PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

25th PAN AMERICAN SANITARY CONFERENCE
50th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., 21-25 September 1998

CSP25/SR/1
21 September 1998
ORIGINAL: ENGLISH-FRENCH-SPANISH

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

Monday, 21 September 1998, at 9:00 a.m.
Lunes, 21 de septiembre de 1998, a las 9:00 a.m.

Outgoing President: Presidente Saliente:	Dr. Roberto Tapia Conyer	Mexico
President: *Presidente:*	Dr. Alberto Mazza	Argentina

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ITEM 1: OPENING OF THE CONFERENCE
PUNTO 1: APERTURA DE LA CONFERENCIA

A. Opening of the Meeting by the Outgoing President, Dr. Roberto Tapia Conyer (Mexico)
A. Apertura de la Reunión por el Presidente Saliente, Dr. Roberto Tapia Conyer (México)

The SECRETARY: said that under the Rules of Procedure for the Pan American Sanitary Conference, the presence of at least 20 countries was required in order to establish a quorum. More than 20 countries were present and seated, and therefore a quorum had been established.

EL PRESIDENTE SALIENTE explica que, debido a que su país ejerció la presidencia de la 24.ª Conferencia Sanitaria Panamericana, él tendrá el honor de presidir la reunión hasta que sea elegido el Presidente de la 25.ª Conferencia. Pide disculpas en nombre del Secretario de Salud de México, que no ha podido estar presente en esta ocasión debido a asuntos de suma importancia en el país. Seguidamente da la bienvenida a todos los delegados y declara abierta la Conferencia.

B. Welcoming Remarks by Dr. George A. O. Alleyne, Director of the Pan American Sanitary Bureau.
B. Palabras de bienvenida del Dr. George A. O. Alleyne, Director de la Oficina Sanitaria Panamericana

Dr. ALLEYNE (Director) welcomed the delegations to the Conference and extended sympathy to the countries that had been affected by hurricane Georges. He noted that

although much has changed since the first Pan American Sanitary Conference in 1902, many old problems and many new ones still remained to be solved. He trusted that the 25th Conference would be as successful as those that had preceded it.

Dr. SHALALA (United States of America), referring to the election of Dr. Alleyne at the last Pan American Sanitary Conference, praised his four year of service and stated that the United States of America was proud to be supporting his re-election this year. She also said that in the new Director General of WHO, Dr. Gro Harlem Brundtland, the Organization had gained a leader with a clear vision and a strong voice for the most vulnerable citizens of the world. She had been particularly pleased to hear Dr. Brundtland, at the last World Health Assembly, call for a worldwide effort to end the major cause of premature death in the Hemisphere, tobacco use. The United States of America shared that commitment and was redoubling its efforts to curb tobacco use by young people. If current trends continued, about 250 million children alive in the world today would be killed by tobacco. Her Department was committed to working whit PAHO/WHO and other agencies to help protect the world's children from tobacco. For example, she looked forward to working with WHO and others on the International Framework Convention for Tobacco Control.

Diseases did not respect borders or distinguish between rich or poor. There was therefore a need, as Octavio Paz, the Nobel Laureate, had said, "To join together in inventing our common future"–a healthier common future. There was need to expand worldwide access to immunizations; extend health service to all; empower women and

their families with economic, educational, and social rights; and eliminate violence in the home against women and children. At the same time, the global fight against infectious diseases must be escalated, and national and regional surveillance systems must be linked. Global partnerships must be forged in fighting this common cause.

Recently the world had mourned the loss of two great pioneers in the fight against AIDS, Dr. Jonathan Mann and his wife, Dr. Mary Lou Clements Mann. In their name, she called for a commitment to continue the battle against AIDS and every other disease.

The nations of the Region were united in their quest for a good life and good health for all their people.

D: Address of Dr. Gro Harlem Brundland, Director-General of the World Health Organization.

D: Palabras de la Dra. Gro Harlem Brundland, Director General de la Organización Mundial de la Salud.

Dr. BRUNDTLAND (Director-General, WHO):

"After almost one century of effective action, the Pan American Sanitary Conference casts today a light of hope into the future of international health cooperation. It is an honor for me to address for the first time this distinguished group of leaders. I come here to share my vision and also to draw inspiration from you.

Together, we are all celebrating this year the 50th anniversary of the World Health Organization. We can look back at impressive achievements, yet we enter a new century where no one could claim that our agenda was fulfilled. There is still so much to do. Our task is clear: to see to it that an effective WHO will be there to pave the way towards better health in all its Member States.

This is the fifth Regional Committee that I have attended since the beginning of this month. Harare, New Delhi, Manila, Copenhagen, now Washington and then Beirut—

they all represent an extraordinary opportunity to tap experiences of health officials around the world.

To me this is key: WHO is complete –our identity intact, our course on target- only if we include the regional dimensions –if we add them up. I see this as a main challenge: to make WHO one, not seven organizations –Geneva and the six Regional Offices.

Let me take this opportunity to share with you a few issues which I believe are important to the Americas, and to share with you the process of change that I have initiated with my colleagues in the WHO Secretariat.

I will start with some observations.

My first observation relates to the need for a broad perspective on health. Important determinants of better health lie outside the health system. They include better education, a cleaner and safer environment, and sustained reductions in poverty. We simply cannot appreciate the health challenges by only focusing on the health sector.

Health workers are on the receiving front of society's problems and inequities, and are often left with dealing with the outcome of events. At the same time we know that making right and timely investments in health benefits society at large.

You, the Health Ministers, already know. Together we need to go beyond and tell Presidents, the Prime Ministers and the Finance Ministers that they are really Health Ministers themselves.

I believe we can succeed in putting health at the center of the development agenda. Not alone. But by gathering our evidence, by matching it with that of others, by becoming better advocates, and by reaching decision-makers with a convincing case. This requires new momentum and new methods of works. I will return in a moment to the subject of health as investment and the need for this message in particular to reach Finance Ministers and Heads of State.

My second observation concerns our need to reach out -to other UN Agencies, to other key players in health, and to civil society. The very notion of a specialized agency makes little sense in this interdependent world. The projects and workplans of WHO will put specific emphasis on these partnerships. WHO can be a stronger lead agency in health by entering into partnership of stakeholders.

