

# HEALTH AS AN ECONOMIC VALUE IN A TIME OF CRISIS<sup>1</sup>

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The economic development of modern times that has taken place following application of technology for the production of wealth has been the greatest in human history. However, the progress achieved and the benefits distributed have not gone hand in hand. While the world's gross product has tripled and the population has increased by a mere two-thirds, wealth has been concentrated in the industrial countries where production is greatest and demographic growth is relatively slow. In contrast, the developing countries have rapidly growing populations, needs, and expectations coupled with low-yielding economies. Forty percent of the inhabitants account for no more than 9% of the total personal income, and the gap between the poor and the comfortably off is widening all the time.

Most countries have established policies that enhance the social value of man through both direct political actions and indirect actions on the part of the economic sector, and considerable sums have been invested in projects to raise individual and collective living standards. Health occupies a prominent place in economic and social development, because of the sizable investments and expenditures in the sector and also because of the population's increasing expectations of better achievements.

As a result, health has come to be viewed as a value of production, for the study of which the discipline of health economics has been created. This latter is really a new field of knowledge that will improve our ability to assess the magnitude of the expenditures and the mounting difficulty of the sector's operation in a scientific manner. (Ten years ago, in totally different economic circumstances, the World Health Organization set the goal of health for all by the year 2000, which we can today view from another perspective.)

This interrelationship between economics, society, and application of technology has produced many approaches to development (among them important ones capable of inducing diverse social attitudes), ranging from health education to manipulations aimed at increasing the consumption of services. High-technology methods for treating complex diseases and indiscriminate consumption of medications have become commonplace because of spectacular results achieved in individual cases; and these trends have produced a significant increase in to-

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tal expenditures. In contrast, there has been growing difficulty in obtaining funds to satisfy the greater demand for health services resulting from a policy of making them universally and equitably available. Moreover, other actions that are more effective because of their impact on large groups—such as primary care programs, immunization efforts, protection against malnutrition, and preservation of the environment are still experiencing financing difficulties—either because no new resources are forthcoming or because existing funding is being diverted elsewhere. In an economy characterized by overproduction, it has not even been possible to organize adequate distribution of food surpluses in areas marked by hunger and poverty.

## The Economic Crisis

In this scenario the economic crisis of the past decade has forcefully intervened, with grave consequences for the developing countries. Prices of imported goods needed for production have been rising continually, while the value of exports has been falling. Unemployment and mounting debt have reduced their economies to critical levels, and the purchasing power of wages in many countries has shrunk by 50%. Their production capacity, governed by markets outside their control, is inadequate to give them flexibility of action. For many countries, the pervasive impoverishment has placed the goal of collective well-being significantly further away—a circumstance also applying to the “health for all” goal, which will not now be easily achievable by the year 2000. The external debt of the poor countries has reached US\$1,035 billion; of this, US\$43 billion was accrued in the past year, US\$35 billion of it in currency revaluations alone. In other words, much of the increase in the debt owed is occurring without usufruct of the money.

Every society is today anxiously exploring ways to promote the health and well-being of its people, and is also exploring systems for providing services to care for the sick. Universality and equity are the health planners’ criteria and are applicable to both the urban and rural sectors, with establishment of a scale of priorities. Because of the greater demand for services arising from higher expectations and larger populations in the face of tight financial resource availability, every possible way of generating income and distributing resources is being considered. Health economics has set efficiency as a priority objective, which justifies review of the traditional operating arrangements and, indeed, renders review of them essential. The present financial stringency, with its serious and apparently permanent constraints, imposes a scale of fundamental priorities favoring the interests of large groups, in order to provide for primary needs that have a relatively great influence on communities’ quality of life—especially communicable disease control, nutrition, environmental sanitation, and protection of high-risk groups. The increasingly clear need to maintain basic pro-

grams and strengthen actions carried out jointly with the community has attained real urgency in many countries.

