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

(THE ECONOMIC CRISIS IN LATIN AMERICA AND THE CARIBBEAN AND ITS REPERCUSSIONS ON THE HEALTH SECTOR)

EXECUTIVE COMMITTEE
PAN AMERICAN HEALTH ORGANIZATION

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

INTRODUCTION

A. BACKGROUND

1. During the 86th Meeting of the Executive Committee of the Pan American Health Organization in June 1981, emphasis was placed on the need to continue studying financial conditions that could affect attainment of the goals of health for all by the year 2000 both in the individual countries of Latin America and the Caribbean, and the Region as a whole. It was also decided to review the related efforts of the Pan American Sanitary Bureau.

2. During the sixties and seventies, growth in the Regional economy and funding for social programs, including those for health, continued to be steady. The Gross Domestic Product (GDP) grew an average of 7.2% annually from 1970 to 1974, 4.8% a year from 1975 to 1978, and 6.5% in 1979.

3. Despite this growth, in the document on strategies of health for all by the year 2000 it was concluded that: "it is... apparent that a new type of economic development, different from and more dynamic than the present type, will be needed. For Latin American and the Caribbean, an economic growth rate of 7.5% a year has been targeted by the United Nations. This represents an intensification of growth and a technological transformation of the Region's economy in comparison with trend projections which would indicate a growth rate of 6.3% per year for the area as a whole. Growth at 7.5% a year for the Region as a whole is necessary in order for the rate of employment to increase at the growth rates predicted for the economically active population."1/

4. In 1980, the Regional GNP grew at a slower rate than in the past, and in some countries the decline was sharply downward. Growth that year was 5.9% above the level of the previous year, but a mere 1.5% in 1981, after which it decreased to a negative 1.0% in 1982 and dived to a minus 3.3% in 1983. According to figures of the Economic Commission for Latin America (ECLA), the avarage annual growth of Latin America since 1981 has been a negative 2.8%.

5. This situation gave ample grounds for the concern felt by the Executive Committee of the Pan American Health Organization, which was reflected in its decisions at the June 1982 Meeting, and by the XXI Pan

American Sanitary Conference the following September. Those decisions were based on documents prepared by the Pan American Sanitary Bureau, and on the specific recommendations made by the Executive Committee's Subcommittee on Long-Term Planning and Programming.

6. The XXI Pan American Sanitary Conference approved a proposal made to it by the Executive Committee of the Directing Council in its 88th Meeting of 29 June 1982, as follows:

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 adopt the following Resolution:

THE XXI PAN AMERICAN SANITARY CONFERENCE,

Having considered the 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;

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 in 1984 of any significant changes affecting the attainment of Health for All by the Year 2000;

b) To advise those Member Governments which may request it on ways to implement the outcome of these studies.[2/]

7. Upon his election as Director of the Pan American Sanitary Bureau in September 1982, Dr. Carlyle Guerra de Macedo noted the effect that the crisis could have on health financing in the Region, indicating that:

"In the economic sector, it is noteworthy that, despite the diversity of systems and stages of development, the national economies will, in general, continue to experience strong pressures as a result of their entry into the world economy. In almost all the countries, internal development policies will be strongly conditioned by the need to bring the balance of payments into equilibrium. In the short and medium term, it is probable that low economic growth rates will continue to prevail and that employment, income and the production structure will change but little. A need for economic austerity measures can be foreseen, and they will affect the health sector as well."[3/]

8. The present Report on the results of the work done by the Pan American Sanitary Bureau is made in compliance with section 3 (a) of Resolution XX. Its preparation has been made easier by the spirit of participation promoted by the present Direction, which has yielded valuable contributions from different staff members at PASB Headquarters and in the various countries, which have participated in preparing data for the Report itself. Contributions have also been made by local staff members of the PAHO/WHO Country Offices.

End Notes, Introduction

1/ Pan American Health Organization and World Health Organization, Health for All by the Year 2000: Strategies, PASB, Washington, D.C., 1980, p. 9.

2/ Resolution XX of the XXI Pan American Sanitary Conference, September 27, 1982.

3/ Dr. Carlyle Guerra de Macedo, Declaration of Principles, Pan American Health Organization/World Health Organization, Washington, D.C., September 1982, p. 2.

CHAPTER I. CAUSES AND EFFECTS OF THE PRESENT SOCIOECONOMIC CRISIS IN LATIN AMERICA AND THE CARIBBEAN

9. The majority of the countries in Latin America and the Caribbean are experiencing the worst socioeconomic recession in 50 years. The causes of that recession are both historical and structural, but they have been aggravated severely by developments since 1981.

10. The crisis was aggravated in 1973 when the OPEC member countries began increasing the price of oil from what was then US$2.91 a barrel. An enormous increase of 160% in 1975 was followed by others that brought the price to US$35 a barrel in January 1983, or 12 times above the starting price in 1973. Since last year the international price has held at US$29 a barrel.

11. The drop of US$6.00 a barrel in 1983 has relieved to some extent the financial situation of the net importing countries, but has also created economic problems for the net exporting countries in the Region, including Mexico, Ecuador, Venezuela and Trinidad and Tobago.

12. The prices of oil and oil products affect the costs of other goods and services, including inorganic fertilizers, pesticides, automotive, aviation and marine fuels, some synthetics used in textiles, bunker oil for the manufacture of cement, and energy for industrial use, home heating and lighting not generated by water or other means.

13. These mounting increases in oil prices triggered a spiral of inflation that struck at a wide range of activities, and also affected the international financing system by shifting to the net exporting countries large volumes of monetary resources which they deposited in or invested through banking institutions. Net importing countries turned to these same institutions for loans to cover balance-of-payments deficits. Interest rates, at first 6% to 7% a year, soared to around 20%; however, when general rates of inflation declined in the more industrialized countries, interest rates did not recede to their original level, but have remained at about 14% to 15% a year.

14. Since 1981 the socioeconomic crisis has been deepened by other factors such as:

a) A deterioration of the international terms of trade with increases in the costs of most imports from the more industrialized countries--owing to the inflationary spiral--and a drastic decline in the value of the principal exports of the countries in the Region to markets in the more developed countries. In addition, customs restrictions in the form of quotas and duties have been imposed on imports of some of them;

b) An increase in Latin America's external indebtedness. In 1981 this indebtedness totaled US$258 billion, from which it increased 12% in 1982 to US$289 billion, and another 20% over the 1981 figure to 310 billion in 1983;

c) The rise of international interest rates has sharply increased the amount of interest due on the Region's external indebtedness. The amount of interest payments as a percentage of the value of exports of goods and services, has evolved as follows since 1977:

1977	12.4%	1979	17.4%	1981	26.4%	1983	35.0%
1978	15.5	1980	19.9	1982	38.3		

d) An abrupt loss of parity of the currencies of many countries in the Region relative to other international currencies, and to the United States dollar in particular;

e) An increase in price indices and rates of inflation in countries where inflation had traditionally been moderate, including Costa Rica, Ecuador and Mexico, and steep increases in those where inflation had historically been high, especially Argentina, Bolivia, Brazil, Peru and Uruguay;

f) A real drop in fiscal revenue and increase of public expenditures;

g) A rising trend of public budget deficits, especially over the last three years in many of the countries in the Region;

h) A decline in private production activity and in public services, with increasing unemployment and limited opportunities of employment for those who otherwise should be joining the ranks of the economically active population;

i) Cutbacks in most public programs, especially those for social purposes, owing to the priority given to the economic and infrastructural sectors as part of fiscal and monetary measures taken to meet the service on the external debt, which affects most areas of national activity, and

j) Declines in the per capita gross domestic product and the standard of living, particularly of the middle and low middle classes and the more deprived strata of society;

k) Exclusion of more people from the monetary economy and restrictions on access to essential goods and services such as education, food, health and housing, and to employment opportunities, which limits their sharing in the benefits of social security.

15. There is a close interrelationship between many causes and effects, and many effects are themselves the causes of fresh problems, which are exacerbated by inflexibilities and dependence on external factors. For example, the extremely unfavorable trend of the terms of international trade caused by the imbalance between exports and imports has been compounded since 1981 by rising real international interest rates. In 1983, a massive recession of the net flow of foreign private capital into the Region also has occurred, and the combination has meant difficulties in renegotiating both the public and the private external debt.

16. This whole situation has been referred to by the Economic Commission for Latin America (ECLA) as one of "overadjustment" imposed by the "financial depression," which in the last year has grown more intense. It underscores even more the dependence of the less developed countries on those that are wealthier and more advanced. This is aggravated by the uncertainty and internal conflicts that trouble some of the developing countries, the hegemony of the great world powers, which polarize East and West, and the varying extent to which all the countries in the Region are dependent on the more industrialized nations for their science, technology and financing.

17. It is now clearer that medium and long-term solutions for the problems of the Latin American and Caribbean countries will not be found only in internal adjustments of the moment, though some of these are also necessary. Those countries will have to undertake major political, social and economic structural changes, as has been suggested in widely differing international forums and documents, among them the Second Development Strategy of United Nations, the New International Economic Order, and the Strategies and Plan of Action of Health for All by the Year 2000.

REPERCUSSIONS OF THE SOCIOECONOMIC CRISIS IN LATIN AMERICA

18. The economic growth of a country is measured by a variety of indicators, the one in widest international use being the gross domestic product (GDP), which is the value of the goods and services produced within a national or regional economy net of foreign transfers.

19. According to ECLA, the Latin American GDP declined 2.8% from 1981 to 1983; over those three years the economic trend was downward, from a growth of 1.5% in 1981 to a decline of 1.0% in 1982 and further decline of 3.3% in 1983.

20. A more representative and sensitive socioeconomic indicator of the effects of the socioeconomic crisis of the last three years is the per capita GDP. From 1980 to 1983 this indicator dropped 9.5% at market prices of 1970, according to the same ECLA source.

21. During the same period the only countries which experienced growth in per capita GDP were Panama, at 3.5%, and the Dominican Republic, at 2.5%, as may be seen in the following table containing data from ECLA. ECLA also shows similar data on Cuba which indicate a consistent increase in its Gross Social Product, defined, in contradistinction to Gross Domestic Product, as the "... sum of gross production in the agricultural, industrial, mining, energy, transportation, communication and commerce sectors."**

Table 1-01

PER CAPITA GROSS DOMESTIC PRODUCT IN U.S. DOLLARS AT MARKET PRICES OF 1970 IN 1980, 1981, 1982 AND 1983, AND TOTAL CHANGES IN AMOUNTS AND PERCENTAGES FOR LATIN AMERICA AND THE INDIVIDUAL COUNTRIES DURING THE PERIOD 1981-1983*[1/]

Country	1980	1981	1982	1983	Change during 1981-1983 Amount	Percentage
Argentina	1.345	1,245	1,159	1,166	US$ 179	-13.3
Bolivia	382	368	326	297	- 85	-22.2
Brazil	958	919	908	844	- 114	-11.9
Chile	1.047	1,088	916	897	- 150	-13.3
Colombia	824	823	816	802	- 22	- 2.7
Costa Rica	974	904	801	778	- 196	-20.1
Dominican Republic	601	611	606	616	+ 49	+ 2.5
Ecuador	732	742	729	883	- 52	6.7
El Salvador	432	380	350	335	- 72	22.4
Guatemala	561	549	515	489	- 11	12.9
Haiti	148	145	142	137	- 37	- 7.2
Honduras	357	346	332	320	- 65	-10.3
Mexico	1.366	1,436	1,391	1,301	- 3	- 4.8
Nicaragua	341	359	342	338	- 40	- 0.9
Panama	1.154	1,176	1,214	1,194	+ 30	+ 3.5
Paraguay	633	665	632	603	- 105	- 4.7
Peru	690	698	683	585	- 15	-15.2
Uruguay	1.423	1,412	1,281	1,200	- 223	-15.6
Venezuela	1.268	1,230	1,197	1,135	- 133	-10.5
Latin America	1.007	997	965	911	- 96	- 9.5

*No data are supplied for Cuba or for the English-speaking Caribbean.

**See ECLA Report E/CEPAL/G.1279, 20 December 1983, Tables 2 and 3, pp. 32 and 33, paragraph 4, as well as the explanatory note on p. 15.

22. Eleven countries posted loses of per capita GDP greater than the regional average of 9.5%, three of these indices declining by more than 20%. These losses over those three years may be presumed to have reduced the standard and general quality of life of the population, particularly among those strata less financially able to cope with prevalent critical conditions.

23. Some evidence of this is supplied by two UNICEF studies, one done in Chile and the other in São Paulo state, Brazil. The one on Chile concluded in translation, that:

"The sharp economic recession of 1975-1976 was accompanied by a drastic curtailment of public expenditure in all the social sectors...the first recessive cycle saw a substantial drop in public expenditures in the health sector for investments and outlays for the acquisition of goods needed for the operation of the system.

"Moreover, investment outlays made no recovery in any year after those considered in this study. To the contrary, they continue to decline until in 1979 they level off at 3% of the public expenditures for health. This figure, about 350 million pesos of 1978, comes to barely 25% of the amount that had been invested in the early years of the decade. Outlays for personnel also fell during the first year of recession, recovered and then fell again with fluctuations after 1980. The tendency of outlays for the procurement of goods is similar. In no year of the period did they again reach the level of 1978.

"The paucity of investment in the sector and the decline in outlays for the procurement of goods have in all probability resulted in a deterioration of the plant and equipment for health and, in consequence, of the quality of care. This is borne out by frequent reports to this effect throughout the period by physicians and other personnel of the sector...

"A reduction of investment in health on this scale made it possible to maintain the levels of health care services in the short run at the expense of programs for the acquisition of equipment, maintenance and expansion of installed capacity. Another contributing factor was the drop in real remuneration to the staff employed in the sector. It may be noted that, in the health sector, about 40% of the total expenditure had gone traditionally for personnel remunerations."2/

24. The study on Sao Paulo also reveals a downtrend of expenditures for health, which by 1982 had dropped 18% since of 1978. The report asserted that:

"The decline in real value of health expenditures is more evidence (for education). Separation of recurrent from capital costs does not change the circumstances, in spite of the loss of capital expenditures for the Ministry of Health which has been seen to be particularly severe.

"...Thus we have a general overview of a decline, or at least of stagnation in health and education expenditures. However, it is not possible to draw the conclusion that this has caused a reduction in services in these areas, either on the part of the state or local government. The major part of expenditures is for salaries, and their stagnation or decline is a result mostly of "salary constriction," to which most public sector employees have been submitted over the past few years. Sooner or later, of course, such a salary policy will affect the quality of services provided."3/

25. It may be that the cases of Chile and São Paulo are not generalizable to other countries in the Region if their governments give priority to the financing of health programs or have developed a greater operating capacity. Either situation could check the decline in per capita GDP.

