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The reform of the health sector and the health policy for the elder adult: contradictory or complementary agendas?

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I will try, in this document, to share certain ideas about which, from my point of view, are some of the most significant traits of what is being discussed in latter years in certain important ambits of the social sphere and of the health sector, with respect to the question of the health of the elder adult. By no means will I make an evaluation of the policies; I will only try to make a detailed account of some of the aspects that I consider more relevant, without entering into details or specific socio-political aspects, but, rather, take a look at those that seem to be of central interest, that have marked the discussion agendas around the health policy for the elder adult.

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In the first place, I want to point out that an important agenda in the health sector and which is guiding many of the health policies of our countries, is that which is linked to the process of Reform. This agenda, like others built around the problem of the health of the elder adult, is a result of the demand for certain actors in specific historic, economic, social, political and cultural circumstances and their transformation into a general policy, derived from the interaction of the actors in conflict around a number of questions perceived by them as social problems.

I think that it is convenient to take a look at the principal tendencies that will influence the structuring of the agenda of the so-called process of reform of the health sector, and likewise at other discussions and proposals around the question of the health of the elder adult. The agendas, to a certain extent, express the first moment of a social policy: the transformation of a specific problem, whether private or of a domestic ambit, such as is the care for the elder, into a question to be debated in the public space that requires public decisions and general policies.

The reform of the health sector was presented as a policy that seeks to find a solution to the inequalities and inequities in the access to health services, to the high costs and to the low quality and efficiency of the curing actions, taking into consideration a scenery of economic crisis and of transformation of the development models, of new risk situations or different vulnerabilities, of varied epidemiological, demographic and social pressure situations.

In turn, the demand for a specific treatment to the elder adult is coupled to the needs felt by that social group, sectorial technical organizations and other actors of society, within a context of demographic change, inequality, discrimination and poverty, that affects in particular the elder adult and that results in different risks for health and access to the services.

These two tendencies, resulting from different dynamics, have confronted the social protection systems and established the need for more effective and equitable public policies. In this manner, the health of the elder adult and its determining factors, have come to demand a differential and integral treatment vis-à-vis the health-illness process.

In this sense, this document has its focus of interest in the process of the structuring of the policy agendas and a political view. We have a first chapter which is an approach to the structuring process of the reform agenda in the Continent, and another that corresponds to the principal orientations of the health policy for the elder adult that arise from other forums that necessarily are not the same of the reform, although with similar concerns; we seek to recover the contextual development of both agendas, their values, ideologies, concepts and proposals, followed by a critical reflection starting from the analysis of the agendas. The development of the argumentation is based on certain existing documents and publications relative to the reform and health policy for the elder adult.

1. The reform and its agenda for the health sector

1.1 The configuration of the reform as a public health problem

The reform is associated to a very specific agenda of prescriptions aimed at promoting a more balanced action, and proposes a change in the operation of the health systems and in the financial aspect in order

to reduce costs, improve efficiency, quality and equity of these systems and promote a mixed system based on competitiveness. The preparation of the agenda started from certain assumptions, among them, the epidemiological an demographic transition, and from the challenges that these two phenomena represent for the provision of health services, due to the increase in chronic and degenerative illnesses and, obviously, for their medical care. It also had the support of the international financing agencies and was promoted with the support of different social forces linked to the entrepreneurial sectors and to financial corporations interested in the opening of new markets (Armada, Muntaner y Navarro; 2001).

This reform agenda was structured on the basis of a diagnosis of the economic crisis of the State of Well Being, and presented as a neo-liberal alternative for the economic recovery and to face the problems relative to the inequalities produced by the financial adjustment policies that affected the well being of certain social groups. A connection was established between the economic crisis and the crisis of health services, which channeled the discussion towards a crisis of a universal nature in the health services systems. This crisis was enclosed in its own frame, restrictive of social policies and sanitary expense control policies.

