated to social security (e.g. in 1977 such taxes represented 22% of total receipts in Nicaragua); (2) participation of other public authorities in FY 1976/77, such sources accounted for 27% and 11% of the total receipts of Canada and the USA respectively; (3) income from capital (e.g. in 1977 such income represented 12% of total Bolivian receipts); (4) other receipts (e.g. in 1977 such other sources represented 19% of total Colombian receipts).

more sophisticated curative services and very few of their resources are devoted to preventive and basic health care programs. In many countries it would appear that only by the national government establishing a clearly defined policy of earmarking a part of total social security health revenue to help subsidize a number of other national health objectives would some of the financial problems involved in rapidly expanding coverage to provide health for all be partially alleviated. In this respect, as can be seen from Table 7, in many countries semi-autonomous social security health programs are themselves directly and sometimes highly subsidized by governments' public revenues. Moreover, insofar as they use public facilities and health personnel who have been educated and trained at public expense, they are also indirectly subsidized.

There is also the question of who actually pays for social security health programs. It is believed that in many systems the incidence of the share of payroll taxes initially paid by employers is to a substantial degree shifted to consumers through higher prices for many goods and services. As a result, some groups of the population, mainly those living in rural areas and the poorest urban groups, help finance social security systems without receiving any benefits. Generally speaking, as the table shows, the insured employees pay only a relatively small proportion of the total costs of such systems.

In general, it is the regressive nature of the real sources of the funds used to finance social security programs and the resulting perpetuation of inequities in income distribution, coupled with their restricted coverage, which is giving rise to growing concern in many of the Region's countries. In the context of strategies to meet basic human needs it would appear that in few of the Region's countries are the autonomous or semi-autonomous social security systems a particularly constructive influence. However, by a redefinition of their policies and roles such systems could become a very constructive factor.

Another underutilized alternative open to many Latin American countries is the imposition of a broader range of user charges on the recipients of publicly financed health care. Very often, even when charges are made for goods and services, they seldom accrue to the account of the government agency actually financing the goods and services. It is thought, therefore, that many governments may wish to undertake a review of the benefits which could be derived from the imposition of user charges for many of the health goods and services now provided free of direct charges. It is not believed that charges should be made for all health goods and services, or that the charges should defray the majority of the costs involved. In the past, when some countries have attempted to introduce charge (or fee) schedules in public health facilities, it has often been found that, largely because of the ineffective methods used, the cost of the administrative and accounting mechanisms required to garner and regulate such charges (or fees) has cancelled out the additional income they were intended to generate. On the other hand, the imposition of a schedule of nominal charges (or fees) for a selected range of health goods and services should not only be regarded as a supplementary source of finance but also as an effective way to minimize the waste and excess utilization which usually accompany the provision of totally free health goods and services. Whenever it is decided to introduce a schedule of nominal charges or fees,

special care must be taken to ensure that the charges do not work against the system's prime objective of providing services to disenfranchised groups and to reduce social inequalities.

As Table 8 indicates, in most (13 out of 18) of the Latin American and Caribbean countries with social security systems, per capita expenditures over the past 10-15 years have risen considerably faster than the cost of living. Even in those countries where this has not been the case, the decline has been relatively modest, averaging (unweighted) 13% lower than the rise in the cost of living. The data also tend to highlight how those population groups covered by social security are far more sheltered from the vagaries of economic cycles.

TABLE 8

INDICES OF ANNUAL AVERAGE BENEFIT EXPENDITURE PER HEAD OF THE TOTAL POPULATION
(Values adjusted according to the cost-of-living indices: 1970=100)

	Year					
Country	1960	1965	1970	1975	1976	1977
Argentina	...	...	...	100	85	85
Barbados	...	...	100	169	189	213
Bolivia	70	...	100	113	122	106
Brazil	...	59	100	233	275	291
Canada	52	65	100	157	165	169
Colombia	...	38	100	134	158	173
Costa Rica	41	51	100	189	253	303
Chile	...	37	100	72	81	97
Dominican Republic	...	...	100	162	172	168
El Salvador	73	89	100	105	109	111
Guatemala	79	86	100	104	98	94
Guyana	...	124	100	78	72	68
Haiti	...	...	...	100	101	115
Jamaica	...	96	100	133	190	189
Nicaragua	...	...	...	100	106	95
Panama	34	65	100	101	113	109
Trinidad and Tobago	...	84	100	123	135	154
United States	53	65	100	152	164	169
Uruguay	...	...	...	100	112	109
Venezuela	72	121	100	238	247	260

Source: ILO "The Cost of Social Security," Geneva, 1981

Public (General Government) Health Expenditures

Compared with many other areas of the world it would appear (see Table 9) that the share of total public consumption expenditure devoted to health is relatively high in many Latin American and Caribbean countries, particularly

TABLE 9

TRENDS IN PUBLIC (GENERAL GOVERNMENT) CONSUMPTION EXPENDITURE ON HEALTH AS A PERCENTAGE OF 1) TOTAL PUBLIC (GENERAL GOVERNMENT) EXPENDITURE, AND 2) GROSS DOMESTIC PRODUCT

Country		1960	1965	1970	1975	1976	1977	1978	1979
British Virgin Islands	1	...	...	19.2	21.2	19.3	19.2	...	...
	2	...	...	2.6	2.6	2.8	2.8	...	...
Honduras	1	14.9	13.7	16.9	16.6	...	...	...	...
	2	1.6	1.4	1.9	2.1	...	...	...	...
Jamaica	1	...	...	...	15.5	13.0	12.7	...	...
	2	...	...	...	2.9	2.9	2.8	...	...
Panama	1	21.1	25.4	24.0	25.7	27.3	26.1	28.6	27.8
	2	2.4	2.8	3.5	3.9	4.3	4.1	4.3	4.3
Peru	1	...	...	13.0	11.4	11.0	9.9	12.7	12.6
	2	...	...	1.5	1.5	1.4	1.5	1.5	1.3
Venezuela	1	...	...	19.1	13.5	12.9	12.6	13.1	12.2
	2	...	...	2.5	1.8	1.9	1.9	1.9	1.6
United States of America	1	4.2	4.3	4.9	6.3	6.3	6.3	6.3	...
	2	.73	.72	.94	1.2	1.2	1.2	1.1	...
Tanzania	1	...	5.6	5.5	6.9	7.1	7.1	7.3	5.4
	2	...	1.0	1.3	2.2	1.8	1.8	2.0	2.0
India	1	...	...	5.2	6.1	6.4	6.8	7.0	...
	2	...	...	.41	.53	.56	.57	.61	...

Sources: UN National Accounts Tapes and IMF.

when compared with such countries as Tanzania and India. The relatively low, but gradually increasing, figures for the United States of America reflect the reliance on private health insurance, both profit and non-profit systems. However, the proportion of total public expenditure devoted to health in Jamaica and Venezuela has tended to decline over the past decade. In the case of Jamaica, this is largely a reflection of the overall economic turmoil which the country experienced in the latter half of the 1970's, and in the case of Venezuela, it is largely a reflection of the reordering of government priorities and the growing emphasis on social security institutions. As shown, there are very large variations in the proportion of GDP devoted to public expenditure on health.

TABLE 10

COMPENSATION OF EMPLOYEES AS A PERCENTAGE OF TOTAL PUBLIC (GENERAL GOVERNMENT) HEALTH RECURRENT EXPENDITURES

Country	1970	1975	1979
Peru	64.4	73.9	68.4
Venezuela	86.9	79.0	80.7
British Virgin Islands	73.3	74.6	75.3
India	69.9	63.1	64.5
Italy	(71) 72.5	64.2	(71) 65.0
UK	49.8	56.1	54.5
Finland	...	76.4	76.6
Norway	72.7	77.8	77.9
Sweden	75.4	77.4	(78) 77.2
Spain	69.4	79.4	(77) 88.5

As the data shown above in Table 10 appear to indicate, with the exception of Venezuela (high) and the UK (low), it would not appear that there is a significant difference between the proportions of total public health recurrent expenditures devoted to the compensation of employees in the Americas and the rest of the world. Health services are very labor intensive and there is a growing tendency for them to become even more intensive; for example, according to a recent OECD report, in many countries staff per hospital bed tended to double between 1960 and 1979.

Private Health Expenditure

Of the Region's developing countries shown in Table 11, only Panama appears to have experienced a relatively constant and positive growth in its private health sector expenditures. The data for Canada reflect the growth of government-sponsored health insurance systems; those for the United States of America reflect the growth of private health insurance coverage and the relatively high rate of inflation in health sector costs.

TABLE 11

TRENDS IN PRIVATE CONSUMPTION EXPENDITURES ON HEALTH AS A PERCENTAGE OF 1) TOTAL PRIVATE CONSUMPTION EXPENDITURES, AND 2) GROSS DOMESTIC PRODUCT

Country	1960	1965	1970	1975	1976	1977	1978	1979
El Salvador	3.6	3.4	4.3	4.4	3.9	3.9	...	...
	2.9	2.6	3.3	3.2	2.7	2.5	...	...
Honduras	6.7	6.8	6.6	5.9	...	...	...	...
	5.1	5.0	4.8	4.3	...	...	...	...
Jamaica	2.6	2.9	3.2	2.3	2.0	1.8	...	...
	1.8	2.1	2.2	1.4	1.3	1.2	...	...
Panama	3.1	3.5	4.4	6.1	6.1	5.6	6.0	...
	2.6	2.7	2.8	3.7	3.5	3.7	3.7	...
Venezuela	...	...	4.3	4.3	4.1	3.9	3.7	3.7
	...	...	2.3	2.1	2.0	2.0	2.0	1.9
Canada	6.4	4.5	3.5	3.0	3.2	3.1	3.2	3.1
	4.2	2.7	2.0	1.7	1.8	1.8	1.8	1.7
United States of America	6.6	7.6	9.5	10.9	11.1	11.5	11.4	11.6
	4.2	4.7	5.9	6.9	7.1	7.3	7.3	7.4
Tanzania	...	1.9	2.1	2.3	...	...	...	...
	...	1.4	1.4	1.7	...	...	...	...
India	1.7	2.1	2.1	2.3	2.5	2.3	2.3	2.2
	1.4	1.6	1.5	1.6	1.7	1.6	1.6	1.5

Sources: UN National Accounts Tapes and IMF

Unfortunately, data showing trends in per capita private consumption expenditures at constant prices on health are not available for most Latin American and Caribbean countries. Those data which are available (see Table 12) tend to indicate a more rapid rate of growth in the 1960's than in the 1970's. The declining data for Canada largely reflect the introduction of government-sponsored health insurance systems. Once again Panama exhibits a relatively steady positive rate of growth, whereas the data for Jamaica highlight its declining economic situation in the latter part of the 1970's.

