



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## 42nd DIRECTING COUNCIL 52nd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., 25-29 September 2000

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### PROVISIONAL SUMMARY RECORD OF THE FIRST MEETING ACTA RESUMIDA PROVISIONAL DE LA PRIMERA REUNIÓN

Monday, 25 September 2000, at 9:00 a.m.  
Lunes, 25 de septiembre de 2000, a las 9:00 a.m.

*President:*

*Presidente:* Dr. Rafael Burgos-Calderón Puerto Rico

*Later:*

*Después:* Hon. Clarice Modeste-Curwen Grenada

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Note: This record is only provisional. The summaries of statements have not yet been approved by the speakers, and the text should not be quoted. Delegates are requested to notify the Conference Documents Center (Room 215), in writing, of any changes they wish to have made in the text. Alternatively, they may forward them to the Chief, Conference Services, Pan American Health Organization, 525 - 23rd Street, N.W., Washington, D.C., 20037, USA, by 31 October 2000. The final text will be published in the *Proceedings* of the Council.

Nota: Esta acta es solamente provisional. Las intervenciones resumidas no han sido aún aprobadas por los oradores y el texto no debe citarse. Se ruega a los Delegados tengan a bien comunicar al Centro de Documentación de Conferencias (Oficina 215), por escrito, las modificaciones que deseen ver introducidas en el texto. Como alternativa, pueden enviarlas al Jefe del Servicio de Conferencias, Organización Panamericana de la Salud, 525 - 23rd Street, N. W., Washington, D.C., 20037, EUA, antes del 31 de octubre de 2000. El texto definitivo se publicará en las *Actas* del Consejo.

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*The meeting was called to order at 9:20 a.m.*

*Se abre la reunión a las 9:20 a.m.*

ITEM 1: OPENING OF THE SESSION

PUNTO 1: APERTURA DE LA SESIÓN

A. *Opening of the Session by the Outgoing President, Dr. Rafael Burgos-Calderón (Puerto Rico)*

A. *Apertura de la sesión por el Presidente saliente, Dr. Rafael Burgos-Calderón (Puerto Rico)*

El PRESIDENTE SALIENTE DA la bienvenida a los delegados y declara abierta la Sesión.

The SECRETARY said that under the Rules of Procedure of the Council, the presence of at least 20 Members was required for a quorum. More than 20 Members were present, and therefore a quorum had been established.

B. *Welcoming Remarks by Sir George Alleyne, Director of the Pan American Sanitary Bureau.*

B. *Palabras de bienvenida de Sir George Alleyne, Director de la Oficina Sanitaria Panamericana.*

Sir George ALLEYNE (Director): This is always for us in the Pan American Health Organization the most important week of our institutional life, and it is a pleasure to see so many of our countries represented here to take decisions about the future of the Pan

American Health Organization. First of all, I would like to thank Dr. Burgos for assuming the Presidency, and I would ask him to convey to the Secretary of Health of Puerto Rico our gratitude for the excellent arrangements that she made when the meeting was held in Puerto Rico last year.

Since last we met our Director Emeritus, Dr. Horwitz, has passed away. He was a distinguished Chilean physician who served with distinction as the Director of this Organization for 16 years. He achieved a reputation for steadfastness of purpose and for acuteness of observation as regards the health problems of this Region. I am going to ask you to stand for a moment of silence in recognition of the memory of the Director Emeritus, Dr. Abraham Horwitz.

*The Members stood for a minute of silence in tribute to  
the memory of Dr. Horwitz.*

*Los miembros, puestos de pie, guardan un minuto de silencio  
en homenaje a la memoria del Dr. Horwitz.*

- C. *Welcome on behalf of the Host Member by Dr. Donna E. Shalala, Secretary, United States Department of Health and Human Services*
- C. *Bienvenida en nombre del Miembro anfitrión por la Dra. Donna E. Shalala, Secretaria de Salud y Servicios Sociales de los Estados Unidos de América*

Dr. SHALALA: I am honored to be at the 42<sup>nd</sup> Directing Council of the Pan American Health Organization. It is a distinct and great privilege to welcome the delegations again to Washington, DC. This is probably the last time I will address you as Secretary of Health and Human Services because I will leave with President Clinton at the end of his term

in January 2001. Driving over today, I couldn't help but reflect on how gratifying my association with PAHO and WHO has been. It has been a great privilege to work with Dr. Alleyne and Dr. Brundtland, and I am deeply indebted to both for their wise Counsel and their visionary ideas for improving international public health. Dr. Alleyne and Dr. Brundtland both know that every nation of the hemisphere has a unique contribution to make to improve the quality of human life. They also know that every nation is an indispensable member of a world team, and they know that all of us stand on the shoulders of public health leaders who may or may not be with us today, but who have worked throughout the last century to create a healthier world. I am talking about former PAHO Directors like Dr. Carlyle Guerra de Macedo of Brazil, Dr. Hector Acuña of Mexico, Dr. Abraham Horwitz of Chile and the former Director-General of WHO, Dr. Halfdan Mahler, who helped create the Health for All alliance. Like his predecessors, Dr. Alleyne has broadened the scope of good health in the Americas, and I want to pay tribute to him and his leadership, as well as to the magnificent staff at PAHO. They have taken on public health challenges that once seemed difficult, if not impossible, to overcome. For example, every year more than 200,000 children under five years of age die needlessly in the Americas from preventable, treatable diseases. PAHO is working to save those lives through simple but timely public health interventions.

In Dr. Brundtland not only do we have a world-renowned public health leader, we have a passionate warrior who is committed to protecting the world's children from tobacco.

Together they are saving millions of children from premature deaths. I am reminded of the great Latin American writer and master of magical realism, Gabriel García Márquez, who once described his most important problem as destroying the line that separates what seems real from what seems fantastic. That has been the challenge to those involved in public health, too—to make the fantastic real. In 1985, who could have imagined that polio would be eradicated from the Americas? Yet less than 10 years later, that is exactly what has been accomplished. That achievement is even more impressive considering that it is only the second time in history—smallpox, of course, being the first—that a disease has been stopped dead in its tracks.

But to leap from dreams and fantasies to reality has been much more than just achieving victory against smallpox and polio. Today, throughout the Americas, childhood immunizations are up and malnutrition is down. We have increased funding to combat the threat of HIV/AIDS in communities around the world. And we are moving towards the development of a framework convention for tobacco control. More children, mothers, and babies around the world are healthier than ever because of WHO and PAHO. But we know that these accomplishments did not happen by magic. They happened because of hard work and a deeply held sense of mission by everyone in the public health community, and we certainly cannot claim victory. More important, we cannot quit now. The fact is that this new century brings with it many unsolved challenges. We must recommit to building upon and

protecting the world's food safety net. We must recommit to working with each other on emerging international issues relating to diets and diseases. We must recommit to the great global campaign against infectious diseases, especially malaria, tuberculosis, and HIV/AIDS. We must recommit to stopping the global spread of antibiotics resistance. We must recommit to developing a database for global health systems, so as to know how to deal effectively with the major causes of death and disability. And finally, we must recommit to escalating the global fight against death from tobacco use. That is not a job for any one nation; it is a job for all nations, both big and small. We are partners in a shared destiny, notwithstanding political or demographic differences. Success or failure in the new century will be determined by the strength of the partnership among nations. We must ensure that public health remains the cornerstone of the broader global policy dialogue, whether it be economic development or global security or the environment or education.

That is the end of my message, but not quite the end of my remarks. The point is that, together, we must put public health on the international agenda. Together, we must keep it there. We each bring something fantastic to the partnership. But few issues can be fully resolved by working alone if we truly want to bring about good health for all. As the American writer Maya Angelou once said, "If one is lucky, a solitary fantasy can totally transform one million realities."



*D. Address by Dr. Gro Harlem Brundtland, Director-General of the World Health Organization.*

*D. Palabras de la Dra. Gro Harlem Brundtland, Directora General de la Organización Mundial de la Salud.*

Dr. BRUNDTLAND: The first meeting in this new millennium is held at a time when there are both great opportunities and great challenges in front of us. I sense that this year is a turning point in our collective effort to improve the health of the world's poorest people. There is evidence of real change in international as well as national perceptions about the absolute importance of improved health.

