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THE POLITICAL ECONOMY OF HEALTH

Health Security and Insecurity in Latin America and the Caribbean

Jorge Nef

I. Introduction

The premise of the 2001 Macalester International Roundtable on Global Health is that a fundamental concern of all societies is how to reproduce and sustain good health, and forestall, cure, or at least contain, disease. As the World Health Organization Constitution states: "Health is a complete state of physical, mental and social well-being, and not just the absence of illness or infirmities." This pursuit is hindered, however, by a number of persistent problems. First, there is the resistance of age-old illnesses, such as tuberculosis, bacterial infections, and viruses, to scientific and technological intervention. Second, there is a conglomerate of health risks, such as cancer, cardiovascular infirmities, and diabetes, which apparently become more acute with increased material progress and aging. Third, there are new health threats, like those affecting the immune and neurological systems, which ostensibly defy current knowledge and prescriptions. Most important, however, is the presence of socioeconomic and political factors that are inimical to health. The latter is not simply a technical problem, related to the medicalization of individuals' ailments. Rather, it is an eminently political terrain where culture, economy, and society interplay and where policy has a fundamental impact upon well-being.

It is commonplace today that poverty, rather than absolute scarcity, lies at the core of health, food, and environmental insecurity. The inability of the poor to access adequate levels of health and health services, coupled with regressive social and economic policies, reinforces a vicious cycle of unemployment, poverty, malnutrition, unhealthy

conditions, disease, and inadequate services, leading to further vulnerabilities. What is less common is a systematic mode of analysis of health insecurity from the perspective of the relationship between poverty, income, and unemployment, articulated in a political economy of health security and insecurity in the Americas. This conveys the need to analyze the above-mentioned multiple malfunctions from the point of view of an integrated Human Security paradigm that emphasizes the interconnectedness of ecology, economy, society, polity, and culture.¹ Health insecurity from this perspective is an aspect of a larger human security problem — “an expression of living conditions in the region [that] reflect the unequal distribution of both the health determinants and the means to compensate such inequities.”²

This interpretative essay³ is an attempt to understand and explain the political economy⁴ of health in Latin American and the Caribbean (LAC). The main analytical focus is the concept of health security as an organizational and logical device to study the complex interrelationships between economy, ecology, society, culture, and polity within the dynamics of development. The general state of wellness in a given population involves a multiplicity of interrelated factors and processes occurring in a structural and historical setting, and having effects upon people and their circumstances. This complex pattern of interactions dealing with the shaping and sharing of well-being, or health system, is affected by pressures from its milieu and, in turn, has an impact upon such milieu. Irrespective of its integration (or lack thereof), it also possesses a degree of institutionalization: a regime, or structure of governance, with norms that regulate the operation of its constituent parts. The concept of system implies two essential properties: that all the components are interconnected, and that changes in any one element of the system, including its context, will have consequences for the entire configuration. Furthermore, it presupposes the existence of various interacting levels or “layers:” micro (household), local, national, regional, and global. It also entails the interweaving of five basic elements: a) a socioeconomic and political (as well as policy) context, b) a cultural matrix that gives the system meaning and purpose, c) structures of stakeholders, resources, and linkages, d) the processes (actions and inactions) whereby the structures generate and allocate rewards and deprivations (i.e., the “shaping and sharing of health”⁵), and e) a set of effects or consequences of such actions or inactions upon the context, the culture, and the structures.

Building upon these five systemic factors, we will concentrate upon a number of interconnected core issues to assess health security and insecurity in the LAC region. The first is the meaning of wellness, health, and health security, including the descriptive parameters of the state of health in the region. The second is the identification of the main “killers” and the predominant sources of disease, as well as the most vulnerable, or high-risk, sectors in these countries. The third is how the various stakeholders (governments, IGOs, NGOs, business, civil society) address these needs through health regimes, and what the role of culture and science is in health maintenance, promotion, and development. Finally, there is the impact of globalization as a two-way process upon the Americas as a whole.

Since the 1980s, the LAC countries have begun to face expanding and converging sets of problems whose common denominator is the fiscal crisis of the state. These affect employment, purchasing power, housing, the safety of drinking water, the quality of sanitation, the growing incidence of new and “old” diseases of epidemic proportions, the deteriorating ecosystem, and the profound inability to meet health challenges. This has happened at a time when social safety nets and health delivery mechanisms are collapsing as a consequence of Structural Adjustment policies. In related areas, like food security, the region has become a net importer, a phenomenon that has coincided with an overall escalation of foreign dependency and inadequate diet. As the region becomes more integrated in circuits of finance, trade, communications, and social interaction, the issue of interconnectedness becomes of capital importance for hemispheric security. Also critical is mutual vulnerability; that is, the extent to which health insecurity in the poorer countries of the South can pose a potentially destabilizing role in the seemingly secure and developed societies of the North.

A. A Problematic “Paradox”

A superficial glance at the general health situation in LAC clearly sets it apart from the other underdeveloped countries of Africa, Asia, and the Middle East: In LAC, there are more doctors, nurses, and hospital beds; the rates of morbidity and mortality are smaller; and there is longer life expectancy and lower infant mortality than in most of the “other World.” These traits appear to correlate with other signs of relative development. The ratio of resources to population is compara-

tively one of the most favorable on the globe. Some of the richest and yet unexploited forests, fertile soils, mineral and fossil fuels, as well as bodies of fresh water, exist there. Food production and consumption per capita, and average income levels, put LAC almost on par with the “transitional societies” of Eastern Europe, and in the developmental tier below the cluster made by the Group of Seven, the rest of the Atlantic community, and Australia and New Zealand.

The paradox is that despite this seemingly exceptional resource endowment, over one-fourth of its population—in fact, over 120 million people—has little regular access to effective health care, safe water, and sanitary facilities. As many as 70 percent of the families in the region live in poverty and some 11 to 13 percent suffer from malnutrition.⁶ There is a dramatic rural-urban split and extreme inequalities in income, power, quality of life, and health distribution. The shrinking access to healthy conditions and well-being seem to be associated with dramatic increases in pauperization, as the declining value of exports and massive foreign debt have wreaked havoc, and unemployment (both open and disguised) has soared. In this convergence of multiple dysfunctions, Latin America and the Caribbean are faced with a many-sided health crisis.

The apparent contradiction of poverty in the midst of plenty raises serious doubts about explaining such crises with conventional theories that concentrate upon “natural” geographical, technological, population, or cultural factors. As previously mentioned, LAC health problems differ from other lesser-developed countries in that the region has the resources, both physical and human, to extend a much better quality of life to all its inhabitants. The problem is that there is an extremely inequitable distribution of benefits, resulting in a highly polarized yet internationally integrated socioeconomic structure. In this sense, health insecurity in LAC is neither a conjunctural problem that will wither away, nor something that will be solved by gradual progress, diffusion, foreign aid, or administrative modernization. It is a structural condition imbedded in the existing “order” and style of development.

B. Health Security

Health security involves the ability of a society to reach and sustain stable and reliable access to well-being while reducing vulnerability to disease. It can be seen as the security and safety of the health system,⁷

defined by the extent of control and reduction of risk and insecurity. Upon investigation, health insecurity, except for its most severe cases, does not appear to affect an entire population in the same manner, time, or intensity. A distinction should be made between transitory and structural health problems. The former refers to emergencies and inadequate conditions as well as insufficient levels of service due to conjunctural fluctuations in supply or effective demand. A structural problem occurs when the means to maintain health are persistently lacking. These concepts must be cross-referenced with another important analytical distinction: the notion of stratified or unevenly distributed risk. Risk, here, is understood as the probability of harm resulting from a negative contingency, a lethal or incapacitating affliction that impacts both expectations and quality of life. Most such contingencies imply, in addition to suffering, a financial liability. Therefore, beyond a physically healthy milieu and the provision of technologies to address ailments, a fundamental component of a health security system is insurance to cover the costs of intervention.

Insurance involves both coverage of contingencies and accessibility to services. Within any country, there will always be those, often a minority, whose level of income seems to be high enough and secure enough to satisfy their own basic health needs (and beyond). Therefore, short of a catastrophic emergency, they appear persistently at a lesser risk. Their only requirements are those of physical accessibility, including using health services abroad. Secondly, there is another segment of the population with income levels sufficient to enjoy generalized well-being and access to health services, but with a propensity to experience a deterioration of their ability to pay. This is a partially vulnerable group that requires not only access to services but also compensatory mechanisms to stabilize incomes and provide coverage in times of emergency. Last, there is the rest of the population, the often large majority that cannot satisfy their basic health needs through the existing socioeconomic order and are constantly at risk. This is undoubtedly the group most affected by unhealthy conditions, little or non-existent coverage, and inadequate access to health services. For them, the health crisis is a concrete and permanent reality. But health is not an individual matter or the protection of discrete groups. From the perspective of an integrated system, the health of the whole, including that of the apparently less exposed groups, rests upon its weakest links. This is the essence of the mutual vulnerability thesis in human security analysis.

II. Risk Factors and Populations at Risk

We can distinguish three general sources of health risk and insecurity, or “threats.” The first threat is premature death (mortality), measured as “potential years of lost life” (PYLL). The second threat is morbidity, the incidence of all kinds of diseases in a population. The third is the inability of a society to tackle disease-producing factors and fatalities resulting from socioeconomic and environmental conditions, as well as restrictive or malfunctioning health care systems. The specific profile of these threats in LAC entail a combination of declining death rates with shifting causes of mortality, declining but volatile disease patterns, and deteriorating socioeconomic and institutional conditions.

A. The Main “Killers”

While death is an unavoidable occurrence, premature death is an indicator of insecurity, inversely related to Life Expectancy, one of the components of Human Development. Mortality rates from all causes in LAC declined steadily in the period between 1980–85 and 1990–95 for both sexes, though the mortality gap between the sexes has remained more or less the same, at 28 percent. In men, the rate went from 1,058 per 100,000 in 1985 to 939 in 1995, a 12.3 percent drop. In women, the rate dipped by 13.1 percent, from 771 to 670 per 100,000. In comparison, the trend in North America was from 783 men per 100,000 in 1985 to 692 per 100,000 in 1995 (–12.7%), and for women from 498 to 475 per 100,000 (–4.6%). Still, the mortality index differentials between North America and the LAC countries remain fairly sharp and relatively steady for men (from 26.1% above the North American rate in 1985 to 26.3% in 1995). In women, while the differential between LAC and North America is much higher than for men (respectively 35.4 and 29.1 percent between 1985 and 1995), the gap has been somewhat reduced. As a consequence of the relative reduction in death rates, life expectancy at birth increased from 65.4 to 69.8 years between 1985 and 1995.

The main causes of death in the region have been grouped by the Pan American Health Organization (PAHO) into four major categories, presented here in order of importance: a) circulatory ailments, b) malignant neoplasms, c) external causes (including accidents, suicides, murders, and other acts of violence), and d) transmissible diseases, including HIV.

1) Circulatory Diseases: Though experiencing a downward trend, from 347 per 100,000 in 1980–85 to 301 per 100,000 in 1990–95, circulatory diseases are, by far, the main cause of death. For comparison's sake, the North American trend moved, respectively, from 352 to 259 in the same period. In LAC, the ratio has remained relatively stable for both sexes in the last decade: 32.1 percent of all fatalities in men and 35.8 percent in women. The proportion of these deaths to total deaths is similar to that of North America, though the figures there are slightly larger: 37.6 percent for men and 40.7 percent for women, both exhibiting a clear downward trend, especially in women. As with all deaths, there is a sex differential. While cardiovascular deaths in LAC are slightly higher as a relative cause of all deaths among women, comparing death ratios for cardiovascular reasons as a whole, women's mortality is on average about 20 percent below that of men.