TABLE 12

TRENDS IN PER CAPITA PRIVATE FINAL CONSUMPTION EXPENDITURE ON HEALTH AT CONSTANT PRICES IN UNITS OF NATIONAL CURRENCY

Country	Currency	Constant prices of:	1960	1965	1970	1974	1975	1976	1977	1978	1979
Canada	Dollars	1971	112.0	87.9	81.7	92.9	95.5	102.2	104.0	108.0	105.8
Honduras	Lempiras	1966	21.6	24.3	24.3	23.4	23.0	...	...	...	...
Jamaica	Dollars	1974	...	...	...	23.3	17.8	15.8	14.0	...	...
Panama	Balboas	1960	10.2	12.5	15.0	17.6	18.4	18.1	18.6	18.5	19.5
Venezuela	Bolivares	1957	148.0	163.0	105.0[1]	...	...	...	...	...	...
USA	Dollars	1970	170.0	217.9	285.0	346.1	352.7	370.0	379.6	393.7	...

Source: UN National Accounts Data Tapes
1/ 1969

Table 13 shows the relatively high proportion of private health expenditures as a percentage of total health expenditures in Latin American and several other developed and developing countries. With the exception of Venezuela, there appears to be a gradual decline in the role being played by the private sector. Nevertheless the table indicates that there is still a lot of room for the expansion of the public sector to capture a growing share within the framework of a more effectively organized and efficiently managed public health care delivery system.

TABLE 13

TRENDS IN PRIVATE CONSUMPTION EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL PUBLIC AND PRIVATE CONSUMPTION EXPENDITURES ON HEALTH

Country	1960	1965	1970	1971	1972	1973	1974	1975	1976	1977	1978
Honduras	76.1	78.5	71.4	74.5	71.6	73.5	68.7	67.4	...	...	...
Jamaica	...	...	...	...	...	...	43.4	33.0	32.2	30.0	...
Panama	52.2	49.0	45.2	48.2	49.6	48.9	48.3	48.8	45.3	47.5	46.0
Venezuela	...	...	47.7	47.9	48.1	55.5	53.4	52.2	51.3	51.8	53.0
USA	85.3	86.8	86.4	85.8	85.6	85.4	85.2	85.3	85.9	86.4	86.5
Tanzania	...	56.9	53.0	51.0	53.2	48.9	44.7	43.0	...	...	...
India	...	...	78.7	77.7	77.1	74.9	74.3	70.3	67.7	65.6	63.2
Spain	...	...	81.6	82.7	81.7	80.4	79.4	75.2	73.3	...	...
United Kingdom	16.4	15.0	15.8	13.6	13.0	12.7	10.7	9.2	8.9	9.0	8.7

Source: UN National Accounts Tapes

A recent study of the costs and utilization of health care services in the Organization for Economic Cooperation and Development (OECD) countries[1] indicates that 5% of the population accounts for some 50% of health care costs and that 10% of the population accounts for about 75% of total health care costs; the remaining 90% of the population accounts for only 25% of total health care expenditures. This is not a reflection of inequality in access to health care, but rather of the extremely high costs of certain types of health care. For example, open heart surgery accounts for 7 to 12 years of the contributions to some form of publically or privately sponsored health insurance scheme.

[1] The OECD has 24 members; these include 19 West European countries plus Australia, Canada, Japan, New Zealand and the United States of America.

As can be seen from Table 14 there are wide variations throughout in the proportion of GDP devoted to public and private consumption expenditure on health. Generally speaking, most Latin American and Caribbean countries are much closer to many European countries, e.g. the United Kingdom and Spain, than they are to other developing regions of the world. From the data shown in Table 14 and that available from a number of individual country "case studies" which have been undertaken by a variety of agencies in many Latin American and Caribbean countries, it is evident that, on the average, this Region devotes some 5% of its combined GDP to the health sector. As is also apparent from the data that, with the notable exception of Panama, the proportion of GDP being devoted to health tended to peak out around the middle of the 1970's. With the exception of the United States of America, a similar tendency is apparent from the data for a number of the world's industrialized countries, including Canada.

TABLE 14

TRENDS IN PUBLIC (GENERAL GOVERNMENT) AND PRIVATE CONSUMPTION EXPENDITURE ON HEALTH AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT[1]

Country	1960	1965	1970	1971	1972	1973	1974	1975	1976	1977	1978
Honduras	6.9	6.4	6.8	6.3	6.5	6.1	6.3	6.4	...	...	...
Jamaica	...	...	...	...	...	...	4.7	4.3	4.2	4.1	...
Panama	5.0	5.5	6.3	6.6	7.5	7.3	7.0	7.6	7.8	7.7	8.0
Venezuela	...	...	4.9	4.6	4.7	3.8	3.1	3.9	4.0	3.9	4.0
USA	4.9	5.5	6.9	7.2	7.3	7.4	7.7	8.1	8.2	8.4	8.5
Tanzania	...	2.4	2.7	3.2	3.0	3.1	3.3	3.9	...	...	...
India	...	...	1.9	2.2	2.1	1.9	2.0	2.1	2.3	2.2	2.2
Spain	...	...	3.9	4.4	4.6	4.8	5.0	5.5	...	...	...
United Kingdom	3.8	3.8	4.2	4.3	4.4	4.3	4.9	5.2	5.1	5.0	5.1

Source: UN National Accounts Tapes

[1]Note: These percentages would be somewhat higher (generally 5-10% higher) if expenditures on capital account were included.

As Table 15 highlights, there are no clear-cut trends in the share of total private consumption expenditures devoted to health. The UK's relatively small proportion is the reflection of the scope and coverage of the country's National Health Service. The data also indicate that in many developing countries throughout the world, private expenditures on health appear to be outranked by expenditures for alcoholic beverages and tobacco. In some countries this is partly a reflection of the role such commodities play in the generation of indirect taxes and government revenues as well as the role of public government agencies in the provision of health care. In many countries, however, the data reflect consumer preferences and highlight the availability of private discretionary income which could be used for more healthy, if not more pleasurable: goods and services. It might be pointed out that, over the past decade, in many developing countries a phenomenal growth has taken place in the production and consumption of alcoholic beverages, especially beer. This growth has far outstripped the growth of other sectors of these countries' economies.

Over the coming decade it is believed that one of the most difficult problems that will be faced by many Latin American countries in their attempt to streamline their existing health programs and extend their coverage will be that of coordinating all public and social security activities in the health sector. In most countries, besides the many social security institutions, there are a host of public and paragovernmental agencies which are active in the health field. The end result is that there currently exists a fragmentation of health resources among numerous administrative entities. This fragmentation of the health sector is frequently detrimental to the development and implementation of comprehensive national health policies and often gives rise to very serious problems stemming from overlapping jurisdictions and interagency conflicts.

TABLE 15

TRENDS IN PRIVATE CONSUMPTION EXPENDITURES AT CURRENT PRICES ON 1) FOOD; 2) HEALTH; 3) ALCOHOLIC BEVERAGES; AND 4) TOBACCO, AS A PERCENTAGE OF TOTAL PRIVATE CONSUMPTION EXPENDITURES

Country			1960	1965	1970	1975	1976	1977	1978	1979
Honduras	1	Food	40.5	40.3	39.3	44.1	...	...	...	...
	2	Health	6.7	6.8	6.6	5.9	...	...	...	...
	3	Alcohol[1/]	5.3	5.7	6.4	6.9	...	...	...	...
	4	Tobacco	1.3	1.5	2.1	2.5	...	...	...	...
Jamaica	1	Food	36.4	32.7	30.5	35.4	33.8	35.1	...	...
	2	Health	2.4	2.8	3.2	2.3	2.0	1.8	...	...
	3	Alcohol	6.2	6.8	5.9	3.7	3.8	3.8	...	...
	4	Tobacco	3.3	3.9	4.2	4.5	4.9	4.8	...	...
Panama	1	Food	39.8	41.3	47.4	59.2	54.8	48.6	51.4	...
	2	Health	3.1	3.5	4.4	6.1	6.0	5.6	6.0	...
	3	Alcohol	6.5	4.8	5.2	4.4	4.7	3.9	4.3	...
	4	Tobacco	2.2	1.9	2.1	2.1	2.2	2.1	2.1	...
Venezuela	1	Food	37.6	36.7	...	...	...	...	...	...
	2	Health	7.8	8.0	4.3	4.3	4.1	3.9	3.7	3.7
	4	Tobacco	2.6	2.8	...	...	...	...	...	...
Canada	1	Food	18.9	17.5	15.9	15.9	15.1	14.9	15.3	15.4
	2	Health	6.4	4.5	3.5	3.0	3.2	3.2	3.2	3.1
	3	Alcohol	3.6	3.7	3.8	3.7	3.5	3.4	3.3	3.2
	4	Tobacco	2.9	2.9	2.8	2.1	2.1	2.1	2.1	2.1
USA	1	Food	17.0	15.2	14.3	13.7	13.2	12.8	12.6	12.7
	2	Health	6.6	7.6	9.5	10.9	11.1	11.5	11.4	11.6
	3	Alcohol	2.0	1.8	2.0	1.9	1.8	1.7	1.6	1.6
	4	Tobacco	2.1	1.9	1.7	1.5	1.5	1.4	1.3	1.3
Tanzania	1	Food	...	45.3	51.1	57.9	...	...	...	...
	2	Health	...	1.9	2.1	2.3	...	...	...	...
	3	Alcohol	...	3.8	3.5	4.4	...	...	...	...
	4	Tobacco	...	1.6	1.0	2.6	...	...	...	...

TABLE 15 (cont.)

Country			1960	1965	1970	1975	1976	1977	1978	1979
India	1	Food	65.7	64.9	63.0	61.4	58.2	59.1	57.2	55.5
	2	Health	1.7	2.1	2.1	2.3	2.5	2.3	2.3	2.2
	3	Alcohol	1.0	0.96	1.8	1.3	1.4	1.4	1.5	1.2
	4	Tobacco	4.7	3.2	2.8	2.6	2.5	2.5	2.4	2.2
Spain	1	Food	51.4	39.3	33.2	32.1	31.4	...	...	...
	2	Health	2.3	3.0	4.7	5.5	5.9	6.0	...	...
	3	Alcohol	2.0	1.7	1.6	1.4	1.2	...	...	...
	4	Tobacco	1.9	1.5	1.6	1.3	1.2	...	...	...
United Kingdom	1	Food	31.9	28.9	26.2	24.5	24.7	24.7	24.1	...
	2	Health	0.94	0.89	0.93	0.78	0.77	0.76	0.72	0.74
	3	Alcohol	1.1	1.2	1.4	1.9	2.1	2.0	2.1	...
	4	Tobacco	5.8	5.4	4.6	3.7	3.6	3.6	3.5	...

Source: UN National Accounts Tapes, 1974.
[1] Includes non-alcoholic as well as alcoholic beverages.

Over the past two decades, problems of this nature have become so endemic that throughout much of the Region it often appears that no single governmental body has a clear-cut and overriding responsibility for national health, or the development and execution of a national health policy covering the entire population. Each of the many central, regional and local government agencies, and the many social security institutions active in the health field, operate programs serving different population groups. To a large extent, the only common thread that has appeared in a number of countries is that the Ministry of Health and its regional counterparts appear to have been assigned a primary responsibility for collective preventive measures, and the social security institutes have restricted their responsibilities to individual curative activities.