I have always believed that real changes in society will not take place unless those who make decisions appreciate the economic dimensions of major issues. This is how thinking about the environment has shifted. It used to be a cause for convinced environmentalists, but many of them were only on the margins when key decisions were made. As the cost of environmental damage has become clear, environmental issues now command the attention of major players within national and international society.

The same is happening in the field of health. Some of us met at the World Health Assembly in Geneva in May. There were already several promising signs then that world leaders recognized a new important linkage. They saw that good health is of central importance to people's economic and social development and that improving poor people's health is key to breaking the cycles of poverty.

Since then we have seen early signs of a world willing to take more decisive action. In July, the thirteenth international AIDS conference in Durban established new norms: that all people living with HIV/AIDS worldwide should have access to adequate care, and that everyone everywhere should be in a position to protect themselves from HIV infection. Also in Durban, the European Commission announced renewed support for the fight against HIV/AIDS, malaria, and tuberculosis. They followed this up with a policy framework which addresses improved access for poor people to essential health goods and services, works to reduce prices of vital medicines and commodities, and aims to create incentives for strategic research to develop new and more cost-effective products for prevention, diagnosis, and treatment.

Later that same month in Japan, I joined leaders of the G8 nations as they met with leaders of G7 countries. Subsequently, the G8 committed themselves to support real improvements in health outcomes among poor communities. They committed to targets set by internal forums for reducing the toll from HIV, from malaria, from tuberculosis, and from diseases of childhood by 2010. There is now a real prospect that increased support will be available for member States and United Nations agencies in their efforts to reduce the impact of diseases on poor peoples well-being. We have to establish means to improve outcomes and to speed up the flow of new resources. It will require a massive effort all around.

The announcements are the fruits of the hard work of thousands of health professionals, by those involved in local as well as national political processes and by many of you here today. Your efforts, whether in local or national programs, in international events or in regional initiatives, have drawn attention to the needless suffering of millions of the world's poorest people.

While health problems have dominated the headlines, we are also on the brink of several important achievements. Let me first mention polio. Although polio belongs to the history books in this Region, the efforts for global eradication continue. We are on track to achieve a global certification of polio eradication by 2005, as planned, although we will not be able to see the last polio case this year as we had hoped. Still, the closer we are to success, the harder we need to work. We must keep in mind that as long as there are still cases of polio in the world, we are all vulnerable. We can achieve full global eradication if we work together. This is the message I will deliver with others here today at the Polio Partnership Summit in New York on Wednesday, when we launch the strategy for the next five years.

HIV/AIDS is a global pandemic. The region of the Americas provides a complex and highly varied epidemiological picture. From the tragic figures of the Caribbean to the relatively positive situation among the Andes nations, we see a mosaic of dominant modes of transmission. The quality and detail of the surveillance data also vary widely, making it important to increase our surveillance efforts. If we are to implement better preventive action,

we need to better understand the infection pattern, who the risk groups are, and why they continue to get infected.

Also in terms of their approach to prevention and care, the countries of this region vary widely. There is a very broad variety of experiences to draw on which is both encouraging and gives reason for optimism. In particular, on the issue of access to drugs for those living with HIV/AIDS, several countries in this region have taken bold and far-reaching steps. As we strive to widen access to care for those living with HIV/AIDS world-wide, we need to draw on the experiences —the opportunities and limitations— of the approaches you have pioneered in this Region. On the issue of HIV/AIDS care, there is a promise of further progress. Following the World Health Assembly in May, WHO —together with UN/AIDS and other United Nations agencies— has pursued its mandate and progressed in dialogue with the pharmaceutical industry. A contact group, due to hold its first meeting in just a few days, will bring together member states, United Nations agencies, and representatives of the industry and of NGOs in what we hope will result in a substantial increase in the number of peoples throughout the world who can access effective care within the context of the wider development of sustainable health systems. We are working, as you know, on the price issue and other issues involved. The initiative is being harmonized with other global and regional partnerships against AIDS. Efforts are initially being taken forward in Africa, but they will move elsewhere soon afterwards, and swiftly lead, I hope, to some real change.

Several other priority health problems are now being addressed by different entities working together in new and effective ways. In my speech to the World Health Assembly, I presented the Global Alliance for Vaccines and Immunization (GAVI) as a prime example of a new model for partnerships in international health. During the Assembly, delegates from the 74 eligible countries received guidelines for the submission of proposals to the Global Fund for Children's Vaccines, and I encouraged a quick response so that support could start to flow to countries by the end of this year. This urges for expediency was heeded—and how! Twenty-four countries submitted proposals to the GAVI Secretariat in the very tight timeframe required. Of those proposals, an independent review committee found that 13 countries were ready to receive vaccines and/or direct financial support, with disbursements starting already in September. The rest will be submitting additional information for the next round so that they, too, can receive support as soon as possible, and another 20 or so countries are expected to submit proposals during the next review in October. The Global Fund supports programs that are designed by countries. It contributes to the sustainability of national health systems and to synergy between immunization services and other health systems components.

We have by now clearly tied the concept of better health to that of economic and social progress, both on an individual and national level. Investments in health are investments in a better future. Nowhere is the link more direct than in the field of child health. I am

extremely pleased that you are discussing the subject of child health in its broader sense, and that the Region is making a concerted effort to strengthen child health and development activities by both looking at existing policies and legislation in the light of children's right and strengthening a wide range of actions and activities for improved child health in a changing economic and social environment. In this context, I am impressed by the enthusiasm and ambitions of the Meta 2002 campaign and the embrace of Integrated Management of Childhood Illness in 19 countries so far. Using IMCI as a strategy to reduce the toll of malaria in children and infants stands to me as a great example of the cross-fertilization we are aiming for in an effective assault on the diseases of poverty.

As you know, WHO is working intensely to strengthen our fight against the diseases of poverty. In doing so, we are improving the exchange of experience, collaboration, and synergy. Countries throughout this Region are contributing to evolving partnerships that are stopping tuberculosis, making pregnancy safer, and rolling back malaria. Partners are learning from each other's experiences. The partnerships have several common features: countries, first of all, are at the hub, and partners reflect shared goals, strategies, and values. They try to respond to people's needs in ways that reflect these people's interest as well as the best available evidence. Resources are used and accounted for with care. The process of implementing partnerships in international health leads to building of more effective health systems. It enables national authorities to set the agenda, giving partners opportunities to

deepen their engagement in health development and to reactivate their financial and technical contributions to countries' health services.

Yet, as our ambitions rise, we need better mechanisms to take proven effective interventions to scale. This means recognizing that the focus of prevention and care is most often in the home—not just within health services. It means that a wide range of partners must be involved. Governments have a central role to play—setting the environment and providing leadership. This immense challenge calls for a massive international effort. I am delighted that many countries in this region are already engaged. I am delighted that the G8 have embraced the need for such an effort and committed to the targets to achieve this. I am delighted that the European Commission will discuss it at a roundtable this week, and that there will be a partner meeting on modalities hosted by the G8 in early December. WHO will help identify channels through which resources for health reach those who need them so that resources are used effectively, and accountability is insured.

Earlier this year Member States encouraged WHO to scale up activities in the area of food safety, sensing that this issue will grow in importance in the years to come, as global trade increases and advances in science present us with new possibilities, choices and, clearly, dilemmas. The wisdom of this global move was supported by the weight the G8 nations gave to the issue of food safety during their last meeting in Okinawa in July. They specifically stressed the need for an active role by WHO and FAO in the work to ensure that the food

we produce, trade, and consume is safe. As with many other areas of health, the resources and the technology to ensure food safety excel in the industrialized countries, while the vast majority of the two million annual deaths from food and waterborne diseases take place in the developing world. Many developing countries do not have the technology, the resources, or the infrastructure to ensure that the food they produce and import is safe. This makes the role of the international agencies particularly important, and WHO will see it as one of our main priorities to make information available widely and to share the advances in our knowledge.