In doing so we must emphasize our comparative advantage: WHO should focus on problems that cross boundaries, on generating and disseminating a global evidence base, on promoting research that goes beyond corporate on national agendas. That is how we can really be efficient and make a difference at a country level, in our technical work and in our setting of norms and standards. That is how WHO will provide the intellectual and oral leadership required to ensure health for all.

These themes of partnership and focus apply to our work in the Americas. There are already ties of cooperation with UNICEF, UNDP, UNFPA, the World Bank and the Inter-American Development Bank, among others. Sub-regional trade agreements, such as NAFTA and MERCOSUR, offer important opportunities for multi-sectoral action for health.

They also invite us to develop better strategies for linking health and trade issues. These include conventional areas of concern, such as harmonization of occupational and environmental health standards. They also involve balancing our mandate to protect the health of people from potential hazards with the imperative to avoid using health regulations as trade barriers. And they include new areas that are increasingly becoming crucial as globalization advances, such as the trade in health-related services and products.

We must also reach out to the private sector. I have said that WHO will engage the private sector in constructive dialogue and this will be of critical importance with regard to the pharmaceutical sector. National and international drug policies should help extend access to essential drugs of good quality, safety, and efficacy. This requires strong national regulatory authority and intelligent government purchasing policies.

We are looking for the right balance. National strategies must ensure equity of access, rational use, and assured quality for existing drugs. Issues of drug financing and affordability are critical. At the same time, to meet pressing public health needs we need new drugs and vaccines. This is true for emerging diseases, but also true because of the serious threat from growing resistance to drugs for common killers such as tuberculosis, bacterial meningitis, and pneumonia. To develop new drugs we need innovative industry research, with appropriate incentives for innovation and protection of intellectual property rights.

International organizations and Governments should address pharmaceutical issues within their areas of competence and responsibility, in order for these important issues to be handled in a satisfactory and timely manner.

It is time for an increased and ongoing dialogue between WHO and the World Trade Organization. I have scheduled a meeting with Director General Ruggiero to discuss how we

can work together on ways to further both international commerce and international commitments to health.

My third observation concerns the shift in the global burden of disease from communicable to non-communicable diseases. Latin America has been at the forefront of this transition in the developing world. But scores of developing countries are moving in the same direction, posing an exceedingly hard challenge to their health systems.

Great gains have been achieved in the fight against communicable diseases. With strong leadership from PAHO, the region of the Americas has led the world in the eradication of polio.

But this progress must not lead to the illusion that infectious diseases are a problem of the past. What we see here, as in many other parts of the developing world, is the simultaneous presence of multiple challenges, involving both communicable and non-communicable problems.

The Region of the Americas is facing this double burden of disease and injury. Most of the countries still suffer and epidemiological backlog of common infections, malnutrition and reproductive health problems. Without having fully solved these challenges, they are already facing the emerging problems represented by non-communicable diseases, new infections and the mounting epidemic of injury from accidents and violence.

Violence is a particular serious challenge for Latin America. This is the region with the highest proportion of deaths and of disabilities-adjusted life years lost to violence. The multiple roots of this epidemic test our ability to work in a truly multisectoral way. It is a clear indication that health must be an objective shared by all society. Together with a comprehensive preventive strategy, we must be ready to offer timely health care of high quality to the victims of violence.

Why is this such a challenge? A lot boils down to the problem of inequality. Many countries in this region have experienced a process of health polarization that fractures society along economic, ethnic and geographic lines.

In the balance sheet of our century, inequality remains as one of the largest social debts.

Contrary to common misconceptions, inequalities do not follow a simple dividing line whereby communicable diseases would be mostly the problem of the poor and non-communicable ailments would affect the rest of the populations. The brutal fact is that the poor suffer higher rates of both types of diseases.

WHO has no choice but to address the double burden simultaneously. As we continue to improve case management, we must seriously focus on controlling risk factors. And let there be no secret: By far the most important is tobacco.

Let us talk about tobacco.

Smoking is probably the single most rapidly increasing cause of death in the Americas. The years of life lost due to premature death from tobacco use will increase five-fold in Latin America between 1990 and 2020.

You are acting—and I lend you my full support. The day I took office I launched the Tobacco Free Initiative, a Cabinet project to add momentum to this critical public health struggle.

I told the World Health Assembly back in May: I am a doctor. I believe in science and evidence. Let me state it clearly: Tobacco is a killer. It should not be advertized, subsidized or glamourized. Adolescents should not be allowed to mortgage their lives to the seductive advertisements of the industry.

WHO's Tobacco Free Initiative aims at galvanizing global support for tobacco control. We need to ensure that our policy is backed by people, money and institutions, not just in Geneva, but also in the Regions and within all Member States. We need to reach in and reach out to build "partnerships with a purpose" for combating this epidemic.

We need to work with the World Bank, UNICEF and the World Trade Organization —with NGOs and civil society. Tobacco is not just another commodity. The World Bank's 1992 tobacco policy includes an important precedent be exempting tobacco and tobacco-related imports from borrowers' agreement with the Bank to liberalize trade and reduce tariff levels.

Our efforts—in the Americas and beyond—will require proper funding. We are earmarking funds to this initiative, cutting down on other activities. But WHO's limited regular budgets cannot cope with this challenge alone. We will need funding from voluntary donations, the governmental as well as the private sector. I hope that you will take every opportunity to involve the highest levels of government and the highest levels of opinion leaders in their efforts to build on the present momentum, secure commitment, and reap the significant health and economic benefits that can be achieved from a reduction in tobacco use.

Let me turn to a topic that I know has been of particular interest to this region. I refer to the role of health in development.

Improvements in health reflect rising standards of living and improved levels of education. Enlightened health policies, too, have allowed some countries to share the powerful potential of modern medicine and public health widely across their populations: Costa Rica's success in the 1960s and 70s is known to us all, but many others showed how much health conditions can improve beyond what one might expect from income growth alone. Income growth, although important for health is but one of a number of factors. Good health policies can achieve remarkable results –with the tools that science has given us today– at any income level.

Let me turn the question around: Have improved health and nutritional conditions themselves contributed to Latin America's economic performance over the past three decades?

Breaking the vicious cycle linking poverty, illness, illiteracy and malnutrition constitutes the central challenge to development policy as the new millennium dawns. Health improvements underpin any strategy for creating an upward spiral where better health improves nutrition, facilitates education and enhances the productivity and incomes of the poor. And these gains will in turn lead to better health.

