Health & Human Development in the New Global Economy:

The Contributions and Perspectives of Civil Society in the Americas

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FOREWORD

"One World, Two Fates," accurately describes the global future foretold in a recent article published in the British journal *The Economist*.[1] The article reports that 98% of deaths in children under five years of age occur in developing countries and makes a plea for strengthening global structures that promote health and nutrition, such as the World Health Organization (WHO) and the Food and Agriculture Organization of the United Nations (FAO). The author suggests that the growing economic surpluses generated by financial speculation and world trade should be reinvested in the human development of the less fortunate. This concern for and attention to the human and social effects of globalization is growing. The United Nations has just published its *Human Development Report 1999,* which also addresses the positive and negative effects of globalization, and many other international health & development organizations have focused their efforts on understanding and influencing this phenomenon for social benefit. Without a doubt, "globalization" has become the *leitmotiv* of our times.

In this new world of dramatic polarization in the distribution of wealth and opportunities, the poorest 20% of humankind benefits from less than the 1% of the wealth, trade, and direct external investment, while the richest 20% of the global population takes 86% of the global economic product. In terms of access to and use of the information and communications media, the growing disparity is even more flagrant: the poorest sector utilizes just 1.5% of telephone lines and constitutes only

1 Jeffrey Sachs, "Helping the Poorest", *The Economist.* 14 August 1999.

0.2% of Internet traffic. It is estimated that half of the inhabitants of our planet have never received a telephone call, an indication of just how far we are from creating a equitable a world society that provides fair opportunities for all.[2]

So where will all this disparity and polarization lead? Some of the foremost ideologues of the New World Order, such as George Soros, Paul Krugman, and Jeffrey Sachs, have anxiously called on those in government to establish new regulatory structures for the market, with a view to reducing economic and social instability in the most vulnerable countries. It is apparent that failing to protect populations at risk for the negative effects of globalization on a worldwide scale is indefensible, as ever-growing numbers of human beings become marginalized from the global economy. The course that we chart for the new century, then, will depend on our ability to find new and just modalities of governance at the national and global levels.

Shaping the specific process of globalization is a core priority for the Strategic and Programmatic Orientation of the Pan American Health Organization (PAHO) in health and human development. Accordingly, PAHO's Division of Health and Human Development, together with support from the University of Texas Medical Branch-WHO Collaborating Center for International Health (UTMB), is interested in disclosing and publicizing the presentations of experts made at the meeting "Health and Human Development in the New Global Economy: Experiences, Opportunities, and Risks in the Americas," held in Galveston from 26-28 October 1998.

The objective of this forum was to examine the impact of the economic globalization process and technological change on health trends in the Region of the Americas. More specifically, the meeting sought to explore how civil society groups can influence the formulation of healthy public policies and monitor equity, in terms of both the health situation and the distribution of health care resources. One of the recommendations that emerged from the meeting was to establish mechanisms within the context of Panamericanism that will facilitate the continuity of a broad partnership between state and non-state actors to promote the adoption of healthy public policies in every country in the Americas, expressed through the "Galveston Declaration," included in this publication.

PAHO hopes that this publication will be of use to decision-makers, experts in the field of health and development, and emerging civil society groups in the Latin American and Caribbean countries, and will help them to better address the enormous risks facing the different sectors of society as a result of globalization and to take advantage of the tremendous potential this process affords, creating a solid foundation for investing in health.

This document addresses a wide range of issues affecting health in the global economy, including the types of economic organization and potential dangers we face at the close of this century. It centers on experiences, opportunities, and risks in the Americas, on health in human development, and on

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2 Human Development Report, 1999.

international and regional integration processes in the new global economy. Some articles analyze the impact of economic reform policies on health in general, and some monographs are written from the perspective of civil society groups in particular countries.

In order to more fully disseminate this collection throughout the Americas and globally, we have posted the chapters in full text on the PAHO website in English at www.paho.org/english/hdp/hdp.htm and in Spanish at www.paho.org/spanish/hdp/hdp.htm. We hope you will peruse the site and refer others who may be interested in these issues to this site, as we will be continuing to add related materials and information.

Finally, we wish to express our gratitude for the impartial collaboration of all the individuals and organizations involved in this publication, and especially to our presenters for their generous contributions.

Juan Antonio Casas
Director, Division of Health and Human Development
PAHO/WHO

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This publication is the result of a collaborative effort between the Division of Health and Human Development of the Pan American Health Organization (PAHO) and the WHO Collaborating Center for International Health at the University of Texas Medical Branch. The chapters are based on the proceedings from a Seminar/Workshop held in Galveston, Texas, October 26-28, 1998, which would not have been possible without the support of the institutions that co-sponsored that event: The University of Texas Medical Branch, The Pan American Health Organization, and The World Health Organization. Dr. John Stobo, President of UTMB, is due special thanks for his support of the Workshop, as is Sir George Alleyne, Director of PAHO, who not only provided material support but also has maintained an ongoing interest in this topic.

Many individuals and organizations also contributed to the creation of this work. Special thanks are due to Alberto Cardelle, who helped to design a program of activities for the Workshop relevant to our collective purpose, and to Ulysses Panisset, who helped develop the idea for the project in its early stages. David Fidler lent great expertise and assistance to the development of the Galveston Declaration—the textual expression of the outcome of the seminar/workshop, as did Martin Hobdell.

Several of the authors included in this volume provided background documents for the Workshop, around which the participants began their discussions. Those contributions are very much appreciated.

Thanks are also due to The Lancet, the North-South Center, Transnational Publishers, CRIES, Common Courage Press, FES/ACE, and Health Promotion International, who granted copyright permission to reprint certain articles.

But none of this would have been possible without the enthusiasm of the civil society organizations who came and participated in the event. They not only donated their valuable time and experience to leading the discussions, but also helped to begin the process of building partnerships and collaborating with universities and intergovernmental organizations. We hope this publication will further their contribution to this process.

—The Editors

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SETTING THE STAGE

FOR

THE WORKSHOP

OPENING REMARKS TO THE WORKSHOP

Health and Human Development in the New Global Economy: Experiences, Opportunities and Risks in the Americas

Harold A. Drayton

Dear Colleagues and Friends,

My very first words must be to extend to each of you a very warm welcome, and to thank you for taking time off from your busy schedules to travel in many cases several hundred miles, to participate with us in what I am confident will be a very useful and productive experience for us all. This Seminar/Workshop, which you have graced with your presence at this morning's Opening Session, is truly a dream come true, especially for Lexi Bambas and Alberto Cardelle, who have been working hard with me these past several months, to design, with your most valuable inputs, a program of activities that would be most relevant to our collective purpose.

The idea for this kind of forum was conceived early one morning just about a year ago, in the course of a discussion with Ulysses Panisset about the potential impact on Health and Human Development of the peoples of the Americas, of the accelerating movement towards Regional Integration and Globalization: a trend characterized by very rapid replacement of Solidarity and Collective Responsibility for social welfare in general, by an emphasis on the “magic of the market”, on individualism, and some would say with selfishness and greed. Would not an even-handed assessment of that impact-opportunities, benefits, dangers and risks-not be a fertile topic for study and exploration in the next in the series of Seminars on Health and Public Policy to be

sponsored by our Center? By the end of that day we had shared the idea with Dr. Antonio Casas, the Director of Health and Human Development of PAHO, and a few weeks later with Dr. Dev Ray of WHO Geneva, and had won their support. By the time we met for our preliminary planning meeting at PAHO Headquarters in Washington D.C. in early April, critical decisions could be taken that the event should include a Workshop component with fairly well-defined tasks; that participants should include not only our traditional allies in Universities in the Region, but as importantly, representatives of as many advocacy and other groups/organizations in the "civil society" of the U.S., and of the countries of Latin America and the Caribbean. And that, the end-product should be a consensus about the most appropriate hemispheric mechanism, that would permit continuity of this broad alliance among "non-state actors": to promote the adoption of 'healthy public policies' in every country of the Americas.

If we do succeed in our efforts over the next three days to "sow some seeds" that will ultimately bear some useful fruit for all of us, it will be as a result of the valuable advice, suggestions and specific technical inputs over the intervening period, that have been contributed so generously: by Tony, Dev, and their colleagues in PAHO and in WHO; and by all those participants who have been in lengthy e-mail correspondence with me, especially since April. But let me be frank: none of the arrangements for this gathering would have been at all possible without the generous financial contributions of both PAHO and WHO; and the unwavering and firm matching support of the President of UTMB Dr. John D. Stobo. For all of that we are indeed most grateful.

INTRODUCTION TO THE WORKSHOP

Health and Human Development in the Global Economy

George A. O. Alleyne

Mr. Chairman, Ladies and Gentlemen. First, let me thank you for your welcome and the invitation to participate in your Seminar/Workshop. It is always a pleasure to be able to return to an academic institution and enjoy the opportunity to engage in discussion about some of the issues that will influence how we order our lives. There is a tendency in all institutions, such as ours, to dialogue with our primary constituents, such as governments or institutions like our own. However, we do not seek to engage in serious debate with the centers of learning from which will come much of the information that will guide what we all must do in the future.

There was a time when my understanding of what was meant by human development was limited to the area of developmental psychology. Human development represented the intellectual, social, sexual, and psychological changes, among others, in the human organism as a product of the interaction between the organism and the environment. There is a considerable body of information on the stages through which the child passes, for example, and numerous tests and scales to measure the various aspects of child development. It was made clear to me that this aspect of the changes or adaptations in humans did not end with childhood, although as one got older the response to the environmental or ecological changes, although definite, were very much slower. However, much of the focus on children was based on the premise that the plasticity of the organism was such at that state, that there was

likely to be prolonged and permanent damage to the person in adulthood if the early environment was inhospitable. I do not wish to discuss that aspect of human development today, although it must be obvious that environmental changes in the broad sense that arise from changes in the global economy will affect how humans grow and develop.

There was also a time when the term "development" was used almost synonymously with the acquisition of material goods and money, and the world was conveniently divided into developing and developed societies. This was a semantic advance over the use of the terms underdeveloped and developed, which in itself really hid the fact that on most occasions we meant to speak of poor and rich societies. Gradually, almost everything possible came to be put in the development basket. Indeed, in a comment that might have been cynical, Arndt says: "Development in the vast literature on the subject appears to have come to encompass almost all facets of the good society, every man's road to utopia."

We owe a great debt to welfare economists, such as Amartya Sen, Mahbub Ul Haq, and their colleagues, who focused the discussion about development on human kind. In the path-breaking United Nations Development Program (UNDP) Human Development Report of 1990, the authors highlighted human well-being as the central object of what had been referred to as 'development,' and promoted the term "human development," which they described as "a process of enlarging people's choices." Arthur Lewis, in a description of the benefits of economic growth and the wealth it produces, also referred to the aspect of enlarging people's options.

Dudley Seers said the following almost 30 years ago in a famous address on the meaning of development:

> The starting point in discussing the challenges we now face is to brush aside the web of fantasy we have woven around "development" and decide more precisely what we mean by it. "Development" is inevitably a normative term and we must ask ourselves what are the necessary conditions for a universally accepted aim—the realization of the potential of the human personality.

Health is among the most important of these choices to which Mahbub Ul Haq refers in the UNDP Report. He postulates that though other choices, such as knowledge gained by education and economic growth or wealth accumulation, were important in the sense that they contributed to health, the healthy state was, in its own right, one of the choices that would be enlarged by human development. Thus, the association of health with human development is independent of the relation of health to any of the other choices that such development permits or has to offer.

My further understanding of the concept of human development has led me to see those choices other than health as being economic growth or wealth accumulation, a safe environment, education that produces knowledge, and a mix of rights and freedoms that are essential for human dignity. We can show that these all interact, and the presence or the increase of one enhances the options for enjoying the others. Thus, accumulation of wealth or economic growth will facilitate the possibility of enjoying good

health, and good health will enhance the possibility of economic growth at the individual and population or national level. A healthier population and the presence of a safe and clean environment will go hand in hand, each one mutually reinforcing the other.

Because of the very nature of the concept of human development, it is difficult to devise absolute measures, although the Human Development Index has gained popularity and is often quoted to compare one country with another. I have to admit my bias against complex indices. We have all seen them come and go. I have wondered at the validity of including a measure of health in an index that measures the extent to which one will enjoy good health. Similarly, if one believes that the critical choices enlarged by human development are multiple, then why should one choose only a limited small number to be included in the index? I am also concerned that the focus has tended to be on the ranking of countries rather than on the improvements that have occurred in the several indicators over time.

If we are going to examine health or any other aspect of human development in relation to the global economy, we should establish some base line of common understanding about the global economy, if that is ever possible. The performance of the global economy as the environment for human development is as fascinating to me as it is obscure. Economic interchange is not new—what is new is that the world's economy may function as a single unit. Castells writes: "…it is only in the late twentieth century that the world's economy was able to become truly global on the basis of the new infrastructure provided by information and communication technologies."

We hear of capital being shifted around the globe in such short time periods and such quantities as to stagger the imagination. There is interdependency of currencies and economies. But the most disturbing fact is that this global economy is asymmetrical and its growth is leaving out a large fraction of the world's population. This fraction suffers not only from being producers of primary commodities of declining value, but also because it lacks much of the institutional infrastructure that will allow full participation. Free market capitalism is the dominant ethic of this global economy and its proponents argue with conviction that it remains the most effective and attractive prospect for increasing global wealth. It will separate the efficient from the inefficient without paying any attention to the cause of that inefficiency. It is ruthless in its quest for resource accumulation and equally nonchalant about resource allocation or distribution. However, no less a person than George Soros has said:

> Although I have made a fortune in the financial markets, I now fear that the untrammeled intensification of laissez-faire capitalism and the spread of market values into all areas of life is endangering our open and democratic society. The main enemy of the open society, I believe, is no longer the communist but the capitalistic threat.

While it is true that free trade and open markets hold out hopes for global prosperity, the events of the last few months have shown the danger of unfettered global economic systems. We have seen crises in countries previously considered as models of economic orthodoxy. The solutions to the crises have

resulted in marked social dislocation, a drop in the standard of living, and such genuine popular hardship that political institutions have been weakened or swept away. What are the effects of this global economy or its failure on the possibility of humans enjoying the option of health?

First, to the extent that the global economy produces more wealth, then health status will improve, as the relation between health and wealth is very clear. This is now accepted as axiomatic and there are numerous studies showing that health status, as measured by any of the conventional indicators, improves with increase in income. The standard explanation for this is that there are improved environmental conditions, such as housing, improved nutrition, the access to information that will induce healthier behavior, and availability of more and better care.

However, this great difference in health between classes, as evidenced by mortality, was not always present. Fogel has shown that the life expectancies of English peers and peasants was not significantly different until the beginning of the eighteenth century. The class differential increased steadily thereafter. One explanation that is intriguing to me is that there were poor health and nutritional practices in both groups, there was equal exposure to hostile environments, and that poor nutritional practices among pregnant women and children contributed to the very poor health outcomes of the rich. The later improvement of the health status of the peers was perhaps related to the fact that they became relatively shielded by better environments from many of the diseases such as diarrhea disease, whose fatal outcome was linked to nutritional status. The search for the interventions that produce most impact on health status in areas of poverty is not academic. There are several attempts to determine the critical and cheapest package of interventions that will produce an impact on health in poor countries.

The concern for attending the unhealthy poor goes back a long time and I found a report from the State of New York in 1900, which read:

> The expenses for physicians and nurses, in attending paupers, in towns where there are no poor houses, form a very prominent article in the amount of taxation. Pauperism and disease, except in an almshouse, are generally associated together, and hence it is that this item of expense is so much complained of in the towns just alluded to.

I wonder how much this sentiment has changed. But as I have said before, the global economy does not produce wealth for all, it induces inequality on a global scale. There is a widening income gap between countries and within countries. The global economy is creating global elites and global paupers and there is considerable concern over this widening income gap within countries and its effect not only on health, but also on social stability.

The importance of income inequality as a determinant of health status, apart from and in addition to poverty, is now well known, although the mechanism through which it operates is less clear. The most complete study of the effect of income distribution on health has come from Wilkinson and the data for the United Kingdom are among his many interesting findings.

Under Thatcher, during the 1980's, income differences widened at an almost unprecedented rate. This was shown conclusively from the changes in Gini coefficients and the ratio of incomes of the richest 20% to the poorest 20%. This widening income inequality was accompanied by the slowing down of the rate of improvement in national mortality rates in infants, children 1-19 years, and adults 20-44 years. Wilkinson writes: "It is hard to avoid the conclusion that the trends in national mortality rates deteriorated as a result of the effects of widening income differentials on the most deprived."

In a complementary fashion, I have been paying attention recently to the possibility that health investment can serve to reduce income inequality. My argument is that an increase in productivity through health investment is likely to be greatest among the poor and, therefore, lead to decreased income inequality. This thesis is, of course, subject to the limitation that the other factors that allow the poor to increase their productivity are in place. Among the other ways in which investment in health, or more specifically, reproductive health, increases economic growth is through stability of population growth. This has been most evident to me in the small countries of the Caribbean, although I am sure that there are numerous similar examples worldwide.

I have posited that irrespective of the state of the global economy, health and economic growth will still be choices implied in human development. Each of the choices will interact with the other. A pertinent question is whether in the global economy, as it prospers or fails, special attention should be given to health in terms of its ability to enhance the other choices. I am most attracted to the possible impact of health on economic growth and finding solid ground for investment in health.

A recent editorial in the British Medical Journal by Professor Normand was titled "Can an economic case be made for investing in health?" and the subtitle read: "No, but it's the wrong question." The burden of this argument was that "productivity and growth (as conventionally measured) are unlikely to be sufficiently increased by health services, for this to be the main justification for health care expenditure." The article goes on to suggest that human welfare should be the main rationale for investment in health.

This thinking is a perpetuation of the myth that investment in health care services is equivalent to investment in improving the overall health of the population. I know that there is an argument to be made that the care services that contribute to persons remaining healthy—although they are not whole in a physiological sense—do permit them to be economically productive. Unfortunately, there are no good indicators to measure this aspect of the performance of the care services. The restoration to health of an adult with pneumonia, the setting of a broken limb, the treatment of a middle-aged adult with heart failure, and the treatment of a person with depression are all examples of how care services may enhance productivity. There are just no good ways to measure these effects in terms of impact on productivity.

But there is yet a wider issue and we must insist that concern for investment in health cover all those preventive and promotive measures that keep a person healthy. Personal care services will always be and should be important as they most often deal with the restoration of what is one of, if not the most, important nonrenewable resource. It is for this reason and because of the growth of technology, along with the imperative to do everything that can humanly be done that care services consume such a large

portion of expenditure in health. There are, of course, good political reasons for such attention to individual care, as economists such as Nancy Birdsall have pointed out.

In work that has been almost forgotten, Fogel has taken a historical approach to health and economic growth. He writes:

> Although the technological process, industrialization, and urbanization of the nineteenth century laid the basis for a remarkable advance in health and nutritional status during the first half of the twentieth century, their effects on the conditions of life of the lower classes were mixed at least until the 1870s or 1880s. The great gains of the lower classes were concentrated in the sixty-five years between 1890 and 1955. Improvement in nutrition and health may account for as much as 30 percent of the growth in conventionally measured per capita income between 1790 and 1980 in Western Europe, but for a much smaller proportion in the United States.

It is intuitively obvious that a healthy population is more productive, although the extent to which the increased possibility of producing actually translates into increased individual or group output will depend on many other factors, such as levels of employment and capability of engaging in the kind of productive activity that is profitable in the given society.

I make the argument that a healthy population makes for increased returns on the investment in education. The population lives longer and, therefore, there is a greater return on the educational inputs. In addition, the healthy, well-nourished child or young person is much better equipped to learn and benefit from the education provided. Investment in education is heaviest early in life with the expectations of societal returns throughout the life span. The investment in health to maximize these returns must be made not only at the beginning, important though this may be, but also throughout the duration of the individual's life. This contribution of health to the formation of human capital as a fundamental ingredient for economic growth is now well accepted at the conceptual level although we still lack many of the empirical studies to quantify it.

I also propose that health can contribute to development of the social capital that is coming to the fore as a critical factor in a country's economic performance. In a recent lecture on the Health of Small States, I outlined how this concept of social capital may be particularly relevant in small communities, but I believe that it is universally applicable. It is a bi-directional phenomenon in that health may induce social capital formation and such capital has also been shown clearly to contribute to health. They are both necessary for a country's economic growth.

The recent crises in Southeast Asia have caused me to speculate on the possible health effects of economic collapse. We see a drop in the standard of living and rising unemployment consequent to the contraction of the economy. Such collapse might have been due in part to the fragility of the infrastructures necessary to sustain a market economy as part of the global movement. But we do not have to speculate in the case of Russia. The entry of that country into the global economy and the transition to a capitalist

market-driven economy have had disastrous effects, as shown by Becker and Bloom.

That country has undergone one of the most remarkable demographic calamities of modern times. We find that life expectancy at birth fell from 69.6 years in 1965 to 67.6 in 1980. It increased slightly in the eighties, but there was a dramatic fall from 69.6 years in 1989 to 64.0 in 1994. There was a sharp increase in cardiovascular disease, as well as increase in deaths due to external causes such as injuries, and even the communicable diseases, such as pneumonia and diarrhea diseases, increased. The most remarkable aspect of this was that there was little change in infant mortality rates and the prime cause was an increase in adult mortality rates. The published evidence shows that this mortality increase was related to the societal and individual psychological disturbance or dislocation subsequent to the marked transition to a new form of economic and social organization. It is relevant to our comments above on social capital that investigators also found that deterioration of that capital might have been a contributor to the increased mortality.

The current stresses in the market option have encouraged me to revisit the history of enthusiasm for this approach. In his gripping book The Commanding Heights, Yergin examines the rise and fall of statism and the capitalist market approach to the global economy. It is clear now that there has to be a symbiotic relationship of the state with the market that protects against the unbridled power of the state while also ensuring that the state blunts the edge of the market in the name of the weaker and more unfortunate of society. I quote from the concluding part of Yergin's book. He writes: "If the market's benefits are regarded as exclusive rather than inclusive, if it is seen to nurture the abuse of private power and the specter of raw greed, then surely there will be a backlash—a return to greater state intervention, management, and control."

He goes on to comment that, at this time, the state is withdrawing from the commanding heights, leaving much more room for the market. But in a significant comment, he says: "This represents a great reconnecting—a conjoining of the beginning and end of the twentieth century. The century opened with markets ascendant and an expanding global economy, buttressed by a spirit of optimism."

This situation, of course, was soon followed by economic depression on a global scale and increasing state intervention. Even within the last 30-40 years there have been changes in economic thinking and practice and the paradoxes that have arisen from them have been well described by Louis Emmerij in the introductory essay to Economic and Social Development into the XXI Century. He cites several paradoxes that must be resolved—perhaps the most pressing being the paradox of globalization: "global wealth and national poverty."

But let me return to the longer sweep and tie health considerations into the changes at the beginning and end of the century. Towards the end of the last century, when markets were ascendant, we saw in Europe the marked inequalities and gross differences in health status between the rich and the poor. Many of the great public health reformers came to prominence on the basis of the poor health conditions in countries at that time, and there was no doubt in many minds that this inequality that expressed itself in ill health was a natural consequence of the market economy.

The revulsion over this state of social deprivation, particularly in Great Britain, saw the determined state interventions with the establishment of social programs intended to correct the inequalities. The

National Health Service was one of the gems of these social programs. I did not know Britain then, but I did know the Caribbean, and was witness to the riots and social upheaval that were the consequence of the inequalities that saw expression in ill health and scarce economic opportunities for the poor. We have now seen the pendulum swinging again with markets ascendant, inequality rising and, at least in some countries such as Russia, a marked deterioration in health status. And even in this country, the USA, there is concern that the inequality created by the market-driven prosperity is having a negative impact on health outcomes.

The view that is most interesting to me is that what appear to be cycles are no more than blips of history as we progress inexorably towards the standard organization of human activity. As Fukuyama would point out, this standard is a liberal democracy and its companion, a liberal market-driven economy. For him, history as a continuous evolutionary process would come to an end with the universal acceptance of the liberal democratic form of government, and man's thirst for recognition would find ultimate expression in the market economy that would be the universal form of global organization of production.

I can see the liberal democracy that favors popular participation permitting or enhancing the possibility of investment in social goods, including health. I have difficulty, born of recent experience, in seeing how these social goods will be appropriately protected or promoted in this liberal economy without adequate state intervention and safeguards.

The more fundamental question at this time is whether the process of reforming or restructuring this global economy will take account of the need to "protect" health and other social goods. Will we agonize after the fact, as we did in the eighties, or will those who now seek to set the global economy back on a track that recognizes the danger of inequalities, accept that the health of populations is as important a choice as those implied in human development? Is it possible to avoid the pendulum swinging too far over, as it did in the middle of the century, and seek to establish the proper balance between state and market such that there is optimum human development?

In this context, there is one phenomenon that is likely to be more important now than before and that is the growth of civil society, which, usually at the national level, represents the social organization that stands between the individual and the state. Much of the confrontational approach to the state is lessening and there seems to be less suspicion by the state of the bona fides of these organizations. Another interesting phenomenon is the globalization of civil society itself and the development of transnational civil organizations. The most famous of these have concerned themselves with environmental issues, but the various international organizations have shown their possible strength in advocating for health issues. I am optimistic that there will be global acceptance by civil society of the universal need to have health assume a prime place among those choices that must be protected.

There are other features of the global economy of today that will affect health, and perhaps the most important is the growth of the technology that permits dissemination of information. Growth in information technology has facilitated the economic globalization process, but, in itself, has repercussions beyond economics and markets.

The most obvious is the increased consciousness about global events. Thus, the health situation of distant parts is available for us to see instantly and images of ill health have been among the most potent in focussing attention on the plight of refugees and displaced persons, for example. These images bring home more sharply than anything else the fact that there are large numbers of people for whom human development is stymied because they do not have the choice of health.

The global economy and the global information spread create global consumer markets, the 1998 Human Development Report points out. The effect that is most worrying to me in health terms is the creation of unrealizable health demands in countries with information, but without the health resources to provide to everyone the medical miracles acted out on television or coming to all the world through advertisements. There is an increasing global market for clothing, music, and yes, tobacco. I do not have to detail here the health effects of tobacco use and the magnitude of the effort needed to stop the epidemic, especially in countries that do not have the necessary regulatory infrastructure.

The global economy also speaks to increased movement and trade in goods and services. There are several areas of activity of the World Trade Organization that will impact on health. The Codex Alimentarius, which figures as one of the "international standards, guidelines and recommendations incorporated into the WTO's agreement on the application of sanitary and phytosanitary measures," has as one of its main objectives protection of the health of the consumers and ensuring fair practices in the food trade. All countries are increasingly conscious of the spread of disease through food, and recent outbreaks of food-borne diseases in this hemisphere heighten the need for strong programs in food protection. The infections caused by cyclospora in Guatemalan raspberries is only one of the many examples of the international transfer of ill health as a result of expanding trade.

Movement of services is and will be affecting health and the General Agreement on Trade in Services sets out the framework for such interchange to occur. We have seen increased trade in health services in this hemisphere and travel for health purposes is a nascent, but important, industry. The global economy will facilitate this movement of health skills and the impact on developing countries has not been explored extensively outside the context of the brain drain from developing to developed countries.

I have covered the wide range of aspects of the global economy and the relationship to health. I have devoted the most attention to the relationship of health to the forms of economic organization and the possible dangers that face us at the end of this century. I have placed a great deal of emphasis on the issue of inequality, which, when held to be unjust and unfair, is to be regarded as inequity. I do this because I believe that it is one of the major problems that face us who are concerned with health, and attention to equity is one of the core value principles of the Pan American Health Organization. It will not remain at the level of a principle, as I have committed the Organization to making it critical to our whole process of planning and programming. Inequity in terms of health outcomes implies that there will be human souls that cannot enjoy development because at least one of the basic and fundamental choices has been denied them.

INTERNATIONAL & REGIONAL INTEGRATION PROCESSES IN THE NEW GLOBAL ECONOMY

GLOBALISATION & HEALTH POLICY:

A Conceptual Framework and Research and Policy Agenda

Kelley Lee

Globalisation is a term that has been used frequently in recent times to describe a wide range of processes and events, including many developments in the health field. As a convenient catch-all, it has been cited as cause and effect of many things—as both a source of widespread integration and disintegration of social groupings and structures; as both a creator of shared identities and a force behind individual alienation; as leading to both the "end of geography" and reinforcement of nationalism and regionalism; and as a facilitator of both greater co-operation and competition among individuals and groups. These varied, and seemingly contradictory, views of globalisation are undoubtedly a result of its complex and multifaceted nature.

While globalisation has been extensively studied and debated since the 1970s in a number of fields, including politics/international relations, business and management studies, cultural studies, futurology and economics, it has only begun to be explored by health researchers and policy makers in the mid-1990s. Suddenly, globalisation has come to be recognised as a highly important and defining feature of health policy in the late twentieth century. In part, this has arisen from reform of international health co-operation, notably the role of the World Health Organisation. Added to this has been awareness of changes in the nature of health issues as a result of trans-border

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challenges (e.g. emerging and re-emerging diseases, environmental change, demographic trends, and technological developments). As a result, many voices have become united in their perceived need for a global approach to health.

While there is growing consensus on the importance of global health, there remains limited empirical research for understanding the nature and impact of globalisation on health, and for informing policy makers on how to respond effectively to emerging challenges. In large part, this is due to an imprecise, and even misuse, of the term globalisation. Because it has come to mean so many things to many people, the term is in danger of becoming meaningless. To address the need for defining more clearly the links between globalisation and health, this paper begins by reviewing some of the key literature on globalisation from other fields. This is a substantial and rather daunting body of work that encompasses a wide range of theoretical and empirical material. While emphasis is placed on the field of international relations (IR), it also includes works from other subject areas. Importantly this review shows that, despite being a highly contested and diversely interpreted phenomenon, three distinctive characteristics of globalisation can be identified.

Based on this review, a definition and conceptual framework is put forth which are used to consider the limited existing literature on globalisation and health. Specific attention is given to how globalisation is currently understood, what features are being given particular focus and, importantly, where there are gaps in present thinking and practice. The paper concludes with a proposed research and policy agenda. While this agenda is a potentially vast undertaking, requiring interdisciplinary collaboration and commitment, priorities based around three key questions can be identified. As well as expanding understanding of globalisation as a highly complex phenomenon, the proposed agenda encourages policy makers at the local, national, regional, international and global levels to think more carefully about the important challenges ahead.

Globalisation and the International Relations Literature

The literature on globalisation is abundant and fast growing, encompassing a number of different subject areas and a broad range of perspectives. The term globalisation was originally coined in the mid-1940s and entered the Webster's American Dictionary in 1961 (Scholte 1997). In the early 1970s, the political economist George Modelski (1972) revived the term to describe the growing impact of multinational corporations on economic relations within and across countries. Over the past three decades, the term has been defined and redefined by many writers, eliciting a fiercely contested debate within widely divided academic and policy communities.

The growth of interest in globalisation in IR from the 1970s came as a reaction to traditional, and empirically inadequate, **realist theories**, which focus on states and intergovernmental relations. Realist theories emphasise relations among powerful governments (i.e. "great powers"), largely via diplomatic channels, and their pursuit of national interests (Morgenthau 1960). By the 1970s the post-war growth

of the world economy, increasingly characterised by international structures of power, production and social relations, (Cox 1987) provided a substantive challenge to dominant modes of thinking and practice. A variety of approaches flourished including world systems theory (Wallerstein 1974), globalism (Burton 1972) and interdependence theory (Keohane and Nye 1977). While derived from a broad spectrum of ideological, theoretical and methodological perspectives, all shared a common questioning of the state as the primary unit of analysis. From this questioning bloomed numerous research programmes concerned with the substance and impact of transnational forces. Importantly, the study of globalisation as it emerged, paralleling schools of political and economic thought, soon diversified in what was studied (ontology), how to study it (epistemology), and conclusions drawn. The two extremes marking the boundaries of this ongoing debate can be roughly defined as liberal theory and critical theory.

Liberal theory (including neoliberalism and rational choice theory) has been the strongest advocate of globalisation, and the often-unstated basis of the proliferation of works within the business and management field. Briefly, globalisation is hailed by liberals as a process of market capitalism triumphing on a world scale. It is held to be an essentially rational process that is freeing the allocative efficiency and productivity of the private sector from the constraints of overly large government and organised labour. Integral to this vision of liberal globalisation is the renewal of modernisation theory and its implied notions of progress. All countries are seen to be converging towards a single global economic system. Ultimately, liberals foresee a borderless world, with private capital achieving global economies of scale for the ultimate interests of all (Ohmae 1990).

This essentially Panglossian view of globalisation, as a liberal utopia, has been sharply refuted by critical theorists who warn of its destructive and destabilising impact. Rather than integrating individuals and groups more closely together with shared interests, critical theory see globalisation as a socially divisive force which exacerbates existing divisions between the “haves” and “have nots” within and across countries (Amin 1997). This has been manifested in the decline of the welfare state, weakened labour standards, increased employment insecurity and greater social exclusion (Kennedy 1996; Wilding 1997). As such, liberals are criticised for emphasising the benefits, and underestimating the costs, of globalisation.

Concern for the human and social costs of liberal globalisation has led some writers to predict that it will eventually succumb to its own internal contradictions. Cox (1995) likens this looming crisis to Karl Polanyi's (1957) analysis of capitalism in the nineteenth and twentieth centuries, which brought greater polarisation of rich and poor, disintegration of pre-existing social bonds, and individual alienation. Others question globalisation as an ideology which, in its present form, should be countered by political resistance “from within civil society and from the base of organised labour and new social movements” (Amoore et al., 1997). Similarly, Gill (1995) writes that “the contestability of, and contradictions in, the practice of neoliberal discourse” need to be highlighted as a starting point to a “wider emancipatory project that seeks to use new forms and modes of knowledge to transcend the dominant economism and reductionism of our time, and to contribute to the possibility for new intersubjectivities and intellectual

and material networks." In general, critical theorists question the long-term social, political and economic sustainability of liberal globalisation, and challenge its reification as self-evident and inexorable.

Between the liberal perspective, with its focus on the "winners" of globalisation, and a critical theory perspective, with its focus on the "losers," many scholars and policy makers are struggling to come to terms with the implications of globalisation for particular areas of human activity. Importantly, it is by recognising it as "a contested concept, not a received theory" (Amoore et al., 1997), that we can begin to reflect upon the complexity of globalisation as both an intellectual and practical phenomenon.

Some Key Features of Globalisation

By the mid-1990s, the term globalisation came to be used so broadly that there has been a real danger of losing sight of it as a distinct phenomenon. As Jones (1995) writes, globalisation is "amongst the most abused and misused terms in popular usage." First, there is no one agreed-upon definition of globalisation because the concept is inseparable from different value-based views of the way in which the world works and ought to work. The descriptive is inextricably bound up with the normative. Second, writers have focused on selected aspects of globalisation that they see as being of key importance. Third, in many cases the term has been used interchangeably with similar terms (e.g. international), leading to further vagueness and overlaps in meaning (see Box 1). Despite continued debate about the nature of globalisation, the extent to which it is occurring, and the balance between its costs and benefits, it is possible to identify three key features.

Globalisation is a process rather than an object or outcome

First, globalisation can be understood as a process, rather than an object or outcome, which is changing the nature of human interaction. This process can be described as 'globalising' in the sense that boundaries of various kinds, hitherto separating individuals and societies, have become increasingly eroded. The timing of this process, and the pace of its progression, remains in dispute. Many writers in business and management studies hold that globalisation is a relatively recent phenomenon, defined foremost by increased economies of scale across national borders of multinational enterprises (Rugman & Gestrin 1997). Globalisation, in this sense, is seen as a largely rational and progressive phenomenon. Many social and political theorists, however, argue that globalisation is part of the much longer historical process towards the development of modernity dating from the fifteenth century (Giddens 1990; Robertson 1992). Therefore, globalisation, encompasses, yet is distinct from, the processes of regionalisation and internationalisation.

Globalisation is a social (human) rather than natural process

Second, globalisation is often assumed to have momentum beyond human control. Indeed, liberal-based views hold that the process is primarily an expression of market forces, driven by the assumed logic of the "invisible hand." It is this belief in the self-regulating powers of the free market, and the

essential rationalism of globalisation, which lies behind claims that individuals must somehow adapt to its inexorable progress. Faced with this "reality," opposition to current forms of globalisation, regulation of its effects, or redirection of it for alternative purposes (e.g. social welfare) is seen as an interference or misguided effort.

Most writers, however, hold that globalisation should be understood as a social construct rather than a natural process. While there are clear impacts on the natural world (e.g. global environmental change), it is human activity individually and collectively which ultimately drives globalisation. The particular form that it takes, how its effects are assessed and responded to, and even how it is understood therefore lies within the power of people to direct, guide and control it. Such power is undoubtedly unequally distributed, and one of the great challenges remains the enfranchisement of a wider constituency to contribute to its definition.

Globalisation has varying impacts on different individuals and groups

Opinion is polarised in the literature on whether globalisation is having positive or negative consequences for individuals and groups. Again, this depends much on the particular vision of globalisation one holds, as well as one's place within the emerging order. Undoubtedly it is a process which affects different individuals, social groups, sectors, countries and regions in different ways. There are both winners and losers. In this respect, globalisation is distinct from interdependence which denotes mutual dependence (and hence mutual costs and benefits). Globalisation may also generate relationships of dependence which create inequitable costs and benefits, as well as reinforce existing inequalities. Critical theorists, in particular, are concerned with the losers of "uneven globalisation," those who experience increased economic insecurity, political alienation and social. The winners in globalisation, in contrast, are advantaged by greater resources, mobility and life opportunities. One of the key challenges for research and policy making is to better understand how globalisation is impacting on different individuals and groups, and how inequities could be mediated.

Spheres and Dimensions of Globalisation: A Conceptual Framework

From the above discussion, globalisation can be defined as a process which is changing the nature of human interaction[1] across a wide range of spheres including the economic, political, social, technological and environmental. The **economic sphere** concerns the production, distribution and consumption of wealth. The organising principles for achieving this, in terms of inputs, modes of production, and scale of operation are argued to be changing as a consequence of globalisation. It is argued that we are moving towards a global economy by which there are larger economies of scale, greater trade of goods, services

[1] The term "interaction" is preferred to "integration". The latter, defined as combining or adding parts to make a unified whole, implies that globalisation is largely a rational and progressive process. Interaction, defined as a mutual or reciprocal action or influence, suggests that globalization can have both positive and negative effects, and may be progressive or regressive.

and capital, and increased mobility of labour. However, this has been an uneven process, with some sectors (e.g. automobile, food) demonstrating globalising features, while others have not.

The **political sphere** concerns the distribution and use of power, in its most organised form through government. Because of globalising forces, many writers argue that who holds power, the forms of power being wielded, and ways that power is being used are changing. This has led to discussion of new forms of political representation (e.g. global civil society, public-private partnerships) and authority (i.e. global governance). The **social/cultural sphere** concerns the collective activities, shared identities and traditions (e.g. values, beliefs, ideas), and support structures of societies. Perhaps the greatest impact of globalisation on this sphere comes from the emergence of a global mass media which, it is argued, is changing underlying cultural foundations. Some believe that globalisation is contributing to new social identities across hitherto separated communities through, for instance, the internet (e.g. global environmental movement).

The **technological sphere** can be defined as the application of knowledge and skills for industry, commerce, the arts and science. Globalisation may be affecting the development of technology, as well as its wider dissemination through, for example, foreign investment. The **environmental sphere** concerns both the natural and manmade surroundings within which people live and interact. It has become increasingly recognised that local environments are intimately linked with the global. The globalisation of particular forms of economic activity (e.g. unsustainable use of natural resources, toxic waste dumping), lifestyles (e.g. consumerism) and social structures (e.g. urbanisation) has contributed to environmental degradation.

