THE RESPONSIBILITY OF THE GOVERNMENTS OF THE WORLD FOR PUBLIC HEALTH

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When I was invited to submit this article, my first wish was to share a vision of the development of Costa Rica's health system, drawing on my public sector experience as a physician with a master's degree in public health and my experience in teaching and emergency and disaster response in Latin America, especially Central America, and, in the last four years, as Minister of Health.

I will give a brief overview of the history and present situation of Costa Rica's health system, including the concept of health-disease and the historical development of the health system, to illustrate Costa Rican society's ethical commitment to the construction of a more just, equitable, and healthy society. I hope that this humanistic vision will encourage readers to seek more integrated management of development policies (Kliksberg 2003; Sachs 2002). In part two, I discuss some lessons learned in the areas of governance, resources, and global threats. In part three, I examine some challenges to the construction of public policy and note those faced by policymakers in the 21st century, concluding with an examination of the international role of public health policy. I hope that this initial attempt to summarize my personal experience will encourage others, whether in political, academic, or civil society settings, to more closely examine the challenges faced in developing citizenship and building democracy, social peace, and justice.

The responsibility of the governments of the world for the public health of their populations is undoubtedly a preeminent challenge. In part two of this article I will give a historical-regulatory and empirical review of the development of Costa Rica's health system. My intention is to show that achievements in health require ongoing and defensive actions, the commitment of the State, and contributions from the population. Naturally, it should be recognized that success is the product not of spontaneous generation, but rather, of action taken to build more just and equitable societies.

I. History and Present Status of Costa Rica's Health System

A. Health as Well-being and the Right to Health

In 2005, when WHO reintroduced the concept of *health as well-being* and as a right, following approval of the concept by the World Health Assembly of 2003, the primary care strategy was renewed for the 21st century.

> Health is a social, economic, and political issue and, above all, a fundamental right. Inequality, poverty, exploitation, violence, and injustice are at the root of ill-health and the death of poor and marginalized people. The approaches to improve the health should address in integrated way their multiple determinants (WHO).

A review of the principles and values that explain how citizens and governments work to attain health, and not only to prevent disease, was proposed, requiring that the social macrodeterminants of health be addressed (Frenk 2004). That resolution acknowledges the importance of a healthy economy, in which wealth generation and distribution through fair labor practices and the setting aside of resources for education and infrastructure improvement determine the health of the populace, families, and communities. This vision also recognizes the importance of different groups' responsibility in constructing their own health, both individually and collectively.

In Costa Rica, in 1994, the concept of the health-disease process was explored, and health was defined as a social product whose biological, social, economic, and environmental determinants need to be addressed. The fact that the development, implementation, and evaluation of health policies require intersectoral and interdisciplinary work was also acknowledged.

This new health concept reshaped the health system, giving the Ministry of Health a steering function, or, regulatory power over health-related matters, while making Social Security responsible for the delivery of services—that is, for operational issues. Hence, the Ministry of Health was assigned four strategic functions: (1) management and leadership, (2) regulation, (3) health surveillance and, lastly, (4) technological research and development. These functions can be seen in the Ministry's current organizational and functional structure. In the case of Social Security, progress has been made through the Administrative Decentralization Act, the creation of health boards, and the strengthening of the modified health care model, as well as the issuing of contracts. These

changes can be analyzed in greater depth in the institutional proceedings and the reports on the execution of loans granted to the country by the World Bank.

In 2004, when primary health care was reintroduced, the country's sectoral reform was more than six years old. On the one hand, it was necessary to meet the challenge of expanding basic service coverage, with the consequent strain on the ability to deliver some services due to delays in the completion of new infrastructure to meet needs detected at the primary level. On the other, the Ministry of Health had replaced the human resources responsible for direct care, which were little developed and had an as-yet insufficient legal framework with human resources willing to take on the challenge of the steering role in health.

The basic purpose of a rights approach in public policy is to facilitate a vision of institutional development centered on people as social actors whose specific rights must be recognized. I should stress that when I refer to the concept of *social actor* I am referring not to people individually but to specific communities that have a series of common elements, whether interests, needs, outlooks, or discourse, allowing them to construct a particular identity.

Public policy is designed to address inequalities and constitutes an excellent complement to universal health policies. To guarantee equity, as noted above, the publicly available information must be improved, and disenfranchised social sectors must be encouraged to participate in evaluating the health services they receive.