In what we can perhaps call the first generation of bio-technological engineering, a number of improved products came on the market. These have been said to benefit producers rather than consumers. For all these products, the main challenge is to ensure safety to consumers and to the environment. Now we are seeing the coming of a new generation of bio-engineered products. These discoveries have potential for higher production, as well as better nutritional value. However, they present new and more complicated questions in relation to their safety and benefit for consumers. It will be a major challenge to ensure proper scrutiny of all potential issues associated with these products. Together with FAO, WHO will do all it can to provide decision-makers with the information they need to decide on such matters. WHO will ensure that high-quality independent science is assembled and coordinated and disseminated into existing intergovernmental mechanisms like the Codex Alimentarius Commission.



An important element of the health system is always the process through which the quality, the safety, and the effectiveness of pharmaceuticals is regulated. WHO continues to establish and develop clear and practical norms and standards to assist countries in the assurance of quality and safety of drugs. Global and regional efforts to harmonize international regulatory and quality assurance norms are important. The Pan American Regional Network for Drug Regulatory Harmonization is a good example of how that work now is progressing.

Let me dwell on the issue of high-quality independent science. Food safety is only one of the many areas where WHO's responsibilities consist of providing the best possible scientific evidence and making it available to all who need it. This is the value we add. While economic, political, or ideological considerations color much of the information that exists on a range of health issues, WHO stands—and must continue to stand—as the voice of good independent science and the defender of a simple set of values—those of the right of all to good health. Good independent science and access for all also underlie our work in health research. Next month I will attend the International Conference for Health Research in Bangkok. The challenge ahead of us is to improve coordination, set clear priorities, and support developing countries' research while preserving the varied and vibrant plethora of health research entities that together drive health research forward.

I am very pleased to see that the pioneer effort on bioethics is being acknowledged and evaluated at this meeting. Through its publications, specialized educational programs, and

research programs, the Regional Program on Bioethics has become a key resource in bioethics for all of Latin America and an inspiration for other regions.

A renewed effort to address diseases associated with poverty should contribute to the development of health systems. The management of any health system is a balancing act: coping with competing demands, matching resources to need, and attempting to ensure that all have access to the care necessary for good health. The balancing act is particularly difficult for those countries whose per capita spending on people's health is less than, say US\$100 per person per year. It is even more difficult in settings where the institutions of government are undermined—or even paralyzed—by conflict.

I have sensed a need to help health ministers assess the performance of health systems in ways that reflect three vital purposes: improving health outcomes, responding to the people and, thirdly, fairness of financing. As you know, this year, WHO attempted such a first assessment using the limited data available in the World Health Report 2000. I appreciate that the report has led to widespread discussions both in national and international media and among health professionals about how best to assess health systems, as well as a more fundamental debate about what makes a good health system. This was in particular the case in this Region.

I hope that the debate has been helpful to legislators as well as to health professionals. Many have had their eyes opened about the importance of health systems performance, and

that, in fact, was a major goal for the whole operation. It has certainly provided me and my staff with new insights. We will work closely with Member States to make better use of existing data sources, and where necessary, to collect new information for the annual assessment of health system performance.

WHO will also be working closely with a number of Member States in an initiative to enhance the performance of health systems to apply the new WHO assessment framework at national and also subnational levels, to use this analysis as an aid to national policy formulation, and to work together to facilitate positive change.

Noncommunicable diseases seriously challenge health systems and provoke difficult decisions on resource allocations. For most of those conditions, there is a lag between exposure to risk and visible outcomes, but policy decisions to deal the shifting burden of disease are required now. During the next 12 months we will be looking particularly at mental health. No country and no community is immune to mental disorders, and their impact in psychological, social, and economic terms is huge. Yet, societies raise barriers to both care and reintegration of people with mental disorders. What makes our task doubly urgent is that there is no reason for inaction, much less exclusion. World Health Day on 7 April 2001, the World Health Assembly in May that year, and the World Health Report for 2001 all will focus on mental health. Together, we will find solutions and will strive to make the necessary changes.

We will also achieve change in another key priority area, namely, in tobacco control. WHO is at the front of this global public health struggle. However, we are not interested in tobacco wars. What we want are tobacco solutions. We have the evidence to convince. We know that higher excise taxes make economic sense in addition to reducing smoking, in particular, among the young and the poor. We know that smuggling is a problem that must be dealt with independently of the price issue. And we know that, in the long term, governmental divestment of tobacco holdings is responsible policy, both economically and healthwise. In October, Member States will begin the negotiations on the Framework Convention on Tobacco Control. This will be the first time that the public health community has led treaty negotiations. The process we set in motion has already fostered a global debate and pushed countries, as well as tobacco companies, to think about their actions from a public health perspective. The success of the FCTC will depend on our ability to link compelling data with robust decisions.

First, there will be two days of public hearings in Geneva. We will listen to the views of all interested parties, including the tobacco producers and the tobacco industry. Then the negotiations will start. Many countries in this Region have shown a strong and active support for the work towards a framework convention. I appreciate this and count on you to continue this support, so that the FCTC can become a strong and effective tool for tobacco control.

There is no need to remind anyone in this Region that disasters and crisis, both natural and man-made, are on the increase, affecting a growing number of people worldwide. There is no shortcut to dealing with emergencies. Spending on preparedness for disaster may seem like resources not being fully used, but the lesson is always that each of our countries will be affected one day in one way or another. There needs to be focus on training, hospital and health services planning, and stockpiling of supplies. WHO has an important function to perform before, during, and after emergencies. Our role is to assist nations with accurate assessments of damage and needs. It is to ensure the best possible coordination of agencies involved and to make sure that long-term health perspectives are built into the emergency relief, so that money spent on an emergency can benefit long-term development goals. And, afterwards, we in WHO need to help countries share their experiences.

Given the major challenges that faces us all –government and technical agencies– how will we respond, and what can you, our Member States, expect from WHO? WHO continues to have a unique role. At all times we pursue the best interests of our constituency– the optimum health of all the people within our 191 Member States. At all times we try to ensure that we are guided by the best available evidence, based on the careful analysis of experience, on the results of relevant research.

The clearest reflection of how WHO is changing to serve Member States better is the upcoming budget, which you will discuss later. The Program Budget 2002-2003 is a key

instrument for advancing the process of change and reform in WHO. Both in its content and in the way it is being prepared, it marks a significant departure from previous biennia.

The budget is a manifestation of the new corporate strategy, which sets out the ways in which WHO's Secretariat intends to address the challenges of rapid evolution in international health. The program and budget for each area of work has been worked out through an Organization-wide process, jointly between staff from Regional Offices and from headquarters. Thirty-five areas of work have been identified for the whole Organization, and they constitute our common building blocks. In the process, we clearly identify the 11 priorities endorsed by the Executive Board and have moved additional resources to those priorities.

The proposals also follow the decisions of the Health Assembly in 1998 to reallocate some regular budget resources between our regions. In line with the flexibility given by the Health Assembly, I have, however, proposed a somewhat lower level of reallocation in the coming biennium. This will benefit those regions, like this one, which are contributing considerably to the transfers. All of this will also give greater importance to the need to focus on the strategic approach to our work in countries. Your Region has, of course, a strong country presence which we will build on.

I believe we are seeing a change in perceptions. Health is bigger news. Health is accepted as a central and necessary element in reducing poverty and ensuring economic

growth and social progress. There is movement among donors to allocate more money towards intervention that will fight diseases. There is a growing realization that we need international agreements and cooperation to fight threats to health, such as from tobacco. In short, health has been placed at the center of the development agenda.

The first decade of this century can become the one in which the world's two billion poorest can share in the health revolution. But there is nothing irreversible in this process. We need to continue our hard work to maintain the momentum. The tiniest sense of complacency may turn health's central role in development from a permanent paradigm shift to little more than this year's fashionable theory.