What is the evidence?

Economists now agree that investments in human resources play a critical role in economic growth and development across the globe. When they think about these investments, however, they often focus on education, and the evidence concerning education's impact is strong. Yet health, like schooling, is a form of human capital, but its role in improving productivity and economic growth has received remarkably little attention in policy and research circles. Until recently, an important initiative of PAHO and the Inter-American Development Bank is generating data and analyses that will substantially strengthen our knowledge base.

Studies carried out in many parts of the world reach an unequivocal conclusion: Health matters for economic performance. Removing financial barriers to health care matters. Assuring good quality of services matters.

The growing understanding of the deep links between health and the economy should help fuel efforts to improve health systems.

So let us move on and talk about health sector reform.

How can we build sustainable health systems that can stand the test of changing times and economic constraints? How can we ensure access to basic health services in

situations where the base of public finance threatens to collapse? Many of your countries experience just that as the world economy is going through such turbulent times.

Each country must choose its own path –based on its pattern of disease, its institutions, its resources, and the needs of its people. But WHO must always be there, ready and able to assist you, and to share with you the experiences gathered through different models applied in various countries.

Recent years have witnessed the emergence of a world-wide movement for health system reform. Half a century after most current arrangements for organizing health care were set in place, we are again living through a period of innovation. Most countries seek to find better ways of facing the complex health challenges of our times.

Your Region has shown commitment to health care reform at the highest levels of political leadership. At the Summit of the Americas, held in Miami in 1994, the heads of state and government addressed this critical issue. Practically all countries in the region are intensely involved in planning or implementing reform processes.

What goals should guide health sector reform? By what criteria should we judge success or failure? I see three concrete goals:

Measurable reduction in the huge inequities that still plague us—inequities both within and across countries; sustained, measurable reduction in the burden of disease; universal access to efficient health services that respect the needs and dignity of each individual.

A key responsibility for Governments should be to secure access to care. Only the public sector can guarantee basic universal rights. That is a useful reminder in this year of the 50th Anniversary of the Universal Declaration of Human Rights as well as of our own Constitution.

The performance of market forces has enormously increased productivity in many sectors of the world economy. The health sector is also benefiting. But just as the private-for-profit sector may be good at allocating resources cost-effectively, it is seldom the key provider of primary health care or the guarantor of securing health services to the poor. Neither will it assure universal access.

We need to start a discussion on norms and standards of a “new universalism”—a new way of addressing universal coverage. This will be a major issue on the agenda of each country. Accordingly it has to be a WHO priority, and we are organizing part of our

work to deal with it effectively. Everything we do should contribute to health sector development. If it does not, we should consider not engaging. The Americas have done a lot in this area, but more needs to be done.

Universal access to quality services is a bedrock principle. Governments should provide strategic leadership—through setting priorities—while accepting that there are limits to the care Governments can finance, limits that each country must decide for itself. But setting priorities and defining limits require knowledge of which efforts will make the best impact, reach the most people, and achieve the most effective results.

WHO should be there to advise you in this process. The new universalism embraces all potential contributors to better health—public sector, private sector or NGOs. Provision of government—financed service must come from the most efficient source, not necessarily from public sector providers.

In order to make health system reform a sustainable process, we must engage in a process of shared learning. Every reform experience contains valuable lessons for other countries. Systematic information on such experience is an international public good. An essential function of institutions like WHO is to mobilize international collective action to ensure that such public goods are effectively produced and disseminated.

In partnership with national policy analysis centers, multilateral development banks and bilateral cooperation agencies, PAHO has been actively involved in recent efforts to develop clearinghouses on health system reform initiatives. These efforts—and similar ones in other regions—will allow us to learn from each other as we pursue this exciting quest for the health systems of the future.

In everything we do there is a growing need to underpin our work with solid facts. We must have the right figures –the right connection and the best evidence—not only the moral conviction that health is essential. We have created a special Cluster called Evidence and Information for Policy. This knowledge base is there for you to use—and to enrich. We will report important facts. And the fact is that healthy people help build healthy economies.

Let me end by sharing with you some key elements of the WHO reform process.

On 21 July I took office and appointed a new senior management team at headquarters level. We are five members from the South and five from the North, six women and four men. All WHO's Regions are represented in a strong global team.

Together with the Regional Directors, the WHO Representatives and more than 3,500 staff we are embarking on a process of change along the lines I presented to the World Health Assembly in May.

We must secure a greater unity of purpose in what we do. We should be very good at what we decide to do—and ready to say that we cannot do all.

We need to be able to say that WHO is one: setting its priorities as one, raising additional resources as one, speaking out as one. Let us not forget: WHO is a small Organization if we measure it against its mandate –and against the scores of unmet needs. WHO is not a deliverer of health services: national and regional authorities are. NGOs, private providers and communities are. You are. It is through our combined efforts that we can make a difference.

At Headquarters, we have grouped the programmes into nine Clusters –each sending a clear message of what business we are in. In the coming months, under the supervision of the Executive Directors, each Cluster will streamline its activities in order to optimize what we can do together—across the Organization and in partnership with others.

We continue to focus on Communicable Diseases and Non-Communicable Diseases. And we are moving to address the challenges of a changing world. The Cluster on Social Change and Mental Health will try to capture the health challenges from changing and aging societies, with a particular focus on the unmet needs within the field of mental health. The Cluster on Sustainable Development and Health Environment will strive to make the link between a globalized world and the strains on people's health from poverty and a growing burden on our environment.

In everything we do we have to remind ourselves: What we do in Geneva or in Washington matters very little if it does not have an impact in the countries in terms of better WHO collaboration, better pooling of knowledge, better global advocacy for health and better resource mobilization.

Not long ago, I met with the Regional Directors for a first discussion of our common work. I see the Regional Directors as an integral part of the senior management team of the Organization and I intend to establish and maintain a closer contact with them. We have started a major modernization of our information technology network which will enable us to link the six corners of the world by the push of a button, by voice or by image in real time. There will be better communication and there will be money saved from doing away with unnecessary travel.

I will establish more direct relations with the WHO country representatives and in a few months, I will invite country representatives to Geneva to learn from their experience and to introduce them to the new WHO and what it has to offer, in order to strengthen the bridges to the Member States and in particular to those in greatest need.