In a number of countries this proliferation of health responsibilities has also led to considerable duplication of effort in the provision or care. It is not unusual to find several different agencies operating health facilities in close proximity to one another while other areas go unserved. Nor is it unusual to find that hospitals and other health facilities are constructed without sufficient attention being given to the need to provide them with adequate operating budgets to cover not only staff salaries but also needed drugs and other medical supplies, as well as repairs and replacement equipment.

Fortunately, it appears that a growing number of governments have recently started to take the necessary action to reduce this fragmentation policy and regain effective control. Frequently this is being accomplished by assigning overall responsibility to the Ministry of Health, or by establishing a coordinating council at the national level, and, sometimes, by a combination of both these approaches.

In addition to the savings which could be derived from better coordination and a clearer delineation of responsibility and authority in the health care delivery systems in many countries, considerable savings could also be made at the micro-level by improvements in medical and administrative management. For example, in the area of reductions in health service unit costs, it is at the facility level (i.e. hospitals, health centers and health posts, etc.) that many countries could derive substantial savings. A pragmatic starting point could be to determine the most economic treatment procedures for common conditions (i.e. appropriate prophylactic, symptomatic or curative procedures) by comparing the efficacy, safety and economy in use of several alternative methods. Appropriate information and persuasion to introduce revised procedures could lead facilities to provide better care at lower costs.

Improvements in the triage of outpatients can lead to significant increases in patient flows and thus allow health personnel to treat more patients at a lower cost per unit of service. In some Latin American countries the average length of stay in hospitals, particularly general hospitals, appears longer than is considered necessary in most other parts of the world.

In these countries the costs per patient discharged when expressed as a proportion of average annual per capita income is often high even though the average cost per inpatient day when measured in the same terms is not greatly different to that prevailing in other parts of the world. In this respect, it is unfortunate that, whereas many countries have adopted ratios and goals for the provision and utilization of health care, they have not established a schedule of unit costs which corresponds to these ratios and goals, as this could allow them to see their future resource needs in a much clearer perspective. A somewhat cursory analysis of some of the fragmentary cost data supplied by a few countries appears to indicate that, unless in coming years several of these countries are able to considerably reduce a number of their unit costs, the attainment of health for all will require a doubling or tripling of the proportion of GDP devoted to health. In one of these countries, for example, it would appear that, based on current unit costs, the country would have to devote close to 16 per cent of its GDP to provide health for all. In another country, the cost of each general hospital discharge was equivalent to almost half the average annual per capita income.

Generally speaking, it would appear that a renewed emphasis on prophylactic measures and more intensive use (increasing occupancy rates and higher turnover rates) of existing hospitals and other facilities coupled with lower unit costs would in a number of countries help alleviate some of the need for additional new facilities and generate savings that could be used in extending health coverage.

In brief, while the information contained in this report and that available from other official sources would appear to indicate that health for all by the year 2000 is an attainable goal, it also highlights a number of steps that will have to be taken in its pursuit.

At the national level these usually include, but are not limited to, enhanced intersectoral collaboration, greater equity in income distribution, and generation of additional public revenues. Within the health sector these usually include, but are not limited to, greater intrasectoral coordination; expansion in the coverage of the organized sector; improved control and management; increased efficiency in the utilization of existing resources; improvements in the organization and delivery of care; greater collectivization of public and private expenditures; improvements in cost accounting; experiments in modified delivery systems; and new approaches to providing and financing health services.

III. TRENDS IN THE ALLOCATION OF EXTERNAL RESOURCES FOR HEALTH AND OTHER SECTORS IN LATIN AMERICA AND THE CARIBBEAN

The challenge of achieving HFA-2000 will require substantial increases in the amount of resources presently going into the health sector. What are the perspectives for additional resources? While it is impossible to see what will occur by the year 2000, recent trends provide insight into the next few years. Despite the dramatic increase in petroleum prices in 1973 and other untoward economic developments, total overall resource flows to developing countries grew rapidly throughout most of the 1970's. In terms of constant 1979 prices, they increased from $48,150 million in 1970 to $88,230 million in 1978. But in 1979 they declined to $83,750 million and then to $80,240 million in 1980. Most of the decline is due to the shrinkage in nonconcessional (hard)[1] resource flows. These flows account for the vast bulk (over 92%) of all the external resources received in this Region and are largely composed of loans from US and West European banks. Worldwide concessional (ODA) resource flows, in constant 1979 US dollars, after having grown from just over $20,000 million in 1970 to about $28,000 million in 1975, reached over $30,000 million in 1980, mainly due to an increase of some $2,000 million in US concessional assistance. Figures for 1981 are not yet available.

Generally speaking, the outlook for increases in concessional aid from the members of the OECD does not look very promising. As this organization recently said with regard to the outlook of its members' multilateral aid activities, "the signs of reversal of the rising trend which appeared in 1980 and early 1981 were evidence of a state of affairs which was already well entrenched.... The grounds on which it had seemed reasonable to argue in 1980 that the rising trend was still solidly established were illusory." Fortunately perhaps, as Table 16 shows, for Latin America and the Caribbean as a whole net disbursements of official development assistance represent a very small and declining share of their combined GNP.

TABLE 16

NET DISBURSEMENT OF OFFICIAL DEVELOPMENT ASSISTANCE (ODA) TO ALL SECTORS AS A PERCENTAGE OF TOTAL LATIN AMERICAN AND CARIBBEAN GNP

Year	From OECD/DAC Countries	From All Multilateral and Bilateral Sources
1973	0.37	0.53
1975	0.36	0.53
1976	0.34	0.47
1977	0.30	0.43
1978	0.31	0.45
1979	0.33	0.46
1980	0.30	0.45

Sources: OECD and World Bank

[1] Loans with a grant element of 25% are defined as concessional. Generally speaking, a loan will not convey a grant element over 25% if its maturity is less than 10 years, unless its interest rate is well below 5%.

The conclusions of the OECD are highlighted by the United States' recent Congressional Budget requests for the Agency for International Development, a major contributor to OECD's bilateral and other multilateral aid activities. In FY1983, the health sector is projected to receive 6% of its total foreign aid to Latin America and the Caribbean as compared to 15% in FY1980. Most bilateral and multilateral aid agencies are giving increasing attention to the needs of China, India, Africa (especially the Sahel) and the world's other least developed countries (LLDC's), and show a growing emphasis for the energy, food and agricultural sectors.

Of OECD countries' total bilateral concessional disbursed aid, Latin America and the Caribbean received 12% in 1980 as compared to 12.3% in 1977. Over recent years OECD countries' bilateral sectoral commitments for health care have tended to decline, from 7.2% of the total in 1974 to 6.3% in 1979 and, because of an unusually large increase in USAID health commitments, to 7.0% in 1980.[1] OECD's definition of middle-income developing countries is those with an income above $500 per capita in 1979, IBRD's is above $370 per capita.

After the OECD member countries, the next biggest source of concessional aid is the OPEC[2] countries. OPEC countries' bilateral aid programs are heavily concentrated on the other Arab countries (especially the "confrontation states").[3] In total, Arab countries received over 80% of the net bilateral disbursements in 1980. Latin America and the Caribbean received $17 million or 0.3% of their net bilateral disbursements in 1980. From multilateral Arab/OPEC sources, Latin America received $6 million, or 2.3% of their total net disbursements.

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1 These figures exclude data for France and commitments for water and sanitation. In OECD/DAC reports, France has, since 1975, appeared to be the largest provider of bilateral aid to the health sector. For example, according to a communication from DAC's Secretariat, in 1980 France's bilateral commitments for health were US$442 million, as compared to DAC'S figure of $430 million for the United States of America. But the French data included $391 million in grants, "the bulk of or totality of which relate to transfers to overseas departments and territories." This is similar to the United States of America, including Hawaii, Alaska and Puerto Rico, etc., in its foreign aid data. Moreover, the French data also include "social security (illness) transfers." Hence, their non-comparability with the data for other countries. The data do include health care, nutrition and population expenditures for all other OECD/DAC countries.

2 Saudi Arabia, Kuwait, UAE, Iraq, Qatar, Libya, Ecuador, Venezuela, Algeria, Nigeria and Iran, and their multilateral aid agencies.

3 Namely (Syria and Jordan), Gaza, the West Bank and Palestinian Refugees in Lebanon obtained $2,600 million or 43%; Morocco, 7%; and Yemen (AR), 5%.

Venezuela was, in 1980, the only OPEC country that made commitments of concessional funds to the IDB.

The health sector has always played a very minor role in the sectoral distribution of OPEC countries' total bilateral commitments. In 1978 it accounted for 0.5% of such commitments.

Non-military concessional aid from countries in the Council for Mutual Economic Assistance (CMEA)[1] has always been comparatively minor, and in 1980 totaled only 5% of worldwide concessional aid. In 1980 some 95% of CMEA aid was extended to PDR Korea, Viet Nam, Cuba, Kampuchea, Afghanistan, and Laos.

As is well known, in fiscal year 1981 the World Bank (IBRD) made only one (hard) health care sector loan: $12.5 million to Tunisia for a family planning and health care project. The IDB also made only one health care loan, of $20.5 million, in 1981, which went to the Dominican Republic. Both Banks, however, made a number of loans to PAHO countries for water and sanitation projects. Moreover, both banks have over the past few years made a number of health care and water and sanitation component loans within the Region. In 1981, for example, the IDB made one health care component loan for $3 million, and the World Bank, five such loans in Latin America and the Caribbean for $42 million.

There is also growing concern that in real terms external assistance and national funding for water and sanitation may be starting to decline or stagnate. If this continues and becomes more widespread, it jeopardizes the goals of the UN Water Decade and impacts on the goals of HFA/2000. At one of the recent PAHO-sponsored seminars on the implementation of the Plan of Action for HFA/2000, a representative from the World Bank said that, over the last two years, there has not been any "enthusiasm for borrowing for water supplies, sanitation, health, nutrition or family planning. Water supplies and sanitation are areas in which the political appeal and political payoff of expenditures is relatively modest. People are not acutely aware and concerned about the importance of water supply and sanitation." He went on to state that people appear to be more concerned about the consumption of other essential ("food") and non-essential commodities, transistor radios, alcohol, and tobacco. He also mentioned the negative impact on governments of rising interest rates on international loans and the resulting debt servicing problems, especially in an era of worldwide recession.

In 1981 the IDB's aid to the developing countries of the Americas was $2,493 million, a paper increase of 8% over 1980's $2,309 million, but in constant dollars this really represented a decrease of some 2%. When coupled with population growth, IDB's aid declined by about 5% in real per capita terms. Health care projects, water and sanitation declined in current dollars from $244 million in 1980 to $208 million in 1981. But in real per capita terms, this decline was equivalent to almost a 30% cut. One may hope this decline is merely a transitory reflection of more careful scrutiny being given to external borrowing than the beginning of a trend.

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1 The USSR and other East European Countries with centrally planned economies.

Generally speaking, the countries of the Region tend to receive relatively little in the way of assistance from the major UN specialized agencies. For example, in 1981 only 1.0% of UNICEF's health expenditures were allocated to this Region.