26. If this has happened, a proper answer is being given to the question posed by UNICEF: "...how can we sustain social progress without an increase in funding?"4/ For this international agency, the solution or "...very probably...the watchword for this decade in favor of social progress should be to 'make the most of the available resources.'"5/

27. On the need to improve the management of national health services so that they will make more efficient use of the available human, financial and material resources and become more productive, while maintaining the effectiveness required for HFA/2000, a number of specific recommendations will be presented in Chapter IV, below.

28. Economic development and the growth of a country's economy do not necessarily imply immediate attainment of the goals of social development; to the contrary, priority has to be given to programs for that purpose and to financing for them. For example, Saudi Arabia has one of the highest per capita GNPs in the world - estimated at US$12,600 in 1981 - and yet had a very high infant mortality of 111 children under one year per 1,000 live births. According to UNICEF data, in Costa Rica and Cuba, with lower per capita GNPs - US$1,430 and US$1,410, respectively, in 1981 - there were 27 and 19 deaths of infants under one year per 1,000 live births.6/

29. Infant mortality in the same age group was 12 per thousand in the United States of America, with a per capita GNP of US$12,820, and the USSR, with a per capita GNP in the equivalent of US$4,550, had 27 per thousand, in both cases owing to policies and practices applied to the country's health programs.

30. The fact that social development is not an automatic or secondary consequence of economic development, but requires an explicit administrative policy decision of government, was addressed in the document of the Ninth Session of the Committee of High-Level Experts (CEGAN) of ECLA, in which it is said, in translation, that:

...economic development per se does not guarantee social development unless steps are taken that promote equity in the distribution of wealth and access for the less privileged to the goods and services of society.7/

INTERRELATIONSHIP OF CAUSES AND EFFECTS

31. In the web of causality in which the range of socioeconomic factors is enmeshed, some of which are particularly exacerbating in time of crisis, they are all so closely interwoven and interdependent that no decision can be taken in isolation. For example, seeking to improve their balance of payments, many countries in the Region have given preference to production and exportation of nontraditional goods that are in greater demand and face less competition in the markets of the more developed countries. This has also been necessary in some cases as a requirement of the domestic adjustment process to which governments have submitted under standby agreements entered into with the International Monetary Fund. The purpose of such agreements is to enable a country to earn more foreign exchange with which to purchase the goods and services it needs for domestic production and service its foreign debt, and to meet the population's demands for food, medicines and other products.

32. As a result of this unprecedented effort, in 1983 Latin American exports exceeded imports of goods and services by US$31,170 billion. According to ECLA data this performance is all the more impressive when considering that it was accomplished on the strength of increases over previous years in the volume of products exported, the prices of which, in most cases, reamined low on international markets. Eight countries earned more from their exports than they spent on their imports, and so enjoyed trade surpluses, while the trade balances of eleven continued in deficit. In 1983 the value of total exports was US$87 billion against imports of US$56 billion.

33. Another effect of that interdependence has been that some items in the popular diet have become scarce as lands previously under cultivation for sugarcane, cassava, tubers, vegetables, pastures, etc., have been diverted exclusively to sugarcane for conversion into fuel alcohol or into products for export alone.

35. Net payments of profits and interest abroad have increased considerably as follows:

US$19 billion in 1980	US$37 billion in 1982
US$29 billion in 1981	US$34 billion in 1983

The reason for the drop of US$3 billion in 1983 is that amortizations were made on the principal of these debts, which has obviously also lowered in the Region's international reserves.

35. According to figures of the Bank for International Settlements in Basel,8/ new loans by international private commercial banks to Latin America, not counting those to Ecuador and Venezuela, have declined considerably since 1981 as follows:

US$21 billion in the second half of 1981
US$12 billion in the first half of 1982
US$300 million in the second half of 1982
US$3.7 billion in the first half of 1983

These loans in 1983 were obtained from international private commercial banks as a result of IMF intervention under standby agreements in effect between the debtor governments and that international agency.

36. Between August 1982 and December 1983, reschedulings of their foreign debts were requested by Argentina, Bolivia, Brazil, Chile, Costa Rica, Cuba, the Dominican Republic, Ecuador, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Peru, Uruguay, and Venezuela.

The number of countries that have had to resort to these negotiations is yet more evidence of the similarity of the situations in which they find themselves as a consequence of the crisis.

37. Another unfavorable development during 1983 was a dwindling flow of capital to Latin America, which was about US$30 billion less than the outward flow of payments of interest and principal on the Region's foreign debt.

In this regard, ECLA says that:

"...as in 1982, [in 1983] Latin America, instead of receiving a transfer of real funds from abroad, made transfers of funds to the rest of the world. This prolonged a situation which, given the relative state of development of the Region, may be described as perverse.

"However, this transfer was very considerable: 20 billion dollars in 1982 and almost 30 billion in 1983, or 19.0% and 27.0% of the value of the exports of goods and services and 2.5% and 4.0% of the gross domestic product, respectively, in those two years. Viewed from another standpoint, this reversal of the flow of net financial payments between 1981 and 1983 was equivalent to a drop of about one-third in the terms of trade."9/

38. Another effect of the influx of foreign capital has been a decline in its trend; the growth of this influx was 7% from 1982 to 1983 and 12% from 1981 to 1982, and so in both years was less than the average growth of 23% per annum during the period of 1977-1981. Even so, at the end of 1983 the foreign debt of Latin America totaled about US$310 billion.

39. The net inflow of capital began dropping in 1981 from US$38 billion to US$16.6 billion in 1982, and to US$4.5 billion in 1983. The causal effect of this was to reduce the surplus on current account from about US$40 billion in 1981 to US$36.4 billion in 1982, and to US$8.5 billion in 1983, the lowest level since 1974.

40. In a recent presentation Mr. Antonio Ortiz Mena, President of the Inter-American Development Bank, illustrated his comments on the net flow of capital with the charts on the pages that follow.

Figure 1.01

External resources: the net flow turns negative

Latin America obtained an additional net external inflow of capital amounting to $20-$22 billion annually in the five years up to 1981. Then, debt service soared, and the region suddenly began to lose international reserves--over $10 billion in 1982.10/

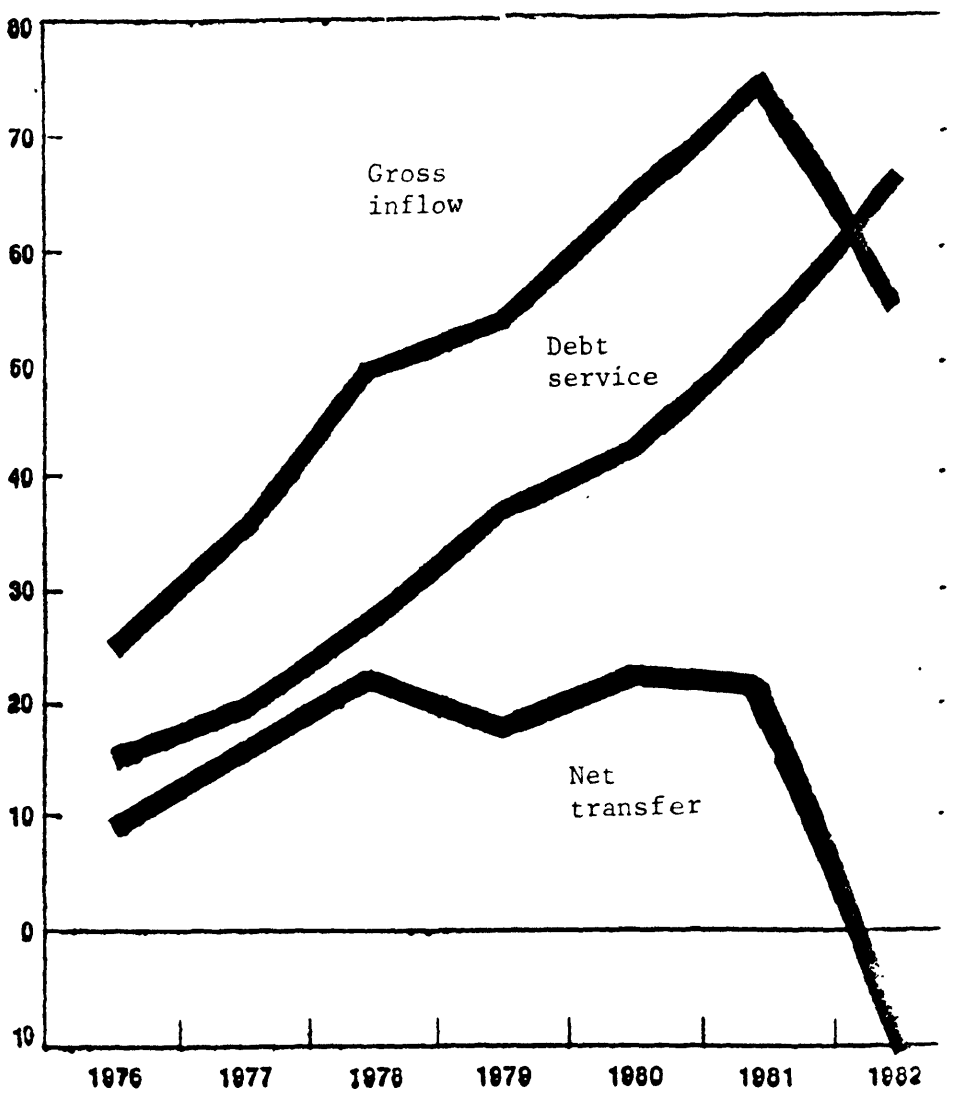


Figure 1.02

The rising cost of borrowing

Latin America had to borrow heavily to pay its oil bills. The region had good access to the private Eurocurrency market, but maturities for loans grew increasingly shorter. 11/

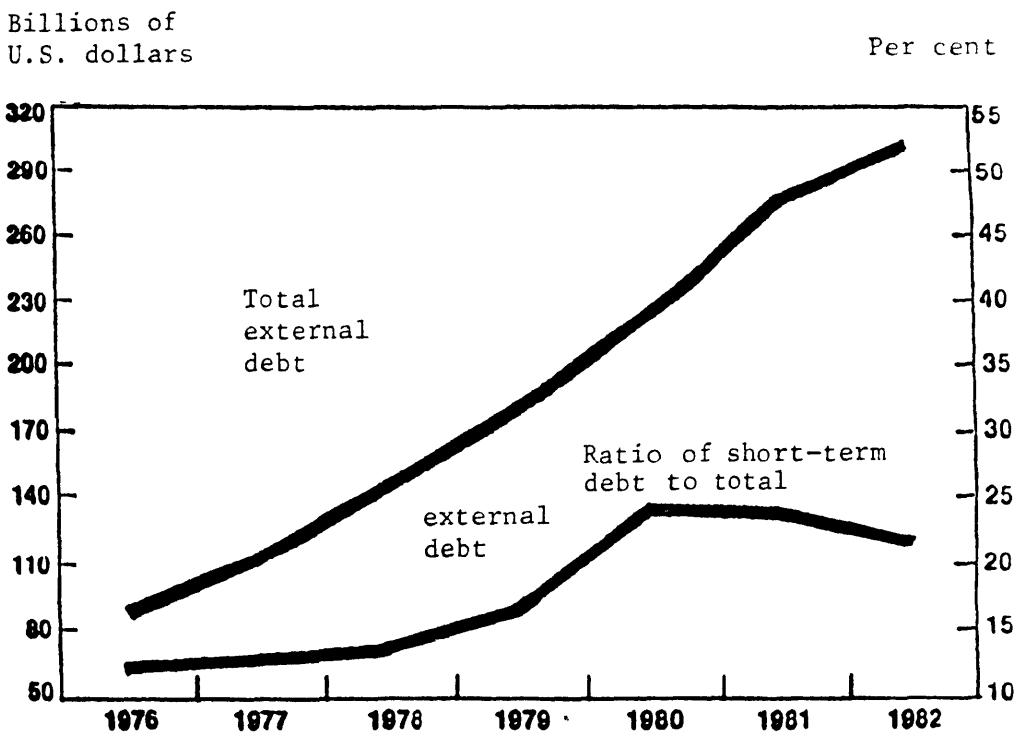
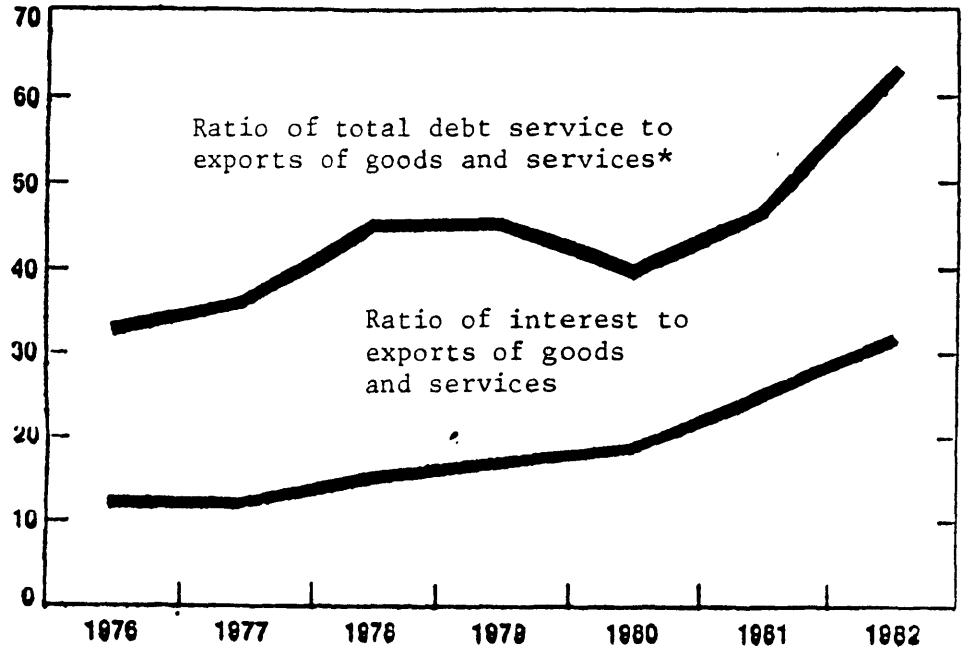


Figure 1.03

Servicing the debt: an increasing burden

By making extraordinary efforts, some countries have achieved favorable balances in their trade accounts. But the surpluses are being wiped out by the increasing service on their external debt. 12/

Per cent



41. Mr. Ortiz Mena indicated that the present crisis originated in 1971, when the United States of America decided to change the Bretton Woods International Monetary System, according to the terms of which United States dollars earned by other countries from their sales to the U.S. were convertible in to gold. When the flow of gold abroad increased, the United States set the value of its currency through the financial market by a "floating" system, and surpluses were handled through the uncontrolled parallel system by central banks, thereby giving rise to the so-called "Eurodollars."