I will invite the Executive Board to closer contact and more focused debates on the challenges facing us. One month from now, I will meet the Board at an informal retreat to introduce the change process and share ideas on the strategic way ahead.

I will establish closer relations with the private sector by inviting industry to roundable discussions and exchanges in order to explore what we can do in common and where our views and interests differ. And I will meet more regularly with the NGOs and define new opportunities of working together.

You know it from the numerous calls from the Governing Bodies; Member States want more relevant and tangible results from our efforts at the country level. The time has come for the Secretariat to make its response. We have initiated a fast track task force to make concrete recommendations on how we can turn the ambitious into reality.

Gradually you will see that we are changing the way we work. More of our work will be organized in projects that cut across Clusters and Regions and that frequently engage other partners. Our aims are high visibility, intensive efforts, tangible targets. We have launched two such projects since 21 July—Roll Back Malaria and the Tobacco Free Initiative, which I referred to earlier.

The bottom line is this: We need to make WHO more user-friendly, more evidence-based, for you, the Member States, who need it most, so that you can get more out of your health policies. This is a process of hope. We can do better. We will do better.

Ministers, Colleagues, Ladies and Gentlemen,

Yes, there are scores of unmet needs. But the health sector has a track record of success over the past half century; it is our mandate, yours and mine, to carry that record forward. Progress in the next century will depend on our ability to explore the potential of the human resource. We go nowhere unless we succeed in building healthy populations in healthy communities.

Science has given us powerful tools. The need now is for political, financial and ethical commitment. Commitment and responsible use of science can aid us in our search forever better ways to prevent and treat the constantly evolving disease challenges we face.

I am hopeful about the Region of the America. You represent the oldest regional health organization in the world. You can be proud of your achievements. Many of our concepts and practices in international health cooperation are the result of the vision and dedication of many generations of public health researchers and practitioners from the Americas. No doubt, the rest of the world will continue to look to the Americas for examples of an effective regional organization.

We can look back with legitimate satisfaction to our accomplishments. But we must also look forward to the challenges that are already with us, many of which derive from the very progress that we achieved during the 20th century. Others are the results of the agenda that we have not been able to fulfill. Still others will emerge as unprecedented problems of the future, and we must be prepared today in order to anticipate them.

These challenges are a call for action –evidence-based and value-driven. Together we can make a difference for health –today and in the times to come. Thank you."

El PRESIDENTE SALIENTE agradece a la Dra. Brundtland sus palabras y destaca que su discurso es de gran utilidad en cuanto presenta un excelente resumen del programa de trabajo de la Organización Mundial de la Salud.

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

El PRESIDENTE SALIENTE anuncia que los países propuestos para constituir la Comisión de Credenciales son Canadá, Nicaragua y Venezuela. Al no haber objeción, quedan nombrados Canadá, Nicaragua y Venezuela.

It was so decided.
Así se acuerda.

Invita a la Comisión a reunirse inmediatamente para revisar las credenciales recibidas por el Director.

The meeting was suspended at 10:00 a.m. and resumed at 10:45 a.m.
Se suspende la reunión a las 10.00 a.m. y se reanuda a las 10.45 a.m.

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

El PRESIDENTE SALIENTE invita al Presidente de la Comisión de Credenciales, el Dr. Lombardo Martínez Cabezas, Ministro de Salud de Nicaragua, a que proceda a dar lectura al informe.

El Dr. MARTÍNEZ (Nicaragua) informa que la Comisión de Credenciales, de acuerdo con el Artículo 26 del Reglamento Interno de la Conferencia, integrada por los Delegados de Canadá, Nicaragua y Venezuela, llevó a cabo su primera sesión el 21 de septiembre de 1998 a las 10.00 a.m. y eligió al Dr. Lombardo Martínez Cabezas, Ministro de Salud de Nicaragua, como su presidente. La Comisión procedió a examinar las credenciales entregadas al Director de la Oficina, de conformidad con los Artículos 17 y 26 del Reglamento Interno de la Conferencia, encontrando que las credenciales de los delegados de los Estados Miembros y Participantes, Miembros Asociados y Estados Observadores que se citan a continuación se presentaron en buena y debida forma, razón por la cual propone que la Conferencia reconozca su validez. Los Estados Miembros y Participantes acreditados son los siguientes: Antigua y Barbuda, Argentina, Bahamas,

Barbados, Belice, Bolivia, Brasil, Canadá, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Estados Unidos de América, Francia, Guyana, Haití, Honduras, México, Nicaragua, Panamá, Paraguay, Perú, Reino de los Países Bajos, República Dominicana, Santa Lucía, San Vicente y las Granadinas, Suriname, Trinidad y Tabago, Uruguay y Venezuela.

Entre los Estados Observadores quedó acreditada España. La Comisión se reunirá nuevamente para examinar las credenciales que faltan y que se reciban.

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 THE RAPPORTEUR
PUNTO 2.2: ELECCIÓN DEL PRESIDENTE, LOS DOS VICEPRESIDENTES Y EL RELATOR

The SECRETARY said that under Rule 18 of the Rules of Procedure of The Pan American Sanitary Conference, the Conference was to elect a President, two Vice-Presidents, and a Rapporteur, who would hold office until their successors were elected.

El PRESIDENTE SALIENTE solicita la presentación de candidaturas para Presidente, los dos Vicepresidentes y el Relator.

The Hon. Dr. Elizabeth THOMPSON (Barbados) commended Argentina and, in particular, the Minister of Health for Argentina, for leading the Region of the Americas in its

struggle for health sector reform in terms of cost effectiveness and relevance to the needs of the people. Argentina had managed its health sector reform so effectively that it had become a model for the rest of the Region.

In view of it's example, her Delegation wished to propose Argentina for the Presidency of the Pan American Sanitary Conference.

El PRESIDENTE SALIENTE, al no haber otra candidatura, considera que la elección de Argentina en la persona del Ministro de Salud y Acción Social, Dr. Alberto Mazza, será unánime.

Decision: Argentina, was unanimously elected to the Presidency of the Pan American Sanitary Conference.
Decisión: Argentina es elegido por unanimidad, a presidir la Conferencia Sanitaria Panamericana.