We are on the brink of seeing real and substantial gains for the health of the poorest, but to do so, we need to have realistic perceptions of what we can all achieve and what would be necessary for us to succeed. First of all, we need to see increases in resources to the poor, not only from governments, but also from donors and foundations. The contributions should add to and not replace existing financial commitments. Secondly, the demand for improved results and measurable outcomes will be relentless. Additional funding will dry up unless it can be shown that increased activities have led to improved indicators within a relatively short period of time. Thirdly, of course, the challenge is more than anything for governments of all Member States. A new focus on health will put increasing demands on countries' funding, on absorption capacity, and on governance. To make substantial and

lasting improvements in health, people themselves and their governments will always be the main driving force. Let us work together to grasp this opportunity. Let us make this decade the decade that spread the health revolution to all.

ITEM 2.1: APPOINTMENT OF THE COMMITTEE ON CREDENTIALS  
PUNTO 2.1: NOMBRAMIENTO DE LA COMISIÓN DE CREDENCIALES

The SECRETARY stated that under rule 31 of the Rules of Procedure, the Committee on Credentials consisted of three Members or Associate Members. The Committee was to be appointed by the Council at the beginning of the first meeting to examine the credentials of the delegates of Members and Associate Members and representative of Observer States and report to the Council thereon without delay. The Committee on Credentials would meet in room 207 as soon as the members had been appointed. The Council would suspend its meeting until the Committee had been able to report back.

El PRESIDENTE SALIENTE anuncia que los países propuestos para constituir la Comisión de Credenciales son Chile, Jamaica y Panamá y al no haber objeción, quedan nombrados Chile, Jamaica y Panamá.

*It was so decided.  
Así se acuerda.*

*The meeting was suspended at 10:10 a.m. and resumed at 10:55 a.m.  
Se suspende la reunión a las 10:10 a.m. y se reanuda a las 10:55 a.m.*



FIRST REPORT OF THE COMMITTEE ON CREDENTIALS  
PRIMER INFORME DE LA COMISIÓN DE CREDENCIALES

El representante de la COMISIÓN DE CREDENCIALES dice que, de acuerdo con el artículo 31 del Reglamento Interno del Consejo Directivo, la Comisión de Credenciales nombrada en la primera reunión e integrada por los delegados de Chile, Jamaica y la República de Panamá, llevó a cabo su primera reunión el 25 de septiembre del año 2000 a las 10:00 a.m. La Comisión procedió a examinar las credenciales entregadas al Director de la Oficina de conformidad con el Artículo 4 del Reglamento Interno del Consejo Directivo y encontró que las credenciales de los Delegados de los Estados Miembros, Miembro Asociado y Representantes de los Estados Observadores que se citan a continuación se presentaron en buena y debida forma, razón por la cual la Comisión propone que el Consejo reconozca su validez. Los Estados que presentaron sus credenciales son: Antigua y Barbuda, Argentina, Bahamas, Barbados, Belice, Bolivia, Brasil, Canadá, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Estados Unidos de América, Francia, Granada, Guatemala, Guyana, Haití, Honduras, Jamaica, México, Nicaragua, Panamá, Paraguay, Perú, Reino de los Países Bajos, Reino Unido, República Dominicana, San Vicente y las Granadinas, Saint Kitts y Nevis, Santa Lucía, Trinidad y Tabago y Venezuela, el Estado Asociado, Puerto Rico, y los Estados

Observadores, España y Portugal. Dice también que la Comisión se reunirá nuevamente para examinar otras credenciales que se reciban en el transcurso de la mañana.

*Decision:* The first report of the Committee on Credentials was approved.

*Decisión:* Se aprueba el primer informe de la Comisión de Credenciales.

ITEM 2.2: ELECTION OF THE PRESIDENT, TWO VICE PRESIDENTS, AND  
RAPPORTEUR

TEMA 2.2: ELECCIÓN DEL PRESIDENTE, LOS DOS VICEPRESIDENTES Y EL  
RELATOR

The SECRETARY stated that, under Rule 16 of the Rules of Procedure, the Directing Council was to elect Members or Associate Members to the Presidency, the two Vice Presidencies, and the office of Rapporteur, respectively, who would hold office until their successors were elected.

The Delegate of CANADA nominated Grenada, represented by its Minister of Health, the Hon. Clarice Modeste-Curwen, to serve as President.

*Decision:* Grenada was unanimously elected to the Presidency.

*Decisión:* Granada es elegido por unanimidad para ocupar la Presidencia.

*The Hon. Clarisse Modeste-Curwen took the Chair.  
La Hon. Clarise Modeste-Curwen pasa a ocupar la Presidencia.*

The PRESIDENT thanked the delegates for having elected Grenada, which was an honor for herself and her country. Acknowledging the mandate given by the Director-General and Dr. Shalala, she pointed out that the decisions taken at the meeting would weigh heavily on the direction of health care in all the Americas. She then called for nominations to the two Vice Presidencies.

O BRASIL nomeou um representante da delegação do Paraguai para a Vice-  
Presidência.

The Delegate of JAMAICA nominated Mexico.

*Decision:* Mexico and Paraguay were elected to the Vice Presidencies.  
*Decisión:* México y Paraguay son elegidos para ocupar las Vicepresidencias.

The PRESIDENT then called for nominations for Rapporteur.

The Delegate of GRENADA nominated Brazil.

*Decision:* Brazil was elected to the office of Rapporteur.  
*Decisión:* Brasil es elegido para ocupar la Relatoría.

ITEM 2.3: ESTABLISHMENT OF A WORKING PARTY TO STUDY THE APPLICATION OF ARTICLE 6.B OF THE PAHO CONSTITUTION  
PUNTO 2.3: ESTABLECIMIENTO DE UN GRUPO DE TRABAJO PARA ESTUDIAR LA APLICACIÓN DEL ARTÍCULO 6.B DE LA CONSTITUCIÓN DE LA OPS

The SECRETARY referred to the provisions of Article 6.B of the PAHO Constitution, pertaining to the suspension of voting privileges of any Member State in arrears in an amount exceeding the sum of two full years' annual payments at the opening of a session of the Directing Council. In keeping with past practice, the Directing Council was asked to appoint a Working Party consisting of the delegates of three Member States to study the application of that article.

The PRESIDENT explained that the Heads of Delegation, meeting earlier that morning, had agreed that Canada, Haiti, and Venezuela would be designated to serve as members of the Working Party.

*Decision:* The Delegates of Canada, Haiti, and Venezuela were appointed members of the Working Party.

*Decisión:* Los Delegados de Canadá, Haití y Venezuela quedan nombrados miembros del Grupo de Trabajo.

ITEM 2.4: ESTABLISHMENT OF THE GENERAL COMMITTEE

PUNTO 2.4: ESTABLECIMIENTO DE LA COMISIÓN GENERAL

The SECRETARY indicated that, according to Rule 32 of the Rules of Procedure, the Directing Council was to establish a General Committee consisting of the President of the Council, the two Vice Presidents, the Rapporteur, and three delegates to be elected by the Council. The President of the Council would serve as President of the General Committee.

The PRESIDENT, explained that the Heads of Delegation, meeting earlier that morning, had agreed that the Delegates of Cuba, Guyana and the United States of America would be designated to join the President, the two Vice Presidents, and the Rapporteur in forming the General Committee.

*Decision:* The Delegates of Cuba, Guyana, and the United States of America, were elected members of the General Committee.

*Decisión:* Los Delegados de Cuba, Estados Unidos de América y Guyana quedan elegidos miembros de la Comisión General.

ITEM 2.5: ADOPTION OF THE AGENDA

PUNTO 2.5: ADOPCIÓN DEL ORDEN DEL DÍA

The SECRETARY explained that, pursuant to Rule 10 of the Rules of Procedure, it was incumbent on the Council to adopt its own agenda, and that in so doing it might make

modifications or additions to the provisional agenda prepared by the Executive Committee and distributed in advance.

El Delegado de VENEZUELA dice que su delegación tiene unas consideraciones que hacer en relación al punto 3.3 del orden del día y pregunta en qué momento las debería presentar.