42. These surpluses were invested as loans in countries having projects that guaranteed satisfactory monetary returns at terms usually of 10 to 15 years and at reasonable interest rates.

43. As indicated in paragraph 2, the first sudden increase in oil prices took place in 1973, when they quadrupled, followed by a second considerable increase in 1979. "Eurodollars" then became "petrodollars," as international financial surpluses shifted to countries that were net oil producers and exporters.

44. As early as 1973, the financial conditions of international lending also began to change with a hardening or worsening of the terms of loans, which contracted to five and seven years. There were also changes in interest rates for private corporations, which rose from 7.5% a year in 1972 to 8.1% in 1973, 9.5% in 1974, 9.6% in 1975, 7.9% in 1976, 8.4% in 1977, 9.3% in 1978, 11.3% in 1979, 14.4% in 1980, 15.5% in 1981, 12.2% in 1982, and 11.1% in 1983.13/

45. Charges on international private commercial loans have always been higher than on those granted domestically on the basis of the prime rate, which in March 1984 is 11.5%. The former carry surcharges for other costs of financial intermediaries, which at present run to about one and three-quarters of the LIBOR (London Interbank Offered Rate), plus commissions and financial insurance, which raise these costs to about 14% or 15% a year. Poorer nations in other regions of the world are authorized loans at lower interest and longer grace and amortization terms.

46. International interest rates went up when the rate of inflation rose in the wealthier and more industrialized countries, but did not follow it back down, among other reasons because of the high fiscal deficit of the United States of America; the government covers this deficit by borrowing on financial markets, which keeps the interest rate at about 11.75% a year.

47. When the financial situation hardened, net oil importing countries had to continue borrowing abroad, many of them to invest sizable amounts in hydroelectric works that in the long run would make them less dependent on oil energy. They also invested heavily in new, nontraditional energy

generation techniques, such as those using biomass and thermal energy, and the manufacture of fuel alcohol and diesel oil from agricultural products.

48. Like liquids under the law of communicating vessels in physics, different macroeconomic factors operate interdependently. Thus, in countries whose tax systems are based largely on customs levies, fiscal revenue diminishes appreciably when the imports that generate those levies decline. There is then a shift to other fiscal policies based more on direct taxes such as those on property, rent, appreciation, inheritances and consumption, among others.

49. Capital movements and foreign investment are used to solve balance-of-payments problems (income outflow of foreign exchange). To improve the international trade balance, imports are cut back and greater exports promoted, particularly those of nontraditional products that may have less competition in the markets to which they are shipped.

50. Increasing these nontraditional exports usually brings no additional income into the treasury, because it is precisely by exempting them from taxation that they are encouraged to increase. Drastic reductions of imports have brought down fiscal revenue and product stocks, including medicines and foods not produced locally.

51. With lower public receipts and increased difficulties and costs of replacing them through accumulation of new external indebtedness, real outlays at constant prices have been reduced. These constant prices are obtained by subtracting the inflationary component from current prices so as to obtain a time series of historically comparable figures in which the trend is apparent.

52. Another device has been printing money, that is, increasing the supply of money without regard for real national output, which accelerates inflation and causes further losses of purchasing power of the currency.

53. In many countries this course has led to sudden and steep devaluations of the national currency relative to stronger international currencies, which has been sought as another means of encouraging exports.

54. In some countries some of these factors have been indexed as a means of averting their secondary effects and make their fiscal and monetary policy decisions more flexible.

55. In some countries of the Region the public deficit has risen steeply relative to GDP and has worked against some of the corrective measures attempted in the internal adjustment process, particularly under standby agreements negotiated and signed between governments and the

IMF. These agreements establish targets for reduction of the fiscal deficit relative to the GDP, which compels some countries to give priority to programs that contribute more directly to economic recovery in the short run. The result is an increase in the relative weight of budgetary allocations for typically economic activities.

56. In the overall development process, the economic and social aspects are two sides of the same coin, and hence inseparable, as has been said by the Director-General of the World Health Organization and the Executive Director of the United Nations Children's Fund, in a statement on primary health care:

"Any distinction between economic and social development is no longer tenable. Economic development is necessary to achieve most social goals and social development is necessary to achieve most economic goals. Indeed, social factors are the real driving force behind development. The purpose of development is to permit people to live economically productive and socially satisfying lives. Social satisfaction and economic productivity will be interpreted in widely different ways according to the social and cultural values prevailing in each society. Everywhere people themselves realize that their motivation in striving to increase their earnings is not greater wealth for its own sake but the social improvement that increased purchasing power can bring to them and their children, such as better food and housing, better education, better leisure opportunities, and, last but not least, better health. Only when they have an acceptable level of health can individuals, families and communities enjoy the other benefits of life. Health development is therefore essential for social and economic development, and the means for attaining them are intimately linked. For this reason, actions to improve the health and socioeconomic situation should be regarded as mutually supportive rather than competative. Discussions on whether the promotion of health only consumes resources or whether it is an economically productive factor contributing to development, belong to the academic past."14/

57. Hence, in addition to the purely economic effects of monetary and fiscal factors, others deriving from production and employment have to be considered; these other effects are both economic and social in nature and have been affected by the downward trend of the GDP as reflected in the following figures estimated by ECLA in constant United States dollars of 1970:

350 billion in 1981
347 billion in 1982
335 billion in 1983

58. This decline is the outcome of widely diverse factors, including some of an economic nature stemming from the recession-cum-inflation,

(which did not occur during the Great Depression of the Thirties), which have adversely affected activity in many lines of production in both the public and private sector; that is, the decline of this activity has also curtailed opportunities for employment and worsened visible unemployment and equivalent unemployment (visible plus invisible unemployment).

59. The figures for urban unemployment are as follows, in mean annual rates for 1983:[15/]

Argentina	4.9%	Costa Rica	9.8%
Bolivia	12.6	Mexico	12.5
Brazil	6.8	Paraguay	9.4
Chile	19.7	Peru	8.8
Colombia	11.0	Uruguay	15.7

60. No country in Latin America or the Caribbean has unemployment insurance such as that available in the more developed countries, which makes the situation in the Region even worse. In recent decades, as the economic situation in the Region improved, governments in Latin America and the Caribbean undertook programs for construction of infrastructure works, housing and social development as a means to generation of full employment. Some of these activities were supported by external financing, and others added to the fiscal deficit and aggravated the countries' monetary problems by being financed by printing money, which was regarded as the lesser evil.

61. In addition, bureaucratic job slots were created for the generation of employment, especially for unskilled labor. In the internal adjustment process to which the countries have submitted in their search for ways out of the economic crisis, these measures have had to be curtailed. Even so, several governments have continued or even expanded programs of minimum employment, as in Chile, or of food subsidies or distribution, as in Brazil.

62. Other countries have been unable to do this, having to direct those internal adjustments called for in their standby agreements with the IMF toward a drastic contraction of demand, for which they have had to reduce the supply of money in circulation and public expenditures not only of the central government, but of the decentralized agencies as well, a course that in many countries has greatly increased the government's consolidated public debt. This is what has happended in Peru, where, according to the Inter-American Development Bank,[16/] the six most important public enterprises accounted for 86% of the public sector's operating deficit in 1982. According to the same source, in Venezuela 69% of public sector expenditures were generated by the decentralized agencies.

63. The adverse effects of the socioeconomic crisis in the labor area have been severe, particularly for the young people entering the labor force each year--estimated at 9 million--because 43.2% of the present population of Latin America and the Caribbean is between 15 and 44 years old. Most of this age group is economically active inasmuch as only a small percentage of the segment between 15 and 24 years of age is enrolled in regular institutions of secondary, vocational and higher education.

64. ECLA's Economic Projections Center is of the view that, as a result of the prevailing situation, the demand and employment opportunities for young people and women is lower than in past decades, and that preference for jobs is given to adult male heads of family. The Center also considers that earlier unemployment calculations are now unrealistic and that the rates are higher than initially estimated. It also suggests that purchasing power of wages will steadily decrease in the next two years. This may also adversely affect future per capita GDP figures and equitable distribution of national income in most of the countries of the Region.

65. Other damage done by the socioeconomic crisis can be measured by the changes that have taken place in prices to the average consumer and urban worker (very few countries have similar indexes for the rural consumer owing to measurement difficulties), and also by modifications of wages and salaries. Changes in prices are measured by a predetermined "basic basket" of goods and services on which family income is spent, including such basic items as food, housing, education, health, and lesser expenditure items for apparel, recreation, etc.

66. According to ECLA figures,[17/] between December 1982 and December 1983 consumer prices rose throughout the region an average of 130.4%. In the countries of traditionally high inflation this average was 153.6%, and in those of traditionally moderate inflation it was 15.7%. The first group comprises Argentina, Bolivia, Brazil, Chile, Colombia, Mexico, Peru and Uruguay, among which the figures in excess of the group average are those of Argentina, Bolivia and Brazil, where retail prices rose 401.6%, 249.0%, and 175.2%, respectively

67. For the countries with moderate inflation, the group average of 15.7% was exceeded by Ecuador with a rata of 65.9% and Trinidad and Tobago with 16.7%. Costa Rica managed to drastically reduce the high inflation set off in 1981, during which year the index of prices to the average consumer and worker rose 65.1% above the 1980 level and 81% in 1982, essentially because of a sudden change in the parity of the national currency in 1981. The Costa Rican colon was devalued from 8.60 to 60.0 in that year, from which it then depreciated in 1982 to 45 colones to the United States dollar, and where it has, currently stabilized. The devaluations of Mexico, Venezuela and Bolivia have also

abruptly changed the rate of exchange of their currencies with the United States dollar. The Mexican peso dropped from 12.5 to the United States dollar in 1976 to 154 in 1982; the bolívar from about 4.5 to the dollar to 11; and the Bolivian peso plummeted from 25 to one U.S. dollar in 1981 to 2,200 to one on the parallel market today, although the official rate is 500 to the dollar.

68. The level of the exchange rate is the outcome of a variety of factors, including the monetary reserves held by a country, which in turn are determined by the components of its balance of payments. In turn, the exchange rate affects price changes just as these impact efforts by employees to have their wages and salaries increased to offset losses in purchasing power. In times of crisis, prices tend to change faster than wages, so that when adjustments are made the gap is usually wider than the changes that have taken place in the market value of the goods.

69. Although short-run adjustment programs tend to keep inflation in check by containing demand, when they fail to do this those who suffer most are people who depend on fixed incomes from wages, salaries, pensions and investments at fixed interest rates which have not been indexed to national rates of inflation. Also hard hit are low and moderate income people, who are less able to protect themselves from situations created by decisions made at levels and in spheres to which they have no access.

70. Loss of monetary parity and the deterioration of international reserves have made it difficult for some countries to buy medicine and drugs, equipment, and replacement parts, for their health programs when those items are of foreign origin and the national monetary authorities restrict the release of foreign exchange for these and others.

71. The above measures of the status of the Regional economy are examples only and by no means constitute a comprehensive analysis of all causes and effects of the present crisis made. Besides, there is no precise dividing line between political and social indicators, such as those described on Chapter 2, which discusses the situation in seven selected countries in the Region.

EXTERNAL AND INTERNAL STRUCTURAL AND SHORT TERM CAUSES AND EFFECTS

72. The term structural is frequently used to describe and define the permanent causes, factors and effects of overall development, while cyclical describes the same aspects but for the short term only. The former are over the long term, while the latter transitory usually lasting less than four years.

73. Those who have studied the origins of the current socioeconomic crisis blame it essentially on structural causes, citing rises in oil

prices as a trigger of the developments of the last decade. These causes have been aggravated by domestic situations stemming from characteristics unique to the countries in the Region themselves, which, nevertheless, have still much in common as subjects of external factors over which they have no control and are therefore spectators of the process rather than actors in it. There is also a fairly widespread - if not actually unanimous - view that the structural crisis and current recession are largely mutually reinforcing, the latter being exacerbated in many countries by high rates of inflation.

74. The traditional devices used in the past by the governments of the more developed countries to regenerate their economies have now proved to have been inadequate for the recovery begun, in some of them, in 1983 to be regarded as solid or and to generate enough momentum to be of benefit to the less developed countries as well. For example, it has not been possible to restore the rate of capital accumulation to the level reached before the onset of the latest decline; such instruments as credit and the traditional fiscal, monetary and trade policies applied in the more developed countries when aggregate demand and production decline are now less effective.

75. The crisis in Latin America and the Caribbean can have adverse consequences for the more developed countries themselves, as has been demonstrated for the United States by the drastic US$21 billion reduction of that country's exports to the Region during 1981-1983 (12 billion dollars of the reduction attributable to Mexico alone). These figures were disclosed by President Ronald Reagan in his report to the Congress in January 1984.

76. Again, according to President Reagan, "seven of the most heavily indebted Latin American countries took in 13.9% of the exports of the United States in 1981... (and) these losses (of those exports), caused by the economic adjustments that these heavily indebted countries had to make, will not be greatly reversed in 1984".18/

77. The foreign trade deficit of the United States during 1983 reached US$60.6 billion, 66% greater than the gap between exports and imports in 1982, which was US$36.4 billion; and 117% more than the trade deficit of US$27.9 billion in 1981.19/ According to the same source, the preliminary estimates for 1984 are of a trade deficit of about US$100 billion.

78. This situation has prompted groups of domestic producers to bring heavy pressure to bear on the Executive and Legislative branches for quotas and restrictions on the importation of some competing foreign products.

79. These figures also bear out the need for interaction between the more and the less developed countries and for efforts to attain recovery objectives in a spirit of solidarity and the international common good, along with fairness and equity in the distribution of welfare and wealth.

80. These efforts should also aim at assisting the less privileged countries and social strata, because "evidence exists to affirm that the general quality of life has declined substantially in most of the countries as a result of the many effects of the crisis in terms of reduced real outlays for education, health and housing brought about by stabilization programs, and because of the weakening of the social security and welfare systems. This has meant less access for the majority of the population to such basic goods and services as food, housing, health and education".20/

EFFECTS OF THE SOCIOECONOMIC SITUATION ON HEALTH INDICATORS

81. As mentioned in the introduction to this document, the main purpose of Resolution XX of the XXI Pan American Sanitary Conference was to determine the possible financial and budgetary implications, at both the national and international level, of the present socioeconomic crisis for carrying out the Plan of Action for implementation of the Regional Strategies for Health for All by the Year 2000. The specific request to the Director of the Pan American Sanitary Bureau was that he continue to examine the international economic environment, and national and international resource allocations to health and related sectors, regarding any significant changes that could affect the attainment of Health for All by the Year 2000.

