EDITORIAL

HEALTH AND THE MACRO ECONOMY IN A BORDERLESS WORLD

Many parameters in the global health equation have changed and are continuing to change in remarkably short time frames. Since health is an integral component of individual and societal function, it cannot escape the blanket changes that are occurring in the macro economy. In turn, the economy of any one nation is no longer entirely in the hands of national policy, rather it is subject to the effects of financial dealers whose effective power may often be greater than that of national governments. Thus the stage is set for complexity of substantial order.

Much global effort is presently being directed to *health sector reform,* with special emphasis on health care financing options. In many countries what exists by way of insurance cover tends to be generous for civil servants versus little or none for the farmers, self-employed and workers in the informal economy, who together often represent more than half the population. This "difficult group" recurrently gets left behind in the attempts to *reform* the system, a major part of the workforce and their families. It is difficult to see much real interest in the relation between health care security and industrial productivity, the competitive edge for which all newly industrializing countries are striving. *Health sector reform* thus seems in large measure to be a phantom in the wind of reality, a health sector initiative divorced from the multi-sector world.

That world is a harsh one. One of the patterns that become clear in analysis of the neoindustrialization process is that history does indeed repeat itself. Many of the mistakes made by the west during the earlier industrial revolution, in terms of rush to produce for profit went along the same paths that poorer nations are now treading: the *Satanic Mills* of British poet William Blake, writing about that earlier revolution in the factories of the center of empire at that time (Kazin, 1975).

Take the example of industrial fire hazards. In Bangkok on 10 May 1993 the worst fire in modern industrial history occurred in the Kader toy factory, with officially 188 dead, 469 injured. Locked doors, barred windows, fragile stairways, narrow or absent fire escapes abetted the carnage. This fire surpassed the previous worst recorded event, in New York in 1911, at the Triangle Shirtwaste Company, in which 146 young immigrant women died in similar circumstances in Manhattan: both fires were related to rapid industrialization, with its lax security standards and thirst for profit, exploiting poor workers per substandard wages (Greider, 1997). The Kader factory was partly owned by the wealthy Thai multinational, Charoen Pokphand Group; no changes were ever laid at its door, it is too powerful politically. A survey at that time showed~60% of factories did not obey the fire safety laws in full. In the months that have passed since that tragedy many more fires have occurred in major buildings in Thailand - factories and hotels - with locked doors and no real evidence of increased security. The story repeats itself over and over in many countries.

Why? Is it profits for the companies? Partly perhaps, but it is also power: no one in politics will stop them, all parties want their patronage. As the multinational juggernaut rolls on, this power expands, but responsibility in each local sphere of activity diminishes. The global economy drives the rat race of competition, governments everywhere compete to attract investment capital and are prepared to pay the social price with little regard to worker safety. Accidents form a major epidemiological disease group, at or near the top of mortality and morbidity statistics, about which lip service is given to the traffic variety, even less service to the factory kind. The macro economic priorities treat health with disdain, health ministries have little cabinet power, industrial and economic ministries lay down the guidelines, and the health sector lacks the knowledge, artifice, financial argument to counter the punches. Moreover, the private health sector makes good money from accident cases and some of the investors in private hospitals are the very capitalists who own the factories. Silence is all too common. History repeats itself, in the full spotlight.

Worse , perhaps, is the minimal information relayed to the home countries of many of the investment merchants; the owners of far off toy

factories have to scan the Wall Street Journal back pages to find a note on the Kader-type fires in poor countries. Even the Bhopal tragedy of India received attention for only a short while and there were no serious Chicago protests against the parent US company at the time. There is a blasé acceptance of the global economic ethic: profits justify the sacrifice, if it is far enough away. The toys flow into the homes of the western wealthy, who heed no conscience at the conditions of their manufacture. Occasionally the western press stirs up the heat of protest at conditions in poor country factories, threatening to take punitive action, oblivious of western industrial history at similar stages of development when the struggle for each industry to survive similarly hung on marginal income.