2) Cancers: The second leading cause of death in the LAC region is malignancies, with an incidence of about 13 percent of all causes for both men and women and showing a small decline between 1985 and 1995. Although the second major cause of death in LAC, cancers have a lower incidence in the "South" than in North America: respectively 122 to 129 per 100,000 for men and 101 to 120 per 100,000 in women.

3) External Causes: The third most prevalent cause of death is the combination of accidents, homicides, suicides, and acts of collective violence resulting in fatalities. This affects primarily men, with an incidence of 136 per 100,000 (14.5% of all causes), as opposed to 33 per 100,000 in women. In the latter case, it constitutes the lowest death ratio of the four relevant causes. This ratio varies considerably from country to country, with its highest concentration in areas of social and political turmoil: Central America, the Andean region of South America, and Brazil. It is also demographically concentrated among the age groups between 15 and 40 years of age, including young women. The driving factor is homicide, which in a number of countries is on the rise, though accidents and social violence play a significant role.

4) Transmissible Diseases: Communicable diseases causing death have an incidence of about 10 percent for both men and women. In the case of women, there was a dramatic drop of nearly 50 percent in the death rate caused by these afflictions (from 146 to 70 per 100,000 between 1985 and 1995). This was largely a result of better perinatal

conditions at childbirth and an improvement in hygienic standards in hospitals, assisted by a general decline in morbidity. Death by transmissible diseases is strongly associated with morbidity indexes and the incidence of viral and bacterial infections (and epidemics), such as measles, cholera, tuberculosis, malaria, and AIDS.

5) Infant Mortality: A special reference should be made to an aspect of premature death that is one of the most constant problems of health security in the region, infant mortality. In itself, it is a most telling indicator of insecurity and a dramatic reflection of poverty. The LAC countries have a comparatively high incidence of infant and child mortality vis-à-vis the developed world (55.3 per 1,000 in 1985 and reduced to 35.5 per 1,000 by 1995). Though this reduction of 36 percent is a remarkable achievement, the fact remains that infant mortality is still five times higher than in North America and six times higher than in Europe. Infant mortality reflects the general levels of poverty, maternal malnutrition, lack of adequate perinatal (pre- and postnatal) facilities, inadequate sanitation, and the presence of infectious diseases. With very few exceptions, social differentials in infant survival are staggering, exhibiting a similar ratio as that between North America and the LAC countries.

The major killers of children under five years of age are acute diarrhea and respiratory infections. The incidence of the former has sharply declined, from 21.6 percent of all causes of child death in 1985 to 8.2 percent in 1995. This trend has likely reflected the measures undertaken to combat the cholera epidemic of 1991. Respiratory ailments, though declining, have surpassed diarrhea as the major cause of death in children, from 16.5 percent in 1985 to 10.7 percent in 1995. By comparison, in North America, diarrhea accounts for only 0.6 percent of all causes of infant death, and respiratory ailments for 2.4 percent.⁸

6) Ill-defined Causes: In addition to the aforementioned causes of death, there is a residue attributed to ill-defined causes (10.1 per 100,000 in 1995), with the largest and growing incidence occurring in the Central American isthmus, a growth from 19.1 to 32.9 per 100,000. An observation of these numbers suggests that the widespread decline of health services in Central America (with the exception of Costa Rica) means that numerous causes of death, especially violent ones, go unreported.

B. The Incidence of Diseases

Morbidity is a complex combination of many bacterial and viral strains, including “old” (cholera, malaria), “new” (HIV, Hanta), and reemerging ones (*Yersinia pestis*, Yellow Fever⁹), as well as a multitude of harmful disorders. The latter include metabolic and nutritional deficiencies, cardiovascular diseases, cancers, diabetes, addiction (alcohol, tobacco, and drugs), psychopathologies, and social pathologies (violence). Some diseases are vector-transmitted (malaria, Chagas, schistosomiasis, dengue and hemorrhagic dengue¹⁰), mainly by insects. Others are contagious but immuno-preventable (diphtheria, whooping cough, tetanus, poliomyelitis, rubella, hepatitis and meningitis). Some are intestinal infections, usually associated with water and food contamination and poor hygiene, such as cholera and intestinal parasitosis. Others are chronic-transmissible (tuberculosis, leprosy, zoonosis). Finally, there is the threat of AIDS. PAHO has listed five major diseases with an impact upon the region: a) measles, b) cholera, c) tuberculosis, d) malaria and e) AIDS/HIV. To these, the Chagas disease (*Trypanosomiasis americana*) must be added. First, we will concentrate upon these morbidity factors; subsequently, we will focus attention on non-contagious ailments and their trends that affect significant sectors of the population.

C. Transmissible Diseases

The following list, though not exhaustive, covers most of the reported cases of some significance, including outbreaks of measles, cholera, tuberculosis, malaria, HIV/AIDS, and Chagas.

1) Measles: Between 1980 and 1999, the incidence of measles declined dramatically, from a near epidemic of 224,382 cases to 2,973. Effective and massive preventive programs (especially immunization), coordinated by WHO/PAHO and carried out by public health agencies in each country, largely accounts for the 98.7 percent decline. This trend is similar to that experienced with other infectious and communicable diseases: “In the period [1980 – 1994] polio was eradicated, deaths by whooping cough and diphtheria...disappeared and tetanus and measles have been controlled.”¹¹

2) Cholera: A similar trend is observable in the case of cholera. In 1991, the peak year of the most recent epidemic, there were 396,533 cases reported. In a six-year interval, there were 1.2 million cumulative cases reported. By 1997, however, the number had dropped to 8,120, concentrated in Central America, Brazil, and the Andean region. The 1991–96 epidemic deserves special attention. Cholera had reappeared after nearly a century, laying bare the precarious living conditions of a great part of the population and causing 12,000 deaths during its reign. Early attempts at control proved unsuccessful. At the end of 1991, it had extended to fifteen countries, from Mexico to Chile. At its peak, there were more outbreaks of the disease in the LAC region than were reported in all of the rest of the world in the previous five years. A persistent endemic pattern emerged in which the disease reproduced and expanded in the midst of deteriorating sanitary standards and falling public health expenditures that resulted from newly imposed policies of Structural Adjustment of the state sector and reduced funding for social programs. Cholera was clearly driven by poverty, but also posed a serious, albeit not lethal, threat to the more affluent sectors of society. The elite depended upon domestic labor and food manipulation often performed by people coming from the poorer and more exposed neighborhoods. This episode played an important role as a warning and in the development of subsequent preventive measures to control diarrhea and infectious intestinal diseases, whose effects have been felt throughout the health system. Cholera still persists as a dormant but periodically reemerging threat whose comeback depends upon misguided policies.

3) Tuberculosis: Unlike the previous two diseases and despite a relatively smaller incidence in the population, TB still presents a serious health risk. With a growing number of cases, 195,748 in 1980 and 223,855 in 1999 (a 12.6% increase), it is the second principal ailment, displacing measles and cholera. If we look at tuberculosis in relation to population, however, the incidence has declined. Nevertheless, given the pernicious nature of the disease and its ability to linger, it presents a much more serious health problem than the above-mentioned diseases. Furthermore, given a growing incidence of resistance to antibiotics in cases of tuberculosis (as is the case with resilient malaria and pneumonia), the potential dangers of uncontrolled outbreaks are a considerable concern.

4) Malaria: Malaria constitutes a real and present danger to the health of the LAC region. While measles and cholera have ostensibly declined, and tuberculosis is not expanding faster than population, malaria has been one of the diseases with an upward curve, from 526,777 cases reported in 1980 to a whopping 1,171,915 cases in 1999. This represents not only the largest morbidity factor, but also one that is extending at an alarming rate, 123 percent in 20 years, or 6.5 percent per annum. It is distinctively a disease that affects LAC, with a heavy concentration in Brazil, the Andean countries, and Central America. In Brazil alone, with over 50 percent of all the reported occurrences, it has grown three-fold (233%), from 176,237 cases in 1980 to 585,769 in 1999. In the Andean region, the rate has climbed even more dramatically. It has expanded four-fold in 19 years, with an index of 342 percent in 1999 over 1980. The pro-rated rate of growth is 18 percent per year, from 85,724 to 379,271 cases between 1980 and 1999.

There are a number of intertwined epidemiological factors — compounded by population movements, environmental conditions, social and demographic instability, patterns of social behavior, and access to diagnostic and treatment centers — accounting for this spate. In the first place, the *parasitum falciparum* responsible for the disease dwells in tropical zones and in swampy areas, being transmitted by mosquitoes (its main vector). According to a 1993 – 96 estimate, this is where between 39.2 and 37.9 percent of the population lives. In total, out of 452 million inhabitants in the LAC countries, over 48 percent reside in areas of high to medium risk and only 29 percent live in areas of little or no risk, mostly in the Southern Cone. While 21 out of 33 countries were located in active malaria transmission zones, not all of them had active programs of control and eradication. The disease has also shown ever-stronger signs of resistance to treatment and preventive vaccination. (Vaccines are said to be effective in about one-third of the cases.) To exacerbate the problems, “drastic budgetary reductions pose a grave limitation in the fight against malaria,” from U.S. \$185 million region-wide in 1980 to 85.7 million in 1996.¹²

5) HIV/AIDS: As in the rest of the world, HIV/AIDS is one of a relatively new strain of viral and communicable diseases to strike the population.¹³ The first reported cases of the mysterious immune deficiency syndrome were in 1981. Ever since, it has grown steadily to become the fifth leading source of infirmity in the LAC countries. Given the so far incurable nature of HIV — which almost inevitably

matures into full-blown AIDS—and its growth pattern, it constitutes a most menacing threat to life and health, well beyond its current incidence in the population. Accurate figures are hard to obtain, given the social stigma attached to the disease. The official number of cumulative AIDS cases up to 1991 was reported to be 85,576. Estimates for 1997 put the figure of adults and children living with HIV in Latin America in the range of 1.3 million, with possibly another 360,000 in the Caribbean.¹⁴ In 1995, there were 31,699 new cases in LAC. Two years later, the figure was 40,867. This is a growth rate of almost 29 percent, a staggering 7.25 percent per annum. If this rate continues unchecked, within one to two decades it could become the number one morbidity and mortality factor in the region. The HIV epidemic in the Americas is very diverse. The Andean countries and Cuba are apparently among those least affected by HIV infection in contrast to several Caribbean states that have been severely hit by the epidemic. By the end of 1999, over 5 percent of adults between 15 and 49 were HIV-positive in Haiti, and in the Bahamas, the adult prevalence rate was over 4 percent.”¹⁵ The impact of HIV/AIDS on potentially lost years of life was 1.1 percent of the index for all diseases and 6.3 percent for the infectious diseases. The direct economic cost of the epidemic, over and above the human drama, was estimated to be over U.S. \$2 billion in 1999 alone.