82. In compliance with that mandate, Chapter I has provided a body of overall macroeconomic and social data, and in some cases references to the situation in the seven countries covered in more detail. Chapter II will examine more specific details of that situation, describe changes that took place in the economy during the period 1978-1983 and trace their implications for the financing of social programs with emphasis on health.

83. Assessing the effects of the crisis on the "health situation," that is, on coverage, on emergency services, and on the details of the allocation of financing of national health services, require data which either did not exist or was unavailable.

84. Distinction would also have to be made between inputs, such as the provision of services, their distribution, percentages of coverage, and results or effects. Such indexes as live birth weight, mortality among infants and children under five, morbidity from malaria, etc., are negative indicators which, however, can indicate measurements of gains. However, these indicators of "health results" are affected not only by inputs for health such as personnel and equipment for immunization, but also by improvements in development and social welfare. For example, an increase of the food supply in a country plagued by production, distribution and financing shortfalls, can give rise to a significant reduction of infant mortality.

85. Measurement by indicators of results is also hindered by other factors. There is a direct general correlation between the GDP and life expectancy at birth. However, this correlation is not absolute, as has been demonstrated in several countries, among them Sri Lanka, where high health levels have been attained with low per capita income levels thanks to the efficient application of very simple public health techniques.

86. While it is important to measure the results of the socioeconomic situation over the long run, it is not always feasible to predict the effect that the level of financing can have on health gains. Moreover, it is possible to predict that a reduction in financing for programs in the social sectors will have negative effects on investments in the health sector and on the trend toward improvement of the health situation. But it could not be predicted that, because of reduction in financing, infant mortality could be reduced or that the life expectancy of the population would be shortened.

MULTILATERAL PUBLIC BANK FINANCING FOR HEALTH

87. Until 1978 the Inter National Bank for Reconstruction and Development (World Bank) did not directly finance health programs but only certain components of health related activities such as water and sewerage. Since 1979, the Bank has begun to provide relatively small amounts of its total loan portfolio for health projects. In 1981 and 1982 such funds reached only 0.1 percent of total loans. In 1983, this increased by 0.5 percent.

88. During last year, the percent of loans of the total portfolio allocated to the social sector reeached 9.0 percent. Of this amount, 6.0 percent was used for water and sewerage, 3 percent for education and the remainder for health, including population programs, nutrition as well as health itself.

89. Loans for water and sewerage increased to 4 percent in 1982 and 6 percent in 1983. Funds for education, on the other hand, fell from 4 percent in 1981 and 1982 to less than 3 percent in 1983.

90. Countries which receive credits for investment programs must finance 90 percent of programs with national resources derived from ordinary budget accounts based on tax revenues or charges to borrowers. Similar restrictions are applied to IMF standby agreements, since both institutions operate according to similar policies and practices, although they have different goals. The World Bank is concerned with programs of structural adjustment over the mid and long term, closely associated with economic development. Indeed, this is the reason that 42 percent of its loan portfolio was allocated to productive sectors in 1983. The IMF grants credit according to a special drawing fund for short term adjustments or emergencies which require funds to improve balance of payments and the capacity to service foreign debt.

91. The World Bank granted a credit to the Government of Peru in the amount of US$35 million for health programs. Depending on an evaluation of the Peruvian experience, the Bank may continue to authorize similar loans to other nations in the future. But it is necessary to bear in mind the objectives of the Bank as expressed in its 1983 World Development Report which refer to:

- The type of administration which should be operational during periods of uncertainty, and which should be effective and efficient;

- the improvement of plans, budgets and evaluation of expenditures;

- improvement of information systems for management purposes;

- improvement in management of decentralized institutions;

- improvement in projects and programs; and

- national community participation.

92. With respect to the mandate of the Inter American Development Bank (IDB), its Special Operations Fund makes loans according to conditions which vary by type of country according to degree of development. In the first category are:

a) Bolivia, Ecuador, El Salvador, Haiti, Honduras, Guatemala, Guyana, Nicaragua, Paraguay and the Dominican Republic. They enjoy preferential, interest rates, usually from between 2 to 5 percent lower than market rates, with 30 to 40 year terms, and grace periods for amortization and interest payments. For the period of 1983-1986, US$100 million is available for these ten countries. This is still not enough to cover all needs, thereby forcing the countries to give priority, once again, to the producing sectors of the economy.

b) Barbados, Costa Rica, Jamaica, Panama, Suriname and Uruguay constitute the second group of countries. They have access to credits with an ordinary rate of interest, higher than that for the first group, which is about 11 percent yearly, less five points. Terms for liquidation of the entire debt range from 15 to 25 years. The grace period for amortization and interest payments is less than that granted to the countries in the first group. For 1983-1986, the amount allocated to this second group is US$800 million.

93. The remaining countries in the Region have to use the other resources of the IDB. These loans are not as soft as these nations are considered to have achived a higher level of economic development and have their own financial resources.

94. During 1981-1983, IDB authorized loans in the amount of US$724 millions for health programs and activities. Included in this figure are funds for drinking water, sewerage and environmental improvements. The distribution oif these resources has been:

1981 US$208 million or 8.3 percent of total loans
1982 US$245 million or 8.9 percent of total loans
1983 US$271 million or 8.9 percent of total loans

95. There appears to be a view in the multilateral and bilateral financial and technical assistance organizations that the social sectors, including health, are plagued by poor management, or at least are open to substantial improvement in the administration of their resources to improve impact. There is also the belief that health sector should generate savings and thereby capitalize more effectively on existing resources before seeking greater outside financial assistance.

96. It has been affirmed that attainment of HFA/2000 consitutes not only a substantive medical and paramedical effort, but it should also be understood as a natural economic achievement:

"The concept of primary health care as a strategy to attain HFA/2000 must meet the requirments of impact, equity, social efficiency, social participation, intersectoral linkaging and cooperation among countries. Its essence is based on the recognition that in order to achieve "Health for All," meeting all those requirements constitutes an economic problem. Such is the relative scarcity of multiple use resources in a given society containing different groups of people with unequal opportunities to express and satisfy their specific needs and aspirations in a space and moment in time. 'Primary health' constitutes a strategy because it proposes to resolve the above problem in a determined fashion by appropriating, recombining, reorganizing and reorienting all the resources (available and potential) from the entire health sector to satisfy the needs and aspirations (in the field of health) for all the society exactly according to the requirements for the goal and regional objectives already spelled out.

"From a strictly 'technical-administrative' perspective, the potential of this strategy lies in the hypothesis, empirically confirmed, that it is possible to solve, efficiently, given sets of health problems with combinations certain technological resources (functions of production), of different complexities, and therefore with varying social costs. It is suggested that there exists a correlation between the complexity of health problems and the complexity (and social cost) of production functions capable of solving them.

On the other hand, empirical evidence also supports the contention that less complex health problems occur relatively more frequently than

those which are more complex. From this it may be deduced that there is a possibility to solve health problems for a given population by organizing levels of care which minimize the social cost. In this way, primary care as a strategy implies organization of services according to levels of care, but can be limited in some fashiion to a single level considered to be minimal.21/

End Notes, Chapter I

1/ The data for 1983 are estimates subject to revision and the changes in 1981-1983 correspond to those accumulated during the same period. Document E/CEPAL/G.1279, p. 33.

2/ Alejandro Foxley and Dagmar Raczynski, Corporación de Investigaciones Económicas para América Latina (CIEPLAN), "Grupos Vulnerables en Situaciones Recesivas: El caso de los niños y jóvenes en Chile, Santiago de Chile", 1983, pp. 31 and 32.

3/ Roberto Macedo, "The Economic Crisis and the Welfare of Brazilian Children: A Case Study of the State of Sao Paulo", UNICEF, June 1983, pp. 43, 44 and 47.

4/ James P. Grant, Executive Director, Fondo de las Naciones Unidas para la Infancia (UNICEF), "Estado Mundial de la Infancia 1984", p. 6.

5/ James P. Grant, loc cit. p. 6.

6/ James P. Grant, ibidem, p. 12.

7/ "Noveno Período de Sesiones del Comité de Expertos de Alto Nivel (CEGAN)", Documento de Trabajo, Montevideo, 18 al 20 de enero de 1984, sn/p.

8/ Doctor Enrique V. Iglesias, Secretario Ejecutivo de la Comisión Económica para la América Latina, "Síntesis Preliminar de la Economía Latinoamericana durante 1983", Documento E/CEPAL/G.1279, p. 30.

9/ Doctor Enrique V. Iglesias, loc cit., p. 29.

10/ Lic. Antonio Ortíz Mena, President, Inter American Development Bank, "The Economic Crisis: Looking Beyond Emergency Measure to Long-Term Needs", FOCUS, January 1984, p. 5.

11/ Lic. Antonio Ortíz Mena, loc cit, p. 6.

12/ Lic. Antonio Ortíz Mena, ibidem, p. 7.

13/ Lindley H. Clarck Jr., "A Remembrance of Interest Rates--and an Editor-Past, The Wall Street Journal", 5 July 1983, p. 23.

14/ Organización Mundial de la Salud/UNICEF, "Informe Conjunto del Director General de la OMS y del Director Ejecutivo de la UNICEF, Atención Primaria de la Salud, Conferencia Internacional sobre Atención Primaria de la Salud", Alma Ata (URSS) 6-12 September 1978, pp. 15 and 16.

15/ Doctor Enrique V. Iglesias, passim, Cuadro 4, América Latina: Evolución del Desempleo Urbano, p. 34.

16/ Inter American Development Bank, Economic and Social Development Department, "External Debt Land Economic Development of Latin America, Background and Perspectives", A Study by Luis Carballo-Raines and Debora E. Rogers, January 1984, p. 91.

17/ Doctor Enrique V. Iglesias, supra, Cuadro 5, América Latina: Evolución de los precios al consumidor, sn/p.

18/ Inter American Development Bank, information received by teletype, 2 February 1984, p 1.

19/ The Washington Post, Trade Deficit for 1983 Hits $ 60.6 Billion, 8 February 1984.

20/ Comisión para América Latina, "Noveno Período de Sesiones de SEGAN", loc cit., sn/p.

21/ Manual sobre el Enfoque de Riesgo en la Atención de Salud, Medellín, Colombia, 1-10 March 1984, Vol. I, Chapters I-IV, pp. 7, 8 and 9.

CHAPTER II. SOCIOECONOMIC TRENDS IN SELECTED LATIN AMERICAN AND CARIBBEAN NATIONS

97. The preceding Chapter has described in some detail the present economic crisis throughout Latin America and the Caribbean. It has shown in broad outline the nature and extent of conditions, especially as they pertain to socioeconomic development, health in particular. In this Chapter the analysis narrows in focus on a review of seven countries. They are: Argentina, Brazil, Costa Rica, Jamaica, Mexico, Peru and Saint Lucia. While these nations do not constitute a representative sample of the Region, they do contain virtually 60 per cent of the population in Latin America and the Caribbean. Thus while it is not possible with scientific accuracy to generalize to the Region the experiences of the group, neither is it possible to dismiss entirely strong suggestions that what is happening in the seven countries may be occurring as well in the remaining nations of the Region. The seven countries included in the sample group were selected for a variety of reasons. Argentina, Brazil and Mexico are the largest territories and represent a total of 52 per cent of the regional population. Also, as large nations, they encounter health and finance problems of a distinct nature and scope than those of their smaller and less developed neighbors. Peru was chosen as an Andean nation, and one which is currently facing a series of severe development problems which were believed necessary to be accounted for in the group. Costa Rica, a small and relatively developed nation, was selected from the Central American area where yet another set of distinct conditions exists. Jamaica is the most advanced country in the English-speaking Caribbean, and Saint Lucia is among the smallest.

98. Before continuing, one important caveat needs to be explicated. In many instances data were not available or were so tentative to be of marginal value only. (A complete list of variables for which data were requested may be found in the Appendix.) Hence it was impossible to present uniformly comparable findings for all countries. What follows, then, is an elaboration of the major points of concern in examining public and private financing of health care and health care systems in Latin America and the Caribbean between the years 1978 and 1982. Countries in the group will be analyzed individually and conclusions regarding the group as whole are presented at the end of the report.

99. While budgeted funds are certainly a measure of health policy intent, as are national plans, they are not useful in evaluating real commitment and outcome. That is an analytical function of expenditures. Consequently, the analysis will be directed almost exclusively at public and, where possible, private outlays for health care and health related activities. It should be noted, in addition, that some definitional problems were present, as might have been expected. Thus health sector, for example, was defined differently in the majority of the nations in

the group. While attempts were made to establish uniform definitions to facilitate comparative analysis, this turned out not to be feasible. Consequently, comparisons between and among nations in the group are difficult but not entirely impossible.

The Economies and Public Spending

100. The macroeconomic indicators in Table 2.1 show a somewhat mixed pattern among the seven countries in the group. Argentina, Jamaica, Peru, Argentina, Mexico and Costa Rica all register declines in GDP as of the last year measured. The two remaining nations experienced small increases. However, during the five year period of measurement, 1978 to 1982, with the exception of Jamaica, the trend had been generally upward until 1982, especially in the case of Costa Rica. That is, if 1978 is compared against 1982 the net difference is positive. No doubt the world and regional economic crises are reflected in these statistics, especially as of 1982, as severe recession and a crushing foreign debt have been taking their toll. Once again it is useful to look at Costa Rica. That nation, which had been experiencing gradual growth since 1978 (although the rate of increase had dropped off), suffered a dramatic plunge in its GDP from 0.8 percent in 1981 to minus 9.9 per cent in 1982. Peru suffered a similarly spectacular decline.

101. A more sensitive indicator of economic vicissitudes, certainly in more human terms, is evidenced in Table 2.2, indicating per capita changes in real GDP. Here the pattern is less encouraging. As of the last year for which data exist, per capita GDP is down in all countries from the previous year, with the exception of Saint Lucia. So while in some countries the overall economic picture is not one of continuous decline, at least in macro terms, per capita examination of the GDP suggests that population growth along with faltering economies have offset whatever minor economic gains may have been achieved. Given the magnitude of the decrease in the regional economy, as presented in the statistics in Chapter I, the picture which emerges here is not so surprising. Indeed, considering the size of the foreign debt and the extent of unemployment a bleaker scenario may well have been expected.

102. But what has been the affect on public spending in the seven nations? How have the various governments been able to cope with public demands, especially for health care, in times of economic hardship? Once again the picture is mixed.