From this perspective, public policy development entails somewhat more than top-down action by the authorities in response to particular problems. It entails the interaction of various stakeholders and factors, as well as economic, social, and political agents, and it should normally be discussed in different spheres of society. It requires the redefinition of the State's traditional role, in which decisions are made by the top echelons of government, to the exclusion of other actors who represent specific interests and positions.

B. Construction of Public Policy: Developing Costa Rica's Health System

In Costa Rica, with the advent of the 19th century Liberal State, the nation enhanced public powers to promote social justice, but without limiting property rights or freedoms. Since the end of the 19th century, and especially as of the early 1940s, Costa Rican

society clearly understood that the right to health was contingent on defending the right to education, work, decent housing, food, adequate clothing, and timely access to health services. Our leaders were well aware that health care must be comprehensive and took the necessary steps for future generations of Costa Ricans to enjoy decent and hence, healthy, lives.

Laws and institutions were created to prevent accidents in the workplace. Labor codes, social guarantees, industrial hygiene, government importation of grains, price controls, an income tax, maximum work hours, a housing board (to promote affordable housing), and rural lending boards were introduced, along with a law against usury and others that gave the State the exclusive right to issue money, regulated the sale of gasoline, telegraphy and telephone services, and insurance, provided protection for mothers and children, school breakfasts, comprehensive childcare centers, minimum wages, and compulsory social security.

Social legislation in Costa Rica is the result of a historical and social process that crystallized in the 1940s. Social Security, initially conceived in the Bismarckian sense of protection for workers, was soon extended to cover families, and in 1961, 20 years after the creation of the Social Security system, the Universal Social Security Coverage Act was enacted. The Social Security Fund was given 10 years to make universal coverage a reality. This step, one of the most important changes in the Costa Rican health system, was first established in law before materializing in the 1970s with the creation of an authentic social security system.

C. Costa Rica and Public Ethics: Health for All, regardless of Gender

In the 1950s, a new development model was adopted in the context of the international promotion of import-substitution policies. In the 1970s, GDP rose and at the same time the health sector's share of GDP increased, from 5.1% in 1970 to 7.6% in 1980. A comprehensive State policy was developed as part of the "fight against poverty," within the context of the National Health Plan, whose basic premises were that: (a) health care is the people's right, (b) the State is responsible for the population's health, (c) health care should be comprehensive, (d) services for prevention should be integrated with treatment, (e) services should be offered in all regions to improve the supply and coverage of benefits to the public; and (f) priority should be given to outpatient care.

Two basic strategies were developed: the provision of universal Social Security coverage; and the expansion of services to include scattered rural and marginalized urban populations.

In the 1970s, to avoid the duplication of efforts, hospitals were transferred from the Ministry of Health to the Caja Costarricense de Seguro Social (Costa Rican Social Security Fund, CCSS); and laws were enacted creating new forms of insurance in order to cover segments of the population whose lack of formal employment made them ineligible for traditional forms of enrollment in the system. The new forms of insurance took effect during the serious economic crisis of the 1980s and their beneficiaries include people insured by the State and those covered under special agreements intended to provide health coverage to the most vulnerable segments of the population. This made it possible to increase insurance coverage from 42% of the population in 1968 to 84% in 1990, and to guarantee access for the entire population, whatever the degree of complexity in the public services network.

In the early 1980s, the country and the health system faced one of the severest economic crises in the nation's history.

> Just a few figures should suffice to show the magnitude of that crisis. Production, which had grown at an average rate of 6% annually for the previous 30 years, fell by 10% between 1980 and 1982. Unemployment, which had traditionally stood at fewer than 5%, nearly tripled to over 14%. Inflation climbed to above 90% in 1982. Wages lost 40% of their purchasing power. Social expenditure plunged from 23% of GDP in 1980 to barely 16% of a smaller GDP in 1982. As a result, poverty practically doubled; thus, in 1982—just as 30 years before—more than half of the Costa Rican population was living below the poverty line (Garnier and Hidalgo 1991).

The health sector responded to this crisis with financial-stabilization measures intended to keep the Social Security system from going bankrupt or reversing the progress toward universal health care made in previous years. The period from 1982 to 1986 saw the "integration of health services" between the Ministry of Health and the CCSS, and an attempt was made to reduce duplications in health care at the outpatient level. This marked the beginning of the CCSS's intervention in preventive care and public health.