Consequently, the proposals in the light of the crisis of the health sector —which is the sectorial reform itself— were articulated with the macro-economic policies and accompanied their development. So that, at the first stage[1], this coincides with the agreements for structural adjustment and with the conditions of the external financial organizations —World Bank and International Monetary Fund— that imposed policies for the rationalization of the public sector as strategies for incidence in the reduction of the deficit and in the decrease of the fiscal burden, liberating funds to cover the external debt.

At a second stage[2], that for many authors is when "analytical and technically founded reform proposals were formulated" (Almeida, 1999-5), what encourages the reform agenda is both the excessive contraction imposed by economic adjustments on the public health systems and by the increase in social inequalities, and the importance of the forces of the market to vitalize the economy, improve the efficiency and the quality of the services offered, having as background the ideological discourse of the ungovernableness of the costs of health systems side by side with the persistence of inequities and waste (World Bank Development Report, 1993:4).

It is at this stage when the World Bank itself creates a special fund to alleviate the adverse economic and social consequences of the adjustment programs and starts to finance the reforms as part of the conditions negotiated on the bases of the economic adjustments (Almeida, C., 2002:96 and 919). The adjustment policy in our countries had serious repercussions on the financing of the social sector, and on the living conditions of ample social sectors. In part, because a high percentage of the population did not have access to health services, added to the existing poverty.

[1] This corresponds temporarily to the end of the seventies and the entire decade of the eighties.
[2] This corresponds temporarily to the decade of the nineties.

1.2 THE ADJUSTMENT POLICY, THE INCREASE IN POVERTY AND IN SOCIAL INEQUALITY AND NEW SOCIAL POLICY ORIENTATIONS

The adjustment policies in our countries had as consequence increased poverty throughout the continent and increased social inequality. Also, new situations of poverty and vulnerability arose, particularly in the urban population, although the situation of the countryside was more severe. The population in a situation of poverty in the region reached in 1990 a figure of 46%, neutralizing the progress of the decade of the seventies.

In most of the countries of Latin America, according to a document of the Economic Commission for Latin America [CEPAL] (1994), an "increase in the difference between the income of 40% of the poorest households and that of 10% of the richest households" was observed, thus increasing the distance between the poor and the rich. The most adverse situations were recorded in Argentina, Venezuela and Brazil. Indigence increased in these countries. The paradox is that social expense shrank in great proportions, especially in El Salvador and Mexico, affecting both the amount and the quality of the services offered.

The number of the poor and indigent, without the social benefits of social security increased. Citing the Economic Commission for Latin America [CEPAL] (1994:37), in the urban areas of ten countries the situation was dramatic for inactive family heads who received some kind of benefit: In Brazil, Costa Rica, Chile and Panama they represented between 12% and 14% of the total; in Colombia, Mexico an Paraguay this varied between 5% and 7% and in Guatemala and Honduras it was 3%. The extreme case is Uruguay where 30% of the family heads were inactive receivers of pensions. This same document revealed that family heads older than 60 years who received some help from social security lived better, decreasing the percentage of poverty in an important manner and with consequences for their well being.

The orientation of the social policy to face this new reality was in the sense of supporting the extreme poverty groups, especially children and women, through intervention packages, "increasing the distance between them and other beneficiaries as the medium and medium low sectors, and adopting a welfare criterion rather than an inclusion criterion" (Horis del Prete, 2003:68). The paradox of the situation is the tendency of the health policy to reduce the fair resources aimed at welfare policies and to make the poor participate in the corresponding costs while at the same time giving priority to specialized medical care and to the development of the private curing sector to the detriment of the preventive measures and to measures of a collective interest. Another paradoxical consequence was the change of the equality approach to the equity approach, where the latter points toward "equality of individual opportunities to satisfy a set of basic needs or socially defined aspirations". Equality is relative and "points towards the distance between social categories with respect to power and wealth" (Garretón, 2001-189).

In this stage of the reform, the scientific elites involved played an important role, acting as ideologists and experts. As ideologists, they structured the technical-scientific arguments which justified the reform and, consequently, they legitimated it in its technical-scientific rationality. As experts, they participated indicating the most adequate knowledge to achieve their goals.