As indicated, the disease is heavily concentrated in parts of the English-speaking Caribbean, with a major incidence in the Bahamas (891.3 per 100,000), Barbados (290.8), Trinidad Tobago (199.9), Belize (88.4), and Jamaica (86.8), whose indexes are closer to the U.S. (225.3). The exception is Cuba, with a reported index of 5.4, one of the lowest concentrations. Brazil has the largest concentration of numbers in Latin America (20,295) as well as a morbidity index of 69.4 per 100,000 in 1997. AIDS contributed 2.6 percent to the PYLL in the country for 1999 (3.2 for men and 1.5 for women). Among the Brazilian population aged 30–39, AIDS was the fourth major cause of death among men and the fifth among women.¹⁶ In the region at large, the disease has become the number one killer among men 30–39 and the second among women in this age range. Unlike in North America, where the predominant factor in the spread is sexual contact among homosexual males, in the LAC region, AIDS is transmitted in about 70 percent of the cases by heterosexual intercourse, which results in a greater velocity of propagation and also leads to HIV-positive children.¹⁷ In recent times, HIV/AIDS has begun to concentrate in socially vulnerable groups,

especially newborn children of AIDS-infected mothers. It has also moved from urban to rural and aboriginal settings, a trend also noticeable with regard to potentially curable sexually transmitted diseases.¹⁸

6) Chagas: Distinctively a New World and specifically Latin American affliction, Chagas disease has debilitating and in some cases lethal effects. In the last decade, between 23,000 and 43,000 people have died annually from it. By 1980, without factoring in Mexico and the Caribbean, there were some 15.8 million people infected and another 90 million at risk. By 1990, it was estimated that perhaps 16 to 18 million people were infected, while another 100 million remained at risk. This makes it a lingering problem of epidemic proportions, yet scantily recorded. Its active agent is the *trypanosome cruzi*, which seems to have developed resistance to treatment. The ailment has a strong incidence in rural and peripheral urban populations, and especially in those without appropriate dwellings. Its main vectors are insects, though transmission also occurs via transfusions and through heredity.

D. Non-Infectious Diseases

The predominant ailments in this category are those associated with genetic and degenerative conditions, environment, and lifestyle. To inventory these is beyond the confines of this essay; however, we will concentrate on the most common contemporary diseases. They include the already discussed main causes of death, such as cardiovascular and circulatory illnesses, cancer, diabetes, psychosocial ailments (for instance, substance abuse and violence), and mental illnesses.

1) Cardiovascular Afflictions: Not only the primary cause of death for men and women, cardiovascular diseases are also the most common, growing, and incapacitating maladies in LAC, though no official morbidity figures or estimates exist. They are closely correlated with four major contributing factors, all associated with “modern” lifestyles: high cholesterol diets, stress and diet-related hypertension, a sedentary life, and the consumption of tobacco.

2) Cancer: Cancer is the second most prevalent non-transmittable disease in the LAC region, yet, as with cardiovascular ailments, there are no official calculations. Its incidence is growing, particularly among those between 25 and 30 years of age, especially women. Some

preliminary statistical analysis suggests that it is associated with aging and increased risk factors (diet, smoking, and especially environmental causes). For men, the main forms of malignancy are lung, digestive track (esophagus and stomach), and prostate. In the more developed countries, lung cancers prevail over those of the digestive track. In women, the predominant forms are cancers of the digestive track (colon and rectum), breast, and uterus.

3) Diabetes: Diabetes is an equally fast growing ailment. Diabetes refers here to both Type I and Type II; the latter connected with dietary habits and lifestyle (and the recent marked trend towards obesity, especially among the poor). It has been estimated that the population suffering from Type II diabetes increased from 11.3 million in 1994 to 14 million by 2000. In the same period, the incidence of Type I (the group with the highest life-threatening risk), expanded from nearly 13 million to almost 17 million. In the ten years between 1985 and 1995, diabetes grew exponentially: 126 percent in the Andean region, 113 percent in Brazil, 107 percent in Mexico, and 44 percent in the Southern Cone. In comparison, the incidence in English Canada also increased by a staggering 147 percent over the same decade.

4) Substance Addiction: Addiction is an underlying health risk factor as well as an ailment in itself. The sources of addiction include "hard" drugs (cocaine and heroine), marijuana, tobacco, and alcohol. Although LAC is a drug producing and exporting region, in comparison with North America, the habitual consumption of heroine, cocaine, and marijuana is much smaller. A partial study, based upon several surveys between 1991 and 1997, indicated an annual propensity for marijuana consumption to be between 7.4 and 8.5 percent for Canada and the U.S. with a spread of 0.5 to 4 percent in Latin America. The propensity was even smaller regarding cocaine use. The U.S. was once again the main user, with 1.7 percent, versus the rest of the region (Canada included), with less than half this rate. The spread was between a high of 0.8 and 0.7 percent for Chile and Canada to a low of 0.2 percent for Bolivia, Mexico, and Costa Rica.

More significant is the problem of alcoholism, one that compounds physiological malfunctions, such as cirrhosis of the liver, and interpersonal violence. It has been suggested that between 6 and 8 percent of the LAC population over 12 years of age are alcohol dependent and an additional 10 percent drink to excess. According to estimates, problem

drinkers constitute as much as 35.6 percent of the male population in Chile and 12 percent in Colombia.

In spite of the general downward trend of an addiction that had epidemic proportions in the 1980s, there is still a tobacco consumption rate well above that of North America. Besides its addictive properties, tobacco has a direct affect on generating or aggravating respiratory afflictions (bronchitis, asthma, emphysema), heart disease, and lung cancer, especially among men, who are its major users by a ratio of nearly two to one. A comparative study of twelve countries, based upon national reports between 1991 and 1996, indicated that the propensity for habitual tobacco use oscillated between a high of 40.4 percent (Chile) and a low of 17.5 percent (Costa Rica). A similar study on the estimated prevalence of consumption among men and women in seventeen countries put the Dominican Republic, Bolivia, Cuba, and Peru at the top of the rank, with Canada, the U.S., Paraguay, and the Bahamas at the bottom.

5) Violence: The intentional use of interpersonal and collective force resulting in bodily harm should also be considered a psychosocial pathology, accounting for heightened levels of health and human insecurity. Between 1984 and 1994, the proportion of the mortality rate due to violence soared from 3.5 percent to 18.4 percent, on the average. Indexes of violence are strongly associated with growing criminality, worsened socioeconomic conditions, unemployment, and civil strife. Also, violence feeds on itself. In the Andean region (especially Colombia), it jumped from an already high 25.2 percent to 51.9 percent. In Colombia, there were three times more homicides in 1997 than in 1984, a time when homicide was already the principal cause of death. In the same period, violence also increased dramatically in Brazil (44%). Though there are practically no available statistics, injuries caused by violence are thought to occur between ten and twenty times more frequently than deaths by violent acts. In this context, some parts of LAC are going through a true epidemic of violence with deleterious effects upon the physical and mental well-being of its inhabitants.

6) Mental Illnesses: Mental illnesses have not been systematically reported for the region as a whole. Several case studies, however, point to a problem of high magnitude and one to which no country is immune. According to a 1998 PAHO study, affective disorders and schizophrenic psychosis exhibited an annual incidence of 1.1 to 4.1

percent of the LAC population, of which 3 to 5 percent were serious disorders requiring professional attention. A Chilean survey indicated that 33 percent of the sample had had episodes of mental or psychosocial disorders, with depression and alcohol dependency being common among men, and depressive states and simple phobias among women. The World Bank estimated that as much as 8 percent of the years of lost life resulting from disabilities is attributed to ailments such as alcoholism, depression, Alzheimer's disease, psychosis, or schizophrenia. This is a much higher incidence than of cancer (5.2%) or cardiovascular diseases (2.6%). The same PAHO study went on to maintain that "there is an inverse relation between socioeconomic strata and the aggregate rate of [mental] disorders: the lower the level, the higher the rate of disorder."¹⁹ The greatest risk obtains within indigenous populations or within those groups who suffer uprootedness or civil strife. Permanent insecurity, alienation, depression, stress, and anguish are closely connected with persistent economic, social, and political turmoil. These traits also reflect a context in which life is both meaningless and precarious, and where social pathologies are culturally reproduced.

E. The Multipliers of Health Insecurity

The health system transcends the boundaries of disease and its management. It is more than medical-technological interventions for the protection and restoration of health. Furthermore, wellness depends upon a number of economic and social circumstances. Health risks, like most other negative contingencies, are not evenly distributed throughout a population; rather, they tend to concentrate in high-risk groups. Though the risk profile of any country or group varies with the nature and intensity of the ailment, there are some people who are persistently at risk in the hemisphere. These tend to be the most economically, socially, and politically vulnerable: poor children, women, the elderly, and native communities. Health risks, including life-threatening ailments, in shantytowns or in rural areas are several times higher than among well-to-do, white urbanites. These conditions — including inadequate housing and sanitation, perilous location, contaminated water, and a host of environmental hazards — also increase the probability of infectious disease, respiratory afflictions, and external health risks (accidents, violence). They are compounded by the inaccessibility of quality and affordable health care, the high cost of

medicine relative to income, and food insecurity. Thus, as the cholera epidemic of the 1990s clearly suggests, there is a vicious linkage between deteriorating sanitary conditions, poverty, morbidity, and mortality. For this reason, populations at risk are more likely to die or become incapacitated as a result of otherwise non-lethal infirmities than the population with access to these amenities.

The general sources of health insecurity, namely mortality and morbidity, reflect a combination of specific underlying problems, such as marginal socioeconomic conditions, preexisting or lingering health hazards, prevailing epidemiological patterns, population movements, and transmission vectors. They also reflect financial stringencies, a huge external debt, insufficient foreign exchange to acquire imported inputs, restrictive conditions in the international arena, lack of autonomous scientific and technological capacity, and organizational and managerial limitations. The externally induced conditionalities contained in Structural Adjustment policies (attached to debt relief packages) play a significant role, too, as downsizing, privatizing, outsourcing, and deregulating impact negatively upon health delivery and overall social policy. These interconnected socioeconomic and environmental factors can be grouped into six contextual variables: housing, sanitation, a clean environment, education, food security, and employment. Their common denominator is income distribution. Nevertheless, the most immediate intervening variable affecting health security and insecurity is public policy. This includes much more than the institutional definition of "health policies" directed from and toward the specific health-delivery sector, but also a myriad economic, fiscal, educational, taxation, and broader "social" and development policies. It is largely the application of these policies that has a deleterious environmental impact, which in turn negatively affects the health of a population. Needless to say, behind all policies there are alliances of diverse sociopolitical interests (including external constituencies) with agendas, ideological discourses, and strategies, all competing for control of the state. Different socioeconomic groups and their political brokers will form alliances to defend their interests, articulate these interests in ideologies, and compete and coalesce to control the state. Once in control, they will try to implement their ideologies in the form of public policies. These policies have an effect on the creation and distribution of public goods and liabilities; in our case, well-being.

1. The Socioeconomic and Environmental Setting

Underneath the oft-repeated characterizations of “underdevelopment,” the overarching issue of the health crisis is poverty. Poverty has many more facets than low income per capita. It refers to questions of distributional inequity, powerlessness, environmental deterioration, and a bad physical quality of life. Substantively, it means marginalization, contamination, hopelessness, and substandard conditions in housing, sanitation, food security, education, and employment, all of which increase health insecurity. According to a report by the U.N. Economic Commission for Latin America (CEPAL), published in 1994, almost 40 percent of all households (comprising over 200 million people) lived below the poverty line. The impact of the 1981–1991 “lost decade” and the subsequent neoliberal “stabilization” policies have accelerated economic concentration at unprecedented rates, reflected in income differentials jumping from thirty-to-one in the 1960s to over seventy-to-one by the end of the 20th century.