One of the main reasons that Latin America and the Caribbean have received so little in the way of concessional aid over the past several years from either bilateral or multilateral sources is the relatively high national average per capita income of most of its constituent countries, which essentially makes them ineligible for such aid. Virtually all of PAHO's Members are considered middle-income countries. Thus, despite the fact that because of the prevailing inequities in income distribution well over 100 million, if not nearer 150 million,[1] of this Region's inhabitants may be said to live in what the World Bank terms "absolute poverty," it receives very little in the way of concessional aid.[2]

The 1981 report of the British Overseas Development Administration (ODA) states "The British Government is providing generous support to those international organizations which give special consideration to the needs of low income countries...." It also states that an ever-increasing amount of British bilateral aid is being channeled to these countries. This is but one example of the policy being adopted by virtually all multilateral and bilateral aid agencies. Canada's aid agency (CIDA) report mentions the same emphasis.

As the figures in Table 17 show, there are large variations in the per capita concessional aid received by different countries and territories in Latin America and the Caribbean. Generally speaking, the large countries tend to receive smaller amounts and the small countries or areas the largest amounts. The 1980 overall per capita average for Latin America and the Caribbean was about $5; that for Africa was about $15.

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1 Based on PAHO's own calculations, there are well over 100 million people living in absolute poverty in this Region. Besides those living in marginal urban slums, ECLA estimates that at least half the rural population lives in absolute poverty. Thus, it would be more accurate to say that today some 150 million people live in such poverty.

2 Mr. McNamara, former President of the World Bank, in 1973 defined absolute poverty as "a condition of life so degraded by disease, illiteracy, malnutrition, and squalor as to deny its victims basic human necessities." More conventionally it has come to mean a level of income in cash or kind so low as to barely support human subsistance. The IDB also uses a very pragmatic and meaningful approach to defining low-income or poverty groups in different countries. Their definitions are based on "the cost of providing a minimum nutritional requirement--or food basket--in each country, and take into account such essentials as clothing, housing and transportation."

TABLE 17

PER CAPITA ANNUAL AVERAGES (1976-1978) OF TOTAL CONCESSIONAL AID, FOR ALL PURPOSES AND SECTORS, FROM DEVELOPED MARKET ECONOMIES AND MULTILATERAL INSTITUTIONS

Country	US$	Country	US$
Argentina	1.18	Guyana	21.32
Bahamas	3.77	Haiti	17.39
Barbados	32.40	Honduras	19.00
Belize	87.60	Jamaica	28.57
Bermuda	1.17	Martinique	658.44
Bolivia	17.10	Mexico	0.68
Brazil	0.89	Netherlands Ant.	185.20
Chile	0.85	Nicaragua	16.99
Colombia	2.65	Panama	19.93
Costa Rica	16.16	Paraguay	15.61
Cuba	4.17	Peru	6.33
Dominican Rep.	7.69	St. Pierre & Miquelon	3614.00
Ecuador	7.63	Suriname	233.51
El Salvador	10.23	Trinidad & Tobago	4.46
French Guiana	1265.00	Uruguay	3.61
Guadeloupe	521.70	Venezuela	-0.43
Guatemala	10.30	West Indies[1]	69.44

Source: UN 1979/80 Statistical Yearbook

1 Antigua, British Virgin Islands, Cayman Islands, Dominica, Grenada, Montserrat, St. Kitts-Nevis, Anguilla, Saint Lucia, St. Vincent and the Grenadines, Turks and Caicos Islands

When one looks at the list of agencies from which Latin American and Caribbean countries have obtained external assistance, one is first struck by their range and diversity, as almost every bilateral and multilateral public source is mentioned, and second by the terms. By far the largest proportion of external financial resources obtained by most countries in Latin America and the Caribbean is obtained on "hard" terms. The external debt of Latin America and the Caribbean has increased over sixfold since 1971, from $25,110 million to $165,379 million in 1980, and whereas in 1971 it represented 32 per cent of the total for the developing world, by 1980 it was 38 per cent. But it is, as Table 18 indicates, the changed terms of this debt which highlights the Region's vulnerability and potentially the biggest detriment to the placement of health sector loans.

TABLE 18

CHANGED STRUCTURE OF LATIN AMERICAN AND CARIBBEAN DEBT

Type of Loan	1971	1980
Concessional Loans	26.0%	7.7%
Fixed Rate Loans	66.6%	33.8%
Variable Interest Rate Loans	7.4%	58.5%
Grant Element (all creditors)	15.4%	-4.9%

Source: IBRD World Debt Tables, December 1981

Variable interest loans are loans with interest rates that float with movements in a key market rate: for example, the London Interbank Offered Rate (LIBOR) or the US prime rate. Developing countries are usually charged an additional premium, supposedly because of the greater risk involved to investors. Of the 15 developing countries in the world with the largest debt servicing payments, six of them are in Latin America: Brazil, Mexico, and Venezuela have the three largest debt service payments; Argentina ranks 9th; Chile, 11th; and Peru, 13th. According to the OECD, in 1981 some developing countries were paying 18 per cent interest on their external loans. The current World Bank rate is 11.6 per cent interest plus a 1.5 per cent fee. There is also a 3-1/4 per cent commitment fee on the undisbursed portion. It appears from World Bank debt data that in 1980 some Latin American and Caribbean countries were already paying interest rates of 16 per cent and more to their private creditors. Even the grant element of Haiti's debt declined from 71 per cent to 46 per cent in 1980 and the average interest rate from private creditors was 12 per cent in 1980. The terms of Brazil's external debt also changed significantly in the 1970's. In 1971, 36 per cent was concessional and only 16 per cent was at variable rates, while by 1980 concessional loans were all the way down to 4 per cent and variable interest rates represented 63 per cent of the country's total outstanding disbursed debt. Over the same period, the country's debt had risen from US$6,441 million to $54,865 million, and the cost of its total debt servicing from $493 million to $8,066 million.

In 1980, on a worldwide basis, external assistence for health, family planning and nutritional supplements as well as water supplies and sanitation totaled almost $5,100 million. This sum was provided by both

private and public agencies on both concessional and non-concessional terms. External assistance for urban water supplies and sanitation represented some $1,500 million. PAHO's share of these funds represented 9% of the total. In the field of health, family planning and nutritional supplements the OECD/DAC members provided on a bilateral basis the largest share. The next largest group of donors were nongovernment organizations (NGO's) followed by multilateral agencies. In the field of water supplies the multilateral agencies (mainly the development banks) provided the largest share, next came the OECD/DAC countries, followed by the NGO's. Neither the CMEA or OPEC countries provided significant sources of finance in these areas.

Only about 1 per cent of this Region's total expenditure on health care and rural water and sanitation systems is currently externally financed. As mentioned earlier, this is partly a reflection of the countries themselves not wishing to seek external funds for such purposes (in the report of a recent World Bank mission to one of the countries in this Region it is pointed out that the Government is unwilling to use external loans for health and other social sectors), and partly it is due to the specific policies of many of the donors mentioned.

There are other reasons why countries are reluctant to seek external aid for such projects:

- There is a relatively high ratio of recurrent costs associated with many investments in health services, ranging from around 20 per cent to upwards of 70 per cent, according to a World Bank study. Usually the recurrent expenditures generated per unit of capital input in the health sector are higher than in most other sectors. Some health projects also require substantial imports of health supplies and equipment as well as spare parts for their ongoing operations.

- Some countries lack the absorptive capacity to expand their health services without creating increasing inflationary pressures within the health sector due to shortages in appropriate personnel and supplies.

It is believed that many of these problems can be overcome, for example, by countries including requests for health component loans in a larger number of their overall agriculture and industrial proposals. Countries could also request funds to help cover, on a declining basis, the recurrent costs for several years after a project has become operational. There is increased recognition of the need for such funds by most external funding agencies. Other measures include restructuring health care delivery systems to make them more cost-effective; expansion of social security systems; and reorganization and increased integration of the unorganized private sector.

This quick review of recent trends leads to the conclusion, that at least in the next few years, the attainment of HFA/2000 in Latin America and the Caribbean will be essentially dependent on the mobilization and utilization of national, public, and private resources rather than external resources. As stated at last year's meeting of the Directing Council, PAHO stands ready to assist countries and has established an Office of Resource Mobilization. Its main responsibilites will be to cooperate with Member Governments in generating and making effective use of information on the costs and sources of financing of national health services. It will also help chart suitable strategies for generating new domestic sources of financing. It may, of course, work with the Member Governments to obtain appropriate financial cooperation on the international scene, especially on favorable terms. When we know more about the use now being made of public and private domestic resources allocated to the attainment of health for all, both PAHO and its Member Governments will be in a better position to take sound decisions on the use of international financial cooperation and on the recurrent costs such investments entail. External funds can be used more sensibly and to greatest effect when a country knows how its own domestic funds are being used.

In a similar vein it is also expected that better management and organization will lead to the more effective use of resources. Countries also need to develop unit cost data, as such data can highlight cost differences for the same or similar procedures provided by various types of facilities. For example, the existing unit costs in one of the countries of the Region imply that it would absorb 16 per cent of its GDP to attain HFA/2000. Another recent study found that the unit costs of outpatient services provided by hospitals were lower than those provided by rural clinics. Available evidence strongly suggests the urgent need to strengthen and reorient the national evaluation and monitoring systems, duly complemented by evaluative research on the health systems and their services, as well as the development and use of appropriate technology in order to maximize the effectiveness and efficiency of the resources available to the health sector.

In brief, for the vast majority, if not all the developing countries in this Region, it is probably not how a country obtains and uses external financing that will decide the outcome of HFA/2000, but rather how effectively a country identifies, mobilizes and utilizes its own national resources. It is hoped that this is an area in which PAHO will in the future be able to cooperate more actively with many of its Member Governments.

However, external resources may in some countries also play key catalytic roles in helping to take new initiatives aimed at promoting changes in the structure and priorities of the health system.

It must be remembered, however, that the above financial requirements are based on extrapolations of actual trends in disease patterns, population growth, and available technology. If in fact these were the circumstances,

the panorama would be discouraging. Fortunately the health sector will not have to do this alone. It is expected that progress in the other social sectors of the countries will greatly contribute in reducing disease patterns; for instance better nutrition, potable water, improved housing and education, and more employment opportunities all will affect favorably the health status of the population. Within the health sector itself more intensive use of available resources, such as shorter stays in hospitals, etc., would certainly lessen the need for resources. In connection with appropriate technology, for example, a water and sanitation economist at the World Bank recently stated that the technology may soon exist to reduce capital investment costs in water and sanitation by two-thirds.

IV. COST ESTIMATES OF HEALTH FOR ALL IN THE DEVELOPING COUNTRIES OF THE AMERICAS

The Secretariat, in collaboration with the Inter-American Development Bank also estimated the additional costs of attaining HFA/2000 in Latin America and the Caribbean. It is estimated that in constant 1980 US dollars, $117,000 million will be required in capital outlays for water and sanitation, and $61,000 million for the capital costs of health care, including malaria and the Expanded Program on Immunization (EPI) activities, etc. This is equivalent to an average of almost $9,000 million a year in capital outlays.