Specifically, they made the translation of the economic arguments for the health sector, prepared its normative frame, the design of the welfare systems, their intervention strategies and the

instruments on which health priorities would be defined; they struggled for the need to train human resources under new principles and with a knowledge capable of making viable the implementation of the agreements and a new dynamic to assign resources that would not contribute to increase the tax burden of the State.

Within the new frame of decision that the reform strived to impose, the needs understood as demands for health would be identified by the epidemiological research and the supply of services and resources and by the health economics. The former, had as a mission to make known the epidemiological frame and, in this sense, it was the one that generated information about the future demands and needs for health services. Health economics furnished the information necessary for the rational and efficient assignment of financial resources for health care, acting both as intermediaries in the financial competence between the needs of chronic illnesses and infectious illnesses, as they were expressed by virtue of the epidemiological transition and through the different instances (World Health Organization. World Health Report 2000:73-77).

Under this methodology, a basic package of interventions was proposed aimed at the lowest income population, to be implemented by the local powers as an optimum expression, in terms of cost-benefit and cost-effectiveness, as well as welfare packages to be guaranteed via insurances and by the private sector or social organizations. In this scheme centered in the curative medical care and in packages offered on the basis of the cost-effectiveness technique, how will it be possible to safeguard the rights of the aged to enjoy a satisfactory health situation, independently of their cultural or economic status and, hence, of their family environment? What health results does the basic package seek to obtain with respect to the aged? Who is responding for the factors that act on the process of aging and not necessarily on the demand derived from an illness? The other question which must be answered is: how will it be possible to guarantee an integral action when the services belong to entities of a different nature that not always act under the same logic?

The reply to this question must be found in the reformed health systems, searching for the specific policies that are being put into practice to respond to the demands of that social group, as well as for the existing information and resources aimed at the care for the elder adults in their different stages. One more question is posed: is it possible to incorporate the considerations of equity with respect to age to the techniques aimed at establishshing and monitoring priorities, for example the cost-effectiveness analysis (Fajardo Ortiz, G. (1993).

2. The health problematic of the elder adult in the perspective of other actors: the claim for an integral approach

2.1. The problematic of the aged as from the agenda of social diversity

One of the characteristics of the last three decades of the last century was the growing presence of the demands of the civil society in the health policies of the Continent. The diversity of the civil society became more explicit with the ethnic, racial, religious, age group, environmental, sexual and many other demands, revealing a world of exclusion, margination, inequality and pain, but also the wish to live in diversity within a frame of respect and of equity. It also

propitiated the proliferation of diverse social organizations as well as the integration of support and research thematic, regional, national and local networks (Forum of Civil Society (1999).

As part of that process, the right to a full life for the elder adult was recognized and it was accepted that old age requires special care and a restatement of society and of culture to protect its social status. This restatement includes a new identity for the aged in society, which will guarantee a dignified position, which will recognize that the diminishing of labor, physical and mental capacities does not mean the loss of the quality of a human being and that the differences in age represent only differences in roles and functions (Morales, M.E.38).

The purpose of these movements was not to deny what is undeniable, that the organism goes through transformations and that at a given stage in life there is a predominance of the chronic-degenerative illnesses originating from previous stages, due to biological and social factors determined by labor and life conditions: hypertension, diabetes mellitus, cardiopathies and problems related to depression (Morales, M.E., 1999:36). On the other hand they claimed the specificity of this social group and the complexity of the situation under constant change, which required new approaches and different concepts of the negative vision of old age, closely linked to the loss of working capacity. It was also recognized that this social group was heterogeneous and that within this group it was possible to distinguish different sub-groups with their own dynamics and characteristics, some of them even in a situation of vulnerability worse than other sub-groups, due to the determinations of social class, genre and ethnical group, according to the exclusion system of each country.

