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Response to Nef

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Response

Anthony Agadzi-Naqvi

In keeping with the theme of the 2001 Macalester International Roundtable, Dr. Jorge Nef has done a fine task of painting a normative picture of what has been and continues to be the political economy governing health care and its delivery in those regions of his attention.

The essence of his "problematic paradox" lies in the fundamental declaration that despite the very favorable resource endowment of Latin America and the Caribbean, a majority of its population today remains poor and vulnerable. With up to 70 percent of families living in poverty, 11 – 13 percent suffering from malnutrition, and millions lacking regular access to proper sanitation, food, water, and health care in this otherwise fertile land, it is indeed difficult to disagree. Using data gleaned from the archives of the World Health Organization (WHO) and the Pan American Health Organization (PAHO), among others, Nef successfully cites some of the more important medical contributors to health insecurity in the region, among them HIV (with upwards of 40,000 new cases of infection annually), cardiovascular disease (the main cause of death in the region), and neoplasms (up to 13 percent of all mortality in men and women). His discussion of infant mortality — which is "five times higher than in North America and six times higher than in Europe" — is particularly commendable for the simple fact that healthy young citizens are a critical determinant in the future of any nation and, as such, are of immeasurable diagnostic and prognostic value in the local economy. Additionally, with World Bank estimates of as much as 8 percent of the years of life lost resulting from disabilities due to alcoholism, depression, Alzheimer's, and schizophrenia in the region, Nef sheds much needed light on the frequently ignored areas of mental and psychosocial well-being.

Another major highlight of Nef's presentation is in outlining the critical role of the WHO and PAHO in directing primary maternal and child care, immunization campaigns, and other facets of public health in the Latin American and Caribbean region. With dramatic decreases in mortality from communicable diseases in women from 146 to 70 per 100,000 between 1985 and 1995, decreasing incidence of acute diarrhea in children under five from 21.6 percent of all child deaths in 1985 to 8.2 percent in 1995, and the eradication of polio, Nef gives credit to one

of the fundamental tenets of medical education: that prevention is better than cure. Effectively, the central role of these agencies in the local economy cannot be underestimated.

Nef's criticism of the prevailing attitude about "health as an individually-centered commodity, which could be bought, sold, and traded to generate profit" is particularly superb. Via a consideration of health on the commodity versus human right spectrum, Nef's attack on managed care organizations resonates with the opinions of socially-conscientious health providers not only in the Latin American and Caribbean region but in the United States and worldwide. He accurately makes the point that managed care companies restrict access to vulnerable groups and compromise on actual health care spending, by maximizing profits to investors and by astronomical administrative expenditure. With millions of people found to be financially undeserving of health care under such reasoning, it is clear that something must be done. The logic of managed care is currently being fought on numerous legal, political, and moral grounds in the U.S. as the public becomes increasingly aware of its limitations and hidden corporate agendas. Nef correctly suggests that in order for Latin America and the Caribbean to join in this battle, they will need more than the currently "trivialized, fragmented, or marginalized" opposition to the movement.

In my modest opinion, perhaps the strongest aspect of Nef's presentation is his reinforcement of the concept of interconnectedness and mutual vulnerability needed to maintain health security. His early remarks that "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" is undoubtedly one of the strongest underlying themes in this conference. Indeed, with the increasing threat of disease pandemics, global travel, and marginalization of the poor, in the words of Nef, "there is an urgent need to rethink health security in the Americas from the vantage point of reducing mutual vulnerability and enhancing collective well-being." As the recent tragedy of September 11, 2001 has shown, we collectively, as global citizens, have a long way to go in resolving conflict. Beyond the scope of this discussion but nevertheless relevant to the theme of health security/insecurity, is the fact of our own mortality. We must consider the repercussions that policy implementation in one part of the world will have in another region, or in another era, when we have been surpassed by future generations.

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From the development perspective, although the quantification of risk and populations at risk is a necessary tool in any analysis of health security or insecurity, it is frequently insufficient given the backdrop of changing socioeconomic conditions sweeping the region. While Nef establishes the fact that the Andean countries and Cuba are apparently less affected by HIV infection than several (English-speaking) Caribbean states or Brazil, for instance, he fails to explain why this is so. There is little mention of the nationwide testing and quarantine programs instituted by the Cuban government in the mid-1980s to isolate and monitor HIV-positive individuals, which though effective, completely ignored the civil liberties of these otherwise "sexually irresponsible" persons.[1] Neither does he discuss the racial underpinnings of this disease in racially charged Brazil. There is a similar lack of explanation in the presentation as to why malaria decreased in incidence in Central America between 1980 and 1999, while in Brazil there was an unequivocal upsurge in new cases reported. Analysis of regional differentials in morbidity, mortality, and other epidemiological parameters is crucial to development. It is important to know why certain policies work where they work, and what can be done to emulate and successfully adapt such models to function elsewhere.