Housing has been qualitatively and quantitatively insufficient in most countries, including those with relatively higher per capita income and ranking relatively high in the Human Development Index. Yet, there are marked differences between countries like Argentina, Uruguay, Chile, Cuba, and Venezuela, with a higher proportion of housing deemed “adequate,” and the lowest group consisting of Bolivia, El Salvador, Guatemala, Nicaragua, and Peru. PAHO’s 1999 report, a study of dwellings in Latin America that used census data from 1981 to 1993, indicated that about 37 percent of the units were marginally suitable for habitation (requiring substantial repairs) and 23 percent were clearly irrecoverable. Both PAHO and the Latin American Center for Demography (CELADE) have noted that deficient housing and living facilities significantly contribute to premature mortality, especially infant mortality. A Costa Rican analysis suggested that infant mortality differentials between families living in inadequate housing versus those in adequate housing were 27 per 1,000 for the former and 16 per 1,000 for the latter, a 69 percent difference. In 1994, it was estimated that throughout the region there was a growing housing deficit of some 20 million units; this after three and a half decades of largely fruitless attempts at dealing with the issue. This failure has been emblematic of the inadequacy of development planning, cooperation, and investment in the region.

The bulk of inadequate housing is located in rural areas and in urban shantytowns, where the population with a greater risk of contracting transmissible diseases affected by their environment is concentrated. This is especially the case regarding vector-transmitted strains like Chagas, malaria, Dengue, and Yellow Fever, and to other diseases such as gastrointestinal and respiratory ailments. These populations also have the highest propensity for accidents and casualties resulting from natural and other calamities like earthquakes, landslides, flooding, hurricanes, and fires. The inadequacy of materials for flooring, roofing, structures, and walls, and the lack of proper ventilation and protection against insects contribute to hazardous conditions. In addition, some of the materials themselves (like asbestos, used in even some substantial dwellings), and gas or electrical lines play a direct role in perpetuating health risks.

Inadequate sanitation correlates strongly with inadequate housing, but even many adequate houses suffer from inappropriate sanitation. According to PAHO, a 1995 study found that 73 percent of the population either had water piped directly to their dwelling or could have easy access to public sources. However, in the rural areas, this ratio was only 43 percent. Additionally, in spite of the fact that over 80 percent of urban inhabitants could obtain water, the water quality was extremely low, with only 59 percent of the water being disinfected in any way (not to mention the unreliability of services). In 1995, over 70 percent of the population had access to sewer services, with a rural-urban split of between 40 and 80 percent.

Environmental threats include sewage, waste, and air pollution, but also encompass a broader complexity and multiplicity of reciprocating issues. The record of environmental calamities in LAC would be too long to discuss; furthermore, it has been treated in an earlier essay.²⁰ Nevertheless, a number of general observations derived from that study are germane to health insecurity. The current environmental situation is one of retro feeding and multiple dysfunctions, producing a chain of vulnerabilities. Current industrial, mining, and agricultural practices, mixed with uncontrolled urbanization, produce an interwoven pattern of biophysical and social stress, with deleterious effects on health conditions.

There are massive problems in sewage treatment. For instance, in Santiago, Chile, until 1997, over 80 percent of the residual water from homes and industries was discharged into irrigation canals, which subsequently were used by the green belt around the city where the

bulk of vegetables for consumption were produced. A similar situation has been observed in Mexico. Discharge of pollutants into lakes, rivers, and streams has affected the delicate balances in riverbeds and coastlines, contaminating fish and mollusks. In oil-rich, mining, industrial, and pulp paper producing areas, rivers have become dumping pools for heavy chemical substances, including mercury and arsenic. While garbage collection appears, on the average, adequate for about 90 percent of the LAC population, this is not the case with its final disposal. Its coverage extends to only 57 percent of the inhabitants. Mixed with such disposal, there is the issue of biological, industrial, and nuclear toxic waste dumped into public and illegal sites, and finding its way to people, dwellings, and water supplies (as in São Paulo in 1995). Air pollution and acid rain are also two persistent and related environmental features, causing vegetation and lakes to die of pervasive hyperacidity. In the two mega-cities, Santiago and Mexico City, as well as in São Paulo, Brazil, air pollution from exhaust emissions and carbon particles has created a situation of almost perpetual emergency. This latest threat affects everybody, irrespective of social standing, especially children and the elderly, who experience an unusually high incidence of asthma and other respiratory afflictions.

Deforestation in LAC accounted annually for roughly 41 percent of the total global loss of forests in the 1980s. On a per capita basis, this makes Latin America the main contributor to “green” depletion. The effect of massive deforestation on biodiversity, compounded by the encroachment of genetic homogeneity brought about by the Green and biotechnological revolutions, has been dramatic. Furthermore, southern South America has the dubious notoriety of being the region most directly affected by increased exposure to solar and cosmic radiation resulting from the ozone “hole” in the atmosphere. (This hazard results from Northern use of fluorocarbons.) The long-range health effects of this phenomenon are yet to be fully evaluated. What is less ambiguous is the overall malignant impact of these trends on environmental sustainability and their linkage to the health of biosystems.

Food insecurity, or the failure to attain and maintain adequate nutrition and access to appropriate diets and food supplies, undermines the health of a population. Though nutritional standards and food security in general improved after the catastrophic “lost decade” (1981–1991), at the end of the 20th century, there were still about 55 million people, or 11 percent of the population, who were clearly undernourished. By contrast, North America had an estimated 5.1 million people in this

condition, a stable 5 percent in the same 19-year period. Though between 1979 and 1992 the proportion of undernourished people in LAC remained at 13 percent and dropped subsequently, the aggregate figures fail to reflect the dramatic situation in most countries. This is because malnutrition in larger countries, like Mexico, Brazil, and Argentina, was either stable or went down, affecting the average trend. Also, the depth of undernourishment, or “food deficit,” is often neglected. This refers to the difference between the average caloric intake of undernourished people and the minimum amount of dietary energy they need to maintain body weight and undertake light activity, or simply maintain minimum levels of health.²¹

An examination of national figures indicates that the debt crisis of the 1980s had a deleterious effect in most countries, with high increases in malnutrition between 1979–81 and 1990–92. The relative recovery of 1996–98 brought back nutritional levels similar to—but in one-third of the cases lower than—those in the pre-recession era. The Dominican Republic, Haiti, Jamaica, Trinidad and Tobago, Guatemala, Nicaragua, Panama, Guyana, Uruguay, and Venezuela were, in fact, worse off after the recovery than in the pre-1979 period. Though the aggregate situation appears to be improving, and some optimistic estimates indicate that by 2015 and 2030, malnutrition may go down to 7 and then 3 percent, respectively, the fact remains that now there is a persistent situation of food deficit and insecurity that negatively impacts all aspects of health.

When food availability is seen in relation to the caloric intake of the undernourished population, the picture is even more gloomy. Most countries, with the exception of Argentina, Uruguay, Chile, Ecuador, and Costa Rica, present deficits well over 10 percent of the minimum daily energy requirements of the population. This means hunger. It should be borne in mind that, while food availability is a function of production and output, actual consumption is a function of disposable income. Once again, poverty emerges at the heart of human insecurity. Three facts must be added to the complexity of the food equation. The first is that as of the 1980s, most countries had become net food importers. Second, these imports are contingent upon foreign currency reserves and a favorable balance of payments, as well as terms of trade. Third, food accessibility is affected by price instability, namely, inflation. In the case of inflation, a common feature of the LAC economic landscape, the poor are hit either way. On the one hand, rising prices of inelastic food commodities primarily affect those with lower

incomes. On the other hand, stability in the current fiscal atmosphere means persistently high food prices, which the poor can ill afford. Seen from this optic, the food situation is by far more multifaceted and less optimistic than the FAO projections indicate.

According to most analysts, education — especially basic literacy skills— is a crucial factor in the promotion and maintenance of health. Tertiary education is also critical as it promotes the development of health-related scientific and technological systems. While exhibiting a literacy profile (87.2%) lower than that of North America (99%) and the other OECD countries, LAC is relatively well-endowed vis-à-vis the rest of the Third World. The rate of the increase in literacy is also steady (0.5 compounded per annum). The trend in primary education closely correlates with a generalized expansion of secondary and tertiary education. However, the various sub-regions and countries therein present marked differences.

At any rate, education per se is not directly a predictor of better health or generalized well-being. The important contribution of education to health is the extent to which it facilitates empowerment, acquisition of know-how, and the ability to affect policy. Ivan Illich's and Paulo Freire's distinction between schooling as mere domestication and education as the practice of freedom is crucial. Most education, with very few exceptions, is traditional and formal, of the "banking" variety, and certainly not a device to bring about active change. This is also applicable to university education, which most immediately affects the formation of health-related researchers and practitioners. By and large, tertiary education in the LAC region is derivative and imitative of intellectual vogues, some already bygone, generated in European and U.S. academic centers. The propensity to copy intellectual trends has affected the nature of research, or rather lack of it, and the prevailing mold of professional training.

The economic climate has an impact on both health conditions and health delivery. In general terms, the LAC economic "disease" is the persistence of a weak and unstable pattern of economic growth. Even when growth occurs, it presents a manifest tendency toward boom and bust cycles, typical of commodity-exporting states. The LAC economies are subject to a historical deterioration in the terms of trade (the ratio of the value of exports to the value of imports), which makes it extremely difficult to generate the conditions for self-sustained, high value-added development. This means that growth ratios fail to translate into economic development, let alone employment or a better

quality of life for most inhabitants. A problem with this kind of economic order is that most countries' comparative advantages are based upon massive exploitation of the wage sector and environmentally damaging practices even more than on the endowment of natural resources or the utilization of abundant capital or new technologies. This has two fundamental implications for the regional political economy. One is that "productivity," *ceteris paribus*, rests directly upon the extreme exploitation of labor: a low-wage economy sustained by political repression. The second implication is that the dominant mode of development is environmentally destructive, in the long run unsustainable, and hazardous to ecosystemic and human health. These two characteristics are congruent, with extremely unequal and growing disparities in income concentration, not to mention wealth. They are also congruent with the high degree of the economies' dependence on external markets, capital, and corporate control, in which local "comprador" elites are the intermediaries and beneficiaries of a system of centripetal accumulation of capital. To all this is added the presence of a permanent debt "crisis," to which both public and private sectors have contributed. International statistics have persistently shown that, for the last two decades, the most indebted countries in the world have been in Latin America and the Caribbean.²² In turn, this high indebtedness, though more "manageable" during the last decade than in the 1980s, sets the parameters for debt-relief packages formulated by international financial institutions, which carry stringent conditionalities that dramatically affect wages and services to the needy.

Under these circumstances, the income levels of working people, including the white-collar middle classes, are generally depressed, so that their purchasing power and access to goods and services is extremely low. This is of particular importance to health coverage, accessibility, and quality. With a deteriorating environment, budget cuts and the privatization of the public sector converge. The result is simultaneously worse health conditions and a drastic rationing of services. As far as employment is concerned, the low wage economy functions with massive unemployment and, significantly, often hidden or disguised underemployment in the informal economy. By and large, the unemployed have only limited access to public health programs, a circumstance that becomes even more pronounced for the underemployed (including the "self-employed" poor), who are cut off from most social benefits, however meager. Low income also affects health-enhancing conditions like good housing, sanitary facilities, water and

air quality, and overall environmental circumstances. Consequently, a vicious cycle is set in motion whose outcome is generalized health insecurity.