103. Argentina, Brazil, Costa Rica and Jamaica all show declines in per capita public expenditures, ranging from a significant 24 per cent reduction in Argentina to just 2 per cent in Jamaica, as is illustrated by the data in Table 2.4.

104. Perhaps he most puzzling sets of figures are those for Mexico and Peru. While GDP in both those countries declined in the last year measured, total central government expenditures increased across the

Table 2.1

AMOUNT AND PERCENT CHANGE OF GROSS DOMESTIC PRODUCT
(1978 Constant Prices, Millions of Local Currency)

COUNTRY	YEAR									
	1978		1979		1980		1981		1982	
	OUTLAY	%	OUTLAY	%	OUTLAY	%	OUTLAY	%	OUTLAY	%
ARGENTINA	5179800	...	5359253	3.5	5405823	0.9	5114706	-5.4	...	...
BRAZIL	3729700	...	4054191	8.7	4251849	4.9	4147921	-2.4	4203630	1.3
COSTA RICA	30193	...	31674	4.9	32107	1.4	32353	0.8	29145	-9.9
JAMAICA	3763	...	3708	-1.5	3506	-5.4	3593	2.5	3481	-3.1
MEXICO	2337398	...	2541447	8.7	2729268	7.4	2791758	2.3	2786213	-0.2
PERU	1672307	...	1743146	4.2	1777860	2.0	1837482	3.4	1720791	-6.4
SAINT LUCIA	187	...	214	14.4	211	-1.7	215	2.3	...	...

NOTE: Constant prices in all Chapter II tables calculated from Official Data.

board and per capita. In Mexico government outlays went up by an extraordinary 25.7 per cent* between 1981 and 1982, no mean feat considering the country's debt position and the conditions of the agreement with the IMF requiring reduction in the deficit from 16% to 8% of GDP by the year 1984. In Peru the increase is not nearly as dramatic--7.7 per cent--but still significant in a country saddled by a large foreign debt and staggering natural disasters which have destroyed much of the agricultural and aquacultural crop. Yet despite these hardships, the Peruvian GDP rose every year between 1978 and 1981 (see Table 2.4), perhaps helping to explain in part the increase in public spending. The same was not true for Mexico. Indeed, the GDP fell while public expenditures rose (see Tables 2.2 and 2.3)

Table 2.2

PER CAPITA GROSS DOMESTIC PRODUCT
(1978 Constant Prices, Local Currency)

	YEAR				
COUNTRY	1978	1979	1980	1981	1982
ARGENTINA	192558	196238	195086	182083	...
BRAZIL	33024	35028	35847	34125[a/]	33775
COSTA RICA	14242	14596	14270	14246	12683
JAMAICA	1775	1724	1616	1619[b/]	1533[c/]
MEXICO	35724	37696	39355	38828	38146
PERU	99424	100818	99992	97785	89082
SAINT LUCIA	1561	1785	1755	1795	...

a/Preliminary Data
b/Revised Estimates
c/Estimates

*This unprecedented growth in the Mexican budget may well be due in part to substantial increases in the Finance and Public Credit account, helping to service an enormous public debt. In 1979 this budget account grew only 0.85 per cent. In 1980, when the the magnitude of the Mexican debt was becoming apparent, the increase rose to 11.0 per cent. When the Public Debt account is added, the respective percentages become 14. 4 and 20.6. Further testimony to the impact of public debt service on federal expenditures growth is evident in the figures for 1981, where the per cent growth of the Public Debt and Finance and Public Credit accounts reached 24.3. In 1982 it was 36.0 per cent.

Table 2.3

TOTAL CENTRAL GOVERNMENT OUTLAYS
(1978 Constant Prices, Millions of Local Currency)

COUNTRY	YEAR 1978	1979	1980	1981	1982
ARGENTINA	829976	817215	718636	648620	498196
BRAZIL[a/]	...	1355821	1631272	1537243	1506556
COSTA RICA	16734	18389	20140	19454	17372
JAMAICA	1229	1537	1282	1641	1645[b/]
MEXICO	937834	1071809	1352043	1445487	1816458
PERU	225070	189803	255379	275077	...
SAINT LUCIA	...	...	...	71	84

[a/] Federal Government expenditures only (and for all subsequent tables).
Excludes transfers from Union budget and sanitation. Includes outlays for INAMPS and Monetary Budget, including subsidies for credit and supply.

[b/] Estimates.

105. Jamaica, too, displayed a similar pattern as in Mexico, increasing public spending at the same time GDP was falling. In Brazil, the reverse may be witnessed. GDP rose slightly at the same time federal spending declined marginally. In Argentina and Costa Rica, both indicators fell; and in Saint Lucia, as in Peru, GDP and expenditures increased simultaneously. On balance, it is difficult to say what the mid term trends (or even short term) will be. More time will have to pass since the brunt of the global economic trauma was felt before clearer patterns of the impact on public and health sector spending emerge.

Table 2.4

PER CAPITA TOTAL CENTRAL GOVERNMENT OUTLAYS
(1978 Constant Prices, Local Currency)

COUNTRY	YEAR 1978	1979	1980	1981	1982
ARGENTINA	30854	29924	25934	23091	17524
BRAZIL	...	11714	13753	12647	12105
COSTA RICA	7894	8474	8951	8566	7560
JAMAICA	580	715	591	739	724
MEXICO	14333	15897	19496	20104	24869
PERU	13381	10978	14363	14639	...
SAINT LUCIA	...	...	...	591	702

106. Another way of looking at public sector commitment is to consider public expenditures as a per cent of GDP (see Table 2.5). Here the picture becomes a little more focused than what has been seen above. Argentina, since 1978, has been experiencing a steady decline in public sector spending as a percentage of GDP, while Mexico has been undergoing a protracted increase, jumping prominently between 1981 and 1982. This complements what has already been exhibited in Tables 2.2 and 2.3. Jamaica, too, has been augmenting the percentage of public spending generally between the same periods of time. Brazil peaked in 1980 and declined slightly in 1981 and then again in 1982. The same is true of Costa Rica. The data reinforce a country-by-country pattern which has been emerging all along. What may be most noteworthy about the data in Table 2.5 are the disparities between and among countries. That is, Mexico and Costa Rica demonstrate strong public sector support, while Argentina and Peru reveal more tenuous levels of commitment, at least in terms of government expenditures as a percentage of GDP. There are doubtless many and complex reasons for the differences. But an analysis of them is beyond the mandate of the report. The fact remains, however, that relative public outlays vary widely.

Table 2.5

TOTAL CENTRAL GOVERNMENT OUTLAYS AS PERCENTAGE OF GDP
(1978 Constant Prices, Millions of Local Currency)

COUNTRY	YEAR									
	1978		1979		1980		1981		1982	
	OUTLAY	GDP %	OUTLAY	GDP %	OUTLAY	GDP %	OUTLAY	GDP %	OUTLAY	GDP %
ARGENTINA	829976	16.0	817215	15.2	718636	13.3	648620	12.7	498196	...
BRAZIL	...	...	1355821	33.4	1631272	38.4	1537243	37.1	1506556	35.8
COSTA RICA	16734	55.4	18389	58.1	20140	62.7	19454	60.1	17372	59.6
JAMAICA	1229	32.7	1537	41.5	1282	36.6	1641	45.7	1645	47.2
MEXICO	937834	40.1	1071809	42.2	1352043	49.5	1445487	51.8	1816458	65.2
PERU	225070	13.5	189803	10.9	255379	14.4	275077	15.0	...	...
SAINT LUCIA	...	...	...	...	...	...	71	32.9	84	...

The Social Sector

107. Having reviewed the principal patterns of government spending, what can be said for public commitment to the social sector in the seven countries under examination? Of all the nations for which data were available, per capita social sector spending in four of them grew, at least between the last two years measured (see Table 2.6). During the period 1978 to 1982, only Mexico registered a steady and noticeable increase in absolute expenditures. However, at the same time, Mexico decreased social sector spending as a percentage of total central government expenditure. Comparing per capita social sector expenditures for the year 1978 and the last year for which data are available, only Jamaica and Mexico show growth. Looking at the last two years on the table, it is clear Argentina and Costa Rica experienced substantial reductions in per capita social spending. The remaining nations weave a varied pattern.

108. Additional evidence pointing to unfixed economic and fiscal patterns may be seen in Table 2.7, showing social sector spending both as a percentage of GDP and total central government outlays. Argentina and Costa Rica remain faithful to the trends which have already characterized their economic and financial performance described in preceding pages of the report. In each case social sector spending may be seen to decline most clearly between 1981 and 1982.

109. Brazil, on the other hand, which exhibited a downward direction in total federal expenditures and per capita GDP, at least since 1980, now realizes a modest gain in social spending when measured against those two indicators. Mexico, which has demonstrated such a strong commitment to public sector activity, as evidenced by previous indicators, now experiences a decline in social outlays as a percent of total public expenditure. At the same time social spending has increased relative to GDP. The apparent anomaly may be explained by a GDP growing at a slower rate than social sector spending.

Health Expenditures

110. Outlays for ministry of health expenditures as a percentage of GDP show a mixed picture, as may be seen in Table 2.9. As may have been predicted, Costa Rica and Argentina exhibit declines. Changes in the other countries, between 1978 and 1982, are slightly upward or do not occur at all. The one noticeable exception is Saint Lucia, which declined substantially. However, Saint Lucia appears to be coming close to achievement of HFA/2000, which may help explain part of the decrease. The same table also indicates public expenditures on social security as a percentage of GDP. Interestingly, Argentina actually shows a slight increase in this measure, as do Costa Rica and Brazil. In fact, only Jamaica and Mexico show declines, though small, between 1978 and 1982.

Table 2.6

PER CAPITAL SOCIAL SECTOR EXPENDITURES
(1978 Constant Prices, Local Currency)

	YEAR				
COUNTRY	1978	1979	1980	1981	1982
ARGENTINA[a/]	8180	8610	10811	9164	6267
BRAZIL[b/]	908	877	777	865	867
COSTA RICA[c/]	2121	2797	2707	2197	1484
JAMAICA[d/]	199	229	213	...	218[h/],[i/]
MEXICO[e/]	2729	2859	3060	3126	3345
PERU[f/]	3853	3202	3292	3328	...
SAINT LUCIA[g/]	...	...	...	...	282

a/ Social Sector includes budget accounts of Ministries of: Culture and Education, Health and Social Welfare (i.e, Social Security, Labor, Housing, Social Assistance, Sports and Recreation, Social Promotion and other, unspecified, agencies).

b/ Social Sector includes Ministries of Health and Sanitation, Education and Culture, Labor, Housing and Urban Affairs, Social Welfare.

c/ Social Sector includes the following sectors: Health, Education, Labor and Social Security, Housing and Human Settlements, Culture and Recreation.

d/ Social Sector includes the following ministries: Health, Housing, Labour, Local Government (and Community Development), Education, Social Security.

e/ Social Sector includes the following sectors: Public Education, Health and Welfare, Labor and Social Security as well as "Controllable Agencies and Public Enterprises."

f/ Social Sector includes sectors of Health, Education and Labor.

g/ Social Sector includes Ministries of Health and Education.

h/ Excludes Ministries of Housing and Labor.

i/ Revised Estimates.

Table 2.7

SOCIAL SECTOR EXPENDITURES AS PERCENT OF TOTAL CENTRAL GOVERNMENT OUTLAYS
(1978 Constant Prices, Millions of Local Currency)

COUNTRY	YEAR 1978 OUTLAY	1978 SSE %	1979 OUTLAY	1979 SSE %	1980 OUTLAY	1980 SSE %	1981 OUTLAY	1981 SSE %	1982 OUTLAY	1982 SSE %
ARGENTINA	220050	26.5	235135	28.8	299559	41.7	257428	39.7	178168	35.8
BRAZIL	102515	...	101511	7.5	92186	5.7	105125	6.8	107901	7.2
COSTA RICA	4497	26.9	6069	33.0	6092	30.2	4990	25.7	3411	19.6
JAMAICA	423	34.4	493	32.1	461	36.0	225	13.7	494	30.1
MEXICO	178577	19.0	192754	18.0	212220	15.7	224754	15.5	244341	13.5
PERU	99490	28.8	89970	29.2	102920	22.9	113535	22.7	...	...
SAINT LUCIA	...	...	...	...	...	...	...	...	34	40.2

Table 2.8

SOCIAL SECTOR EXPENDITURES AS % OF GDP

	YEAR				
	1978	1979	1980	1981	1982
COUNTRY	%	%	%	%	%
ARGENTINA	4.2	4.4	5.5	5.0	...
BRAZIL	2.7	2.5	2.2	2.5	2.6
COSTA RICA	14.9	19.2	19.0	15.4	11.7
JAMAICA	11.2	13.3	13.2	6.3	14.2
MEXICO	7.6	7.6	7.8	8.1	8.8
PERU	3.9	3.2	3.3	3.4	...
SAINT LUCIA	...	...	...	...	...

For Mexico, this is one of the few indicators which revealed a slight downturn in an otherwise relatively positive trend for health. A more accurate indicator of the relative status of health care expenditures within the public sector, however, is the total of health ministry and social security outlays as a percentage of GDP. With the exception of Saint Lucia, the countries in the group have significant publicly supported social security programs. Once again the general pattern which has been traced in previous tables emerges. Costa Rica shows a significant reduction in expenditures on health and social security combined. Argentina displays a stable pattern as does Brazil. One nation which requires special comment here is Peru. While on other indices it has exhibited a relatively low degree of social sector support, it is clear from the data in Tables 2.9 through 2.11 that there is a slightly stronger commitment to health and social security, both within the social sector itself and as a percentage of central government expenditures, than would otherwise have appeared to be the case.

111. Social security expenditures demonstrate an even more impressive record. In Mexico the reverse happens, as indicated elsewhere. That is, while in budgeted and per capita expenditures there is an increase in health and health related support, as a per cent of social sector and central government outlays a constant decline since 1978 is quite evident. The remaining nations all show increases, however modest they might be. It should be pointed out, however, that social security costs are not necessarily all health related. Social Security data from Mexico

and Costa Rica are limited only to health expenditure; however, unfortunately, it was impossible to partial out for the group as a whole what percentage of social security actually went to underwrite health costs. Thus any interpretation of the data needs to be conditional.

112. As a percentage of total central government expenditures, health and social security, not unexpectedly, by and large adhere to the same trend (see Table 2.10). Taken separately, health ministry outlays, however, are less consistent with former patterns. They decline in Peru, Jamaica and Saint Lucia. This is also the case for Argentina and Costa Rica, as might have been anticipated in light of all the foregoing data. In Brazil there is a trace of upward movement. Combined with social security a more familiar set of trends appears, but not entirely. Most significant are the declines in Mexico and Jamaica. Where total public expenditures and social sector outlays had been increasing, the health sector was not keeping pace. While this is a disturbing statistic for those in the health field, in the case of Jamaica it is attenuated by two factors. First, the degree of decline is small. Second, it is much too early to establish if this is a trend or simply a one or two year break in an otherwise more positive cycle.