As well as recognising the diverse manifestations of globalisation, it is important to understand the nature of the changes being brought about. As described above, the process of change can be described as globalising in the sense that boundaries of various kinds are becoming eroded. This erosion can be seen to be occurring along three dimensions: spatial, temporal and cognitive. The **spatial dimension** concerns how we experience and perceive physical space. On the one hand, there is a growing "sense of the world as a single place" (Robertson 1992) due to increased travel, communication, trade and other shared experiences. This process of spatial globalisation can be seen to occur gradually over many centuries, from the rise and fall of ancient civilisations, to the age of imperialism and the industrial revolution. Since the end of the Second World War, there has been an intensification and diversification of interaction, enabled by the development of mass transportation and communication technologies. This has led, as Cairncross (1997) argues, to the "death of distance." More accurately, perhaps, rather than becoming irrelevant, there have been profound changes to how physical space is experienced and perceived—a "re-territorialisation" rather than "de-territorialisation" of human activity. Novel ways of defining physical space, such as cyberspace and virtual reality, are also changing human experience. At the same time, there is evidence that globalisation may be reinforcing geographical boundaries or creating new divisions within and across countries. The rise of nationalism in parts of the world, for example, illustrates the continued importance of geographical territory for many. Thus, the spatial dimension of globalisation is creating diverse changes to the physical boundaries of human interaction. Geography

continues to be a fundamental parameter for human societies, but how we experience and perceive space is changing (Gottdiener 1998).

The **temporal dimension** concerns changes to the actual and perceived time in which human interaction occurs. In many ways, there seems to be a speeding-up of timeframes. A notable example is communications which, with the development of satellite technology, facsimile, and the internet (including email) enables within microseconds. In comparison, half a century ago it took weeks for a letter to be delivered trans-atlantically by ship. New technologies, accompanied by deregulation, have also led to an acceleration of currency trading, totalling US$1.7 trillion daily world-wide, two-thirds of this trade for less than seven days (The Economist 1997). Similarly, mass transportation, in the form of high-speed trains and supersonic airplanes, enables travel to distant locales within a few hours.

The **cognitive dimension** of globalisation concerns changes to the creation and exchange of knowledge, ideas, norms, beliefs, values, cultural identities and other thought processes. How we think about ourselves and the world around us is being changed by globalisation. The causes of this are varied including the mass media, educational institutions, think tanks, scientists, consultancy firms and "spin doctors." On one hand, there is a greater sharing of thought processes in the form of popular culture (e.g. Hollywood films, pop music, fashion), scientific research, and international agreements (e.g. human rights). On the other hand, there is resistance to the globalisation of thought processes through, for example, the exemption of cultural industries from free trade agreements, and resurgence of religious fundamentalism (Beyer 1994).

As well as identity, scholars have begun to consider the impact of globalisation on knowledge creation through the universalisation of the English language, educational institutions, research and development, and business and management practices. While there is more knowledge generating activity than ever before[2], many question its increasing commodification (e.g. intellectual property law[3]), normative bases, and capacity to be adapted to local needs. Thus, globalisation is centrally about "our mental frameworks—for example the way that we think about social institutions and forms of political authority in the brave new world of a globalising capitalism" (Gill 1997). The apparent move towards a "unified consciousness"[4] holds collective possibilities, as well as inherent contradictions.

Globalisation and Health: An Historical Perspective

Using the above conceptual framework, the relationship between globalisation and human health can begin to be explored more fully. If one accepts that globalisation has been a gradual process over many

2 For example 95% of all scientists and technologists who ever lived are currently living (Kennedy 1998).

3 This has largely been pursued through the adoption and enforcement of stronger and more uniform intellectual property laws within the GATT, WTO and World Intellectual Property Organization (WIPO).

4 This is a term used by Antonio Gramsci to describe an earlier form of globalisation during the Enlightment. Hoare Q. (ed.) (1977), *Antonio Gramsci, Selections from the Political Writings, 1910-20* (New York: International Publishers), p. 12. See also Sassoon A. (1997), *Gramsci's Politics, Second Edition* (Minneapolis: University of Minnesota).

centuries, rather than decades, we can see that health has been intimately linked to historical change. Clark (1997: 280) dates globalisation to the migration of homo sapiens out of Africa: "In becoming global, humans, plants, animals, and diseases have co-evolved; i.e. evolved together as a package of interdependent life systems." Robertson's (1992) historical stages of globalisation dating from the fifteenth century, however, seem to fit more appropriately with the history of medicine. Until this period, as Hays (1998) writes, "Humans on different continents, and their accompanying parasites, had a period of separate evolution." This isolation ended with the age of exploration, trade, conflict and imperialism which brought "movement of a wide assortment of animals, insects, and parasitic micro-organisms" across continents. Accompanied by the spread of European hegemony, this led to an unprecedented introduction and spread of many new diseases to hitherto unaffected populations. Diseases such as smallpox and measles were introduced by Europeans to the Americas with devastating effects (Crosby 1972). At the same time, diseases such as syphilis from the Americas and typhus from Asia were introduced to Europe. Hence, changes in the spatial dimension of human interaction were beginning to have consequences for patterns of health and disease.

With continued migration of human populations, and their concentration in larger and more densely populated communities, the temporal dimension of globalisation began to affect human health. From the seventeenth century, industrialisation, urbanisation, military conflict and socio-economic upheaval created conditions of increased vulnerability to disease. Despite the adoption of early public health measures, notably quarantine, inequalities in living conditions and a lack of basic medical knowledge allowed many communicable diseases to spread more rapidly and frequently. Cholera emerged from India in 1817 to begin the first of six pandemics over the next hundred years. Diseases such as influenza, tuberculosis and poliomyelitis spread globally during this period, the former killing tens of millions following World War I. Typhus and syphilis continued to inflict a heavy toll, particularly on ill-equipped and often ill-disciplined armies moving about Europe and the colonies. Other types of diseases, with consequences for human health, also benefited during this period. The most infamous perhaps was the potato blight which spread quickly from the north-east coast of North America in 1840 by ship to Europe in 1845, eventually causing widespread starvation (Cohen 1989). In the above examples, countries were faced with an unprecedented number and frequency of threats.

Spurred by these new threats, and assisted by major advances in medical, the nineteenth century saw increased bilateral, regional and international co-operation on health matters. The creation of the Office International d'Hygiène de Publique in 1907 further standardised and routinised the collection and dissemination of certain health information and eventually paved the way for the establishment of the World Health Organisation in 1948. This process of knowledge creation and sharing across countries signalled the growing cognitive impact of globalisation, a process that gained further momentum with the professionalisation of the health field, establishment of research and training institutions world-wide, and exponential growth of scientific meetings, publications and other modes of interaction.

To summarise, the initial impact of globalisation on health has been spatial, with human contact leading to the spread of diseases across a wider distance. As human interaction intensified further, the

rate at which health was affected increased. Partly in response, globalisation eventually influenced knowledge about health and health care across countries. In the late twentieth century, to the extent that there are simultaneously spatial, temporal and cognitive dimensions at play, it can be argued that this stage of globalisation and its impact on health is distinct. It is for the purpose of better understanding globalisation and health in its current form that this paper now turns.

Globalisation and the Health Literature

There has been a growing but uneven literature on globalisation and health since the mid-1990s. To a large extent, this writing is proving subject to much of the familiar hyperbole and ideological divisions found in other fields. Many works do not clearly define what they mean by globalisation, while others misuse the term to describe quite distinct phenomena. For example, Fidler (1997) defines the "globalisation of public health" as the situation in the late twentieth century whereby "sovereign states no longer can protect the health of their citizens without international co-operation." However, as described above, governments recognised this vulnerability much earlier. Similarly, Freeman et al. (1996) define globalisation as transborder health issues arising from the North American Free Trade Agreement (NAFTA). This could more accurately be described as regionalisation.

In terms of the spheres of globalisation, the literature has strongly focused on the **economic sphere**, notably the direct and indirect impacts of global trade and production on health. The conclusion of the Uruguay Round of the General Agreement of Tariffs and Trade (GATT)[5] in 1994, and the creation of the World Trade Organisation (WTO) in 1995, have led to concerns about inadequate protection of public health interests, especially in low-income countries (Navarro 1998; Zarilli and Kinnon 1998), and the more indirect impact of globally traded goods and services. Of particular concern is the lack of agreed-upon and enforced regulations to protect health through, inter alia, quality assurance, hygiene standards, labelling, ethical marketing practices and occupational safety. Diseases transmittable by the global trade of goods and services (e.g. foodborne diseases) have also been given particular attention (Kaferstein et al., 1997). While some international agreements exist, such as the Agreement on the Application of Sanitary and Phytosanitary Measures and the Codex Alimentarius, the extent to which their stipulations have primacy over, for example, rules of the WTO, remains unclear (Fidler 1996). The 1997 ruling by the WTO on U.S. hormone-treated beef imported to the European Union in favour of American producers, and the ruling in favour of Ethyl Corporation over the Canadian government under rules have added to these concerns. Implications for health are also raised by the so-called "race to the bottom" in social welfare provisions (i.e. low pay, child labour) as governments compete for global trade and investment (Deacon 1997).

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5 The General Agreement on Trade in Services (GTS) signed at the Uruguay Round excludes health services. However, regional negotiations and future world trade negotiations may seek to include them within trade provisions.

The anticipated impact of globalisation on health has also generated a growing body of work in the **environmental sphere**. Gaining momentum after the U.N. Conference on Environment and Development in 1989, at which WHO was given responsibility for following up health-related goals of Agenda 21, research has been initiated on the links between global environmental change and human health. The health implications of global climate change has received particular attention (McMichael 1995; McMichael and Haines 1997; Haines and McMichael 1997), including epidemiological impacts on diseases such as malaria, cholera, schistosomiasis and Lyme borreliosis, (Wilson et al., 1994; Murray and Lopez 1995; de Cock et al., 1995; Barthold 1996; Colwell 1996; Patz et al., 1996; Wise 1997). The problem of harmful transborder externalities created by industrial hazards and toxic waste dumping is also being explored (Castleman & Navarro 1987; Castleman 1995). Consideration of the policies needed to mitigate these effects, and the mechanisms (e.g. remote sensing, global observation systems) needed to help human populations adapt to foreseen changes, are being explored.

Less attention has been given to the **political sphere**. A notable exception is Moran and Wood (1996) who describe four ways in which health policy is becoming more "globalised": (a) changes to policy making whereby global networks among policy actors have developed, or global actors penetrate policy making in individual states; (b) implementation of health policy whereby health services or health care users migrate across national boundaries; (c) organisation of production and supply of health products (e.g. equipment, drugs); and (d) the "mind set" of national policy makers (e.g. health sector reform). This is a useful starting point for exploring globalisation and health policy, but broader political issues beyond the health sector also warrant further consideration. The bringing together of the substantial literature on global civil society (Walzer 1995), transnational policy networks (Haas 1992), world civic politics (Wapner 1997) and non-state actors with specific health issues could yield a rich area of research to better understand changing power relations and policy processes which effect health. This has been done to a limited extent in relation to HIV/AIDS (Lipschult 1992; Gordenker et al., 1995), abortion policy (Crane 1994) and population (Lee & Walt 1995; Dodgson 1998) to analyse transnational policy processes and explore structural features of an emerging global political economy (Lee & Zwi 1996).

A related concern is the reform of international health co-operation and the possible need to strengthen global governance for health. Since the early 1990s, there has been substantial analysis of the reform of WHO and other health-related international organisations amidst changing health needs, policy actors and resources (Lee and Walt 1992; Walt 1993; Vaughan et al., 1995; Lucas et al., 1997). More recently, WHO reform has begun to be linked to globalisation. Kickbusch (1997), for example, argues for a "new public health" which *inter alia* addresses the challenges of globalisation through involvement of private sector players, the health care industry, information industry and "lifestyles" industry. Others have put forth proposals to create a system of global health co-operation (Sterky et al., 1996; Frenk 1997; Raymond 1997; Institute of Medicine 1997; Jamison et al., 1998; Lee 1998). As reform efforts continue, it might be useful to draw from the rich literature on global governance which has been applied, for example, to the environmental field (Young 1997) and financial markets (Kapstein 1994; Reinicke 1998).

The **social sphere** has also received limited attention although scholars in social policy have drawn links to health issues. Deacon et al. (1997) are notable in their attention to the social policies of the World Bank, IMF, other UN organisations and European Union and the prospects for global social policy. Others recognise the need for political leadership to place the social impact of globalisation much higher on national political agendas (Sewell & McDowell 1998). Overlapping with the study of politics, the growing role of global social movements (Ray 1993), such as the International Women's Health Coalition (Dodgson 1998), and the problems of social exclusion within and across countries have also been understood in relation to globalising trends.

Finally, despite a rich body of work on the cultural aspects of globalisation (Jameson & Miyoshi 1998), this has yet to be fully explored in relation to health issues. In "AIDS as a Globalizing Panic," O'Neill (1990) considers AIDS as "one of a number of panics of a political, economic, financial and 'natural' sort to which the global order responds with varying strategies of crusade, sentimentality or force." Such "globalizing panics...rely heavily upon the media and television, newspapers, magazines, films and documentaries to specularize the incorporation of all societies into a single global system designed to overcome all internal division." Altman (1996) examines the "paradox of the apparent globalization of postmodern gay identities" or "internationalization of a certain form of social and cultural identity" as a result of forces of global change (e.g. HIV/AIDS) which has led to homosexuality being increasingly interrogated. More broadly, Kalekin-Fishman (1996) explores the meaning and significance of ethical choices in health under globalisation, defined as "social process in which the constraints of geography on social and cultural arrangements recede and in which people become increasingly aware that they are receding." Bettcher and Yach (1998) point to the need for a globalisation of public health ethics given that many public health challenges transcend state borders.

As well as the spheres of globalisation, the literature is uneven in terms of attention to its spatial, temporal and cognitive dimensions. Most writers have focused on the **spatial dimension**, exploring how globalisation is changing the geographical spread and incidence of, for example, particular diseases (Wilson et al., 1994; Winker & Flanagin 1996). This has been especially so in popular writing and, to a lesser extent, science journals which have played on fears of plague and pestilence (Preston 1994; Garrett 1996; Ryan 1996). The end of the Cold War fuelled a search, notably in the U.S., for new threats to national interests. In this context, emerging and re-emerging diseases (U.S. National Science and Technology Council 1995), biological and chemical weapons, illegal drug trafficking (Stares 1996) and global demographic shifts (Lynn-Jones & Miller 1995) have been cast as new security issues.

In summary, the health literature on globalisation is a growing body of work with a strong emphasis on the economic and, to a lesser extent, environmental sphere. While addressing important changes, greater understanding of the political, social and cultural spheres is also needed. Furthermore, the spatial dimension of globalisation has dominated the health literature, with only limited attention to potential temporal and cognitive changes. To encourage a more comprehensive understanding of globalisation and health, and contribute to the strengthening of policy responses, a research and policy agenda is put forth below.

A Proposed Research and Policy Agenda

Despite growing recognition of the impacts that globalisation is expected to have on health, there remains limited empirical research to understand its specific impacts and to inform policy makers on how to respond effectively to these challenges. Undoubtedly, this is a formidable endeavour because it brings together at least two multidisciplinary fields—globalisation and health. To begin organising and prioritising the many issues of potential concern, it is useful to consider the following questions:

(a) To what extent is the globalisation of health occurring within different spheres and along different dimensions?

Globalisation remains a highly contested phenomenon. Lively debate continues over whether it is actually occurring, over what period of time, and to what extent. Empirical research would need, foremost, to establish the degree to which globalisation is actually taking place in relation to the health sector. This would begin with the development and use of a commonly agreed-upon definition, as well as methods of measuring globalisation in relation to the health sector. The task would be twofold. First, a better understanding is needed of the extent to which health determinants are becoming globalised. Health determinants include the broad underlying economic (e.g. income per capita, industrialisation), social (e.g. urbanisation), political (e.g. democratisation) and cultural (e.g. status of women) factors "which determine health and are responsible for, and propel, the health transition" (Beaglehole & Bonita 1997:8). They also include health systems that provide preventative and curative care. It is expected that globalisation has thus far had a greater impact on the broad determinants of health than on health systems, which remain located and regulated at the national level. Nonetheless, we might ask to what extent public and private activities in the health sector (e.g. service provision, research, training, financing) can be described as spatially, temporally or cognitively global.

Second, there is a need to understand the extent to which patterns of health and disease within and across countries are becoming globalised. There is some evidence to suggest, for example, that the incidence of certain diseases (e.g. foodborne diseases, tobacco consumption, obesity), as well as specific health risks (e.g. violence, injuries), may be showing changes of a global nature. The degree that this is occurring, and how this is linked to broader determinants of health, needs more detailed study.

(b) What positive and negative effects is globalisation having (or expected to have) on the health of particular individuals and groups?

One of the key reasons that globalisation remains so contested is that it affects different individuals and groups very differently. Within the current form of globalisation, characterised by neoliberalism and economic exigencies, among the "winners" are transnational corporations, political and economic elites, the capital- and information-rich, and the appropriately educated/skilled and relatively mobile within the workforce. Yet there are also "losers" within this process—small local businesses, socially excluded or marginalised (e.g.

underclass), the capital- and information-poor, and the inappropriately educated or unskilled (Rifkin 1996). While there remains disagreement whether these adverse effects are "temporary wrinkles" in an essentially progressive process, as liberals argue, or an inherent feature and contradiction of neoliberal globalisation, as critical theorists argue, more empirical evidence is needed to describe and document these effects.

The proposed agenda would thus seek to understand whose health is being affected by globalisation and in what ways. Current, largely national measures of health status are insufficient for understanding global patterns of health and ill health. For example, the so-called 'health transition' occurring in many countries, from communicable to non-communicable diseases, relies on aggregate national statistics that do not sufficiently capture subtrends within and across countries and regions. Thus, there is a need to supplement traditional measures with new measures that recognise the possible re-territorialisation of health trends. In this way, a more detailed understanding of the health "haves" and "have nots" being created by globalisation can be achieved.

(c) What policies are needed to optimise the benefits, and mitigate the costs, of globalisation for health?

A fuller understanding of the impact of globalisation on health, based on the empirical research ascribed above, could in turn be used to inform policies that optimise its benefits and mitigate its costs. So far health policy makers have seen globalisation as a largely economic phenomenon or one they have limited capacity to influence. By recognising globalisation as a complex and multifaceted process, with both direct and indirect consequences for health, policy makers could engage the globalisation debate. This is needed at many different levels—locally, nationally, regionally, internationally and transnationally. How this should be achieved in relation to specific issues, stakeholders and institutional mechanisms, and for what purposes, suggests a rich area of research and policy debate.

Using these questions as a starting point, a research and policy agenda can be identified as a menu of key topic areas for further development. While not comprehensive, this agenda encourages a broad and multidisciplinary approach to globalisation and health.

The Agenda

The impact of the global economy on health.

Trends toward a more global economy are expected to have direct and indirect effects on health. The trade and production of health and health-related goods and services raise issues concerning, for example, access to health care and development of needed drugs and supplies. More indirect effects arise from the global trade and production of goods and services that may create externalities for health. The way in which food and drink products, for instance, is increasingly organised and marketed globally (e.g. tobacco, alcohol) have consequences for health. The conditions by which goods and services are produced in the global economy can also have indirect consequences for health (e.g. child labour, low

wages, occupational health and safety standards). Finally, a global economy can influence the way in which health is financed by determining available resources (e.g. global economic crisis) or the propagation of policy ideas.

Global governance for health.

In a more diverse and complex global health arena, there is need for political mechanisms that lead to timely and effective policy making. Existing international organisations focus largely on states and their government representatives. While still centrally important, to the extent that health involves both public and private interests, including an emerging global civil society, there is need to enhance existing mechanisms. As Fuchs (1996) argues, globalisation is creating an institutional vacuum as a result of a discrepancy between power and responsibility. He writes, "politicians, although responsible for global social development, no longer have all the power needed to define the social frame and discharge that responsibility." Global business interests, in particular, have increased economic power but have not assumed social responsibility. Similarly, Falk (1997:125-30) warns that "there is little, or no, normative agency associated with this emergent world order: it is virtually designer-free, a partial dystopia that is being formed spontaneously, and in the process endangering some of the achievements of early phases of statist world order." With globalisation may come the need to enhance international governance towards global governance for health.

The epidemiological impact of globalisation.

The changing nature of human interaction has historically shaped patterns of health and disease. Broadly, a distinction can be drawn between existing health conditions which have increased in scale as a result of globalisation (e.g. cholera, obesity) and those that have arisen as a result of globalising forces such as climate change, migration and urbanisation (e.g. drug resistant tuberculosis, BSE). Epidemiological data remains largely defined by country, with available data aggregated to understand international (nationally comparative) patterns. In contrast, global patterns include subnational patterns across countries (e.g. a growing middle-class in many low-income countries) and regions (e.g., middle-income countries). There is a need therefore to develop the means of identifying and measuring emerging global patterns, their characteristics, and the extent to which they are linked together by globalisation.

The impact of global information and communications on health.

There is no other sector that has undergone more rapid change in the past two decades, in terms of new technologies and policies, than the communications sector. While the Industrial Revolution of the nineteenth century was powered by mass production and manufacturing, the main driver of the "post-industrial" society has been information. Understanding the impact of this change on the health sector has so far received limited attention. There are many hopes that cheaper and more powerful technology will allow lower-income countries, in particular, to better share health research and information (e.g., telemedicine). Yet there are also concerns about the appropriateness and accessibility of western-defined

and owned technology (de Janos 1998). The challenge will be to balance the potential benefits of creating a global health information and communication system (e.g. surveillance) with the need to accommodate the needs of particular communities.

Summary and Conclusion

This paper reviews the substantial literature on globalisation and finds that it is a much disputed phenomenon. In part this is due to a lack of clarity in the use, and often misuse, of the concept. However, there are also clear ideological differences that influence descriptive and prescriptive writing on globalisation. In clarifying its key features, this paper defines globalisation as a process which is changing the nature of human interaction across a range of and across three dimensions. This conceptual framework shows that globalisation has so far been seen as an economic process, and a broader approach is encouraged. Indeed, the neglect of other spheres (e.g. environmental, political, social) may be seen as contributing to some of the negative consequences of globalisation thus far.

Understanding and responding to the impacts of globalisation on health is a vast and multidisciplinary endeavour, and invariably the task can be organised in numerous ways. Above all, there is an urgent need for empirical research, accompanied by the development of analytical methods, which recognises the distinct nature of the present form of globalisation and the complex ways it is affecting human health. Only then can there be a convincing case for challenging the underlying tenets of globalisation, as it is presently being played out, as a rational process offering benefits to all.

APPENDIX 1.
Some basic terms and definitions

state/nation—A state is generally characterised by a permanent population, defined territory and a government capable of maintaining effective control over its territory and conducting international relations with other states. A state is sovereign when it asserts the ultimate authority within a distinct territorial entity and membership of the international community. A nation is a broader term referring to a group of people who share a common identity, history, language, culture, ethnic or racial origins, religion, economic life, geographical location or political base. The terms are often used interchangeably or together i.e. nation-state.

regional—An activity which involves individuals or groups from more than one state located within a specific geographical region. These include regional trade agreements such as the North American Free Trade Agreement (NAFTA), and regional bodies such as the European Union (EU), Association of Southeast Asian Nations (ASEAN) and Organisation of African States (OAS).

international—A term which means, strictly speaking, interstate or intergovernmental (i.e. between or among governments). The terms crossborder and transborder are sometimes used synonymously.

multinational—An activity which takes place in more than one nation or state. A multinational corporation (MNC) is one which replicates its operations in more than one country (e.g. MacDonald's Restaurants, Arthur Anderson Consultants).

transnational—An activity that crosses above (international or global) or below (subnational) state boundaries including the movement of physical objects (e.g. goods, people), information (e.g. mass media, scientific knowledge), services (e.g. banking), and money and credit (e.g. foreign investment). A transnational corporation is one which is essentially based in one country but with elements of its operations located in other countries (e.g. Sony Corporation).

supranational—A body holding power and authority higher than or above that of the government of its member states. For this authority to be created, a state must first agree to defer its sovereignty by becoming a signatory to a binding treaty. The limited number of supranational bodies currently in existence include the European Court of Human Rights and World Trade Organisation. The creation of a range of supranational bodies to govern the main features of international relations would constitute a world government.

interdependence—A term which implies that actors are interrelated or connected such that something that happens to at least one actor will affect all other actors. Whether all actors are affected equally will define whether the interdependence is symmetrical (mutual interdependence) or not (dependence).

complex interdependence—A model of world politics which assumes multiple channels of contact between societies, an absence of hierarchy among issues, and a minor use of force or military power. By focusing on transnational relations, the actors, environments, structures, processes and outcomes of world politics are more numerous, complex and less certain.

global—A term to denote a sphere encompassing the geographical entirety of the world (e.g. ecosystem), or the interests and activities of its diverse social structures (e.g. households, societies, markets, states). It combines the elements of international and multinational with a strong degree of integration between the different national parts (O'Brien 1991:5).

globalism—A view that selected problems (e.g. population control, environmental degradation) can only be dealt with on a global scale, involving both state and non-state actors. Co-operation must be conducted among a system of mixed actors who should participate in both defining and implementing policy responses.

globalisation—A process of closer interaction of human activities across a range of spheres including economic, political, social and cultural. This interaction can be described as occurring along three dimensions: spatial, temporal and cognitive.

TABLE 1: Spheres and Dimensions of Globalisation

DIMENSIONS			
SPHERES	**Spatial**	**Temporal**	**Cognitive**
ECONOMIC	global production and trade (e.g. food, cars, illicit drugs) global financial markets (i.e. big bang)	increased speed of global financial transactions (e.g. currency speculation)	global spread of neoliberal economics global revival of stakeholder capitalism
POLITICAL	global level political representation (e.g. global civil society, global governance)	increased speed of political change (e.g. collapse of Soviet bloc)	global spread of democratic principles development of global support for basic human rights
TECHNOLOGICAL	global satellite communications network	increased speed of communication (e.g. email vs. letter)	exchange of ideas through websites
ENVIRONMENTAL	global climate change (e.g. greenhouse effect, El Niño)	accelerated resource depletion	global environmental awareness (e.g. Green movement)
SOCIOCULTURAL	transnational social movements (e.g. global women's movement) pressures on social welfare systems world-wide global mass media and telecommunication (e.g. CNN, Internet)	faster social mobilisation across countries (e.g. environmental movement) increased social instability (e.g. breaking of iron rice bowl, cradle to grave)	individualism versus communitarian principles global youth culture dual nationality and citizenship

TABLE 2: Potential Impacts of Globalisation on Health

DIMENSIONS			
SPHERES	**Spatial**	**Temporal**	**Cognitive**
ECONOMIC	global production and trade of health goods and services global resurgence of tropical diseases (e.g. malaria) due to greenhouse effect	faster spread of diseases due to global trade and production (e.g. foodborne diseases, cholera) faster development of drug resistance due to commercially driven use of antibiotics slower development and dissemination of control and treatment for "unprofitable" diseases faster development and dissemination of drugs for "profitable" conditions (e.g. Viagra)	global mindset of national policy makers in applying economic rationale to health sector reform (e.g. WDR 1993)
POLITICAL	transnational health policy networks (epistemic community, world civic politics) health needs of refugee populations within and across state boundaries	faster deterioration of health status due to political instability (e.g. former Soviet Union) slower response to public health threats due to unclear global authority	change in expectations towards role of state in health financing and service provision (i.e. welfare state)
TECHNOLOGICAL	global disease surveillance and monitoring system	faster production of health knowledge and information	global policy strategies
SOCIOCULTURAL	mobilisation of global women's health movement at ICPD (1992) global changes in distribution of poverty within and across countries	faster spread of communicable diseases through social mobility (e.g. tourism) faster dissemination of health education and training through global communication	global adoption of healthy or unhealthy lifestyles global spread of western biomedical discourse

TABLE 3: A Globalisation and Health Research and Policy Agenda

THE IMPACT OF THE GLOBAL ECONOMY ON HEALTH

(a) To what extent is the globalisation of trade and production in the health sector and related sectors occurring?

- analyse the extent to which there is global trade and production of goods (e.g. pharmaceuticals, medical supplies) and services in the health sector
- analyse the global trade and production of goods and services with an indirect impact on health (e.g. food, tobacco)
- determine whether there are global trends in health expenditure (i.e. public expenditure, private spending, aid)
- understand the impact of global economic crises on health expenditure notably in low-income countries
- analyse whether the lending policies of multilateral development banks are being influenced by global financial trends
- explore global level influences on health care financing reform

(b) What positive and negative effects are global trade and production having (or expected to have) on the health of particular individuals and groups?

- analyse the impact of the global economy on health and safety standards and wage levels
- identify global patterns of ownership of health and health-related goods and services
- explore the consequences of globalised intellectual property law in relation to access to health information, research patterns
- determine whether public expenditure on health affected by the global economy (e.g. race to the bottom, financial crisis)
- analyse trends in health expenditure in relation to specific populations and health needs

(c) What policies are needed to optimise the benefits, and mitigate the costs, of global trade and production for health?

- assess the adequacy of existing legislation to protect health against hazardous and unsafe goods and services
- explore how health interests can be represented appropriately in global trade negotiations
- explore innovative means of financing health sector aid amid globalisation (e.g. Tobin Tax)
- review health care financing reforms and their appropriateness to meeting global health challenges

TABLE 3 (continued)

THE IMPACT OF GLOBALISATION ON THE NEED FOR GLOBAL GOVERNANCE OF HEALTH

(a) To what extent is globalisation affecting the way in which health policy is/needs to be carried out?

- to determine the extent to which state and non-state actors, and their interests, are changing as a result of globalisation
- to develop an agreed typology of state and non-state actors in the health sector
- to analyse the adequacy of existing mechanisms of health policy making for representing state and non-state actors amidst globalisation, and to explore how state and non-state actors could work more effectively together in the development of global governance for health
- to study how globalisation is addressed by the existing mandates of international health organisations
- to assess the extent to which existing institutions are accountable, transparent, participatory and democratic (i.e. good government) in relation to global health interests

(b) How are existing mechanisms of governance influencing the positive and negative effects of globalisation on the health of particular individuals and groups?

- to analyse the adequacy of existing public health measures (e.g. legal, institutional) for addressing transborder health risks
- to assess the extent to which there is a global civil society emerging in health and its role in policy making
- to understand whether the diversity of health actors is contributing to increased/decreased resources, and clearer/less clear priority setting

(c) What policies are needed to create global governance for health that would optimise the benefits, and mitigate the costs, of globalisation?

- to define what forms of global health governance is needed in relation to the changing role of the state
- to define the underlying rationale for global governance (e.g. global "social contract")
- to identify whom should participate in global health governance and their relative rights and responsibilities
- to explore the required links, mandates, relative resources and authority among institutional mechanisms at different levels of governance
- to explore the balance between formal and informal mechanisms

TABLE 3 (continued)

THE SOCIOCULTURAL IMPACT OF GLOBALISATION ON HEALTH

(a) To what extent is globalisation affecting the social and cultural aspects of health?

- To determine the extent to which there is an emerging global understanding of health and disease
- To understand global patterns in lifestyle that are affecting specific health conditions (e.g. tobacco use, diet)

(b) What positive and negative social effects is globalisation having for particular individuals and groups?

- To understand the links between globalising forces and social inequalities
- To identify the extent that there of a "race to the bottom" in social welfare policies as a result of global economic competition?

(c) What policies are needed to optimise the social benefits, and mitigate the social costs, of globalisation?

- To review the policies of aid agencies for their effectiveness in addressing global patterns in social inequality (e.g. poverty)
- To explore policy initiatives for creating greater social justice and how this could lead to a more sustainable globalisation

THE IMPACT OF GLOBALISATION ON THE EPIDEMIOLOGY OF HEALTH AND DISEASE

(a) To what extent is globalisation influencing patterns of health and disease?

- to develop methods for identifying and measuring global patterns of health and disease
- to identify global patterns of health within and across countries
- to study how specific disease patterns may be changing as a result of globalising forces
- to define how global health patterns are distinct from international or regional health patterns

(b) What positive and negative effects is globalisation having (or expected to have) on the health of particular individuals and groups?

- to identify the populations within and across countries affected by global patterns of health and disease
- to understand factors behind advantaged and disadvantaged populations
- to identify global patterns of inequality in health status, access and service provision

TABLE 3 (continued)

(c) What policies are needed to optimise the benefits, and mitigate the costs, of globalisation for health?

- to consider how global epidemiological data can be used to develop appropriate global health strategies
- to assess the adequacy of existing surveillance and monitoring systems for addressing globalisation

THE IMPACT OF GLOBAL INFORMATION AND COMMUNICATIONS ON HEALTH

(a) To what extent is the globalisation of information and telecommunications affecting health?

- to understand the extent to which health information and communications is becoming globalised
- to analyse the influence of global information and communications on individual and group perceptions of health and ill-health (e.g. healthy lifestyles)
- to understand the current and potential impact of global telecommunications on the delivery of health care

(b) What positive and negative effects is global telecommunications having (or expected to have) on the health of particular individuals and groups?

- to identify any global patterns of inequity in accessing health information and technology
- to determine the extent to which a wider range of stakeholders can be better represented through global communications
- to understand how global marketing through information and telecommunication technologies can adversely affect the health of selected populations (e.g. tobacco, alcohol)

(c) What policies are needed to optimise the benefits, and mitigate the costs, of global information and communications for health?

- to explore how global information and communications can improve access to health care for remote communities and low-income countries, facilitate health promotion, and enhance training and education
- to identify how global disease surveillance and monitoring, and other information needs, can be improved

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THE INTERNATIONAL DIMENSIONS OF ECONOMIC DEVELOPMENT

Clive Thomas

Outlining the compelling features of the new global economy is crucial to the success of our endeavors, as one of the remarkable features of our times is the extent to which, unlike previous eras, human endeavors are conceived, designed and implemented as global projects. Whether it is the activity of powerful trans-national companies (TNCs), the action of billions of individual consumers worldwide, the pursuit of national defense, the provision of health care, or the advocacy of social and environmental concerns, the injunction to "think globally" is followed more and more every day. This paradigm shift, from a conceptual pre-occupation with the national to the global is of incalculable importance. Understanding the international dimensions of development, or globalization as it is more familiarly known, is therefore an essential requirement of our project, which is:

> To initiate the creation of an effective transnational collaborative network of groups from civil society in order to exercise influence on the formulation of healthy public policies, to maximize benefits and to mitigate the adverse effects on health of current international trends.

Since the 1990s, globalization has been generally acknowledged as the driving force behind international developments. There is, however, a peculiar 'disconnect' in the discourse on this subject. While several analysts claim that the term is hackneyed, abused, and no longer constitutes a fruitful category of analysis, books,

articles and commentaries on the subject continue to proliferate, particularly over the past year, as concern about the spreading Asian crisis has grown. Several factors contribute to this contradictory state of affairs. One is that much of the discourse on globalization has been preoccupied with textual exegesis aimed at establishing the 'true' origin of the term. This has introduced an unnecessarily esoteric slant to the debates, which is unfortunate, as there is broad-based agreement that the earliest systematic application of the concept was in the field of international relations. It is useful to recall that the term was introduced in that field in response to two practical concerns of the 1960s and early 1970s, although it later emerged as an alternate paradigm. Those concerns were whether multi-national companies (MNCs) should plan their operations on a global strategy or continue to rely principally on national markets and, whether a nation's economic (and to a lesser extent political) interests were best served by supporting regionalism or multilateralism. The rest, as the saying goes, is history.

Another contributory factor to the "disconnect" has been those debates based on a priori theorizing as to whether globalization is intrinsically a new or old phenomenon. Since the literature shows wide agreement that globalization is a phenomenon of global capitalist development, this debate is somewhat sterile as a correct answer to this question cannot only be a matter of a priori theorizing but one of empirical demonstration as well.

Most perplexing of all is the consideration that, within the confines of the discourse on globalization there is no universally canvassed, let alone accepted definition of the term. Unfortunately, several writers have ignored this and have proceeded to discuss globalization without any explicit delimitation of the term they employ. This has produced shifting goal posts during the discourse, which have further served to confuse the issue. In addition, as it is now widely admitted, different linguistic traditions complicate the debates. For example, in ordinary usage, Latin languages tend to stress the spatial/geographical dimension of the term, while English usage stresses the peculiar combinations of geography and economics.

Following this introduction I propose next to outline the boundaries of the term as employed in this presentation and examine some related definitional issues. I shall then proceed to establish the salient dimensions and characteristics of international development and globalization. In conclusion, I shall indicate actions and lines of development that are of interest to the themes of this Seminar.[1]

Interpretation

The UNDP Human Development Report, 1997 has characterized globalization as follows:

A dominant economic theme of the 1990s, globalization encapsulates both a description and a prescription. The description is the widening and deepening of international flows of trade, finance and information in a single, integrated global market. The prescription is to liberalize national and global markets in the belief that free flows of trade, finance and information will produce the best outcome for

[1] Some of the ideas in this paper are more fully developed in Thomas 1998A, 1998B and Thomas (forthcoming).

growth and human welfare. All is presented with an air of inevitability and overwhelming conviction. Not since the heyday of free trade in the 19th century has economic theory elicited such widespread certainty (UNDP, 1997, p. 82).

This characterization is a useful starting point from two standpoints. One is that it links globalization to policies of market liberalization and in the process it describes its economic dimensions succinctly. In view of the leading role material provisioning performs in contemporary society, this is obviously an important dimension to capture. Globalization, however, is indissolubly linked to several non-economic and non-material dimensions of international development. For example, its occurrence relates directly to the following:[2]

- Unprecedented changes in ideas and belief systems (social construction), politics and ideology, at both the global and national level.
- A transformed international system. The collapse of the previous bipolar world along with its two major rival ideologies and the emergence of a single hegemonic power and ideology reflect this.
- The proliferation of social problems, many of which are 'transboundary' and, therefore, global in scope.
- The unprecedented rise of global forms of inter-governmental management. This has entailed the emergence of sites of authority and legislative provision which cover areas that hitherto were seen as falling within the compass of states and, indeed, as defining their sovereign role in the international community, e.g. the regulation of capital flows and macroeconomic policies.
- The intensification of environmental threats to the sustainability of planet earth.

Such linkages lead to the inescapable conclusion that international development (globalization) is a multi-dimensional process. It embraces material as well as non-material areas of life and, it links the economic to the social, political, cultural, legal, institutional and environmental aspects of society. This, therefore, is the premise of this presentation. The obvious inference that follows, is that if we seek to influence the outcomes of this process then the use of multi-disciplinary methods is essential. No one discipline can provide all the answers over so wide a range of human experience.

A number of important issues arise from this observation. One set relates to the concern referred to earlier, which is, how does globalization compare with previous eras of international development? In its assessment, should historical continuity or disjuncture be stressed? Is this distinction important? My response is that the distinction is important, as the distinguishing features of the present process do not relate to the sheer magnitudes involved, important as these are, but to their qualitative differences as well.

It is true, as several analysts have reminded us, that earlier eras of international development witnessed human migration on a far larger scale than today. It is also true that, much as it does today, earlier eras combined international development with liberalization, if the latter were similarly defined as

[2] See Thomas 1998A.

the systematic removal of national trade and financial barriers and the promotion of economic linkages across huge geographic spaces. Indeed the empirical data show that trade of the industrialized nations as a percent of production was about the same in 1913 (13 percent) as it is today (14 percent). Direct overseas investment of these countries, as a percentage of GDP, was also roughly the same in 1913, 3 percent, as it is today, 4 percent, and is probably lower now than it was in the 1890s. Despite the 'hoopla', production from a national basis remains today more important than from overseas subsidiaries, in spite of the rapid expansion of the latter. External trade of the developed economies remains a comparatively small proportion of GDP (5 percent in the European Union). North-North trade still accounts for the bulk of global trade, 75 percent, and South-South trade only 10 percent. The Boards of the major international firms still have little representation from 'foreign' directors. It is also true that in earlier periods the process of liberalization was supported from above and bolstered by political sanctions. This was particularly the case where colonial rule prevailed. Indeed we might go further and note that it is similarly true that great inventions and innovations in science and technology made the earlier eras possible. Moreover, like today, these scientific and technical changes covered a very wide span of human endeavor: nutrition, agriculture, industry, finance, health, education, weaponry, navigation and so on.