Several studies point to the public system developed in Costa Rica as one of the instruments that allowed the country to attain a high degree of human development despite an underdeveloped

economy. Costa Rica's system is universal, equitable, and based on solidarity. Its underpinnings are the expansion of public health and a unique social-security model in which workers are required to join and vulnerable groups are protected by means of enrollment through the State and other mechanisms to ensure universal coverage.

The social and health policy in place in the country since the 1970s has led to a drop in the birth rate and in total and child mortality and to an increase in life expectancy at birth. These achievements were exemplary, as infant mortality declined from 61.5 per 1,000 births in 1970 to 13.6 in 1991 and life expectancy rose from 65 years in 1970 to 75 in 1991.

D. Quality Services, Equity and Solidarity: the Challenge of the Steering Role in Health

As noted by Leonardo Garnier (2005):

> The crisis bought other changes. In terms of the international context, the world went from the period of nationalistic developmentism and the Welfare State—to a certain extent, protected by the Cold War—to the era of the "Washington Consensus," which, after the Cold War, was erected on the reality of globalization and the rhetoric of globalism (Beck 1998) to promote a series of reforms aimed at economic opening, liberalization, deregulation, and privatization. This was based on the—apparently economic, but, in reality, ideological—assumption that the causes of both the crisis and the poor performance of domestic economies were all linked to the excesses of state interventionism during the preceding decades.

In Costa Rica, the aim of health sector reform, which began in 1994, was to improve the quality and timeliness of access for the entire population. Unlike other reform processes in Latin America, Costa Rica's fostered the planning, financing, and public delivery (direct or indirect) of services. Ten years later, 88% of the population was covered, the infant mortality rate had declined to below 10 per 1,000 live births (9.8 in 2005), and life expectancy was above 80 years. From this standpoint, the "Costa Rican style" reform that was proposed and implemented has been a success, making Costa Rica's health system one of the best performing.

This success in public health requires the country to address emerging problems that will be the challenges for the future. To quote Juliana Martínez (2005), a researcher who has documented the impact of health reform:

> In the 1990s, the CCSS stopped investing in services and equipment of its own; it adopted a policy of greater private contracting of services although it lacked an up-to-date cost accounting system with which to compare its results with the costs of the private services that it procured (Herrero and Durán 2001). What estimates there were showed that procuring private services was systematically more expensive than providing services directly (Legislative Assembly 2001) …the quality of the private services provided through Social Security left much to be desired and, in general, [these services] were evaluated only in response to complaints or accidents.

Spending on private health care increased (Picado, et al. 2003) from 23% in 1991 to 30% in 2001, although this was mainly among the higher income quintiles: 58.2% of the increase corresponds to the highest income quintile, while only 2.4% of all private health expenses were incurred by the poorest quintile of the population. Expenditures on private care were mainly for outpatient medical visits, dental work, drugs, and laboratory and office tests. The upper and middle-upper income quintiles meet their health care needs by paying out-of-pocket, while the rest of the middle- and the low-income sectors wait their turn to receive care from public services.

Through the accreditation of health services, the Ministry of Health evaluated structural standards for a basic care floor in every public hospital in the country in 2004 and 2005. The findings reveal significant deficiencies in infrastructure, but especially problems in providing human resources specifically for direct care. There is an excessive concentration of functions and an excessive workload, which undermines staff motivation and performance. Despite these and the other problems detected, I must note that sectorization has significantly contributed to improving access to services by the groups at the greatest risk.

Costa Ricans need to begin discussing these problems. This discussion must not focus solely on actuarial or technocratic issues. Since the dialogue will have serious implications for the health and well-being of Costa Ricans, it should be eminently political and democratic. Moreover, with the construction of an agenda to promote health with private-sector service providers based on a recognition of the commercial nature of such providers, the ethical standards of access, universality, equity, and quality may prevail. It is significant that this discussion has begun at three important meetings: one convened by a nongovernmental organization during the run-up to the presidential election; another by PAHO, the Ministry of Health, and the State of the Nation, among other agencies; and the

third, by the Academy of Medicine, on the Challenges faced by Social Security in Costa Rica (Academia de Medicina, Costa Rica, 2006). Despite these beginnings, I am convinced that Costa Rican citizens need to study the issue in greater depth.