Dr. Alberto Mazza took the Chair.
El Dr. Alberto Mazza pasa a ocupar la Presidencia.

El PRESIDENTE, después de dar las gracias a todos los delegados por haberlo elegido y a la Delegada de Barbados por sus palabras, dice que se encuentra muy complacido de presidir la Conferencia. Destaca el importante papel que la OPS, próxima a celebrar su centenario, ha venido desempeñando desde 1902 en el contexto de la salud de los pueblos de América, papel que se refleja en mejores niveles de cobertura y en una atención médica de mejor calidad. El proceso de reforma del sector de la salud es una necesidad impuesta por la complejidad que acarrean los cambios tecnológicos del mundo

moderno, los que a su vez permiten alcanzar mejores condiciones sanitarias. Incita a todos los presentes a contribuir a que la Conferencia haga un aporte importante a este proceso de transformación, como ha venido haciendo la OPS en los últimos años.

Indica a continuación que corresponde elegir dos vicepresidentes y propone las candidaturas de Barbados y Honduras.

Decision: Barbados and Honduras were unanimously elected to the Vice Presidencies of The Pan American Sanitary Conference.
Decisión: Barbados y Honduras son elegidos por unanimidad a las Vicepresidencias de la Conferencia Sanitaria Panamericana.

El PRESIDENTE propone al Perú, para la posición de Relator.

Decision: Peru was unanimously elected to serve as Rapporteur.
Decisión: El Perú queda elegido por unanimidad para servir como Relator.

ITEM 2.6: MODIFICATIONS TO THE RULES OF PROCEDURE OF THE PAN AMERICAN SANITARY CONFERENCE
PUNTO 2.6: MODIFICACIONES DEL REGLAMENTO INTERNO DE LA CONFERENCIA SANITARIA PANAMERICANA

Dr. JIMENEZ (PAHO) referred to Document CSP25/3 and recalled that in 1996 the 118th Session of the Executive Committee had proposed reviewing the Rules of Procedure for each of the PAHO Governing Bodies to modify gender-specific language.

In the course of the initial review, the Rules of the three Governing Bodies had shown inconsistencies that needed adjustment in order to reflect current practice and actual membership of the Organization.

The 39th Directing Council (1996) had agreed, at the request of the Director, to postpone consideration of the modifications until a broader review was carried out. The review had been completed and the Director had submitted the proposed amendments to the Rules of Procedure of the three Governing Bodies to the Executive Committee in June 1997.

A working party set up by the Executive Committee to study the modifications to the Rules had subsequently proposed adoption of the amendments by the Executive Committee and had asked the Committee to recommend their adoption by the Directing Council and the Pan American Sanitary Conference.

The amendments fell into several categories, including gender-neutral language, editorial clarification, reordering, and changes, the reflection of actual membership and practice, equivalence between different working languages, and general consistency between the Rules of Procedure of the three Governing Bodies.

The Executive Committee and the Directing Council had adopted their new Rules in 1997. In accordance with Rule 65 of the original Rules of Procedure, the Pan American Sanitary Conference was requested to consider adoption of the amended Rules by adopting the proposed resolution contained in the Annex to Document CSP25/3.

El RELATOR dice que el siguiente proyecto de resolución sobre el tema aparece en el documento CSP25/3.

THE 25th PAN AMERICAN SANITARY CONFERENCE,

Considering it advisable that the Rules of Procedure of the PAHO Governing Bodies be brought in line with current practice and that similar rules for each body be consistent;

Aware that the proposed amendments to the Rules of Procedure of the Directing Council and the Pan American Sanitary Conference were thoroughly reviewed by the Executive Committee and the Working Party it established for this purpose;

Considering that the Executive Committee, by Resolution CE120.R17, and the Directing Council, by Resolution CD40.R17, adopted the modifications to their Rules of Procedure, and recommended that the Pan American Sanitary Conference adopt its amended Rules; and

Bearing in mind the provisions of Rule 65 of the present Rules of Procedure of the Conference,

RESOLVES:

1. To thank the Working Party of the Executive Committee for its comprehensive review of the Rules of Procedure of the three Governing Bodies of the Pan American Health Organization.

2. To adopt the amended Rules of Procedure of the Pan American Sanitary Conference as they appear in the Annex to Document CSP25/3.

LA 25.ª CONFERENCIA SANITARIA PANAMERICANA,

Considerando la conveniencia de que los reglamentos internos de los Cuerpos Directivos de la OPS sean acordes con las prácticas actuales y de que los artículos semejantes en los reglamentos de cada cuerpo sean congruentes entre sí;

Consciente de que las modificaciones propuestas de los reglamentos internos del Consejo Directivo y de la Conferencia Sanitaria Panamericana fueron examinadas a fondo por el Comité Ejecutivo y el grupo de trabajo formado por este para dicha finalidad;

Teniendo en cuenta que el Comité Ejecutivo, mediante la Resolución CE120.R17, y el Consejo Directivo, mediante la Resolución CD40.R17, aprobaron las modificaciones de sus respectivos reglamentos internos y recomendaron que la Conferencia Sanitaria Panamericana aprobara las modificaciones de su Reglamento Interno, y

Teniendo presentes las disposiciones del Artículo 65 del Reglamento Interno de la Conferencia que está vigente,

RESUELVE:

1. Agradecer al grupo de trabajo del Comité Ejecutivo el examen integral que efectuó de los reglamentos internos de los tres Cuerpos Directivos de la Organización Panamericana de la Salud.

2. Aprobar las modificaciones del Reglamento Interno de la Conferencia Sanitaria Panamericana, tal como aparecen en el anexo al documento CSP25/3.

El PRESIDENTE, al no haber observaciones, declara aprobada la resolución.

Decision: The proposed resolution was adopted.
Decisión: Se aprueba el proyecto de resolución.

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 ARTICULO 6.B DE LA CONSTITUCIÓN DE LA OPS

The SECRETARY read out Article 6.B of the PAHO Constitution and recalled that it was the practice of the Conference to appoint a Working Party consisting of Delegates of three Member States to study the application of that Rule.

El PRESIDENTE propone que los Delegados de Antigua y Barbuda, México y Uruguay sean elegidos para constituir el Grupo de Trabajo e informa que dicho Grupo

contará con la cooperación del Sr. Mark Matthews, Jefe del Departamento de Presupuesto y Finanzas.