In spite of all this, nonetheless, the essential features of the present international system constitute a qualitatively distinct phase of international development. The details of these features are presented later. For immediate purposes, however, it is important to note that the present process is occurring after the previous eras of international expansion and development had already exhausted their potential. It starts, therefore, from a higher level of integration of world markets. It is also noteworthy, that despite past achievements, the scope of the scientific and technical revolution underlying globalization is held by most commentators to be truly phenomenal. This is particularly the case for those areas that play leading roles in global market integration—communication, transport, information and weaponry (enforcement).[3]

Another set of issues arising from the earlier observations made, pertains to whether international development along present lines is inevitable and irreversible. In other words, is the process immutable? Are the outcomes likely to be favorable or unfavorable? Many analysts view globalization as immutable, signifying the inexorable march of progress and the continued development of modern capitalism on a world scale, a process that started in the 19th century. Globalization, the argument goes, carries the benefits of specialization and the division of labor to the world level. It promotes competitiveness, permits the reaping of economies of scale, secures economic restructuring and industrial re-organization, provides for the wider availability of technology and, offers dynamic opportunities and gains for far-sighted, risk-taking entrepreneurs. To these analysts, whether it is human aided and directed or not is immaterial, as

[3] Data from the UNDP show that maritime transport costs fell by two-thirds between 1920 and 1970; operating costs per mile for airlines fell by 60 percent between 1960 and 1990; and telephone calls cost 2 percent of what they did before World War II. In addition, we have the information superhighway of the internet. Trade barriers have also declined worldwide, exchange controls have been substantially removed in most countries and the Uruguay round has reduced tariffs substantially. It is these changes that give practical meaning to today's notions of a 'global village' and 'global market place'.

its immutability is a desired feature. It follows, therefore, that policies which facilitate the process and remove barriers and impediments to its spread, so-called liberalization, would maximize economic growth and promote human welfare worldwide. This is indeed the basis of the linkage between globalization and liberalization.

The premise is that liberalization fosters the growth of markets. Markets in turn promote competition and efficiency. Markets are also socially cohesive, in that they form the meeting place for the mutually shared interests of producers and consumers. Free world markets for commodities, services, productive factors, and finance would, therefore, lead to global convergence of economic and political systems. If development means expanding options and opportunities, then unfettered globalization produces these. The corollary of this is that a 'minimalist' state facilitates the processes of globalization. That is, a state which focuses on market support, regulatory activities and the provision of maximum opportunities for private individuals and firms to own, control, and distribute society's resources. Paralleling this, global and regional inter-state organizations also need to be minimalist, rule-based, and with little or no discretionary authority.

To be sure, this approach is strongly challenged. Critics have stressed that markets usually generate instabilities and inequalities in rates of growth and economic performance among participants. They widen gaps in income, wealth, consumption, power, capabilities, and access. Markets also respond to money income, not the needs of people. Instead of being socially cohesive, their stress on the survival of the fittest, the private, the personal and the individual, make them potentially destabilizing, conflicting, and contradictory. Unrestrained market-led development, therefore, contains lethal self-destructive properties. Its very 'successes' breed polarization. This in turn produces conflicts and challenges to the process, which can lead to self-destruction. Globalization, rather than leading to inclusion and integration of countries and groups within countries may well produce the opposite – exclusion and marginalization. Critics point to past and present experience, particularly the current 'Asian crisis' in support of this view.

The reason for this very wide difference in interpretation is three-fold. To begin with, the former approach treats markets as if they are benign mechanisms that simply produce price signals to guide the allocation of resources. In truth, however, they are social institutions that embrace certain essential social properties. Power is one of these. Power is vested in markets and their effectiveness depends on a conglomeration of social attributes: trust, rules, rights and obligations, informational access, the regulation of participants, and the certainty of contract enforcement. These considerations indicate that there is need for both individual and institutional intervention to prevent the occurrence of market deformations, particularly in circumstances where the social attributes required to make markets effective are lacking. Rather, therefore, than a doctrinaire appeal to a minimalist state, individual and collective political and social action is constantly required by states and international organizations to shape the outcomes of economic processes. Put bluntly, the political and social determination of the operational framework of markets is required. Consequently, even if it is accepted that globalization is here to stay, ipso facto, this does not justify a blind faith in a market-led process without collective public intervention at the national and international level to design its operational framework and shape its outcomes.

Another reason for the difference in interpretation is that much of the debate has tended to polarize the options and choices before countries, as they consider their responses to globalization. Frequently these are presented in a sharply dichotomous manner, with the options being either extreme laissez-faire or extensive state ownership and intervention in the economy. The final reason, is that much of the debate fails to take into account the actual variations of capitalist society that exist; ranging from U.S. libertarian capitalism, through different brands of West European welfare capitalism, to the enormous variation of capitalist societies found in Latin America, Asia, Africa and the Caribbean.

Features of Globalization

At this stage we can return to the issue raised earlier: is globalization a new phenomenon? And, if so, in what way? The point may be raised as to whether an answer to this question is important? My view is that it would be if the response focuses on the salient features of the process at work. I shall now proceed to do this, under four general headings:

- economic,
- ideological, political and international relations,
- social, and
- environmental.

Economic Features

At the economic level three features of the process stand out as historically unprecedented:

- The explosive growth and profound transformation of international production, investment, consumption and trade that has been occurring in recent times.
- The profoundly dramatic all-round improvement in well-being that these have made possible.
- The highly uneven development that has occurred and the unprecedented widening of economic gaps, which these developments have produced both among and within countries.

The details in support of this follow.[4]

International Production: Over the past decade, international production has grown faster than both global output and trade. At about US$9 trillion its value is now greater than that of global exports of goods and non-factor services. The foundation of this development is the shift of global production in favor of services and knowledge intense activities.

[4] The information is from publications of the international agencies cited in the references: UNDP, UNCTAD, UNCTC, UNESCO, FAO, IADB, World Bank, and IMF.

International production is highly concentrated geographically. Three major blocks: the USA, European Union and Japan, along with the 'emerging' economies as significant players, account for almost all of this output.

It is also highly centralized among firms. The largest 100 TNCs control about one-fifth of global assets (87 of these are in the three major blocks). The USA is the leading player and within that country 25 TNCs account for half of its outward stock. This ratio is comparable to that for the large majority of developed countries for which data are available. Worldwide, five TNCs control more than half the global market for consumer durables, automotive, airlines, aerospace, electricity, electronics and steel. Five control more than 40 percent of the market for oil, personal computers and the media.

While among the top 100 TNCs there are only two from the developing countries, a similar concentration is already apparent there. Twenty-eight of the top 50 TNCs in the developing countries are located in China including Hong Kong, and Mexico alone.

The pattern of international capital flow has been very uneven. About 60 percent of the flow take place among developed countries. In 1996 the flows to the developing countries was $129 billion or 37 percent of the total. Two-thirds of this went to South, East and Southeast Asia ($81 billion), 30 percent went to Latin America and the Caribbean with most of this concentrated in Brazil, Mexico and Argentina. Africa received less than five percent of the foreign direct inversion (FDI) inflows.

Two broad factors have driven these developments. One is cross-border mergers and acquisitions along with inter-firm agreements. The other has been the liberalization of FDI worldwide. Of the nearly 600 regulatory changes in FDI worldwide, ninety-five percent were in the direction of greater liberalization. At the beginning of 1997 there were 1330 bilateral investment treaties worldwide, a three-fold increase in half-a-decade.

In recent times, foreign portfolio equity investment has grown rapidly. This investment has a shorter time horizon and is more speculative than FDI. It differs from FDI by the degree of management control it can exercise over the company in which it has invested. (The dividing line is normally a threshold of 10 percent equity stake.)

World Wide Consumption: The worldwide growth in private and public consumption matches the unprecedented expansion of international production. Current consumption expenditures (estimated at $24 trillion) are twice the level of the mid-1970s. This growth in consumption covers expansions in basic services e.g. health, safe water, sanitation, schooling, and transportation, as well as food, clothing, shelter, and manufactured items. Globalization is integrating consumer markets worldwide, creating outlets for new products, common forms of consumer financing and consumer sales outlets. Many products are advertised at the global level. Many fear a global 'monoculture.' As Norberg-Hodge reminds us:

> Although this sameness suits the needs of transnational corporations, which profit from the efficiencies of standardized consumption, in the long term a homogenized planet is disastrous for

> all of us. It is leading to a breakdown of both biological and cultural diversity … The myth of globalization is that we no longer need to be connected to a place on the earth. Our every need can be supplied by distant institutions and machines… Globalization is creating a way of life that denies our natural instincts by severing our connection to others and to nature. And – because it is erasing both biological and cultural diversity – it is destined to fail (Norberg-Hodge, 1996 p. 20).

As with international production, the worldwide distribution of consumption is very unequal. For example, while since the mid-1970s, the industrial countries had increases of the order of 2.3 percent per annum and in East Asia 6.1 percent, in Africa south of the Sahara, current consumption levels are down by one-quarter over the same period. It has been estimated by the UNDP that over a billion persons do not have access to clean water; one quarter are badly housed; and that one-fifth do not have access to modern health services. UNDP also reports that 20 percent of the world's population in the highest-income countries account for 86 percent of total private consumption expenditures and the poorest 20 percent only 1.3 percent.

Attention is also drawn to the pressures this expanding consumption has placed on the environment. While earlier fears about rapidly dwindling non-renewables and physical scarcities have not emerged, concerns now focus on pollution and waste and the deterioration of the state of the renewables. The environmental impacts are also asymmetrical. The dominant consumers are concentrated in the industrial countries but the environmental damages from their consumption fall heavily on the poor (UNDP, 1998).

Financial Transactions: The explosive growth of financial market transactions worldwide is unprecedented in its magnitude. A defining feature of globalization is that financial capitalism is its leading edge. The current estimate is that financial market transactions now exceed $1.3 trillion, as compared to only $15 billion in the mid-1970s. Then it represented about five percent of the GDP of leading industrial countries; today it exceeds 1000 percent. In addition, about 80 percent of FDI flows are spent on changing ownership of capital rather than new lines of production, the so-called 'virtual economy.'

The proximate causes of these highly fluid movements of international finance are: the liberalization of financial markets worldwide, the increasing concentration of funds in the hands of institutional investors, the increased risk-taking attitudes of investors, and the information revolution.

Experience of the Asian crisis already shows that an adverse movement of this finance is frequently unrelated to the state of a country's economic fundamentals (e.g. Malaysia). Indeed, we might go further, this experience challenges the validity of the so-called 'lessons of the tequila effect' on globalization, derived from the earlier Mexican crisis. These lessons are that: capital controls and financial repression could insulate an economy from the contagion effect of financial shocks elsewhere; that countries like Asia, where capital controls were in place and the activities of domestic financial institutions were more 'regulated' than in Latin America, were to be emulated as they would not succumb to contagion effects; that a high level of domestic savings, as also occurs in Asia, would keep financial shocks and crisis at bay;

and that prudent fiscal policy is enough to prevent spill-over effects on the economy of a financial crisis started elsewhere. Malaysia, Singapore and Thailand all had budget surpluses and in the Philippines the estimated deficit for 1997 was less than one percent of GDP, yet these were engulfed in the Asian crisis.[5]

Together, these occurrences highlight two remarkable situations recently created by globalization. One is, if the soundness of a country's 'economic fundamentals' does not matter in determining its exposure to international crises then national macroeconomic management in the present environment of international finance is virtually unattainable, without an international authority to regulate the private international financial system. Second, because financial capitalism is the leading edge of global capitalism, it has made short-term profits and capital gains divorced from actual production gains, the prime determinant of global capital flows. This creates an exceptional level of global economic instability.

Regionalization. The emergence of several formidable regional trading blocs alongside the internationalization of production and the explosive growth of financial transactions is a modern phenomenon. Some of these blocks are continental in scope and categorized as 'megablocs,' leading to concern as to whether these constitute 'building blocks' or 'stumbling blocks' in the process of globalization.

Accompanying this are two related phenomena namely: the erosion of support for non-reciprocity and special one-way preferential trade arrangements that favor developing countries,

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5 The following long quote from a speech by Dr. Mahathir Bin Mohammad, Prime Minister of Malaysia, makes the point, poignantly:
Many foreigners – including the most tough, hard-nosed personalities and organizations – told us the most flattering things, which strengthened us in our conviction that our "fundamentals" were very strong indeed. The annual World Competitiveness Yearbook, issued by the prestigious International Institute for Management Development (IMD) told Malaysians, for example, that we had some problems here and there, some quite serious. But on the basis of what it called the "overall evaluation of the strength of the domestic economy at the macro level," Malaysia was the second most competitive economy in the world. We were in the best of company. At number one was the United States. At number three was Singapore. At number four was Luxembourg. The IMD was not the only one with such a good impression of my country one year ago. In mid-June 1997, just two weeks before the July 2 collapse of the Thai Baht which resulted in a horrendous collapse of the regional currencies, Mr. Michel Camdessus, Managing Director of the IMF was handing bouquets to Malaysia for our sound economic management, for our superb economic fundamentals. He told an international conference on Global Capital Flows in Los Angeles, and I quote, "Malaysia is a good example of a country where the authorities are well aware of the challenges of managing the pressures that result from high growth and of maintaining a sound financial system amid substantial capital flows and a booming property market." He noted: "Over the last year, output growth has moderated to a more sustainable rate, and inflation has remained low. The current account deficit – which is primarily the result of strong investment spending – has narrowed substantially. The increase in the fiscal surplus targeted for this year is expected to make an important contribution towards consolidating these achievements…" You may say there is no need for more testimonials. But how about the banking and financial sector? If you can believe Mr. Camdessus, again I quote: "The Malaysian authorities have also emphasized maintaining high standards of bank soundness. Non-performing loan ratios of financial institutions have fallen markedly in recent years; risk-weighted capital ratios are above Basle recommendations…" In the same Los Angeles speech, Mr. Camdessus said, " In an effort to increase the flow of comprehensive up-to-date and reliable information to markets, Malaysia was also among the first to subscribe to the IMF's Special Data Dissemination Standard." So on June 17, 1997, just two weeks before the currency hurricane struck, the IMF gave Malaysia not just a clean bill of health but the IMF in fact praised Malaysia's economic fundamentals. The IMF had the best of things to say about our economic management. And the IMF commended Malaysia to investors as an economy that "justifies the confidence of the markets."

and the worsening of the net barter terms of trade of both primary commodities and manufactures exported from the developing world. The lack of international concern over these serves to highlight the reduced importance of the developing countries to the global capitalist economy. This has been brought about in part by the shifts in global production that have taken place, particularly the relative decline of low-wage labor intensive manufacturing and the dramatic rise of knowledge-based employment (requiring massive strategic investments in human resource development).

Corporate Reorganization. A rapid reorganization of corporate structures is also underway. The unparalleled rise of transnational corporations themselves is one reflection of this development. This has led to a faster growth of 'captive exchanges' within the same firm structure, than the more traditional 'arms-length trade' in international transactions.

Changes in the form of firm competition have also occurred. In general, these reflect the reduced importance of geography and national territory in defining the mobility of firm assets.

In order to gain the advantages of scale and scope, firms are frequently constrained to focus their operations on those that are 'core' and 'essential' for their maintenance of control and improved competitiveness, and to contract-out or build alliances and networks with other producers to fulfill their 'non-core' needs.

Labor. There has also been a profound transformation and re-configuration of labor markets worldwide. A marked asymmetry in the mobility of the productive factors accompanies this. The mobility of capital, finance, and even knowledge and skills is far greater than that of labor. The basis for this distinction lies in cultural, political and racial barriers to the movement of people, especially from the developing world.

Unequal Economic Outcome. The economic outcome of these complex processes has been very unequal. Inequality has been growing worldwide and within countries. Thus whereas in 1960, 20 percent of the world's people who lived in the richest countries had 30 times the income of the poorest 20 percent, by 1995 it was 82 times as much! As the UNDP observes frequently these inequalities overlap: the poor and the rich, men and women, rural and urban, and ethnicity and political affiliation. These inequalities occur within the rich countries as well. The US Census Bureau reported in 1996 the widest gap between rich and poor in the USA since the end World War II. While a few developing countries are now classed as emerging nations because of their spectacular growth, ten times as many developing countries are still excluded.

The UNDP (1998) estimates that one-quarter of the world's population remains in severe human poverty while about one-third suffers from income poverty, i.e. survive on less than one US dollar per day. While poverty has fallen more in the last half-a-century than in the previous five centuries, and child death rates have halved over the past decade, and malnutrition has declined by one-third, and

the number of children out of primary school has fallen from over one-half to one-quarter, yet 160 million children are out of school, and one-half a million die in child birth (at rates 10-100 times greater than in industrial countries).

As PAHO (1998) reports, in the Americas vaccination campaigns, improved nutrition, better safe water and sanitation programs, and improved health facilities have produced significant improvements in the health of the people. Average life expectancy has risen (from 68.7 years to 71.1 years) over the past decade, the infant mortality rate has fallen to 27 per 1,000 births and those without access to health care have been significantly reduced. However, in health the gap between the rich and poor countries still exists. The infant mortality rate in Haiti is more than three times the regional average. Chronic diseases have assumed greater importance in the poorer countries. In addition, for the Region as a whole, the number of AIDS cases represents half of the global total.

In summary therefore, the metaphor drawn by the UNDP is apt:

> Proceeding at breakneck speed but without map or compass, globalization has helped reduce poverty in some of the largest and strongest economies—China, India and some of the Asian tigers. But it has also produced losers among and within countries. As trade and foreign investment have expanded, the developing world has seen a widening gap between winners and losers. Meanwhile, many industrial countries have watched unemployment soar to levels not recorded since the 1930s, and income inequality reach levels not recorded since the last century. The greatest benefits of globalization have been garnered by a fortunate few. A rising tide of wealth is supposed to lift all boats, but some are more seaworthy than others. The yachts and ocean liners are rising in response to new opportunities, but many rafts and rowboats are taking on water – and some are sinking (UNDP, 1997 p. 9).

Liberalization. Even the institutional and legal mechanisms of liberalization are themselves unevenly developed. There is a concentration of power and authority over the process that mirrors the economic concentration. Many developing countries had embarked on liberalization because of IMF/World Bank conditionalities linked to structural adjustment programs financed by them and have to continue this through membership of the WTO. Areas of economic control that previously fell within national compass, e.g. macroeconomic management and the regulation of capital flows in regard to their uses, timing and rules for investors, are no longer meaningfully so. But while liberalization of their trade barriers are being promoted, countries in the South do not benefit to the same extent as the industrial ones from increased openness .We have already noted this in regard to the mobility of labor.

Real prices of commodities traded internationally are now 45 percent below the level in the 1980s, and 10 percent below the lowest level of the Great Depression in 1932. Barriers to developing countries exports to the industrialized countries cost them $60 billion annually. On average, the Uruguay Round has reduced tariffs for industrial country exports to 20-25 percent, but for developing countries exports,

it remains at 45 percent. Developing countries also face higher levels of tariffs on items processed from their raw materials (tariff escalation), discouraging the industrialization of these commodities. There are as well considerable non-tariff barriers placed against their export e.g. anti-dumping measures, and the special arrangements for trade in items of concern to them, like textiles and agricultural commodities. While global trade is growing faster than global income, for 44 developing countries it is declining. For the least developed countries whose population is one-tenth of world population, their share has halved over the past decade and a half and is now only 0.3 percent.

In conclusion, the economic features support the conclusion that a world economy rooted in global markets, technology and production is rapidly replacing one based on national economies and national markets. In the face of revolutionary changes in science and technology that are truly trans-boundary, but have to be utilized in finite spaces, even the most powerful countries now find that their national borders have lost much of their protective capacity. This has produced qualitative changes in the scale and complexity of economic activities. While this does not make globalization economically deterministic, it does however distinguish it from the past. Particularly as in the past the drive in this direction was more often than not heavily based on 'political voluntarism,' that is, the will of the leading powers to 'push' economic changes along. Today the basis of the drive is beyond the scope of the individual nation-state.

Ideology, Politics and International Relations

In the field of ideology, politics and international relations unprecedented changes have also occurred. Four of these stand out:

- The collapse of East Europe socialism and the previous bipolar world of two economic and social systems. This has not only led to the emergence of a single hegemonic power and ideology, but to the disappearance of important 'third spaces' at the political, economic and international level. This development has provided the ideological underpinning for globalization and liberalization in their present form.
- The dramatic break-up of old states, the emergence of new ones and further threats of its continuation.
- Changes in the global forms of inter-governmental management, which have de-emphasized the United Nations system in the area of social and economic matters and propelled the rise into prominence of sites of international authority (the IMF, World Bank and the WTO) that are decidedly undemocratic in their structure. This development has placed greater emphasis on risk management, the prevention of contagion effects of crises and shocks, and the initiation of steps toward rule-based non-discretionary forms of global management backed by automatic non-discretionary sanctions to enforce compliance. It has also given institutional support to the equal treatment of non-equals in the global economy, the enforcement of full reciprocity and the working assumption that the international market place is a level playing field.

- The retreat of the state, particularly evident in its reduced role in economic production and the universal tendency to promote the private sector as the engine of economic growth and the role of private decision making in determining societal outcomes. These have been accompanied by a shrinking membership of traditional, but important institutions, such as political parties, trade unions and cooperatives, as well as generally reduced voting percentages in national and local elections. As indicated earlier these intergovernmental institutions of globalization now directly control areas of economic decision making, which were previously within the direct compass of national governments.

Social Features

At every social level, from the individual, family and household to the national level unprecedented changes have also occurred. These changes have manifested themselves dramatically, at the global level. These can be seen in the rapid worldwide growth of migratory populations, the increasing threat of transborder crimes (linked to narco-trafficking, money laundering and terrorism); the emergence of a growing, and for some disturbing, global, social and cultural homogenization; the rise of social pathologies linked to poverty and jobless growth; the marginalization/exclusion of significant sections of the population in all countries; and the unabated significance of war and civil conflicts in human affairs. The last is linked to the influence of the media, arts, literature, cinema and television development in the North on the rest of the world. The shift to the individual and personal has emphasized the role of competition and acquisition and has undermined solidarity and cooperation in social life, worldwide. Together these dramatize the instabilities that now prevail and can only be associated with a period of profound change.

Environmental Features

Environmental degradation has emerged as a matter of international urgency. As noted earlier, while environmental stress due to the depletion of non-renewable resources has not occurred as had been first predicted, pollution and waste from consuming these resources and the deteriorating base from which renewable production occurs, e.g. poor land use, fish stock declines and reduced biochemistry, have turned out to be the unanticipated culprits.

In summary, therefore, the combined effect of the features—economic; ideological, political and international; social; environmental—distinguishes globalization as a new stage in the long-term evolution of global capitalism. While a borderless world is far from a reality, the inter-regional and international scope of many forms of social, political, economic and cultural activity has dramatically widened and intensified in recent times. The result is that the dynamic interconnectedness of contemporary global society is far more extensive and intensive than it has ever been and, seems destined to continue this way. Globalization continues to exert pressure on countries to change policies and institutions in certain ways. One of these is to accept the relative erosion of the influence and actions of conventional and established authorities such as the nation state and inter-state organizations like the United Nations. This acceptance

has tended to shift the balance of power in favor of capital. But, perhaps most important of all, is the fact that major institutions and actors in society now think and, increasingly act, globally. As Henry Wendt, Chairman of the Anglo-American pharmaceutical corporation, Smith Kline Beecham has stated in an interview with the Conference Board (1993):

> The transnational corporation has . . . global vision and orientation that transcend definitions of national identity. It sees the entire world as its market and customer base. That's the most important feature of the transnational corporation. With that view, then, it locates its research and manufacturing facilities, even its headquarters, any place in the world that makes sense in terms of serving the global market. . . For the transnational, its so-called home market is global, and a decision is based on whether it advances the company's global competitive advantage (Wendt, 1993, p. 36).

Indeed, he goes on to assert that this paradigm shift has led to a situation where, the modern TNC is now the most accountable institution in the world and the one that also maintains the highest standards. He declares that:

The modern corporation is held to higher standards and is more accountable than any other institution. I certainly wouldn't argue that the managers of transnational corporations have intrinsically higher moral values than other people. Transnational corporations act with integrity because the stakes are so high. They don't want to be embarrassed, or maybe even prosecuted, in a major market. So as corporations increase their global presence, they assume more responsibility for their actions, not less. More often than not, they're held to the highest standards rather than the lowest, or even the average (Conference Board, 1993, p. 36).

The Way Forward

I would like to spend the remaining time at my disposal exploring a few concerns relating to possible policy responses. To begin with, there is the frequent observation, that while there are many critics of globalization there are comparatively few constructive proposals. It is alleged that the focus has been too much on 'critique, critique of critique or deconstruction, deconstruction of deconstruction,' and so on. And, that while critique, i.e. negation implies an affirmation, the discourse is short on explicit affirmations and hence normative and program oriented alternatives (ISS, 1997). This statement is somewhat overstated. There have been a significant number of institutions and individuals worldwide, particularly NGOs and scholars, who have offered normative program-oriented alternatives. The problem has less to do with the availability of constructive alternatives, and more to do with the failure to have available proposals adapted by those who can make a difference.

The Asian crisis, along with the present threat of global recession has, however, led to policy

interventions, many of which are in direct opposition to those advocated on the basis of neoliberal orthodoxy. Thus capital controls and financial repression have re-appeared in macroeconomic management in Asia. Previously privatized ventures have been re-acquired by governments in some developing countries, usually after their failure as private businesses. China, which is the least 'open' of the emerging economies, has been for some time now the largest beneficiary of private capital flows. Citizens in several countries have rebelled against government actions to bail out financial institutions in distress, at the public's expense. There is indeed an international outcry against socializing the losses of financial institutions and introducing the moral hazard of benefiting those who have taken imprudent risks with other people's money. There have been as well, many and varied calls for prudential and regulatory oversight of private financial institutions and for taxes on hot-money flows. The twin pillars of the international financial system, the IMF and World Bank, have been criticized from surprising quarters for inadequate action and action biased in favor of the financial community. There has even been a strong dose of self-criticism. The media report the World Bank President, James Wolfensohn, as stating:

> We need to go beyond financial stabilization. We must focus on the social issues… We must consider the financial, the institutional and the social together. We must learn to have a debate where mathematics will not dominate humanity, where the need for often drastic change can be balanced with protecting the interests of the poor (Daily Gleaner, Jamaica, October 7, p. 24B).

He goes on to draw a vivid image of the impact of the Asian crisis referring to these as "dark, searing images of desperation, hopelessness and decline." The Chief Economist at the World Bank, Joseph Stiglitz, has echoed this emphasis on pro-poor distributional issues:

> In the midst of economic crises, newspaper headlines are dominated by the falls in exchange rates and stock indices. Behind the headlines, however, are large increases in unemployment, poverty, malnutrition, child labor and prostitution. The political, economic, psychological and even physiological effects of these problems can persist long after the stock markets and exchange rates have recovered. I do not believe that the interests of the most vulnerable – the workers and the small businessmen, the farmers and the day Laborers, the children whose education will be interrupted and their health devastated by malnourishment – were taken into account as fully as were the perceptions of the investment community … I am not sure their voice was heard, that either they had a seat at the table or their interests were well represented (Ottawa Citizen, September 30, 1998).

The difficulty of course is that in the face of the prevailing variety of circumstances and capacities of participants in the process, a general solution to all the problems posed by globalization, i.e. a one-size-fits-all approach, would be unworkable. Indeed the approach has not only to be adapted to different

circumstances and capacities, but to the particular range of issues to be addressed. A good starting point therefore, might well be the very premise of this gathering: "the promotion of an effective transnational collaborative hemispheric network of groups of civil society that can capitalize on technological and other benefits of globalization."

Given the uneven capacities among the institutional participants in this effort, two clear priorities immediately emerge. These are that the rules of engagement in the network should not replicate this unevenness and the need therefore, to set as a goal, the requirement to raise the institutional capacities of all elements of the network to a critical minimum. That is, a minimum which ensures a real, as distinct from a nominal role, for those within the network. In large measure, this refers to issues of human resource development and access to technical, informational, financial and other support mechanisms.

Further, if the network is to respond to the needs of the participants, then its design, operationalization, monitoring and review should also be a genuinely collective endeavor. Otherwise, there would be no guarantee that it will not itself reproduce some of the unevenness and inequalities that we have observed in the process of globalization. Building solidarity among groups within civil society contrasts with the competitive operations of the international market place, but it is the only sure way to ensure desirable outcomes in the areas of health and human development.

While the intended network is an end in itself, it is at the same time an important means toward an end. The network therefore has to reach early agreement on its priority tasks and focus. Some of these, around which discussion can follow later, already emerge from the analysis of globalization. These include:

- **Research and Development on globalization**, that is understanding the process, its means, outcomes, institutions and actors, and relatedly, its health impacts.
- **Strategizing areas of intervention**, for example, shaping public policy, especially laws and regulations, public budgets and spending priorities; influencing the activities of inter-governmental agencies; devising modalities for informational access; securing the provision of safety nets for the disadvantaged; promoting the use of suitable technologies and so on.
- Canvassing the greater use of **democratic sites** of authority.
- **Promoting technical** cooperation among the network participants.
- Advocacy for, and the dissemination of **'healthy' policies.**
- **Building solidarity** with other related civic groups and sectors, as well as inter-governmental bodies. For example, in such areas as environment, human rights, and development oriented civic action programs, as well as agencies like PAHO/WHO, UNDP, UNICEF and UNESCO. Solidarity with groups promoting desirable global objectives, e.g. the World Social Summit and the 20:20 Compact is also important.
- **Garnering resources** and promoting their effective use.

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NAFTA & THE PERSISTENCE OF POOR LABOR CONDITIONS IN CHILE

Fernando Leiva Letelier

"Chile is an example of the future that awaits Latin America." With these words President Clinton welcomed Chilean president Frei during his visit to the U.S. in early 1998, and renewed his commitment to incorporate Chile as NAFTA's fourth member.

However, if Chile represents the future that through NAFTA U.S. policy seeks to fashion in the hemisphere, then it is a future where workers have been stripped of basic rights and forced to toil for below-standard wages, inadequate benefits and at grave risk to their health and well-being.

RECHIP[1] and other members of Chilean civil society affirm that Chile's incorporation into the present NAFTA or, the signing of Chile-US bilateral agreement without improved and enforceable labor and environmental clauses in the core text, will only perpetuate and intensify the perverse effects of Chile's development model including:

- economic growth based on the expansion of low-paying, low-quality, short-term jobs with inadequate legal protection;
- environmental degradation and erosion of living conditions for communities near mining, hydroelectric, agroexport, and lumber mega-projects due to the weakness of government institutions to prevent environmental destruction;

This paper was used as a background paper for the conference Health and Human Development in the New Global Economy in Galveston, Texas, October 26-28, 1998.

1 The Red Chile por Una Iniciativa de los Pueblos was founded in 1992. It is a coalition of non-governmental, environmental, women's, labor and native people's organizations working to construct socially equitable and environmentally sustainable hemispheric integration.

- continuance of authoritarian enclaves in the political system and legitimization of an "incomplete" democracy that, even with General Pinochet's upcoming retirement as Commander in Chief of the Army, continues to remain hostage to military power; and
- increased social polarization and inequality as Chile joins Brazil as Latin America's country with the worst income distribution.

Each of these characteristics —daily experienced by the majority of Chileans but rarely reported in the U.S. media[2]— undermines the notion that liberalization of trade and investment, with deregulated and flexible labor markets will, by themselves, establish a socially desirable path to sustainable development. Chile's current labor and environmental reality attests to the failure of such a strategy. Yet incorporation into NAFTA would not only intensify these perverse effects, but would validate Chile as a model of policies to be followed by other Latin American countries.

A recent publication of Chile's Dirección del Trabajo[3] warns about an "alarming increase" in the "instability and lack of security at the workplace" and "scant recognition and respect for workers." This negative assessment is based on a 1996 study showing that one out of every five workers (20.5% of salaried workers) lacked the written contract required by law.[4] This is indeed an unsettling deterioration with respect to 1992, when workers without contract represented 14% of wage workers.[5]

A grim picture of current labor conditions emerges from recent Dirección del Trabajo statistics, in sharp contrast with the rosy image painted by pro-NAFTA accession lobbyists of Chile as an economically sound, fully democratic and socially equitable nation that should be "rewarded" by making it NAFTA's fourth member.

Labor Conditions in Key Export Sectors[6]

A review of the latest data on labor conditions throws light on the "dark side" of Chile's recent economic expansion, raising troubling questions about the wisdom of supporting present fast-track authorization request with its weakened labor and environmental commitments.

a. Chile's impressive export growth has been based on natural resource and extractive activities.

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2 For an example of reporting celebrating Pinochet and the economic model see, Calvin Sims, "Era Ending for Chile as Pinochet Plans Exit," New York Times, 25 September 1997. Mr. Sims writes. "General Pinochet ... is widely respected in Chile for initiating the social and economic changes that have led to the country's prosperity."

3 The Dirección del Trabajo, or Labor Directorate, is a division of Chile's Labor Ministry entrusted with the mission monitoring compliance and interpreting labor legislation.

4 Temas Laborales, Año 2, No. 5 (January 1997). In addition, the study found that of these, 24.2% of earned below minimum wage and 46% of them worked more than 60 hours, beyond the maximum legal limit of 48 hour work week.

5 On the basis of MIDEPLAN, Departamento de Planificación y Estudios Sociales. Encuesta CASEN 1992.

6 For more details see Magdalena Echeverría, "Mejores Condiciones de Trabajo: Un Desafio Actual" [Better Labor Conditions; A Current Challenge], Temas Laborales. Año 1, No. 2, January 1996. Santiago: Dirección del Trabajo.

Chile's exports totaled US$ 15.3 billion in 1996, over 88% of which consists of natural resources with low levels of processing. In the case of Chilean exports to the United States, which reached US$ 2.56 billion in 1996,[7] this proportion is much higher.

This is illustrated by considering the 10 most important Chilean products exported to the USA in 1996:

1. Copper cathodes (US$ 406.7 million);
2. Fresh grapes (US$ 328.5 million);
3. Copper blister (US$ 155.6 million);
4. Gold (US$ 139.8 million);
5. Salmon fillets (US$ 87.3 million);
6. Fresh Salmon (US$ 65.5 million);
7. Wood (pine) studs (US$ 51.2 million);
8. Wood (pine) boards (US$ 48.5 million);
9. Apple juice (US$ 42.9 million);
10. Wine (US$ 42.4 million).

These 10 products alone add up to $ 1.37 billion representing 53% of Chile's total exports to the USA.

b. Workers in the principal export sectors labor under especially poor conditions.

According to Dirección del Trabajo statistics,[8] the percentage of workers with "precarious" jobs, i.e. jobs that lacked a labor contract, had no social security, no health benefits, and had wages below minimum wage, represented:

- 55% of agricultural workers;
- 52. 1% of workers in forestry;
- 50.7% of workers in lumber-extraction and
- 36% of workers in fishing sector.

A quick review of the conditions of workers producing the types of goods exported to the United States, reveals the dramatic conditions they face.

Fruit-Export Sector. Chile's fruit and produce exports are planted, picked and packed by an estimated 500,000 workers during the high season, 80 percent of which are temporary workers, the majority of them women. These workers face harsh conditions and confront legal constraints on exercising basic labor rights such as collective bargaining and the right to strike. This makes them vulnerable to life-threatening and demeaning abuses on the part of employers.

- 52% of temporary workers in agro-industry packing plants work 10-16 hours a day; 25% work Sundays and holidays during the high season.

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7 Chile's imports from the U.S. reached US$ 4.11 billion in 1996.

8 Malva Espinosa et al., "Precarización del empleo: Un mal moderno?" [Increasingly Precarious Jobs: A modern ailment?] Departamento de Estudios, Dirección del Trabajo, Temas Laborales. Año 2, No. 5 (January 1997), p 4.

The use of pesticides such as lindane, pentachorophenol, paraquat and parathion—condemned by the World Health Organization for their linkage to birth defects, neurological damage and cancer—are regularly used in fruit and grape production.

- A study of female grape workers showed that 62% of those working in the field and 42% of those working in packing houses had suffered ailments from exposure to pesticides.
- A survey of 213 agricultural sites in Chile's central and main fruit-growing region carried out in 1993 by the Directorate of Labor showed numerous violations by growers in the application of pesticides.[9]

Twenty and eight-tenths percent of the violated maximum allowable exposure times by having workers working more than 48 hours a week.

- 67.8% of sites lacked adequate personal safety equipment;
- 51.2% lacked a Joint Health and Safety Committee as mandated by Chilean law;
- 36.9% did not wait the mandated time before workers re-entered fields sprayed with plaguicides;
- 51.3% of workers applying highly poisonous pesticides lacked adequate training;
- 11.7% of the site's products lacked adequate labeling.

Forestry and Lumber Workers. Forestry and lumber exports have experienced tremendous growth over the last two decades, representing in 1995, 16% of Chile's total exports. Yet Chile's Dirección del Trabajo discovered that 28.6% of forestry workers and 31.2% of lumber extraction workers lacked a contract.[10]

An inspection carried out in 1995, of 29 contractors in native forest management in Chile's southernmost region found striking precarious labor conditions: 31 % lacked a register of workers at the site, 10.3% had excessively long work days 13.8% were late in paying wages 34.5% of the sites lacked drinking water, and 58.6% lacked adequate bathrooms.[11]

Fishing. Export-oriented fishing and processing (canning, fresh-frozen and salmon-trout) has become an important activity generating many new jobs. However, these have not been jobs that enjoy basic worker protection. Temporary, fixed-employment, and even child labor are common especially during the summer or peak production periods.

Salmon has become one of the important products exported to the United States. The cultivation of salmon takes place in floating pens subject to strong wind and wave action, which can create serious

9 Dirección del Trabajo, Departamento de Estudios, based on information provided by the Fiscalization Department.
10 Espinosa et al., op.cit., p. 5, infra 17.
11 Table 3: Principales Infracciones laborales en Empresas Contratistas Forestales, Region XII (1995), Dirección del Trabajo, Departamento de Estudios, Temas Laborales. Año 2, No. 5 (January 1997), p 11.

risks for workers. Chile's salmon industry shows a 20% accident rate, one of the highest in the country. A Dirección del Trabajo study of salmon fisheries in the Lake Region found that 44% of the enterprises lacked adequate flooring and railings on the pens.[12]

Mining. The United States is Chile's main foreign investor and mining is one of the key sectors where U.S. investments are concentrated (See Annex 1). U. S.-based mining corporations, along with those from Canada, European, Australia and Japan, make Chile one of the world's top producers of copper and gold. The expansion of mining activity in Chile, however, is having negative effects on working and occupational health conditions, as many of these new sites are located 2,000 meters above sea level and close to 60% of miners are forced to live away from their homes in work camps.

Competition and weak labor legislation have led to an increase in the use of contractors and subcontractors in mining operations. In 1994, for example, 30% of Chile's mine workers worked for contractors and subcontractors, whereas only 70 percent were permanent employees. The frequency of accidents is significantly higher for subcontractors than for permanent workers.[13]

A 1996 inspection of mining conditions at 50 mining sites and the 439 companies working in them showed serious limitations in areas of basic safety and health.[14]

- 44% of the companies lacked Joint Safety and Occupational Health Committees mandated by law;
- 32% had not drawn up Rules and Procedures for Safety and Occupational Health mandated by law;
- 32% had insufficient drinking water and 30% drew drinking water from natural sources without adequate certification;
- 19% had bathrooms in bad conditions;
- 30% workers ate their food at the point of production in a toxic atmosphere;
- 11 % had dining rooms not separated from toxic environment;
- 20% lacked lockers, and 41% had lockers without dividers to separate clean from contaminated clothes;
- 22% had dressing rooms without showers and 24% without hot water showers for washing off toxic residues.

The data above illustrates the conditions workers face in those sectors that constitute the pillars of Chile's export model.

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12 Departamento de Fiscalización, Dirección del Trabajo, Temas Laborales. Año 2, No. 5 (January 1997), p 13.