E. Collective Rights and Financial Sustainability: Challenge and Opportunities

An analysis of the trajectory of some Latin American countries following the State reforms that began in the late 1980s and continued into the 1990s points to one overriding fact: economic opening coincided with the declining role of the State and the social security system (Rodrik 1998). Thus, on the one hand, these economies' degree of exposure to external shocks increased just as the level of collective safety net offered by democratic rule declined.

As a result of these policies in Latin American countries with more tolerance for inequalities than that evidenced in the history of Costa Rica—where social values are paramount—growing economic insecurity has led to a risk of declining popular support for democracy. This, in turn, leads to a questioning of the political and economic system. Examples of these reactions abound.

The right to health and to the means for attaining it has traditionally been grounded in the principle of strong social cohesion. Nothing moves the citizen conscience more than inequities vis-à-vis disease and death. In a time of crisis and possible changes in the health system, we must appeal to the people's traditional solidarity and demand that the State play a more interventionist role to strengthen it.

Furthermore, there is no evidence that the search for social cohesion—understood as a prerequisite for the continued existence of social systems despite the challenges posed by the multiculturality of their members, the concentration of wealth, and the disenfranchisement of and inequality among individuals—is an obstacle to economic efficiency. On the contrary, wherever democracy has been established, it has required solidarity-based institutions. And societies with the highest degree of solidarity are far from being those with the worst outcomes.

In the context of globalization, the opening of countries to international trade, irrespective of ideological considerations, may or may not pose a threat. Societies that are capable of designing, implementing, and evaluating specific measures to avert the negative effects and to make the most of the opportunities stemming from the exchange of goods, services, and population groups are the

ones that have advanced in human development. Many lessons have been learned. Placing human beings at the center of development in terms of the use of natural resources and constructing settings characterized by peace and social justice are the dream and goal of government leaders for this century. Undoubtedly, that is the objective expressed in the Millennium Development Goals. In a health system that depends on employment policies, with mobile populations being incorporated into the workforce through a variety of mechanisms, attaining this goal is necessary for reasons related to rights, justice, and solidarity, in addition to this population's potential contribution to the system's financial sustainability.

Stiglitz maintains that social policy should be guided by four basic principles: universality, solidarity, efficiency, and comprehensiveness. Nevertheless, there has been some confusion over these principles in recent years, as instruments for targeting; criteria for equivalence between contributions and benefits; decentralization; and private-sector participation have been promoted, supplanting the principles in social-sector reforms. The instruments should be subordinate to the principles, and targeting should be viewed as an instrument to improve access and expand service coverage and never as substitute for universality (Stiglitz 1973).

This view of citizen's rights is shared by contemporary approaches to development, such as the "human development" theory (UNDP 1994) or A. Sen's theory of "development as freedom" (1999). These approaches view human beings as the reason for economic development rather than making people's needs secondary to the exigencies of the market. This is the breadth of contemporary discussion.

From a more practical perspective, in the following section I will recapitulate my contribution to the development of a more just, more equitable, and more solidary health system. I hope, moreover, that the reader will also be able to identify the challenges and the obstacles from an ethical perspective.

II. Some Lessons Learned

A. Reflections on Governance

The construction of public health policies requires an analysis of governance as it exists, as well as of what it should be. Such an analysis, in turn, requires an in-depth knowledge of the condition or situation that policymakers want to consolidate or

change and the systemic organization of the scientific evidence. It also requires certainty about the course and the goal, which is basic—simple and efficient—organization. Essential conditions for this are a respect for diversity, recognition of the different interests, the ability to negotiate, and good institutional and interpersonal communication, as well as a capacity to follow through on agreements and assume them responsibly. Motivation most often depends on access to all the available information, and the participation of the various groups from the beginning, that is, as soon as the problem, condition, or situation in which policymakers wish to intervene is identified: the result—the formulation of sustainable health policies—depends on this.