By the year 2000, these capital outlays will generate $17,600 million a year in recurrent costs for water and sanitation (of which it is anticipated that at least $11,600 million will be accounted for by user charges). For health care, we estimate the additional recurrent cost will be around $18,000 million. Thus, by the year 2000, recurrent health care costs should be around $50,000 million a year (including the $32,000 million being spent on health in 1980); water and sanitation will add $6,000 million in recurrent costs; and capital costs for health care, water and sanitation, etc., will add from $3,000 million to $6,000 million to these figures. This represents a total national (public and private, capital and recurrent expenditure) on health, rural water supplies and sanitation of around $60,000 million a year by the year 2000. The role of social security institutions could be crucial in the financing of many health care capital and recurrent costs.

WHO/Geneva has developed very much lower estimates of the costs of HFA/2000. One reason for the contrast between WHO's HFA/2000 cost estimates and those of PAHO stems from the fact that the primary health care (PHC) services provided in this Region will be of a different nature from those provided in many other developing areas of the world. In this respect, it hardly needs to be mentioned that this Region is already relatively well endowed with health (except nursing) personnel and health facilities. For example, according to recently published WHO statistics, the Southern Cone of the Americas has one physician for every 659 inhabitants, whereas Eastern

Africa has one physician for every 17,480 inhabitants. In other terms, the Southern Cone has 27 times as many physicians as Eastern Africa. Moreover, there is nearly a tenfold apparent difference in the per capita incomes of the two areas. As mentioned above, there are countries and areas within PAHO that are not so well endowed. The Caribbean and Central American countries, for example, have on an average about 1,500 inhabitants per physician and considerably lower average per capita incomes. Total Latin American and Caribbean expenditures of some $8,000 million in 1981 on pharmaceuticals and other health related products was, for example, probably higher than total health care expenditures of the more than 360 million people living African countries. PAHO's minimum goals vary considerably from those selected by WHO, e.g. life expectancy at birth, PAHO 70 years, WHO 60 years; infant mortality per 1000 live births, PAHO 30, WHO 50. PAHO's goals, as one would expect, also tend to be more complex or sophisticated and somewhat closer to those of WHO/EURO. Growing urbanization is also another important factor influencing health care delivery systems in this Region. By the year 2000, three quarters of this Region's total population will live in urban communities.

Moreover, when it comes to the implementation of programs and the mobilization of resources for the attainment of HFA/2000, Latin America and the Caribbean are faced with the need to confront and overcome a broader array of health and socioeconomic problems than most developing areas of the world.

For example, the spectrum of major diseases that will have to be overcome ranges all the way from the parasitic and communicable diseases that are common to the majority of developing countries (not to mention some that are virtually unique to the "New World" (e.g. Chagas' Disease) to the chronic and degenerative diseases of later life that take such a heavy toll in the "old world." For example the 1980 Annual Report of the Director of PAHO mentions that "malignant neoplasms have been identified as the second most frequent cause of death in 30 of 37 American countries and territories."

Although, given the current status of the world economy, the figure of $60,000 million a year may seem somewhat awesome, representing as it does a virtual doubling of the amount being spent on health care in 1980, it appears that HFA/2000 lies within the Region's grasp.

PAHO estimates that even if the Region's real annual GDP growth rate is as low as 4%, and only 4-5% of the total GDP is devoted to the health sector, then, if these financial resources are effectively and equitably utilized, HFA will be attainable. For some of the Region's countries which are not so well developed, it is obvious that significant amounts of external aid will be required to achieve comparable levels of health care throughout the Region. Hopefully, with the rapid economic growth of a number of the Region's newly industrializing countries, a considerable amount of this assistance can be provided from within the Region, current precedents being the aid programs of Venezuela, Mexico and Trinidad and Tobago in the field of oil imports.

The average growth rate of Latin America's and the Caribbean gross domestic product (GDP) was over 6% per year throughout the 1970's, whereas in 1980 it fell to just over 3% before falling to just over 1% in 1981. There are however a number of experts who believe that with the bottoming out of the recession in the United States of America and many of the West European countries, the developing Americas may by the mid 1980's see a return to annual growth rates of 6% a year or even higher.

V. ESTIMATE OF THE INVESTMENT IN HEALTH FACILITIES FOR THE PERIOD 1981-2000 NECESSARY TO ATTAIN THE GOAL OF HEALTH FOR ALL BY THE YEAR 2000 (HFA/2000) THROUGH THE PRIMARY CARE STRATEGY

The purpose of this section is to set forth an estimate of the necessary capital investments in hospitals and other health facilities and recurrent costs to attain the goal of HFA/2000 and the regional characteristics of the primary care strategy.

There is no comprehensive and readily available information concerning HFA/2000 that would be useful for the regional analysis of physical and financial resources required. It is therefore necessary to construct estimates based on pragmatic assumptions and recent cost data developed by the IDB.

The magnitude of the goal of HFA/2000 and the regional characteristics of the primary care strategy will make it necessary for countries to modify their current approaches to the delivery of health services. They will have to develop and implement new procedures and appropriate technologies that will substantively alter their current health production functions and the quantity and structure of the physical, human, and financial resources that are required. It will therefore be impossible to give an exact estimate, in absolute and relative financial terms, of the resources that will be required in order to attain the goal until the countries have developed new approaches and production functions that will maximize the effectiveness of the resources to be utilized, to bring about the desired anticipated status, in accord with each country's particular characteristics.

Notwithstanding the above statement, an analysis of the primary care strategy as it has been defined by the countries, together with the experience gained during the last eight years in the development of the extension of coverage in the Region, makes it possible to assume with a degree of certainty that:

1. It will be necessary to maintain or to expand the existing hospital capacity in a country whenever an increase in the access of the unserved or underserved population to primary and less complex services engenders an increase in the demand for services of greater complexity. Currently some 65%

of the population reside in urban centers of more than 20,000 inhabitants (it is expected that, by the year 2000, 76% of the population will be urban), and the profile of health needs is changing, with more problems emerging that require a higher degree of sophistication of resources for their appropriate treatment (cardiovascular diseases, tumors, etc.).

2. Unorthodox solutions for expanding coverage through minimum care delivered by the "informal sector," i.e., rural assistants, lay midwives, etc., necessarily involve expansion of the health facilities of the more formal or institutional sector as indispensable technical and logistic support to the activities of the "informal providers."

3. The changes in procedures and technology required by the primary care strategy will affect both the structure of production, in regard to human resources, supplies, technology, and the organization and administration systems, and also the quantity, quality and structure of the services provided, as well as the total number of beds and minimum health facilities needed.

4. The hospital establishments in the Region show, on the average, a strong degree of obsolescence due to old age, lack of maintenance and poor design. (It is estimated that 50% of the beds are obsolete.) Experience in the Region indicates that the hospitals in urban centers, even with the effective coordination and organization of peripheral satellite clinics, would have to carry out functions similar to those of rural basic health facilities, depending on the scope and features of the primary care strategy. These support functions involve the care of cases referred by basic facilities for diagnosis and/or treatment, as well as supervision and logistical support.

5. Moreover, analyses undertaken in some countries show that a nursing auxiliary (the most frequent principal resource for basic health facilities) cannot carry out useful activities for a population in access of 3,000 people.

6. Consequently, the following basic assumptions are proposed with regard to the method for estimating the investment needed for the periods 1981-1990 and 1991-2000:

6.1 Maintenance of the current ratio of beds per population (3 beds per 1,000 population).

6.2 Replacement of 50% of the existing beds which are obsolete, with estimation of the resources needed to provide adequate maintenance.

6.3 Attainment of a ration of one minimum unit for every 3,000 rural inhabitants.

6.4 It is assumed that the replacement of obsolete beds and the achievement of the goal of one basic health facility for every 3,000 rural inhabitants will be accomplished during the relatively earlier stages of the programs, given the need to reach, as quickly as possible, total coverage.

6.5 The situation in 1980 indicated that a group of 13 countries, whose population corresponded to 49% of the Latin American and Caribbean total, have yet to attain the regional average of 3.0 beds per 1,000 inhabitants. In order for these countries to attain the average level, it will be necessary to provide approximately 245,000 more beds, in addition to those required by the growth of the population and obsolescence. It is probable, therefore, that the investments with regard to hospital beds in that group of countries will represent a high percentage of the total investment proposed for the Region.

6.6 The average unit costs used in the estimate were those utilized by IDB in 1980: $45,000 per general bed and an average of $40,000 per health post/center (they include the cost of construction, as well as fixed and mobile equipment, in 1980 dollars). Annual recurrent expenditures were estimated to represent 30% of the cost of the investment.

6.7 The estimates corresponding to malaria, immunization, water, and basic sanitation are based on projection of the current costs of the programs and on projected demographic and population trends.

6.8 The impact on the operational capacity of the health systems of such a significant increase in physical resources over so short a period of time will make it necessary to revise the strategies for administrative and manpower development, and hence the nature of technical cooperation generally involved in extranational loans.

TABLE 19

ESTIMATES OF ANTICIPATED ADDITIONAL CAPITAL AND CURRENT EXPENDITURES REQUIRED TO ATTAIN HFA/2000, TOTAL INVESTMENT EXPENDITURE FOR THE PERIOD 1981-2000 AND CURRENT EXPENDITURE FOR THE YEAR 2000
(in thousands of millions of 1980 US dollars)

Type of Expenditure	Investment	Current Expenditures
	1981-2000	2000
1. Extension of Coverage of Health Care to All	61.0	18.3
2. Immunization (EPI)	0.01	0.05
3. Malaria Control and Eradication	0.01	0.4
Subtotal, Health Care	61.02	18.75
Water and Sanitation	117.0	6.0[1/]
Total, Health Care Plus Water and Sanitation	178.02	24.75

1/Excludes an estimated $11,600 million to be paid for by user fees.

TABLE 20

TOTAL CAPITAL AND CURRENT HEALTH EXPENDITURES BY THE YEAR 2000
(in billions of 1980 US dollars)

Additional current expenditures on health services, water, and basic sanitation	24.75
1980 existing health expenditures (brought forward)	32.00
Estimate of minimum annual capital expenditure	3.25
Total* expenditures HFA by the year 2000 (includes expenditures in health services, malaria eradication, immunization, water, and basic sanitation)	60.00

* It is assumed that all additional capital outlays ($178.00) will have been completed in 1999 and in full operation in the year 2000.