Another side of the macro economic health equation is the effect of stringent limitations in western counties that encourage flow over into less regulated nations struggling to penetrate western markets. The price is often high. During the Reagan and Bush presidencies the US Trade Representative, Carla Hills, spent an inordinate amount of effort to force US cigarettes on developing nations, at the very time that rigorous restrictions were being enacted in the USA itself. She did so by treatening retaliation against imports of goods from those countries, in defiance of GATT regulations. All this, knowing so well the health hazards of tobacco, together with the pressure to increase cigarette consumption in some of the world's poorest populations whose health was already marginal. The trade weapon was used to great effect. There was little outcry in the US health sector: presumably the problem was seen as remote from their local responsibility. Again, we see the health sector's parochialism and inability or failure to act at the point of macro policy formulation: the sector's lobbyists are too concerned with the relatively trivial issues of hospitals and clinics for the wealthy. Sale for profit is the master of health policy. Prevention is of secondary consideration, since it does not make money. Thus again the health sector loses opportunity to uphold the ideals for which it pretends to stand guardian. Gone is even the pretence used in the long western debate that there is no conclusive evidence that smoking causes disease: no need, raw exertion of money and its interdependent political power is all that is required the capital-hungry new environment.

The recent slumps in the Southeast Asian economic growth curves serve to illustrate further the narrow margin of safety on which financial stringency sits. Suddenly the currency values of Malaysia, Philippines, Indonesia, Thailand have been placed on a slippery slide, in part as a result of bad financial management, in part for lack of caution on developmental priorities, in part because of the power of financial investors and currency market dealers. The upward curves are suddenly seen to be shaky, investment is seen to move on to greener pastures *en masse,* employment tumbles, stress-related illness climbs steeply, the uninsured die from treatable diseases, families suffer malnutrition. The social infrastructure is unable to cope with the emergent demands. Political leaders look for scapegoats.

Just how tenuous development strategies really are suddenly becomes starkly clear. The richer class base is affected - they see luxury imports rise in cost, but the poor are more affected - they see their subsistence levels disappearing beyond reach, unemployment suddenly a reality. Equity becomes even more distant as a goal. The immediate focus of governments is with fiscal salvation, rather than with social survival, so it becomes a test of the depth of pre-existing infrastructure, with some failures inevitable. What takes time to digest is that ups and downs of macro economies will continue as infinitum, that adaptation to the swings is basic to survival in situations where national governments can only pretend to be in control. When things go wrong, at best they can simply react meekly to IMF rescue packages rather than call the tune and even these life savers have limited power alongside the financial marketeers.

The health of nations swings with the financial vicissitudes, the public health sector must cope with sliced budgets, disease control planning is put on hold, poor health contributes to reduction in industrial productivity. Health and education mold and sustain human resources, in that role they should project themselves to the forefront of economic planning, for without skilled human resources competitiveness diminishes. These two sectors have a tough task, for they must remain true to their original compassionate callings on the micro scale, yet become financial planners on the macro scale, focused on where each nation is going economically. Few courses on health economics focus on the macro issues of national planning, rather they retreat into micro elements of cost management to keep the

ships afloat. Failure to tackle the macro challenges leaves health strategies to the financiers.

However, there are wider implications still, for the big swings of uncertainty in financial solvency are likely to be with us for a long time, requiring planning for the eventuality at any moment. The myth that the market can deliver all is exploded: that is the difference from past history. The market is delivering greater inequity, at the same time it delivers rising GDP figures. Health is captive, as is education - the so-called "non-productive" areas of governmental responsibility. Market forces favor the private sector, the entrepreneurial sector but they do not favor equidistribution of outcomes. By the same token, central planning is dead, or almost dead except in some social democracies of western Europe. So in all honesty we in a barren field, unsure of which direction to take towards the promised land. Health is part of that uncertainty, but at least it can have hope if it accepts the challenge to become a player in the macro economic stakes.

This conceptual approach to a continually changing global economy whose major national bases can change swiftly requires a sweeping reform of health policy formulation way beyond the financing reforms now under revision. It must go beyond the above arguments for human resource development. Moments of reduced money flow can disrupt disease control programs precipitously, leading to epidemics of serious moment. Since such programs need to be multi-country in basis to be realistic, their insulation against market shifts is even more difficult to plan ahead. Yet contingency plan we must, well beyond annual national budgets, even though national governments hold limited sway in the market plays. These plays straddle the globe, moving capital from one place to another in short time frames, as finance ministries in many countries put out their hands for investment, even though today's input may leave tomorrow. The resulting ups and downs of purchasing power represent macro shifts which alter the affordability of basic health care for the majority whose lives hang by threads of employment uncertainty. The health paradigm bears little resemblance to those of the past, the competent health planners in this new environment are few, the challenges need continual redefinition.

Chev Kidson

REFERENCES

Kazin A, ed. The Portable Blake. New York : Penguin, 1976.

Greider W. One world, ready or not : The manic logic of global capitalism. New York : Simon an Schuster 1997.