EDITORIAL

HEALTH, WEALTH AND THE WORLD AROUND US

Equity is perhaps the most elusive goal of human society. There is a general perception that the free market has provided evidence of positive economic growth in many countries. whether the starting point was rich or poor. To that extent it must surely be said that the triumph of market forces over central planning in the past two decades has been very positive. Whether that is a real triumph in terms of resource distribution is more problematic. On the one side of the debate is the evidence that in some societies, even though the rich have in many cases gained disproportionately, the poor have also gained and risen from below the poverty line. On the other side is the argument that the principal gain is by the already wealthy, witness Brazill's dubious current qualification for IMF rescue funds in view of the total capital held within the country but its gross maldistribution in megapolises like Sao Paulo.

Despite the protestations of some government leaders in Southeast Asia, the financial crisis in our region over the past 18 months is arguably self-inficted rather than the outcome of machiavellian currency trading, according to some analysts. Krugman (1998) argues this case with conviction and flare, but admits that floating currencies are targets or rapid outflow as well as inflow of global capital. When growth is rolling along at 8% or so for 10-20 years it is not surprising that private sectors feel confident to borrow heavily and that lenders accept as collateral real estate of uncertain real tradable value: understandable but careless in retrospect. Whatever the totality of underlying factors, the wisdom of hindsight does not assist the unemployed as their lines grow rapidly longer, nor the destitute who have no convenient social security or benefits to fall back on to. The poor suffer unfairy while the formerly rich get by.

The macroeconomic equation is complex but it does not go away. Can the situation be quantified in a way that will leave lessons learned? How does health fare in the market economy? How does health fare in a grossly inequitable society. Southeast Asia has had it share of economic glory with many years of rapid growth during which some social reforms have seen light of day but most are at best half born. Under the media displays of company wealth vanishing, it is not easy to evaluate the relationships between wealth, poverty and disease, health systems and health policies, their successes and their failures. Globally we talk about diseases of poverty but do not often have hard evidence; even if we think we have that we find it difficult to provide readily understandable data to the finance community.

The paper by Indaratna *et al* (1998) in this issue sets out to use geographical information systems (GIS) to go a little distance along that road. They map dengue and malaria against averaged income on a decentralized scale, in terms of per capita gross provincial product (GPPpc) and against health care resource distribuition in Thailand. What they find is that although Thailand has great disparities in wealth among the 77 provinces, malaria - globally trumpeted as a classical disease of poverty - is concentrated not in the poorer provinces of the northeast but in less poor provinces along the western border. Transborder population mobility is the chief culprit. The Thai public health sector provides free treatment for malaria to all comers. both as a public good and because this policy should reduce the transmission reservoir. Dengue on the other hand is distributed much more uniformly; it is a disease of economic development in the context of the vector breeding sites (cans, tires, etc) whereas the major malaria vector is a forest breeder. In a sense the different distribution patterns of both diseases are related to economic factors but different ones. What the malaria maping does not show is the migration of non-immunes from the poor northeastern provinces to the richer ones where work opportunities are better. A similar pattern has occcurred in Sri Lanka following the construction of the Mahaweli dam: poorer migrants from non-endemic areas moved to malaria endemic areas to take up farm land offers where they succumbed to malaria (Wijesundera, 1988).

Too often health research focuses on micro events rather than attempting to look at the broader picture and to convey this in quickly understandable format. Color maping can be done skilful enough to pemit instant pattern recognition by finacial planners as well as health planners steeped in the jagon.

This is its beauty and its clarity. Redistribution of asymmetric health care resource can be policy driven at macroeconomic level with the help of such evidence, whereas nice tables of statistically significant figures alone may fail to convince because the emphasis is lost in the details and financial planners do not have the time or the patience to do the analysis. A great deal more work is needed to optimise the kinds of appropriate data sets required from multifactorial sources but the message is already clear from this simple exposition.

Back from colored clarity to hard theory: can rapid economic growth be trained to produce greater equity? Or are we to withness endless "business cycles" in which discarding big sections of the workforce are the norm and honest workers are thrown out in the street without succour? Will giant mergers continue to be the norm, with their downsizing" signatures? Who will pick up the health care tab? Can "health care reform" cope with such volatility? Will disease run rampant among those laid off work? Will the slums of Sao Paulo expand to fill the globe?

The world around us is changing faster and faster, it is dominated by economic rationalism, the market is said to be the best determinant among many bad ones, planners plan only to awaken tomorrow to a new day that does not took like the one they carefully designed. Political instability follows and occasionally chaos reigns.

These issues are central to public health policy. Concentration on the macro picture but in decentralized format is a necessity. Acceptance of the uncertainty factors, of the volatility of market forces is central to wisdom. Planning for currency devaluations and revaluations requires flexibility. Over capitalization of the private sector needs also to be factored into the equation, in the light of sudden shifts of health care burden from private to public sector which strain carefully planned resources. Health is not to be an alms recipient but a pragmatic realist. Equity must be real, sustainable and linked to serious macroeconomic action to reduce the size of the populations struggling below the poverty lines. But presenting the data is instantly absorbable format is a more realistic starting point the reams of figures.

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REFERENCES

Indaratna K, Hutubessy R, Chuprapaphwan S. Application of geographical information systems to co-analysis of disease and economic resources: dengue and malaria in Thailand. *Southeast Asian J Trop Med Public Health* 1998; 89: 669-84.

Krugman P. The accidental theorist. New York: WW Norton, Co 1998.

Wijesundera M deS. Malaria outbreaks in new foci in Sri Lanka. *Parasitol Today* 1988; 4: 147-9.