TABLE 21

ESTIMATE OF THE POTENTIAL FINANCIAL RESOURCES AVAILABLE FOR HEALTH EXPENDITURES, BASED ON DIFFERENT HYPOTHESES OF THE REAL GROWTH OF THE GDP (IN CONSTANT 1980 US$) AND THE TOTAL (PUBLIC AND PRIVATE) PROPORTIONS ALLOCATED TO THE HEALTH SECTOR

An annual growth rate of 4% of the GDP will generate a GDP of $1,512,000 million by the year 2000	Projected per capita expenditure 1980 US dollars 1/
If 4% of the GDP is assigned to health, the amount available for such expenditures will be $ 60,000 million	$ 99
If 5% of the GDP is assigned to health, the amount available for such expenditures will be $ 75,600 million	$124
If 7% of the GDP is assigned to health, the amount available for such expenditures will be $105,800 million	$174
The average per capita GDP would be $2,500 (the average in 1980 was $1,900)	
An annual growth rate of 5% of the GDP will generate a GDP of $1,831,000 million in the year 2000	
If 4% of the GDP is assigned to health, the amount available for such expenditures will be $ 73,200 million	$120
If 5% of the GDP is assigned to health, the amount available for such expenditures will be $ 91,600 million	$151
If 7% of the GDP is assigned to health, the amount available for such expenditures will be $128,200 million	$211
The average per capita GDP would be $3,000	

1/ In 1980 the average per capita expenditure in health for Latin America and the Caribbean (excluding the expenditures for water and basic sanitation) was approximately $85, while in the United States of America it was approximately $1,110.

TABLE 21 (cont.)

An annual growth rate of 7% of the GDP will generate a GDP of $2,670,100 million by the year 2000	Projected per capita expenditure 1980 US dollars[1/]
If 4% of the GDP is assigned to health, the amount available for such expenditures will be $106,804 million	$176
If 5% of the GDP is assigned to health, the amount available for such expenditures will be $133,505 million	$220
If 7% of the GDP is assigned to health, the amount available for such expenditures will be $186,907 million	$307
The average per capita GDP would be $4,400	
If average annual real growth of the GDP stays at 4% for the decade of the 80's and 7% in the 90's, the GDP in the year 2000 will be $2,008,500 million	
If 4% of the GDP is assigned to health, the amount available for such expenditures will be $ 80,340 million	$132
If 5% of the GDP is assigned to health, the amount available for such expenditures will be $100,425 million	$165
If 7% of the GDP is assigned to health, the amount available for such expenditures will be $140,950 million	$232
The average per capita GDP would be $3,300	

VI. CHANGES IN PAHO'S ORGANIZATION, RESPONSIBILITIES AND OTHER FACTORS AFFECTING ITS ACTIVITIES AND RESOURCE NEEDS

It would perhaps be helpful to review the highlights of the implementation and implications of a number of recommendations and resolutions stemming from PAHO's Governing Bodies.

The decision to shift from an essentially Zone Office configuration to country-level management and decision-making emphasized the need at all levels for an influx of new disciplines, skills and experience, particularly with respect to planning and management, analysis and evaluation, and information systems. At the Headquarters level the initial step was to consolidate and reorganize some 14 separate and compartmentalized departments within the Secretariat into four integrated Divisions with a multisectoral approach. These currently comprise the Divisions of Disease Prevention and Control; Comprehensive Health Services; Environmental Health Protection; and Human Resources and Research, and with supporting mechanisms provided by the Office of Administration. With these consolidations, certain focal points were needed to design and deliver the monitoring and evaluation process and respond to the increasing demands for information and analysis. The immediate Office of the Director was strengthened to reinforce the Organization's responsiveness to changing policy and direction and to coordinate delegation of responsibility and authority to the field. This included the expansion of the Organization's capacity to undertake long-term planning and economic and financial analysis; the appointment of an Operations Manager with a staff of health program analysts to monitor field activities and provide a focal point for Country Representatives; a Liaison Office to provide closer ties with other international organizations and the promotion of other bilateral and multilateral coooperative ventures; an Office of Resource Mobilization to help develop and improve national and international financing mechanisms; and, finally, a Legal Office to provide necessary expertise and the appropriate counsel in support of the numerous agreements, contractual arrangements and legal matters in PAHO. Also in response to the XXIV Meeting of the Directing Council (1976), an Emergency Preparedness and Disaster Relief Unit was established.

The Divisions were given the new role of providing normative guidelines and support to country-based activities. Country Representatives became the focal points through which all PAHO activities in a given country are channelled and were given a new role as managers of PAHO country activities.

Area Representatives were given two important responsibilities in addition to their host country duties, namely, to coordinate intercountry activities and to serve as the PAHO extension for assisting subregional organizations such as the Andean Group, the English-Speaking Caribbean, etc.

The implementation of this reorganization brought with it a whole new orientation and perspective. For example, the policies established by PAHO's Governing Bodies recognized the importance and the integral relationship between the health sector and overall socioeconomic development. Thus, the impact of the New International Economic Order represented a new challenge which requires broad-based management and longer range planning by the health sector. This means development of comprehensive information systems and the analysis of ongoing activities as well as the more innovative application of appropriate mechanisms to redeploy available resources where needed and in a more timely and effective manner.

To strengthen the program and managerial capacity of field officers, a series of training seminars and workshops were held for AR's, CR's, and administrative field staff. The success of these has resulted in an annual Field Managers Meeting, which has improved Headquarters-field communications. It has provided a forum for active discussion and closer participation in implementing new policies as well as to provide timely and valuable feedback on problems at the country level which require a more broadly based analysis for their effective resolution.

To assess the financial and budgetary situation realistically, it is useful to review where the Organization appears to be heading and the extent of progress that has been made in responding to the policy shifts and guidelines which emanated from the New International Economic Order. The period from 1976 through 1982 can be summarized as one of significant and continuing adjustment and change both in terms of operational style and organizational development. Even though a wide spectrum of differences is represented in our Governing Bodies, effective regional policies and strategies have been developed, and the mutuality of interest in achieving common health goals has produced the Regional Plan of Action aimed at providing health coverage to all of the peoples of the Americas. In this respect the Organization has made the changes requested by its Governing Bodies in a very timely and effective manner.

It is important to remember that PAHO, had been very successful over the years in operating as a basically centralized Organization. The process of shifting to country-level programming and responsibility initially caused significant readjustments and the emergence of new problems and issues in PAHO's delivery of cooperation and provision of services. Moreover, during this same period, requests for cooperation were rapidly increasing, and the type of requests became more diverse. An important factor was that PAHO's membership increased from 27 to 32 countries during the period 1976-1982. This combination of factors was not only increasing PAHO's costs, but doing so at a time when inflation was outpacing real increases in PAHO financial resources. To bring about more effective management and improve the processes for conducting the Organization's activities required increasing staff productivity and instituting cost-cutting measures and savings as well as reductions

in some lower priority programs. Attitudes and philosophical approaches to programming also had to be changed. The traditional practice of relatively independent vertical programming with little communication and cooperation across divisional lines or technical disciplines had to be converted to a team-oriented problem-solving approach over time. In addition, new disciplines were needed and the expertise had to be found and recruited. To meet these challenges a series of analytical studies and evaluations were initiated reviewing organizational, functional and program areas. These various endeavors involved scientific and technical experts, management consultants, government officials and selected advisory committee members. The Executive Committee also expanded its role through the establishment of special working groups or subcommittees in the planning, programming and budgeting processes.

In September/October 1979, PAHO reviewed and approved its first Biennial Program and Budget for the years 1980 and 1981, and the evolution of a different and more responsive PAHO was under way. Other such efforts which highlight the progress and participatory approach involved the development of Regional Strategies for health for all by the year 2000 and the resultant Plan of Action; the Study of WHO's Structures in the Light of Its Functions; and the evaluation program of Pan American Centers. The impact of these various efforts resulted in the establishment of some new functions and activities and the modification and integration of others.

The key to improving the PAHO responsiveness rested on engendering a greater spirit of interdisciplinary cooperation and mutual support among and within all its constitutional components.

To keep pace within policy and program changes, PAHO has utilized a wide range of management tools and approaches designed to strengthen and improve administrative support activities. A major area of concern involved the communications capability, particularly between Headquarters and the field. Use of the telephone, although indispensable in certain situations, was discouraged in favor of telex communication, which provided less costly service and a hard copy record. This change in operations was accompanied by the installation of improved telecommunications equipment at Headquarters and the deployment of 18 additional telex terminals at PAHO country locations. This more than doubled the telex network and allowed PAHO to be in direct line contact with all but two of the countries in Latin America and most of the Caribbean. It has been estimated that the savings to the Organization is well over US$100,000 at 1980 prices annually. However, the speed and increased capacity for automated and instantaneous communication provided an important and significant improvement in the Organization's responses to its Member's needs.

A key factor in improving administrative and management techniques focused on the effort to reduce the length of time that was required for transmitting and receiving information and communications, both external and internal, to PAHO. Thus a number of the necessary improvements that were implemented involved a significant investment of resources in the beginning for technology which would generate savings over the long run. Such tools as the microcomputer and word processing systems, which required considerable initial investment, are now generating savings close to US$2 million a year at 1980 prices. Mail service was another problem. Delays in delivery used to average from 10 to 15 days or more and those in the "or more" category caused frustrations for both sender and recipient. Utilization of innovative delivery mechanisms has resulted in the average time of mail delivery being reduced, in some cases to two or three days. We mention these examples of supporting activities which we often take for granted, and yet they are so essential to the effective operation of the Organization's activities.

Along with the emphasis on management tools, parallel efforts were initiated on staff development and training. This required an extensive effort in strengthening personnel classification, procurement, financial management and accounting, grants and contracts systems. These improvements, along with a significant increase in staff participation in the decisionmaking process, have made considerable progress in bringing staff and management closer together.

To ensure the best possible use of extrabudgetary resources. A Headquarters Project Review Group was established to review these activities in terms of PAHO priorities, feasibility and sound management procedures in this implementation. This has improved the operation and screened out projects that were not germane to the Organization's priorities.

PAHO was made the WHO focal point for TCDC activities and, as a further support to field activities, established closer working relationships with the International Community including the IDB, World Bank, IMF, UNDP, UN/ECLA, UNICEF and UNFPA.

The need for maintaining an effective overview of the allocation of PAHO resources consistent with the changing health needs of the countries led to the design and development in 1976-1977 of AMPES, the American Region Programming and Evaluation System. AMPES serves as a useful tool for the programming, execution, monitoring and evaluation of the programs of technical cooperation with the Member Governments. An important component of the system is the feedback mechanism which facilitates objective dialogue with the countries and results in appropriate program adjustments and thus more effective allocation of the Organization's resources.

TABLE 22

CHANGES IN THE BIENNIAL BUDGETS OF MAJOR INTERNATIONAL ORGANIZATIONS AND CHANGES IN THE BIENNIAL REGULAR BUDGETS, AND TOTAL EXPENDITURES OF WHO AND PAHO (in millions of US$ and percentages (1976/77 = 100))

	Organization		1976-1977	1978-1979	1980-1981
1	IAEA	US$	83.6	119.5	169.3
		Percentage	100.0	142.9	202.5
2	ITU	US$	56.6	82.5	91.1
		Percentage	100.0	147.8	161.0
3	FAO	US$	167.0	211.4	278.7
		Percentage	100.0	126.6	166.9
4	UNESCO	US$	200.8	263.7	354.0
		Percentage	100.0	131.3	176.3
5	UN	US$	784.0	1090.0	1339.0
		Percentage	100.0	139.0	170.8
6	WHO Reg.	US$	286.1	354.3	427.3
		Percentage	100.0	123.8	149.3
7	WHO Total	US$	549.1	710.6	831.6
		Percentage	100.0	129.4	151.4
8	PAHO Reg.	US$	55.5	64.8	76.6
		Percentage	100.0	116.8	138.0
9	PAHO Total	US$	127.8	149.0	172.0
		Percentage	100.0	116.6	134.6

Sources: WHO, PAHO, UN and GAO

As Table 22 shows, PAHO's Regular Budget and the Organization's total level of expenditure have over the past six years had the lowest level of increase of any of the major international organizations. This despite the fact that the developing countries in the Western Hemisphere have both the world's highest rate of population growth (2.7% a year) and the world's highest rate of inflation (averaging over 50% a year). Between the 1976-1977 biennium and the 1980-1981 biennium, the increase in PAHO's Regular Budget and total expenditures was over 60% lower than IAEA's. The increase in PAHO's total expenditures has been 15% less than WHO's.