113. Of more concern is Mexico, where the decrease has been generally sustained since 1978. Yet, this in turn is offset, as can be seen in Table 2.12, which display a general increase in per capita health and social security expenditures.

114. The directions in Argentina and Costa Rica also give rise to concern. Since 1978, Argentina has been spending progressively less on health in proportion to total social sector expenditures. And for the last three years shown on Table 2.11, 1980 to 1982, Brazil has also accumulated a signficant decrease in health care and social security expenditures as a per cent of social spending. The situation in Jamaica has been variable. The one surprise, outside of Mexico, is Costa Rica. That nation, which has shown a consistent decline in health care outlays on every other indicator, does relatively much better than other members of the group in defending and increasing proportionately health expenditures in the social sector.

115. Finally, it is instructive to examine the data in Table 2.12 on per capita health and social security spending. Costa Rica and Argentina, once more, register declines, the former beginning in 1979 and the latter in 1980. Peru varies, but generally the pattern is upward. Jamaica is also uneven, but the changes are very small, pointing to a moderate stability in per capita expenditures. Only Mexico and Saint Lucia indicate clear upward trends, and this is in keeping with the patterns which have now been seen to exist.

Table 2.9

COMBINED MINISTRY OF HEALTH AND SOCIAL SECURITY EXPENDITURES
AS PERCENT OF GROSS DOMESTIC PRODUCT

	YEAR														
	1978			1979			1980			1981			1982		
COUNTRY	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL
ARGENTINA	0.5	0.9	1.4	0.8	0.9	1.7	0.4	1.0	1.4	0.3	1.1	1.4	...	...	...
BRAZIL[a/]	0.2	1.2	1.4	0.2	1.2	1.3	0.1	1.1	1.3	0.1	1.3	1.4	0.2	1.2	1.4
COSTA RICA	1.0	5.5	0.5	1.2	6.0	7.2	1.3	6.2	7.4	1.3	5.6	6.9	0.9	4.0	5.6
JAMAICA	2.4	0.2	2.6	2.5	0.4	3.0	2.3	0.5	2.8	...	0.1	...	3.0	0.3	3.3[b/]
MEXICO	0.5	3.3	3.8	0.4	3.2	3.6	0.5	3.1	3.5	0.5	3.0	3.6	0.5	3.3	3.8
PERU	1.0	2.1	3.0	1.0	2.0	3.0	1.0	2.5	3.5	1.0	2.8	3.8	1.2	2.0	4.0
SAINT LUCIA	10.7	...	...	0.0	...	...	4.9	...	...	5.1	...	...	...	...	...

[a/] Does not include costs for sanitation.
[b/] Calculation based on estimates.

Table 2.10

MINISTRY OF HEALTH AND SOCIAL SECURITY EXPENDITURES AS PERCENT OF CENTRAL GOVERNMENT OUTLAYS

	YEAR														
	1978			1979			1980			1981			1982		
COUNTRY	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL
ARGENTINA	3.0	5.5	8.4	5.0	6.0	11.0	2.9	7.6	10.5	2.5	8.3	10.8	2.2	6.8	9.0
BRAZIL	...	...	...	0.5	3.5	4.0	0.4	2.9	3.3	0.4	3.4	3.8	0.4	3.2	3.6
COSTA RICA	1.9	9.9	11.8	2.0	10.3	12.3	2.0	9.8	11.8	2.1	9.4	11.5	1.6	7.8	9.4
JAMAICA	7.3	0.7	8.0	6.1	1.0	7.1	6.4	1.3	7.7	...	0.2	...	6.3	0.7	7.0
MEXICO	1.2	8.2	9.4	1.0	7.6	8.6	0.9	6.2	7.1	1.0	5.9	6.9	0.8	5.1	5.9
PERU	7.2	15.4	22.6	8.9	18.2	27.1	6.9	17.4	24.3	6.6	18.5	25.1	...	...	...
SAINT LUCIA	...	...	...	...	...	...	...	...	...	15.6	...	...	13.6	...	...

Table 2.11

MINISTRY OF HEALTH AND SOCIAL SECURITY AS % OF SOCIAL SECTOR EXPENDITURES

	YEAR														
	1978			1979			1980			1981			1982		
COUNTRY	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL
ARGENTINA	11.2	20.6	31.8	17.4	20.8	38.3	7.1	18.2	25.3	6.3	20.9	27.3	6.2	19.1	25.2
BRAZIL	6.3	45.3	51.6	6.1	47.1	53.2	6.4	51.5	57.9	5.2	49.8	55.0	6.1	44.9	50.9
COSTA RICA	7.0	36.8	43.8	6.2	31.2	37.4	6.6	32.5	39.1	8.3	36.6	44.8	8.0	39.6	47.6
JAMAICA	21.2	2.1	23.3	19.0	3.2	22.2	17.7	3.5	21.3	...	1.5	...	21.1	2.3	23.4
MEXICO	6.4	42.9	49.4	5.4	42.5	47.9	5.8	39.5	45.3	6.4	37.7	44.1	5.7	38.2	43.9
PERU	16.4	34.9	51.2	18.7	38.5	57.2	17.1	43.1	60.3	16.0	44.9	60.9	...	...	...
SAINT LUCIA	...	...	...	...	...	...	...	...	...	...	...	...	33.9	...	...

Table 2.12

PER CAPITA HEALTH AND SOCIAL SECURITY EXPENDITURES
(1978 Constant Prices, Local Currency)

	YEAR														
	1978			1979			1980			1981			1982		
COUNTRY	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL	MOH	SS	TOTAL
ARGENTINA	919	1686	2605	1501	1793	3294	763	1969	2733	582	1916	2498	387	1194	1581
BRAZIL	58	411	468	53	413	467	50	400	450	45	430	475	52	389	442
COSTA RICA	149	780	929	174	872	1045	179	880	1059	181	804	985	118	588	707
JAMAICA	42	4	46	44	7	51	38	8	45	...	2	...	46	5	51
MEXICO	176	1172	1348	153	1216	1369	178	1207	1386	199	1179	1379	191	1277	1468
PERU	968	2062	3030	976	2001	2977	992	2496	3489	965	2714	3679	1076	2455	3531
SAINT LUCIA	168	...	...	...	...	...	86	...	...	92	...	...	96	...	...

116. If, as has been illustrated, health care expenditures in the public sector are being reduced in a majority of the seven countries under examination, how then has this impacted distribution of financial resources within the sector? Have there been any significant changes in patterns of expenditures, by type of outlay and, if so, to what degree? Once again, it needs to be explained at the outset that few data were available. Even with that limitation, it is important to present what information exists.

117. The majority of disaggregated data dealt with salaries in the various ministries of health. While admittedly this is only a partial indication of types of expenditures within the ministries, it does point to the fact that salaries are a major (and in some instances the major) component of outlays (see Table 2.13). In Jamaica they have remained around half of all costs. In Costa Rica, with the exception of 1981, they have accounted for over 50 per cent, peaking in 1982 at 63.5 per cent. A similar if not identical, pattern emerges for Mexico. Indeed, as of 1982 salaries for the Mexican health sector climb close to 70 per cent of total sector outlays. Only Argentina reveals a generally declining and relatively small percentage of ministerial expenses as salaries. This might have been explained by a significant predominance of capital over recurrent costs. Yet this has not been the case. Recurrent costs ranged from a high of 94.4 per cent of all ministerial outlays in 1978 to a low in 1982 of 73.3 per cent.

118. A few data were also available on public expenses for hospital care. While the information is scarce, it does support the patterns which have been developed throughout this Chapter. In Costa Rica, for example, there has been a drop in hospital outlays from a high of over one billion colones in 1980, during the five year period under study, to a low of 663 million in 1982, or a 34 per cent decline. Brazil shows more stability, with outlay differences ranging only from a low of 57 billion cruzeiros to a high of 62 million.

The Private Sector

119. If, as a rule, public expenditures on health (and social security) as a proportion of social sector spending for the group have been falling, what if anything can be said about the ability of the private sector to help shoulder some of the increased health care burden? As data were available for just three countries, and only for 1982 in one of them, the question is really unanswerable. It simply needs to be stated here that the study did attempt to collect data on the private sector as a potentially important component of the entire health care system.

Table 2.13

SALARIES AS PERCENTAGE OF TOTAL HEALTH MINISTRY EXPENSES

COUNTRY	YEAR 1978 %	1979 %	1980 %	1981 %	1982 %
ARGENTINA	42.6	20.2	37.0	36.2	31.3
BRASIL	...	...	...	...	...
COSTA RICA	55.0	58.7	59.2	51.1	63.0
JAMAICA	...	51.1[a]	48.8	...	48.1[a]
MEXICO[b]	48.3	53.5	54.0	62.5	67.0
PERU	...	47.5	44.2	48.6	63.5
SAINT LUCIA	...	...	...	...	...

[a] Calculations based on estimates.

[b] Data are for entire Public Health Sector.

CHAPTER III. UPDATING SELECTED DATA IN THE BACKGROUND DOCUMENT ON THE NATIONAL AND INTERNATIONAL FINANCIAL AND BUDGETARY IMPLICATIONS OF THF REGIONAL STRATEGIES AND THE PLAN OF ACTION FOR HFA/2000

120. In this chapter, selected statistical tables from the "Background Document on the National and International Financial and Budgetary Implications of the Regional Strategies and the Plan of Action for HFA 2000" will be updated and briefly examined. Because only two years have elapsed since analysis of the data in the Background Document, it will not be possible to establish subsequent trend lines documenting changes since 1979. Nevertheless, useful and important tentative conclusions can and will be made. From the preceding pages, it has been made clear that of health care financing in Latin America and the Caribbean is not growing and, indeed, in many cases is declining in real terms. Based on the data in the Background Document, published in 1982, optimistic projections for expanding public health care financing were made. Due to the economic crisis which soon followed completion of the report, there was strong concern that the impact on health care would be significant. In terms of the available data, then, has this been the case? What follows is an attempt to answer this question. But once again it is necessary to caution the reader that findings from the analysis are tentative. More time will have to pass before firm conclusions are able to be established.

121. In Table 3.1 nine out of 11 countries, for which data were available for 1981 show that health care expenditures, as a percentage of total central government outlays, were smaller in the last year indicated than in the first year. This is not markedly different from the data in the Backgound Document which showed that 18 out of 23 nations reflected a similar pattern. Given the nature of the economic crisis a more accelerated decline may have been anticipated in 1982. However, that is no doubt attenuated by the fact that the crisis did not began to be felt until during 1981 when most countries were spending funds already appropriated.

122. A more significant and serious indicator, at least for the goals of primary care and HFA 2000, is the jump in expenditures in the public sector on hospitals between 1972 and 1979, noted in the Background Document. However, with the exception of the U.S., four countries in the Hemisphere--the only ones for which data were available--registered declines in expenditures for hospitals and clinics as a percentage of total central government health care outlays as of 1981. Whether or not this is a change in the previous trend has yet to be established. In the meantime, it is important to keep in mind that a "trend toward 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."*

*Plan, P. 14.

Table 3.1

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

Country	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982
Argentina	3.8	2.5	2.6	4.1	2.7	2.2	1.7	1.73	1.37	...
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	10.19	10.76	...
Bolivia	7.8	8.9	8.4	8.0	8.0	8.0	8.3	...	7.21	...
Brazil	6.8	6.9	6.5	7.5	8.1	7.8	8.5	6.54	7.37	...
Chile	8.0	7.3	6.9	6.5	6.4	6.4	6.54	7.37	6.40	...
Costa Rica	3.1	4.0	4.3	4.6	3.2	3.7	2.4	5.05	...	...
Dominica	...	...	...	10.6	12.7	9.6	8.8	...	...	...
Dominican Republic	11.7	10.9	6.8	8.7	...	...	...	9.27	9.67	...
El Salvador	10.4	1.03	8.2	9.2	9.8	8.9	8.7	8.97	9.39	6.95
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	2.37	1.86	...
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	...	...	...	14.58	...	...
Panama	15.1	13.8	14.5	13.2	14.5	15.1	12.3	12.71	13.24	...
Peru	3.3	3.0	2.8	2.8	2.7	2.6	3.7	4.52	5.30	...
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	3.76	3.14	...
Venezuela	10.8	7.5	7.6	7.2	7.3	8.0	9.1	...	...	...

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

Table 3.2

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

Country		1972		1979	1981
Argentina		33.3		78.6	71.2
Barbados		75.6		72.1	...
Bolivia	(1973)	23.1		40.1	...
Brazil		82.0		85.0	83.1
Chile		87.5		92.5	...
Costa Rica		...		...	...
Guatemala		71.0		79.3	...
Dominica (Millions)	(1976)	72.1		65.0	...
Honduras		87.0		49.0	...
Mexico		59.8		90.7	...
Panama (Millions)	(1973)	92.2	(1978)	93.8	89.1
Peru		...		...	...
USA (Millions)		85.1		92.9	94.1
Canada (Millions)	(1971)	55.1		59.0	56.1
Guyana	(1973)	93.5	(1978)	95.4	...
Nethelands 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 and 1982.

123. In many countries in the Region social security accounts for a large portion of health care expenditures. As such, it is an obvious and sensitive indicator of the status of support for health care. According to data in the Background Document, social security and welfare and health, as a percentage of total central government expenditures, grew from 27.4 percent in 1973 to 28.3 percent in 1979. By 1981 however, this pattern for the Region had been reversed and declined to 26.0 percent, according to the IMF.*

*IMF Government Finance Statistics Yearbook, 1983.

124. Another set of statistics, however, does not exactly point to what could be called an emerging pattern of decreases in health care financing in the public sector, as may be seen in updated figures in Table 3.3. What appears here instead is a mixed picture, certainly in regard to the Latin American and Caribbean nations included in the table. Some countries show declines in health care outlays. Others show increases. And one--Venezuela--reveals a seesaw effect. Of course, there are too few data and too few Hemispheric countries to be able to come to any firm conclusion about the region as whole, save to observe that what had been a relatively stable and upward pattern over the past decade now may be changing. More important is the need to interpet these data in light of the rest of the information presented in this Chapter.