The SECRETARY proposed that the floor be offered to the Delegate of Venezuela prior to consideration of Item 3.3 on Wednesday, 27 September.

The PRESIDENT, noting that there were no objections to the provisional agenda, declared it adopted.

*Decisión:* The agenda was adopted.

*Decisión:* Se aprueba el orden del día.

- ITEM 3.2 ANNUAL REPORT OF THE DIRECTOR OF THE PAN AMERICAN  
SANITARY BUREAU, 1999
- PUNTO 3.2 INFORME ANUAL DEL DIRECTOR DE LA OFICINA SANITARIA  
PANAMERICANA, 1999
- ITEM 4.2 HEALTH SITUATION AND TRENDS IN THE AMERICAS
- PUNTO 4.2 LA SITUACIÓN SANITARIA Y SUS TENDENCIAS EN LAS  
AMÉRICAS

The PRESIDENT invited the Director to present his annual report for 1999.

The DIRECTOR noted that the Organization had to be sensitive, and responsive, to the currents that swirled around the regions. Therefore, his annual report, coming at the end of a decade, a century, and a millennium, took into account the situation of the Americas at that particular juncture.

Most worrisome was the continuing poverty in the Region. In Latin America and the Caribbean area alone, almost 40% of the population had incomes of less than \$2.00 a day. Although the situation had stabilized in terms of percentage, the absolute numbers had risen. Fortunately, during 1998-1999 there had been no major financial crises in the world. Economic growth, measured from the beginning to the end of the last decade, had been very positive, although that improvement had not been enough to free the Region from the scourge of poverty. The decade had also seen growing acceptance of the need for socially responsible growth.

During 1999 political stability had been the rule in the Americas, and those transitions that had occurred had gone smoothly. At the end of the decade there appeared to be less

ideological rhetoric about the powers or the roles of the State versus private enterprise, along with general agreement that the discussion should not turn around the size of the State's role but rather around its genuine response to the people's needs and circumstances.

The theme of the Annual Report was "Advancing the Peoples Health," and his message opened with the affirmation that "justice is the first virtue of social institutions, as truth is of systems of thought." He was confident that the Region had the necessary means for its population to enjoy the optimum state of health as a matter of social justice. That idea was enshrined in the concept and practice of health for all. The essay described some of the elements of social justice that he felt were important—namely, the elements of equity, liberty, and fraternity—and pointed out how they were expressed in the work of the Organization.

His introductory message also referred to the role of the State in health. In addition to the regulatory role, the steering role of the State was important in order to ensure that equity prevailed within health. In the final analysis, the countries themselves would be the principal actors in advancing the peoples' health. The efforts in the countries would be the result of joint action by all the social partners—the public sector, the private sector, and non-governmental organizations—in the steering role of the State.

He was not comfortable with the common assertion that many failures in the application of technologies of proven usefulness were due to lack of political will. On the contrary, he felt that veins of rhetoric allowed national and international technical advisers to



evade or renege on their responsibilities. The Organization was responsible for putting before the ministries of health the kinds of programs that would enable them to take appropriate action and not hide behind the excuse of “lack of political will.”

Progress was being made toward advancing the peoples’ health. The report showed that the appropriate skills and tools were being acquired.

The countries deserved congratulations for the improvements they had made in the collection of their data sets. Still, there was an urgent need to improve the public health information used periodically to assess the health situation and analyze trends. It was essential to improve the comparability, validity, and reliability of health information in order to identify and quantify the inequalities that disproportionately affected people in one or other geographic area. The population’s health was both a product of society and an indispensable contribution to economic growth and political stability. The Organization’s commitment to improving the capacity to measure, monitor, and understand the complex dynamic of population health—which responded far less to the usual medical care interventions than to changes in the physical and social environment—had been demonstrated during the past year. PAHO’s approach to measuring changes in health clearly delineated the social factors associated with unjust deprivation because of race, ethnicity, gender, place of birth, or other characteristics. The examination of such factors was important in determining where the inequalities lay and what measures needed to be put in place in order to reduce them.

One of the most egregious manifestations of inequity in the Region was that related to gender, which was being addressed by the Program on Women, Health, and Development. In the area of scientific knowledge in health, the Latin American and Caribbean Center for Health Sciences Information (BIREME) had been instrumental in developing the Virtual Health Library—a great reservoir of information available to the ministries of health in the Region. Research efforts had focused on bringing together networks of institutions and persons engaged in research throughout the Region. A major advance had been the creation of the International Advisory Committee on Bioethics in May 1999.

At the Fifth International Conference on Health Promotion, held in Mexico and cosponsored by the Organization, the countries had agreed to develop their own national plans for health promotion. The year 2000 marked the end of the decade devoted to implementing the plan of action agreed upon at the World Summit for Children, during which PAHO had participated actively in follow-up. During 1999, particular attention had been given to the health and development of adolescents and young adults and also to health of the older population. In the latter area, efforts had focused on the theme chosen by the World Health Organization for the International Year of Older Persons: “Active Aging Makes the Difference.” As part of the work undertaken in nutrition, efforts had been devoted to supplementation with vitamin A, iodine, and iron. PAHO took the reduction of tobacco use very seriously: efforts in that regard involved both preventing the onset of smoking and the

promotion of smoking cessation, and significant headway was being made in both areas. In mental health, major focus had been given to the 24 million persons in the Americas suffering from depression. During 1999 activities had been undertaken to ensure that their treatment went beyond the province of psychiatrists to include family care as well.

The environment continued to be a source of work for the Organization. A development that he believed had great potential was the formation of “ecoclubs,” initiated in Argentina. Efforts toward the elimination of lead from gasoline had been bearing fruit: by the end of 1999, 19 countries in the Americas had banned the use of lead in gasoline, and every country had specific plans for reaching that goal. With regard to the control of air pollution, there had been notable advances in many countries of the Region. On the issue of water quality, there had been cooperation with the SEARO Region in efforts to reduce arsenic in water. Health and sanitation education in schools had been the subject of intensive work during the year, as well.

Health systems and services development also continue to be a subject of great concern and area of concentrated work. A study carried out in 1999 revealed that most, if not all, the countries in Latin America and the Caribbean were either planning or had begun to implement health sector reforms. Since 1997, PASB had been working actively to profile the countries’ health service systems, including the monitoring and evaluation of the reform processes. By the end of 1999, profiles had been completed for 20 countries.

In other activities, progress had been made toward ensuring that all the blood products in the Americas would be safe, and there were prospects for additional funding in that area. In 1999, PAHO had promoted a multi-year plan to implement preventive oral health programs in the national level, with the goal of having “healthy smiles” on all the youngsters in the Americas. In the area of human resources—one of the centerpieces of any progress in health sector reform—cooperation had been initiated with the Economic Commission for Latin America and the Caribbean (ECLAC) to create an exemplary human resources model. Much of the focus was on the training or retraining of persons already in service. Keeping in mind that health in the Region included the health of indigenous populations, PAHO had stepped up its activities in that area.

In the area of communicable and noncommunicable diseases, the threat of tuberculosis was still present and malaria continued to be a problem. While the eradication of measles remained a challenge, the Americas was expected to reach the goal of measles elimination by the end of the year 2000. The PAHO Revolving Fund for Vaccine Procurement continued to thrive. He would not comment extensively on the subject of AIDS as it would be addressed in a separate item of the agenda. However, Dr. Brundtland had referred to the goal of reducing the number of AIDS deaths in children under the age of 5 by 100,000, and he was pleased that the First Ladies of the Region had embraced that goal. The program on cervical cancer had received a boost with support from the Bill and Melinda Gates

Foundation, and it was hoped to reduce mortality in the area by the application of appropriate technologies. Antimicrobial resistance was becoming a major public health problem, and considerable attention had been given to the issue at the Meeting of Ministers of Agriculture and Health.