13 Between 1990 and 1994 for example, the data frequency of accidents was: in coal (142.8 subcontractors, 50.7 permanent workers), in saltpeter (40.9 subcontractors, 28.6 permanent) and in large copper mines (19.5 subcontractors, 9.2 for permanent workers). These figures are drawn from the overview by Magdalena Echeverria, "Mejores Condiciones de Trabajo: Un Desafio Actual," in Temas Laborales. Año 1, No. 2 (January 1996).

14 "Resultados Programa de Fiscalización a la Minería, 1996," Dirección del Trabajo, Departamento de Estudios Temas Laborales. Año 2, No. 6 (May 1997).

Existing Labor Legislation Inadequately Protects Labor Rights

The bleak picture described above is the outcome not only of inadequate enforcement mechanisms for already existing norms but also of Chile's current labor legislation which fails to provide Chilean workers with adequate protection for internationally recognized labor rights and grants employers multiple loopholes to manipulate the law against workers' interest.

The 1990-1993 labor reforms did not substantially modify the essence of the 1987 Pinochet Labor Code, but rather maintained an institutional framework highly prejudicial to workers. Three core rights are inadequately protected in the letter of the law and in the labor practice of employers: the fight to organize, collective bargaining, and the right to strike.[15]

1. Freedom of Association and Protection of the Right to Organize

Public employees do not have the right to form unions but only "associations" which do not have the right to strike or to engage in collective bargaining. Article 161 which allows firing based on the "needs of the enterprise" (rationalization, modernization, changes in productivity, demand, etc.) is widely used to dismiss workers engaged in union organizing. A 1994 Ministry of Labor survey of 5,569 enterprises documented the extent to which Chile's labor legislation failed to adequately protect Chilean workers.[16] An important finding of the extensive study revealed that termination of work contracts based on the "needs of the enterprise" more than doubled in the three-month period after collective bargaining processes and the legal constitution of unions. Under Art. 163 if a worker is able to demonstrate that he/she was unjustly fired, employers only have to pay minimal fines and reinstatement is not mandatory.

2. The Right to Bargain Collectively

Numerous legal limitations undermine the exercise of this right by Chilean workers. The current Labor Code not only restricts who can participate, thereby limiting the scope of collective bargaining, but also curtails employee access to information relevant to the collective bargaining process. In fact, in 1995 only 12.9% of Chile's wage workers bargained collectively, a decline from the early 1990s when the percentage was over 14%.

Only company unions (63% of all unions) can engage in collective bargaining processes. Seasonal workers in transitory workers' unions (3% of unions) or inter-company unions (12% of unions) are *de facto* excluded, since these workers can exercise this right only if employers agree to it. Article 304/305 excludes public workers, employees of private enterprises with 50% of their revenues provided by the State, and temporary and seasonal workers.

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15 For an excellent and detailed analysis see Carol Pier, "On the Eve of Free Trade Extension to Chile: Chilean Labor Law and Practice Through the Lens of NALLC," Unpublished manuscript, Harvard Law School.

16 Dirección del Trabajo, Cuadernos de Investigación No. 1, 1994.

The current Labor Code allows employers to arrive at agreements with individual workers, groups of workers or a union, allowing them to fragment workers. One strategy used by employers to weaken labor has been for employers to create multiple legal entities "and even though the operate side by side, have the same owners, carry out identical activities and employees work under the same roof, from a legal point of view, these entities are considered as separate companies."[17] Employers then hire employees who labor side-by-side but who have different legal employers. In this situation, workers can and do form "inter-company" unions, and 8% of Chile's unionized workers are in these types of unions. Current labor legislation allows this union to engage in collective bargaining processes only if the employer agrees to do so, *de facto* denying workers this right. In 1995, for example only 0.2% of all bargaining processes involved inter-company unions, in spite of the fact that 12% of Chile's unionized workers belong to this type of union.[18]

3. The Right to Strike

All types of workers excluded from collective bargaining (seasonal, temporary, short-term fixed workers, public employees) are denied the right to strike. Chilean labor law allows for employers to hire replacement workers during the first day of a strike if the company's final offer readjusts wages in the same proportion as variation of the Consumer Price Index. These and other provisions (i.e. after 15 days employers can hire workers from the striking union, etc.) effectively curtail this basic labor right.

The 1994 Labor Code contains numerous other provisions that allow employers to deploy a wide range of strategies to achieve "labor flexibility." The overall outcome had been to encourage the transferring the costs of economic restructuring onto workers and has stimulated employers to adopt productive strategies based on labor cost reduction, subcontracting, use of temporary/fixed-term workers, homework and externalization.[19]

The 1995 Proposed Reforms to Labor Law

In early 1995, the Frei government sent Congress a package of reforms geared to strengthen labor rights and re-equilibrate labor-capital relations. The proposed reforms:

- Protect from dismissal workers who participate in the formation of a union;
- Indemnify workers and unions in the case of disloyalty or union busting;
- Require employers to provide relevant information to workers;

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17 Cristián Dinamarca, "Reflexiones sobre la negociación colectiva en Chile," Temas Laborales. Año 1, No. 4 (September 1996). Santiago: Dirección del Trabajo, p.3.

18 Dinamarca, op. cit. supra 15.

19 For a more detailed analysis see, Fernando Leiva, "Flexible Labor Markets, Poverty and Social Disintegration in Chile 1990-1994, The Limitation of World Bank Policies," Unpublished Manuscript.

- Broaden the scope of matters that come under collective bargaining to include work conditions and employment;
- Eliminate the rights of employers to hire strike replacement workers; and
- Provide the right to inter-company and transitory workers unions to engage in collective bargaining.

The willingness of the Frei government to promote these reforms was based on the realization that Chile's acclaimed labor legislation—even after the 1990-1993 Aylwin reforms—remains grossly and unjustly tilted towards employers, providing numerous loopholes for abuse and anti-union practices.

The lack of effective legal protection for Chilean workers and the free-reign enjoyed by employers in preventing legal fights from being exercised has been further documented by the a subsequent *Centro de Estudios de la Realidad Contemporánea* (CERC) survey: 50 percent of non-unionized workers do not join a union due to the fear of being fired.

Changes in Legislation are Hampered by Many Remaining Authoritarian Enclaves

Passage of this legislation is blocked by the authoritarian enclaves embedded by the military regime (1973-1990) in the 1980 Constitution. The most blatant of these are the lack of full subordination of military to civilian authority and the undemocratic nature of the Chilean Senate, where nine Pinochet-appointed Senators have the power to effectively block significant changes in labor legislation as well as defeat equity-enhancing policies.[20]

Labor reforms are blocked not only by "Pinochet's battalion" in the Senate, but they are also vehemently opposed by business groups, the World Bank and especially by the American-Chilean Chamber of Commerce, the organization that represents the interests of U.S. investors in Chile.

Inequality and Social Polarization Increase as "Growth with Equity" Fails

While social conditions have improved over the last years, Chile still confronts serious social problems. Real wages have increased but one needs to recall that Chilean wage levels had reached extremely low levels. Two-fifths of those in the labor force earn wages insufficient to meet the basic needs of the average family. Real wages have increased at rates far below gains in average productivity, so that from a distributional aspect, workers have not significantly benefited from rapid economic growth.

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[20] Even though these nine senators ended their eight-year term in December of 1997, the new set of nine designated senators do not promise much improvement. Three will be appointed by anachronistic and dishonored Supreme Court, four by an armed forces controlled National Security Council, and two by President Frei.

The decreasing power of workers to defend the conditions of remuneration and expansion based on natural resource exports produced with low-wage/flexible labor are two reasons why economic growth has been accompanied by increased economic inequality. The income share of the poorest 20% of Chileans declined from 4.6% in 1992 to 3.9% in 1996, while the richest 20% increased their share from 55.6% to 57.1% over the same period.

For a Socially Equitable and Environmentally Sustainable Basis for Hemispheric Economic Integration

Chileans want their social and environmental conditions and standard of living to improve in the future, and not to become locked for posterity at their present low levels, or to have them even further eroded by NAFTA or NAFTA-like agreements.

For this reason, we hold that hemispheric economic integration will be a win-win situation for all parties involved only when environmental and labor clauses are incorporated into the core of the agreements and given the same level of protection that NAFTA provides to investors and corporate property rights. The present NAFTA, the current fast track authorization with its weakened social and environmental commitments, or a US-Chile bilateral agreement without significantly enhanced environmental and labor clauses incorporated in the text, will only perpetuate and intensity labor vulnerability, environmental degradation, social polarization, and "low intensity" democracy which have become the daily experience by Chileans as the fruits of economic expansion accrue to a small minority.

THE FTAA: REALITY & EXPECTATIONS

Manuela Tortora

"Oft expectation fails, and most oft there where most it promises."

—Shakespeare

Introduction

On September 1, in the city of Miami, the negotiations on the Free Trade Area of the Americas (FTAA) entered a decisive phase. After more than three years of preparatory work, the countries of the hemisphere (with the exception of Cuba) decided to begin negotiations within eleven working groups and that all talks must conclude, whether or not successfully, by the year 2005.

Thus, during the coming months, the Foreign Trade Ministries and other economic bureaus of Latin American and Caribbean countries will focus on these negotiations.

It is not an exaggeration to view the FTAA project as a political investment and an economic bet of major significance in the history of hemispheric relations. Whether the expectations it has given rise to, ever since the 1994 Miami Summit, both within governments and the private sector, will match the results remains to be seen. For the moment, it appears that the road to the FTAA is mined with frustrations.

Towards a New Hemispheric Relation?

Ever since the XIX Century, relations between the United States and the countries South of the Rio Grande have been marked by a lack of understanding, asymmetries

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and tensions. After an array of political initiatives ranging from the Monroe Doctrine of 1824 to the "carrot and stick" of the 1930s, it was not until the "good neighbor policy" and, particularly, President Kennedy's Alliance for Progress that the issue of "cooperation" was introduced for the first time in the debate on hemispheric relations.

The following decades were characterized by ideological differences in both the political (within the framework of the cold war) and economic area (particularly regarding trade and investment) and by new initiatives launched by the United States in an effort to restructure hemispheric cooperation by targeting only a selection of countries. During the 1980s, with the foreign debt crisis and the Central American conflict as a background, Washington announced the Caribbean Basin Initiative, then the Andean Trade preferences, and finally the hemisphere-oriented Bush Initiative, which in 1994 became the FTAA.

The main difference between this project and the previous ones is that the FTAA is not conceived as a "welfare" cooperation system in which the United States grants unilateral concessions and assistance, but as a new economic relation based on reciprocity, the exact content of which will depend on the results of the negotiations.

The shift in Latin American and Caribbean countries' economic policies that began at the end of the 1980s, is the new background for this latest initiative without them Washington would not even have conceived an FTAA and the other capitals of the Americas would not have accepted it. It implies two fundamental changes: first, the opening up of national markets, which constitutes the FTAA's ideological foundation; second, the concept of reciprocity, that is, the abandonment of the differential treatment which was, until the last decade, the cornerstone of Latin America's foreign economic policy vis-a-vis the USA and the rest of the industrialized countries.

To a large extent, the expectations derived from the FTAA spring from a belief that the new ideological consensus, which has brought uniformity to the economic policies of the hemisphere's countries, and the disappearance of Cold War conflicts will insure the success of this initiative. In reality, these are necessary conditions, but they are not enough to spell 'success'.

On the economic negotiations table, the similarity of ideas and a favorable climate for expanding relations do not guarantee results that will meet Latin American and Caribbean long-range development priorities and the region's need to strengthen its new political relation with the USA through updated economic cooperation instruments.

The question here is, what place does Latin America hold on the United States' global foreign policy map? One of the expectations unleashed by the FTAA is that the region supposedly holds a extra weight on the scale of Washington's concerns, and that this gives it the "right" to expect preferential treatment compared to other regions of the world.

In reality, there is no such priority in the political area nor in the economic and trade issues, especially if we consider the countries of Latin America and the Caribbean as a whole (with the exception of Mexico, a neighboring country).

To begin with, on the economic front, current trade figures between the United States and its future

FTAA partners are not so significant as to warrant granting more importance to that project over many other USA priorities in the international arena. Only 19.5% of USA exports and 15% of its total imports are to and from Latin America and the Caribbean (including Mexico). In 1950, those figures were 27.9% and 34.1%, respectively; in this sense, the FTAA was more justifiable then than now.

On the political front, and still from Washington's perspective, the new hemispheric relation (with or without the FTAA, but strengthened by the FTAA) that result from economic globalization and the absence of ideological conflicts, result in an agenda that reflects the USA's objectives for any area of the world: the struggle against drug trafficking, immigration controls, human rights and democracy, environment protection, "good government" and the fight against corruption.

The United States' Negotiating Technique

It is important to point out that the economic policy of the United States is determined first by objectives defined in terms of issues, and second, in terms of partners or economic fora. The questions this policy asks are, for example, what are our businessmen's interests regarding the treatment of foreign investment in all external markets? And, then, where can we negotiate bilateral or multilateral instruments that allow us to obtain our objectives in the area of foreign investment? On the other hand, Latin American countries, generally, tend to proceed in the opposite direction: first they define their position in regard to the forum or their counterpart and, then, in terms of their objectives regarding the issues to be negotiated.

This is why the United States introduces *ab initio* its views on issues such as investment, services, intellectual property, subsidies, competitiveness and, recently, electronic trade, regardless of the type of negotiation or its counterpart's degree of development.

And when new issues arise (that is, new general objectives) that were not taken into account when defining its original position, the United States introduces them a posteriori, during the negotiating process or at the end of it. For example, in 1994, when the draft project for the Free Trade Treaty of the Americas (FTTA) with Mexico and Canada was completed, two new Annexes, one on the environment and another on labor legislation, were added as a result of the US Congress' preoccupation with these issues and were made obligatory for the successful conclusion of the agreement. That same year, during the last days of the Uruguay Round of Multilateral Trade Negotiations, the United States (on that occasion, with the support of France) brought to the negotiating table the same environment and labor issues. Since this was a multilateral forum that encompassed, at that time, close to 130 countries, it did not succeed in obtaining the same type of commitment achieved on the other issues of the Round.

By defining *ab initio* its global objectives in terms of issues rather than fora, the United States derives a double advantage: on the one hand, it achieves coherence in its foreign policy (at least in the economic arena), on the other, it is able to proceed "in a spiral". In other words, Washington presents a specific position in a bilateral or multilateral forum; once it achieves its goals there, it proposes it as the "floor" for the next negotiations, and so on. Thus, its position becomes, alternatively, the "floor" and "ceiling"

of each negotiation as the initial objectives are achieved or new issues added. Currently, Washington's possibility to improve its negotiating objectives is greater than in the 1980 since the United States has begun, or is about to begin, simultaneously, economic negotiations in 11 bilateral, regional or multilateral fora, ranging from the new World Trade Organization's rounds to possible agreements with the European Union and the Asia-Pacific region of particular importance to US interests.

In this "spiral" process, the FTAA is, for Washington, of greater priority than the global trade liberalization rules (for goods and services) agreed upon in the Uruguay Round and the Free Trade Treaty of the Americas, and at the same level of importance as integration arrangements such as the Andean Community and MERCOSUR which, in its opinion, constitute discriminatory barriers that affect its products' access to these markets.

In this sense, some day the FTAA will become a point of reference for negotiations with Asian countries and, later, within the WTO. Within the context of the United States' international economic policy, the "preferential" character of FTAA agreements tends to erode as other economic arrangements are reached with other regions. Thus, it is logical to conclude that once the FTAA encompasses existing sub-regional integration arrangements (Andean Community, MERCOSUR, Central American Common Market, CARICOM) the trade liberation commitments obtained within it will "level off" completely. The same will happen once the WTO's multilateral norms resemble those agreed upon within the FTAA.

The Context Determines the Content

As long as the world economy remains stable and grows, the United States' foreign economic policy will progress in a spiral pattern. In fact, ever since the beginning of the Uruguay Round in 1986, the USA's ever wider initiatives have been made possible by a favorable international environment. This approach has allowed the USA to score several successes: the inclusion of issues such as agriculture, services and intellectual property into multilateral trade norms (this would have been unthinkable up until the beginning of the 1980s); the conclusion of free trade agreements with Canada, Israel and, above all, the Free Trade Treaty of the Americas, which in 1984 became a model to be followed by Washington; the introduction into the WTO agenda of the so-called "new" trade issues (first the environment, then competitiveness, investments, government purchases and, more recently, trade facilitation and electronic trade—leaving aside, for now, the labor issue for which the USA did not obtain a consensus in the Singapore Ministerial Conference); and the FTAA project which should become the next model to be followed in economic negotiations, as long as the international context allows it to progress towards its original goal.

Today, one could say that the FTAA negotiations began at the wrong time. The monetary and financial crisis that began in South East Asia over a year ago—and which is, undoubtedly, a large scale systemic crisis—will be the FTAA's worst enemy as far as expectations are concerned.

We are learning that the crises stemming from globalization (the first such crisis was Mexico's, in 1994-95) typically proceed along two stages: one is unexpected, swift and far reaching, within and without

the directly affected countries, and in a few days causes the collapse of currencies and financial systems; the other is more extended in time and the devaluation that occurs during the fist stage produce the predictable result of increasing the competitiveness of exports from the countries that originated the crisis.

During the last months of the year and the first months of the coming one, the countries of the hemisphere (together with the other actors on the international stage) will witness the effects of the second stage of the crisis. In Andean, MERCOSUR, and Central American countries, governments and businessmen are already expressing their alarm over the "invasion" of imports from the Asian countries that have devalued their currencies. There is talk, once again, of adopting "safeguards," restrictions, and controls, the typical tools of trade crises which had been abandoned ever since the debt crisis.

The current Russian collapse will cause the same effect, even if at a smaller scale as far as trade is concerned, at least for those products Russia and its neighbors can export at a massive scale (for example, minerals, iron, steel and chemical products). Let us hope that the next crisis does not occur in China. A devaluation would cause a surge in that country's already highly competitive exports.

Likewise, the US Congress is following, with some concern, the reduction of that country's traditional agricultural trade surplus with Asian countries, which adds to the growing general trade deficit with that region. The same is occurring after four years of the FTTA: the trade liberalization measures and the devaluation of the peso have favored Mexican exports to the point that many US enterprises view them as a potential threat.

Because of these fears—which were already apparent even before the current crisis—Chile was unable to join the FTTA three years ago. They are the reason the US Congress does not grant the Executive the fast track negotiating authority it needs to insure its counterparts that the agreements reached will not be modified by Congress.

Consequently, during the next months, this hemisphere's trade ministers' priority will not be to insure the liberalization of trade, but rather to attempt to lessen the effect of competition from South East Asian countries, Japan, Russia and its neighbors and, perhaps, China.

Were the systemic crisis to deepen, causing a world recession that directly affects industrialized countries and the USA in particular, the current protectionist temptations would become harder to resist. For the FTAA project to progress, it will need to offer Latin American and Caribbean countries and the USA and Canada very attractive benefits to compensate for the real or imaginary risks this type of economic opening could entail.

The Limits for Negotiations Within the FTAA

Which of these are possible, and what can we expect from the negotiations? Once again, expectations exceed reality.

Leaving aside the context of the crisis, what are the FTAA's theoretical achievements? As mentioned above, for the United States the FTAA is just a dot in its world map that would allow it to: expand its

access to the hemisphere's markets; eliminate or at least reduce the deviation of trade and investment caused by sub-regional integration arrangements; improve intellectual protection and investment treatment rules in the hemisphere; and insure that Latin American and Caribbean countries commit themselves to continue and deepen their current economic policies. To this, we must add the important objective of setting a precedent for future negotiations with other trade partners in other regions of the world.

On the other hand, the list of benefits for Latin America hardly matches the above. As far as access to the US market is concerned, current tariff levels are already quite low and, anyhow, most of the region's products already enter the US duty free, thanks to existing preferential agreements. The only thing left to do would be to request the *sine die* consolidation of those mechanisms and the inclusion of sensible products currently excluded, request difficult to obtain.

Another request Latin America could make, which would be more relevant for the region's trade, refers to US trade legislation tools that allow for unilateral measures and non-trade-related sanctions and barriers of wider scope and discretion than other countries' regulations. Mexico obtained positive results in this regard within the FTTA, however, it is unlikely that this treatment will be extended to all countries in the hemisphere.

We are left, then, with one of the FTAA's major expectations, that is, the consolidation of economic liberalization policies to insure internal stability and attract foreign investment. There is no doubt that a project such as the FTAA may contribute to these objectives. However, expectations in this regard are weakened by the turbulent international reality, the implications of which are of such magnitude that not even the best FTAA can stop them.

TOWARDS A CARIBBEAN-AMERICAN STRATEGIC ALLIANCE

Norman Girvan

Hemispheric Integration Gathers Momentum

Formal negotiations to establish the Free Trade Area of the Americas (FTAA) were launched at the 2nd Summit of the Americas held in Santiago de Chile in April 1998. In the run-up to the summit, several agreements or proposed agreements among integration groupings in the hemisphere were announced. In this article, we review these and other recent developments from the perspective of the interests of Caribbean Community (CARICOM) member states.

Among the most significant pre-Summit developments of interest to CARICOM are[1]:

- Agreement on the establishment of a Free Trade Zone between MERCOSUR-the South American Common Market (whose members are Brazil, Argentina, Uruguay and Paraguay) and the Andean Community to come into effect in January 2000. The FTZ would incorporate the vast majority of the economies on the South American continent five years before the FTAA comes into effect.

This paper was used as a background paper for the conference Health and Human Development in the New Global Economy in Galveston, Texas, October 26-28, 1998. This is a slightly revised version of an article titled "Caribbean-Central American relations and the FTAA," published in FES/ACE (1998) reprinted here with permission.

1 Most of the information in this article on developments since the beginning of 1998 comes from the CRIES Network services, Noticias de Integracion (Spanish) and Integration News (English). These services draw on newspaper and news agency reports in, and on, the Greater Caribbean. Specific documents, reports, etc. are individually referenced.

- A proposal from the Dominican Republic for the formation of a Strategic Alliance between the Caribbean and Central America, to be discussed at a meeting of Foreign Ministers of the two subregions in May. The proposal envisages a free trade area embracing the two subregions and the coordination of external trade negotiations across a wide front.
- Signing on April 16 of a free trade agreement between the Central American Common Market (CACM) and the Dominican Republic, to come into effect in January 1999.
- Signing on April 18 of a trade and investment agreement between the CACM and MERCOSUR.
- Joint commitment between the CACM and Chile to negotiate a free trade agreement.
- On-going negotiations on a free trade agreement between Mexico and three Central American countries -Guatemala, El Salvador and Honduras- scheduled to be completed in July.

The CACM countries are also taking steps to strengthen their own internal integration system, and to diversify and restructure their extra-hemispheric trade relations. The Presidents of the "Isthmus" (Central America and Panama) met early this year and agreed on an action plan to strengthen the Central American Integration System (SICA). A Central American ParliamentæPARLACEN—is now functioning and will soon commence debate on a proposal for the establishment of a Central American Union.

In external relations, developments in recent months have included:

- A CACM-EU (European Union) Ministerial meeting to amplify trade and development cooperation between the two groups: the EU is to extend trade preferences for CACM countries to some agricultural products.
- A CACM-Canada agreement on trade, investment, and trade promotion.
- Ongoing negotiations on trade and economic cooperation between the CACM and Japan, Taiwan, Korea, and Morocco.
- A proposed meeting of the Heads of Government of Central America, Belize and the Dominican Republic, with 18 Governors of southern U.S. states, to discuss trade and investment promotion. The meeting is planned to take place in Puerto Rico in August 1998.
- Coordination of the positions of Central America and the Dominican Republic for the Santiago Summit.

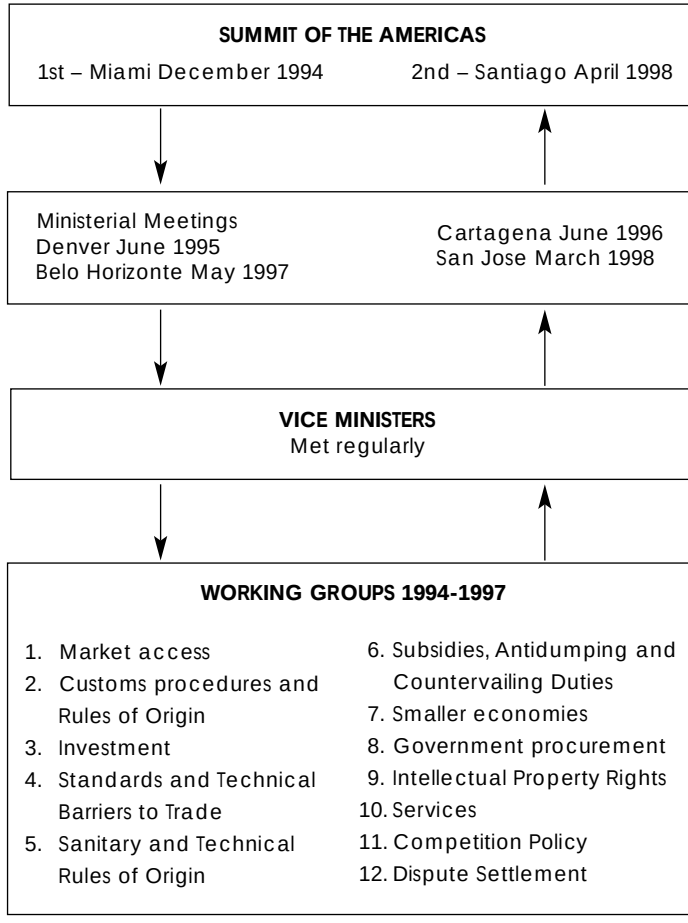
There are other indications of a more active Central American policy in the Caribbean basin. For instance, President Alemán of Nicaragua has recently been to the Dominican Republic, Governor Rossello of Puerto Rico has been visiting Central America, and the Cuban foreign minister Roberto Robaina recently addressed the Central American Parliament. The Central American airline—TACA—has announced plans to begin services to Cuba and the Dominican Republic, and moves are afoot to abolish visa requirements between the Dominican Republic and several Central American countries. There have also been calls for the Dominican Republic to become a member of the Central American Parliament.

In summary, our Central American neighbours are accelerating their efforts to develop trade relations

with other countries and subregional groupings within the hemisphere, as well as to restructure their extra-hemispheric trade relations. As part of this process, they are reaching out to other countries in the Caribbean Basin, with the Dominican Republic positioning itself to act as a bridge between the two subregions. At the same time, they are strengthening their internal integration arrangements in the aftermath of the end of civil conflicts in that hitherto troubled region.

The bigger hemispheric picture shows that the other principal subregional groupings are also establishing trade agreements among themselves in the run-up to the start of formal negotiations on the

Figure 1. Background to the FTAA negotiations



Source: Author, based on information in FTAA (1998a, 1998b).

FTAA. The pattern of events suggests that the major players in the hemisphere are seeking to establish, and to strengthen, their bargaining positions in anticipation of the upcoming negotiations.

What of the position of CARICOM? How should it respond to the proposed alliance with Central America? And how will it reconcile its trade relation negotiations with the EU and its lobbying for NAFTA

BOX 1.
FTAA negotiations: structure and principles

The Declaration of San Jose, adopted at the Ministerial Meeting of March 1998 and ratified at the 2nd Summit of the Americas, outlined the following structure and principles on the FTAA negotiations.

Structure

Negotiations to be the direct responsibility of a Trade Negotiating Committee (TNC), at the Vice Ministerial level, meeting twice a year. Negotiations to be concluded by January 1, 2005. Final stages will be co-chaired by Brazil and the United States. Nine negotiating groups were established on:

1. Agriculture
2. Market access
3. Investments
4. Services
5. Government Procurement
6. Competition policy
7. Dispute settlement
8. Intellectual Property Rights
9. Subsidies, antidumping and countervailing duties

A Consultative Group on Smaller Economies will monitor negotiations and report directly to the Trade Negotiating Committee on matters affecting the interests of smaller economies.

General principles

1. Decisions will be made by consensus.
2. Negotiations will be transparent.
3. The agreement will be consistent with the terms of the WTO.
4. The agreement will improve on WTO rules and disciplines wherever possible.
5. Negotiations will be simultaneous and will be treated as parts of a single undertaking.
6. The FTAA can co-exist with bilateral and sub-regional agreements, where the terms of such agreements are not covered by, or go beyond, the terms of the FTAA.
7. Countries may participate individually or as a member of a sub-regional integration group negotiation as a unit.
8. Special attention is to be given to the needs and conditions of smaller economies.
9. In various thematic areas, measures such as technical assistance and longer implementation periods may be included to facilitate the adjustment of smaller economies.
10. Measures to facilitate smaller economies should be transparent, simple and easily applicable.
11. Countries to ensure that their laws, regulations and procedures conform to the FTAA agreement.
12. Differences in the level of development among countries are to be taken into account.

Source: based on FTAA (1998c).

parity with the FTAA negotiations? Is there a risk that we will be left behind, or marginalised, in the FTAA process as the larger players position themselves?

In attempting to elucidate these questions, this article continues by reviewing the process leading up to the FTAA negotiations and discusses the content of the proposed Caribbean-Central American alliance against that background. We also point to the implications of the proposed changes in the EU-ACP relationship, and review the progress of establishing the CARICOM Single Market and Economy. The possible future role of Cuba in these processes is also discussed. Finally, some conclusions are drawn on the various strands of the external negotiation strategy of the subregion.

The FTAA process 1994-1998

The FTAA process that began in December 1994 has proceeded at several levels, as shown in Figure 1. The aim is to conclude negotiations on the establishment of a hemispheric free trade zone by January 1, 2005. The technical preparations have been carried out in 12 Working Groups whose themes relate to the main subject areas expected to be covered by the agreement. Support has been provided by the IDB, the OAS, and ECLAC.

The Declaration of San José, adopted by trade ministers in March 1998 and ratified at the Santiago Summit, sets out the main elements of the framework of formal negotiations to commence by June. The agreed structure, negotiating groups, and principles of the negotiations are shown in Box 1.

The seventh principle is of particular interest. It permits countries to participate in the negotiations either individually or as a *member of a sub-regional integration group negotiating as a unit*. Present thinking is that MERCOSUR, the Andean Community, the CACM and CARICOM may negotiate as groups, whilst the three members of NAFTA will negotiate as individual countries. If Chile teams up with MERCOSUR, and the Dominican Republic and Panama join either with CARICOM or with the CACM, the result could be to reduce the effective number of FTAA negotiating units from 34 to seven (Table 1). MERCOSUR, in which Brazil is the predominant economy, is clearly the strongest negotiating group, whilst the U.S.A. predominates amongst the NAFTA countries. After these two are a second tier of major players: Mexico, Canada, and the Andean Community.

To a significant extent, therefore, the course of the FTAA negotiations will be conditioned by the bargaining relationship between the U.S. and MERCOSUR, led by Brazil. Already, Brazil has signaled that the extent of its own participation in the FTAA will be conditioned on the degree to which the agreement provides access to the huge U.S. market. For its part the U.S. has had its position considerably weakened by the failure of the Administration to secure "fast track" negotiating authority from the Congress. In the absence of this authority, any agreements have to be submitted to Congress for ratification section by section, and not as a single inter-related whole as called for in principle number 5.

In this context, the free trade agreement (FTA) between MERCOSUR and the Andean Community will strengthen the negotiating hands of the two groups by establishing a South American FTA in advance

Table 1. Major Negotiating Players in the FTAA Ranked by GDP

Country/Group	Population		GDP	
	Million	% total	US$ Billion	% total
1.USA	263.1	35.0	6952.0	76.0
2. MERCOSUR and Chile	216.1	28.7	1062.0	11.6
3. Canada	29.6	3.9	568.9	6.2
4. Mexico	90.1	12.0	250.0	2.7
5. Andean Community	100.5	13.4	232.6	2.5
6. CACM, Panama, DR	39.4	5.2	58.5	0.6
7. CARICOM	13.4	1.8	20.3	0.2
Smaller Economies (6+7)	52.8	7.0	78.8	0.9

Source: based on data in World Bank World Development Report, 1997; Ceara Hatton (1998)

of the hemispheric FTA. It provides a "second-best" alternative for these countries should the anti-free trade sentiment in the U.S.A. continue to hamper progress in the FTAA negotiations, and it raises the possibility of eventual convergence in the negotiating positions of the two groups. It would also provide a transition period for the enterprises of these countries to adjust to heightened competition before full exposure to competition from U.S. firms.

In the case of the Central American Common Market, similar considerations apply to the trade agreements with MERCOSUR, the Andean Community, Chile, and the Dominican Republic, and to the proposed agreement with CARICOM. The tremendous disparity in size between the two subregions and the other main players is highlighted in Table 1. The smaller economies—the CACM, CARICOM, the Dominican Republic and Panama—together make up just 7 percent of the total FTAA population and only 1 percent of the combined GDP. It will, therefore, be necessary for these countries to do their utmost to maximise their bargaining power in the FTAA negotiations, and to strengthen the competitive competencies of their businesses to respond to the challenges and opportunities arising from hemispheric trade liberalisation.

CARICOM and the FTAA

Over the course of the past 6 years CARICOM and its member states have been pursuing a two- or three- track policy in relation to the hemispheric trade negotiations. Within the FTAA process itself, CARICOM allied itself with Central America and the non-anglophone states of Haiti and the Dominican Republic in the Working Group on Smaller Economies, chaired by Jamaica. The objective was to secure acceptance of the principle of special treatment for the smaller economies of Central America and the

Caribbean on account of their weak competitive position (Bernal 1998). Such treatment could be a waiving of the requirement for full reciprocity in free trade, or allowing a longer period of transition for the phasing in of the free trade requirements, or some combination of both.

At the same time, and outside of the FTAA process proper, the same group of countries lobbied hard for "NAFTA parity"—extending the benefits enjoyed by Mexico under NAFTA to the Caribbean Basin (CBERA) countries. In fact, the latter is of more immediate urgency than the FTAA for the countries exporting garments and textiles to the United States (Jamaica, the Dominican Republic, Haiti, and others), which have been losing foreign investment and jobs to Mexican locations.

A third track—that of seeking accession to an expanded NAFTA—was of interest to some CARICOM countries in the early 1990s. This occurred during the time when the U.S. Administration had "fast track" negotiating authority to expand NAFTA through a series of bilateral negotiations. Hence, in 1992-1994 Jamaica and Trinidad and Tobago took steps to meet NAFTA eligibility criteria by means of bilateral treaties with the United States, and by securing a steep reduction of the CARICOM Common External Tariff (CET).

The fate of the three tracks is a sobering lesson on the weak bargaining position of small countries in trade negotiations with the U.S. and the wider hemisphere. First, NAFTA membership receded into the distance, as the U.S. Congress balked at empowering the Executive Branch to negotiate bilateral expansions of the Treaty. In effect, CARICOM had made concessions on the CET and received nothing in return.

BOX 2.
Smaller Economies: Report of the Independent Group of Experts

Findings

1. FTAA should recognise that smaller countries (SCs) face particular policy concerns.
2. Appropriate mechanisms to facilitate SCs participation in FTAA is needed.
3. SCs should participate fully in FTAA.
4. Small economies (SEs) must view FTAA as part of their strategic global repositioning plans.
5. FTAA should be part of wider hemispheric process as set out in Miami Plan of Action.
6. FTAA should be a balanced, comprehensive, single undertaking of rights and obligations. It should give special consideration to the needs of SEs regarding:
   - Phased implementation
   - Flexibility
   - Joint participation: Central American and Caribbean countries may participate as a group.
7. Specific issues of particular importance to SEs are trade frictions, investment, capital flows, services, labour mobility, tourism, rules of origin, fiscal revenue, Lome Convention ompatibility, technical and financial assistance for negotiations, and the role of the private sector.

Source: based on Report (1997).

Second, the U.S. Congress also balked at supporting for NAFTA parity for the Caribbean Basin Initiative (CBI) countries, in spite of successive attempts over the years and most recently in November 1997. The simple fact is that CBI countries do not command the same political clout as the voting districts in the Congress, which fear further job losses from extending NAFTA privileges to these countries. With the Cold War over, the Administration can no longer use the "communist threat" as a leverage. And, as the FTAA process gathers momentum, the case for making a special arrangement for one group of countries outside of the FTAA agreement will weaken.

With regard to the Working Group on Smaller Economies in the FTAA process, in the final stages of preparation for the 2nd Summit the U.S. opposed acceptance of the general principle of "special treatment" for this group of countries as a separate area of negotiation. This is consistent with the drive by the developed countries to dismantle trade preferences and non-reciprocal market access for selected groups of countries, as shown in the WTO Treaty negotiations. The compromise formula, in terms of the FTAA process, is to give "special consideration to the needs" of this group of countries by means of technical and financial assistance for negotiations, and by allowing the possibility of phased implementation of particular obligations.

The compromise was signaled in the report of the independent group of experts on smaller economies delivered in August 1997 (Box 3). Interestingly, the Business Forum that preceded the San José Ministerial Meeting took a stronger line in support of the principle of special treatment for smaller economies than the expert working group (Box 4). But by that time the die had been cast. The Ministerial Meeting confirmed the U.S. position of no separate negotiation group on smaller economies, though recognizing that this group has special needs which should be taken account of in facilitating their full integration in the FTAA. A Consultative Group on Smaller Economies is charged with the responsibility to monitor the negotiations and to bring the needs of this group of countries to the attention of the Trade Negotiation Committee. As noted by Lande (1998:9), the fact that the Consultative Group will not be able to negotiate or make proposals constitutes "a serious limitation on its role."

Hence, the smaller economies face a formidable task in these negotiations. In effect, they will have to make their inputs and to monitor negotiations in all nine negotiating groups. The process will be highly technical, and the realities of bargaining power mean that these countries could easily be sidelined to the role of spectators to the negotiations among the major players. There will be no "blanket agreement" for smaller economies, for instance, on a longer period of implementation for all the provisions of the FTAA Treaty. Rather, any concessions of this kind will need to be negotiated on a case-by-case basis, under conditions of varying degrees of bargaining power.

In summary, NAFTA membership appears to be out, NAFTA parity remains elusive, and any possibility of securing special concessions for small economies within the FTAA Treaty will have to be negotiated on a case-by-case-basis between 1998 and 2005. The agreed structure of the negotiations means that this cause will have to be pursued through the route of "integration group" rather than that of "smaller economy group," though the Consultative Committee does give the smaller economies direct

access to the TNC. It is for this reason that coordination and collaboration in the negotiations among the CACM, CARICOM, the Dominican Republic and Panama makes strategic sense, at least as a general principle.

BOX 3.
Small Economies: Conclusions of San José Business Forum Workshop, March 16-18 1998

1. Full participation of Small Economies (SEs) in the FTAA is necessary, but the legitimate fears in some countries of the risks inherent in the FTAA should be recognised.
2. SEs are defined as the 21 countries of Central America and the Caribbean. Any other country with similar characteristics may join this group.
3. Guarantees to SEs in the FTAA process should comprise:
   - Technical assistance
   - Financial support
   - Differential treatment—the particular claims of Haiti are endorsed
   - Transparency.
4. Priorities for SEs should comprise:
   - Improvement in welfare and the quality of life of population as the ultimate rationale for the FTAA
   - Strengthening of competitiveness by appropriate government/macroeconomic policies
   - Business efforts to improve competitiveness
   - Creation of a Negotiating Group on Small Economies in FTAA negotiations
   - Closer Caribbean-Central American Cooperation.
5. Mechanisms of facilitation for SEs should comprise:
   - A programme of trade facilitation, including use of the Internet
   - Impact study of the socio-economic consequences and the opportunities created by FTAA for SEs, with action recommendations
   - Strategic alliances among businesses in SEs
   - Linkages of SE small and medium enterprises with the international market.

Source: based on report in ACS Bulletin, Vol.1, No.7, March 1998.

Although the smaller economies have a relatively small share of the FTAA population and GDP, together their resources are obviously greater than that which either of the two sub-regional integration groups could command by itself, let alone any one of the 21 countries individually. Moreover there are the diplomatic and political connections that each member might contribute to such an alliance: CARICOM, for instance, has strong traditional relations with Canada, and the CACM with Mexico.