125. While it may be expected that some of this decline would be compensated for by increases in private expeditures for health, this has not been the case, certainly not with respect to the four nations already cited--Honduras, Jamaica, Peru and Venezuela. The data in Table 3.4 below show that private consumption expenditures as a percentage of GDP, between 1975 and the last year measured, declined in Jamaica, remained the same in Panama and increased only slightly in El Salvador, Honduras and Venezuela. Nevertheless, given the lack of data on Latin America and the Caribbean for the years 1980 through 1982, it is not possible to make any definite statements regarding relevant patterns that are not already noted in the Background Document. As is asserted "...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"* (see, for example, Table 3.5).

126. The Background Document examined patterns of public and private consumption expenditure on health as a percentage of GDP. Using identical sources, it was impossible to update the information except in four countries, two of which are in Latin America, as may been seen in Table 3.6.

127. While clearly not enough time has lapsed in order to make any conclusive statements as to current trends, nor are their enough data yet available, it is not surprising that the trend from the previous years continues into 1980--except in India--the year before the start of economic crisis. Still, as has been evidenced on preceding pages, the overall picture is one of what appears to be the beginning of a general decline in health care expenditures.

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*"Plan of Action for the Implementation of the Regional Strategies for HFA/2000. Financial and Budgetary Implications." PAHO, August 6, 1983.

Table 3.3

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	1980	1981
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	...	...	...	...	14.1	...
	2	1.6	1.4	1.9	2.1	...	...	...	...	1.9	...
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	8.3	...
	2	2.4	2.8	3.5	3.9	4.3	4.1	4.3	4.3	1.6	...
Peru	1	...	...	13.0	11.4	11.0	9.9	12.7	12.6	14.0	13.3
	2	...	...	1.5	1.5	1.4	1.5	1.5	1.3	2.0	6.3
Venezuela	1	...	...	19.1	13.5	12.9	12.6	13.1	12.2	11.4	13.7
	2	...	...	2.5	1.8	1.9	1.9	1.9	1.6	1.8	1.9
United States of America	1	4.2	4.3	4.9	6.3	6.3	6.3	6.3	...	6.0	6.0
	2	.73	.72	.94	1.2	1.2	1.2	1.1	...	1.1	...
Tanzania	1	...	5.6	5.5	6.9	7.1	7.1	7.3	5.4	5.5	...
	2	...	1.0	1.3	2.2	1.8	1.8	2.0	2.0	1.8	...
India	1	...	...	5.2	6.1	6.4	6.8	7.0	...	6.9	...
	2	...	...	.41	.51	.56	. 57	. 61	...	...	6.1

Sources: UN National Accounts Tapes and IMF.

Table 3.4

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	1980	1981
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	...	...	...	...	6.9	...
	5.1	5.0	4.8	4.3	...	...	...	...	4.7	...
Jamaica	2.6	2.9	3.2	2.3	2.0	1.8	...	...	2.0	...
	1.8	2.1	2.2	1.4	1.3	1.2	...	...	1.3	...
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	4.7	4.2
	...	...	2.3	2.1	2.0	2.0	2.0	1.9	2.5	2.4
Canada	6.4	4.5	3.5	3.0	3.2	3.1	3.2	3.1	3.1	...
	4.2	2.7	2.0	1.7	1.8	1.8	1.8	1.7	1.7	...
United States of America	6.6	7.6	9.5	10.9	11.1	11.5	11.4	11.6	12.0	12.7
	4.2	4.7	5.9	6.9	7.1	7.3	7.3	7.4	7.7	8.0
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	1.9	...
	1.4	1.6	1.5	1.6	1.7	1.6	1.6	1.5	1.3	...

Source: UN National Accounts Tapes and IMF.

Table 3.5

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	1979	1980	1981	1982
Honduras	76.1	78.5	71.4	74.5	71.6	73.5	68.7	67.4	...	...	...	...	70.9	...	...
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	...	63.0	...	...
USA	85.3	86.8	86.4	85.8	85.6	85.4	85.2	85.3	85.9	86.4	86.5	...	87.5	...	...
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	...	68.7	...	...
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	8.8	9.0	8.7	...	...	...	...

Source: UN National Accounts Tapes and IMF.

Table 3.6

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	1980
Honduras	6.9	6.4	6.8	6.3	6.5	6.1	6.3	6.4	...	...	...	6.7
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	4.1
USA	4.9	5.5	6.9	7.2	7.3	7.4	7.7	8.1	8.2	8.4	8.5	8.8
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	1.9
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.

128. Another set of indicators used in the Background Document which has been updated here is the series of trends in private consumption expenditures on selected consumer items as a percent of all private consumption outlays and as expressed in current prices. The Background Document states that "there are no clear-cut trends in the share of private consumption expenditures devoted to health"* as revealed in the data en Table 3.7. The updated information and conclusion are little changed from the 1982 report. The picture of societies spending relatively little on health, certainly in comparison to combined expenditures for such "anti-health" items as alcohol and tobacco, continues unabated from 1960. It is interesting to note, however, that in the most developed nation, the U.S., relative private expenditure on health is much higher than in the rest of the countries. Yet in Honduras a similar pattern emerges, while in Canada the proportion of private expenses on health is very small. Once again, the pattern is confusing and not open to facile analysis.

129. So far the examination has focused on health care expenditures as a measure of the status of health care financing in Latin America. There is a different type of measure which needs to be mentioned, the debt structure. Little has changed, at least for the better, since the Background Document was published. As may been seen in the table below, the largest change has been in the drop in the percentage of concessional loans, as a component of the debt structure, along with a substantial increase in grant elements. What was stated in the Background Document in 1982 holds true more than ever today; that the changed terms of the debt since 1971, exacerbated in 1982," highlight the Region's vulnerability and [make it] potentially the biggest detriment to the placement of health sector loans."* Such a situation is obviously of major importance to the affected countries. As revenues, especially in the public sector, decline, as the result of crushing external debt and high inflation, there will be increasing pressure to reduce public sector expenditures. What the eventual impact will be on the health sector can only be surmised at this point, other than to speculate that the present situation does not augur well for public sector programs based on the need for high-cost investment.

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*Plan, P. 29

Table 3.7

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	1980	1981
Honduras	1	Food	40.5	40.3	39.3	44.1	41.1	41.1	41.2	41.2	41.2	...
	2	Health	6.7	6.8	6.6	5.9	6.9	6.9	7.0	7.0	7.0	...
	3	Alcohol[1/]	5.3	5.7	6.4	6.9	...	...	...	...	...	...
	4	Tobacco	1.3	1.5	2.1	2.5	0.7	0.7	0.7	0.6	0.6	...
Jamaica	1	Food	36.4	32.7	30.5	35.4	33.8	35.1	38.0	36.5	35.5	...
	2	Health	2.4	2.8	3.2	2.3	2.0	1.8	2.0	1.2	2.1	...
	3	Alcohol[1/]	6.2	6.8	5.9	3.7	3.8	3.8	4.4	4.3	4.2	...
	4	Tobacco	3.3	3.9	4.2	4.5	4.9	4.8	4.9	5.3	5.4	...
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[1/]	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	4.7	4.8
	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	15.2	...
	2	Health	6.4	4.5	3.5	3.0	3.2	3.2	3.2	3.1	3.2	...
	3	Alcohol[1/]	3.6	3.7	3.8	3.7	3.5	3.4	3.3	3.2	3.3	...
	4	Tobacco	2.9	2.9	2.8	2.1	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	12.7	12.6
	2	Health	6.6	7.6	9.5	10.9	11.1	11.5	11.4	11.6	12.0	12.7
	3	Alcohol[1/]	2.0	1.8	2.0	1.9	1.8	1.7	1.6	1.6	1.7	1.6
	4	Tobacco	2.1	1.9	1.7	1.5	1.5	1.4	1.3	1.3	1.2	1.2
Tanzania	1	Food	...	45.3	51.1	57.9	...	...	...	...	...	...
	2	Health	...	1.9	2.1	2.3	...	...	...	...	...	...
	3	Alcohol[1/]	...	3.8	3.5	4.4	...	...	...	...	...	...
	4	Tobacco	...	1.6	1.0	2.6	...	...	...	...	...	...

Source: UN National Accounts Tapes, 1974.

[1/] Includes alcoholic as well as non-alcoholic beverages.

130. This is yet another persuasive argument for the need to look for other than financial resources to improve and extend health care coverage. As a result, the countries should seek to rationalize as much as possible allocation of resources in the health sector. For example, mechanisms for integrating social security and public health are urgently needed in order to avoid duplication of effort and at the same time offer greater health care coverage. In addition to intersectoral linkages, it is necessary to look for ways in which the health sector can be more fully integrated into national development planning processes. Development models used to date have not done this.

131. Finally, it is worthwhile to recall the low level of health-related loans on the part of the multilateral banks as cited in Chapter I. This is certainly a far from encouraging sign for the health sector. Even the Pan American Health Organization, as the multilateral presence in the Region most directly concerned with health, has not significantly increased its budget over the past several years. The average annual increase has been, since 1980, only 5.2 percent,* or just barely enough to keep up with U.S. inflation.

Table 3.8

CHANGED STRUCTURE OF LATIN AMERICAN AND CARIBBEAN DEBT

Type of Loan	1971	1980	1982
Concessional Loans	26.0%	7.7%	2.2%
Fixed Rate Loans	66.6%	33.8%	30.3%
Variable Interest Rate Loans	7.4%	58.5%	62.5%
Grant Element (all creditors)	15.4%	-4.9%	17.3%

Source: IBRD World Debt Tables, December 1981 and 1982.

*These figures are derived from biennial PAHO budgets for the years 1980-1981, 1982-1983 and 1984-1985.

CHAPTER IV. CONCLUSIONS AND RECOMENDATIONS

A. Conclusions

132. There is consensus that the current socioeconomic crisis in Latin America and the Caribbean is the worst of the last 50 years, more severe than the one which gave rise to the Great World Depression of the Thirties. There is also a widespread view that some countries have suffered more than others because of their dependency on developed nations and their own domestic policy adjustments.

133. In addition, most experts blame the crisis on essentially structural causes aggravated by short-term factors associated with domestic adjustment policies and measures, as well as simultaneous recession and inflation in some of the developed countries. In other cases, the crisis stems from noneconomic domestic problems, particularly internal and international warfare.

134. The macroeconomic characteristics briefly reviewed in Chapter I indicate the range of contributing causal factors, showing how causes and effects have been joined, even if they have been treated separately for analytical purposes. Somewhat similar is the dichotomy sometimes suggested to exist among factors involved in the overall development process, some of which are social or economic, but all so closely interrelated that it has been necessary to pay special attention to the former for purposes of this document, in order to lay a firm foundation and provide a clear frame of reference for determining their possible social and even political repercussions.

135. It is anticipated that for the rest of the first half of this decade the socioeconomic crisis will continue, and there are factors that could make it even worse, some of them entirely beyond the power of the Latin American and Caribbean countries to control within their own borders.

136. On the basis of the work of the ECLA Economic Projections Center, this situation may be expected to worsen if the decline of per capita GDP of the last three years persists in 1984. It is worth remembering that the Regional average per capita GDP declined US$10, or 0.9%, in 1981; US$32, or 3.3%, in 1982; and US$54, or 5.6%, in 1983.

137. If conditions were to exist for a firm recovery of the Latin American and Caribbean national economies by an increase in GDP of at least 5-6% a year in the second half of the decade - which would depend on internal as well as external factors - ECLA considers that the Regional per capita GDP would rise in 1990, in the optimistic projection, to the same level as in 1980, which means that 10 years of development would have been lost.

138. The demographic predictions are based on a natural population increase of 2.5% a year for the rest of the decade, and of 2.0% a year during the Nineties. If GDP were to rise between 5% and 6% a year, the result would be a net increase in per capita GDP of between 2.5% to 4.0%, respectively.

139. However, in order to provide employment opportunities not only for those entering the labor market for the first time, but also for many of those already in the labor market who are unemployed or underemployed, faster growth of the economy is needed, which the ECLA Economic Projections Center estimates at not less than 7.0% a year.

140. Impediments to the achievement of full employment of the economically active population have a negative impact on both the economy as a whole and on the financing of social security programs, which depend for their income on contributions from workers, employers and the government.

141. Many of the young people who today have no access to employment in the formal sector enter the informal employment sector, and thereby do not contribute to support of social security institutions whose growth would thus be slowed, along with that of some of their benefits, particularly for the aged. Having no formal employment, those working in the informal sector are not covered by labor insurance, which provides preventive and curative health services to workers and their immediate families.

142. Another damaging effect of the socioeconomic crisis, caused by interntional reserve restrictions in many countries and by those imposed on the importation of goods and services, has been the curtailment of the acquisition of medicines and drugs abroad, reducing the stock of imported goods in many countries and impeding maintenance of vehicles and equipment requiring foreign replacement parts.

143. Priority has been given to service on the external debt, regardless of whether or not that obligation is covered by the provisions of the standby agreements which most of the countries in the Region have entered into with the International Monetary Fund. This service on the foreign debt has consumed a high proportion of export earnings in many countries. Moreover, in the last 18 months of 1982-1983 export earnings have become the main source of foreign exchange, now that the flow of capital into the countries of Latin America and the Caribbean has dropped so substantially.

144. Internal adjustments required under the standby agreements also include conventional monetary and fiscal measures to reduce aggregate demand and expenditures from the treasury and decentralized public agencies. Fiscal austerity programs usually reduce a large proportion of

public investment and, to avert social problems, give priority to salaries; as a result, a high percentage of budgets goes for fixed expenditures for the payment of wages and salaries and for adjustments made in response to the demands of trade unions to prevent major losses of the purchasing power of real wages, particularly in countries with high and structured inflation.

145. Provisions are also favored which would make exports of the Latin American and Caribbean countries more competitive on foreign markets. To this end, one internal adjustment measure promotes the devaluation of national currencies regarded as overvalued. Sooner or later, however, this has a ripple effect resulting in, among others things, changes in the prices of imported goods.

146. As the currencies of many countries have steadily lost value - either abruptly or through frequent mini devaluations - their economies have become "dollarized." Although local currency is still legal tender, it is only used in transactions of little importance and small amounts, while for others the prices are set and revised in terms of parity to the United States dollar. Examples include the purchase and sale of property and vehicles, setting of rental rates, and for production and service contracts.

147. Many internal adjustments, such as the increase of export volumes, have been neutralized by external adjustments which, as they are made outside their sphere of influence, are beyond the control or reach of the less developed countries. This continues to happen despite all the efforts they have made to gain a voice and vote in matters that seriously affect them and to change international agreements governing those matters.

148. In many other cases these internal adjustments have been guided by policies and measures established by such agencies as the IMF, the World Bank, AID, etc., which giver priority to middle and long-term changes designed to reactivate production in agriculture, industry, mining, energy, etc., so as to increase exports or reduce imports and thereby redress or improve the balance of payments of countries and enable them to meet their foreign debt commitments.