The recent policies cutting back public spending have inevitably caused financing capacity to contract. In a number of countries this has led to paring of the health sector budget, notwithstanding warnings that deterioration of health levels would have a negative impact on production, which would in turn spur a greater demand for services and thereby establish a vicious cycle. This becomes more serious when one considers that expectations of economic growth in the poor countries were not realized in 1986 despite the adjustments made, and that the shadow of slow economic growth again hangs over 1987. Cutbacks in per capita expenditure on social services and corresponding reductions in the health sector are becoming more marked, with a resulting increase in the social debt. Generally, the prospects for maintaining the economic resources that support the poor countries' health programs are becoming increasingly dim; and certain components of the goal of health for all by the year 2000, devised in a totally different economic context, will have to be redefined.

## The Health Situation

To resolve the growing financing difficulties while trying to meet the people's expectations of a better quality of life, comprehensive and intersectoral actions are needed to achieve a better utilization of all resources that will provide universal protection with special attention for the groups at greatest risk. In this regard the responsibilities of the health ministries are becoming increasingly broad and complex; besides seeking high-efficiency resource investments in the health sector, they must also stimulate great activity in related sectors. Among other things, education today encompasses change and formation of habits and customs that safeguard, maintain, and promote health. Its relationship with the production sector is very close, not only in determining conditions that will prevent organic deterioration of workers but also in bringing about wage policies and specific investments that will channel more resources to health care.

The big problem is finding new economic resources to add to existing ones in order to properly finance primary care and preventive health programs. Experience shows that it is very difficult to completely change the direction of expenditure of programs that have been underway for a considerable time and that may have created a cultural pattern in the population, with the result that it is frequently necessary to find additional financing for new objectives.

Under the earlier health concept of caring for the sick, both public and private services would open their doors, expecting a demand directly related to the actual number of sick persons and what people could afford. It was not necessary to promote the services provided, because the prevailing environmental conditions and diseases normally assured the demand.

When the concept of the entire population being entitled to health protection was established and the commit-

ment was made to provide services, it was concluded that these services could produce a better return if preventive measures were strengthened—this being something that is preferably accomplished by means of simple measures in the home, at the workplace, and elsewhere, and by means of changes in individual behavior. Within this context, the community is now seen as the focus for preventive measures, health promotion activities, and curative primary care—all conducted within an integral program caring for the individual, his family, and his environment. The behavior of the latter three generate a wide range of actions affecting living standards—actions relating to housing, water, and nutrition; personal hygiene, general education and (particularly) health care education; trash collection and care of the environment; utilization of free time; wages; and electrification. Many of these actions are financed by household income and constitute an excellent opportunity for obtaining active participation, both in health promotion and in the direct financing of simplified medical care. Using the home as if it were a hospital room, hospital care programs can provide ambulatory surgery and treatments in the course of home visits. By means of technical and administrative decentralization, health regions can be set up, administrative responsibilities can be delegated to simplified levels, and direct community participation can be instituted. The representative organizations involved can assume partial responsibility for certain health programs such as maternal and child health, physical rehabilitation, and care of the elderly.

The overall responsibility for this integration of multidisciplinary activities is shared, although the health sector is clearly the one that receives the greatest benefits and should therefore assume the leadership in mobilizing the community and persuading the other public and private sectors to cooperate on an integral plan. The financing of this multiple participation will also be derived from a variety of sources including the national budget and the resources of the participating organizations—sources that can obtain financing from the individual, his or her family, and the community's own organizations in order to solve problems. In this field there is an enormous potential—the generation, organization, and development of which is an area where the traditional medical organizations still lack sufficient experience.

The situation is disturbing, both because of the factors involved and because there does not seem to be any prospect of improvement on the horizon for the poor countries. Very definite and clearcut political actions will be needed in the years ahead for integral utilization of public and private resources in order to maintain the health of the community, before deterioration of that health becomes one more element that aggravates prevailing levels of poverty and its consequences.