The Proposed Caribbean-Central American Alliance

The content of the proposed alliance is summarised in Box 4. The objectives are wide-ranging, covering (a) creation of a free trade area, (b) functional cooperation in the promotion of investment and tourism and in the liberalisation of sea and air transport services, and (c) support of external negotiations over NAFTA parity, the FTAA, and the EU-ACP relationship, as well as the coordination of WTO negotiations. Several observations are in order.

BOX 4.
Proposed Caribbean-Central American Strategic Alliance: Summary Objectives

1. Creation of free trade area embracing CARICOM, CACM, the Dominican Republic, and Panama
2. Increased competitiveness of business enterprises
3. Investment promotion (domestic and foreign)
4. Liberalization of air and sea transport services
5. Tourism promotion
6. Coordination of policies and strategies vis-à-vis:
   - NAFTA parity negotiations
   - FTAA negotiations
   - Cariforum-EU negotiations
   - WTO negotiations

Source: based on text of the proposal published in ACS Bulletin, March 1998; Vol.1 No.7; reprinted in FES/ACE 1998.

First, the creation of a Caribbean-Central American Free Trade Area (CCAFTA) is not only consistent with the FTAA process, but is also in line with the observed trend towards establishing inter-group FTAs in advance of the FTAA itself. The aim of strengthening the ability of the private sector to meet FTAA challenges through inter-group free trade is very clearly spelt out in the proposal, as is that of strengthening the negotiating position of the participating countries.

This is a laudable objective but, as in all schemes of this kind, some countries and enterprises will be better able to take advantage of free trade than others. The group comprises countries with widely different economic structures. It has been suggested, for instance, that the smaller countries of CARICOM in the O.E.C.S. are primarily exporters of primary agricultural exports and of services (mainly tourism), and have little to gain from a free trade area in general. Differences in levels of industrial development among countries in a free trade area can also cause frictions, a problem that both the CACM and the CARICOM have had to wrestle with. Already, Nicaraguan manufacturers have expressed concerns about

the possibility of competition from manufacturers operating in the DR's industrial free zone, when the CACM-Dominican Republic FTA comes into effect.

Second, it seems significant that the Dominican Republic is proposing to promote Caribbean-CACM free trade and functional cooperation outside of the framework of the Association of Caribbean States (ACS). The ACS's work programme is centred on cooperation in trade, transport and tourism. On the face of it the Strategic Alliance will duplicate the work of the ACS.

The reasons for this almost certainly have to do with complications arising out of the membership of the "G3" countries, and of Cuba, in the ACS. Mexico, a NAFTA member, will be negotiating individually in the FTAA, while Colombia and Venezuela may negotiate as members of the Andean Community. Cuba so far has not been involved in the FTAA process because of the US embargo, though as we point out below this may well change before the negotiations are over.

By restricting itself to the members of CARICOM and the CACM plus two of the three "non-affiliated" members, the proposed alliance recognises the growing significance of integration groups in trade negotiations. Evidently it offers a more secure place in the FTAA negotiations for the Dominican Republic itself and for Panama, which would otherwise be in danger of being marginalised.

Third, the proposal indicates that NAFTA parity is still very much on the agenda as far as the Caribbean Basin countries are concerned. The NAFTA push is mentioned twice in the document and is the first area of external policy that is targeted for coordination among the members. While the document refers to NAFTA parity as "an intermediate step towards the FTAA," the real attractiveness of this arrangement is that it would provide non-reciprocal access to the U.S. market equivalent to that of Mexico in other respects. Whether Caribbean Basin countries can command the kind of support in the US Administration and Congress to ensure passage of such a measure, especially in the post-Cold War setting, remains to be seen.

A final observation relates to the objective of mobilising support for Cariforum countries in their efforts to preserve existing Lome IV benefits with the EU. This appears to overlook the difficulties this would pose for the Central America countries. The EU banana regime has already pitted banana exporters from Cariforum and from Central America against one another. It is likely that this will continue, as the Central and South American exporting countries are supporting the U.S.A. in rejecting the European Commissions' proposed modifications to the marketing regime.

At the same time, the EU is in dialogue with Central America on trade and development cooperation (Hansen and De la Ossa 1997), including the possible extension of trade preferences to agricultural products. It is difficult to envisage a situation in which the Central American countries acquiesce to, let alone give active support to, the preservation of EU trade privileges for one set of developing countries over another.

Further, it is not clear whether this objective in the proposal of the Dominican Republic takes into account the radical restructuring of the Lome arrangements presently envisaged by the EU, a question we take up next.

The EU-ACP Relationship

Last February the EU Commission published the negotiating guidelines it is recommending to the EU Council and Parliament on new cooperation agreements with the ACP group of countries when Lome IV expires in the year 2000. The recommendations would, if implemented, represent a fundamental departure from the current Lome arrangements insofar as these have been characterised by a single agreement with all the ACP countries, whose terms are limited to development aid and one-way trade preferences. This would be replaced by up to six regional and sub-regional "free trade area" type agreements with groups of ACP countries providing for the phasing out of the one-way trade preferences, which would in principle be retained only for the poorest countries, the majority in sub-Saharan Africa. A strong element of political conditionality would also be introduced into the EU-ACP relationship (see Box 5). The new agreements would come into effect in 2005.

These proposals have been greeted with dismay from many quarters within the ACP group. Within the Caribbean, Jamaica and Barbados in particular have voiced strong objections to the linking of political conditionalities to the EU-ACP trade/aid relationship, and to the principle of separate agreements with different ACP subgroups. At the EU-ACP Ministerial meeting in May it was reported that the necessity for a rethinking of these aspects of the Commission's proposals was conceded by some EU delegations (Jessop 1998b). At the same time it became evident that there are divisions within the ACP group on these points, with several African governments in particular feeling that there is little option but to negotiate on the EU's terms.

From the perspective of Caribbean trade relations there are several immediate points of interest in these developments. First, the one-way trade preferences with the EU may well expire in 2005, and they will last until then only if the WTO grants the EU request for an extension to that year. After 2005, only Haiti is likely to benefit from one-way preferences as of right. The possibility of negotiating a phased introduction of free trade with the EU remains open. One wonders if the coincidence of the period of negotiations for the EU-ACP free trade agreements with those for the FTAA, is really a coincidence at all. In any case, the demands of the two sets of negotiations are certain to impose considerable pressures on the scarce technical negotiating resources of the small countries of the region.

Second, the Commission's proposals place heavy emphasis on regional free trade and integration within the groups with which the EU will make "subregional" agreements. In effect, Cariforum countries will not only be negotiating en bloc, but will be expected to strengthen their own free trade and integration efforts to make better use of the new agreement with the EU.

Third, the admission of Cuba to the ACP Group for the upcoming negotiations must now be regarded as a serious possibility. Cuba has now applied formally and this has received the endorsement of the Cariforum countries. Cuba was granted Observer status to the ACP group at the May EU-ACP Ministerial meeting, and was warmly welcomed. If Cuba eventually attains full membership, its impact on the rest of the Caribbean will depend very much on how pro-actively the Cariforum countries take

BOX 5.
The Successor to Lome IV: A Scenario

The European Commission has published its recommendations to the EU Council and Parliament on guidelines for the negotiation of new cooperation agreements with the African, Caribbean and Pacific (ACP) countries. They amount to a fundamental departure from the essential features of the present and past Lome Conventions: a single agreement with the entire group, covering development aid and non-reciprocal trade preferences. Among the significant proposals for the new arrangements are:

- Introducing stronger political conditionalities into the relationship, relating to human rights, representative democracy, the rule of law and good governance.
- Focusing on poverty alleviation by supporting the spread of markets, the strengthening of private enterprise, the emergence of active and organised civil society, the enhanced participation of women in economic and social life, and regional integration and cooperation.
- Substituting global ACP non-reciprocal trade preferences with up to six regional and sub-regional "economic partnership" agreements with Africa (4), the Caribbean and the Pacific. Initially these will provide for varying degrees of reciprocity, but eventually they will be phased into free trade areas with the EU. In principle, one-way trade preferences will be retained only for the poorest developing countries ("LLDCs"), which will include non-ACP members.
- A 7-year implementation schedule as follows:
- The EU will seek WTO permission to maintain the current Lome arrangements in place until 2005.
- September 1998-2000: the EU and the ACP negotiate an umbrella agreement establishing the basic principles of the new relationship.
- 2001-2003: the EU negotiates regional and sub-regional agreements with specific groups and individual countries within the ACP providing, inter-alia, for the phasing out of one-way trade preferences.
- 2005: new agreements come into effect.

So far the ACP Group has not had the time or opportunity to formulate a response. The ACP-EU Ministerial Council Meeting to discuss the proposals will be held in Barbados May 5-6. The recommendations go to the EU Council at its meeting in June. Formal negotiations on the successor to the Lome Convention, which expires in March 2000, are scheduled to commence in September 1998.

Sources: based on EC (1998), Jessop (1998).

advantage of the opportunities that Cuban accession presents for strengthening the negotiating position of the group. For instance, Cuba may need support from the rest of the group in resisting political conditionalities, whilst the whole group has a common interest in negotiating a period of transition that permits an orderly adjustment to conditions of two-way free trade.

Finally, it may be observed that the demands of the EU negotiating process must have represented a considerable distraction from those of the FTAA process in recent months, and this problem is likely to get more acute. In the case of CARICOM, member states have also been preoccupied with the implications of the WTO ruling on bananas, with the process of amending the Treaty of Chaguaramas, with organising a relief effort in Montserrat, and with helping to resolve the post-election dispute in Guyana. The Regional Negotiating Machinery, set up to coordinate external negotiations, is still short of money to finance its activities, and has applied for an IDB loan for this purpose. All this indicates the pressures on relatively small countries with limited resources of technical personnel, arising out of the rapid changes in world trading arrangements.

The CARICOM Single Market and Economy

At the recent intersessional meeting of CARICOM heads in Grenada, the Jamaican Prime Minister expressed the view that the Community should complete the process of establishing the Single Market and Economy before pursuing integration arrangements with other countries or groups. The analysis in this paper suggests that it does indeed make good strategic sense to consolidate a strong Community as a platform for the FTAA and for EU-ACP negotiations. This has the added advantage of establishing the basic terms on which new members of the Community are admitted. Besides Haiti, these could include the Dominican Republic and Cuba.

On the other hand, the pace and sequencing of the FTAA and the EU-ACP processes call into question the viability of waiting until the CSME process is completed before new free trade agreements are contemplated, such as the possible Caribbean-Central American Free Trade Area. One problem is that the legal process of establishing the CSME is cumbersome and long-drawn out. The Treaty of Chaguaramas is being amended by means of the adoption of nine different protocols. Each protocol has to go through a technical and Ministerial Committee to the Heads of Government for approval. It then has to be ratified by the signatory governments, and then implemented by means of legislation or administrative law. So far only Protocol I has passed through all the stages required for provisional application. The status of the other eight is shown in Box 6.

Given CARICOM's recent performance on this matter, the prospects for having all 9 protocols approved, signed and ratified by the end of 1999 to bring the Single Market and Economy into effect during that year appear to be dim. There needs to be a considerable increase in the pace and the urgency with which the member Governments regard this process, one that is informed by the far-reaching implications of the FTAA and EU-ACP scenario.

Box 6.
Status of the CARICOM Single Market and Economy
Target year for establishment: 1999

Protocol	Subject	Status March 1998
I	Organs and Institutions of Governance	Already provisionally applied
II	Provision of services, rights of establishment and movement of capital	Requires two more signatures for provisional application
III	Industrial Policy	Ready for signature July 1998
IV	Trade Policy	Ready for signature July 1998
V	Agricultural Policy	Ready for signature July 1998
VI	Disadvantaged Countries, Regions and Sectors	Ready for signature July 1998
VII	Transportation Policy	Ready for signature July 1998
VIII	Competition policy	Ready for signature early 1999
IX	Disputes settlement	Ready for signature early 1999

Note: Application of a Protocol requires signature and ratification by a majority of member governments. Establishment of Single Market and Economy requires that all nine Protocols be applied.

The Position of Cuba

There is now a real possibility that Cuba will soon be an active player in Caribbean and hemispheric trade negotiations. Since the beginning of the 1998 there have been steps towards relaxation of the U.S. trade embargo, and some signs that the gradual lifting of the embargo may be in sight. For instance, representatives of some 50 American firms recently met with Cuban Government officials in Cancun; and the U.S. Chamber of Commerce has now gone on record as calling for the lifting of the embargo. Pressure on the U.S. Administration is also building up from the other FTAA players. Several countries deplored Cuba's absence from the Santiago Summit, Prime Minister Arthur of Barbados being particularly outspoken on this issue. Prime Minister Chretien of Canada visited Cuba immediately after the Summit; and several Latin American nations abstained for the first time from a U.S.-sponsored resolution condemning human rights violations in Cuba. By mid-May, the U.S. had agreed to waive the provisions of the controversial Helms-Burton law in respect of EU firms, a significant dilution of its effective coverage.

Cuban membership of CARICOM is now being actively mooted. Prime Minister Douglas of St. Kitts and Nevis spoke openly about the possibility on a recent visit to Havana; and the U.S. is reportedly offering no opposition to such a move. Cuba has now formally applied for membership of the ACP, with the support of Cariforum countries. It has re-established diplomatic relations with Spain, which may support its ACP application. Diplomatic relations have also been re-established with the Dominican Republic after a break of 39 years. The likelihood is increasing that Cuba will be at the FTAA negotiating table long before the negotiations formally conclude in 2005.

This raises intriguing questions about the form of future Cuban relations with integration areas in the Caribbean and Central America. Several observations are in order here. First, if Cuba accedes to the ACP it will almost certainly do so as part of the Cariforum countries. In this case, the question of a CARICOM-Dominican Republic-Cuba Free Trade Area will certainly be on the agenda.

Secondly, if and when Cuba is admitted to the FTAA negotiations, the possibility of becoming a member of the Consultative Committee on Smaller Economies will be open to that country, as well as that of becoming a member of a Caribbean-Central America strategic alliance.

Third, in such a scenario, the question will arise as to whether Cuba will seek formal association with a sub-regional grouping, and if so, whether this will be with CARICOM or with the Central American Integration System (SICA). In the recent past Cuba has had warmer relations with CARICOM than with Central America, primarily for political reasons. However this has been changing with the end of the Cold War and of the Civil Wars in Central America. For instance, the Cuban Foreign Minister recently spoke by invitation to the Central American Parliament, where he was warmly welcomed. The Central American airline, TACA, recently announced the commencement of services to Cuba and the Dominican Republic.

Clearly there will be the attractions of linguistic affinity and to some extent of cultural similarity, as well of geographical proximity, pulling Cuba towards Central America. But Cuba also has strong cultural and political ties with the Caribbean that were cemented during the decades of its isolation from the rest of the hemisphere.

For CARICOM, the question will be whether the Community will be willing and able to make an historic transition from being primarily English-speaking and with a predominantly Afro- and Indo-Caribbean ethnic and cultural identity, to one that is majority French and Spanish speaking in population, with a strong Hispanic cultural element. Here, a long-term proactive vision is called for. With Cuban membership, CARICOM would command considerably more economic and political clout. This might also make CARICOM membership more attractive to the Dominican Republic, which has been drawing more closely to Central America in recent times. Without Cuban membership, CARICOM will remain a relatively insignificant player in hemispheric economic and political affairs. And we know that the world has become a very inhospitable place for small countries.

Conclusion

What can one say, by way of conclusion, about the prospects for a Caribbean-Central American Alliance and the implications of the FTAA process? At least five points may be highlighted from the developments reviewed here.

One is that in both the FTAA and the EU-ACP processes, the Caribbean is being treated as a group and not as individual entities. In other words, whether we want it or not, whether we like it or not, we will have to negotiate as a united community and as a united region. In addition, as the pace and complexity of negotiations are growing almost exponentially (and we have not here discussed the WTO), the need to make best use of scarce technical resources compels us to negotiate as a single entity.

Second, consolidating our internal integration arrangements is not an alternative to collaboration in external trade negotiations, but an indispensable complement to it. Hence the CARICOM Single Market and Economy, far from being rendered irrelevant by hemispheric trade liberalisation, has become a strategic necessity for participating in international trade negotiations from a position of greater strength.

Third, the proposal for a Strategic Alliance points us in a direction beyond CARICOM to Cariforum, and beyond Cariforum to Central America. Given the direction of both the FTAA and the EU processes, it makes strategic sense to forge closer links with the Central American countries, building contact and trust in a solid manner over time.

Fourth, the conflicting interests of countries within such a grouping need to be taken into account, as they represent potential sources of tension and conflict that can undermine the cohesiveness of the group. Two such potential points of conflict are the banana question with the EU, and the possibility that the more industrially developed countries will be in a position to reap greater benefits from a free trade arrangement, than the smaller states and service-oriented economies. These issues will need to be handled with care, in order to ensure that an alliance of this kind does not break up prematurely.

Fifth and following from the above, a strategic alliance will need to be firmly grounded in the involvement of business interests and of civil society. It cannot be a governmental initiative only, or else it will almost certainly founder. It is notable that there was minimal involvement of English-speaking Caribbean businesspersons in the San José business forum preceding the Ministerial meeting in March of 1998. Conscious efforts will have to be made to overcome the traditional barriers of language, transport and communication that result in our business people looking northwards only.

Considerable progress has been made with regard to civil society and non-governmental organisations in the integration processes as evident in the activities of organisations such as the Caribbean Policy Development Centre and the Association of Caribbean Economists in the Caribbean, and of the Consultative Committee of the Central American Integration System, the Civil Initiative for Central American Integration and the Central American Committee on Intersectoral Coordination in Central America (Serbin 1998, Girvan 1996). For the Greater Caribbean, CRIES has promoted the formation of the Permanent Forum of Greater Caribbean Civil Society, which made a presentation to the meeting of the

Council of Ministers of the Association of Caribbean States in Cartagena in November 1997. At the hemispheric level, a People's Summit of the Americas was organised as a parallel activity of the Summit of the Americas in Santiago in April, that adopted an agenda of social concerns to counter what the participants perceived as an exclusively market-oriented integration process (Gonzalez 1998). The growing weight of civil society in integration processes has received official recognition in the Santiago Plan of Action adopted at the Second Summit of the Americas, which makes provision for the involvement of this sector.

Finally, it may be observed that however these developments unfold, it is evident that the English-speaking Caribbean is being pushed inexorably into closer trade relations and governmental collaboration with its Spanish-speaking neighbours. Governments, businesses and civil society will need to wake up to this reality, forging new relationships and alliances with their counterparts in these countries if we are to participate proactively, and to our benefit, in the wider processes of hemispheric integration.

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SOCIAL POLICY & THE FTAA

Manuela Tortora

Since the Miami Summit of 1994, the initials "FTAA" have been associated with purely economic ideas: free trade and market access, investment protection and promotion, competition, trade in services, etc. They are also associated with the most novel and ambitious plan ever formulated in the field of hemispheric relations which aims to create an economic bloc that will be highly significant within the world system.

Over the past four years, the process for setting up the FTAA has occupied an increasingly important space on Latin American and Caribbean government agendas both as far as their foreign economic policy is concerned as well as how various internal policies are defined. The negotiation process itself has not even started as such, but a lot of effort has already been invested in the hemispheric working groups, and the task of identifying the national norms and policies that will need to be adjusted or substantially changed in order to be compatible with the FTAA has already been undertaken.

In short, the expectations generated by the "FTAA project" have acquired a specific determining weight that is proportional to the scope of the project and the impact its implementation would have on Latin America and the Caribbean's development. The region is fully aware of the political, economic and social implications of a project of this kind, but the preparatory work being carried out by

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the governments and the agencies involved tends to focus solely on its "economic" (some would say "commercial") content. The FTAA's effect on intra- and extra-hemispheric trade and investment flows are being avidly studied, but the analysis of the political and social aspects (and we should include the cultural aspects as well) of this initiative is being set aside as a matter of little urgency. The following preliminary reflections on the subject are inspired by the urgent need to provide a precise and operative base for the link between Latin America and the Caribbean's social development and the FTAA and solely aim to stimulate further investigation of the subject.

The Importance of the Subject

It is too soon to make any statements regarding the impact of a free trade agreement whose contents have yet to be defined. The technical work carried out by the hemispheric working groups since 1995 do provide a broad and up-to-date insight of the norms and policies that exist in the hemisphere as far as the economic aspects of hemispheric free trade are concerned, but the scope of the commitments that could be agreed to in the negotiation process is still a big unknown.

In terms of Latin America and the Caribbean's development, the most important unknown quantity is the social impact the FTAA may have throughout its implementation. "Social impact" should be understood in the broadest sense of the term to include the possible direct and indirect, positive and negative, short and long-term implications of the free trade area inasmuch as these can be identified and analyzed.

As far as the most immediate and visible social impact is concerned, this would involve assessing, for example, the generation of employment by an eventual increase in hemispheric exports as well as the loss of jobs brought about by the competitiveness of imports. It would also means studying Latin American and Caribbean countries' capacity to attract both national and foreign productive investment as a result of the economic potential the FTAA provides.

If longer periods of the FTAA's implementation are taken into consideration, the social impact is highly important in the long term because there should be a relationship between the quantitative growth of trade and investment in the countries participating in the FTAA on the one hand and a qualitative evolution of the standard of living of their inhabitants on the other. There are obviously many variables that affect social development (or "human development," as the UNDP puts it), and it is difficult to distinguish between those that stem directly from the FTAA and those that stem from the many other local, regional or international processes and phenomena underway. The quality and effectiveness of national social policies that might be stimulated and supported by the FTAA process also play a part.

The social impact of the FTAA can to a certain extent be "foreseen" a priori before it comes into effect, and the predictions regarding its implications in terms of employment or the competitiveness of exports, for example, should therefore be used as support information by the negotiators. It is of course extremely difficult to make reliable predictions in this area, but the mere introduction of the social aspect

in the preparations for the negotiation process could affect the final features of the commitments that are to be assumed under the FTAA.

The fact that the FTAA's social impact, especially in the long term, will continue to be an unknown quantity regardless of the efforts devoted to the subject does not lessen its importance. The social aspect of a project of this kind is crucial to both the evaluation and the credibility of the initiative itself. As the FTAA begins to produce results, the success and cost of this economic process will be measured by indicators of social development rather than by trade and investment indicators, and by its improvement of the standard of living of the people of Latin America and the Caribbean rather than by its elimination of tariff and para-tariff barriers. Moreover, it is the measurement of the FTAA's results in social terms that will largely determine the feasibility and duration of the project. It is therefore important to consider the political context into which the proposed hemispheric free trade area is being introduced.

The Subject in Context

The new hemispheric relationship proposed by the FTAA, which for the first time involves countries with different levels of development and distinct cultures, arises as one of the results of the economic opening process undertaken in Latin America and the Caribbean which in turn stems from a significant change in the development model pursued by the region.

The United States could not have launched the FTAA project if the countries of Latin America and the Caribbean had not begun to pursue economic strategies based on insertion into the international economy and competitiveness which justify and sustain the idea of a free trade area of this kind. For Latin America and the Caribbean, the FTAA represents the realization of its aspiration to culminate the efforts made in national opening processes with the establishment of a new economic relationship among the countries of the hemisphere. This aspiration is not solely commercial as it transcends the need to find new markets and more foreign investment; above all it is a political aspiration inasmuch as it confirms the United States' interest and Latin America and the Caribbean's willingness to uphold the model of economic openness and "lock in" through international commitments that prevent any turning back.

From a historical perspective, the decade of the nineties and the FTAA project represent a new cycle in hemispheric relations which, since the Monroe doctrine, have been subject to their ups and downs and have gone through such contrasting phases as the "good neighbor," the "carrot and stick" approach, the Alliance for Progress, United States' support for military regimes, the Caribbean Basin Initiative, the Bush Initiative, the tensions generated by the external debt crisis during the "lost decade" the protectionism of the 1980's, the recent "certifications" in relation to drug trafficking, etc.

The FTAA is therefore being launched within a context of profound transformations that have both political and economic (and even ideological) scope and are rapidly changing the physiognomy of the region as well as its position on the world stage. Regardless of its future success or failure, this project represents the desire to start a new phase in both the individual economic policies of the participating

countries and hemispheric relations as a whole. It remains to be seen whether, through the negotiations that are to be launched at the Santiago de Chile Summit and through the subsequent implementation of the commitments assumed, the FTAA will continue to be a factor of change at the internal and the hemispheric level or if, on the contrary, it will suffer the same ephemeral fate of other analogous projects that have been launched during previous phases of relations between the United States and Latin America and the Caribbean.

The stakes are far higher for Latin America and the Caribbean than for the United States and Canada as far as the FTAA is concerned. The failure of the FTAA would provide further grounds for questioning the validity of economic opening policies as an instrument for furthering development.

If the FTAA is successful, however, the positive long-term results in terms of the well-being of the population will prove that the pursuit of these policies was the right course of action despite the social sacrifices involved. Within this context of change and in light of the development needs (and especially the social development needs) of Latin America and the Caribbean, the "FTAA bet" should be complemented by strategic elements such as the following.

A hemispheric cooperation project and not just a free trade project or an energy cooperation project such as the one recently proposed. The Declaration of the Miami Summit of December 1994 constitutes a broad framework of reference that includes the free trade area as an important, but not an exclusive, element of a plan for new global hemispheric relations. The underlying ideas of the text in fact go beyond the mere liberalization of trade and investment flows proposed in the FTAA and constitute a valid point of departure for launching a new phase of integral hemispheric cooperation. The operative content of that hemispheric cooperation, within the framework of the general principles and objectives agreed upon by the Presidents in Miami in defining the region's the social development aspirations, still needs to be defined, however.

As a corollary to the above, the FTAA and the complementary instruments for enhancing free trade should represent a project for addressing the asymmetries that exist in the hemisphere. The hemispheric working group on the smaller economies has broken important ground in this respect. The more significant task of moving from merely politically acknowledging the existence of asymmetries among the 34 countries involved to actually translating the implications of these asymmetries into operative terms within each of the commitments contracted under the FTAA now needs to be undertaken. This means introducing the social development variable into each of the areas of negotiation, as the asymmetries are most clearly apparent in differences in living standards. As we pointed out above, an initiative on the scale of the FTAA undeniably has social implications, and one means of tackling them is by starting with the recognition of the asymmetries that exist in each of the areas that are to be negotiated.

Finally, the new hemispheric relationship should be based on a project to ensure feasible and sustainable articulation among the commitments stemming from the FTAA and the progress made by the integration schemes currently in force among Latin American and Caribbean countries. Since 1994, the declarations of Presidents and Ministers of the hemisphere have included the acknowledgement that

the FTAA shall not replace intra-regional integration. But only the specific negotiations will be able to determine how to preserve the political and economic assets being capitalized in schemes different from the FTAA and more advanced than it, such as MERCOSUR. Given the acknowledgement that these intra-Latin American processes have their own life independent of the FTAA, social issues, such as the free movement of labor and professional services, should be included with operative content in any attempt to articulate hemispheric commitments and commitments assumed under regional integration schemes.

In short, the FTAA is taking shape within the context of a new hemispheric relationship that cannot be limited to market liberalization. The definition of a social policy "of the FTAA and for the FTAA" that is appropriate within this new context will have to take all the elements that characterize it into account: the positive and negative effects of globalization, the asymmetries in terms of development, the political commitment that the integration schemes represent, and the ideological and geopolitical changes brought about by the end of the Cold War.

Social Issues in the Hemisphere

For several decades and especially since the consolidation of democracy in the region, the design and implementation of social policies has been a recurrent item on the agenda of Latin American and Caribbean governments and has taken shape either in the form of "populist" initiatives or as compensation for the recent decisions taken under the economic opening and "structural adjustment" policies. It is in social policy, however, that the gap between discussion and results, rhetoric and concrete measures is most apparent.

Social policy in any national situation is by definition extremely complex. The results are slow in coming and barely perceptible in the short term, and social policy is far more difficult to effectively implement than trade policy, for example. In addition to these intrinsic difficulties, Latin America and the Caribbean countries also suffer from decades-old imbalances in their social structures; wealth distribution indicators that reveal greater inequality than in the least developed countries of the world; and inefficient, insufficient, and poorly equipped state institutions.

The impact of the economic opening process and the globalization of the economies is placing additional stress on these structural weaknesses, making them more apparent and worsening them. Statistics show that the benefits brought about by the economic reforms of the past few years are not being translated into a better distribution of wealth: the trickle down effect is in the best of cases, taking time to get underway. Even the countries with sustained and stable growth rates are not managing to guarantee "growth with equity" to coin an ECLAC phrase.

The expectations generated by the FTAA therefore face a double paradox. At the internal level, Latin American and Caribbean democracies must provide visible answers in terms of social development or run the risk of losing their credibility and jeopardizing their governance. To date, however, very few

of the region's social policies can be classified as having been a success. In terms of hemispheric relations, the FTAA syntheses the hope that the proposed economic and commercial changes will result in a fairer social development. For this to happen, however, the FTAA will have to go beyond merely opening markets to include instruments of co-operation in areas of social policy, and this has so far not been proposed, not even in theory.

The above-mentioned social policy "of the FTAA and for the FTAA" should be characterized by operative elements that enable these paradoxes (both at the national level of the participating countries and in terms of hemispheric relations) to be effectively tackled.

Before considering some of the elements that could form the practical content of this desirable (but hypothetical) FTAA/social policy link, it should be borne in mind that we are treading on very difficult ground in terms of the traditional negotiation patterns of "giving something in exchange for-" that govern trade negotiations. Given that the asymmetries existing between the negotiating parties are particularly evident in terms of social development, what could the region's countries offer, for example, in exchange for cooperation instruments to support micro enterprises? As it would be difficult to negotiate within the area of social policy alone, "crossed concessions" might have to be made, in other words, concessions in another area under negotiation in return for those granted in the area of social policy. The asymmetric nature of social development, however, in reality makes pursuing the concept of reciprocity impossible and imposes the need for cooperation rather than negotiation.

Furthermore it should be remembered that the priorities of the social agenda of Latin America and the Caribbean are hardly compatible with those of the social agenda of the United States. The former are basically "positive" and focus on the search for social equity (the eradication of extreme poverty, job creation, concern for the informal economy, education and health, the integration of marginal social groups, etc.) while the latter are by contrast basically "negative" priorities as they focus on controlling drug trafficking, migration and "social dumping" (the term used for the supposed unfair competition posed by imports in the United States market that are cheaper than national goods due to less stringent labour norms and lower salaries). The asymmetry between the United States and Latin America in this case is not reflected by statistical data and is more a question of priorities and approach.

The FTAA/Social Policy Link: From Theory to Practice

Any practical suggestion regarding this subject obviously loses validity if there is not first a conceptual framework that enables the exclusively economic and commercial scope of the FTAA to be expanded so that the social aspect of the project is given due consideration from the outset. The observations made in the above sections could be complemented by some practical suggestions regarding how to introduce concern for social development into the process underway for the creation of the hemispheric free trade area.

As part of their general methodology, all the negotiation groups that are set up should, under their sectoral mandate, provide for the consideration of the social implications of the commitments that are

defined. The social aspect of the FTAA would in this way be treated "horizontally" in all the subject areas of the project. This would not, however, remove the need for an ad hoc linear treatment of the matter in addition to the sectoral approach of each negotiation group. The collaboration of regional and international economic agencies to support the national diagnoses each country should make on an individual basis, could be essential in this respect.

Additional negotiation mechanisms should be set up parallel to the negotiation of the FTAA to define hemispheric cooperation instruments in areas such as education and health, scientific and technological development, and the eradication of extreme poverty, which are at least as important as trade as far as Latin America and the Caribbean countries are concerned.

Mechanisms should be agreed to for assessing the new hemispheric relationship that arises from the FTAA as well as any other collateral instruments that are signed within the context of the Declaration of Miami. These assessments should be made not just in terms of trade and investment flows, but also in terms of impact on social development by using indicators that measure, for example: the relationship between new foreign investment and job creation; the opening of economies and increases in the added value of exports; the installation of foreign companies and the transfer of technology; trade creation and the reduction of the informal economy; the protection of intellectual property and support for national research; the opening up to foreign competition; and the increase in the productivity of Latin American and Caribbean countries.

Hemispheric cooperation initiatives could be decided upon to support the government institutions in charge of social policies (ministries of health, education, research centers, etc.) within the framework of the general purpose of strengthening the State's capacity to distribute the economic benefits derived from the FTAA. In this respect, it is important to emphasise that it is the State (and its institutions) that will need to be more effective in articulating its economic and its social policies: the increasing role of non-government organisations in areas of social policy can complement, but not replace, state action in this field. These actions would coincide with the support for "good government" that the United States and other industrialized countries are promoting under their policies of aid for bilateral and multilateral development.

Finally, the feasibility of using resources derived from the hemispheric initiative to finance social development programmes in the poorest countries of the hemisphere and in the social sectors that will least benefit from the FTAA could be studied. A "hemispheric solidarity tax" could be established, for example, as a small percentage of the dividends that have been generated by foreign investments or by the exports, thanks to the FTAA.

Conclusions

The proposals made above imply tasks that need to be carried out in addition to those currently involved in the preparation process for the FTAA, which already represent a significant burden for the governments of Latin America and the Caribbean. There is no doubt, however, that if the FTAA (or any

other hemispheric initiative) comes about, it will become increasingly necessary to consider the social implications and draw up the corresponding courses of action. As was pointed out above, the "social implications" are both positive and negative: the distribution of the benefits of the FTAA and the measures needed to compensate its costs.

The first tasks obviously have a national nature: each country will have to assess its current social policy and work out what will be needed in the context of a hemispheric free trade area. Secondly, the definition of a social policy "of the FTAA and for the FTAA" will have to be based on the articulation of each country's needs and the potential for new hemispheric cooperation. The first tasks do not eliminate the need for the latter, nor vice versa.

If the Hemispheric Summit of Santiago de Chile in April 1998 decides to launch the negotiations, it seems that the main difficulties in the medium term will not stem from the absence of a "fast track" for the Clinton Administration but from the absence of studies on the social benefits of the FTAA for the developing countries of the hemisphere, and consequently from the absence of diagnoses of the social implications of the commitments the negotiators could agree to.

As was mentioned above, the "FTAA bet" which above all is a bet on a new hemispheric relationship, is a politically and economically larger risk for Latin America and the Caribbean than for the United States and Canada. The United States Congress' attitude in rejecting the "fast track" request reveals that the United States' political investment in this hemispheric initiative is subject to electoral whims and does not coincide with the strategic scope of the project. In short, the FTAA is generating far greater expectations in Latin America and the Caribbean than in the United States which means the region is assuming a proportionally higher level of commitment and undertaking greater preparation efforts.

The introduction of the subject of social policy in a market opening initiative such as the FTAA requires far more specific proposals than those made here. All the participating countries need to broaden their vision of the FTAA's objectives, think in terms of long-term development and review the hemispheric relationship. Principles and instruments of cooperation, solidarity and joint responsibility need to be incorporated in the concept behind the project itself. Human capital needs to be given its rightful place in a project, which though originally commercial by nature, has significant social and political implications.

Economic opening needs to be seen as a process that is highly dependent on a context of democratic stability and equity, as without these, the process is unsustainable. The FTAA needs to be seen as an instrument of integral development and not just as a response to the globalisation of the world economy. Above all, bold proposals need to be made in the face of the bold impact of globalization.

HEALTHY PUBLIC POLICY & THE WORLD TRADE ORGANIZATION

A Proposal for an International Health Presence in Future World Trade/Investment Talks

Ronald Labonte

Over the past two decades the ability of national governments to regulate economic practices in ways that might be considered health-promoting has been reduced by two interrelated phenomena: the dominance of a neoliberal economic orthodoxy, which emphasizes free (unregulated) markets and a "minimal" welfare state, and the growth in regional and global free trade and investment agreements. There is mounting evidence that policies based on neoliberal economic theory, including free trade/investment agreements, may seriously undermine public health by increasing social inequalities, depleting natural resources and increasing environmental pollution. This article calls on the public health community to join in lobbying efforts at national and international fora to include in global trade/investment agreements "social clauses." These clauses, based on existing multilateral declarations monitored by United Nations agencies, are currently unenforceable. Their attachment to enforceable multilateral trade and investment agreements, however, would help to ensure that the benefits of a global economy are health-promoting by dent of being socially just and environmentally sustainable.

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This article begins by defining and critiquing some of the basic tenets of neoliberal economic orthodoxy, which underpin the push towards global free trade and investment agreements. It then describes the current status of these agreements, and provides examples of how such agreements might imperil public health. It proceeds to a discussion of the social clause initiative, and concludes by advancing a proposal for a public health lobby presence at those fora where trade and investment agreements are negotiated and monitored.

Neoliberal Economic Orthodoxy

Neoliberalism is both a philosophy of human existence and a theory of political economy. Philosophically, classical and neo-("new") liberalism hold that individual autonomy is the superordinate human goal and that the rational pursuit of self-interest, particularly economic self-interest, is ultimately utilitarian, creating the greatest good for the greatest number (Olson 1966, Ferree 1992). The political problem for neoliberalism becomes one of ensuring personal freedom against interference from the collective in the form of state regulation, except in a very limited set of circumstances. Social justice, as a contrasting philosophy and political theory, argues that individual responsibilities to others is the superordinate human goal and certain forms of private behaviors, particularly economic or market activities, must be collectively regulated (Frazer and Lacey 1993, Labonte 1995). The political problem becomes one of using state or community norms to ensure that utilitarian goals are also socially just and environmentally sustainable.

Neoliberalism's emphasis on individual autonomy, and the subsequent efforts of its proponents to enshrine in law certain individual rights, has been an important counterbalance to the potential coercive and undemocratic use of power by governments or political leaders (Chapman and Shapiro 1993). But the extension of these rights to economic practices, particularly in neoliberalism's arguments for unregulated markets and "welfare state minimalism" (Pierson 1994), has come under sharp criticism from those more aligned with a social justice ethic. The free markets claimed by neoliberal economists as most efficient in achieving "the greatest good for the greatest number" necessarily create losers as well as winners, rendering it quite rational for losers to demand some compensatory regulation (Dahl 1993). This is especially so since, even if markets were truly "free" and operated with textbook perfection, their outcomes would still rest on pre-existing inequalities in the distribution of wealth, resources and status between people and place (Smith 1995). More importantly, the oft-cited "trickle down" claim of neoliberal economics—that free markets can solve the problem of social inequality by creating wealth that trickles down to all people—is not supported historically (Amin 1997, Hettne 1995). The past two decades of economic and social policies based on neoliberal orthodoxy, such as privatization of public services, declining government economic regulation and increased free trade and investment, have seen global wealth inequalities more than double (New Internationalist, January 1997). Even among the twenty-nine member nations of the Organization for Economic Cooperation and Development (OECD), the so-called "rich nations club," income inequalities over the past decade have worsened in every country

but one, and are now at their worst recorded levels in the US and the UK (Public Citizen 1997, Reich 1997). The one exception (Canada) was not due to a freer or more efficiently functioning market, but to the redistributive effects of health and social programs and direct income transfers undertaken by the government (National Forum on Health 1997).

Markets are efficient means for resource allocation decisions when there is a single, clear goal, and different investment, production or purchase options to achieve it (Daly and Cobb 1989, Saul 1996). This is rarely the case for social or environmental objectives. More importantly, markets are blind to distributive equity and ecological scale (Daly and Cobb 1989). They are not, in the absence of government interventions, geared to produce a fair distribution of burdens and benefits, nor to watchguard the sustainability of ecosystems or natural resources.

Neoliberalism's Critique of the Welfare State

The public health problem with neoliberal economic orthodoxy is less its emphasis on markets as the means to generate wealth than its corollary criticism of government regulation and, in particular, of welfare state programs designed to buffer the inequalities created by market economics. A complex mix of social programs and economic and environmental regulatory policies, the welfare state in economically advanced countries arose partly in response to political claims of organized labour, women's groups, ethnoracial minorities and other disenfranchised peoples, partly to mitigate conflicts caused by market-generated inequalities and partly to meet private industry's needs for healthier, better educated workers through publicly financed programs (Miliband 1973, 1987, Skocpol and Amenta 1986, Pierson 1994). The relationship between capitalist economic practices and the welfare state has thus been a contradictory or ambivalent one (Offe 1984), with benefits and costs to both sides and various groupings in civil society jockeying to tip the hand of the state in one direction or the other. Over the past twenty years, however, a neoliberal orthodoxy has prevailed in most countries and, with it, an assault on the role of government in regulating economic and social affairs. Pierson (1994), in an essay on the decline of the modern welfare state, distills neoliberalism's critique to six points:

1. The welfare state is uneconomic, displacing market discipline for capital to invest and labour to work.
2. It is unproductive, displacing labour from the market-disciplined private sector to the wage inflationary public sector.
3. It is inefficient, delivering programs prone to the political claims of organized interest groups rather than the service claims of individual consumers.
4. It is ineffective, failing to eliminate poverty or social inequalities through its redistributive programs.
5. It is despotic, overweening individuals with regulations.
6. It is a denial of civil liberties, taxing individuals (especially successful entrepreneurs) for universal programs that deny their individual rights of choice.