Even using the US inflation rate, which greatly understates the overall regional inflationary forces confronting the Organization, the real financial resources available to support the ever-increasing burden of responsibilities and activities being undertaken by PAHO are rapidly declining. For example, as a comparison of the data in Table 22 and those concerning the rate of inflation in the United States the Organization's Regular Budget would have needed to have been over $8 million larger in the 1980-1981 biennium to have kept pace with inflation. Similarly, its total expenditures for the biennium would have needed to have been some $23 million larger. Based on the World Bank's projections of its Official Development Assistance (ODA) Deflator, the amounts required to maintain the equivalent of PAHO 1976-1977 Regular Budget in 1982-1983 and 1984-1985 would be $100.0 million and $115.6 million respectively, instead of the $90.3 million and $106.7 million foreseen in the Proposed Program and Budget approved last year (Official Document 169). In terms of total expenditures (i.e., including extrabudgetary resources), for the same years the Organization would need $230.2 million and $266.0 million respectively. If we take into account population growth in the developing Americas during this same period, these figures would have to be increased by an additional 17, 18 and 19% for the respective bienniums. In other words, whereas in 1976 PAHO's Regular Budget provided for an expenditure in the developing Americas of US 8 cents per capita by 1981, in real terms per capita expenditures had decreased to a mere 6 cents per capita.

Over recent years there has been a massive decrease in the resources made available to this Region from various United Nations sources, and this decline will continue unless the Member Governments take action to reverse or forestall these declines. For example, in 1980 this Region received only 1% of the total resources which UNICEF allocates worldwide to health projects. Given the debt servicing problems of most of our Member Governments, which makes additional loans for the health sector unlikely, and the large number of people living in absolute poverty throughout this Region, it is necessary to stress the need for a more active and cohesive regional role in matters affecting the distribution and utilization of the funds and other resources available from various UN agencies, particularly WHO.

At last year's meeting of the Executive Committee and at that of the Directing Council it became clear during the discussion of the 1982-1983 budget that some Member Governments were strongly opposed to any increases in PAHO's 1984-1985 regular budget, even those necessary to help alleviate the pressures of inflation on the Organization's activities. The Secretariat was forced to cut back the equivalent of 123 person/years of effort as well as a number of other activities in order to live within the confines of the regular budget approved for the 1982-1983 biennium. Quite frankly, because of anticipated decrease in real terms of PAHO's extrabudgetary resources during this current biennium, further and more extensive cuts in many of this Organization's activities may be required.

The Pan American Health Organization, which this year marks 80 years of international health cooperation, has undertaken a great number of trailblazing activities for more than three generations. This was the first Region of the world to call for and to achieve the eradication of smallpox; the first Region to endorse and actively pursue the extension of health services to all using primary health care--which is now more popularly known as HFA/2000. This Region is also the sole Region which has maintained its goal of eradication of malaria rather than its control. If the present funding trends continue over the upcoming years, PAHO's role as a leader in international health and as a vital catalyzer for health for all will be seriously jeopardized.

TABLE 23

EXAMPLES OF AVERAGE PROJECTED COSTS (P-4)[1]

Year	CPC Bridgetown	AREA I Caracas	AREA II Mexico	AREA III Guatemala	AREA IV Lima	AREA V Brasilia	AREA VI B. Aires	PAHO/HQS Wash. D.C.
1982	59,680	82,310	58,870	60,880	58,070	57,880	108,360	54,940
1983	63,650	90,910	63,050	65,660	62,050	61,660	120,950	58,840
1984	67,750	99,400	67,550	70,550	66,140	65,540	133,460	62,880
1985	71,930	107,990	72,130	75,340	70,130	69,340	146,060	67,000
1986	76,250	116,630	76,820	80,160	74,340	73,150	159,200	71,400

[1]Note: Projected average staff costs are based on UN salary scales. As indicated, PAHO's salary costs, particularly for field staff, are expected to increase at a considerably faster rate than provided for in the Proposed Program and Budget (Official Document 169, 1981) approved last year. In this respect it should be pointed out that PAHO, unlike WHO/ Geneva, has, from a financial point of view, been badly hurt by the movement of a larger proportion of its staff to the field, it being far less expensive to maintain staff at PAHO's Headquarters than in the field. It should also be pointed out (see Table 24) that PAHO's average staff costs are considerably lower than those of other WHO Regions and WHO/HQ. It will be recalled that WHO and PAHO professional salaries as well as those of other UN agencies are set by the UN General Assembly and not by this Organization.

TABLE 24

AVERAGE ESTIMATED COST OF WHO PROFESSIONAL STAFF BY LOCATION [1]

Professional Staff at Regional Offices and Headquarters	(a) 1980-1981 Estimated Cost of One Man-Year	(b) 1982-1983 Estimated Cost of One Man-Year	(c) Increase in Cost (b) - (a)
Africa	53,400	64,000	10,600 19.85%
The Americas	40,660	53,600[2]	12,940 31.82%
South-East Asia	46,602	56,225	9,623 20.65%
Europe	59,459	78,950	19,491 32.78%
Eastern Mediterranean	43,585	61,416	17,831 40.91%
Western Pacific	50,350	64,200	13,850 27.51%
Headquarters, and global and interregional activities	71,833	80,262	8,429 11.73%
Global average	52,270	65,522	13,252 25.35%

Source: WHO Proposed Program and Budget 1982-1983 p. 18, Geneva 1980.

1 See Annex 5 of WHO document for method of computation of estimates, paragraphs 14-17.

2 This was an estimate developed by WHO in 1980. More recent calculations indicate the average cost will be $56,890 for PAHO/HQ professional staff.

It should also be noted in passing that PAHO/HQ average general service staff costs are half of those of WHO/HQ.

During the period 1976 to 1982, PAHO has experienced an increase of some 140% in the cost of the average airline ticket it has purchased and close to 170% increase in average per diem costs.

TABLE 25

INFLATION RATES
UNITED STATES OF AMERICA, LATIN AMERICA AND THE CARIBBEAN

Year	Annual Change in US/CPI	Cumulative Change 1976 = 100	Latin America and the Caribbean[1]
1976	5.8%	100.0	57.1%
1977	6.5%	106.5	48.3%
1978	7.5%	114.5	41.4%
1979	11.3%	127.4	47.6%
1980	13.5%	144.9	56.1%
1981	10.4%	160.0	61.0%
1982		173.4	
1983		186.8	
1984		201.4	
1985		214.9	

Sources: IMF, International Financial Statistics, and the World Bank, 1982 World Development Report for the cumulative data for the year 1982 through 1985.

Note: The 1982-1985 figures are based on World Bank deflator projections.

[1]Excluding Venezuela

SUMMARY OF DISCUSSION OF THE PRELIMINARY BACKGROUND DOCUMENT ON THE NATIONAL AND INTERNATIONAL FINANCIAL AND BUDGETARY IMPLICATIONS OF THE REGIONAL STRATEGIES AND THE PLAN OF ACTION FOR HEALTH FOR ALL BY THE YEAR 2000

Country Participants

Chile

Dr. José M. Borgoño
Dr. Héctor Rodriguez

Mexico

Dr. Ramón Alvarez Gutiérrez

Panama

Dr. Benigno Argote

Uruguay

Dr. Armando López Scavino
Mr. Oscar Martín

The Subcommittee on Long-Term Planning and Programming of the Executive Committee, after an introduction by Dr. Héctor R. Acuña and Dr. S. Paul Ehrlich, Jr., and a brief presentation by Dr. Phillip Musgrove, discussed the document presented. The following reflects comments of Subcommittee members:

It was noted that the document fulfills the request set out by the Executive Committee to the Director for a study of the financial and budgetary implications of the Plan of Action. In that regard, the study was viewed as detailed and complete.

It was remarked, in reference to a term used in the study, that health expenditures are too often regarded by some as "unproductive consumption," when in fact they should be regarded partly as investments in themselves and partly as complements to other forms of human capital formation, such as education. Although such investments may take relatively long periods to yield results, this does not necessarily mean that their economic returns are low. These impacts are in addition to the undoubted substantial direct effect of health expenditures on human

welfare. The health sector needs to stress all these aspects in dealing with other sectors.

The financial and political strength of social security systems was noted, thus leaving little prospect of their being absorbed by the health sector. The expansion of social security, however, could be a means by which some countries could partially solve the problem of extending health services to the underserved population. The crucial objective, they noted, is to avoid duplication of effort and excess costs. At least, therefore, a division of labor between social security and public health institutions has to be achieved so that preventive and curative measures are balanced and equity and efficiency promoted.

While in absolute financial terms external resources may represent only a very small portion of total health expenditures, external cooperation can be a vital catalyst in two respects: first it provides orientation to national governments and fosters cooperation among them, and, second, it often permits the financing of new and innovative directions in health services and programs which might not be attempted if they had to be financed from the regular budget.

A strong consensus of Subcommittee members was expressed that, while the total resources might be available, the crucial decisions remained those of the countries in restructuring the current systems, using funds more efficiently and effectively.

The Subcommittee emphasized the need for intersectoral linkages and the difficulty in accomplishing them, given the fact that all too often the necessary political decisions to bring them about were not taken. It also emphasized the need for mechanisms to be made available which could be used to promote such coordination.

Subcommittee members noted that the document summarized some of the serious implications for the Organization of past budgetary decisions and the continuing environment of inflation, and emphasized the need for continuing examination of this subject.

A view was expressed that the major issue affecting resources available to the health sector is the political determination of the priority to be given to health by government. It was also noted that community participation's potential role in reducing overall costs of health for all and making other investments more effective was not estimated in the document. The Subcommittee members also noted that community participation and other factors in the primary care strategy might reduce the overall costs of health for all, although that was not certain, and continuing analysis of these possibilities was needed.

Similarly, it was noted that sectors other than health of the Member Governments should be urged to examine the document and consider its implications. It also was noted that the standards for determining the costs of health for all should be in a continuing process of refinement and would require periodic examination.