Vis-à-vis this situation, the challenge was to listen to the voices of the elders, defined as the most authentic expression of their needs, that claimed for a special care capable of incorporating both the physical dimension of the body, and the social and psychical dimension (Robles Silva, 2001:563), by the promotion of policies that would include support and care networks that would not separate them from their social-cultural-family environment and that would attend to the complexity of the phenomenon that had a biological manifestation, but that was also of a social, economic and cultural nature. The identity of the elders was recognized beyond that of a person bearing a variety of illnesses that required medical services.

Women organizations argue that "aging is marked by genre" (Morales, M.E., 1999:37). They make the observation that the resources for menopausal disorders do not exist in the same proportion as those applied to control the reproduction capacity; that women live longer and perform roles in society that many times are not valued economically. The above poses, in the perspectives of women organizations, not only problems related to personal care, as those assigned by the role of genre, but demand health policies where the central reference axis for the election of objectives will the elder woman.

They also observe that the elder woman continues to develop the role of n untiring worker who takes care of all and of everything, a work that is not remunerated and that is fundamental for the reproduction of the family, but not properly recognized socially. They argue that in a situation of widowhood, the possibility of women to remarry is smaller than that of men, and degenerative and disabling illnesses compel them to depend on the care of a member of the family or institution. This question becomes

increasingly complex with the decrease in the rates of birth, encouraged in previous contexts by many governments and international organizations and that has meant a reduction in the number of the members of the family. We could add to this dynamic the new roles that women have held in social life, the reduced space inside the homes that has contributed to weaken the solutions within the family space, such as the proposal, commonly discussed today, of decreasing hospitalization times increasing the time of care by the family, or better said by women, or the proposals of community work for health. Both proposals are based on the premise that woman is a sub-employed labor force that can easily assume an additional labor burden (Standing, H., 2000-6).

2.2. The problem of the aged in the perspective of cooperation organizations within the frame of the United Nations

Another phenomenon of great transcendence and that has contributed to make known the question of the health of the elder adult and in particular that of the aged, was the increase in the intervention of the international cooperation the United Nations organizations. This intervention could partly be explained by the demographic tendency of the aging of population, mainly in the developed world and, in a lesser intensity, in nations with a medium degree of development. This tendency was perceived as a problem for social security and health systems, for the families and for the governments, as it could be appreciated that it was becoming an increasingly central problem of the everyday life.

In 1979, the World Health Organization approved the first specific resolution relative to elders care and, in 1982, it held in Vienna the World Conference on Aging that had several repercussions. Other Conferences were held, in which research goals were defined, agreements were reached, committees and institutions were organized and it was possible to involve different organizations in the initiative and the community of investigators in akin matters. This set of actions culminated in the development in Havana (1992) of the first international seminar "Care for the aged in Latin America, needs and perspectives", followed by other events promoted by the Latin American Demography Center (CELADE) (Alfonso Fraga J. and Correa, M. M., 1999:442).

A concern that is present in all these meetings and that becomes a conceptual base to orient the policies is, in the words of Alfonso Fraga (ob.cit:460), the reaching of consensuses that will put in motion the international community around the problem and that, consequently, will lead to "implement actions and policies that will avoid the negative consequences that would cause that the aged will become a social burden, if the development of society is not adapted in certain fundamental aspects".

We must emphasize that, as from this moment, there has been an increment in the number of publications, research work and actions aimed at facing the problem, promoted by society organization or by the public power through the social policy.

2.3. The most ample involvement of the scientific community

The scientific community has responded to the summons of the United Nations organizations, contributing with information for the study of the aging phenomenon, in a dynamic and multidimensional perspective based on an interdisciplinary approach. The challenge for many investigators consisted in generating knowledge adapted to the reality of the countries in order to propose the policies derived from that knowledge,

with the purpose of reaching their viability, consistence and effectiveness.

An important step has been to start from the assumption that health at old age does not necessarily constitute a unidirectional process, nor necessarily a process of an irreversible deterioration, accepting that there are different ways of aging that "depend to a great extent on the living conditions and on behaviors related to these conditions throughout life" (Ham Chande, R., 2001:557). Consequently, aging was defined as a dynamic and complex process in which the style of life of the different generations and environments — both social and physical— to which individuals are exposed, has an effect on the deterioration of their health and, hence, on their condition at the time of reaching an old age (Wong, R. and Lastra, M. A., 2001:521).