While some of this critique is useful in drawing public attention to inefficiencies or regulatory abuses in government programs, strong counter arguments have been raised for each of these claims. Much of governments' present high public debts, for example, were not caused by uneconomic social programs but by low inflation/high interest rate policies of greatest benefit to global bond markets and banks (Goudzwaard and de Lange 1994, McQuaig 1995, Boyer and Drache 1996). The most market-driven health care system in the world, that of the United States, is also the most inefficient and expensive (Rachlis and Kushner 1994), raising questions about the presumed efficiency of market discipline over public regulation. While welfare programs have failed to eliminate poverty, the fault is not with these programs per se. The market-generated income ratio between Canada's wealthiest and poorest quintiles is 22:1, but after taxes and transfers this lessens almost five-fold to 5:1 (National Forum on Health 1997). The modern welfare state can be despotic, yet there is also evidence of its empowering effects for socially disadvantaged groups (Labonte 1994).

It is not my intent to fully explicate or refute neoliberalism's critique of the welfare state, but only to show that there are holes in many of its assumptions. Economists and political scientists themselves disagree on many of these points. Yet neoliberal economic ideas and their anti-state discourse have become an orthodoxy routinely propounded in the mass media with the certitude of a "TINA"—There Is No Alternative. Governments must spend less. Governments must regulate less. Market forces must be freed to prevail. This TINA, in turn, is accompanied by two major transformations that most economists agree seriously challenge continuance of the welfare state: Technological changes that have displaced the need for unskilled or semi-skilled labour, and the rapid growth of regional and global free trade and investment agreements (Uchitelle 1997, Courchene and Stewart 1992).

Different countries have gone down different policy paths in response to the "crunch" of declining employment and taxable wealth required to fund social programs (Graham and Lightman 1992). Early adopters of the neoliberal ideology (primarily anglophone countries such as the United States, the United Kingdom and Aotearoa/New Zealand, and now increasingly Canada and Australia) rapidly reduced welfare entitlements and minimized state interference in labour market adjustments. Some of these countries have kept unemployment rates relatively low, but only by allowing the increased strength of globalized capital to "discipline" wages downwards, thus increasing health-compromising internal income inequalities (Betcherman 1996, National Forum on Health 1997). European countries, with a stronger history of organized labour and class politics, adopted state interventionist programs favouring growth in high-technology, highly skilled jobs, and many still support welfare programs that redistribute wealth (Amin 1997, Pierson 1994, Gill 1995). But their unemployment rates are stagnantly high (Streeck 1996), increasing public deficits are forcing them towards the same welfare minimalism adopted by those countries with a more explicit neoliberal agenda (Pierson 1994) and their emphasis on training their workforces to compete better in the elite "knowledge" economy may eventually reduce top-end wages by creating a surplus of over-qualified workers for a diminishing number of positions (Bienefeld 1996).

The problem of enduring unemployment and employment insecurity ranks high in both political

and public concern in all economically advanced countries. Policy options do exist, including legislation to shorten work weeks and share employment more equitably, or changes in taxation policies that would broaden governments' revenue base and tax wealth in more progressive (redistributive) ways. Detailing such alternatives is beyond this article's scope, if for no other reason than countries vary considerably in the existing repertoire of policies upon which any reforms would be built. The concern, instead, is that government's political will to enact such alternatives has been tempered by the dominance of the neoliberal orthodoxy, and may now be forcibly constrained by the new regime of international free trade and investment agreements.

Economic Globalization and Free Trade/Investment Agreements

For much of market capitalism's history, most market activity was confined to national boundaries where labour and the state could exact some reciprocating social duties on capital (Daly and Cobb 1989). This is less so today in an increasingly globalized economy. Globalized trade is not a new phenomenon, but its pace has increased dramatically in the past thirty years, outstripping growth in economic production. This means that international trade has become an increasingly important means by which corporations generate profits. Indeed, over forty percent of global trade actually takes place between different parts of the same transnational corporation (New Internationalist, November 1997), where each transaction becomes a means of adding profit. Part of the reason for this is that the nature of international trade has changed. Whereas transnational companies once produced goods entirely within one country or plant and then marketed them abroad, today companies are increasingly dividing the different stages of commodity production between many nations. This allows them to take advantage of, for example, design or technical knowledge in one country (usually a first world country) and low labour costs in another country (usually a second or third world country). The resulting growth in corporate economic power has been phenomenal. Today, of the world's one hundred largest economies, fifty are transnational corporations (New Internationalist, November 1997).

Accompanying this growth in trade, however, has been corporate dissatisfaction with the old regime of tariffs on imported goods through which national states once protected their domestic industries. When corporations based all of their production within one country, these tariffs were to their advantage. Now that they no longer do so, they are a disadvantage. In 1947, the average tariff on manufactured imports was 47%. Under international free trade agreements, it is set to fall to just 3% (New Internationalist, November 1997).

The World Trade Organization

International trade agreements are monitored and enforced by a new multilateral body called the World Trade Organization. (Regional trade agreements, such as the North American Free Trade

Agreement, or NAFTA, have separate administrative bodies.) The WTO was established in 1995 after the last round of agreements negotiated through the GATT, or General Agreement on Tariffs and Trade. The WTO is headquartered in Geneva and governed by a biennial Ministerial Conference composed of representatives of each signatory state, about 130 nations. Unlike other multilateral bodies, such as United Nations agencies, the WTO can impose penalties on member countries that fail to comply with the trade agreements. Rulings are made by an international tribunal, whose deliberations are not public and whose decisions are binding. The intent of the agreements is to remove trade tariffs or other border restrictions on the import and export of goods and services.

This global free movement of goods and services, proponents argue, should benefit poorer countries with their comparative advantage of lower labour costs. This may be true in theory, but there are two problems with this argument. First, some reductions in global income inequalities may be achieved by ensuring freer markets for the textiles industries of poorer countries, which are large-scale employers (OXFAM 1996). But, revealingly, textiles are one of the goods still excluded from free trade agreements, allowing wealthier countries to impose stiff tariffs to protect their indigenous textile industries (Amin 1997). (Trade in textiles is governed by a complex quota system that will not be phased out until 2015.)Most trade actually takes place between within transnational corporations or between the so-called "Triad" (North America, Europe, Japan/Upper Income Asia), with the single exception of manufactured goods requiring unskilled labour (Petrella 1996). Between 1980 and 1990, for example, the world's share of trade in manufactured goods for the Triad rose from 63% to 72% (exports) and 68% to 72% (imports), while for the poorest 102 countries it fell from 8% to 1% (exports) and 9% to 5% (imports). Projections of long-term winners and losers from liberalized trade agreements place the Triad strongly in the black, and Africa, lower-income Asia (e.g. Indonesia, India) and the Mediterranean countries in the red (Voluntary Services Overseas 1996). By the year 2000, for example, sub-Saharan Africa is expected to lose $1,200 million annually from its current level of trade (New Internationalist, November 1997).

Second, even if free trade did benefit poorer countries, the equitable apportioning of its benefits would depend upon strong government policies aimed at wealth redistribution. The chimera of global competitiveness, fostered by free trade agreements, appears to be working against this. Recently, both South Korea and Hong Kong repealed labour legislation in the name of making their workforces more "competitive." Similar arguments have also been made by politicians in the world's most economically advanced countries. The one exception to this pattern may be the European Union, and its attempt to develop a supranational social charter (the "social chapter" on labour rights) alongside its liberalized trade agreements. This task, however, has proved difficult and so far there is little evidence of declining individual or regional income inequalities within the EU (Amin 1997, Streeck 1996). Even if the social chapter were enacted and gradually expanded beyond labour rights, it would require imposing tariffs on goods imported from poorer nations and restrictions on capital mobility, both of which are, or will be, disallowed under liberalized trade and investment agreements.

Free trade agreements may also imperil national policies to protect the environment (Boyer and

Drache 1996, Hettne 1995). A GATT panel ruled in 1991 that the US could not ban imports of Mexican tuna on the basis that Mexican drift-net practices violated US environmental regulations and endangered dolphins. While not disagreeing with the American argument, the panel declared the import ban "protectionist." The initial ruling by GATT's successor, the WTO, affirmed that free trade agreements are likely to accelerate this deregulation pattern. The US was told it could not ban gasoline imports from Brazil and Venezuela because they failed to meet US clean air legislation but, instead, that it would have to amend its environmental legislation or face retaliatory trade sanctions worth $150 million a year (Schrybman 1997).

The Multilateral Agreement on Investments

Investment agreements, which already form part of NAFTA, are now being negotiated on a more global scale by the member nations of the OECD. Called the Multilateral Agreement on Investments, or MAI, negotiations are expected to be completed by April 1998. Non-OECD countries are expected to begin to sign on shortly after, although whether the MAI becomes part of the WTO or is administered by a separate multilateral body is still being debated. The pressure for poorer nations to comply with the MAI will be great. Presently, most foreign direct investment (FDI) flows between OECD nations and, while the share of this investment for non-OECD countries has increased in recent years, most of this share has gone to just a few countries, such as China (New Internationalist, November 1997).

The intent of the MAI is to create a single regulatory framework for investments, the global flow of which has grown faster than trade (New Internationalist, November 1997). The agreement rests on two principles: Non-discrimination, meaning governments must treat investment the same regardless of where it comes from, and assured protection for investors, meaning governments cannot expropriate the assets of foreign investors without market-valued compensation. The agreement legally limits how and when nations can set investment policy. Governments, for example, will be required to treat foreign investment the same as domestic investment, and will not be allowed to impose performance requirements on investors. Some of these requirements, such as setting affirmative action or hiring quotas for local workers, targeting specific regions or sectors for investment/development, or legislating that some portion of profits must be reinvested locally, have been used by governments in the past to ensure that social benefits arise from foreign, primarily transnational corporate investment. The MAI also adds one new power to investors and corporations that they do not have under WTO agreements: They will have the right to sue national governments before international tribunals for failure to deliver on all of the MAI's benefits. This is the first time any international agreement effectively elevates private corporations to the same status as nations. Once again, these tribunals will be closed and their decisions binding. Also, unlike WTO agreements, which cover only those trade items specifically mentioned in them, the MAI is like negative option advertising. Only those items, or "exemptions," specifically mentioned will be outside of the agreement (CCPA Monitor, April 1997).

Under draft MAI provisions, national governments would lose their ability to direct foreign investment to particular sectors of the economy based on social or environmental objectives, or to give preferential treatment to local economic initiatives. If Mexico, for example, wanted to offer low-interest loans to local farmers to produce value-added products such as confectionary items, canned foods, boxed cereals or prepackaged meals, it would have to offer the same low-interest loans to transnational giants like Kraft or General Foods. These provisions could make it almost impossible for local businesses to develop in poorer countries. Even such traditional public health issues as tobacco control could be undermined by these agreements. Under GATT, the predecessor to the WTO, the US forced the Thailand government to repeal its public health law banning all tobacco imports. The ruling allowed Thailand to continue a ban on advertising and public vending machines because the intent was not to impede free trade but to protect public health. Under the MAI, the intent of national legislation is no longer what tribunals will consider. Instead, they will rule only the effect: Does the national regulation discriminate against foreign investment or trade in any way? Some analysts fear that foreign tobacco companies could use the MAI to sue governments over tobacco control policies that discriminate in favour of existing or domestic brands (Public Citizen 1997).

This is not idle speculation. NAFTA is presently the only multilateral agreement allowing foreign investors to sue national governments that have signed it, and is the "test" model for the MAI. As soon as NAFTA was approved, the US-based Ethyl Corp launched a suit against the Canadian government for $350 million in damages ("expropriated" potential profits) due to that country's ban of the fuel additive, MMT. This ban was undertaken on the grounds that MMT is known to increase toxic automobile emissions and may cause human health problems. Ethyl will argue its case behind closed doors. No health or environmental organization will be able to intervene. The eventual ruling will be final with no opportunity for appeal. Similarly, a US hazardous waste company is suing Mexico for lost profits due to regulatory delays in granting it an operating license, owing to Mexico's concerns that the proposed site is not environmentally safe. Again, the eventual ruling will be made in secrecy and will be binding (Schrybman 1997).

The MAI could also make it more difficult for governments to fund social programs or redistribute wealth. As Canada's Department of Foreign Affairs and International Trade admits, "governments the world over [must now] compete aggressively for foreign investment" which requires "convincing a foreign investor to choose Canada over other locations" (Department of Foreign Affairs and International Trade, 1996). Part of this "convincing" lies in reducing tax burdens to attract investment (Public Citizen 1997). The proposed MAI, by making it easier for investment to move from country to country, increases this "competitive pressure." Moreover, to tax wealth, it must remain more or less within national boundaries. The proposed MAI would give investors greater freedom to move profits out of countries, possibly to "tax haven" nations, reducing even the amount of potentially taxable wealth that remains.

Confronting "TINA"

In the absence of international public regulation of this unfettered flow of goods, services and capital, social inequalities and environmental degradations are likely to worsen. This poses a new challenge for public health activists. Most "healthy public policy" work, where it is being undertaken, is directed locally in a defensive reaction against national or sub-national policies that capitulate to global capital (i.e. organizing opposition to neoliberal attacks on welfare state programs). Or it may be directed proactively in efforts to build stronger coping ties and informal economies between the poor and middle class. But the environmental aphorism, "think globally, act locally," may no longer pertain to environmental and human health threats posed by economic markets and investment system that now operate globally. As Hart argues,

> the realms of production, exchange and consumption have largely escaped from the effective regulation of the territorial nation-state, while the people who make up that state remain largely attached to it...Globalization is pointing to the need for global governance...a re-alignment in the authority exercised by or through extra-national rules and institutions (1996, p.7).

There is a pressing need to find ways to regulate global capital by imposing reciprocating social responsibilities that would permit the re-creation of health promoting welfare state policies (Amin 1997, Betcherman 1996, Hettne 1995). Since capital is now global, these policies must also be global, or at least supranational (Bienefeld 1996). The problem becomes: How can civil society, represented through its nation-state institutions, regulate a global market, when all of its abilities to do so remain locked within national legal and policy frameworks?

The "Social Clause" Campaign

For many years, the answer to this question focused on reform of the United Nations and its many agencies, which should remain an important focus of activity (Amin 1997). Certainly, there are many progressive multilateral agreements the UN has announced over the years, e.g. the Convention on the Rights of the Child, the International Labour Code, Agenda 21 and the Alma-Ata Declaration. These agreements focus on the responsibilities of national governments for human rights, social welfare and environmental protection. Different UN agencies have responsibility to monitor national enactments of these declarations or codes within national policies. But, unlike the WTO and the MAI, these agreements lack any enforcement measures and the only power UN agencies have for national compliance is moral suasion. Ironically, if this article's analysis of the impact of these trade/investment agreements is correct, the ability of most nations to comply with voluntary social and environmental agreements will actually decrease. This asymmetry between enforceable agreements for business interests but unenforceable

agreements for social or environmental interests has led many NGOs to begin to posit a second answer to the question of how to regulate a global economy: Use the WTO and MAI agreements, which are currently written to benefit the interests of capitalists and investors, as opportunities for re-uniting the false schism between economic development, social development and environmental protection. Specifically, an international NGO movement is building in support of appending "social clauses," such as UN agreements on labour, human rights and the environment, to trade and investment agreements. These currently unenforceable agreements would become enforceable by having access to the same penalty measures in place for the WTO or MAI.

Lobbying on this idea began at the December 1996 first Ministerial Conference of the WTO. With the support of organized labour groups and other public-interest NGOs, OXFAM advocated that the WTO strike a Working Group to look at incorporating the International Labour Code within its agreements. OXFAM emphasized the need to move slowly in such incorporation, noting that for many countries, particularly poorer nations, the task of coming to terms with current WTO agreements is already straining their policy resources. But there is no reason why, over time, additional UN social and environmental agreements might not also be incorporated within WTO agreements, or appended to the MAI.

The WTO and whatever regulatory body is established to monitor the MAI would not be responsible for overseeing implementation of these social clauses. UN agencies with mandates for these conventions would maintain their monitoring responsibility, but would have at their disposal the enforcing powers of the WTO and MAI. These enforcement powers may have to be amended somewhat, to include sanctions by all signatory nations against non-complying countries, binding on both trade (excluding humanitarian) and investment. But this is no different than bilateral and multilateral agreements used against politically "renegade" countries, such as Iran or, historically, the former apartheid South Africa.

Despite initial support from several European countries and the US,[1] the December 1996 initiative failed. Most of the NGO forces surrounding the WTO and MAI at present are those favouring more liberalized trade and investment agreements. They claim that "the piling on of social causes [in trade and investment agreements] may appear politically expedient, but will be a key cause for divisiveness and dissent within the WTO and thus inhibit progress..." (Czinkota in Minyard 1996). As Minyard (1996) argued with respect to the OXFAM proposal, "the ILO [International Labour Organization] exists to deal with labour matters, and the WTO must not become embroiled in such non-trade areas unless it wishes to become, like the United Nations, overcome with minutiae and bureaucracy." But these arguments miss the point of the social clause campaign, which is not opposed to global trade or investment, and proposes only to append already existing multilateral agreements on social and environmental policies to the WTO

[1] It may strike some readers that US government support for such an initiative flies in the face of its largely neoliberal economic policy platform, to say nothing of its own failure to date to ratify many of the International Labour Code conventions, including its six core standards (Hart 1996). Some observers at the Ministerial Conference argue that the US never seriously supported this initiative, but wished to use it as a bargaining chip for other concessions (International Institute for Sustainable Development 1996).

and MAI in order achieve symmetry in compliance measures. Moreover, there are precedents. The Montreal Protocol on Ozone-Depleting Substances successfully used the "stick" of trade sanctions to obtain rapid national compliance. Even free-trade advocates in the OECD are tentatively exploring the argument that, in such transboundary environmental issues as global climate, biodiversity, desertification and endangered species, "multilateral environmental agreements may need to include trade restrictions," including linking such restrictions to WTO-monitored agreements (Long 1996).

Overcoming "Backdoor" Protectionism

Opponents to the OXFAM proposal included several developing countries, and it is here that the proposal to link social clauses with trade and investment agreements requires greater detailing. Part of developing nations' support for free trade and investment reflects the Western education of many of these countries' leaders, education which has been steeped in neoliberal economic ideas for the past twenty years (Amin 1997). Liberalized trade and investment, to the extent it opens markets of wealthier countries, may bring short-term hard currency to low-waged countries, even if the longer-term impact is increasing wealth disparities within and between nations. Many economically developing nations also argue that linking trade to social clauses would discriminate unfairly in favour of wealthier countries which already have welfare infrastructures and considerably more national wealth. Poorer countries would be less able to comply with social clauses, risking first world trade sanctions against their competitive labour advantage. Simply using the enforcement measures of the WTO or MAI for social clauses could paradoxically make life worse for many of the world's poorest.

The case of child labour stands as an example. Several developing countries, particularly those with large textile plants, argue that enacting International Labour Code policies on child labour could force children away from their parents working in factories and onto more dangerous and unsupervised streets. But this is not a "TINA"; it is merely a local contingency that must firstly be respected if it is secondly to be remedied. As Leslie (1992) argues, "it would...be salutary to put policy questions first, and, in light of substantive policy goals, to tackle the more technical and indeed arcane questions involved in the financing of social programs." Mechanisms for disbursing trade benefits more equitably within and between nations could make it possible for textile factories, to continue with the example, to gradually implement health and education programs for workers and their families within the factories themselves. These mechanisms would introduce social programs to the constellation of work and social relationships currently existing within economically developing nations, rather than imposing European or North American models from on high. This principle of "differential compliance" for poorer countries is already recognized in many UN declarations, including agreement on the need for wealthier countries to provide economic and technical assistance to poorer nations to help them achieve compliance. This agreement, however, presently remains unenforceable and, at least in trade-related matters, one effect of the WTO has actually been to foreclose "special and differential treatment for developing countries" (Hart 1996, p.8).

Parallel Global Policy Agreements

Such mechanisms would likely have to include multilateral agreements on taxation of trade and investment profits in a way that would both stem the flow of capital from poor to rich nations, and create a pool of capital available to poorer nations for endogenous economic and social welfare development (Boyer and Drache 1996). For example, growth in global short-term investment and currency transactions has far outstripped growth in international trade or long-term capital investment, posing another significant threat to national welfare policies (Epstein 1996). Currency speculators have the ability to earn huge profits playing "casino capitalism" (Strange 1986), but at the expense of determining national currency values and thus the ability of nations to repay debts and earn revenue through trade. Short-term finance markets, aided by microtechnology, now see over $1.2 trillion per day change hands, forty times more than the value of "liberalized" trade (Helleiner 1996). The recent collapse of the Malaysian stock market, and subsequent devaluation of its currency, has renewed calls for implementation of a Tobin tax. Named for the Nobel economist, James Tobin, the tax was originally proposed for foreign exchange transactions, and would be levied at a very low rate of between 0.1% to 0.5%. This would serve to dampen unproductive but highly damaging forms of currency speculation. Proponents are now calling for its extension to other forms of financial investments, such as stocks, bonds and derivatives. If implemented, such a tax would also create a potentially enormous revenue pool that could be used to pay down government debts (especially for poorer nations) and fund compliance with social clauses (Chorney 1996). A so-called "carbon tax" on fossil fuel consumption, creating an international pool of capital derived primarily from disproportionately consuming wealthy nations, has also been proposed, and could be used to finance basic environmental infrastructures (water, sanitation, housing) in poorer nations, as well as transfers of ecologically cleaner technologies. A GDP-proportionate levy on nations signatory to trade and investment agreements, or a tax on all trade and investment overseen by the WTO, could similarly create a fairly large development fund. The EU's regional economic development funds represent a potential model (Streeck 1996), although its many weaknesses, such as economic development superseding social development and countries using the funds to avoid their own internal investment in poorer regions, would have to overcome.

The Need to Work Both Nationally and Globally

The social clause campaign, to succeed, requires strong national commitments to social equity and ecological sustainability, which perforce requires a political suspension of belief in the neoliberal economic agenda and its anti-state ideology. It also requires that more progressive social movement groups, particularly those within nations, shift their critical stance from opposition to the state, which undermines its legitimacy and therefore its power to stand against the global economic tide, to opposition to the tide that is rapidly swamping it. Nothing in my argument for work at a global level, particularly at the WTO or MAI, precludes the fundamental importance of organizing within and between nations. Indeed,

multilateral trade and investment agreements are still between nations, not above them. The issue becomes one of confronting nations, and the world press, on the inseparability of social and environmental policy from economic development—development, not in the sense of growth and profit, but in the older meaning of providing efficiently for basic human needs.

While there is already some support for social clauses within member states of the European Union, their accomplishment is a formidable task. Not all political economists concerned with globalization consider pursuing their inclusion in trade and investment agreements a viable strategy, arguing that we lack a sufficiently developed global polity to make them workable (Amin 1997). But if the social clause initiative is seen partly as a social marketing counter-message to neoliberalism, confronting trade delegations and the world press on the social and ecological obligations of trade and investment policies, it remains an important and necessary, if not necessarily sufficient, strategy.

A Proposal to Build a Public Health Lobbying Presence

The long-term goal of this proposal is to establish healthy public policies (social clauses) within current and future world trade/investment agreements. The immediate objectives are:

- To create a health NGO lobby presence at the WTO, specifically around its biennial Ministerial Conferences, and at whatever regulatory body assumes responsibilities for the MAI; and
- To work alongside the efforts of other public interest NGOs, especially those representing development concerns in poorer nations.

There is also a role for national public health and other equity-oriented national NGOs to pressure members of their own country's trade delegation to the WTO or MAI negotiations. However, if the goal is to establish global policies restricting the unhealthy practices of global capital, an international health NGO, or group of such NGOs, is required, and for three reasons:

1. To speak with the authority of a global voice.
2. To ensure some degree of global consensus and equity in articulating that voice, i.e. to avoid a public health imperialism by activist individuals and groups from wealthier nations.
3. To support national public health associations and other grass roots organizations in building local constituencies where alternatives to the neoliberal free trade/investment regime might be discussed and advanced politically.

Several potential groups might play a lead role. The World Federation of Public Health Associations, an NGO umbrella of national public health associations, may be well positioned, as is the International Union for Health Promotion and Education. Others could include the International Peoples Health

Council, a loosely structured network of primary health care reformers, and any of a number of physician groups, such as Physicians for Global Responsibility. There is no shortage of organizations or networks. Rather, there is generally a shortage of resources to buy the human time required to mobilize them, for it is unrealistic to assume that a meaningful health lobbying role could be exercised without logistical and staff expenses. Fortunately, there is considerable policy analysis and lobbying skills residing within several national public health or related organizations, independent policy groups, university-based public health and health promotion research centres (e.g., the network of World Health Organization collaborating centres) and, most importantly, international public interest NGOs.

The task becomes one of creating a nodal point or group that might begin to strategize around the ideas in this proposal, assemble the policy and evidence-based arguments, and loosely coordinate the efforts of national health groups. Already, four national public health associations (Canada, Aotearoa/New Zealand, Australia and England) have passed or are considering resolutions on this issue, or are otherwise working to deepen an analysis of the "social clause" strategy and develop national and international lobbying opportunities. These tasks are made easier by ongoing innovations in computers and electronic communication, and a list-serv already exists for discussion of the ideas in this proposal.

To conclude my proposal, then, I am seeking the following:

1. Helpful ideas about the general argument in this paper.
2. Contact information on any organizations and individuals willing to advance work on it.
3. An organization willing to support the initial development of an international health NGO presence at the WTO.

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GLOBALISATION, INTERNATIONAL HEALTH & A NEW INTERNATIONAL RELATIONS FRAMEWORK

Alberto J.F. Cardelle

The fundamental argument of this paper is that in practice there has been an intricate and reciprocal relationship between international public health and the practice of international relations. But that unlike the reality, the discipline, or the study of international relations has neglected or even scorned the idea that health is an international issue. And while the discipline has been able to get away with this thus far, the current process of globalization is going to present a serious threat and challenge to some of the basic notions of international relations—basically the country centered perspective of international relations.

The paper begins with a very quick review of the historical relationship between the two fields, and then looks at how the existing theories of international relations are inadequate and incapable of integrating health considerations. The paper concludes by proposing four areas in which public health practices and problems will pose a threat to the primacy of the nation-state.

An Historical Interdependence

International health practice, and more importantly the global infrastructure, upon which the practice is built, has been shaped by the relations or the interdependence

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among nation-states. What I mean by this is that major developments in the infrastructure, which has guided the practice of international health, have been conditioned by political, social, and economic determinants at a global level. For instance, the first formal organizations established to address international health concerns emerged in the 13th century, when the city-states of northern Italy established public health committees and coordinated their activities in order to combat the effects of the Black Plague (1347-1351).[1] Centuries later, the debilitating effects of a yellow fever epidemic in the Americas, and most important its threat to hemispheric trade, led the U.S. Department of Health and Human Services to convene the ministers of health of Latin America and organize the Pan American Sanitary Bureau, the first international health organization of its kind and the precursor of today's PAHO. Similarly, the breakdown of the international system of nation-states during WWII—and the need to create a system based on the promotion of peace (positive peace) through socio-economic programs instead of through diplomacy (League of Nations)—led to the founding of the UN, the World Bank, the IMF and the World Health Organization.[2]

The Study of International Relations

The development of a discipline of international relations has been considered disorderly and incomplete, even within the already messy realm of the social sciences. If one were to use a metaphor to characterize the development of international relations it could be best described as "a piece of an ancient parchment upon which writing has appeared, been erased (although not completely) and then covered over by new writing."[3] Throughout this long process that is supposed to have commenced in 1645 with the Peace of Westphalia (when the modern nation-state is said to have emerged), the discipline remained isolated and was treated as an issue exclusively for nation-states and the exercise of power between them. In the history of modern international relations, since the establishment of the League of Nations, it has been dominated by the Cold War and the debates have been framed in draconian terms of right and wrong, and war and peace. The interpretation rendered by the traditional international relations theory of international health issues are narrow and dismissive. International relations theory is divided into three paradigms or three different perspectives. The realist, pluralist and globalist perspective.

For those within the ***realist*** approach, the state is a unitary, self-enclosed, and principal actor in international relations and therefore would be concerned with health issues in terms of how international outbreaks of disease affect the distribution of power and national security of nation states, as well as how the international manifestation of disease could give rise to new forms of international conflict.

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1 Gomez-Dante "La Evolucion de la Salud Internacional en el Siglo XX". Salud Publica de Mexico, 33:4, p314-329.
2 Pannenberg, C.O. "Shifting Paradigms of International Health".
3 Stark, J. "International Relations and Public Health" presentation at a PAHO Human resource Workshop in Galveston March 1996.

The next paradigm begins to open the space for other concerns and other actors within the concepts of international relations. Authors in the ***pluralist*** school are concerned with non-state actors and how the different countries of the world are interdependent—therefore, for this school, the State is not a unitary actor, and so they would be concerned about how institutions of international society and existing mechanisms for inter-state cooperation facilitate the identification and management of international health problems. These scholars would look at the important role played by PAHO, WHO, NGOs and multinational organizations.

But these two approaches fail to conceptualize the new forces and trends in the current era of international relations: globalization. These traditional approaches are inadequate in that they are based on assumptions that the nation-state will continue to be sovereign and principal actors within international relations, and that international relations is autonomous from domestic political relations. Presently the process of globalization is expanding and integrating the concept of international interdependence "into a system of relations in which the different actors are just components of the same system." Where once countries could be described as billiard balls bumping into each other, now they are gears in one enclosed system.

Globalization is defined by the IMF as "the growing interdependence of countries worldwide through the increasing volume and variety of cross-border transactions in goods and services and of international capital flows, and also through the more rapid and widespread diffusion of technology."

This is sufficient as far as it goes, but it doesn't go very far, and it's symptomatic of international relations theory. That is to say, international relations concepts assume entire domains of social and political life and are subsumed within greater nation-state market activities. But unlike "theoretical globalization," "real globalization" can be better described as " a social process in which the constraints of geography on political, economic, social, and cultural arrangements recede and in which people become increasingly aware that they are receding." In other words, globalization entails not only economic transactions, but associated political practices, social and cultural norms and health considerations.

Public Health Threats to the Traditional State System

The traditional international relations approaches are going to become increasingly limited as a framework within which to conceptualize and address the multitude potential questions that arise in the practice of international public health. This emerges primarily from the frailty of state sovereignty in the face of globalization and international health problems. Because of the forces of globalization, international health issues are beyond the capacity of nation-states. The primacy of the state as well as the autonomy of international relations are limited in the face of a growing sense of planetary consciousness, and non-territorially-based issues. Let me explain. Globalization compresses the world through four interrelated forces: i) worldwide circuits of governance, ii) an expanding sphere of communications/information, iii) the creation of a single world-economy, and iv) a variety of new political cultures and subcultures. The effects of these forces is to create issues that no single nation can address independently, and convert issues that were national level concerns into international issues. Let's take a look at each of these forces individually.

Worldwide circuits of governance, in other words a new global sovereignty, is emerging due to the intricate and wide-ranging legal and institutional structures established by international health agreements. Before the establishment of the United Nations, the international system of governance was non-hierarchical, that is, no one country could, without the use of force, impose policies on other countries. But through the increased interdependence and globalization, the system of governance shaping international relations is becoming increasingly guided by established formal and informal regimes that have emerged in order to solve global problems requiring international cooperation. States are relinquishing their rights and duties as sovereign entities to new centers of international authority, which adds new levels of norms, principles and rules.

Agreements such as The 1978 Alma-Ata Declaration, which established an over-arching norm to attain the ultimate goal of "Health for All," have served as the yardstick by which to measure and hold states accountable.[4] Over the last ten years the norms and principles governing international health have widened considerably. Four major international declarations, *The World Summit for Children, The World Summit on Population, The Rio Summit and the World Summit on Nutrition*, and *The Regional Miami Summit and the Summit of Sustainable Development*, have committed signatures to over 60 different resolutions concerning the provision and/or the protection of rights of individuals to basic health care.[5]

The expanding sphere of communications/information erodes the difference between the "domestic" and the "international" and threatens the traditional concept of international relations as being autonomous from domestic politics. International health concerns blur the difference between the two because national level disease outbreaks, the control of which is dependent upon the state's internal ability to enforce health regulations, threaten the internal security of states and citizens globally.

In an era of rapid transportation, global production systems, population growth, and overcrowding, the capacity to improve the surveillance, control, and enforcement of health issues both across and within our borders becomes paramount. With one million people crossing an international border everyday, diseases and sequelae cannot be expected to isolate themselves within families, communities, regions, or nations.

The most recent outbreak of Hepatitis A from contaminated Mexican strawberries places the issue in the limelight. The lack of health regulations in one country results in disease outbreaks in a second country, and solutions no longer fit within the neat concepts of developed and developing countries but dependence becomes trans-regional (not in terms of geography but in terms of core-periphery).

The creation of one global economic system introduces a number of constraints to the ability of states to govern in a sovereign fashion. The increased integration of the global economy implies that the policy

4 PAHO/WHO "Health For All In The Americas" Washington, DC, 1995.
5 RESCA "Cumbres Internacionales y Condiciones de Salud" Costa Rica, 1995.

decisions with the biggest impact on international health are taken by states themselves. The almost universal acceptance of market-based economics increases the economic incentives that are not necessarily compatible with those of international health protection, and undermine the authority of states over international health issues.

Let me explain again. The IMF is correct in asserting that the world-economy is the motor driving globalization. The new economic model (neoliberalism) that is unfolding globally is based on strategies involving fiscal restraint, economic liberalization, deregulation, and export-led growth. This has entailed a massive restructuring that has resulted in significant reductions in the power and autonomy of the state, because in order for countries to become competitive in the emerging global market, they must adhere to some very strict economic recipes. Among the most important are deregulation and a reduction in state budgets. This translates into health care systems with embedded market based incentives—mainly cost-recovery and privatization. This process, coupled with other economic measures which aim at increasing the flexibility of labor and tend to increase unemployment and expel workers into the informal sector, decreases access to health care.

Although there is an intense debate concerning the degree to which governments are restricted in the face of these global trends, especially in terms of broad-based systemic issues such as health care, the space available for alternative proposals is minimal. For instance, most countries of Latin America have very low domestic saving rates, and therefore any capital for economic development must be international. But their capacity to attract this capital is dependent upon international investment ratings, which in turn are dependent upon how well countries fit within the international economy. In other words, there are new rules of the game, and in order to develop their economies, countries have to play by them.

The increase in the variety of new political cultures and subcultures creates a new "transnational civil society" concerned with the quality of the international health care system, which results in a fourth force threatening the concept of state sovereignty. Certain aspects of the "new rules of the game" within current global norms increases international standards of transparency and accountability in business and finance, labor practices, environmental protection, and public health policies. Also, international commitments to address basic social issues and encourage greater civil society participation, while at times more the object of lip-service than action, nevertheless are now based upon authoritative documents to which citizens can be expected to appeal in bringing pressure upon governments. The growing number of NGOs, social movements, and associations concerned with international health have produced a host of transnational actors that derive their strength from their ability to organize political action and influence public and political policies, to create a greater respect for international health concerns.

Conclusions

The development and implementation of international health policy highlights "a fundamental discontinuity in the contemporary system of states."[6] Current international relations concepts of globalization do not have the necessary tools for understanding how these health threats affect the international system of states. The current debate on fast-track legislation is a very clear example. Although issues such as intellectual property become integral to the negotiation of trade agreements, other global concerns such as health standards and environmental protection are seen as exogenous to the agreements, a purview of the traditional state-centered agenda.

6 The different categories upon which this paper is based were adapted from; Hurrell A. "International Political Theory and the Global Environment" in Booth K. and Smith S. (Eds.). *International Relations Theory Today* (University Park: Pennsylvania State University Press, 1995).

CASE STUDIES ON THE EFFECT OF ECONOMIC REFORM POLICIES ON HEALTH

MARKET FAILURES & MORAL FAILURES:

The Privatization of Health In Peru

Jim Yong Kim, Aaron Shakow, and Jaime Bayona

Benedicta Sanchez[1] started coughing during the winter of 1994, but at first she paid it little attention. Born in a rural province north of Lima, the 38-year old woman had moved to the shantytown district of Carabayllo, on the northern fringe of the Peruvian capital, when her husband found agricultural work nearby. From the time of their arrival in 1990, the couple and their two adult daughters had lived on the brink of starvation. Some weeks, Benedicta and her husband were able to earn as much as 20 Soles (US$8), but this income was unpredictable, and often the two of them brought in far less, or nothing at all. Anticipating sporadic shortfalls, they struggled to save what little money they could.

But Benedicta had more than a cold. For months she'd been losing weight and waking up at night with drenching sweats. One evening, Benedicta's oldest daughter Maria returned from night school to find her mother coughing up blood-streaked sputum. Maria had recently heard a radio announcement that described the symptoms of tuberculosis and urged people experiencing them to seek help. Maria decided to stay home from work the next day in order to take her mother to the nearest public health center, a 15-minute bus ride away. Although patients are charged two soles

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1 Names of all individuals described in the case studies have been changed.

(US$0.80) for most visits to this clinic, TB check-ups are free. This, as Benedicta and Maria were told, is because the Peruvian Ministry of Health sees TB as a very serious problem.

After taking her mother to the clinic for various tests three days in a row, Maria began to worry that she might lose her job if she didn't return to work. Later that week, after receiving inconclusive TB test results from the clinic's lab, Benedicta went alone to the nearest public hospital, a half-hour bus ride with a twenty-minute walk from her home. There, health workers informed her that she needed to purchase saline solution, surgical tubing, gloves, and a syringe before a definitive diagnosis could be made. Benedicta was also told that the National TB program would not cover their cost, which amounted to almost 10 soles (US$4).

Benedicta panicked. She had been told at the clinic that her treatment would be free. She explained to the nurse that she had only enough money for bus fare home, one sol.

"Señora, how can you leave your house and come all the way here with just one sol?" the nurse asked her.

"Señorita," replied Benedicta, "If I had known I was going to have to pay, I would not have come at all."

Benedicta returned home without even being diagnosed. When Maria asked her mother that evening what the doctors had said, Benedicta told her that she was fine, that she didn't have TB after all. Benedicta knew that Maria would make her return to the hospital if she learned the truth. And she knew that to purchase the supplies for her treatment, she would have to deplete the family's meager savings, and perhaps threaten its survival. So Benedicta made a calculated choice: she said nothing, and went on coughing.

Public and Private in the New World Order

Over the last twenty years, Benedicta's experience has become commonplace in developing countries. Her aborted contact with the Peruvian health-care system typifies the way in which state abdication of responsibility for certain services can lead to the propagation of illness. In the literature of health and public administration, such displacements of responsibility are known euphemistically as "cost shifting," "cost sharing," or, in Peru's case, "funding demand but not supply." Through them, many social and economic functions that were previously paid for by government agencies are privatized—transferred to non-governmental organizations, private companies and sometimes, with tragic results, to impoverished individuals like Benedicta Sanchez.

These decisions, of course, are not arbitrary. Often they are mandated by state planners in developing countries under great pressure to reduce costs and bring greater "efficiency" to health-care systems. The term privatization, though imprecise, is now the gloss most widely used to describe this broad range of policy initiatives that confine governments' fiscal obligations in the health sector.