With the main momentum of globalization stemming from elite "Western" corporate and governmental groups seeking "to enhance Northern economic, military and political interests over those of the countries of the [Latin American and Caribbean] region," there is clearly a lot of room for blame. To a large extent, I understand and agree with Nef's comments in attributing health insecurity in the region to the "North-South commercial, technological, financial, and political regimes which reinforce domestic elite rule." His expert comments are clearly well justified by tomes of research and data, and one only need glance, for instance, at the corporate philosophies and profit-motives behind the *maquiladoras* and sweatshops all over the developing world to be convinced of the simple fact that richer nations continue to exploit poorer ones. This being said, I find that Nef overemphasizes the negative impact of such regimes on national policy initiatives, reinforcement of internal social inequalities, and conflict in the Latin American and Caribbean region. I argue that his overarching focus on the "North" subtracts from personal responsibility and the need to fight for just social causes. On a personal level for instance,

it is considerably easier to blame someone else for one's problems than it is to accept the fact that greed and unrealistic expectations may be at the root of one's dissatisfaction. On a national level, a similar line of reasoning can be applied to the fact that leaders of developing nations will frequently blame external powers for a country's economic misfortune when, in reality, they squander national wealth on lavish personal lifestyles. The demise of health security in the Latin American and Caribbean region is as much a function of neocolonialism and "old-fashioned" imperialism as it is a function of the corruption and poor judgment exercised by leaders in these nations. There are many examples of developing nations who have overcome the historical odds, and have succeeded in instituting health care delivery measures for the vast majority of their citizens, among them Costa Rica and Cuba. There are also many examples of self-sustaining health and developmental policy changes generated "by the people, for the people," at local and regional levels in many developing nations. Failure to address the success of these projects, no matter how minimal they may seem, is a disservice to the intellect and diligence of such communities.

Beyond stressing the harmful effects of free trade and globalization à la WTO and NAFTA, Nef's essay is strangely devoid of insightful solutions into "this type of globalization [which] is intrinsically dysfunctional to health security." It is not clear in his presentation whether he advocates increasing protectionism as a mechanism to enhance self-governance or rather if enhancing regional interdependence and trade (albeit minus "Northern" input) is the solution. By saying that in the context of such North-South imperialism, the role of multinational agencies (like MERCOSUR and PAHO) is "despite promises and good intentions, largely ambiguous, rhetorical and of limited effectiveness" portrays a rather defeatist attitude that does little to serve what I believe should be the extended theme of this Roundtable: "The Body, *solutions* to health."

In a similar vein, Nef provides plenty of examples of bottlenecks in the health care delivery system: "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." However, Nef once again provides neither an explanation for why these trends are observed nor any insight into what simple governmental policies could alleviate such problems. It is

again imperative that we analyze each country's specific situation. Are we training too many primary care doctors and not enough specialists? Is the delivery of health care providers to rural areas adequate and, if so, is remuneration commensurate with the level of responsibility? These are all issues that are frequently overlooked in the scope of health care analysis.

"Health Security and Insecurity in Latin America and the Caribbean" clearly demonstrates the shortcomings of "Northern" interference in the health care delivery system of the Americas. And rightfully so, for particularly in light of the recent World Trade Center events, it is clear that the "developed" world has done enough to earn itself a bad reputation and be downright despised. That the developed world, dressed up in a colonial suit with a bible in hand, came to Africa to pillage and plunder, is accepted by even the most resistant of supremacist scholars. In the recent U.N. summit on Racism, held in South Africa, European nations even went as far as to offer their regrets for the slave trade (albeit short of a frank apology). Furthermore, that the First World draped in "neo-colonial" garb continues to plunder and impose its power on poorer nations is also widely accepted. The bottom line, however, is that no amount of past or ongoing damage should absolve the leaders of developing nations of their integrity and social responsibility.