At the beginning of his administration he had made a commitment to the dual principles of equity and pan-Americanism. Those principles continued to underlie PAHO'S work. He had also promised that special attention would be given to the program on immunization. In that regard, he had created the Division for Vaccines and Immunization. In 1999 he had created the Health Analysis Program to give emphasis to the importance of collecting good data. In addition, the Office of Analysis and Strategic Planning had been strengthened. At this re-election he had stressed the importance of a shared agenda for health cooperation, and since then such an agenda had been formally adopted with the collaboration of the Inter-American Development Bank and the World Bank.

He then referred briefly to several improvements in administrative practices, noting that it was important to show not only technical capability but also transparency and efficiency. The output of the Organization's translation software had increased by 10% since 1998. The technical programs had increased their production of documents, and greater and more effective use was being made of them. PAHO's information systems had entered the new millennium with no hitches. The procurement system had been improved, and a new

personnel evaluation system had been implemented. With regard to resource mobilization, in 1999 more than \$50 million—about 40% of the total budget executed—had come from extrabudgetary sources. Public information activities continued to put the work of the Organization before the public, which he regarded as a social responsibility. At the same time, the scientific public had been kept informed through a number of scientific and technical publications.

In Puerto Rico there had been discussion of developing a strategic fund for the purchase of essential public health supplies. That fund had since been initiated with a deposit toward its capitalization of \$5 million by the Government of Brazil, and it was now ready to be expanded to all the countries of the Americas. Initially, the fund would be restricted to five sets of medications: antiretrovirals for AIDS; drugs for tuberculosis; drugs for malaria; insecticides; and drugs for leishmaniasis.

In conclusion, he hoped that he had given an overall impression of advancement in peoples' health in the countries of the Americas.

The PRESIDENT invited Dr. Carlos Castillo Salgado to present the item on Health Situation and Trends in the Americas.

El Dr. CASTILLO SALGADO (OPS) dice que, de acuerdo con los indicadores promedio, en 1999 la salud en las Américas nunca había estado mejor. Sin embargo, las mejoras no se han registrado de la misma forma en todos los países ni en los diferentes

grupos de población de cada país. En cuanto al análisis de la información, se dio impulso al desarrollo de los análisis locales con información subnacional, que es esencial para identificar y medir las desigualdades existentes en salud. Es importante destacar que por primera vez los análisis se presentaron no solo en función de promedios nacionales sino también de la distribución, para poder establecer los niveles de salud de los distintos grupos de población. Explica que en la Organización tienen mucha importancia los conceptos de equidad y panamericanismo, ejes fundamentales de la cooperación, que han permitido la transformación incluso de los sistemas de información y análisis.

Menciona que, en los últimos años, la Región de las Américas en conjunto ha experimentado una importante transición demográfica con un gran porcentaje de urbanización. Asimismo, se ha observado una polarización epidemiológica que se seguirá registrando. Uno de los objetivos fundamentales de la OPS es fortalecer la capacidad nacional para analizar la situación del sector salud y resolver las grandes inequidades que persisten en la Región. Según la información presentada por los países, en 1999 hubo un gran crecimiento de la población de las Américas, que llegó a los 823 millones de habitantes en contraste con los 331 millones de mediados del siglo anterior. Dicha población representa, 14% de toda la población del mundo y se espera que, para el año 2025 se incremente hasta más de los mil millones. Un tercio del total de la población está localizada en los Estados Unidos, otro tercio en el Brasil y México, y el tercio restante en otros 45

países y territorios. También ha aumentado la importancia relativa de la población de América Latina, que en 1959 no representaba ni la mitad de la población de las Américas, para 1995 había llegado a representar el 61% y para 2025 se espera que representará 65% de toda la población de la Región.

Según los análisis realizados, la transición demográfica en la Región ha tenido distintos niveles, que van desde una transición incipiente en dos países hasta una transición avanzada en 12 países. Esto ha exigido que las líneas de cooperación de la Organización tengan que responder a la situación particular de cada uno de los países. Al seguir el concepto de equidad, es importante para la OPS observar las distintas tendencias de riqueza en la Región.

El orador muestra una gráfica que indica el crecimiento del producto interno bruto de los países a partir de 1970. En consecuencia, se han reconocido cinco conglomerados de países. El grupo 1 representa a los países que han tenido un crecimiento sostenido y, en algunos casos, hasta gigantesco comparado con el resto. Sin embargo, los países del grupo 5 no han tenido cambios significativos desde los años setenta. Esto es importante porque los indicadores socioeconómicos tienen una gran influencia en los niveles de equidad en salud y las necesidades insatisfechas. También cabe mencionar que, en los grupos 2, 3 y 4, en la década de los ochenta hubo un deterioro fundamental, lo que ha llevado a reconocer que los promedios no son suficientes para poder establecer las diferencias existentes en la Región entre países ni aún en el interior de los mismos. Por ejemplo, el grupo 1 de mayor desarrollo



registró una tasa de fertilidad de 2,1 contrastada con la tasa del grupo 5 que fue de 4,7. Esto indica la necesidad que tiene la OPS de ajustar continuamente la cooperación y los esfuerzos que hace para responder a las necesidades insatisfechas de los distintos países.

A pesar de que la Región de las Américas es un continente urbano, en el interior de los países las distintas unidades subnacionales tienen un porcentaje de urbanización totalmente distinto, de forma que no es suficiente marcar los promedios nacionales. Hay que tener en cuenta la distribución de esas diferencias dentro de los países, lo cual solo es posible por medio de los datos básicos que cada uno de los países ha desagregado para sus unidades subnacionales.

Al referirse a la distribución de la esperanza de vida, dice que el incremento en toda la Región ha sido enorme, pero existen diferencias y vacíos importantes en el interior de los países. En cuanto a la tendencia de la mortalidad infantil, desde 1950 puede observarse una reducción; sin embargo, se mantienen desigualdades entre los distintos grupos de países. Por lo tanto, los promedios tienen que estar acompañados de la distribución de las diferencias.

El Dr. Castillo explica que como causas de mortalidad y mortalidad las enfermedades crónicas y las causas externas tienen tanta importancia como las enfermedades transmisibles y que unos países deberán concentrarse en las enfermedades crónicas y otros en las transmisibles. La OPS ha tratado de desarrollar y facilitar la recolección, análisis y disseminación de la información disponible y ha examinado la aplicabilidad de los distintos

indicadores para medir las inequidades en salud desagregadas geopolítica y poblacionalmente. También al evaluar estos indicadores conjuntamente con las autoridades nacionales se ajustó la aplicabilidad de estos indicadores al nivel local en cada país. En la Región hay mucha información desagregada a nivel estatal, municipal y local que permite medir la desigualdad y desarrollar estrategias de intervención efectivas, así como establecer prioridades para apoyar a los países en esas tareas.

O Ministro José SERRA (Brasil) cumprimenta os secretariados da OPAS pela apresentação do seu relatório anual e agradece as iniciativas anunciadas pelo Dr. Alleyne para a implementação do fundo rotatório de medicamentos. O governo brasileiro depositou \$5 milhões nesse fundo e a OPAS está procurando adquirir no mercado internacional a um custo inferior ao que é praticado no Brasil, uma série de medicamentos solicitados pelo Ministério da Saúde. Com uma política racional e integrada de compra de produtos essenciais para a saúde, o Brasil já conseguiu reduzir o custo dos medicamentos contra a AIDS em 72,5%, em média. A criação deste fundo possibilitará reduzir ainda mais esses custos e ampliar o suprimento da demanda interna das populações mais carentes. Além disto, a implementação de um banco de dados internacional sobre preços de medicamentos, proposto pelo Brasil, permitirá a otimização dos processos de compras dos países das Américas e representará, a curto prazo, uma resposta eficaz para este problema. Convida, portanto, os estados membros presentes a esta reunião a apoiarem esta proposta brasileira

referente ao banco de dados e a aderirem ao fundo rotatório de medicamentos. Isto aumentará o poder de negociações da OPAS no mercado internacional, melhorando as condições dos países para atender as necessidades básicas de medicamentos e de outros produtos estratégicos para a saúde.