Privatization in the World

The basic idea of privatization is quite simple: a transfer of assets or responsibilities from the public to the private sector. Governments have been doing this since the earliest days of the "public sector"

itself, but as a pillar of neoliberal ideology, privatization had special importance to the right-wing coalitions that brought Margaret Thatcher and Ronald Reagan to power.[2]

"The American people," wrote Reagan's Commission on Privatization in 1988, "have often complained of the intrusiveness of federal programs, of inadequate performance, and of excessive expenditures. In light of these public concerns, government should consider turning to the creative talents and ingenuity in the private sector to provide…better answers to present and future challenges." On the principle that "a free people should be responsible for their own development," the Commission went on to identify instances of waste or inadequacy, or where private enterprise was impeded from supplying a service by "excessive regulation." This anecdotal argument led the authors into a seemingly logical fallacy: without presenting any evidence, they concluded from isolated examples of state inefficiency that "privatization is growing because it delivers major savings or improved service quality, or both."[3]

The evidence that services were improved or made less expensive by privatization remains deeply ambiguous; the growth of this phenomenon, however, was indisputable. The 1980s saw rapid acceleration worldwide in the sale of state-owned companies: the World Bank recorded a total of 6,832 such transactions between 1980 and 1992.[4] By 1997 the global proceeds from privatization had reached $153 billion.[5]

But the "growing" trend toward private ownership of public resources was not overtaking wealthy countries alone. Historically, the governments of poor countries have owned and overseen large sectors of their economies, partly to promote social goods like employment, and partly because the state was often the only local actor with the funds and motive to promote essential industries. Some government-controlled enterprises turned a profit; many others, however, cost far more to maintain than they earned in revenue.

There were several reasons for this inefficiency, including corruption, outdated technologies and a poorly-educated work force. Subsisting on minuscule salaries, which they frequently received regardless of productivity, managers of state enterprises often had limited funds to invest in new equipment or training and saw few incentives to change. Institutions like the U.S. Agency for International Development (USAID) under President Reagan urged poor countries' governments to sell off such enterprises in order to acquire badly needed cash, shed costly obligations and render industry more efficient through the operation of market forces.[6] USAID and other development agencies moved rapidly to prod governments in this direction with specific incentives, including assistance in renegotiating the commercial loans on

2 On the historical roots of privatization in the social services see Bahmueller, 1981; also Gurin, 1989.

3 Linowes, Anderson, Antonovich, *et al.*, 1988, p. 3; as of 1992, three World Bank researchers were forced to conclude that "much of the divestiture debate has been intuitive, theoretical, and even ideological" (Kikery, Nellis, and Shirley, 1992, p. 27).

4 Kikery, Nellis and Shirley, 1992, p. 22.

5 OECD, 1998, p. 150.

6 USAID, 1986.

which many countries had fallen into default.[7] By 1991, developing country governments had sold 2,162 state enterprises, about one-third of the world total.[8]

This stance, however, had many critics—particularly in and around the developing world. Many planners and economists, even some at the World Bank itself, contended that privatization of state-owned enterprises tended to concentrate wealth, and to exacerbate economic inequalities.[9] As of 1991, one journalist noted, 37 Mexican businessmen, who together controlled 22 per cent of the country's gross national product, were the primary stakeholders in all but one of the country's public sector sell-offs. "Few nationals," she reported, had access to "the money or international contacts to buy government-owned companies. This constrains the number of eligible bidders, weakens bids and means that the few who are able to purchase previously state-owned enterprises can extend their economic reach."[10] Others, noting the efforts of USAID to secure an American interest in newly privatized industries, have contended that the agency's advocacy of privatization in poor states is designed primarily to benefit U.S. private and corporate investors.[11]

Certainly, there are instances in which money-losing "white elephants" must be sold in order to free up scarce resources in poor countries, though a government can often earn more over the long run by implementing measures to render public enterprises more efficient.[12] But this difficult calculation is abstract—it fails to capture the social costs of privatization policies. By relinquishing control of industries and services, governments lose their ability to ensure an equitable distribution of the resources they generate. To Benedicta Sanchez, for example, platitudes such as "financing demand but not supply" have a deadly ring. Unable to afford the price at which health care was offered, getting sicker was the only currency she had left.

Privatization of Health Care in Peru and its Potential Implications

The Peruvian government, like its analogues in many other poor and heavily-indebted countries, faces substantial constraints in determining social policy. When, in the late 1980s, former President Alan Garcia set a limit (ten percent of export earnings) on the sum that could be applied to yearly debt service payments, the international financial institutions led a retaliatory campaign against the Peruvian

7 USAID, 1987; AID established its Private Enterprise Bureau in July 1981, just after Reagan took office, with the stated purpose of promoting "global integrated capitalism" by reducing aid recipients' levels of public sector ownership. Subsequently, the agency's loans and grants were made conditional on implementation of privatization strategies. In Costa Rica, for example, funds were not released until 42 of 47 state-owned enterprises had been closed, transferred, or liquidated under AID supervision. In Panama, the agency conditioned "program assistance" to repair damage from the 1989 U.S. invasion on formulation of a blueprint to reduce tariffs, curb government spending, and sell off state industries. Meanwhile, AID was constructing an international network of enterprise funds, designed to ease American investment "in new private businesses, joint ventures or recently privatized enterprises" (Martin, 1996, p. 148).

8 Kikery, Nellis and Shirley, 1992, p. 23.

9 See for example Ferreira, 1997.

10 Carlsen, 1994, p. 18.

11 Martin, 1996.

12 The IDB, for example, has been able to detect little appreciable effect of privatization on Latin American growth indicators (IDB, 1998). The authors presumed that their measures were inadequate (p. 56).

government, with devastating effects on the populace.[13] Poor countries considering unilateral reductions in debt service payments could not help but get the message—the price of resistance would be far higher than the savings from withholding payment.

In 1990, Alberto Fujimori, a relatively unknown professor who had been the president of the National Agrarian University outside Lima, astonished the Peruvian cognoscenti by winning the presidential election on a populist platform. Donning a poncho and other peasant garb and taking his campaign directly to the poor, Fujimori distinguished himself from his opponent, acclaimed author Mario Vargas-Llosa, who maintained close ties to the oligarchy that had ruled Peru for many decades. During the campaign Fujimori promised his supporters that any plan to re-initiate debt payments would be gradual and sensitive to the most vulnerable members of Peruvian society. Just after his stunning victory, the president-elect flew with several of his top advisors to New York for a meeting with executives of the IMF, World Bank, United Nations and other multilateral agencies. When one of his economic planners laid out the new administration's sketch for a gradual approach to correct Peru's hyperinflation, those across the table put their collective foot down.

'He was talking about Howdy Doody and the others talked to Fujimori about the facts of life,' a dismissive participant recalled. The president-elect emerged from the meeting convinced that the only feasible approach to Peru's economic recovery—or to renewed IMF and World Bank help, at any rate—involved a monetarist shock treatment.[14]

Persuaded by this forceful approach, the Fujimori government acted quickly, sparking a deliberate recession, slashing price supports for food and fuel, devaluing the currency, and imposing a 14 percent sales tax on all domestic purchases. In the year after this structural adjustment program—"Fujishock," as Peruvians called it—was implemented, the consumer price index shot up at a rate of 7,650 percent, and the value of wages dropped precipitously.[15] Health sector inflation was the highest of all consumer-spending categories: the cost of care rose 8,400 percent during 1990-91.[16] Meanwhile, the population officially classed as poor jumped from 7 to 12 million between 1990 and 1991, even as state social spending plummeted.[17]

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[13] In 1985 Peru's total external debt was US$12 billion, with debt service of $1.4 billion annually. About one third of this sum was owed to multilateral and bilateral lenders. By 1988, when García cut annual debt service to $347.1 million (9.7 percent of GDP), external loan principal had risen to $15 billion, and multilateral institutions held approximately half of this total, with an interest arrears of $2.97 billion (IDB, Economic and Social Database). This afforded agencies like the IMF a great deal of leverage, as they withheld short-term cash infusions until policy changes were implemented.

[14] Guillermoprieto, 1994, p. 84.

[15] Análisis Tributario 5(51):1992; PREALC estimates cited in Jiménez, 1996. The consumer price index is a measure of the average change over time in the prices paid by urban consumers for a fixed "market basket" of consumer goods and services. A normal annual rise is in the vicinity of two or three points.

[16] Iguiñiz, Basay, and Rubio, 1993.

[17] Attempts to determine precise poverty figures in Latin American countries are famously difficult (see Kim et al., *Dying for Growth*, Chapters 2, 3; also Mejía and Vos, 1997). By government assessments, using the World Bank's "absolute poverty" threshold ($300/month for a family of five), 50.7 percent of Peruvians were beneath the poverty line in 1997, down from the 1991 high of 57.4 percent (Cuánto, 1998). After five years of economic growth under Fujimori, according to the Lima newspaper *Gestion*, 4.5 million Peruvians, 19 percent of the population, were living in extreme poverty as of 1997, without access to sanitation, water or electricity (cited in Schemo, 1997).

Over the next three years, however, Peru staged an "astonishing recovery."[18] Having put his country, in the words of one admiring journalist, "back on the world map," Fujimori's IMF-inspired austerity measures reduced annual price inflation to 23 percent by 1994, and boosted GNP growth to over 12 percent, the highest growth rate in Latin America.[19] Foreign direct investment, negative $7 million in 1991, picked up briskly as overseas financiers began "crawling all over Peru," pouring $2.86 billion into the Peruvian economy.[20]

One crucial component of the "shock therapy" implemented in 1990 was Fujimori's privatization initiative. Selling off assets and unlocking state obligations gave the government an immediate source of liquidity to resume debt payments. As a reward for the government's compliance, the IMF granted Peru a one-year grace period on late interest payments—provided that it continue to pursue the inflation-busting "stabilization package" and reform its systems of law and taxation along free-market lines. With direct assistance from the United States, Japan and several European countries, Fujimori initiated regular debt service to the IMF; by 1996 he closed on an agreement to reschedule $10.5 billion in commercial debt, and signed new contracts with nearly all of Peru's international creditors.[21]

Ironically, the privatization of Peru's state industries was heavily promoted by many of the same multilateral agencies that had urged the government to buy them in the first place. During the 1950s and 60s World Bank officials strongly supported state investment in industries like telecommunications and transportation. Two-and-a-half decades later President Fujimori—prodded again by the World Bank and IMF—sold much of its share in the Peruvian telephone system to pay a fraction of the interest on some of the very loans which had been taken out to build it. Between 1991 and 1998, the government privatization agency Copri liquidated 97 percent of the state's assets in fisheries, 90 percent of its banks, 85 percent of its factories, and 70 percent of its interests in mining and energy.[22] While privatization did provide Peru with sufficient cash flow to get back on the world map and in investors' good graces, it proved completely insufficient to pay down the country's loan principal, which increased from $16.3 billion to an estimated $27.5 billion between 1990 and 1997.[23] In fact, proceeds of privatization have not even been enough to pay annual debt service. During 1996, which saw more state enterprises sold than any other year to date, debt service exceeded the proceeds of privatization by $300 million. [24]

Several elements of Peru's neoliberal reform ensured that an inordinate share of its burden would fall on the shoulders of the poor. Almost immediately after it assumed power, the Fujimori government moved to cut tariffs and personal income tax; by 1997 both corporate and individual tax rates had fallen

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18 Scott, 1994.
19 Harding, 1992, p. 12; IDB, Economic and Social Database.
20 World Bank, 1997; Vogel.
21 U.S. Department of Commerce, 1997.
22 Luxner.
23 IDB, Economic and Social Database.
24 U.S. Department of Commerce, 1997; IDB, Economic and Social Database. Privatization proceeds were $2.6 billion, while debt service amounted to $2.9 billion.

by 60 percent from their 1986 levels.[25] The slack in state budgets was taken up, in part, by value added taxes on consumer products. This trend, in fact, was region-wide, and resulted in a highly regressive tax structure that has made poor people disproportionately responsible for public fiscal obligations—most prominently such high-budget items as debt service.[26]

Cuts in social spending could not help but severely impact on the quality and quantity of state health sector funding. According to the Peruvian National Planning Institute (INP), health spending in the early 1990s remained at levels well below those of a decade before;[27] even by 1995, while some initiatives like the National Tuberculosis Control Program were well-funded, spending for health care as a whole was inconsistent. By November of 1997, under pressure from creditors and aid agencies, the Peruvian government officially implemented a realignment of national health care financing strategy.[28]

The privatization of state enterprise had first encroached on health institutions early in the 1990s, in the first wave of Fujishock. Many private companies ceased to underwrite health-care benefits that state employees had taken for granted, and other workers were pushed into the informal economy, where benefits were nonexistent. The government's reform plans, first drafted soon after Fujimori's assumption of power, formalized the trend away from direct central government involvement with health care.[29] As Health Ministry officials took care to point out, their culmination in the Health Law of 1997 was "a change in the rules of the game," the canonization of a model that claimed "to improve the quality of life of Peruvians" by "improving productivity and eliminating unnecessary spending on health."[30]

The 1997 Health Law was foreshadowed in a series of planning documents, whose texts bore a striking similarity to two decades of pronouncements from Washington D.C. "The Ministry of Health," the model stated, "will remove itself from the administration and direct provision of health care services."[31] Individuals would thereafter be required to purchase their own health insurance, selected from among a competing array of providers. The individual citizen's obligation to purchase insurance was designed to erase any potential for what economists term "moral hazard," the risk that people to whom services are provided free of charge will use them unnecessarily. While the state would offer assistance to those who could not afford basic insurance coverage, all health costs not covered by this "basic package" would have to be assumed by the individual.[32] In this fashion, the state would move from "financing the supply of health services" to "financing the demand."[33]

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25 IDB, 1998, p. 44.
26 Lacey, 1996; see also IDB, 1998, pp. 181-186.
27 Republic of Peru, 1992, p. 87.
28 Between 1994 and 2000, the World Bank, IDB, and several bilateral aid agencies are slated to supply half of the funding for the Ministry of Health's three highest-priority intiatives, in infant health, women's health and infectious- disease control (Comité Nacional del CAME, 1998).
29 See Republic of Peru, 1991.
30 Republic of Peru, 1996a; Republic of Perú, 1996b, p. 1.
31 Republic of Peru, 1996c.
32 Republic of Peru, 1997a, p. 4.
33 Republic of Peru, 1996b, p. 4.

In keeping with Peru's 1994 constitution, both the planning model and the 1997 Law itself claimed to promote and defend the individual's right to health.[34] The form in which this "right" was to be realized, however, was strikingly limited: "the exercise of free choice" among a range of services.[35] While, in a broad sense, the "protection of health" was seen to be in the public interest—mandating state regulation, surveillance, and promotion—the actual provision of curative or rehabilitative health care was not expressly guaranteed by this "right." While Peruvians would be entitled to "unrestricted access to health services and to choose the provisional system of their preference,"[36] there was no statement on how the state would ensure that the poor majority would be able to pay for these services.

In attempting to decipher the rationale behind the Law of 1997, we find that the *ideology* of privatization played an extremely important role. The most influential consultants in international health settled on privatization as their policy instrument of choice, despite lacking any real evidence that its health benefits or fiscal advantages would accrue to the entire population. Their leap of faith, it seems, drew upon a deep cultural cache, a powerful investment in free-market prescriptions.

Intellectual Antecedents

As in Peru, the worldwide debate over privatization is ultimately less about the real-world efficiency of market-oriented social policies than about fundamental philosophies on the proper relation between individuals and the state. Benedicta's experience is emblematic of a conflict at the heart of privatization debates, particularly in the social sector.

Always contentious, allocation of expensive resources like housing, health care and education is perennially governed by hierarchies of wealth and social standing.[37] For this reason, many argue, the distribution of basic goods and services must not be left up to the vagaries of the market; doing so would exacerbate existing inequalities within society, significantly curtailing poor people's access.[38] Resources like health care, in this view, must be seen as a basic human right, for which society, operating through the organs of government, is collectively responsible.[39] The role of the state is precisely to overcome the inequalities of the market, "either by regulating it or displacing it as a mechanism for allocating resources."[40]

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34 Republic of Peru, 1995a; Republic of Perú, 1996b, p. 2; see also Ugarte and Monge.

35 Republic of Peru, 1996b, p. 2.

36 *Proyecto ley*, cited in Republic of Perú, 1997a, p. 5.

37 The inequity in access to health care exists both within and between nations. According to one estimate, countries with per capita annual incomes above $8,500 accounted for 89 percent of global health expenditures in 1994, even though they comprised only 16 percent of the global population; residents of poor countries, meanwhile, lost 1.3 trillion disability-adjusted life years to disease, 93 percent of the worldwide total (Schieber and Maeda, 1997; cited in Iglehart, 1999).

38 See Lappé, Schurman, and Panaker, 1987.

39 Harvard Law School, 1995.

40 Watkins, 1997; also Gilson, 1989; WHO and UNICEF, 1978.

The notion of a human right to health care and other essential social goods is seldom contested overtly by those who draft privatization strategies. Nevertheless, their prescriptions for decentralization and market autonomy are underwritten by a neoliberal ideology that may ultimately be incompatible with social rights. During the mid-1970s Robert Nozick, an influential libertarian political philosopher, summed up this emerging attitude in a pithy revision of the old socialist motto, "To each according to their need, from each according to their ability." "From each as they choose," wrote Nozick, "to each as they are chosen."[41]

Nozick's concept of volition is, arguably, the very spirit of privatization policies in the social service sector. In poor countries like Peru, it takes on a deeply paradoxical edge. There, for large segments of the population, the choice being exercised is between life-sustaining food and life-preserving medicine; and the reforms which have forced this "deliberation" are being implemented, to a significant degree, in order to maintain loan regimes entered into by no choice of their own. Volition seems almost incomprehensible when juxtaposed against the raw need of poor people for essential resources like food and health care. In a market economy, one should note, poverty is exactly tantamount to "not being chosen."

Privatization of Health Care in Wealthy Countries

In the United States, health care has long been much more decentralized and market-oriented than in other industrialized countries. During the 1970s, however, the spread of privatization was greatly accelerated by changes at the national legislative level. As early as 1973, Congress moved to further free-market competition in the health sector through the HMO Act of that year, which gave health maintenance organizations, then mostly non-profit cooperatives, a number of tax advantages.[42] HMOs were a product of the baby boom; charging cheaper premiums than traditional health insurance plans, they paid doctors and hospitals a fixed amount per patient, giving them financial incentives to reduce expensive procedures and decrease the length of hospital stays. This arrangement separated health care's fiscal administration from its actual provision, pitting providers (doctors or hospitals) against each other in direct competition for patronage while HMOs themselves competed for the business of consumers, who, presumably, had sufficient information and discretionary power to choose among practitioners and between health-care plans. As Congressional proponents observed, this notion of "managed competition"—whose fundamental assumption was that state services were inferior to those of private companies—was the cornerstone of any attempt at health-care privatization.[43]

In the U.S., national divestment from the social sector and local privatization of health systems proceeded in lockstep. Together they acted to superimpose market values onto medical care and to

41 Nozick, 1974, p. 160.
42 Gates, 1996.
43 Enthoven, 1988.

promote direct corporate investment. Frequently, though, the immense profitability of such investment came not through managerial efficiency—as supporters claimed—but simply by charging more for premiums or by reducing expenditures on medical care.[44] When executives reached the limits of these savings, both private and non-profit HMOs began to lose millions.[45] In the end, the radical changes in administration seem only temporarily to have slowed rising health costs, which federal analysts project will double between 1998 and 2007.[46]

More troubling still is the impact such changes have on this country's most vulnerable members. Despite America's massive health expenditure, the highest level (per capita) on earth, this form of organization has led to some disturbing outcomes. Out-of-pocket medical costs, particularly for fixed-income elderly people, have risen astronomically over the past decade-and-a-half: one hundred fifty percent during one six-year period in the 1980s. Those pierced most brutally by this spike on the graph, of course, were the uninsured, whose number rose from about 27.5 million in 1978, to 37 million in 1986, to the 1997 figure of approximately 43.4 million, fully 16.1 percent of the population.[47] Poor people have been buffeted from two sides: first by the revocation of direct benefits like AFDC and then by cuts in subsidies to local health authorities, who are responsible for an increasing proportion of their care.[48]

Recent research has shown that privatized managed care health providers, non-profit and for-profit alike, go to some lengths to avoid expensive care and uninsured patients, shifting responsibility to public providers. In one 1996-1997 survey of almost 11,000 physicians, doctors deriving most of their income from managed care were considerably less likely to provide treatment to people who could not afford payment.[49] Investor-owned companies in particular, it seems, actively avoid low-income people by screening out those unable to pay.[50] One study showed that 75 percent of for-profit agencies limit access to some types of clients, along with 61 percent of non-profits.[51] If a health facility was located in an area whose low-income population was too high, companies often closed it down. "We simply can't have a hospital on every corner," rationalized a top executive for Columbia/HCA, the nation's largest private hospital chain. "We just can't afford it."[52]

Even when low-income people have some coverage through government agencies, there is evidence to suggest that outcomes at HMOs are distinctly worse for poor patients with chronic health problems

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44 This was suggested by several studies in the early 1980s (for example Pattison and Katz, 1983). By the end of 1998, amid reports of heavy corporate losses, researchers were projecting HMO premium increases of up to 20 percent for consumers whose insurance was issued by their employers, and 40 percent for those with individual policies (Kilborn, 1998c). Meanwhile, a 1997 survey by the California Medical Association indicated that of the state's 15 largest HMOs, medical expenditures averaged only 82.6 percent of the total, with administration and profits accounting for the remainder (Sinton, 1997).

45 Abelson, 1999.

46 Smith, Freeland, Heffler, *et al*., 1996; see also Iglehart, 1999.

47 Freeman, Blendon, Aiken, *et al*., 1987; Sulvetta and Swartz, 1986; Kuttner, 1997.

48 Baxter and Mechanic, 1997.

49 Cunningham, Grossman, St. Peter, Lesser, 1999.

50 Marmor, Schlesinger and Smithey, 1987. See also Dumont, 1992.

51 Cited Bergthold, Estes and Villanueva, 1990, 25.

52 Eckholm, 1994.

than for wealthier consumers.[53] One reason for this differential care is that private insurers have increasingly refused to cover the Medicare and Medicaid recipients who were steered into their plans during the 1980s and early 90s, leaving exclusive responsibility for their treatment to already-beleaguered public hospitals.[54] The result is high rates of disease and morbidity among the American poor, some in de-industrialized urban zones approximating those of deeply impoverished countries. During the last two decades, these indicators have worsened significantly. Several epidemiologists have tried to gauge the relationship between income level and early mortality; according to one of these studies conditions of poverty led to over 91 thousand U.S. deaths during 1991, a rate of 82.3 per 100,000 people, and an 11 percent increase over 1973. Among African-American men the rate was 355 per 100,000, up 39 percent over 1973.[55]

The exodus of private HMOs from Medicaid is a direct outgrowth of their inability to deliver on promises of cost and efficiency benefits, which, during the 1980s and 90s, convinced state agencies and private employers to shift 85 percent of American consumers into HMO plans. A recent report by the Department of Health and Human Services projects that total U.S. health-care expenditures will increase $1.1 trillion between 1997 and 2007, an average annual rise of 10 percent.[56] Indeed, the failure of "managed competition" to hold down costs in the long term indicates a structural flaw in the notion that free markets can deliver more cost-efficient medical care. Over thirty years ago, Nobel Prize-winning economist Kenneth Arrow observed that health is the classic example of an "imperfect market," where consumers cannot understand fully the product, nor producers entirely their clients' needs.[57] In the meanwhile, under the supervision of international finance institutions like the World Bank and IMF, privatization was made an explicit condition of poor countries' debt rescheduling. Although the health sector was relatively peripheral to the IFIs' prescriptions, their impact on it was nonetheless profound.

Privatization of Health Care in Developing Countries

In wealthy communities, the various elements of health privatization are riddled with inequities and contradictions. They focus the resources of a highly-developed and well-funded medical system on an increasingly narrow segment of the population. For those unable to afford fees and premiums associated with private HMOs, they ensure inferior service at more inconvenience and greater out-of-pocket cost. In many cases they fail to guarantee that all citizens will have access to even the most basic health services.

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53 Ware, Rogers, Davies, *et al*., 1986.

54 Kilborn, 1998a; see also Pear, 1998; Kuttner, 1997.

55 Hahn, Barker, and Teutsch, 1996; see also Hahn, Eaker, Barker, *et al*., 1995; Lynch, Kaplan, Pamuk, *et al*., 1998.

56 "Rising Costs in Health Care," 1998.

57 Arrow, 1963. Smith and Lipsky make a similar point in concluding that "[If government health] professionals often find it difficult to evaluate the quality and cost of health care…surely the citizenry will find the task equally if not more problematic" (1992, p. 237). Arrow has argued in a recent interview for a "single payer" centralized health care system as the most rational way to allocate scarce resources ("Interview with Kenneth Arrow," 1995).

But if such grave flaws are endemic to the privatized American model of "managed competition," then their potential impact on countries with weak health systems and vastly more impoverished populations is far worse. Nevertheless, in Peru and many other poor countries that have implemented structural adjustment programs, policies with striking affinities to those of North America are being imposed. Such planning, by one assessment, has four primary elements: decentralization of health planning, finance and procurement; promotion of private insurance plans; contracting out to non-profit entities for primary health care; and the imposition of sizable user fees for drugs and curative care.[58] As in developed countries, these all conspire to reduce the resources available to free public health institutions. And in fact, undermining free health providers is partly a strategic decision by those who design health privatization policies. In the words of one proponent, "If people can obtain health care for free or at a uniformly low cost, they will not have much incentive to pay insurance premiums to cover unexpected health hazards."[59]

The claims, meanwhile, are expansive. Policies such as private insurance are held to "mobilize more resources for health care delivery," and to "promote equity, improve economic efficiency, raise the quality of medical services and allow consumers more choice in selecting and paying for their treatment" in the bargain.[60] Even in utterly impoverished countries like Uganda, one article reported, mission hospitals were able to recoup as much as 95 percent of their operating costs through the imposition of user fees. This development, argued the authors, would "mobilize revenues, promote efficiency, foster equity, increase decentralization and sustainability, and foster private sector development."[61]

In a setting like Uganda where the average person lives on 55 cents daily, the quality of services provided to the poor must be suspect if 95 percent of its cost is paid directly by the consumer. Moreover, the studies which suggested full cost recovery from user fees rarely accounted for ancillary expenses such as administrative costs; as Hammer and Gertler note, "There is little if any credible data on this important issue."[62] Finally, data from many other settings indicate that the collection of user fees have generally contributed little to the actual financing of health care, yielding, on average, only five percent of service costs.[63]

Even when a concerted effort is made to reinvest funds appropriately, it remains ambiguous whether the revenue stream from user fees is indeed sustainable in poor countries. The most fully developed experiment to date is the Bamako Initiative, launched jointly in 1987 by the WHO and UNICEF, which envisioned a network of revolving drug funds financed by charging patients for essential pharmaceuticals. These funds were to be managed at the village level, and stocked by purchases from commercial manufacturers.

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58 Turshen, 1999, p. 47.
59 Shaw and Griffin, 1995, p. 3.
60 Shaw and Griffin, 1995, p. 8.
61 Shaw and Griffin, 1995, pp. 13-14.
62 Hammer and Gertler, 1997, p. 5.
63 Creese, 1991.

The Bamako design has been implemented throughout sub-Saharan Africa, and been rather successful in some venues at maintaining a stable supply of medications—mostly for very small institutions that dispense drugs for a limited range of ailments.[64] According to several analysts, the success of these smaller rural subcenters at recovering costs owes more to the fact that they are residents' only health-care alternative than to their true affordability.[65] And even in these venues, Bamako Initiative funds were far from self-sustaining, in part because they suffered under a flood of inappropriate and expensive drug exports to Africa from pharmaceutical companies in industrialized countries.[66] In the end, then, decentralization of this kind has not proved truly sustainable; it has, however, accelerated the push toward private economies among people who often can ill afford them.[67] This is apparently true *even for public services* that are supposed to be free, as underpaid government employees supplement their income through informal charges.[68]

Ironically, just as Peru and many other countries were implementing health sector privatization on the basis of their recommendations, many World Bank officials had begun to back away from their earlier stance on privatization in general, and cost recovery in particular. The Bank's official strategic document for health and nutrition noted in early 1998 that "direct out-of-pocket health expenditure continues to be a distinctive feature of many low- and middle-income countries." This reality—which the Bank, of course, had long been promoting—was seen to "undermin[e] the social protection that could be provided by the HNP [Health, Nutrition and Population] sector even in low-income settings." Shifting to private providers, they went on, was even less advisable: "Because of cost and the pronounced market failure that occurs in private health insurance, [it]…is not a viable option…in low- and middle-income countries."[69] Meanwhile, countries like Peru were proceeding with their reform packages, which included just such prescriptions.

As in Peru, recent data from around the world suggest a quantifiable correlation between policy innovations such as "cost shifting" and the incidence of public health failures. One study traced a relationship between increased maternal and infant mortality in Zimbabwe and sharp declines in the use of prenatal health facilities after user fees were imposed.[70] Another found that fee increases and the incidence and duration of infectious diseases were directly related; the authors theorized that "prices hurt health…by delaying treatment to the point of reducing the efficacy of medical intervention."[71] A researcher working in Indonesia has even shown that a 100 percent fee hike had a negative effect on health sufficient to reduce labor force participation among women.[72] World Bank health economists do

64 Shaw and Griffin 1995, p. 17; see also McPake, 1993a.
65 Hammer and Gertler, 1997.
66 Goodman and Waddington, 1993.
67 Hammer and Gertler, 1997, p. 12.
68 Okuonzi and Macrae, 1995; cited in Turshen, 1999, p. 50.
69 World Bank, 1998, p. 8.
70 UNDP, 1997, p. 175.
71 Hammer and Gertler, 1997.
72 Gertler and Molynueax, 1997.

not dispute such findings, but minimize their importance, arguing that they are "anecdotal," or that any slack in consumption at public health facilities is usually taken up by private practitioners and "self-treatment"[73]—a category that bears troubling resemblance to suffering in silence.

The 1997 Peruvian Health Law's replacement of government functions with private enterprise makes evident that user fees at public health facilities are only the surface of the privatization model. In a more general sense, market efficiency, the ability to "choose," is rapidly becoming the governing standard of access to care. This is a matter of immediate interest to others besides the Peruvian populace. As early as 1995, foreign insurance companies and health maintenance organizations were already looking eagerly southward at the opportunities presented by neoliberal reformers. In the words of one industry publication,[74] "A new generation of pioneers is emerging as U.S.-based insurers embark on a journey to compete in a Latin American market still in the throes of democratization and privatization." The author went on, "This will open doors to multinational insurance providers with expertise in underwriting and loss control. The forecast, according to many industry experts, calls for a broad acceptance of products and services already developed and delivered by American and European providers." By 1997, private U.S. concerns had purchased public facilities in settings as diverse as Puerto Rico and China.[75]

As recent history in wealthy countries has shown, however, this trend is a serious problem for the most vulnerable segments of the population. Just as with home mortgage loans and grocery stores, private health care is subject to considerations which often have little do with people's needs and everything to do with companies' bottom lines. When profit margins dictate, it is all too easy to "red-line" impoverished areas, rendering the notion of choice a bitter falsehood.[76] The plight of the 40 million uninsured and under-served in the United States will be nothing in comparison to what awaits the poor of Peru, a country whose poverty is much deeper and whose needs are concomitantly greater. As we have seen, even limited implementation of private payment schemes can lead directly to potentially deadly outcomes. To a significant segment of the population, the intensified privatization of health will be almost as bad as no health care at all.

Conclusions

The worldwide adoption of privatization strategies in recent years has gone forward with great fanfare. Free competition and the profit motive, proponents argue, are inherent guarantors of market efficiency, national economic well-being, and even improved health outcomes. When consumers have the right to choose between numerous options, they will invariably pick the best combination of savings and quality; the health-care system, along with the rest of the economy, will become less expensive, more effective, and more productive.

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73 See for example Filmer and Pritchett, 1997.
74 Schwartz, 1995, pp. 36-40.
75 Pallarito, 1997; "Hurdling a Great Wall," 1997.
76 See for example Himmelstein, Wolfe, and Woolhandler, 1993.

In fact, as we see repeatedly, the real world lays such optimistic projections to rest. Even President Reagan's Privatization Commission was forced to admit that health care was a potentially inappropriate venue for competitive markets, given a tendency toward "adverse selection" of good insurance risks in preference to the elderly and poor.[77] Despite this concern, the commission did not substantially modify its recommendations to push forward with the privatization of the health-care system. As many poor and elderly Americans have discovered, the most pertinent choice afforded by health-care privatization consists largely in insurers' tendency not to choose *them*.

In developing countries, the principles of privatization have been applied to health services with similar disregard for the health of the poor and marginalized. The apparent failure of "cost recovery" as a means of funding health care in poor nations, acknowledged in passing by development specialists, has meant only that this strategy would give way to more fully private provision, under the slogan "financing demand but not supply." The capriciousness of such policy shifts highlights the lack of accountability with which multilateral agencies have designed, disseminated and implemented their models. The penalties for failure have been borne by the poor, the infirm and the vulnerable in poor countries that accepted the experts' designs.

As in most indebted countries, debt service is now one of the Peruvian government's largest budget items, amounting in 1996 to about 24 percent of total expenditures.[78] Given its external debt obligations, the Peruvian government has limited latitude in setting social policy. The successful campaign by international financial institutions to undermine the Garcia government in the 1980s has served subsequent administrations, in Peru and elsewhere, as an inviolable object lesson. Judging, however, that juxtaposing debt service and reductions in health-care expenditures would not be well received, Peruvian health planners attempted to convince poor citizens and their advocates that cutting overall expenditure on health was *desirable*. To this end, the Law of 1997 was offered. Through it, and through the "efficiency" and "choice" which it claimed to promote, the Peruvian health-care system would function better and more fairly.

Where the country's poor are concerned, this contention is suspect. Amid the deep misery of districts like Carabayllo, we see once again that the poor of Latin America are being enlisted to help make up budget shortfalls they did nothing to cause, so that debt they did nothing to incur can be repaid endlessly. Not only is this inequity a moral wound in the Peruvian polity but it is also, with the inexorable logic of disease and mortality, a physical one as well.

Indeed, opposition to policies like Peru's health reform should not rest solely on abstract moral grounds. Benedicta's illness, tuberculosis, is a mortal threat to the public health and acts as a significant brake on overall productivity.[79] In recent years TB has grown markedly in poor countries worldwide, largely among the most vulnerable members of the population.[80] The case of Benedicta Sanchez makes clear that even partial privatization of the responsibility for health services can lead to non-treatment and

77 Linowes et al., 1988, p. 194.
78 Calculated from IDB, Economic and Social Database.
79 World Bank, 1993.
80 WHO, 1998.

the propagation of a deadly disease—this, even in a country that boasts one of the finest TB control programs in the world. Though the actual cost of treatment for her disease would have been borne by the state, Benedicta "chose" to forego a definitive diagnosis of tuberculosis so that her family could eat. By imposing the criteria of choice on people who are in no position to exercise it, health-care reformers have prioritized financial outcomes over health outcomes and further imperiled the health of the poor.

Are there alternative paths? Does it matter that the poor were not a party to the debt burden assumed by Peru's elite rulers over the last 30 years? Would it be unjust to hold those who stood to profit most from loans responsible for their repayment?[81] Such an "historical accounting" of national debt is by no means an unprecedented notion. In the former Zaïre, for example, negotiations with international finance institutions have been intertwined with the effort to unseal the Swiss bank accounts of Mobuto Sese Seko's kleptocracy. Alternatively, the banks that participated in the "orgy of lending" to Latin American governments in the 70s and 80s could be held accountable for their imprudent loans—a solution applied as a matter of course in the First World.

Another, much more modest proposal would be to extend to poor debtor states the progressive bankruptcy exemptions that residents of wealthy countries take for granted. In the United States, for instance, bankruptcy laws ensure that someone who owes $5000 to a credit card company need make payment on that debt only in amounts that permit her to buy essentials like food, shelter and medical care. Meanwhile, in Peru and other poor countries, public indebtedness has caused whole populations to go hungry. Recent moves by the IMF and World Bank to enshrine the principles of bankruptcy law on an international level, among them the Highly Indebted Poor Countries (HIPC) Initiative, have been sharply limited in scope and ambition.

In Peru, as elsewhere, drawing the boundaries between the public and the private is a contested endeavor. While this debate proceeds, millions throughout the world die because they cannot pay for essential medical treatments. The debate over health-care privatization, then, should open up a larger, more difficult question: the need to understand the process by which burdens in human social life come to be considered public or private responsibilities. To Peru's policy makers, at home and abroad, it is clear that the country's external debt will remain a public burden. Meanwhile even the poorest Peruvians are finding sickness and health to be increasingly private affairs.

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[81] See Iguiñiz, 1995.

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THE IMPACT OF STRUCTURAL ADJUSTMENT POLICIES ON HEALTH & HEALTH SERVICES IN THE CARIBBEAN

Elsie Le Franc

There is now abundant evidence of the significant and even enduring association between poverty, socio-economic status, and health (Arber 1997; McIntyre 1997; Townsend et al., 1990). Health inequalities and differentials have not only been documented in a wide variety of countries, but have also been found to persist in spite of changing illness profiles for the country as a whole, and/or of general increases in national income levels (McIntyre 1997). However, there continues to be a great deal of debate on the questions of causation and explanation. Several factors have been identified as the possible causes of health inequality, and at different times have included, for example: gender, ethnic status and culture, income, occupation and labor market status, lifestyles, and the social and physical conditions at the workplace (Arblaster et al., 1995; Blaxter 1990; Davey-Smith et al., 1990; Duncan 1996; Hillier and Kelleher 1996). But by and large the specific causal pathways are still not as clear as might be desired. In this ongoing search for the socio-economic risk factors, it has not always been easy to distinguish "markers" from "cause."

Since structural adjustment policies were implemented as the antidote for the economic difficulties experienced by many of the countries in the developing world, there have also been a number of studies which have sought to determine the impact of these policies on the social sector in general, and on the situation of the poor, in

particular. The influential work *Adjustment with a Human Face* was one of the earliest and more well-known attempts to document the negative impacts of these policies, and suggest more humane or equity-sensitive economic growth strategies. In most instances, however, and certainly in the Caribbean region, the analyses of the cause-and-effect relationship between structural adjustment on the one hand, and the increase or exacerbation of social problems and inequities on the other, have more often than not depended on the examination of apparently associated trends and patterns, and on before and after analyses. In so doing, at least one critical assumption has been necessary: if structural adjustment policies appear to be associated with increasing poverty and socio-economic inequality, then since these latter two variables are known to be linked to poor health status and health inequalities, the policies *ipso facto* must be the cause of any deteriorating health status and increasing health inequality that one has been able to document. It has usually been expected that this can take place along one or two of the following paths: on one, the adjustment policies directly influence and shape the social and economic factors that in turn impinge on health status and health service utilization; and on the other, the policies undermine the ability of the health care system to deliver adequate and quality care, and in so doing contribute to health status degeneration.

It is not necessary to get into the debate on whether it is the policy itself, or its inadequate, inefficient, or insufficient implementation that constitutes the real source or cause of the social problems that would seem to be linked with SAP implementation with a remarkable degree of regularity. However, it must be conceded that SAPs could well be one of *several* factors influencing health status and health inequality. Further, the expected link between the character of the health infrastructure and health inequality may not be as simple and straightforward as anticipated. In a recent paper by Wagstaff (1998), it was argued that health inequalities do not appear to be particularly, nor necessarily associated with the structure and organization of the health delivery systems. Comparing the health situation in a number of developed and developing countries he found that the degree and character of the health inequalities in countries with widely differing health systems did not follow the patterns anticipated. Thus, for example, the heavily private sector-dominated health system in the USA and the more equity-conscious national health service in the UK showed rather similar types and degrees of health inequity.