While it is true that health care is a considerable expense, it is also true that improving the general water supply, immunization, and literacy rates does a lot to boost the health security of a community, and *is* often economically feasible. In this sense, I believe Nef's assessment of education in the region and its potential impact on health care is inadequate: If "most education in the region…is traditional and not a device to bring about active change," then what can be done to alleviate this situation? The 21st century is as much about recognizing where we—or our predecessors—have gone wrong as it is about finding concrete solutions to these problems. From grassroots mobilization to teaching our children to treat others as they would want to be treated, there are clear and identifiable ways to implement change.

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The 2001 Roundtable should focus not only on the ill body as we know it, but also on the role of the self in being ultimately responsible for the prevention of disease. The challenge of a good liberal arts education is

that it must guide us through the process of critical inquiry and simultaneously equip us with the skills and resources to answer complex questions. Most of my own ideas for this response arose from a dire need to answer some of the questions posed by Nef. As profound as the issues outlined in Nef's essay are, there are some simple, common sense solutions unfortunately not articulated by the author.

Although we should never surrender our moral judgment to cost-benefit analysis, it can help us in evaluating the potential benefits and risks of a particular health policy or change to a community. In designing or evaluating projects to help women, for instance, benefits may be understated because a woman's work — at home or in the field — is typically undervalued in the marketplace. For instance, in estimating the costs and benefits for a water delivery system, if women's work has no market price, then the benefit of not having to haul water is undervalued and the opportunity cost of a woman's time is overlooked.[2] The fundamental problem in relying exclusively on the market is that many inputs and outputs are not accurately priced, or, as in the preceeding example, are completely undervalued. Clean air and water had no price in most economies until at least the 1970s. This is still the case today in both developed and developing nations. Many industrial establishments, in an effort to maintain profits, undervalue these resources and continue to dump toxic waste into the air and water.

If synergistic effects are ignored, an individual project in housing or health care is undervalued and consequently will not be undertaken. Consider that when the health center at Las Heras, Mendoza in Argentina was built, water lines were laid and neighborhoods along the way were connected. Gastrointestinal disease, a major source of illness for the community, virtually disappeared.[3] Similarly, if an economy is viewed as one body, and *all* benefits and costs are acknowledged, a pipeline's contribution to productivity and an individual student's school performance would be a part of the accounting equation. Devising a new accounting equation system is complex but not insurmountable. It is certainly what some developing nations ought to consider in reevaluating their health care delivery status.

Clearly, the nature of medical education has to change to emphasize prevention, surveillance, and epidemiology, because (at least in realistic terms) therapies to common ailments can be a significant expenditure for a nation. The training of a public health doctor in Latin America and the Caribbean must thus incorporate more study in sta-

tistics, epidemiological analysis, health education, and sanitation. These are all disciplines that have traditionally been lacking in hospital-trained physicians[4] whose education has otherwise hinged on the "intellectual vogue" models (emphasizing basic clinical pathology) of European nations, and echoed by Nef earlier in his essay.

Regarding interconnectedness and mutual vulnerability, it is important to stress that if a rural hospital is an outcast zone, it will forever remain an undermining factor in national primary health care. Recruiting doctors to work in remote areas with less than glamorous problems, and with people they have not grown up appreciating, will also require some attitudinal changes. Medical education will have to stress the primary value of health posts, and pay may have to be higher in order to attract doctors and nurses.

Health insecurity, as portrayed by Nef, is indeed largely a function of market economy failure. However, a defeatist approach does not help the situation. Across the world, there are numerous microsolutions to development — innovative, often community-based projects undertaken with minimal funding, and with enormous success. By emulating such initiatives and maintaining personal integrity and vision, we can strive for more universal standards of health care in the developing world.

Notes

1. Marvin Leiner, *Sexual Politics in Cuba: Machismo, Homosexuality, and AIDS* (Boulder, Col.: Westview Press, 1994).

2. Keith Griffin and Terry McKinley, *Implementing a Human Development Strategy* (New York: St. Martin's Press, 1994), p.13.

3. Eileen Stillwaggon, *Stunted Lives, Stagnant Economies: Poverty, Disease, and Underdevelopment* (New Brunswick, N.J.: Rutgers University Press, 1998), p. 283.

4. Fraser Brockington, *The Health of the Developing World* (Lewes, Sussex: Book Guild Limited, 1985), pp. 57, 66.