The representation of individuals, public and private groups, institutions, civil society, the media, academia, and researchers is fundamental, as are local, subnational, national, regional, and global visions. This applies to those who benefit from a policy and as well as to those who feel that their interests have been harmed and to those whose interests have in fact been harmed. It also includes policymakers. As noted above, maintaining the support of the different social actors depends on having clear rules, access to information, and the ability of people to express their ideas and positions as well as to disagree. It also depends on having clear rules that point to where we are going, what we hope to attain, what we expect, and what instruments or mechanisms are available to ensure quality products. That is, it depends on establishing the terms of reference to which we as a group are committed.

Once the leader of the process has taken up the challenge, he or she must clearly understand that his/her personal challenge is to identify the needs of the various groups, use the best tools with which to call for a consultation, and lend credibility to the process. Moreover, the leader must have the financial, technical, technological, and logistical resources, as well as room to be creative. In the political arena, the leader must assess the political capital, that is, determine the degree of freedom to bring up strategic topics and propose collective behavioral changes. As if this were not enough, the construction of health policies must be seen as an opportunity to consolidate leadership and not one for the expending of excessive personal, family, institutional, government efforts. From the standpoint of leadership, the process of measuring Essential Public Health Functions at the national and subnational level leads to a qualitative assessment of the health system's performance. It may even turn into an opportunity to

carry out a tactical assessment of the degree of competence in the country in order to respond to the different needs requiring policies, plans, or programs. Undoubtedly, this is a positive experience for any country.

An active dialogue, under conditions of equality, and an ongoing exchange between members of different cultures are basic elements in policymaking. In fact, in several processes led by it, the Ministry of Health has held an ongoing dialogue with social groups from other cultures. In such a dialogue, we should gather information on the knowledge and practices of other cultures and compare it with the knowledge and practices of our own culture. In this exchange and encounter, we need to be open to the generation of innovative practices and knowledge and to their finding expression in policies, programs, and projects targeting specific groups with specific needs.

An analysis of social forces and, especially, of how such forces are expressed, requires attention and dedication. These forces can be visible and can express themselves transparently or, conversely, they may be amorphous; however, they are, strong enough to prevent the objective from being attained or, worse, to change the objective. The forces can also be individuals (people who receive a benefit or are harmed), special-interest groups (workers, professional trade associations, unions), companies whose objectives have been threatened or undermined, the media (which shape public opinion and see a controversy as an opportunity to make a profit). In addition, they may be the expression of internal and external institutional resistance. In short, forces at times take on the form of resistance arising from institutional, personal, gender, intergenerational, and even ideological vanity.

In devising specific policies, expressions of sociocultural resistance, ideas, beliefs, and practices normally come into play. The most controversial policies are those related to sexuality and involving beliefs, theories, and practices, in addition to reality and responsibility, at different societal levels. This health field-system has several responsibilities, including reducing the health-information and knowledge gap, so that individuals and groups make informed decisions based on their own needs. Condom use, for example, has elicited varied reactions—some related to morality—that hinders or delay action by groups and individuals to prevent and avoid disease and death, as in the case of AIDS. Are there alternative methods of protection? Who is responsible? Where does that responsibility begin and where does it end? Should moral or

religious considerations take precedence? What are the arguments? Are the arguments based on reason or rooted in belief systems? Who assumes, vis-à-vis population groups, responsibility for progress being made or not being made in matters related to health? Although the health sector is not directly responsible for introducing sex education in childhood, can the sector wait amidst the appearance of cases and potentially avoidable deaths?

Another example related to sexuality is the introduction of contraceptives for use after intercourse. In recent years, this issue has drawn the attention of the general public, academics, religious groups, gynecologists, and rights advocacy groups. Articles, reports, and discussions have examined the possible effects on conception. Some groups support their arguments with religious beliefs, others, scientific arguments, and still others, women's right to decide. It should be noted that the sale of any drug in Costa Rica requires sanitary registration similar to that of other countries. Nevertheless, right now, that process has not begun and the controversy alternates between moments of tension and periods of silence. The questions that need answering are: How do these controversies arise? Who is responsible for them? Who benefits from the situation? Who is harmed by it? Will women's and rights advocacy groups press forward in this struggle? Have private enterprise, producers, and distributors played a socially responsible role?

