The concept of intersectoral relations is alive and well in the Region of the Americas. However, the distance between rhetoric and reality remains far too great. While there are certain natural linkages of health with other sectors occurring at the community level and through inter-ministerial coordination in specific programmes at the national stage, only limited consideration is given to the implications for health goals and health conditions of macro-economic policies.

The present economic crisis has underlined in stark terms the requirement that adjustment policies be concerned with the health of the poor as well as with the balance of payments. Moreover, the crisis has made primary health care not merely the chosen strategy but the strategy most likely to provide an appropriate response to the current austerity environment which dominates decision-making in much of Latin America and the Caribbean.

The 1978 Declaration of Alma-Ata set the global stage for changing the inward-looking attitude of health professionals to a broader, more comprehensive vision of the important role that other sectors must play in achieving Health for all goals. In the Americas, that awareness took a specific form. “Promotion and improvement of intersectoral linkage and cooperation” was designated as a regional objective of the Health for all strategies, with an emphasis on the “linkages between health and national socio-economic policies and planning”. Increasingly, intersectoral coordination was conceived as the primary engine to overcome inequities in health conditions.

Mixed results

As the decade of the 1980s began, Latin America and the Caribbean had already undergone a great many fragmented and partially successful experiences with intersectoral action at the community, regional and national levels. Integrated community development projects in rural areas and regional development plans focused on raising both income and living standards in previously neglected areas. National food and nutrition plans also demonstrated some limited success. In most instances, the absence of stable political commitment prevented sufficient resources from being dedicated to putting the various plans into effect over a sufficient time period to generate a broad national impact.

A 16-nation study by the Pan American Health Organization also cited institutional limitations and rivalries as being responsible for the absence of nationally successful intersectoral coordination. In most instances, the health sector was not included in the national decision-making process for priority economic development goals and policies or for the distribution of public resources. Even the wide prevalence of ministries of planning in the Region of the Americas, with two decades of experience in national development planning, had not remedied this problem.

The national planning institutions were themselves divided into separate sectors, so that there was little cross-fertilisation of ideas on the potential health impact of macro-economic policies or investment projects. Nor could the potential be realised of other
Research cannot take place in a vacuum. All health-related activities need to be integrated into national decision-making processes.

sectors collaborating in the advancement of health goals, or of health contributing to the achievement of broader national economic objectives. The development style predominant in the Region, based on a growth model, tended toward “trickle-down” theories where social development was viewed as an automatic and eventual consequence of economic growth.

The dominant experience of intersectoral collaboration occurred at the inter-ministerial level, where a wide variety of quite specific linkages was forged between health and education ministries on the one hand, and health and agriculture on the other.

When new emphasis fell on intersectoral action as part of the Health for all strategy, efforts were made to expand intersectoral action to attain broad national impact. Inter-ministerial cooperative ventures have become even more frequent between health and agriculture (in the fields of nutrition and the use of pesticides), between education and health, and between health and housing. A limited number of positive examples are now beginning to produce nationally impressive results.

Colombia is one of those countries where the Rural Integrated Development project, begun in 1982 with both national and World Bank funding as well as support from PAHO/WHO, UNDP, UNFPA, UNICEF and the World Food Programme, was designed to be a major force in reducing inequalities. Based on a national analysis of the geographic regions with greatest economic and social needs, the priority municipalities in the five participating departments were chosen. The indicators used included infant mortality, illiteracy, and health service coverage.

The project focuses on farmers with less than 20 hectares and seeks to expand their production capacity with new farming practices. At the same time, the economic objectives are linked to the extension of health services and water services along with the construction of latrines. Since 1982, the project has involved major increases in levels of immunizations, the construction and equipping of 75 new health posts, and improvements to another 43 facilities through a primary health care strategy that is reaching an estimated 80 per cent of the 2.1 million residents in those five rural departments.

The critical national decisions that were taken were to integrate health and economic considerations into the initial selection of the rural areas to be served, and to ensure the intersectoral composition of the interventions which were designed to increase both family income and access to social services. Initial reports indicate a reduction in infant mortality in the targeted areas.

Another good example of effective socio-economic development at the national level is in Costa Rica which, despite its category as a middle-income country, succeeded during the 1970s in achieving levels of health equivalent to more developed countries. One particularly impressive indicator was the reduction of infant mor-
Rhetoric and reality

tality from 66.8 deaths per 1000 live births in 1970 to 20.8 deaths per 1000 live births in 1980. Equity-oriented social development policies had prevailed for several decades. Rising economic conditions and the conscious spread of the benefits of economic development reduced poverty to barely one-quarter of the population by 1980.

The democratic system permitted the popular desire for improving living standards to be reflected in a continuing priority on extending both education and health services. In the 1970s, public spending on education averaged more than 30 per cent of the federal budget, literacy reached beyond 90 per cent, and the percentage of women between 20 and 34 years of age who completed primary school rose from 42 per cent in 1970 to 65 per cent in 1980.

As economic progress was occurring, national health policy sought to extend coverage to the high-risk rural population through a primary health care strategy. The Rural Health programme, begun in 1971, sent health workers out into previously unattended rural communities, built a host of small rural health posts, and set up community-based health committees. Intersectoral linkages with the national institution dedicated to general socio-economic improvement in rural areas, the National Directorate of Communities, gave the health sector an additional ally in public policy decision-making.

The drop in infant mortality and the increase in life expectancy at birth in Costa Rica during the 1970s was directly proportional to the coverage and number of years of the Rural Health Programme—a tribute to its success. The increase in life expectancy at birth in those rural areas served by the Programme was actually greater than in some urban areas where primary health care interventions were unavailable. Similarly, although there was little change in access to food in those areas, the reduction in infectious diseases as a result of health interventions improved nutrition status and permitted the significant improvement in infant mortality and life expectancy.