Cumprimenta o Dr. Alleyne, cuja gestão à frente da OPAS é muito bem vista pelo Brasil e é considerado como parceiro no enfrentamento das principais questões de saúde do nosso país. Em relação à questão do tabaco, a Câmara dos Deputados do Brasil já aprovou um projecto de lei proibindo a propaganda de cigarros na televisão, no rádio, em cartazes, jornais e revistas. Se for aprovado pelo Senado Federal em outubro, a propaganda de cigarros será praticamente banida do Brasil.

Com relação às doenças infecto-contagiosas, como a poliomielite, o Brasil hoje pode dizer que já as erradicou de seu território. No tocante à AIDS, o processo brasileiro hoje é mais conhecido internacionalmente e requer muitos recursos -- \$500 milhões ao ano para a entrega de medicamentos gratuitos e pelo menos 20% desse valor para o trabalho de prevenção. Graças a essa ação dos governos federal, estadual e municipal e à cooperação das ONGs foi possível deter o avanço da AIDS. Contudo, é também imprescindível reduzir o custo dos medicamentos.

Outro terreno em que o país fez uma conquista importante é o da mortalidade materna, que não vinha decrescendo como a mortalidade infantil no Brasil. Em dois anos o

país conseguiu reduzir em cerca de 25% a mortalidade materna no âmbito do sistema único de saúde. Para isto contribuiu a redução drástica (de mais de 10 pontos percentuais) dos partos realizados sob a forma de cesarianas. Também se conseguiu recentemente vincular receitas tributárias às despesas do setor da saúde nas esferas federal, estadual e municipal, uma vez que as três atuam de maneira cooperativa e coordenada na área da saúde.

Há um outro ponto que foi abordado pela Diretora Geral da OMS e que tem sido, de parte do Brasil, objecto de bastante preocupação. Refiro-me ao último relatório apresentado em meados deste ano e que pretendeu organizar sob a forma de *ranking* entre diferentes países a performance de seus sistemas de saúde, ordenando do melhor ao pior. Para isto, não só se preparou um grande lançamento publicitário como se fez uma ampla divulgação de algo que teve grande repercussão política nos diferentes países, pelo menos no Brasil. Foram juntados cinco indicadores que combinam nível de vida, de saúde, de distribuição de saúde, capacidade de resposta do sistema de saúde (*responsiveness*), financiamento dos sistemas de saúde, etc.

Para que serve um sistema de indicadores sociais? Deve servir para nos dizer qual é a situação de um país determinado, para nos permitir comparar países e para derivar sugestões de políticas de saúde. No nosso entendimento, e isto é dito respeitosamente, os indicadores apresentados pelos secretariados da OMS não cumprem essas finalidades como indicadores. Têm erros conceituais, metodológicos, e uma base empírica muito pobre. A respeito da base

empírica, basta dizer que, segundo nossos técnicos que obtiveram essas informações junto à própria OMS, dos 191 países alinhados para o *ranking* apenas se dispunha de dados completos para 5. No que se refere à contribuição financeira “*fairness of financial contribution*” se dispuseram de dados para apenas 21 dos 191 países. Para os outros 170 fez-se uma regressão múltipla, resultando num ajuste muito baixo, de 26%. No entanto, esses dados foram utilizados como corretos, ou seja, para fixar um coeficiente de justiça nas contribuições financeiras à saúde de 191 países se dispuseram de dados apenas para 21 deles e para 170 foram feitas estimativas econométricas de resultados bastante precários. No que se refere à distribuição da saúde entre a população, não houve dados a esse respeito, mas foram utilizados indicadores sobre escolaridade, pobreza e distribuição da renda que não são indicadores de saúde. E no que se refere, por exemplo, aos indicadores de vida, conhecidos como DALYs, na verdade não se dispôs de dados sobre países. Estes foram agrupados e foram feitas suposições sobre essa expectativa de vida, porque o indicador DALY é a esperança de vida descontada dos anos de incapacidade física. Chegou-se, de fato, ao indicador, que é praticamente idêntico ao da esperança de vida, dado antigo e tradicional aqui apresentado como um dado novo.

Mesmo para os países onde havia disponibilidade de dados, como o Brasil, as informações foram extremamente precárias. No caso brasileiro houve verdadeiras aberrações na utilização de fontes, nos equívocos, nas estimativas erradas. No que se refere

aos conceitos, é importante levar em conta que em nenhum dos indicadores o trabalho se preocupou em medir o impacto das ações de saúde sobre a distribuição e sobre a justiça social e, praticamente 75% do grau conferido a cada país reflete apenas a distribuição da renda, pobreza e outros indicadores sociais que não são de saúde, mas que foram apresentados ao mundo como tal. Não se estimou também o impacto das políticas de saúde nesta distribuição, o que seria elementar para apresentar-se dentro de um indicador. No que se refere, à justiça das contribuições financeiras à saúde, não se procurou medir o impacto do gasto da saúde sobre as pessoas, no sentido de se verificar se ele é progressivo ou regressivo. Isto foi omitido do marco conceitual deste relatório, o que explica como chegamos a resultados estranhos. Por exemplo, de acordo com esse sistema de indicadores, o sistema de saúde da Ilha de Malta tem melhor desempenho do que o da Noruega. O do Marrocos é melhor do que o do Canadá, o da Grécia é melhor do que o do Reino Unido, o de Benin é melhor do que o do Brasil, o de Qatar é melhor do que o do México, o do Senegal é melhor do que o da Argentina e do Uruguai, e o da Arábia Saudita é melhor do que o dos Estados Unidos. Ou seja, se um indicador chega a resultados tão pouco razoáveis, isto denota que ele é pouco apropriado. A metodologia utilizada foi tão deficiente que ainda que se se dispusesse de dados nacionais suficientes para uma análise comparada entre os países chegaríamos a situações desse tipo. Num país A que tem muita pobreza, o sistema de saúde poderá ser péssimo, mas será considerado mais homogêneo e, portanto, de

acordo com os indicadores da OMS será considerado melhor que o sistema de saúde de um país **B** onde há menos concentração de pobreza e menor homogeneidade. Mesmo que o sistema do país **A** seja péssimo ele será melhor do que o do país **B** devido a outras condições que não são do sistema de saúde. Um tal *ranking* apresentado por uma instituição historicamente respeitável como a OMS, com a melhor das intenções, teve, e ainda tem tido, um grande impacto político em muitos países, inclusive sobre a auto-estima de cada um dos sistemas avaliados de maneira tão flagrantemente equivocada.

Em razão disto, estamos propondo que se encaminhe através da Diretoria Executiva da OPAS uma resolução dos países americanos para que esse estudo seja suspenso até que seus pressupostos conceituais e metodológicos de obtenção de dados sejam debatidos entre os países membros. Não é errado a OMS tentar construir um único índice-síntese de desempenho dos sistemas de saúde. O erro é não discutir previamente com os países membros que fundaram e mantêm a instituição estes pressupostos metodológicos conceituais e a base empírica possível de ser trabalhada. De fato, um trabalho como o que foi publicado poderia muito bem ser uma espécie de *discussion paper*, um texto acadêmico para debate acadêmico e não integrar um relatório da OMS e receber a chancela, apoio e respaldo dessa instituição e ter a repercussão política que teve. Venho da vida acadêmica, além da política. Respeito os trabalhos acadêmicos, as elucubrações que se façam, as simulações, etc., mas isto é diferente de um relatório como o da OMS. Esta suspensão para discussão é

fundamental. Não adiantará no ano que vem promover pequenas correções, porque os erros são bastante profundos. Por exemplo, no que se refere à resposta dos sistemas de saúde às demandas da população, afora o fato de que não se tinha dados e que foram pesquisados alguns países, no caso brasileiro foram consultadas 33 pessoas para se saber qual o grau de reação (*responsiveness*) do sistema de saúde. Mas mesmo se se dispusessem dos dados a esse respeito seria preciso olhar o lado conceitual. Nesta questão do grau de reação não se incluiu nenhuma pergunta a respeito da eficácia do sistema de saúde. Portanto, os problemas conceituais são bastante sérios. E apelamos para que os países americanos apóiem esta posição. Não no sentido de coibir a investigação, mas no sentido de que ela seja feita de forma responsável, debatida e que esteja à altura das tradições da OMS. Quase todos sabem que não sou médico, que sou o primeiro Ministro da Saúde do Brasil que não é médico. Sou economista. E este estudo de indicadores em grande parte foi feito por economistas. Ao lê-lo e analisá-lo detidamente, lembrei-me de uma frase da eminente Professora Joan Robinson, de Cambridge. Ela dizia: “quando os alunos me perguntam se vale a pena estudar economia, eu digo que vale não para encontrar respostas acabadas a respeito do que fazer na realidade, mas vale a pena estudar economia pelo menos para se aprender a não ser enganado pelos economistas.”