Decision: The Delegates of Antigua and Barbuda, Mexico, and Uruguay were appointed members of the Working Party.
Decisión: Los Delegados de Antigua y Barbuda, México y Uruguay quedan nombrados miembros del Grupo de Trabajo.

ITEM 2.4: ESTABLISHMENT OF THE GENERAL COMMITTEE
PUNTO 2.4: ESTABLECIMIENTO DE LA COMISIÓN GENERAL

El PRESIDENTE explica que los jefes de la delegación han convenido en que los Delegados de Brasil, Cuba y Estados Unidos de América se incorporen a la Comisión General.

Decision: The Delegates of Brazil, Cuba, and the United States of America were elected members of the General Committee.
Decisión: Los Delegados de Brasil, Cuba y los Estados Unidos de América quedan elegidos como miembros de la Comisión General.

ITEM 2.5: ADOPTION OF THE AGENDA
PUNTO 2.5: ADOPCIÓN DEL PROGRAMA DE TEMAS

The SECRETARY introduced the provisional agenda contained in Document CSP25/1, Rev. 1, which had been prepared in accordance with Rule 11 of the revised Rules of Procedure.

El PRESIDENTE dice que, de no haber objeciones, da por aprobado el orden del día.

Decision: The agenda was adopted.
Decisión: Se aprueba el orden del día.

ITEM 3.2: ANNUAL REPORT, 1997, AND QUADRENNIAL REPORT, 1994-1997, OF THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU
PUNTO 3.2: INFORME ANNUAL, 1997, E INFORME CUADRIENAL, 1994-1997, DEL DIRECTOR DE LA OFICINA SANITARIA PANAMERICANA

Dr. ALLEYNE (Director) congratulated the Director-General of WHO on her moving and stimulating address and Dr. Alberto Mazza on his election as President of the Conference. He then outlined the background against which the Quadrennial Report of the Director (1994-1997) was set. The general panorama of the Americas had included political, social, and economic features that had guided and conditioned the work of the Organization in the previous four years.

In political terms, the Member States had committed themselves unreservedly to the democratic process. There had been commitment at a number of summits to the Free Trade Agreement of the Americas and to open regionalism. That had resulted in the strengthening of the MERCOSUR and CARICOM processes. The Ministers, Cancilleres, and Presidents of Central America had met to forge a common union. The Andean countries had renewed and revitalized their agreement to work together for the health and wellbeing of the peoples of the Region.

Trade among the countries of the Region had been a major consideration. CARICOM had broadened to include CARIFORUM, including other countries of the Caribbean. Those countries had also negotiated with the European Union to try to arrive at more equitable solutions to the problems besetting them.

Almost all governments in the Region had been working toward reform of the state, discussing legislative reforms and macro-stability, investment in basic social services infrastructure, and protection of the environment.

The economic situation between 1994 and 1997 had begun with optimism and a background of three years of solid economic growth. Foreign capital had flowed into Latin America, and 1994 had seen a growth of 5%, with an increase in social sector spending, even though that did not reduce unemployment.

It was evidence of the solidarity of the Region's systems that the economic crisis in Mexico and Argentina in December 1994 had not had serious effects on the rest of the Americas. In spite of an economic reversal in 1995, the countries persisted with economic reforms to balance periodic highs and lows. 1996 and 1997 had seen the stabilization of the Regional economies to a growth rate of 3.5% in 1996 and 4% in 1997.

It was a matter of concern that the economic recovery of the Region had not been matched by a similar improvement in social health, unemployment, and income distribution. However, many of the economic advances had been made against a background of natural disasters such as El Niño, highlighting the vulnerability of the Region.

The Director congratulated the Publications Program and Dr. Navarro for the production of the new Quadrennial Report, which focused on the fulfillment of the commitments made to the Region. The introduction to the Report contained a mission statement focusing on PAHO's technical cooperation to achieve health for all in the Americas. The aim of the Report was to present an account of what PAHO had achieved and how its talents had been used. Earlier Quadrennial Reports had combined the work carried out by the Secretariat and the countries. The 1994-1997 Quadrennial Report described the extent to which the Secretariat had contributed to the health of the countries of the Americas.

Changes in health were slow. It was therefore important to examine the impact of PAHO's efforts in advancing the health of the Region. PAHO had devoted much attention to the concept and practice of evaluation and to the development of programming instruments to measure results.

The idea of Pan Americanism within health underlay much of PAHO's work in the previous quadrennium. Although enthusiasm for Pan Americanism had waxed and waned since the early years of the century, in spite of the steady increase in the number of Members States, there had recently been more sustained initiatives to develop a more genuine hemispheric agenda. Some attributed the driving force behind Pan Americanism to concern for trade and aid. However, global integration and the technological revolution were creating more porous national boundaries and playing a principal role in the resurgence of Pan Americanism. The interchange of ideas and the increasingly close ties

between the rich and poor areas of the globe were encouraging a sense of the interconnectedness of peoples.

PAHO's work centered on the international dimension of health, and health had figured in every jointly undertaken Pan American initiative. The overarching problem for health continued to be inequity. The search for equity in health should address equity in terms not only of the availability of health services but of the environmental conditions that impacted on health.

PAHO continued to believe that investment in health could reduce income inequality and encourage economic growth. The essence of the Pan American approach to health was that joint action must be based on results, although that did not imply that every country must participate in cooperative alliances to the same extent.

By what token did PAHO claim leadership in the Pan American venture? Leadership did not come as a right, but needed to be earned. PAHO's leadership was based on a number of factors, namely the creation and dissemination of information, the innovations brought before Member States, the ability to anticipate trends and movements that kept the Region on the crest of social change, and evolutionary flexibility.

PAHO understood its role of Regional Office of WHO as being an integral part of a global enterprise with eyes firmly fixed on Pan American history and the entire Pan American constituency. The diversity of experience of the Americas could, PAHO believed, serve as a laboratory for the rest of the world, fortifying and enriching global action.