B. Some Reflections on Resources

It is frequently, and justifiably, said that additional resources are needed to maintain achievements and tackle new health challenges. However, the ability to garner support for budget hikes is directly related to the soundness of the arguments put forth. These arguments need to be persuasive about the impact of proposed budget increases. Making the impact evident to decision-makers and the general public is a priority. A lower death rate, increased coverage, a longer life for future generations, and higher quality services are long-term goals. The alternative, then, is to set goals that are potentially attainable in the midterm and that will be perceived by health workers and the population as a step forward.

In the search for new resources, political, strategic, and ethical considerations also come into play. Sources of funding may be structural or short-term. Structural changes such as raising contribution rates or incorporating new groups are the most beneficial actions for the system, since debt for infrastructure projects should be properly

justified. In Costa Rica, where most resources are currently used to pay the country's debt, a fiscal reform has been proposed to increase the resources available for social investment. However, after five years, it has not been possible to gain the Legislative Assembly's approval of this proposal. The following strategic actions need to be encouraged: (1) using unutilized resources; (2) mobilizing resources within the sector itself; (3) improving collection; (4) promoting local government participation; (5) seeking strategic partnerships with academia, organized groups, and private enterprise; (6) seeking international support. In fact, these strategies complement one another, since none of them can single-handedly solve the problem of limited resources. A solidarity-based universal system such as Costa Rica's faces challenges related to the population's health-disease profile, an aging population, disabilities, and the cost of health care. Thus, ensuring that contributions are paid and avoiding payment delinquencies, even by the State itself, are ongoing strategic actions.

Economic resources are a necessary, but insufficient, condition for achieving good outcomes in health care; that is, reducing infant mortality, keeping communicable diseases under control, and dealing with new health problems also require instruments and mechanisms to ensure efficiency, quality, and sensitivity in health services. In addition, mechanisms to allow citizens to evaluate the performance of the system and transparency in the use of the public funds are also required. Successful efforts to promote efficiency are those that, without overlooking health objectives, make proper use of the available resources, whether human, physical, technological, or IT-related.

In designing, implementing, and evaluating instruments for improving efficiency, policymakers must not overlook the fact that cutting costs through downsizing can be detrimental for administration. In managing health workers, job security, wages, compensation, and incentives as well as regulation and recognition mechanisms must be taken into account to gain workers' collaboration in and commitment to such sensitive topics for the population as the prevention or treatment of illness.

Another issue that I would like stress is the allocation of economic, technological, infrastructure, and human resources based on the health needs of the various population groups, according to age or ethnicity, geographic area, or gender. Several documents published by the Ministry of Health with the support of the Pan American Health Organization and technical groups in

Costa Rica have shown that life expectancy at birth in indigenous populations is 20 years shorter than that of the rest of the population (Ministry of Health 2004). It has also been shown that there is a greater concentration of strategic human resources (physicians per inhabitant) in urban areas than in areas with greater poverty (27 vs. 7 physicians per 10,000 inhabitants) and a lack of certain medical specialties and professions. The purpose of seeking a fairer and more equitable allocation of resources is to guarantee that benefits are consistent with the particular cultural characteristics and needs of different social groups. A principle of equity based on respect for diversity and access—understood as not only availability but timeliness, functionality, distance-time, costs, and sociocultural aspects—is directly linked to the management of human resources for health.

On the topic of human resources, I would like to share the concerns of students, parents, the education and health sectors, and citizens in general regarding the lack of certain strategic resources such as anesthesiologists and the explosion of university degree programs that do not serve the needs of the population or the health system. Examples of this are the 17 degree programs in public and private universities in psychology; 8 degree programs in medicine, 8 degree programs in nursing, among others, in a country with a total of population of 4.2 million (PAHO/WHO 2006, 2003). In addition, most graduates of these programs prefer urban areas, where the supply of jobs is greater.

Since its origin, Costa Rica's health system has been governed by principles such as solidarity that guide its institutional and social work. Policy orientations aimed at putting these principles into practice are one of the concerns and tasks of policymakers. Some successful strategies in Costa Rica and in the world, such as primary health care, referred to in the Declaration of Alma-Ata and in the most recent WHO resolution, once again allow health systems to be consolidated. This is because these strategies include intersectoral and multidisciplinary work, the use of appropriate technology, and community participation to strengthen the principles on which solidarity based—that is, they focus on how society is organized to offer quality services to the population. This is a new opportunity to revitalize primary health care to tirelessly seek the implementation of programs and strategies to ensure that the population remains healthy, prevent infectious disease, achieve a healthy lifestyle, prevent premature deaths, and reduce the number of persons with disabilities.