A 1998–99 ILO report indicated that even in the rare occurrence of upward fluctuation in economic performance, these have “not been matched by improved employment. Although overall growth reached 5% in 1997, accompanied by a decline in inflation from very high levels and improved real wages in several countries... unemployment in the region increased between 1991 and 1996, reaching 7.4% in 1997.”²³ Symptomatic of this tendency was the case of relatively “well-off” Argentina, where—after stabilization and Structural Adjustment measures—the rate of economic growth between 1991 and 1997 was 5.8 percent per year. “However, the unemployment rate *increased* between those years, rising from 6.3% in 1991 to a maximum of 17.5% in 1995, dropping to around 15% in 1997.”²⁴ In 1998, of a limited group of only twelve countries where data existed, unemployment rates were 13.2 percent for Argentina and Barbados, 15.2 percent in Colombia, 15.5 percent in Panama, 11.3 percent in Venezuela, 10 percent in Uruguay, 9.5 percent in Peru, 7.9 percent in Brazil, 5.7 percent in Chile, and 3.4 percent in Mexico.²⁵ It should be recognized that increases in unemployment in almost all of the countries have paralleled declines in public expenditures, affecting in particular social security funds, welfare, and health insurance plans. As a whole, Latin America presents the most extreme case of income disparities in the world, a tendency that became even more exaggerated in the last decade. Between 1980 and 1990, those living below the poverty line in LAC *increased* from above 120 million to over 200 million,²⁶ and from 41 to 46 percent of the population.²⁷ Central America has been the most seriously affected by the double impact of concentration of wealth and the spread of poverty: with the exception of Costa Rica, reportedly nearly 80 percent of its inhabitants were unable to access a basic food basket and half of these were destitute.²⁸ According to the same report, in Guatemala between 1977 and 1994, there was an accelerated concentration of wealth and resources,²⁹ with fewer than 2 percent of the landowners owning more than 65 percent of the total farmland. Between 1990 and 1993, after just two years of Structural Adjustment, the poverty rate in Honduras increased from 68 percent to 78 percent of the total population. In Nicaragua, as a result of the contra war and the implementation of austerity measures, in the early 1990s, over 70 percent of the economically active population was unemployed, or underemployed.³⁰ Illiteracy,

which had been effectively reduced to 12 percent between 1979 and 1989, actually *increased* in 1993 in absolute and relative terms. The same was the case with infant mortality, which increased from 50 per 1,000 in the 1980s to 71 per 1,000 in 1991 and 83 per 1,000 in 1993.³¹

2. The Policy Context

The combination of higher educational levels (relative to other underdeveloped areas) with limited opportunities for social advancement (caused by extreme income concentration, scarce job opportunities, and glaring inequalities) makes for a very volatile political environment. Irrespective of the rhetoric of a pretended “democratization” in the 1980s, the dominant political forms in the region are, by and large, “low-intensity” or restricted forms of participation. Either disenfranchisement or outright repression prevails, and the bulk of civil society is excluded. In addition, the reduction of the size and scope of the state, a phenomenon referred to as the “receiver state,” generates an enormous volume of unfulfilled demands and expectations and an underdeveloped public sector. The political process becomes a combination of recurring frustrations, unrest, and virtual rebellion, coexisting with authoritarianism and policy deadlock, which makes both governance and governability extremely difficult. The formulation as well as the implementation of health and social policies in LAC is conditioned by such a constricted framework.

a. Social Actors, Interests, and Alliances

An analytically useful characterization of the stakeholders in the LAC health system has to go beyond formalistic economic and technical labels, such as “users,” “providers,” or “government.” It must address the heterogeneity, complexity, dynamism, and internationalization of concrete social groups and their political representations (or lack thereof) in the shaping and sharing of well-being. Health processes involve not only policy-making and implementation, but also the structuring, transformation, and overall performance of the health system and its governing regime.

The transformation of health problems through decisions, actions, non-decisions, and inactions, entails a form of brokerage between perceived needs among the population and the official sphere where these needs are translated into public commitments and supports (financial,

legal, or material). The relevant actors on the “input” side include organized interests, such as medical and health-related associations (colleges of physicians, and paramedical associations); professional organizations; public health activists; organized labor; peasant federations; and, increasingly, new social movements like aboriginal groups, mass organizations, local NGOs, independent research centers, and advocacy groups for environmental, social, or economic causes. Other relevant actors are institutional groups from within the public sector, private health entities, national and international insurance companies, business associations (including domestic and international Chambers of Commerce), and international organizations. There is also an incipient presence of community health interests. Many actors, such as institutional groups, businesses, and international organizations, perform multiple roles by articulating and promoting their interests as well as by performing various levels of delivery functions within the health system and regime.

An important current trend is the growing alliance of transnational and local actors. This represents one of the major directions of globalization. (The others are regionalization and internationalization.) By far the most powerful interests in the regional health system are the private insurance companies that sell coverage.³² Most of these corporations are either branches of, or have made strategic business alliances with, large international, mostly U.S., insurance consortia, the likes of Aetna, CIGNA, Principal Financial Group, American International Group, and EXXEL. They are also the principal beneficiaries and advocates of privatization schemes throughout the LAC countries.

Since the mid-1990s, U.S. managed-care organizations and investment funds have rapidly entered the Latin American market. The exportation of managed care has been linked to privatization and cutbacks in public-sector services; international lending agencies such as the World Bank and the International Monetary Fund usually will not make additional loans unless these cutbacks have been made. Although privatization does not necessarily lead to the introduction of managed care, the two often occur together and involve the participation of U.S. insurance companies and multinational corporations.³³

The new economic rules, including the provision of services under emerging free trade norms, make this tendency even stronger. The potential Free Trade Area of the Americas (FTAA), the main point on

the agenda of the 2001 Summit of the Americas in Quebec, and the World Trade Organization will be primary rule-making international organizations occupying the center of the global trade regime. Because of the enormous profitability of the health market and the influence of these interests within the neoliberal global economic regime, national governments are at a loss in attempting to resist pressure from international financial bodies such as the IMF, the IBRD, and the Inter-American Development Bank. These financial entities are not above exerting their considerable influence to push, albeit not always successfully, for a redirection of sectorial agencies in the U.N. system, like the PAHO or the WHO, to follow their ideological lead.

Private transnational conglomerates have acquired controlling interests in some of the largest insurance companies in Latin America, as illustrated by the case of Aetna buying up 49 percent of Brazil's mammoth Sul America Seguros, with 1.6 million enrollees. Aetna has also purchased interests in the Chilean publicly subsidized managed care organizations, the ISAPRES, introduced during the military regime. Through the ISAPRES, now bidding in other regional markets and also via joint ventures, Aetna's operations had, by 1999, expanded to Mexico and Peru. The American giant, CIGNA, has also expanded into Brazil, with 2.5 million enrollees through joint ventures, encompassing 1,400 hospitals, 3,800 clinics, and 10,500 physicians. It has branches in Chile, Guatemala, Argentina, and Mexico. The Principal Financial Group is associated with banks in numerous joint ventures throughout Argentina, Brazil, Chile, and Mexico, and also delves into life insurance. The same is true for the American International Group, which has obtained the lucrative right to administer public and private pension funds in Argentina, Chile, Colombia, Mexico, and Peru. Because many countries link pension plans to health care benefits, this strategy has allowed them to have additional capital to expand operations, constituting a model for the development of managed care. Last, but not least, the highly diversified EXXEL Group, incorporated in the Cayman Islands, has aggressively entered the Latin American health care market. It represents a new corporate strategy by redirecting U.S. investments into the region, circumventing traditional reporting requirements or controls by American regulatory agencies. It has acquired three major Argentinean prepaid plans, thus creating the largest managed care organization in that country. It is well-connected in high political circles and, reportedly, has developed plans to enter managed care markets in Brazil, Chile, and Uruguay.³⁴

Resistance to the globalizing and privatizing drives along the lines of ISAPRES has been articulated by heterogeneous national alliances that include medical associations, health activists, NGOs, and popular and community organizations. The key issues have been restricted access to vulnerable groups and reduced spending on actual health services, resulting from administrative costs and return to investors. A related theme has been the increased barrier to care emanating from co-payments that puts even greater pressure on an already strained public system. Intellectually, some of the discourse of the resistance to globalization has been nurtured by the analysis provided by international agencies like the WHO and especially the PAHO. In a sense, the confrontation has centered on two different models, visions, or “cultures” of the health system.

One of these views, congruent with the prevailing market logic, looks at health as an individual-centered commodity, which can be bought, sold, and traded to generate profit. The user is a “consumer” who buys a service to satisfy a need, the quality and quantity of which is a function of the client’s capacity to pay. The other view, dominant among popular organizations, socially conscientious health practitioners, NGOs, and international organizations, looks at health as a human right, which cannot be traded or made a source of individual profit. Here, health is a public or collective good, the provision of which is essential to society’s welfare. This dichotomy is also present with regard to many other valuables, like environment, food, or education. The public debate, irrespective of the existence of “gray” areas, is polarized on one or the other side of commodification. The ability of the various groups to generate viable alliances to control the public policy process conditions the nature of the public options available, and their outcomes. So far, in spite of a generalized rejection of the market health model by large contingents of people in most countries, the odds are overwhelmingly on the side of business, as governments of many stripes have increasingly adopted a neoliberal policy “software.”

Therefore, the commodification of health seems to be here to stay, especially in the new global context. Current public policies tend to give an aura of formal and procedural legitimacy to neoliberal schemes, independent of who sits at the helm of the state. In fact, it seems as if governments in the Americas have moved beyond Duverger’s characterization of “Pluto-democracies” into the realm of plutocracies with popular support. Under this arrangement, a frag-

mented and increasingly powerless and apathetic “public” simply rubber stamps decisions made by transnational oligarchies, the latter possessing the ability to set and alter the rules of the game. In the present atmosphere of limited, “low intensity” democracies and receiver states brought about by an incomplete transition from authoritarian rule, there is little room for substantive democracy, let alone equity-producing policies. Opposition is often trivialized, fragmented, or marginalized by highly concentrated systems of communication and propaganda, whose main function is to manufacture public consent by means of arousal as well as quiescence. Furthermore, most transcendental issues are excluded from public debate, and referred to transnational and non-democratic arenas of decision making. The prevailing development model puts a premium on maintaining a skewed pattern of property, income, power, and well-being, conditioned by market mechanisms that simply reproduce the status quo. This system of cumulative inequalities is at the center of health insecurity in the region.

III. Health Systems and Regimes

On the “output” side, the sets of rules, structures, and practices that govern the creation and distribution of health in LAC involve the juxtaposition of regional, national, and sub-national actors with diverse functions and agendas. At the level of the region as a whole, the most identifiable normative structure is the Pan American Health Organization (PAHO). It is not a policy-making body, yet it is the most ostensible component of a regional health regime for the Americas. It provides for a degree of regional integration in the normative, standard setting, and facilitating spheres. It contributes to strategic intelligence — the analysis, discussion, teaching, and consultation — on regional health matters. In practical terms, PAHO’s contribution is geared more to LAC than to North America. It is also split between two political mandates: that of the multilateral WHO, under the U.N. system, and that of the OAS, under strong U.S. domination. Though this dualism is conducive to paralysis, PAHO has been generally successful as a benchmarking and doctrine-producing entity. Numerous initiatives, such as primary care, maternal and child care, massive vaccination, and monitoring, have found their origins in the agency’s persistent work. In fact, PAHO and WHO have been continuous “global” forces in international cooperation, shaping the nature of health sys-

tems and policies long before the term *globalization* was coined; this despite relatively modest success in policy implementation.