Mme FORTIER (Canada) félicite la direction et le personnel de l'organisme pour la production du rapport annuel de l'an 2000. L'ampleur des questions soulevées dans le



rapport et les discussions portant sur les indicateurs de l'état de santé témoignent de nombreuses façons qu'utilisent l'organisation pour améliorer la santé. Dans ce rapport, la direction affirme que la santé est un bien public et souligne comment les soins devraient rehausser la liberté, en donnant des chances égales d'accès aux soins de santé, sans égard au statut social, ou à l'allégeance politique.

Dans cette optique, lors d'une réunion des premiers ministres des provinces et territoires, tenue il y a deux semaines, avec le premier ministre du Canada, ces derniers ont réitéré leurs engagements, ont renforcé et renouvelé le système public de soins et de santé en privilégiant le partenariat et la collaboration. Selon les Premiers Ministres du Canada, les objectifs clés du système canadien de santé sont les suivants: a) Préserver, protéger et améliorer la santé des canadiens et b) S'assurer que les canadiens ont un accès dans des délais raisonnables à un ensemble de services de santé appropriés, intégrés et efficaces, où qu'ils soient au Canada, en fonction de leur besoin et non de leur capacité de payer.

Les engagements pris par les Premiers Ministres visent à assurer la viabilité à long terme des soins de santé, une meilleure intégration des soins hospitaliers, des soins primaires, des soins à domiciles et des soins en milieu communautaire. Il permettra une plus grande insistance sur la protection et la promotion de la santé, de même qu'un partage plus efficace de l'information au sein des administrations et entre celles-ci. Dans le cadre de ce renouveau,

les gouvernements collaboreront avec les autochtones, leurs organismes et leurs gouvernements pour améliorer leur santé et leur bien-être.

Continuing in English, she said that Canada's prime ministers had affirmed their belief that the key goals of the health system in Canada were to preserve, protect, and improve the health of Canadians and ensure that Canadians had timely access to an appropriate, integrated, and effective range of health services anywhere in Canada, based on their needs, not their ability to pay. The work flowing from that commitment would ensure the long-term sustainability of health care services in future years. It would also provide greater integration of hospital, primary, home, and community care, more emphasis on health protection and promotion, and more effective information-sharing within and across jurisdictions. As part of that commitment, her Government would work to improve the health and well-being of the country's indigenous population.

Canada was impressed with the range of health information provided in the Director's report. The collection, publication, and wide dissemination of basic health information at the national and regional levels was absolutely vital to help countries improve health, regardless of their level of technological development. The reference to equity in the report and its importance in the provision of basic health information could not be overstated. Providing information that pointed up the disparities in health status made governments acutely aware of their obligations to the entire population. Canada had recognized the importance of a sound

information base and accountability to the population and planned to publish annual reports that would measure, track, and report on performance. The reports would allow ordinary Canadians, health care providers, and decision-makers to judge whether health services were adequate and identify where improvements were needed.

Her Delegation was pleased to note that the Director's report underscored the importance of collecting information on different population groups. National averages alone could not provide an accurate account of health status. Canada had long stressed the need to take marginalized populations into consideration in PAHO programs. Aboriginal populations, in particular, had health outcomes that might be far different from those in the rest of the population. Canada looked forward to seeing that type of information in future publications on health status in the Americas.

Her Delegation also welcomed the report's emphasis on strengthening health collaboration in the Americas. Canada was an active and eager participant in technical collaboration with its sister countries in the Region. It engaged in that collaboration in the spirit of Pan Americanism. In April 2001, heads of government from North America, Latin America, and the Caribbean would meet in Quebec City for the next Summit of the Americas. Health would be recognized at the Summit as an important element in promoting the broader goals of democracy and prosperity. The issue of connectivity would be used to show how countries in the Americas could stay connected and collaborate on important issues such as

health. Canada hoped that PAHO's participation at the Summit would help highlight the importance of health issues and the search for common solutions to common problems.

The use and control of tobacco was an issue of concern to all citizens of the Region. The problem had been well researched and was well understood, and solutions had been well articulated. Indeed, there were few social or health problems in which the cause-effect relationship was as well understood. Canada was pleased with the work done to date by the Organization and with the progress made in some countries to counter tobacco use. Canada also strongly supported the Framework Convention on Tobacco Control, which would be a vital tool in national and international efforts to reduce tobacco consumption. Her Delegation hoped that the Convention would lead to improve exchanges of information among countries on tobacco addiction, testing, and product standards; efforts to reduce tobacco supply by developing alternative crops for farmers in tobacco—growing areas; and agreements between countries to restrict tobacco advertising, improve health warning on packaging and labeling, and facilitate collaboration on the smuggling of tobacco products. Canada applauded PAHO's efforts and urged it to continue to play a leadership role in assisting countries to develop their capacity to put in place tobacco control policies.

Dr. NOVOTNY (United States of America) commended the Director and the staff of PAHO on the annual report. Each year the Director thoughtfully emphasized a theme that was an integral part of his overall agenda for equity. He continues to reinforce the perspective

of public health as an essential public good and critical resource for human development. As with past reports, the report for 2000 advocated the need to improve the capacity to measure, monitor, and better understand public health and its determinants, one of which was the health care system. It also reflected PAHO's critical role in helping shape data so as to enable Member States to make more informed decisions when formulating policies and programs and add value to national strategies. His Delegation agreed with the emphasis on collecting data on different subnational groups. In the United States, efforts are focusing heavily on health disparities between groups based on race and socioeconomic status.

The report of the Director also reflected the strong partnerships and shared vision of health among the countries of the Americas. The Region's shared passion and solidarity in grappling with public health concerns had enabled effective change in many areas.

The United States was very interested in PAHO's revolving fund for the purchase of antiretroviral drugs, tuberculosis drugs, malaria drugs, and drugs used against leishmaniasis. His Government was engaged in discussions with pharmaceutical companies and non-governmental groups to try to identify ways it could assist in providing access to treatment for HIV/AIDS. PAHO had an excellent record of supporting the purchase of vaccines through a similar revolving fund, and his Delegation hoped that the new fund would be equally effective. However, the United States had some concern about the impact of drug donations on the sustainability of the revolving fund.

The advancement of health was a complex and dynamic process that required commitment from the highest levels of government, and information and data were essential elements to good management leadership, and decision-making. Sound science and information were a cornerstone of effective policy formulation, as the Delegate of Brazil had pointed out. PAHO's technical cooperation had complemented the leadership and vision of WHO in regard to the difficult problems associated with measuring health system performance. His Delegation applauded WHO's efforts and looked forward to hearing how the criticisms voiced by Brazil and perhaps other PAHO Members would be addressed. The United States agreed that more country consultation on the development of those types of health indicators was necessary.

El Sr. GONZALEZ FERNANDEZ (México) dice que, en opinión de su equipo, el informe del Dr. Alleyne es muy completo y añade que, aunque ya se han dado datos sobre México, algo importante es que en el último sexenio se ha invertido en salud en su país más que en ninguna otra época. Explica también que, sin ser economista, le resultan convincentes las razones dadas por el Ministro de Salud del Brasil para estar precavido respecto de los economistas. Por esa razón, México se suma a la propuesta brasileña y apoya la moción que ha presentado el Brasil respecto del informe de la OMS.

*The meeting rose at 12:30 p.m.  
Se levanta la reunión a las 12:30 p.m.*