PROPOSED RESOLUTION

NATIONAL AND INTERNATIONAL FINANCIAL AND BUDGETARY IMPLICATIONS OF THE REGIONAL STRATEGIES AND THE PLAN OF ACTION FOR HEALTH FOR ALL BY THE YEAR 2000

THE EXECUTIVE COMMITTEE,

Having considered the preliminary background document prepared for the Subcommittee on Long-Term Planning and Programming of the Executive Committee which describes the financial and budgetary implications of the Regional Strategies and Plan of Action;

Noting that the document was prepared with the cooperation and participation of specialized personnel from other international agencies;

Bearing in mind that the document was prepared in keeping with the concerns expressed at the 86th Meeting of the Executive Committee; and

Recognizing that the document contains important implications for the capacity of the Member Governments and the Organization to achieve the goals of health for all by the year 2000,

RESOLVES:

To recommend to the XXI Pan American Sanitary Conference, XXXIV Meeting of the Regional Committee of the World Health Organization for the Americas, that it approve a resolution along the following lines:

THE XXI PAN AMERICAN SANITARY CONFERENCE,

Having considered the document prepared for the Subcommittee on Long-Term Planning and Programming of the Executive Committe, which describes the financial and budgetary implications of the Regional Strategies and Plan of Action;

Bearing in mind Resolution XI of the XXVIII Meeting of the Directing Council which adopted the Regional Plan of Action for health for all by the year 2000 and Resolution WHA35.23 in which the World Health Assembly adopted the global Plan of Action for implementing the global strategy for health for all by the year 2000; and

Noting the revisions and recommendations made by the Subcommittee on Long-Term Planning and Programming and by the 88th Meeting of the Executive Committee,

RESOLVES:

1. To express appreciation to the Director for the study on the financial and budgetary implications of the Regional Strategies and Plan of Action.

2. To urge Member Governments to examine the implications and recommendations contained within the study and consider actions to enhance the likelihood that resources will be available and will be used in the most efficient and effective manner to permit the attainment of health for all by the year 2000.

3. To request the Director:

a) To continue to examine the international economic environment and national and international resource allocations to the health and related sectors and to inform the 92nd Meeting of the Executive Committee of any significant changes affecting the attainment of health for all by the year 2000; and

b) To advise those Member Governments which may request it on ways to implement the outcome of these studies.

executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

88th Meeting
Washington, D.C.
June-July 1982

Agenda Item 26

CE88/25 (Eng.)
28 June 1982
ORIGINAL: ENGLISH

REQUEST OF THE INTER-AMERICAN COMMISSION OF WOMEN (CIM) FOR ADMISSION INTO OFFICIAL RELATIONS WITH THE PAN AMERICAN HEALTH ORGANIZATION

The Director has the honor to submit to the 88th Meeting of the Executive Committee of the Directing Council, for consideration, the request of the Inter-American Commission of Women (CIM) for admission into official relations with the Pan American Health Organization.

Background

In a letter of 22 April 1982 the President of the Inter-American Commission of Women (CIM) informed the Director of the Commission's interest in attending as observers the meeting of the Executive Committee of the Pan American Health Organization.

In his reply of 3 June 1982, the Director of PASB advised the President of the CIM that the request for establishing official relations between PAHO and CIM would be presented for the consideration of the Executive Committee so that the request could be transmitted to the Pan American Sanitary Conference.

Background Information on the Inter-American Commission on Women (CIM)

The Commission was established in 1928 at the Sixth International Conference of American States, held in Havana, Cuba, and it was accorded permanent status by the Eighth International Conference of American States, held in Lima, Peru, in 1938. It was the first official intergovernmental agency created expressly to ensure recognition of the civil and political rights of women. As a Specialized Organization of the OAS it enjoys the fullest technical autonomy. It is governed by its Organic Statute. Its relations with the OAS are governed by an Agreement signed with the Secretary General of the Organization, as authorized under Chapter XXI, "The Specialized Organizations," of the Charter of the OAS.

The Organs of the Commission are: The Assembly of Delegates; the Executive Committee; the National Committee of Cooperation; and the Permanent Secretariat.

The member states of the OAS have the right to be represented on the Commission. The government of each member state appoints a Principal Delegate and may appoint alternates and advisers. The President is elected from among the Principal Delegates composing the Commission.

For more than 50 years the CIM has been working for the extension of civil, political, economic, social, and cultural rights to the women of the Americas; it has been studying their problems, proposing measures to solve them, and encouraging their participation in the community.

Legal Basis

Article 26, "Relations with other Organizations," of the PAHO Constitution allows the Conference or the Council to make suitable arrangements for consultation and cooperation with other organizations interested in or concerned with public health.

Resolution XXVIII of the XIV Pan American Sanitary Conference (1954) sets forth the criteria to be observed in establishing official relations with international and inter-American organizations. In its XXVII Meeting (1980), the Directing Council of PAHO approved Resolution XXXVIII on mechanisms for the establishment of relations with inter-governmental organizations. The two resolutions are appended as Annexes I and II.

Recommendation

The CIM is an inter-American specialized organization, of recognized standing, whose aims and purposes are in conformity with the spirit, purposes and principles of the Constitution of PAHO. As such, its recognition by PAHO is clearly within the guidelines of the attached Pan American Sanitary Conference resolution. The CIM has requested that official relations with PAHO be established, in order to grant it Observer status before the PAHO Governing Bodies, on the issue of Women and Health and Development.

The Director supports this request and recommends that the Executive Committee adopt the attached proposed resolution, which proposes that the Pan American Sanitary Conference establish these official relations with CIM. It should be observed that, under Resolution CD28.R38 (Annex II), the Conference must approve such a resolution by a two-thirds vote.

In view of the CIM's specific request that it be allowed to participate as an Observer before the 88th Executive Committee on this issue, the Director also recommends that the Executive Committee, as an interim measure, accord such status on an ad hoc basis.

Proposed Resolution

THE EXECUTIVE COMMITTEE,

In view of the Director's report on the 22 April 1982 request for Observer status to PAHO received from the Inter-American Commission for Women, an Inter-American Specialized Organization;

Considering the importance of full discussions of the issue of Women and Health and Development; and

Bearing in mind the PAHO policies towards opening official relations with other inter-governmental organizations in the Hemisphere,

RESOLVES:

1. To accord to the Inter-American Commission for Women ad hoc Observer status for the 88th Meeting of the Executive Committee, for the issue of Women and Health and Development.

2. To recommend to the Pan American Sanitary Conference adoption of the following resolution:

THE XXI PAN AMERICAN SANITARY CONFERENCE,

Considering that the Inter-American Commission for Women is an Inter-American Specialized Organization devoted to the development of civil and political rights of women in the Hemisphere;

Considering that the Inter-American Commission for Women, through its President, has requested the establishment of official relations with PAHO by according to it the status of Observer to meetings of the Pan American Sanitary Conference, PAHO Directing Council and PAHO Executive Committee, with regard to the issue of Women and Health and Development; and

Acting pursuant to Article 26 of the PAHO Constitution; and in accordance with Resolution XXVIII of the Pan American Sanitary Conference and Resolution XXXVIII of the XXVII Meeting of the PAHO Directing Council,

RESOLVES:

1. To express its satisfaction that the Inter-American Commission for Women has indicated its desire to enter into official relations with PAHO.

2. To declare that cooperation with the Inter-American Commission for Women and Health and Development will serve the best interests of PAHO and of the women in the Western Hemisphere.

3. To welcome the Inter-American Commission for Women into official relations with PAHO and thereby to accord it the status of Observer to PAHO, without vote, but with rights of participation (with the permission of the Chairman), in discussions of the issue of Women and Health and Development, in open meetings of the Pan American Sanitary Bureau, the PAHO Directing Council and the PAHO Executive Committee.

Annexes

CSP14.28 The XIV Pan American Sanitary Conference,

Considering that collaboration in matters of common interest to the Pan American Sanitary Organization and other international and inter-American organizations contributes to the fulfillment of the objectives of the Organization, as stated in the Pan American Sanitary Code and in the Constitution of the Organization,

RESOLVES:

That the Pan American Sanitary Organization establish and maintain cooperative relations with other international and inter-American organizations in the manner that it deems appropriate; that the criteria given below be observed when the Pan American Sanitary Organization establishes cooperative relations with any other international and inter-American organizations; and that these relations be established or maintained in accordance with the provisions set forth in Article 23 of the Constitution.

Criteria

1 The organization shall be concerned with matters falling within the competence of the Pan American Sanitary Organization.

2. The aims and purposes of the organization shall be in conformity with the spirit, purposes, and principles of the Pan American Sanitary Code and the Constitution of the Pan American Sanitary Organization.

3. The organization shall be of recognized standing and shall represent a substantial proportion of the persons organized for the purpose of participating in the particular field of interest in which it operates. To meet this requirement, a group of organizations may form a joint committee or other body authorized to act for the group as a whole.

4. The organization shall have a directing body and authority to speak for its members through its authorized representatives; evidence of this authority shall be presented if requested.

5. The organization shall normally be inter-American in its structure and scope, with members who exercise voting rights in relation to its policies or action.

6. Save in exceptional cases, a national organization that is affiliated to an inter-American nongovernmental organization covering the same subject on an international basis shall present its views through its government or through the inter-American nongovernmental organization to which it is affiliated. A national organization, however, may be included in the list after consultation with, and with the consent of, the Member Government concerned, if the activities of the organization are not covered by any international organization or if it offers experience upon which the Pan American Sanitary Organization wishes to draw.

Oct. 1954 OD 10, 29

RESOLUTION XXXVIII OF THE XXVII MEETING OF THE DIRECTING COUNCIL

PROCEDURES FOR THE ESTABLISHMENT OF RELATIONS WITH INTERGOVERNMENTAL ORGANIZATIONS

THE DIRECTING COUNCIL,

Recalling Resolution CSP14.28 of the XIV Pan American Sanitary Conference, which set forth the criteria to be observed by the Pan American Health Organization in establishing official relations with international and inter-american organizations;

Considering that procedures are needed for application of the criteria set forth in Resolution CSP14.28 and to establish the status of the observers of regional and subregional intergovernmental organizations; and

Having considered the recommendations set forth in Document CE84/7, presented by the Director, having noted Resolution XXIII of the 82nd Meeting of the Executive Committee, and following the recommendation of the Executive Committee at its 84th Meeting,

RESOLVES:

1. To observe the criteria adopted by the XIV Pan American Sanitary Conference in Resolution CSP14.28 for the establishment of official relations with regional and subregional intergovernmental organizations.

2. To establish the rule that the approval of two-thirds of the Directing Council or Pan American Sanitary Conference is required for the establishment of official relations between the Pan American Health Organization and a regional or subregional intergovernmental organization.

3. To establish that a regional and subregional intergovernmental organization with which the Organization maintains relations may:

3.1 Be invited to attend the Meetings of the Executive Committee, the Directing Council, and the Pan American Sanitary Conference, to which end it may designate a representative to act as an observer;

3.2 Collaborate, on request, in the programming and execution of joint activities;

./...

3.3 Submit to PAHO its views and observations on programs underway in areas of mutual interest;

3.4 Request joint participation with PAHO in conferences, seminars, or working groups;

3.5 Participate, in accordance with the applicable Rules of Procedure, but with no vote, in the open sessions of the Governing Bodies of PAHO in the terms of the invitation issued by the Secretariat.

(Approved at the sixteenth plenary session,
2 October 1980)