As mentioned in the first part of this article, the amount of economic resources allocated for comprehensive health care is a constraint that has existed in the past and will undoubtedly persist. Therefore, there is a need to seek and identify new resources and to be more efficient—and, especially, in health-related matters—for greater effectiveness. If the country's most widespread health problems are chronic diseases, cancer, and accidents, how should the health system respond? Budgets reflect this priority, but only otherwise unneeded funds are allocated to it. Is it the health authorities who strive to obtain resources, or are decisions on resources taken at another level, one whose political responsibility is macroeconomic stability and not health? Despite these dilemmas, policies must move forward. But what is the role of a health leader? First, to be efficient, effective, and transparent; second, to possess a greater capacity to negotiate and convince other actors that achieving the desired results requires more resources. And if those resources are not obtained and the public questions the lack of resources, accountability must be upheld.

C. Reflections on Global Risks

In this section I will address several issues, including natural disasters, population movements, and global threats such as SARS and avian flu.

Adverse or catastrophic events have been increasingly frequent and severe in the Central American region. These events add complexity to the analysis of the health needs of populations that have often made great sacrifices to invest in development and which in the wink of an eye might lose not only the opportunity to make such investments but also forfeit as much as 50 years of progress, as occurred in the case of Hurricane Mitch (PAHO 2000).

The skills that the country must develop go beyond the health system and disaster preparedness and are related to avoiding and reducing the potential for sickness, injury, or death as a consequence of natural disasters. Transcending the response phase and taking up issues related to reducing vulnerability are related to human development, that is, to people, and represent a commitment to society. A society that has historically placed special emphasis on education, health, decent housing, respect for nature, and peaceful coexistence without an army is also capable of building a less vulnerable future.

Several documents from the International Strategy for Disaster Reduction state that vulnerability to natural disasters is related not only to social vulnerability, with or without poverty; but to the real possibilities of populations located in areas of natural or man-made threats to be informed, to their capacity to organize, and to their ability to mobilize resources and intervene in their community environment. In this regard, health system operations are interdependent with other sectors of society; accordingly, programs and plans must be comprehensive and integrated to avoid the duplication of efforts and wasted resources. Who is responsible for ethical issues in disasters, and how do they address them? When public buildings and dwellings are built in risk areas, is this fact made clear? Do communities have opportunities for proposing corrective measures?

A second issue I would like to discuss in this section is the movement of people and groups, whether for tourism or because of social exclusion. A quick overview of these two types of movement might lead one to conclude that they have nothing in common. However, they both use specific goods and services and they both create sociocultural, labor, and commercial changes. Both phenomena spur societies to examine their own sociocultural values and achievements as well as the limitations that are identified by the inhabitants themselves. Dealing with these two realities will undoubtedly lead to more tolerant, just, and equitable societies.

In the case of tourism, in different countries it has been possible to document the need for strict regulations on the use of natural resources such as water and on the protection of watersheds from different sources of pollution or contamination as well as the protection of beaches and forests, to cite just a few examples. There are numerous regulations governing the protection of sociocultural values such as language, buildings, and historical heritage, in addition to infrastructure and logistical requirements to allow the tourist industry to operate satisfactorily. The possibility of changes in consumption patterns as a result of exposure to different lifestyles can be seen in changes in diet, clothing, leisure activities, and people's own reality—that is, in one's possibility of resembling and becoming culturally similar to others.

To meet the needs of groups that move in response to social exclusion, health care must be adapted in specific ways. In addition, receiving countries must recognize the contributions made by and the rights of those groups. These movements can

occur within a country or subregion (such as Central America) or at the regional level, as with Latin Americans who go to the United States; or they may be intercontinental, as in the case of emigration from Africa and Ecuador to Spain. Another important issue is the lack of information about the concept of health and the practices and customs that people take to their new countries of residence, and on how these concepts, practices, and customs are utilized by health services, as well as information on interpersonal norms that may or may not be accepted. Receiving countries also react in a variety of ways, from allocating community or institutional resources to receive the new immigrants to deporting those who are undocumented; from welcoming them into the labor market to forcing them into the informal job market; from providing comprehensive care for immigrants to disavowing their health care rights. How feasible is it to give recent arrivals the benefits that the receiving society has developed over many decades. Is a developed country expected to receive excluded populations in the same manner as a developing country? What are the minimum requirements that the international community is willing to establish for sending countries?