Among all the aspects of intersectoral relations between health and the larger society, perhaps the most striking change from past decades has been the proliferation of attempts to examine the impact of industrial and commercial activity on the environment and on human health. Far more attention is being paid to this problem by national governments today. International financial institutions are also responding to criticism that they had not hitherto adequately analysed the potentially adverse impact of the economic infrastructure on the environment and on health. The region as a whole still lacks a fully developed set of legal, institutional and technical instruments to ensure that possible harm to the environment is considered before major industrial developments take place.

Among recent activities undertaken to boost national capabilities to conduct environmental impact assessments, one example is the Caribbean initiative to control coastal water pollution among the countries of Antigua, Dominica, Grenada, Saint Christopher and Nevis, Saint Lucia, Saint Vincent and the Grenadines, through AMRO/PAHO, UNEP and the Caribbean Community (CARICOM). The countries were worried by the direct health implications of pollution as well as by the economic consequences for their important tourism industries.

A second example is a project supported by the Pan American Centre of Ecology and Human Health of AMRO/PAHO, which involves research into the frequency and distribution of cancer pathology due to chemical contamination of the environment. The first stage studied the epidemiological aspects, and a second stage will survey Latin American industrial activities using substances which the International Agency for Research on Cancer has concluded are carcinogenic. The School of Public Health of Chile is responsible for the first stage and the Environmental Sanitation Technology Company (CETESB) of Sao Paulo, Brazil, for the second. These two examples typify the increasing concern with the intersectoral aspect of industrial development and the realisation of regional health objectives.

As a result of the economic crises, intersectoral linkages have become the focus of renewed attention not only by the health sector but by the most powerful national political leaders. The world recession of 1980-81 sharply reversed almost two decades of positive growth (although growth was unevenly distributed and some 150 million people remained in poverty) in Latin America and the Caribbean. In the 1970s, regional economic growth
grew at an average annual rate of more than 6 per cent. In 1981, regional economic performance plummeted. Real per capita income actually declined 3.7 per cent in 1982, 5.7 per cent in 1983, and showed a bare rise of 0.2 per cent in 1984. In 12 countries, real capita income dropped again in 1984, and average gross domestic product (GDP) per capita in the Region was equal to the level of 1976. For nine countries, GDP per capita in 1984 was lower than it had been in 1970.

Unemployment rose dramatically, and inflation in 1984 in Latin America and the Caribbean soared to an average of 175.4 per cent. The available data show significant increases in the numbers of people living in poverty. The debt crisis was also a dominant feature of government concern, as debt payments consumed nearly 40 per cent of the region's export earnings in 1983. Accumulated debt in 1984 reached US$360 billion, nearly US$24 billion more than the regional gross domestic product.

The nations of Latin America and the Caribbean were faced with demands for adjustment policies which inevitably included austerity in public expenditures. The consequences were an increasingly consistent pattern of reduced public spending for health, although the levels and the timing of those reductions differed among the various countries. There was a decline in real spending per person of up to 20 per cent in Colombia, Honduras, Jamaica and Uruguay, 25 per cent in Barbados, Chile, Ecuador and Venezuela, and more than 40 per cent in Argentina, Costa Rica, Guyana, the Dominican Republic and Surinam, between the peak period of spending in 1979, 1980 or 1981 and the lowest subsequent year.

Disquieting trends

The combined consequences of the economic crisis in reducing income and raising poverty levels and of austerity in public health spending are beginning to be seen. Increased malnutrition is occurring in Costa Rica and Bolivia. A halt to the decline in infant mortality in Costa Rica and a sharp rise in infant mortality in the state of Sao Paulo have been reported. Similarly there has been a dramatic increase in infant mortality in Bolivia related to malnutrition. UNICEF and PAHO/AMRO studies point toward rising malnutrition, increases in morbidity, and a slowdown in the previous trend towards reduced infant mortality.

These factors have produced a new awareness of the direct consequence of macro-economic policy-making on health services and on health conditions generally. Even though studies of the health consequences of the recent adjustment policies are far from complete, the available information clearly demonstrates that the direction of change is almost uniformly negative. In that situation, there is a clear need:

- to monitor the implications for health and nutrition of macro-economic policies;
- to identify those complementary policies which can avoid the most serious health consequences, particularly to the most vulnerable population groups, without undermining the basic economic adjustment objectives;
- to ensure that poor people have adequate access to food;
- to maintain cost-effective interventions such as immunization programmes and oral rehydration within the primary health care strategy;
- to emphasise the importance of assuring safe drinking water;
- to avoid cutbacks of tropical disease control measures.

There are clear examples in Argentina, Brazil, Mexico and Peru of efforts to protect the poor. Recent reports from Sao Paulo for example, show targeted spending by both the State and municipal governments on vegetable gardens, on opening wholesale food distribution centres to the consuming public (with savings up to 40 per cent), on creating food cooperatives among the poor, and finally on direct food distribution programmes. In Argentina too, there is new emphasis on food distribution programmes for the poor, to prevent a drop in nutritional status.

Intersectoral linkages which combine increased family income, education, and effective health services targeted to the most high-risk groups can yield positive improvements in health conditions. At the same time, there is a growing awareness that the failure to take account of the implications of macro-economic policies and projects on the environment and on health can have serious negative consequences for national health goals. What Latin America and the Caribbean have learnt from the economic and adjustment crisis is that understanding the nature of intersectoral linkages and promoting mutually productive intersectoral cooperation are not merely desirable; they are essential to the achievement of both Health for all and economic development objectives.