The Quadrennial Report described partnering for health, a concept that involved a two-way process. Achieving health for all required the orchestration of many players. PAHO was proud of its capacity to mobilize resources for the countries of the Americas. The Organization's budget had channeled around $400 million to health projects in the Region. Pan Americanism was best reflected in the technical cooperation among the countries. The Report outlined a number of areas of technical cooperation among rich and poor countries, such as cooperation between Cuba and the United States of America, Bolivia and Mexico, Peru and Ecuador, Brazil and Paraguay, Canada and the English-speaking Caribbean, and among the Caribbean countries themselves. PAHO had set up special funds to catalyze inter-country activities.

In the subregion of Central America, PAHO had supported health sector reforms, channeling $100 million to strengthening national capabilities in human resources, equipment maintenance, physical resources, technical and scientific information, better access to essential drugs, integrated health systems, and disaster preparedness.

In the context of country-to-country collaboration, the Report also stated that many of the activities had been taken to higher levels, such as the hemispheric Summits. Country collaboration outside of the Summits had included the contributions of the Governments of Spain and the United States of America.

PAHO sought collaboration with the media to disseminate information on health maintenance and disease prevention. The Organization had also published a news

magazine, created its own web site, and initiated contact with religious organizations as a means of stressing the importance of health for human well-being.

The Strategic and Programmatic Orientations set up at the beginning of the quadrennium divided PAHO's areas of activity into five sections. Under Health and Human Development, the Report outlined the commitments made and the results achieved. One important result was the publication of the basic indicators for 1998, showing the usefulness of the interventions. PAHO had developed a computerized geographic epidemiology system to map the health situation at the local, district, and national levels. Another important publication was *Health in the Americas*.

PAHO had continued to strengthen links with parliaments and elected representatives, as well as becoming more proactive in seeking out collaborating Centers.

One area of particular concern to PAHO was prevention and control of domestic violence, one of the most egregious manifestations of discrimination in existence. Public health tools at PAHO's disposal could contribute partly to the solution of the problem, which should not be left purely to the criminal justice system. On that basis, PAHO had set up community networks to prevent violence against women and provide health care to those abused. Research in that area would continue.

The Report explored the nexus among health, development, and tourism and the importance of recognizing the connection between the health of the peoples and that of the environment.

In disease prevention and control, one of the most dramatic achievements had been in the area of immunization. Polio had been eradicated in the Americas, and the campaigns to increase coverage of pertussis and measles were underway. The Organization was committed to seeing the Region certified free of measles by the year 2002. The immunization programs of the Region had been greatly supported by the First Ladies of the Region. Integrated management of childhood diseases also accounted for a dramatic reduction in deaths from diarrheal diseases, acute respiratory infections, and malnutrition. Emerging and reemerging diseases were an area of considerable concern. Argentina, Chile, and the United States of America had established a network of centers and agencies to assist PAHO in dealing with those diseases. It was to be noted that Chagas' disease had also been eliminated in parts of the Hemisphere, and that Uruguay had managed to interrupt the transmission of pertussis within its borders.

AIDS continued to be a major concern in the Hemisphere. A technical group set up for horizontal cooperation in AIDS had stimulated non-governmental action against the disease. There were still considerable risks from non-communicable diseases, such as cervical cancer and diabetes in the Region.

The food safety program continued to be of importance on account of both the disease and the attendant economic factors. Revenue from food exports from the Americas totaled around $8.5 billion per year. Where PAHO had been able to assure the physical protection of food from rats in one area of the Region, plague had been controlled and sometimes even eradicated. In veterinary public health, the eradication of

foot-and-mouth disease from large areas of the southern continent had been a major achievement resulting in a trade advantage of millions of dollars to the countries concerned.

In supporting the development of health systems and services, the focus had been on reform and strengthening the capacity of ministries of health to carry out their normative role. Laboratory and blood bank services standards were set out in the Report. It was hoped that in the future all blood supplies in the Region would be safe.

An important but sometimes overlooked area of public health improvement was oral health. The effect of PAHO's salt fluoridation program had resulted in dramatic reduction of dental caries in children, particularly in Jamaica (86%).

The Report also made reference to the need for networking to prepare for emergencies and relieve disasters.

The commitment to promotion and protection of public health involved social capital as an important ingredient of economic growth. PAHO had also worked assiduously in the areas of health of adolescents, tobacco, drugs, and alcohol abuse. In environmental health, 1995 had seen the development of a Pan American Charter that formed the template for many of the activities carried out in the countries of the Region.

PAHO was also participating in a worldwide movement based on rethinking the role of governments and the process of UN reform at the country level.

Finally, the Report outlined some of the work carried out in reviewing and restructuring budget, finance, and general administration practices, with the result that

PAHO had some of the lowest administrative costs of all the international organizations. Of the resources available to the Organization, over 80% were spent on technical cooperation with the Member States. PAHO's budget was small, but although over 45% of the total budget came from extra-budgetary resources, PAHO would never accept funds that did not target the priorities set up by the countries. With regard to personnel, during the period 1991-1998 the number of full time international civil servants had been reduced from 1,222 to 863, but the Organization had managed to reinforce staffing by imaginative approaches to human resources; 75% of staff working for the Organization were working at the country level because PAHO had become a decentralized Organization.

There had been considerable administrative innovations in personnel evaluation, an increase in the number of women professionals hired, reduced costs in providing corporate information, and cost recovery from the sale of PAHO publications.

The Report detailed activities carried out by PAHO in support of and with the support of the countries. The Director urged the countries to use the Report as proof of the work of the Organization and what had been accomplished with the resources provided by the Member States.

El PRESIDENTE felicita al Director por su informe, que refleja fielmente la labor realizada con éxito por la Organización en los últimos cuatro años para prestar cooperación a los países.

El Dr. PICO (Argentina) también felicita al Director por la calidad de su informe cuadrienal, cuyo contenido es en cierto sentido un llamado a la reflexión sobre cómo han evolucionado la Región y la OPS, superando los inconvenientes propios de todo sistema abierto y complejo, fuertemente relacionado con el ambiente y bajo la influencia de factores políticos, económicos, sociales y culturales externos al sector de la salud. Hace hincapié en la labor conjunta de todos los países, que ha permitido consolidar una región con su propio perfil pese a los problemas del medio, a las debilidades y virtudes del sistema, al pluralismo ideológico, a las diferencias geográficas y a las distintas estructuras organizativas de los países.