Moreover, new threats to populations, such as SARS and avian influenza, have also emerged. The consequences of the cases of SARS in Canada, China, and other Asian countries overburdened those countries' health systems and, moreover, shed light on weaknesses at various governmental levels. The World Health Organization alert on the risk of an avian influenza pandemic also raised concerns among the public about the need to prepare for a disease whose aggressiveness is still unknown. However, resources have been made available throughout the world to produce vaccines, drugs, and medical supplies; health workers have been trained; and national and regional response plans for the public and private sectors have been prepared. Some of the discussions on this issue have focused on the fact that resources have been concentrated to respond to a risk perceived by some as remote while developing countries have not succeeded in solving problems related to communicable and maternal and child illnesses. However, the health sector must be prepared, and at the same time make official information available to the population. The risk of causing panic in response to this type of threat requires careful, evidence-based management, and that information be transmitted calmly but without minimizing the risks.

Global risks are but one example of the contradictions faced by health leaders. The impact on health, the economies, and the safety of populations has yet to be documented.

III. Challenges to Public Policy-making

- More resources are required to sustain the achievements of Costa Rica's health system and to face challenges; hence, fiscal reform is inevitable.
- It must not be forgotten that achievements in health are the linchpin for tackling new challenges and developing new ways of organizing and building partnerships with the academic, private, and public sectors and with citizens, and the codes of ethics for these relations must be explicitly stated in documents and adhered to by the parties.
- New forms of technical and financial cooperation between middle-income countries are required to break the vicious cycle of better health system performance coupled with less technical and financial cooperation. That is, a new international ethic is needed in which resources are provided for health systems on the basis of their performance—their achievements; in addition, countries should no longer be classified according to their gross domestic product.
- Health decisions must be based on scientific and empirical evidence, the knowledge gap must be narrowed, and knowledge must be made available to the public to allow it to make the best decisions about the wide range goods and services available.
- The State as regulator must recognize the interests of diverse stakeholders, in addition to playing an active role in ensuring that health benefits reach everyone and that diversity is respected and taken into consideration.
- Social and political partnerships capable of turning conflicts over resource allocation into basic agreements on agendas and development policies, despite their complexity, are a priority.
- Mechanisms and instruments need to be developed for reporting crimes committed by civil servants and establishing sanctions.

- Stronger guarantees are needed regarding freedom of the press and information to promote and defend the rights of the neediest individuals.

"Problems are solved not with a smaller State but with a more active State."

IV. Conclusion

The current situation requires us to rethink social protection within the framework of integral solidarity, combining contributory and noncontributory mechanisms. There is a need to reach a consensus on a new social pact with social rights and the right to health the focal point. In this social pact, inequalities and budgetary constraints would be viewed as social problems that should be solved collectively in order to address these rights and make them a reality. Attaining health for all of the country's inhabitants, despite the contradictions, is the challenge of the past, the present, and the future for health leaders who assume responsibility for public policy-making.

The democratization of knowledge and technology makes the people better able to make demands and express disagreement and to participate in their own health care and that of other family members and their communities. It also obliges health leaders to be informed, to know how to integrate and communicate, to constantly assess their own performance, and to establish a reference group or designate external evaluators. Some of the new competencies of these health leaders for the 21st century will require the integration of knowledge, work in rural areas, teamwork, leadership, flexibility, reading, and contact with health workers and the population at the subnational, national, and global level. Thus, analytical, intuitive, cognitive, gender, and technological forms of knowledge must converge for decision-making.

Costa Rica's history in the field of health provides empirical evidence that the health system does more than simply deliver services to cure illness, since it has been a basic element in the construction of a Costa Rican identity; that is, the population has a public health culture rooted in rights, equity, and social justice that was constructed in a different economic and social context. The future is going to be determined by the capacity of political leaders to bolster achievements and face challenges without losing the values that gave life to present-day Costa Rican society. Finally,

governments are also responsible for forging alliances with each other and ensuring that international cooperation understands, supports, and contributes to the allocation of more resources to high-performing countries that show improvements in living conditions and the quality of life if they adopt fair and equitable public health policies.

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