149. The funds that the World Bank lends for programs in the social sectors of countries do not even reach 10% of its total loans, and come to a mere half of one percent for health, population and nutrition. Loans made by the IDB for health, drinking water and sewerage hardly exceeded 8% of its total loans in 1981, and reached about 9% during 1982 and 1983.

150. Other bilateral agencies, such as AID, beleive there were large investments in the past. But with savings and better internal efficiency, the countries would meet the goal of HFA/2000. Despite external aid, the countries have still had many financial and administrative problems.

151. The view is fairly widespread in many international financing and technical-financial collaboration agencies that the health sector is not well managed and needs substantive improvements to become effective, efficient to attain the goals of primary care by making rational use of already available resources, such as highly qualified professionals who recevied their basic or specialized training abroad. Coordination among the operations of the various institutions comprising the health sector, including private sector, also needs to be achieved.

152. In some countries conventional medical practices still prevail or, in the best of cases, parallel efforts to make changes according to the spirit of the goals of HFA/2000. There are some who consider that if the health sector wants more external financing for its investments, it must first generate savings and make better use of the resources already allocated to it. External financial support has to be seen as a complement and not a substitute for internal efforts to achieve greater organization.

153. In other cases, a gap has existed between high-quality medicine available to a minority of the population and a simplified medicine on which most of the population must rely, which runs counter to the Strategies of Health for All by the Year 2000.

154. Some resources are being used inefficiently; others are entirely wasted. Savings in some nonpriority programs and activities would result in additional resources for primary health care.

155. In addition, less and less international and domestic financing is available for new investments in physical infrastructure and for procurement and maintenance of equipment and vehicles for health for two reasons: a) because it is felt that enough has been spent on such goods in the past, indeed more than could be fully and efficiently and in relation national development levels; b) because international agencies for multilateral and bilateral financing and collaboration now have less resources to work with. In addition, they give higher priority to financing of production sectors of the economy on the premise that these contribute to recovery faster in the short run.

156. The trend toward reduction of support for social expenditures as a percentage of total public budgets is not restricted to the less developed countries alone, but is also true of some of the more industrialized countries.

157. Information from the study of seven Latin American and Caribbean countries suggests as yet ill-defined trends. Nor is it possible to say with precision what effects the social and economic crisis from 1981 to 1983 has had on the national financing of social programs, those for health in particular.

158. Because there were relatively few social, political and economic changes in the Region over the two year period updating the previous study, new trends have yet to be firmly established.

159. What can be concluded is that there is nothing in the short-term to justify any expectation of improvement in the negative developments already identified. Hence, use of projections based on previous years, when in most countries sustained economic growth permitted relatively generous allocations to social sectors, could lead to erroneous interpretations or false expectations of what could happen in the future.

160. A realistic view of the crisis by those in the social sectors, will make them better able to prepare for and deal with it. In the decision-making process, real knowledge of problems improves possibilities for solving them in a timely fashion. This is a responsibility that falls essentially on the individual country, and new ways should be found for overcoming the crisis in a spirit of regional and international cooperation.

161. Efforts to acquire the economic and financial data in the seven countries shows that, owing to the very specialized nature of the subject, which has been the exclusive province of other agencies and not those dealing with health sector, this sector is placed in a weak position for compiling, processing and analyzing such data. However, it is on the basis of these data that plans and programs are formulated and budgetary allocations and external financing decisions made. They also form the foundation for guiding formulation and evaluation of policies based on monitoring and evaluation of actual activities.

162. Many health sectors have not participated effectively in the national planning process, and their relations with the central planning agencies, the ministries of the treasury or finance, and central banks are, with few exeptions, tenuous. This hampers institutional relations. As a result, other agencies know few details of the work done in the health sector. This impedes more effective intersectoral coordination.

163. Moreover, in many countries of the Region the different public institutions that should be coordinated with the health sector continue to function independently, making intersectoral realtions difficult.

164. From the information available on the seven countries it is evident that the respective status of health care expenditures varies widely, according to the several measures used.

165. Definite and consistent trends are apparent only in Argentina and Costa Rica, but they are, unfortunately, negative in both cases. For the other countries, however, it may be concluded that the relationship between health expenditures and GDP also varies as a result of decisions taken at the national level. Because of this, the socioeconomic crisis has had different repercussions from one country to another, and at different times during the years considered.

166. It is possible that countries which had previously made larger investments in health infrastructure had been able to deal more effectively with crisis and its repercussions.

167. It also seems, for other countries, that the period from 1978 to 1982 was one of transition, and that the real effects of the crisis will probably emerge more clearly in the years ahead, possibly in 1987 and 1988.

168. The updating of data for all the Region demonstrates that, in general, there has been no significative change for the countries as a whole regarding financing of health programs, even though in the majority of them a decline in those expenses has occurred in relation to total government outlays. Further details on those figures are presented in Chapter III which represents an updating of the information contained in the document presented to the Subcommittee on Long-Term Planning, to the Executive Committee and to the Pan American Sanitary Conference in 1982.

169. A reduction in financing of public health hospitals has occurred which could be positive for HFA/2000, if this means a change in orientation toward financing of primary health.

170. As to concessionary loans, there was a significative decrease, but donations to countries for general activities increased.

171. It has not been possible to calculate projections nor to establish future trends for all the Region, as insufficient data were available for the years 1983-1984. Within the list of information which was requested from the seven countries (see Annex II), projections for the years 1984-1987 had been included. Unfortunately, the data were unavailable.

172. Acquisition of the information for the "social sectors," referred to in Resolution XX, has also had its limitations; first, beacuse of the variety of standards used to determine what constitutes a definition of "social." Some countries have included education, health, labor, social security, drinking water and sewerage, housing and social welfare. In others, the definition is narrower, and housing and drinking water and sewerage are included in either infrastructure or economic sectors, espeically housing which is frequently subsumed under economic sector.

173. Financing for housing has suffered a significant set back as a result of the crisis, since the latter has sent interest rates soaring and made it difficult to obtain credits for programs whose finaicial recuperation is a long term proposition, somehwere between 10 and 20 years.

174. In the countries where the government or public institutions have undertaken important low income housing programs, the difference between the costs of real interest which they have to pay for foreign credits and

lower subsidized rates charged to borrowers, has been covered by resources and charged off as a social-financial cost. When standby agreements have been neogotiated and sogned with the IMF, it has been necessary to adjust interest rates to real levels, eliminating subsidies and adding carrying and administrative costs. This has made it very difficult for borrowers to service their debt. The lack of new soft loans makes it difficult for important social programs to be continued, but does allow for generation of new employment and use of high grade national raw materials

175. Another aspect which exacerbates financing of low income housing programs is the high rate of inflation in so many of the countries in the Region, which distorts the relationship between fixed wages and salaries, on the one hand, and interest rates and mortagage terms on the other In many cases such costs constitute the major family expense for low and middle income people, when it should never exceed more than 10 or 20 percent of family income.

B. Recommendations

176. Analysis of available data in this study shows that future financial resources for the health sector may not even reach 4 percent of GDP, which, under different conditions, was felt to be a reasonable figure in the 1982 document. This may be due to the present socioeconomic crisis and in the face of projections of what will happen throughout the rest of the decade, as was indicated in the optimistic hypothesis, i.e., that in 1990 the per capita GDP will be the same as in 1980.

177. This evidently may have a negative impact on the proposals of the governments to achieve HFA/2000. For if resources available to the health sector are reduced, there is the clear and present danger of a corresponding reduction in health services. Hence, recommendations which can be made according to present judgments are framed according to a set of general principles, which provide a greater understanding of the availability and optimal utilization of human, financial, and physical resources.

It is recommended:

a) To conduct an analysis in each of the countries of available resources in the health sector. These studies should be the direct responsibility of the governments and their health institutions.

b) To review different forms of financing of national health service systems in each country, including the public and private sectors, in order to improve efficiencies, effectiveness and equity.

c) To analyze the utilization of resources in terms of cost-effectiveness and productivity, by institution and national program. Productivity and cost analyses should include, among other things, human capability and technology support.

d) It is necessary to promote intrasecotral improvements in order to allow the different health institutions to coordinate more effectively their programs and activities, including those with private entities which belong to the national health system. Community pariticipation should also be encouraged in the effort to achieve HFA/2000.

e) Intersectoral coordination should be improved in order to obtain the most efficient use of national resources and satisfy national development goals, as well as to integrate more effectively activities of institutions working toward similar social goals. It is therefore recommended that the mechanisms be found to promote this kind of intersectoral coordination according to conditions in and characteristics of each country.

f) To improve the management of the different institutions which comprise the health sector, placing emphasis on information and financial management, with the purpose of improving national policies, plans and programs, especially on the basis of information gained through evaluations and monitoring.

g) It is critical to promote, in addition, greater integration of the health sector within the national development planning process, providing fresh views in order to alter present theories, methods and and practices of planning.

TENTATIVE INFORMATION THAT THE STUDY GROUPS SHOULD OBTAIN, IN THE SEVEN SELECTED COUNTRIES

1. The actual plan for health, officially approved for 1983;

2. Short, medium and long term objectives of such plans as specified in detail in official documents, for example, in the National Plan of Development or in the health-sectoral plan;

3. Public budget assigned to the health sector for 1983, broken down by destination and origin for the ministry of health, and other public institutions decentralized by regions/parishes and functions;

4. Public budget assigned to other social sectors, such as education, labor, housing, etc. for 1983, broken down by destination and origin for the respective ministry other public institutions decentralized by region/parish and functions for each of those sectors;

5. Resources of the private sector assigned to health in 1983, indicating destination and origin of the resources;

6. Chronological information, historic and prospective for the 1978-1987 period for: Gross domestic product in absolute figures and as percentage of growth in relation to the base year (1978 = 100 percent); total expenditures for 1978-1982 and projected for 1983-1987 for the ministry of health and broken down: in current and capital expenditures, in absolute numbers and as percentage of increase in relation to the base year (1978=100 percent); total expenditures for 1978-1982 and project for 1983-1987 for the public agency for social security broken down in: recurrent and capital expenditures, in absolute figures and as percentage of increase in relation to the base year (1978=100 percent); retail price indexes as percentage of increase in relation to the base year (1978=100 percent) for 1979, 1980, 1981 and 1982 and a projection for 1983-1987;

7. Observed trends and projections for the sectoral distribution of recurrent expenditures of the public sector during the 1978-1987 period, in absolute figures in dollars and as percentage of distribution of the total of the respective year. Breakdown in three big groups of sectors,* social, economic, and infrastructure, and within each one of these groups by the divisions that will take place in the respective country, for example health, education, labor, housing, etc., for the social; farming and animal husbandry, mining, industry, hunting and fising, forestry, etc., for the economic; and construction, transportation; energy, etc., for the infrasture sector;

8. Trends (1979-1982) and projections (1983-1987) for the recurring spending distribution of the Health System during the period 1978-1987, in absolute terms and s a percentage of the total distribution for the respective year. Information should be divided by public and private institutions,* indicating in the former case the institutions that form part of the central government, and separately, the ones that are territorially and functionally descentralized;

9. Observed trends and projections one for the distribution of the health system's expenditure during the 1978-1987 period in absolute terms and as percentage of the total distribution of the respective year. Breakdown the information by entities:* public and private, indicating in the first group the one that are from the central government and in the other group the ones the decentralized, entities, by function and territory;

10. Trends and projections for the distribution of the health system's expenditures during the 1978-1987 period, in absolute terms and as percentage of distribution of the total of the respective year. Breakdown that information in the same way as indicated in No. 9 above, starting with the*;

11. Financing sources of the entities of the national health system, in thousands of dollars during the 1978-1982 period and in the projection for 1983-1987, breaking down for each year the part coming from the government budget, form social security quotas, from services provided and other income. Breakdown the information in two grupos*: public sector and private sector, giving for the first one details for central public entities: ministries of health and decentralized functionally and territorial, with a breakdown of each;

12. Structure of the expenditures of the entities of the national system of health, as tendency of the evolution observed and one expected for 1978-1987, in the same way as it was requested for other points before, for the constituent of the hole health system, in thousands of dollars. Breakdown the expenditure for personnel, construction, maintenance of equipment and buildings, medicines and drugs for each year. Also breakdown the information as indicated in No. 11 starting from the asterisk on page 1;

13. Tendency of the evolution of the expenditures of the entities of the national health system during the 1978-1982 period and the porjection for 1983-1987 for drugs and medicines, breaking down the information depending on the national or international origin and to the cost in thousand of dollars; breakdown that information by sectors, public and private and within the first one by entities that form it;

14. Tendency of the evolution of the expenditures of the entities of the national health system during 1978-1982 and the projections for 1983-1987, for expenditures of investment as per space distribution: central, metropolitan, other urban and rural areas.

APPENDIX II

OFFICIALS PARTICIPATING IN THE STUDY

A. Nationals

Argentina

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*General Study Coordinator.

APPENDIX III

OFFICIALS OF INTERNATIONAL ORGANIZATIONS INTERVIEWED FOR THIS STUDY

Luis Olivos, Deputy Chief, Program Division and Chief of the Latin American and Caribbean Branch, United Nations Fund of Population Activities.

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Vera Kalm, Director of the External Relations Division of WHO, New York.

Carlos García-Tudero, Interregional Adviser, Department of Technical Cooperation for Development, United Nations.

Faquir Muhammad, Director Public Administration for Development, Department of Technical Cooperation for Development, United Nations.

Christian Ossa, Chief International Economic Branch, General Analysis and Policies Division, Office for Development Research and Policy Analysis, Department of International Economic and Social Affairs, United Nations.

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Edward Rizzo, Consultant, Division of Agricultural and Life Sciences, Maryland University.

Jorge Ruiz Lara, Assistant Administrator, Department for Economic and Social Development, Inter-American Development Bank.

Roberto Mayorga Cortés, Member of the Directing Council of the World Bank.

Carlos Quijano, Assistant to the Vice President Executive for Latin America of the IBRD (World Bank).

Eduardo Weissner Durán, Director, Occidental Region for the International Monetary Fund.

Ricardo Cibotti, Director of the Economic Development division of ECLA (Economic Commission for Latin America).

Andrés Bianchi, Economic Development Division of ECLA.

Germán Rama, Social Development Division of ECLA.

Enzo Faletto, Social Development Division of ECLA.

John Durston, Social Development Division of ECLA.

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Oscar Julián Bardeci, Director of the Latin American Demographic Center (CELADE).

Carmen Arretx, Chief of the Demographic Department of CELADE.

Guillermo Maccio, Officer of CELADE.

Alfredo Costa Filho, Director of the Latin American Center for Economic and Social Planning (ILPES).

Jorge Israel, Officer of ILPES.

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