The other global aspect in the health regime is the expanding role of transnational insurance companies in setting the actual agenda of the LAC health system and regime. The importance of this thrust upon the domestic scene is a function of the influence of international finance capital, supported by the main agencies of the global economic regime (IMF, IBRD, WTO, IDB), with the backing of the ruling elites of the two North American countries. Though successive Canadian governments have consistently defended their “compassionate,” publicly-funded health care model vis-à-vis that of the U.S., in practice, their enthusiastic adherence to free trade has generated a paradoxical double standard that undermines the very system they proclaim. On the other hand, American-made “market” health has severe limits in its internal operation, with governments having to yield to pressure from internal constituencies uneasy about unrestricted neoliberal policies. Thus, American elite behavior abroad is by far more extreme than at home, which may account for a proclivity to dump contradictions outside national boundaries.

A. National Health Systems

The operational side of the shaping and sharing of health is firmly embedded in national policies and agencies, namely, national ministries of health and a complex network of institutions (agencies, hospitals, clinics, institutes, policlinics, and dispensaries), all the way to the local level. These organizations are ultimately the main arenas where health professionals and the public interact. Most countries in the region are heavily centralized, even those — like Mexico, Brazil, Venezuela, and Argentina — that have a formally federal system of government. These systems vary significantly in size, coverage, accessibility, quality, personnel profile, financial resources, modus operandi, technology, and levels of effectiveness. They also vary in relation to existing problems and health conditions, as well as in the nature of the specific sociopolitical and policy context. In some countries, like Uruguay, Chile, and Argentina, the evolution of health care, public health, welfare, and social insurance well preceded the emergence of its North American and even European counterparts. These are “old” systems institutionalized in norms, practices, and expectations, coexisting side-by-side with relatively new and often precarious

modalities for health preservation and delivery. Therefore, it is difficult to have a modal national system that characterizes the entire region. Rather, a composite description of national health system profiles and trends can be attempted, looking at health expenditures, coverage, number of physicians and nurses, and availability of hospital beds.

The general regional tendency of the health delivery system over the last twenty years has been, with the exception of the Central American isthmus, one of fast expansion of expenditures on health as a proportion of the GNP (71% in 12 years, or 5.9% per annum). This has occurred despite the fact that *public* health expenditures have tended to either remain stagnant or decline, though with a great deal of variation among countries. Regarding both physicians and nurses, without exception the pattern is one of rapid growth: in the case of doctors, 133 percent in 19 years, or 7 percent per annum. Where the tendency is distinctively stagnant (and at times even regressive) is in hospital beds, reflective of an overall institutional crisis in public hospitals. In the last fifteen years, health expenditures experienced an explosive growth. This was accompanied by a dramatic shift in composition from public to private expenses and a rapid expansion of private insurance schemes.³⁵ A 1995 study of nine countries suggested a pattern of predominantly private, out-of-pocket, and commercial insurance financing that averaged 59 percent. The variation among countries ranged from a maximum 66 percent private to 34 percent public (in the case of Brazil) to a minimum of 13 percent private to 87 percent public (Cuba). Likewise, a comparison of coverage for the best and worst served sectors of society for eight countries, prepared by the International Labour Organization, reveals an extremely uneven picture.

In spite of seemingly salutary indicators of human resources and expenditures, the system as a whole presents distinct weaknesses. One obvious limitation is the extremely low incorporation of locally generated science and technology. While developed countries invest roughly 2.7 percent of their GNP in scientific and technological activities, the LAC figures oscillate between 0.24 and 0.75 percent (between a four- and twelve-fold difference). It is also concentrated in five countries: Argentina, Brazil, Chile, Mexico, and Venezuela (to which the exceptional case of Cuba must be added). While the U.S. invests about 60 percent of all funds spent on health-related scientific production in the world, LAC contributes a paltry 2 percent. This is particularly pronounced in the area of pharmaceuticals. The impact of patent protec-

tion and exclusive rights on this imperfect market has had a very negative effect on the lesser-developed LAC economies, with the countries with already established industries faring slightly better.³⁶ Lack of endogenous research in the health field also contributes to the repetitive and engineering-like programs in medical and health-related schools, such as pharmacology, dentistry, and the like. Other limitations are more institutional in nature. For instance, in English-speaking countries, the ratio of nurses to physicians is much higher: over three to one in the non-Latin Caribbean and nearly four to one in the United States. In Latin America, this relationship is reversed, with a ratio of four or five physicians per nurse. This feature illustrates a significant bottleneck in health care. Health delivery systems in LAC also lack flexibility and adaptability to meet new challenges. The application of Structural Adjustment models and the restriction of public sector expenditures in health have severely diminished the capacity of public institutions to deliver general and comprehensive health care. In many cases, this has resulted in the restriction and even interruption of basic services.³⁷

As the 1999 PAHO report noted, in a sociopolitical setting characterized by both a formal return to democracy and effective social marginalization, profound contradictions for the health system are likely to emerge. On the one hand, this system suffers from a general lack of organicity, an increasing fragmentation, a growing inequality in reaching health attainment levels, expanding corruption,³⁸ and a greater incapacity to serve the public. On the other hand, there is the nearly insurmountable issue of self-government while simultaneously lacking a legitimate political mandate as well as efficacy.³⁹ The consequence of these dysfunctions has been that the region's health delivery mechanisms, though quite large, are increasingly insufficient to meet pressing social needs.⁴⁰

Confronted with a profound and growing accessibility crisis, many popular and community organizations have attempted to develop survival strategies in the context of an ever more "informal" subsistence economy. Some have evolved into new social movements, such as the massive Landless Peasant Workers Movement (MST) in Brazil.⁴¹ These groups emphasize self-help and autonomy through persistent mobilization by means of critical pedagogy and political action. Health improvement is part of a comprehensive strategy of resistance, occupation, and production. Also, an unintentional consequence of the Structural Adjustment-inspired process of localization (intended to

fragment and municipalize national health systems) has been the emergence of community organizations pressing for greater coverage, quality, and accessibility. Community health has been one of the outcomes.

Likewise, in conjunction with mobilization and community organization, there has been a marked resurgence of “traditional” indigenous health practices. These have always been part of “folk” conceptions of wellness, being rooted in Amerindian and Afro-American culture, with their emphasis on the restoration of harmony between the body and its spiritual and natural surroundings. The presence of shamans, *brujos*, *curanderos*, and herbalists has been a persistent trait in the countryside, often blending healing with religious rituals. What is new about this return to tradition is that it has resulted in numerous cases of syncretism in health practices — conventional, homeopathic, and indigenous—forced by economic necessity (e.g., the prohibitive cost or unavailability of services or medications). This has meant the blending of conventional and mainstream Western medicine with indigenous knowledge at the community level, where both kinds of medicine are available in the same dispensary. There are remarkable working examples of this in Cuba and Ecuador, though they have yet to be systematically studied and evaluated on a regional basis.⁴² All these incipient forms of empowerment and experimentation have a potentially important role to play in reinventing a citizen-oriented, not just a client- or user-oriented, public health system. The same goes for the redefinition of “patient” and its place in the health process.

B. Systems’ Goal Attainment and Performance

The WHO’s *World Health Report 2000*⁴³ developed a sophisticated and complex methodology for assessing the performance of health systems, in which the various goals for health systems and their measures were spelled out.⁴⁴ The framework concentrated on several measures, or dimensions, of goal attainment and performance, converging upon a synthetic summary index. These dimensions referred to disability-adjusted life expectancy (as a measurement of the society’s level of health); health equality in terms of child survival; responsiveness (level and distribution); fairness of financial contribution; performance for level of health; and overall health system performance. The ordinal and interval data thus obtained allow for a tentative measure of outputs and outcomes of health security in 191 countries. This model has

been adapted here to assess specifically Latin America and the Caribbean.⁴⁵

Overall health at the national level is measured by the DALE index: life expectancy adjusted by disease-causing disabilities. Distributional health equity is measured by a most sensitive indicator developed by UNICEF,⁴⁶ the equality of child survival up to five years of age. Responsiveness is a perception index, surveying a wide array of practitioners, regarding the ability of the system to meet health challenges. Its distribution refers to the perceived equity of such responses across society. Fairness in financial contribution measures the extent to which people can afford health care above and beyond meeting their basic needs. Goal attainment is a composite index of the previous measures, valuating the extent to which health level and distribution, adequate and equitable responsiveness, and financial fairness are being accomplished. Health expenditure per capita is the contribution of society as a whole (both private and public sector) to health objectives.

The highest composite values for goal attainment entail a combination of life expectancy free of disabilities, a more equitable distribution of survivability for children, and the highest perceived capacity to respond to needs in an equitable fashion and in the most financially fair and equitable way. In Latin America, Chile appeared at the top with an index of 86, over a possible maximum of 100, a slightly exaggerated value. It was followed closely by Cuba (84.2) and Costa Rica (82.5). Uruguay, Argentina, and Mexico also came close to accomplishing systemic goals. The amount of dispersion among countries and clusters of countries was significant, ranging from a low of 62.8 for Haiti to the values mentioned above. As a group, the Southern Cone countries and the English Caribbean exhibited high attainment values. By contrast, Brazil (with 68.9), the largest country in the area, appeared far from attaining an adequate and equitable level of health. By way of comparison, Canada and the United States respectively presented values of 91.7 and 91.1, well ahead of all the other nations in the Americas.

When the comparison focuses on health expenditures (from both public and private sources), the dispersion increases even more. As expected, the U.S. and Canada top the list with \$3,724 (the largest in the world) and \$1,836 per capita per year, respectively. By contrast, the LAC countries range from \$1,230 in the Bahamas to \$80 in Guatemala and \$55 in Haiti. Paradoxically, some of the top goal-attainment countries had relatively modest expenditures: Chile with \$581, Costa Rica with \$498, Colombia with \$507, and particularly Cuba, with only \$109.

An examination of the expenditure figures in relation to goal attainment and performance (that is, systemic efficiency with regard to both the existing level of health and the country's potential) suggests two important traits. One is that there seems to be no strong and direct relationship between health cost or expenditure and service. The other is that size is not necessarily a predictor of efficiency, let alone effectiveness. In health, as in many areas of technology, big is not synonymous with "beautiful." If one looks at the index values for the U.S., the performance of its health system (0.774) is not only well below its potential (as is the case of another giant, Brazil), but also well below its health-level performance vis-à-vis Canada and the top ten LAC countries. Underperformance with reference to existing health levels and distribution as well as low responsiveness and unfairness seem to prevail, especially when costs and expenditures are factored in. This is also the case with overall system performance. With the exception of Colombia, Chile, Dominica, Cuba, and Costa Rica, all systems are well below their current potential to generate and share health.

Furthermore, this systemic comparison leads us to address two substantive considerations not reflected in the figures. One is the extent to which national systems perform and attain health objectives beyond the stated indicators, as is the case with the accessibility of medication. For instance, Uruguay, despite a lesser-structured system than that of Chile, provides for free or highly subsidized medication, while neither Chile nor Colombia do so. Another consideration in overall performance is the extent to which there is a citizen-based system and whether citizenship, rather than "prosperity," is the cornerstone of the public health system. This tradition is still very strong in Uruguay and, to a lesser extent, persists in the exceptional case of Costa Rica, while in Chile it has been substantively eroded.

IV. Conclusion

Health goes beyond medical technology, scientific knowledge, and financial resources, important as they are. It is definitively more than a technical problem of gadgets and "hardware." It refers basically to people and the satisfaction of one of their most valuable needs: the quantity and quality of life. This tentative exploration into the political economy of health security and insecurity in the hemisphere has suggested that well-being involves a complex interplay of biological, environmental, economic, social, political, and cultural factors.