In this sense, among the factors with direct effects on the health of the elder adult "are the attitudes and perceptions towards health and the use of services, family bonds, private transferences and the accumulated exposition of the individual to different environments, as well as his labor and health record, the migratory experience of the individual and his family bonds and public transferences" (Wong and Lastra, ob.cit:523).

On the other hand, the perception that the increase in life expectation was not necessarily implying the enjoyment of life with quality, made it necessary to develop investigations aimed at a better knowledge of that new reality and at quantifying the life expectation free of disability, the life expectation without dementia, the life expectation in hospitals or asylums (Ham C. Ob.Cit:558).

This perspective articulates the increase in the cost of sanitary benefits that the elder adults will require throughout life. This viewpoint induces a general demand for a change in the social policy, because a good part of the population of the Continent lives under the devastation of poverty, without sufficient resources to cover the basic needs for food, housing, education; a situation that may be aggravated with the low coverage of public services and the practical inexistence of preventive actions and health promotion. These factors are the cause for reaching old age with health problems that represent high expenses for the public sanitary system.

In turn, aging is described as a specific situation inherent to a stage of life in which certain functions are lost, characterized by the lack of autonomy, but that not necessarily refers to an illness. This loss of autonomy is associated to a complex of situations in life such as the loss of a job, loneliness, social margination and depression. It is recognized that these diverse situations of life increase with the lapse of time, accumulate and have a reciprocal influence. Consequently, it is considered that the solution is not to medicate the aging process, because we are not facing a necessarily pathological situation that can be solved if treated as such; a response in terms of a social policy will be required that is not necessarily found inside the family, nor only in the curative medical services, and that must help the persons to recover their independence, a condition indispensable to avoid isolating them from social life (Scortegagna, R. 1995).

Within this frame, the knowledge about the specificity of aging has advanced considerably, with the contribution of multiple disciplines, that seek to recover the aged for society, demonstrating how aging affects each one individually, like the mere idea of being young, and that this situation demands a specific concept of well being that refers the place for personal care to a public ambit and the need for sources of income to solve the

needs in a stage of life with a negligible productive capacity.

We can say that, at present, the question of the aging of population, the problems it represents for the individuals and for the collectivities, and the situation of vulnerability encountered with respect to the distribution of social resources have been submitted at the debate panels. This implies that public policies, and more specifically, social policies, must include specific components aimed at the care of that social group as subjects to social rights, in an integral perspective that goes far beyond the simple care for the elder persons with little results in their quality of life.

In this sense, it is necessary to guarantee social and economic security and, likewise, the opportunities to contribute to the national development. To prepare initiatives destined to other age groups, to the sons and daughters, to the grand sons and grand daughters, to promote changes in the relationship among generations, as well as in health and social security institutions in the sense of searching a specific normality for the aged "definable as the degree of functional autonomy they enjoy with respect to the process they are living" (Scortegagna:405), but also in economic institutions to "strengthen the capacities of the countries to face effectively the aging of their populations and the special interests and needs of the aged" (PHO/WHO):97).

3. Proposals of action that seek a reco very of the aged for society

In the present government of Mexico City, a social policy aimed at adults older than 70 is being put in practice, that seeks to raise their quality of life improving their material conditions, attending in an integral manner to their subjective and particular needs and decreasing the inequality before illness, death and access to health protection. To this effect, this policy defined that all adults older than 70 had the right to a universal pension (in March 2001 it was 13 dollars; in December of the same year, 22 dollars; in October 2002 28 dollars; in 2003 29 dollars and by 2004, 32 dollars), and a gratuity in medical services and medicines. A Health Identity Card was issued for Elder Adults and the integration of social support networks and training actions for personnel in gerontology and geriatrics as well as home medical calls and society sensitization actions for a culture of aging were promoted.