Del informe se deduce que los países deben sentirse orgullosos de la OPS, que tanto ha contribuido a mejorar la calidad de la vida y la salud de los pueblos de las Américas y que, en el marco de las orientaciones estratégicas y programáticas acordadas ha sido promotora de los procesos de cambio del sector de la salud, que desde luego todavía hay que profundizar. Agradece el apoyo dado por la Organización a su país, que a su vez se siente comprometido a seguir ayudándola a mejorar sus procesos técnicos y administrativos. Argentina también se compromete a fortalecer los mecanismos de articulación, coordinación y complementación con los demás países y espera que las representaciones de la OPS fortalezcan su colaboración con los Ministerios de Salud, adaptándola aún más a las necesidades locales, y que se incremente la cooperación técnica horizontal entre países con problemas, realidades sanitarias y raíces culturales comunes en el marco de un auténtico panamericanismo.

Dr. SATCHER (United States of America) noted that the Quadrennial Report of the Director reflected the strong partnerships and vision for health shared by the countries of the Americas, as exemplified by the Summit of the Americas, the Initiative for Health in Central America, and the Regional System for Vaccines. Much still remained on PAHO's public health agenda, including the issues of an aging population, the emergence and re-emergence of infectious diseases, the increasing incidence of chronic diseases, and the health challenges of the Region's special populations, including women, minorities, and adolescents. The development of priorities and the tackling of new public health issues had to reflect an environment of continuing change and would represent a shift in focus for PAHO and other multilateral organizations. It was important to make maximum use of technical cooperation and the limited financial resources available, especially through partnerships between PAHO and other interested agencies.

The vision put forward by Dr. Brundtland for the future work and achievement of the World Health Organization would serve as an important guide for the six Regional Offices.

El Dr. RODAS (Ecuador) felicita al Director por su informe tan concreto, que revela los logros de la Organización bajo su mando. Destaca que el concepto de panamericanismo, la mejora de los indicadores de salud a pesar de tantos desastres naturales, y la visión del futuro están claramente reveladas en el informe. Agradece el apoyo que siempre ha dado la Organización a su país, así como su constante atención a las

necesidades del país y a las disposiciones locales, regional y nacionales, en los niveles operativo, gerencial y ejecutivo. Señala ejemplos de apoyo concreto, que han culminado en el Ecuador en políticas de Estado propicias para elaborar un plan nacional de salud partiendo del nivel local. La OPS también está apoyando a su país en desarrollar un concepto integral e integrado de la medicina, que comprende tanto lo preventivo como lo curativo, la educación para la salud y la creación de ambientes saludables. A continuación expresa que, al igual que no es posible hablar de progreso y desarrollo de un país sin considerar la salud, y tampoco es posible hablar de la salud sin destacar a su relación con la alimentación, la educación, la vivienda, la comunicación, la producción y el trabajo, la recreación, etc. Por último menciona la importante labor que el Ecuador está haciendo en la provincia de Loja, fronteriza con el Perú, en estrecha colaboración con las autoridades de este país vecino a fin de conseguir que la salud sea un puente para la paz.

El Dr. MARINKOVIC (Bolivia) felicita al Director por su informe y su labor y le agradece el respaldo y apoyo que siempre ha dado a su país, especialmente en la implementación de su plan estratégico de salud y en su proceso de reforma del sector sanitario. También apuntó a la necesidad de seguir cumpliendo con las tareas que falta realizar, quizás con mayor decisión, y con la OPS desempeñando un papel más protagónico en ese proceso. Señala la importancia de hacer entender a quienes manejan las finanzas nacionales que los recursos destinados al sector de la salud representan una inversión y no un gasto. En el marco de este proceso de concienciación, la OPS debe

apoyar las actividades de las instituciones subregionales en los países andinos, coordinando las actividades que realizan estos países como parte del Convenio Hipólito Unanue.

Para terminar, alude a los logros alcanzados y a lo que queda por hacer, entre otras cosas, acelerar la eliminación de la falta de equidad en la Región y hacer ver a las transnacionales farmacéuticas los problemas que provocan en las economías nacionales y sobre todo en el sector de la salud.

M. AISTON (Canada) félicite le Directeur et souligne que les quatre dernières années ont été marquées par une amélioration de l'état de santé des habitants des Amériques. L'OPS a joué un rôle important dans cette amélioration et le Canada est heureux de constater le rôle directeur de l'OPS dans la facilitation de la coopération technique entre les pays.

De plus, un certain nombre de pays ont accompli des progrès notables dans la mise en application de stratégies pour améliorer la santé et ont pris des mesures pour empêcher l'apparition ou la réapparition des problèmes de santé. L'OPS a participé à un certain nombre de ces activités en offrant au pays membres une expertise technique et en leur fournissant des exemples de meilleures pratiques empruntées à d'autres pays de la région. Le Canada estime que des progrès sensibles ont été réalises dans le domaine de la santé.

Mr. Aiston, continuing in English, then proceeded to comment on areas mentioned in the Report, starting with health systems and services. In the last four years Canada had shifted the emphasis of its public health institutes from a predominantly hospital-based

approach to a more community-based approach. The provincial governments were re-examining the way health services were provided, and in some the decentralization process was completed. There continued to be a commitment to maintain a publicly funded and managed health system, which he believed was the only approach that would ensure equitable access to health service. Health was not a commodity; it was a right.

He was pleased to see the continued emphasis on equity, an area in which Canada intended to work with PAHO and other countries.

With regard to the provision and use of health information, Canada had begun to establish a health information highway which would link users and all parts of the health system. A ministerial council on health information structure had been formed to ensure that the public, as consumers and participants, would be the key beneficiaries of this initiative.

With respect to assessing and managing risks to health, the good work done by the Organization in the areas of immunization, environmental health, food safety, and disease surveillance, inter alia, had had a marked impact on reducing risk in the Region. Canada would continue to improve its national programs in that regard.

Canada would give its support financially, in the form of technical expertise, and through the Governing Bodies of the Organization, to the priorities in the program that had been laid out. He was aware that WHO initiatives would not always respond to the needs of the Region, which had its particular history, conditions and needs. Accordingly, he called for a teamwork that respected not only the communality but also the diversity between nations.

El PRESIDENTE dice que se levanta la sesión de la mañana y seguirán con las intervenciones a las 2:30 p.m.

The session rose at 12:25 p.m.
Se levanta la sesión a las 12.25 p.m..