Throughout the various sections of this essay, four major themes have been explored. The first is the meaning of wellness, health, and health security, including the main parameters of the state of health in the region. The second is the identification of the main killers and predominant sources of disease, as well as the most vulnerable, or high-risk, sectors. The third discussion concerns how the various stakeholders address these challenges through health regimes, and the role of culture and science in the maintenance, promotion, and development of health. Finally, there is the impact of globalization upon health security at all levels and how insecurity in the South exacerbates vulnerabilities in the North.

A. Health and Disease

Regarding perceptions of health in LAC, it should be noted that the region, though heterogeneous, is largely within the cultural domain of Western civilization. Therefore, the prevailing views about “wellness” are not too dissimilar from European and North American outlooks. There are, nevertheless, significant variations and discontinuities among countries, regions, social classes, and ethnic groups. The mainstream definition of health is heavily influenced by the medical conception of disease and its treatment, in which health is basically understood as the reduction of ailments and the postponement of death by means of professional, medico-pharmacological intervention. This 19th century positivist ideology is still the hegemonic paradigm⁴⁷ throughout the medical establishment and is reproduced through the curricula in most of the faculties of medicine, pharmacology, dentistry, nursing, and the like.

In the early 20th century, the positivist and largely individualistic conception attached to an “engineering-like” liberal profession was challenged by another view of health that included sanitation, disease prevention, and public health. The *salubristas*, the practitioners of this modality, were inspired by U.S. efforts to eradicate unhealthy conditions and epidemics (mainly in Panama and Cuba in the early 1900s), but developed a distinctively Latin American approach. Between the two World Wars and the late 1940s, they left their imprint on the Pan-American Health Office (subsequently, Pan-American Health Organization) of the Pan-American Union (after 1947, the OAS). Though both conceptions have common roots, even today there seems to exist “a profound epistemological, theoretical and methodological crisis. A

sign of the crisis is that the current conceptual development of public health cannot address concretely the issue of health as such: its object continues to be sickness, the latter treated in a residual and partial manner in terms of 'risks and its factors' "48

This recognition has given rise to a third view. It has partly evolved from the public health tradition and partly from a convergence of social and environmental sciences and health sciences. This is what, for lack of a better term, could be called an "ecosystemic" approach. It is a new perspective, much in vogue in international discourse at the WHO and the PAHO, in which health is seen as an integrated aspect of human security and as a human right, together with education, environmental sustainability, food, and social security.

A fourth and increasingly dominant perspective since the late 1970s is the neoliberal concept of health as a commodity or consumer good, driven by technology and profit, and operating in an increasingly globalized environment. From this viewpoint, the free trade of services facilitates a more efficient allocation of resources, based upon market mechanisms and comparative advantages. This concept gained significant ground through the "market-friendly" reforms induced in most countries by an alliance of international financial institutions, transnational insurance and investment companies, and politico-bureaucratic elites in the North. Many emerging business alliances between LAC, North American, and European interests have also been busy lobbying in the region (and in Canada as well) for the adoption of a "Chilean-type model," using Chile as a "beachhead." This formula entails the combination of ISAPRES (health care management conglomerates similar to American HMOs) and Pension Management Funds (AFPs) that profit from captive markets and ultimately receive financial and political support from governments. The lure of easy money also makes this project an attractive proposition for many health professionals, nurtured by the present imitative and highly "global" professional ethos.

These four views, despite their divergent intellectual and ideological traditions, represent both modern *and* conventional (or nearly conventional) approaches. As mentioned earlier in discussing shrinking accessibility and the health-delivery crisis, Latin America and the Caribbean and even North America present syncretistic adaptations of "holistic" Amerindian and African traditions coexisting side-by-side with conventional health cultures. In these, the "biological" health situation is inserted in a context in which sickness and illness receive care and attention, but in which social, cultural, psychological, symbolic,

and spiritual “realities” intersect. The reemergence of these traditions and their amalgamation with some forms of conventional practices appear to correlate with a breakdown of the financial foundations of the current health system.

Assessing the state of health in the region, the record of disease in LAC constitutes a complex pattern of ailments, both contagious and non-contagious, intertwined with socioeconomic multipliers and accelerators. At the center of these health conditions is the fact that economic and social circumstances (in one word, poverty), facilitated by current development policies, present a higher personal and systemic health risk than diseases, strictly speaking. Any assessment of the health crisis must start by recognizing the interconnectedness of health risks, socioeconomic and political inequities, and the environmental unsustainability of current development strategies.

B. Threats and Vulnerability

The principal sources of disease and life-threatening afflictions have tilted heavily and with very few exceptions (like tuberculosis, malaria, and HIV) from infectious to non-infectious diseases. Among these, “modern” cardiovascular afflictions and cancers are gaining prominence in the regional pathological profiles. But there is also a major epidemiological threat gathering momentum. If left unchecked and without major technological breakthroughs, it is likely that within the next decade, AIDS/HIV may become one of the top sources of disease and death in LAC. This may alter trends of the last decades: people as a whole have been living longer, and the dangers of women’s death at childbirth and the once pervasive infant mortality rates have decreased significantly. Despite these improvements, poverty has maintained persistent pockets of extreme vulnerability. These include poor women and children, the elderly, the undernourished, and native communities. These weak links in the health chain threaten the functionality of the whole system. Mutual vulnerability is compounded by limited access to health care resulting from market-imposed rationing. Perhaps the greatest health problem in the region is neither disease itself nor the absence of technology, but instead socioeconomic and political.

C. Health Challenges and Responses

To summarize the argument, in “a general context characterized by political inclusion [formal democracy] and social exclusion, the main risks consist of the growing fragmentation of the health systems, the increasing inequities in health levels and in the access to health services, the great difficulties to govern the system and the loss of effectiveness of such system.”⁴⁹ Furthermore, the “application of economic adjustment models [and] the restructuring of public sector expenditures has generated a reduction in the ability to supply [health] on the part of government institutions and, in many cases, the limitation and interruption of some basic public health services.”⁵⁰ Largely as a consequence of self-destructive policies, health systems and their delivery mechanisms are in crisis in most countries in the region, even those hailed by the World Bank and Northern institutions as “models” to be emulated. Popular responses have been localized and basically unstructured. In many places, however, massive protests, combined with survival strategies at the community level, have suggested new vistas with which to approach health issues.

An examination of both attainment and performance in the LAC health systems suggests that many countries have shown imagination, financial efficiency, and effectiveness in managing their own health problems — far greater than in some developed countries. This has been the result of long established traditions in numerous places, and not simply the unrestricted adoption of technology and imported models. “Hard” science and technology are important drivers in the improvement but they are far less significant in the aggregate than the “soft,” organizational, managerial, financial, and policy-making implicit technologies that underpin the medical, engineering, and pharmacological “gadgets” essential for health maintenance and recovery. True, there is a large and expanding scientific and technological gap, but the biggest and paradoxically more manageable gap is political, organizational, managerial, and institutional. Most importantly, many efforts at improving health tend to ignore the importance of capacity building and citizen participation.

D. Globalization and Regionalization

The main impetus of globalization has come from elite groups—business and government—to create a wider area of the Americas as a

mechanism to enhance Northern economic, military, and political interests. The ideology of free trade essentially means the ability of capital to move unperturbed across national boundaries. There is a remarkable and unfortunate continuity between globalization, neo-colonialism, and “old fashioned” imperialism. It is not an integration of peoples but a plutocratic arrangement to redefine the rules of the game away from domestic democratic controls. This process offers little in the way of improving health conditions, let alone solving the current health crisis in the hemisphere, except for the already integrated socioeconomic elites. While summitry can articulate a formal health agenda, as has already happened,⁵¹ the real goal of the summits has more to do with trade and facilitating elite accommodation than with addressing a people’s agenda focused on the environment, labor, substantive democracy, and, of course, health. The prevailing pattern of scientific and technological development and production makes innovation a prisoner, and an instrument of those who control power and wealth. It is not a panacea to enhance health conditions for most inhabitants in the hemisphere, both South and North. Free trade rules (as defined by GATT and now the WTO, NAFTA, and the soon-to-be FTAA) are not about freer technology diffusion and utilization so that societies can solve their problems. Rather, it is about capital mobility, profits, social control, and the commodification of social values. This type of globalization is intrinsically dysfunctional to health security.

Despite promises and good intentions, the role of international agencies (meaning truly multilateral and not bilateral interests disguised by a multilateral cloak) remains largely ambiguous, rhetorical, and of limited effectiveness. Alternatively, the emergence of new groupings, such as MERCOSUR, offers institutional opportunities for regional health security. Yet, such regional initiatives are marred by false starts and relentless undermining by those who espouse and benefit from globalization. Unlike in Europe, these attempts at regionalization in the LAC countries are extremely timid as far as the development of a regional health security system is concerned. Beyond rhetoric, the bulk of those advocating free trade in the Americas seem to be more interested in merchandising health services than in creating a healthier region, where people can live without the fear of sickness or inability to afford health care.

There is a profound irony here. By putting profits over health, those who feel protected in their high-technology islands of wealth and privilege are, in fact, not only increasing the vulnerability and insecurity of

**Comparative Estimates for the Americas 1997–99:
Economics, Defense, Human Development and Population⁵²**

COUNTRY	GDP p. capita 1999	Growth/ GDP 1999	Debt/ GDP 1999	Inflation (annual) 1999	Defense exp/GDP 1999	Forces per 1000 1999	HDI 1997	Population in 1000 1999
Canada	24,800	3.7	93.0*	1.7	1.6	2.0	0.932	29,512
United States	33,100	4.2	59.3*	2.1	3.3	5.0	0.927	275,636
Mexico	8,200	3.7	33.5	16.6	0.9	1.9	0.786	104,087
Cuba	2,400	6.2	80.0	7.0	5.0	5.1	0.765	11,003
Dominican Rep.	5,500	8.2	28.7	3.0	0.5	2.0	0.726	7,582
Haiti	1,100	2.5	30.6	8.7	0.1 ^a	0.7 ^a	0.430	7,019
Bahamas	14,500	4.0	8.3	1.5	0.1	2.9	0.851	300
Jamaica	3,500	-1.0	57.6	5.9	0.1	1.1	0.734	2,512
Trinidad	11,400	7.0	45.6	2.6	0.1	2.0	0.797	1,359
Guyana	3,700	2.0	193.8	5.0	0.1	1.9	0.701	846
Suriname	5,100	4.0	39.1	21.1	3.0	4.9	0.757	418
Belize	2,800	4.6	38.6	-1.2	2.5	4.3	0.732	242
Guatemala	4,000	3.5	28.6	4.9	7.8	2.6	0.624	12,224
Honduras	2,200	-1.9	83.3	11.6	0.2	1.2	0.644	6,795
El Salvador	2,900	2.6	17.4	0.5	1.1	2.7	0.674	6,179
Nicaragua	2,200	4.0	231.0	10.9	0.9	3.3	0.616	4,816
Costa Rica	7,500	8.3	33.6	10.0	0.5 ^a	2.3 ^a	0.801	3,722
Panama	6,900	3.2	55.7	1.3	0.5 ^a	4.1 ^a	0.791	2,880
Colombia	5,800	-5.0	44.7	11.2	2.9	3.6	0.768	42,400
Venezuela	8,000	-7.2	71.1	23.6	0.5	3.3	0.792	24,238
Brazil	6,300	0.5	40.0	4.9	2.7	1.8	0.739	164,000
Paraguay	3,700	0.0	22.6	6.8	1.4	3.6	0.730	5,639
Uruguay	9,100	-2.5	40.1	5.6	2.6	4.6	0.826	3,264
Argentina	10,100	-3.0	51.2	-1.2	1.9	1.9	0.827	37,300
Chile	12,200	-1.1	50.7	3.3	4.0	5.8	0.844	15,088
Bolivia	3,100	1.1	65.9	2.1	1.7	4.0	0.652	8,140
Peru	4,500	3.8	50.9	3.5	1.6	4.4	0.739	25,916
Ecuador	4,300	-7.0	107.3	52.3	2.3	4.5	0.747	12,884

Sources: ISS, *The Military Balance 2000–2001*; PNUD *World Development Report 1999*.