One of the features of the program is its simplicity:: registrations are made without bureaucratization, through a direct request by the person interested or by a close family member, at the Health Centers of Care Modules. Up to the present time, there are 325,000 persons registered, 61% are women. Of the universe taken care of, only 23% has that resource for a living. It is recognized that this program has had a positive impact on the quality of life of this social group because it has made possible an improvement in nourishment, to make certain purchases that they could not afford before, to feel more secure and independent, to collaborate with the family, to go out more often and to have access to health services (Gallardo, R. (2003).

Programs of this nature, strongly oriented towards results, made up of a complex of actions aimed at very specific objectives, are legitimated among the population and facilitate their success. Their implementation did not require the creation of new services but only to recognize the problems of the aged and to procure their autonomy, understood

as an expression of health for the aged and their families. To many, what this program is achieving may seem of little importance, but its results are very specific.

Also in Brazil, after seven years in Congress, the Statute of the elder adult was sanctioned by the president of the Republic and will benefit around 20 million of Brazilians. "Its 118 articles set forth an arc of legal guaranties that society owed to its elder adults. From now on, they will have an ample legal protection to enjoy their rights without depending on favors, without suffering humiliations and without begging to exist" were the words of the present president of Brazil, Lula da Silva (free translation of the author).

I mention these two experiences, but other may exist that seek to recover the place of dignity of the elder adult and indicate that the problem of the elder adult is part of the concern of our governments and that a turnaround in this process will hardly occur.

4. Possible differences of the agendas

The fast and brief review of the process of preparation of certain health policy agendas that are guiding specific programs for the elder adult, offer political solutions that arise from different technical and ideological bases and that are the expression of disputes both in theoretical-conceptual and socio-political terms. In this sense, they define the coordinates of the debate and confrontation and the legitimate ambits of intervention, they have incidence in the reproduction or transformation of social relations built around the inequities relative to age and determine the place and the role assigned to the elder adult in each program as well as in society.

The agenda for the reform of the health sector, structured as an alternative to the State of Well Being, had as principal task the legitimization of a process of decision founded on a specific knowledge, capable of scientifically identifying the social needs; a strategy in accord with the moment of the surging of the problem of the increase in the cost of care services and of the decrease in the resources for the social sector, within a context characterized by demographic, epidemiological, social and economic transition that leads to pressures on demand. The equilibrium between needs and resources was the defining axis of social intervention, in such manner that it will not become a burden for the economic area. Within this frame, the proposal for the reform of the health sector was not intended to eliminate social or age differences as a strategy to fight inequity, but as an instrument for the management and administration of the costs and resources to guarantee the coverage of the most needy groups that did not have available the conditions necessary to satisfy their needs in the market.

The agenda of social diversity, constructed as an alternative to the corporativistic, discriminatory-monolithic State, had as principal task the legitimization of social diversity and the incorporation of new demands for and rights to social policies, a strategy accord to the surging of diverse mobilizations around questions of ethnics, genre, age and sexual options that demanded recognition and the construction of a new social integration no longer referred only to the labor world or to the economic-social sphere, but to specificity by virtue of other social roles, such as the aged, the fathers, the mothers and the ill, situations that generate specific inequities.

In turn, the organizations linked to the United Nations, oriented by the values of human and social rights, had as principal task the legitimization of individuals as

holders of rights in their quality as human beings and, in order to enjoy them, they had to count with the potentialities and capacities to develop as such, "hence the need to insure them, to recognize them and to build social conditions for their exercise and, at the same time, to be alert about the conditions that inhibit or hinder them and, particularly, about those that threaten them" (Figueroa Perea and Sanchez Olguín, 1999:81).

The strategy promoted by the Government of Mexico City, like the new legislative frame in Brazil, are located within the concern of the Agenda of Social Diversity and of that created around the notion of the social right. Consequently, both proposals seek to strengthen the position of the aged in society by intervening in the social relations that hinder their fulfillment as citizens. They also express the concern regarding the nature of the development and of the economic and social policies that exclude certain social groups from their benefits.

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