^a=No military forces; only police and other security forces.

*=The bulk of the U.S., and to a lesser extent Canadian, debt is internal debt, unlike that of the LAC countries, which is foreign debt.

those “below,” but their own as well. The structural violence of exclusion seems to generate a built-in feedback loop. As the cholera epidemic of the 1990s, the expanding threat of AIDS, and the persistence of diseases resisting conventional treatments remind us, in an integrated biosystem, the security of the whole is not a matter of building technological fortresses. Instead, security rests in the recognition that there are links of mutual vulnerability between the seemingly stronger and the weaker components of such a system, and that North America

will remain at risk for as long as poverty, inequality, and powerlessness persist in the Southern hemisphere.

There is an urgent need to rethink health security in the Americas from the vantage point of reducing mutual vulnerability and strengthening collective well-being. This means the construction of a security community in all its interrelated levels — regional, national, local, household — and dimensions. The constitution of such a community traverses the redefinition of an *accountable* regime with a strong civil society, effective citizenship, critical awareness, and democratic vigilance. ●

Notes

1. The term *paradigm* has been used in the sense given it by Thomas Kuhn, *The Structure of Scientific Revolutions*, 2nd ed. (Chicago: University of Chicago Press, 1970), pp. 15–17, as an implicit body of intertwined theoretical and methodological beliefs that permit selection, evaluation, and criticism.
2. Organización Panamericana de la Salud, *La Salud en las Américas I* (Washington, D.C.: OPS/PAHO, 1999), p. 277.
3. Used in the sense given it by Max Weber, *The Theory of Social and Economic Organizations*, translated by A.M. Henderson and Talcott Parsons (Glencoe: The Free Press, 1974), pp. 90–92.
4. For a definition of political economy and its application to development theory, see Martin Staniland, *What is Political Economy? A Study of Social Theory and Underdevelopment* (New Haven: Yale University Press, 1985), pp. 1–9.
5. See Harold Lasswell, *Politics: Who Gets What, When and How?* (New York: McGraw Hill, 1936), pp. 3–25.
6. See J. Vanderkop and J. Nef, “Food Systems and Food Security in Latin America: A Systemic Approach to Politics, Ideology and Technology,” in J.I. Bakker, ed., *The World Food Crisis: Food Security in Comparative Perspective* (Toronto: Canadian Scholars’ Press, 1990), pp. 97–136. Current calculations are based upon data derived from the World Bank, *World Development Report 2000/2001* (New York: Oxford University Press, 2000), pp. 276–286, and the Food and Agriculture Organization (FAO), *The State of Food Insecurity in the World. 2000* (Rome: FAO, 2000), pp. 2, 5, 27–30.
7. See Didier-Roland Tabuteau, “Introduction to the Concept of Health Security,” *Proceedings of a Seminar on the Pharmacists at the Crossroads of New Health Risks: An Indispensable Partner for their Management* (Brussels: the Council of Europe, 1999), pp. 1–12. See Council of Europe web site.
8. *Epidemiological Bulletin* 21, no. 4 (2001).
9. Yellow fever has been found only in jungles. It remains a small but stable and deadly disease, with 175 cases in 1993 and 79 deaths. In 1995, there were 155 cases and 80 deaths.
10. Dengue and hemorrhagic dengue are mosquito-transmitted diseases that reemerged in 1993, reaching their maximum point in 1995: 316,187 cases and 113 deaths.

11. OPS/PAHO, p.38.
12. Ibid., p. 109.
13. Other “new” strains are Hanta, legionellosis, and hemolytic ureic syndrome; all three with extremely small incidence.
14. Pan American Health Organization (PAHO), *Update on the Global HIV/AIDS Epidemic*, December 1999.
15. PAHO, *Update on HIV/AIDS 2001*.
16. OPS, p. 39.
17. Ibid., p. 17.
18. It has been estimated that there were over 36 million people in the region suffering from curable sexually-transmitted diseases, many of them indigenous peoples.
19. OPS/PAHO, *La salud en las Américas*, Vol. 1, Publicación científica No. 569 (Washington, D.C.: OPS/ PAHO, 1998), p. 200. Other statistical information from pp. 85 and 199. At the time of the OPS[7]/PAHO study, the comparative rates for affective disorders and schizophrenic psychosis in the U.S. were reported to be, respectively, 11.3% and 5.0%; between four and five times larger than in the LAC region.
20. See Jorge Nef and Wilder Robles, “Environmental Issues, Politics and Administration in Latin America: An Overview,” in Joseph Jabbra and Onkar Dwivedi, eds., *Governmental Response to Environmental Challenges in Global Perspective* (Amsterdam: IOS Press, 1998), pp. 43–62.
21. Food and Agriculture Organization (FAO), *The State of Food Insecurity in the World 2000* (Rome: FAO, 2000), p. 1.
22. Out of the seventeen most indebted countries in the world in 1988–1990, twelve were in the LAC region, a condition that still persists, though it is no longer “news” since lenders seem to be facing less danger of default. Restructuring policies pursued by most regimes during the 1970s, combined with heavy borrowing from private and public sources of international finance, brought about a per capita debt of nearly \$1,000 by the late 1980s, compared to a regional per capita income of slightly over \$1,500. The annual interest service on the debt alone averaged well over 33 percent of total export earnings for the same period. The total debt represented about four times the export earnings, with an annual growth rate of indebtedness of over four percent. Though the extremity of indebtedness has subsided since the 1980s and early 1990s, Argentina, Chile, Ecuador, Honduras, Jamaica, Nicaragua, Panama, and Peru still had a debt ratio of over 50 percent of their GNP in 1998. See the World Bank, *World Development Report 2000/2001*, pp. 314–315.
23. International Labour Organization, *World Unemployment Report 1998–99*, p. 3.
24. Ibid., p. .
25. Ibid., p. 7.
26. William I. Robinson, “Central America: Which Way after the Cold War?,” *NotiSur* 4, no. 8 (25 February 1994): 1–9, especially p. 5.
27. See Oscar Altimir, “Income Distribution and Poverty through Crisis and Adjustment,” *CEPAL Review*, no. 52 (April 1994), *passim*.
28. Ibid., p. 6.
29. *NotiSur* (14 January 1994): 9.

30. Ibid.
31. Robinson, p. 6.
32. Unlike in the U.S., pharmaceutical companies play only a secondary role at the moment, since “cutting edge” drugs in the LAC countries are a relatively smaller component in rising health costs.
33. Karen Stocker, Howard Waitzkin, and Celia Hiriart, “The Exportation of Managed Health Care to Latin America,” Health Policy Report, *New England Journal of Medicine* 340, no. 14 (1999): 1131–1136.
34. Ibid., pp. 1122–1134.
35. OPS/PAHO, p. 340.
36. Ibid., p. 335.
37. Ibid., p. 278.
38. See Paul Constance, “Dangerous Prescription,” *IDB America* (Washington, D.C.: Interamerican Development Bank, February 21, 2002), pp. 1–7. The article makes reference to a recent comprehensive study by an IDB senior economist that suggests that, despite great variations from country to country, corruption is rampant and expanding in public hospitals throughout Latin America. The practices involve anything from stealing medical supplies and time, to charging for free services, to gross overpayment of supplies. See also, the interview with the author of the report, Bill Savedoff, in Constance, “Shining light in dark corners,” loc. cit.
39. Ibid.
40. Ibid., p. 280.
41. See Wilder Robles, “The Landless Rural Workers Movement (MST) in Brazil,” *Journal of Peasant Studies* 28, no. 2 (January 2001): 146–161.
42. A field study of these syncretic approaches to health care in North America can be found in Ken MacQueen, “The Best of Both Worlds. British Columbia Aids the Merger of Traditional Chinese Practice with Western Medicine,” *Maclean’s* (12 March 2001): 44–47. A Cuban case study can be found in Stacey Busse, “En busca de otros caminos: Transcending Medical Boundaries in Cienfuegos, Cuba,” unpublished M.A. Thesis, Department of Sociology and Anthropology, University of Guelph (February 2001).
43. See World Health Organization (WHO), *The World Health Report 2000* (Geneva: WHO, 2000), pp. 144–150 (Statistical Annex, containing basic operational definitions). The statistics included in this essay were constructed on the basis of the Tables contained in the report, pp. 152–203.
44. The overall effort was implemented in 1997 by means of a comprehensive methodology, which included factor analysis, multiple imputation for missing data, remote sensing, and household surveys. The World Health Organization’s Global Program on Evidence for Health Policy, in collaboration with its regional offices, was charged with carrying out the project.
45. Responsiveness was based upon a survey of over 2,000 qualified respondents in selected countries rated in terms of these factors: dignity, autonomy and confidentiality (jointly termed “respect of persons”), promptness of attention, quality of basic amenities, access to social support networks, and choice of care provider. Fairness of financial contribution and financial risk protection is viewed as the ratio of total household expenses

on health to personal income above subsistence. Performance measures how efficiently health systems translate expenditures into health (measured by DALE). Performance on the level of health is defined as the ratio between achieved levels of health and those that could be achieved by the most efficient health system. Overall performance is measured in a similar way by relating a system's achievement to the system's expenditure (pp. 144–150).

46. See UNICEF, *The State of the World's Children 2001* ((New York: UNICEF, 2000), pp. 76–111.

47. See Kuhn. This professional matrix is the prevailing practice, theory, and discourse among practitioners in the West: Europe, North America, the Caribbean, and Latin America.

48. OPS/PAHO, p. 277.

49. loc. cit.

50. Ibid., p. 278.

51. PAHO, *Health in the Summit Process* (Washington, D.C.: PAHO, 1998), pp. 6–52. The document examines Initiative Numbers 17, 18, 23, and 47 at the Miami and Santiago Summits, and outlines the initiatives for the Quebec Summit. Most of these initiatives encompass target-setting for the member states, such as equitable access to basic health services (including the reduction of maternal and child mortality, eradication of measles, AIDS prevention, etc.); strengthening women's roles in health; partnership in pollution prevention; bacteriological quality in drinking water; and low-cost health technologies (drugs and vaccines, information and surveillance, and water quality). The agenda also contains a call for health sector reform.

52. This Table was calculated by the author on the basis of individual country data provided in the International Institute of Strategic Studies (IISS), *The Military Balance 2000–2001* (London: Oxford University Press, 2001), pp. 25, 54, 227–251; also from the United Nations PNUD, *Informe Sobre Desarrollo Humano 1999* (Madrid: Mundi Prensa Libros, 1999), pp. 134–241. No information has been reported for the following Caribbean countries: Anguilla, Antigua and Barbuda, Barbados, Bermuda, Cayman Islands, Dominica, Grenada, Martinique, Monserrat, Netherlands Antilles, Puerto Rico, St. Kits/Nevis, the Grenadines, and Turks and Caicos Islands; in total, 13 cases. The IISS figures for the GNP in LAC presented in this Table are higher than those prepared by U.N. agencies, like the World Bank and the UNDP.