In the Caribbean, the search for cause-and-effect relationships is hampered by the insufficiency and unevenness of the available data. The kinds of time series data necessary for meaningful or conclusive analyses are often non-existent, or of uncertain quality. SAPs were implemented in Jamaica, Trinidad and Tobago, Guyana, Barbados and Grenada; but Jamaica was the only country in which the period of "adjustment" exceeded 3 years. In Guyana there were "on-and-off" arrangements with the IMF over a period of about 12 years, but if the periods during which the relationship was suspended or terminated due to the failure to satisfy IMF's requirements are extracted, the actual periods of "adjustment" was relatively short. In Jamaica, the formal program of borrowing form the World Bank began in 1982, but if one includes the years when the government found it necessary to draw on IMF credit and therefore adhere to its regulations and conditionalities, it can be argued that this country was subjected to SAP measures for almost 20 years (1973-1992).

Jamaica would therefore seem to be the best and most feasible case for the investigation of the possible effects of SAPs. Moreover, while it is possible to examine mortality trends in most of the countries mentioned, morbidity data series that could give some indication of the changing patterns of the disease burden do not exist. Something could be said about the trends in communicable diseases, and it might be possible to infer something from these conclusions about the changes in the public health system. But it is not really reasonable to try to draw significant correlations or even causal associations. In Guyana for example, there had been a long period of economic decline—certainly since the mid-1970s—prior to the formal introduction of SAPs in the 1980s. It is true that this is one of the few English-speaking Caribbean countries in which life expectancy has actually fallen (from 69 years to 64 years over the 1980-92 period). According to all the poverty estimates, Guyana has the largest proportion of persons below the poverty line, and under-nutrition, and communicable disease such as malaria, gastroenteritis and malnutrition persist at alarmingly high levels. However, there is very little available data that would allow the kind of analysis required to conclusively establish causal and specific relationships with SAPs.

Many of the countries in the region such as Guyana, Trinidad and Tobago, Belize, Grenada and St. Vincent have conducted surveys of living conditions and/or poverty assessments. In these countries it is possible to explore the relationships between poverty and health status. However, only in Jamaica have these surveys been conducted systematically over a long enough period; in all others they were individual studies. Since 1989 the Planning Unit of Jamaica has fairly consistently collected data on a range of social and demographic conditions and behaviors, and has also sought to estimate the levels of poverty on a regular basis. For all of these reasons, we have decided to focus almost all our attention on Jamaica as a case-study even though the remit calls for a Caribbean-wide analysis.

Structural Adjustment in Jamaica

Structural Adjustment programs are normally designed to stabilize the economy and re-orient it toward private-sector production and management. They are also supposed to shift resources from consumption to investment. During the period in question, at least three agencies (IMF, World Bank, & USAID) were integrally involved in the formulation and application of the macro-economic policies. Joint missions established cross-conditionalities and recommended measures on a uniform basis. It is therefore difficult to disentangle the specific impact of Structural Adjustment, and it is instead more feasible to talk of macro adjustment policies (MAPs). MAPs had a fairly constant set of policy prescriptions and objectives, which may be listed as follows:

- Liberalization of exchange controls and currency devaluation;
- Limits on public borrowing and spending through budgetary cuts, the removal if subsidies and divestment of state-owned enterprises;
- Tight limits on wage and salary increase, and the removal of price controls;

- Severe limits on domestic credit, particularly to the public sector, and the pursuit of high interest rate policy so as to contain liquidity in the economy; and
- Liberalization of the import regime.

MAPs had the very clear effect of increasing the cost of living. Basic food subsidies were removed, and there have now been a number of studies showing the fairly clear linkage between the monetary and exchange rate policies on increasing inflation (Bennett 1993; 1994). In Figure 1 we show the changes in the exchange rates, and in the consumer price index. The fairly parallel movement of both indices can be seen.

FIGURE 1.

Figure 1A.

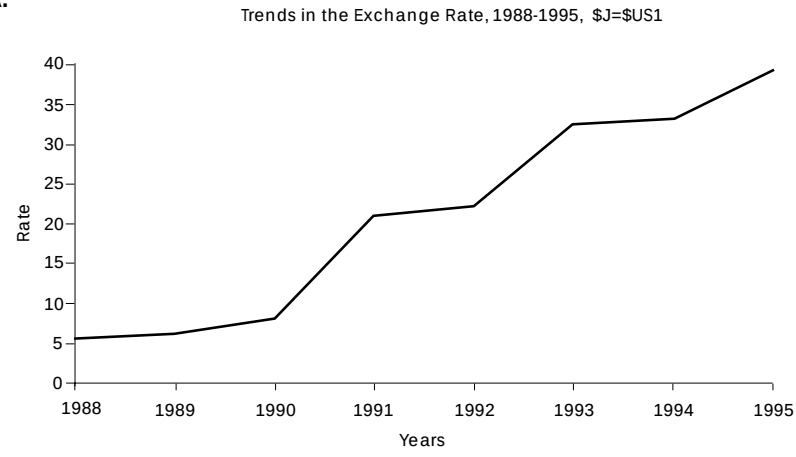
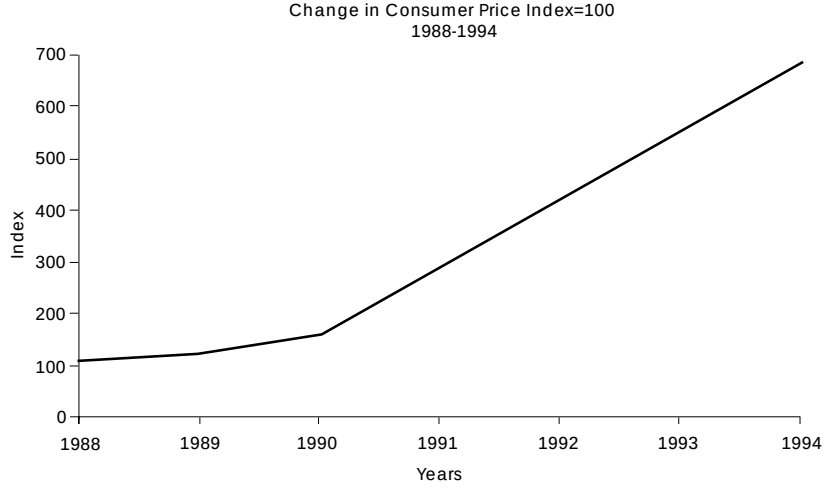
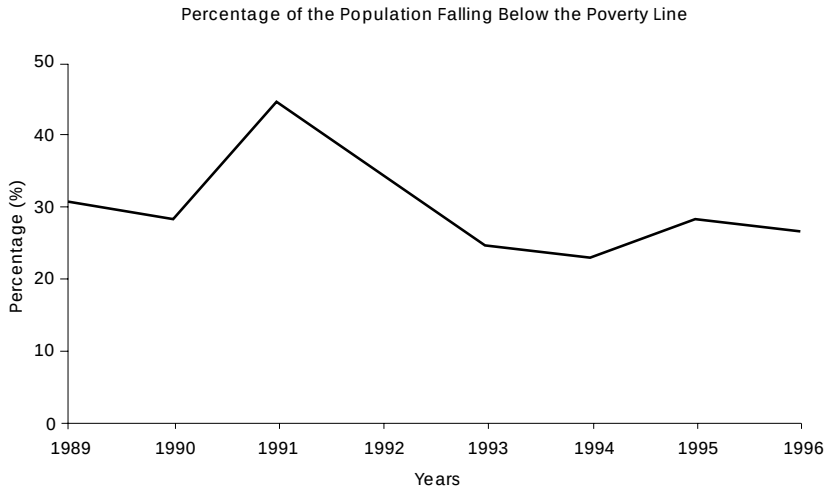


Figure 1B.



Over the 16 year period (1980-1996) in only 4 years did the GDP per capita (US$) grow by more than 4%. In all other years the growth rates were either negative or less than 3%. Indeed the average growth rate for the entire period was a mere 0.048%. Any growth experienced, for example between 1987-1992, was largely in the bauxite and financial sectors; the manufacturing sector largely disintegrated, and the productive agricultural sector—with the occasional exception of the non-traditional segments—has been in general decline. Most recently, the financial sector has experienced major decline and fall-out; and the rather severe and widespread character of this collapse could well be an indication of the fragile and ephemeral nature of the earlier growth. In this economic climate the labor force participation rates among males in particular began to show downward trends, unemployment rose, and the wage labor market contracted. This rather relentless economic stagnation and decline are reflected in the consumption and poverty data generated by the Surveys of Living Standards for the 1989-96 period. In Figure 2 we show the pattern since 1989.

FIGURE 2.



The downward trend in consumption, as well as the growing numbers falling below the poverty line, are clear. The devaluation and deregulation policies appeared to have had the greatest impact in 1991: the proportion of the population falling below the poverty line was very high (45%), and consumption levels very low. The recovery in 1993/94 was short lived, as the trend resumed its downward movement. In general, the inflation control policies did not continue even when very little growth occurred. Over the 1990-96 period, general consumption fell by 5%; the consumption of food and beverages decreased by approximately 7%; personal care by 30%; and education and recreation by 27%. There were also negative changes in the

consumption of poultry, fish and cereals (SLC 1996). The greatest changes in consumption were in the Kingston Metropolitan area. This was also the only area to show continuing increases in the proportion of the population falling below the poverty line. For the country as a whole, the only areas showing increased expenditure were in health care, transportation and housing expenses. We shall return to this point shortly.

The Health Sector

In light of this stubborn persistence of economic failure, what have been the fortunes of the health sector? Two aspects will be considered: health status and health utilization patterns.

Health Status

Given the foregoing discussion, the picture presented by the data from the SLC is both puzzling and surprising. In Table 1 we show the trends in self-reported illness for the 1989-1996 period. They suggest two conclusions: the poorer quintiles are healthier than the wealthier ones; and levels of reported illness have fallen.

Table 1. Percent of Persons Reporting an Illness in a Four-week Reference Period 1989-1996

	1989	1990	1991	1992	1993	1994	1995	1996
Quintile 1	14.9	17.3	12.1	10.1	12.1	13.5	10.4	9.6
Quintile 2	17.1	16	14.4	9.8	12.8	13.6	10.5	11
Quintile 3	17.1	16.3	14.1	11	12.5	13.9	7.5	10.2
Quintile 4	17.9	22.1	11.7	10.8	10.4	11.3	10.1	10.6
Quintile 5	17.1	19.8	16	11.4	11.3	12.2	10.7	12.2

Source: Survey of Living Conditions, 1989-1996. STATIN, Jamaica.

Not only is this counter intuitive, but it also flies in the face of the experiences of most other countries in the world. However, when we look specifically at the reports of protracted illness, the association between level of consumption and the reported incidence of this type of illness is clearer and closer to the expected direction. The data are provided in Table 2.

Table 2. Percent Reporting a Protracted Illness, by Consumption Quintile 1990-1996

	1990	1991	1992	1993	1994	1995	1996
Quintile 1	24.9	26.8	40.8	37.1	32.8	25	32.1
Quintile 2	24.8	27.8	34.6	34.6	29.8	30.4	27.6
Quintile 3	17.6	34.5	35.2	26.1	26.4	35.4	34.3
Quintile 4	16.9	23.9	35.4	43.9	36.4	34	37
Quintile 5	15.6	15.9	28.6	36.7	26.2	36.3	31.3

Source: Survey of Living Conditions, 1989-1996. STATIN, Jamaica.

Even so, the data is somewhat misleading. A first examination of these data suggests that not only is the incidence level increasing, but also that the poor may be bearing a disproportionate amount of this increase. The percentage reporting a protracted illness rose from 19.6% in 1990 to 33.3% in 1996. In 1990, of those in the poorest quintile who reported an illness, 25% indicated that the illness was a protracted one. By 1996 this percentage had increased to 34%. The comparable figures for the wealthiest quintile were 16% and 32%, repectively. However, additional manipulation of the data shows that if protracted illness is calculated as a percentage of the total sample rather than of the number of persons reporting an illness, the level is in fact quite constant—ranging only from 3.1% to 4.3%.[1] Exploration of other data such as those on hospital utilization does show rather significant increases in the incidence rate of chronic diseases such as diabetes mellitus and neoplasms. But it will be necessary to ask if the differential reported incidence of protracted illness has been presented as a proportion of total illnesses or of the total sample.

I will return to this issue shortly, but first it is necessary to point out that there are a number of other reasons why it is important to look more carefully at the SLC data. In particular, it is difficult to accept that the poor are healthier than the rich, and in spite of falling consumption levels and rising poverty, are getting healthier. One reason we may question this finding is that the same SLC data set shows that all quintiles report increases in the proportions seeking medical care. In the lowest quintile the figure jumped from 44% in 1989 to 55% in 1996. Over the same period, the change for the wealthiest quintile was more modest—moving from 52% to 58%.

[1] Personal communication from Kristin Fox, ISER, UWI. October 1998.

FIGURE 3.

Figure 3A.

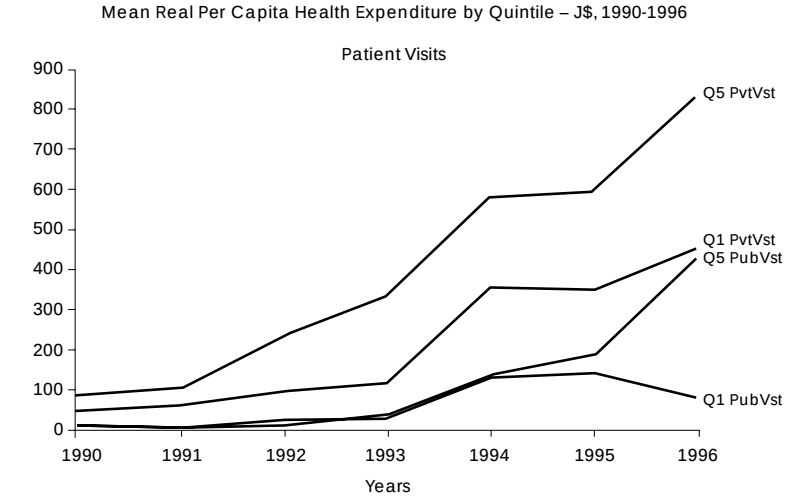
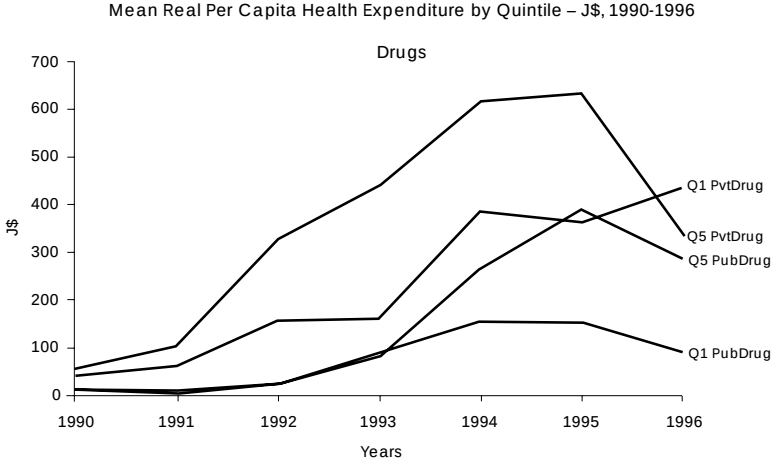


Figure 3B.



Also, data on curative visits to health centers for diseases that are often sensitive to the state of the public health sector as well as to living conditions, suggest that there is a fair amount of slippage. Hospital utilization data show that the rate for gastroenteritis rose 70% over the 1989-96 period. By 1996 it was in fact the second leading cause of morbidity. Similar trends may be observed in respect of acute respiratory infections: the number of curative visits to PHC facilities increased by 23% (Economic and

Social Survey of Jamaica 1989-1997).[2] The incidence of skin diseases also rose: whereas up to early 1990 they accounted for about 5% of total visits, by 1997 this figure had moved to 7%. Finally, as will be seen later, there is evidence that the highest levels of hospitalization occur among the 2 poorest quintiles, and at greater rates of increase than among the wealthier quintiles.

Out of all of this at least three questions immediately arise: first, what do the real increases in out-of-pocket health expenditures really mean? Clearly the introduction of user fees and other forms of cost sharing will account for some of these increases; but how much of this may also be explained by the increased incidence of illness, and/or the fact that illnesses are probably being presented later and their management are therefore probably more costly? Second, are illnesses being generally underreported in the survey unless their presence is chronic and cannot be easily ignored? Recalling the discrepancy between protracted illness as a percentage of reported illness versus of the total sample of persons, the logical explanation is that there is underreporting somewhere; but is it acute illnesses that are being underreported? If so, is it the poorer individuals who are underreporting? Until and unless there is a firmer understanding, it is difficult to meaningfully interpret the data in the table showing an apparent closing of the gap between the incidence of protracted illness between the poor and the rich.

There is however a very general question here that needs to be addressed: are there changing perceptions of illness that are being affected by having to make difficult choices in an increasingly tight economic situation? Related to this is the possibility that individuals may be looking for alternative forms of health care or even delaying the search for medical care. This could help explain the increasing role of hospitalization in the health care system, and also that there is a slight increase in the severity of illness as indicated by the mean number of days of impairment: this moved from 4.7 in 1990 to 6.3 in 1993 and 6.0 in 1996. In this regard, it is interesting to note that in Guyana—the other English-speaking Caribbean country with long periods of economic decline and a fairly substantial experience with MAPs—the poor appear to be healthier than the non-poor, and the severity of illness is also higher among the poor (Theodore 1997).

There is another possible explanation of the puzzle referred to earlier, and with which we have to grapple. If it is indeed true that the poor are healthier than the rich (especially in respect to acute illnesses), might any of this be explained by the early toll of violence? Examination of hospital discharge information confirms the general impression that in Jamaica, violence places excessive burdens on the health care sector. From as far back as 1988, either Accidents/Poisonings/Violence or Trauma/Injury has been one of the top 2 causes of morbidity. In 1997 the leading causes of both mortality and morbidity were accidents, injury and septicemia (Health Information Unit; Economic and social surveys of Jamaica 1989-1997). Violence might not necessarily be caused by poverty alone, but it is not unreasonable to expect that tight and worsening economic conditions increase the risk of crime, and interpersonal conflict and violence. An interesting exercise might well be to compare the differential life expectancy rates of persons

[2] Some of this increase could be explained by the increasing use of the public health sector after 1995; but certainly not all, as the trends were not always in the same directions.

in the different quintile groups. Another information gap that urgently needs to be filled is the trends in mental illness. Anecdotal and impressionistic information suggest that there are significant increases here, but as yet there are no meaningful data that may be used.

Health Services Utilization

The impact of MAPs on health expenditure has been marked, and has had predictable consequences on service utilization patterns. Real official expenditure declined significantly over the entire period, and relative to other Caribbean countries remains quite low. Real per capita expenditure, at US$ 25, was one of the lowest in the region. Expressed as a percentage of total expenditure, it fluctuated quite significantly, but over the 1982-1995 period fell from 7.2% to 5.7%. In general, capital expenditure suffered to a greater extent than did recurrent expenditure, although this too suffered declines as the tertiary sector increasingly accounted for a greater share of the public expenditure at the expense of the more human resource intensive primary health care sector (Caribbean Health Reform 1996). Conservative estimates of public health care system put the shortfall in 1997 at approximately J$ 333 million (Theodore 1997).

The main consequences of these fluctuations and cutbacks have been declines in medical supplies and the availability of drugs, deterioration of in the hospital infrastructure, chronic shortages in health personnel, and a serious decline in routine preventive maintenance. The accompanying degeneration in the quality of service largely explains the decline in the use of the public sector and the sharp increase in the use of the private sector. By 1994 private out-of-pocket health expenditure accounted for approximately 66% of total health expenditure. Similarly, private expenditure on pharmaceuticals has been estimated at 70% of all drug expenditure (Yearwood 1997). The introduction of user fees in the public health sector and the increasing economic stringencies will help to explain the return of many to the public sector, as may be seen from the figures in Table 3.

Table 3. Number of Curative Visits to PHC Facilities 1986-1997

1986	1,309,598
1987	1,062,486
1988	976,713
1989	1,019,182
1991	1,040,533
1993	780,687
1994	743,495
1995	656,000
1996	809,824
1997	831,110

Source: Economic and Social Surveys of Jamaica, 1986-1997.

The search for care varied over the period and would seem to indicate 3 things: the effect of economic hardship; the search for services, and probably doctors; and the increase in hospitalization. The percentage of those reporting illness and seeking medical care rose from 49% in 1989 to 55% in 1996, even though there was a dip in the very difficult 1990-91 period. The poorer showed greater fluctuations in use. Theodore's 1997 analysis of the SLC data revealed that "in the relatively prosperous year of 1989, 44% of those [in] the poorest quintile who reported illness sought medical care. With increased economic hardship from 1990 onwards, the percentage declined to as low as 35% in 1992, before rising to 53% in 1996."

Secondly, fluctuations in the use of the primary care sector are off-set by the use of the out-patient facilities, which could be taken as one indication of the search for better curative services, as shown in Table 4.

Table 4. Level of Care (%) of Respondents Used 1989-1996

	Primary	*Out-Patient*	*Hospitalization*
1989	75.7	18.9	2.9
1990	74.3	21.2	4.5
1991	75.7	18.5	5.8
1992	72.0	17.7	3.5
1993	68.3	24.8	3.8
1994	78.1	15.7	5.4
1995	76.6	17.9	6.2
1996	74.6	20.8	5.4

Source: Survey of Living Conditions, 1997.

Thirdly, the rising trend in hospitalization is clear—moving from 2.9% of those ill in 1989 to 5.4% in 1996. The 2 poorest quintiles show both greater utilization of the hospital and fluctuations in its use. This could support the argument that the severity of illness and late reporting appear to be highest among the poorest groups. Since it is the poorest who largely utilize the public health sector, it is not difficult to discern the likely impact of service deterioration on their health status, as well as on their perceptions of proper health-seeking, or illness-management behaviors.

Conclusion

The data on health status trends in Jamaica present a somewhat confusing and even contradictory picture. Nevertheless, from the analysis of the annual Surveys of Living Conditions, as well as aggregate data reported by the Health Information Unit, it seems possible to suggest by way of a conclusion that

the relentless economic stagnation and deterioration, and its associated declines in consumption patterns are, at a minimum, associated with increases in non-immunisable communicable diseases, the incidence of acute respiratory tract infections, cardiovascular disease, and the level of violence. The downward movement of many of the social and health indices during and after 1991, when the adjustment was particularly harsh, is striking. Perhaps the more critical issue however, is the negative impact on perceptions of illness, illness management, and health-seeking behaviors. If indeed the need to make difficult choices in stringent economic circumstances is inducing less attention to primary health care, changing definitions and perceptions of illness, greater delays in the search for health care, and the consequent increase in illness severity and hospital use, then urgent attention needs to be given to the identification of community-oriented mechanisms to correct such a trend. Considerably more work, especially of a qualitative kind, is needed to help disentangle the complex of factors involved in this evolving pattern, if appropriate policy measures are to be formulated.

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MALARIA CONTROL IN NICARAGUA:

Political and Social Influences in Disease Transmission and Control Activities

Richard Garfield

Malaria has long been a major health problem in Central America. The annual number of reported malaria cases in Central America tripled from 1975 to 1980.[1] Although Central America contained 3.5% of Latin America's population, it accounted for one-third of all reported malaria cases in the hemisphere.[2] Nicaragua's post-1979 malaria control program substituted earlier insecticide-based control strategies to emphasize community education, recognition of mosquito breeding sites and clinical symptoms, increased training and supervision of auxiliary staff, and improved access to sites for early treatment.

Up to 60% of the Nicaraguan population had malaria during the 1930's. From 1934 to 1948, 22.4% of all registered deaths were due to malaria. Up to 70% of all hospital beds were occupied by malaria patients during epidemics. Mortality due to malaria progressively declined after a national malaria control program was started in 1947, but incidence rates did not. By 1979, vector control activities had come to a near halt during the revolutionary war and malaria incidence rose rapidly.

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1 Pan American Health Organization. *Status of malaria control programs in the Americas*: 33rd annual report. Washington, D.C.: PAHO, 1985.

2 Wernsdorfer, W.H. The importance of malaria in the world. In Kreier, J.P. (ed), Malaria. Volume one: Epidemiology, chemotherapy, morphology and metabolism. N.Y.: Academic Press, 1980.

A nationwide mass drug administration campaign in 1981 involved many community groups and about a third of the population in malaria control efforts. Since 1982, community involvement in malaria control was greatly expanded. During 1983-1989, Nicaragua experienced the 'contra' war. Contra attacks on the civilian population limited voluntarism for health, education, and agriculture development activities. Diagnostic and treatment facilities remained intact in most of the country but preventive anti-malarial activities were reduced in scope in remote and war zones.

In 1990 national elections took power away from the FSLN party, and 'de-socialization' of the health system, which had begun in the late 1980s, accelerated. Public per capita medical care visits declined from an estimated high of 89% of all visits in 1983 to 66% in 1992; the proportion of all prescriptions provided through the public system of care declined from 75% in 1983 to 34% in 1992. By 1994, a three-tiered system of care had been reestablished. Public hospitals served the indigent, social security services served those with salaried jobs in the industrial sector, and private care was widely available for the affluent. International lending institutions encouraged further privatization, decentralization, and cost recovery efforts in the health system. The government nonetheless maintained an extensive public health service infrastructure. Subsequent elections in 1996 led the country to the political right, disbanding of the Sandinista army, and decreased funding for public health services. The effects of this process of defunding and decentralizing health care on malaria and malaria control are analyzed here. A plea is made to reorient economic structural adjustment policies to improve malaria control.

Background

The main malaria vector in Central America, Anopheles albimanus, tolerates a wide variety of breeding conditions. Its preference is for sub-lit pools. Highest adult densities occur during the rainy season (September-January). The vector is predominantly zoophilic with only 20% of females feeding on human beings in typical Central American transmission conditions.[3] Its tolerant breeding habits, it intermediate flight range, the high densities of adults during the rainy season, and the rapid development of resistance to residual insecticides make vector control difficult. It has exhibited resistance to all insecticides in common use, including DDT (dicophane), dieldrin, malathion, propoxur and chlorfoxim.[4]

In most years, 5-10 cases of malaria are reported per 1000 inhabitants in Nicaragua. At this level of transmission, long-lasting human immunity to malaria is lacking.[5] The proportion of cases diagnosed as *Plasmodium falciparum* (*P falciparum*) varies from 8% to 30% of all cases. The lowest proportion of P falciparum cases occurs in the years of lowest transmission of malaria. This may be explained by the longer

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extrinsic period needed by *P falciparum* than by *P vivax* for development in the mosquito; control measures that shorten the average life span of the vector reduce *P falciparum* cases more than *P vivax* cases.[6]

Epidemiological assessments are based on surveillance data collected each month by the Division of Control and Eradication of Malaria and Aedes (DICEMA) of the Ministry of Health. These data are generated by passive case-finding by volunteers and health professionals who treat suspected (from symptoms) or confirmed (from blood smears) malaria cases. Data on insecticide use and breeding site control was compiled from monthly DICEMA reports.

Mass Drug Administration

During the years of FSLN administration from 1979-1990, the number of primary health care facilities tripled, private medical practice was restricted, user fees were eliminated, and volunteers and paramedical personnel were involved in health campaigns in poor urban and rural areas.[7] Most of these services were maintained, albeit in impoverished form, as a safety net during the country's economic decline in the late 1980s.

In the light of increasing incidence of malaria during revolutionary war of 1979 and building on the enthusiasm of other health campaigns in 1980, ambitious goals were set for the 1981 Mass Drug Administration (MDA) campaign. Broad chemotherapeutic coverage was to be achieved throughout the country simultaneously to:

(1) prevent new malaria infections
(2) cure subclinical cases; and
(3) reduce the transmission of malaria.[8]

MDA has generally been used to reduce morbidity and mortality during epidemics or to prevent infection among selected groups of individuals.[9] The target population was so large as to be unique in the history of malaria control with MDA as the prime means of control.[10]

Results of the 1981 MDA

The total number of reported malaria cases fell considerably from November 1981 to February 1982.[11] The decline began a month before the MDA, during a breeding-site control campaign. The MDA

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11 Garfield, R.M. & Vermund, S.H. Changes in Malaria Incidence After a Mass Drug Administration in Nicaragua. *The Lancet* 1983; 2: 500-3.

had a differential impact on the two parasite species. Although the incidence of P vivax cases had returned to endemic levels by March, 1982, the number of P falciparum cases continued to decline and stayed below endemic levels for three more months before surpassing endemic levels in June, when flooding throughout the country led to unseasonably high levels of mosquito breeding.

Taking the monthly average of the prior two years' incidence rates as a baseline, there were 9200 fewer cases of malaria than expected during the four months of reduction in general incidence. The reduction was 1500 cases in October and 7700 from November to February. In view of a heightened awareness of the population toward symptoms of malaria as a result of the campaign, the reporting of symptomatic cases likely improved after the MDA; the decline in reported malaria incidence for the four months following the MDA is therefore a minimum estimate.

Community Involvement

MDA campaign activities in 1981 engendered unprecedented involvement of both the general population and the public health authorities in malaria control. Widespread community mobilizations for malaria control are rare in the Americas.[12] Starting in 1982, community-based organizations in Nicaragua helped promote improved sanitation, including vector breeding site reduction. They administered educational programs to improve case finding, and followed patients to increase compliance with treatment. The community volunteers served to rapidly mobilize resources for chemotherapy and breeding site control during local outbreaks. Insecticide spraying for control of adult mosquitoes was reserved for such outbreaks, due both to the widespread resistance to Anopheles albimanus in Nicaragua and to the high costs of pesticides.[13] This community-based control strategy was based on continuous epidemiological assessment of routine data for planning locally-designed control activities.

MINSA, the Nicaragua Ministry of Health, subsequently stratified communities according to the level of their transmission potential to determine when and where to supplement conventional malaria control activities with focal MDAs and breeding-site control activities. Such efforts, when targeted towards specific high-risk areas and populations, proved to be very effective for malaria control in Nicaragua in the1980s.

The Contra War

'Contra' attacks first reached high levels during the summer of 1983.[14] Eight of the country's 16 states were repeatedly subject to 'contra' attacks. These states are the same ones that the government

12 Garfield, R.M. & Vermund, S.H. Health Education and Community Participation in Mass Drug Administration for Malaria in Nicaragua. *Soc Sci Med* 1986; 8: 869- 78.

13 World Health Organization. *Chemotherapy of Malaria and Resistance to Antimalarials. Technical Report Series* #529. 1973 and World Health Organization. Malaria Control in Countries Where Time-Limited Eradication is Impracticable at Present. WHO Tech Rep Ser # 537. Geneva, 1974.

14 Garfield, R.M.; Frieden, T. & Vermund, S.H. Health related outcomes of war in Nicaragua. *Am J Pub Health* 1987; 77: 615-8.

identified as the 'war zone.' The other eight states were rarely or never subjected to military attack, and their data were aggregated as the 'non-war zone.' The non-war zone states are those in the west and northwest, which account for 1.9 million people, while 1.3 million live in the war zone states.

The absolute numbers of recorded malaria cases from 1974 to April 1985 from the eight states experiencing the most military hostilities (war zone) were compared to the eight states without such activities (non-war zone).

Results of Community Involvement and Contra War

A divergent trend is evident in the period that began with the 1981 Mass Drug Administration campaign and the 'contra' war which followed it. Ninety-six percent more slides were examined for malaria parasites during January 1983-April 1985 in non-war areas than the average during those months in the 1974-82 baseline period. Increased sampling occurred in each of the eight states in the non–war zone. This rise in the number of slides tested accompanied a 62% decline in the number of cases reported. Almost 11,000 fewer cases were reported from January 1983 to April 1985 than were predicted by the 1974-82 baseline.[15] This figure is considered a minimum estimate of the decrease in cases given the near-doubling of the number of samples tested. Expected seasonal fluctuations in incidence were largely suppressed at these low levels. The decrease in the proportion of all cases diagnosed as *P falciparum* was greater than the reduction in the overall number of malaria cases. An 88% reduction in *P falciparum* cases occurred, nearly leading to the disappearance of this species in the non-war zone.

There was a similar rise in the number of slides tested in the war zone during January 1983-April 1985 (1974) compared to the 1974-82 baseline. This rise was maintained even after contra attacks increased during mid-1983. The number of reported malaria cases in the war zone rose 17%, yielding 3650 cases in excess of expected levels from January 1983 to April 1985. Despite a rise in the number of cases reported, *P falciparum* cases fell by 56%.

Structural Adjustment Programs

The collapse of state socialism in Eastern Europe, recession, and the increasing influence of international banks over health policy in developing countries resulted, together, in a wave of privatization and defunding of government-run social welfare programs in many developing countries in the 1990s. These pressures were great in Nicaragua, where the Sandinista Party in 1990 was the first socialist-oriented regime to peacefully relinquish power following electoral defeat. In 1990 a centrist government took power, pledging to shrink government and implement free-market policies in all sectors, including health.

MINSA struggled to maintain the public system of health care. Privatization, nonetheless, occurred

[15] Garfield, R.M. & Vermund, S.H. Health Education and Community Participation in Mass Drug Administration for Malaria in Nicaragua. *Soc Sci Med*; 8:869-78.

through reduced health sector employment, closing of primary care sites, institution of user fees, designation of private beds in public hospitals, loss of international aid, the withdrawal of social security funds, substitution of the ethos of service for that of entrepreneurialism, and the relaxation of administrative mechanisms that had limited the role of hospital-based curative care. Only 20% of the $68 per capita spent on health was private in 1983; by 1992, 48% of the $41 per capita spent on health in Nicaragua was private.[16] These trends accelerated following the election of a rightist president in 1996 and the subsequent further strengthening of the role of the World Bank and Inter-American Development Bank in health services and policy.[17]

Structural adjustment policies are designed to achieve economic growth through the promotion of free international markets. Budget deficits are reduced through cutting public expenditures, especially in unprofitable sectors of the economy such as health. Demand for imported goods is reduced through devaluations of national currency. Export-oriented sectors of the economy are promoted, government-run industries are privatized for purchase by foreign firms, and wage protections and public subsidies are eliminated. Local government becomes more important as a decentralized coordinator of private resources than as the distributor of central government resources.

In Nicaragua, malaria control was supposed to be protected from privatization under the structural adjustment program. It was understood that malaria is mainly a disease affecting the very poor, who would not likely pay for user service fees. Even if they could pay, malaria control must be carried out preventively, through centrally administered programs, to be effective. The malaria control system was largely spared budget cuts and staff dismissals.

But structural adjustment and privatization nonetheless have had a strong effect on the malaria control system. To decrease public payrolls, a voluntary retirement plan was established in 1990. It was applied indiscriminately in the health sector, resulting in the elimination of 500 of the 4000 posts for nurses and doctors. Many experienced malaria control and statistical staff left as well, greatly weakening the technical experts at the national level available to the malaria control program.

Many rural people who made a living on small or medium-sized farms could no longer get credit, which increasingly went to export-oriented industries. These people flooded into slums of the capital city in the 1990s, forming large marginal settlements on low wet lands near a large lake at the northern border of the city. In 1995, 34% of all people in the country lived in the capital. For the first time since the insurrection in 1978-79, Managua became a major focus for malaria transmission.

Results

Leaders of decentralized health services, enjoying less central government support, devised new mechanisms to generate program resources. One of these, starting in 1996, was to charge individuals for

16 Garfield, R.M.; Low, N. & Caldera, J. Desocializing Health Care in a Developing Country. *JAMA* 1993: 270 (8): 989-93.
17 Curtis, E. Child health and the international monetary fund: the Nicaragua experience. *The Lancet* 1998; 52:1622-24.

the laboratory services used in examining slides to diagnose malaria. No such user fees had ever existed since malaria control became a national priority in 1947. The proportion of the population getting examined for malaria immediately dropped, creating an increasing reservoir of P parasites among partially or untreated people.

Deteriorating public salaries and a loss of the espirit de corps of public service present in the health system throughout the 1980s led to reduced productivity among malaria control staff. In 1990, 77% of all antimalarial treatments were given to the patient in directly observed therapy over a five-day period. This insured complete treatment and a low rate of treatment failure, thus reducing the human reservoir for continued disease transmission. In 1996, only 47% of all treatments were provided via directly observed therapy.

Effective malaria control in a mesoendemic area like Nicaragua depends on rapid local assessments and interventions. These have been provided by local volunteers in villages throughout the country since the 1940s. There are still more than 5000 volunteers in Nicaragua, but they are less often being visited, encouraged, or supplied by malaria control workers. As a result, the percent of all malaria cases diagnosed from slides that the volunteers had collected fell from 50% in 1990 to 35% in 1996.

Ironically, ecological changes created enhanced opportunities for malaria control in the 1990s. Cotton, which had been the most important national export in the 1960s and 1970s, stymied malaria control by making pesticides far less effective at killing Anopheles mosquitoes. In the 1990s cotton prices fell and little land has been devoted to its cultivation. Concentration of at-risk populations in Managua and increasing effectiveness of pesticides for malaria control created excellent opportunities for improved malaria control.

These advantages were overwhelmed by weakened administration, a poorer system for diagnosis of cases, a rise in the proportion of people failing to take complete treatment, and decreased coordination with local malaria control volunteers.

From 1992-1996, the number of malaria cases per 1000 population tripled. The increase in the proportion of the population with malaria was higher in the late 1990s, and the increase from usual levels of the disease were larger than at any time in the past three decades.

Discussion

Cautious interpretation of these data is advised as the passive case-finding system fails to detect all positive malaria cases. It nonetheless appears to provide an accurate reflection of incidence trends in Nicaragua, particularly at extremes of epidemic or greatly reduced levels of transmission. Decreased reporting of malaria cases in the non-war zone during a period of expanded search for cases almost certainly reflected an actual decrease in the number of cases. Similarly, during a period of increased reporting such as in the 1990s, persistent high incidence reflects a failure to control malaria transmission.

In areas like Central America, where malaria transmission is unstable, methods that depend on community participation and are planned on the basis of routine surveillance data may be sufficient to

control malaria transmission. The World Health Organization in 1974 recommended such a strategy after reviewing selected failures of its eradication program. The Nicaraguan experience in the 1980s demon-strates that an integrated approach to malaria control can indeed be effective where social stability, wide-spread health education, and strong program administration exist.

The contra war in the 1980s limited the implementation of the community-based strategy and was responsible for continued high levels of P vivax transmission in the war zone. Malaria control was especially difficult in the northern mountains and the semi-tropical southern and eastern sections of the country, the same zones in which the contra war was fought. Crowding, living under makeshift shelters, and large- scale population movements commonly occur among displaced people and troops. Each of these factors promoted malaria transmission despite improved application of conventional control measures. Neighboring Costa Rica and Honduras also reported outbreaks in previously low incidence areas inhabited by refugees and Contra troops. The war thus constituted a substantial barrier to effective malaria control, both inside and outside of the war zone.

Ironically, it now appears that the contra war was less of a barrier to effective malaria control than the structural adjustment program of the 1990s. A community participation strategy could have continued to improve malaria control throughout Nicaragua with the end of the contra war in 1990. Social stability, combined with the unplanned reduction in planting cotton, could have greatly enhanced local outbreak control with the selective use of local mass drug administration and focal sprayings. Instead, neglect of the rural poor, the loss of timely epidemiologic reporting, and decreasing utilization of local volunteers for blood slide detection and directly observed therapy for malaria has resulted in an epidemic greater than any since malaria eradication began in Nicaragua in 1947. Most ironic of all is that the greatest number of new cases is occurring on the outskirts of Managua, within a few kilometers of the national office of the malaria control system at the Ministry of Health.

Structural adjustment is supposed to make more efficient use of limited resources in the health sector. It is supposed to mobilize local resources through decentralized planning. In some countries it has indeed done this, at least for urban workers in the formal economic sector. In the Nicaraguan case, with a disease predominantly of rural (or ex-rural) poor, structural adjustment has done neither. In light of the new World Health Organization initiative 'Roll Back Malaria,' consideration should be also made of an effort to 'Roll Back Structural Adjustment,' at least in some of its unintended or inappropriate applications. A radically revised strategy will be needed to return to the successes in malaria control, which occurred in Nicaragua under the decentralized community mobilization strategy of the mid-1980s.

Such a strategy should include the following:

- Strengthening the technical capacity of national staff and prevention of loss of expert, experienced staff to the private sector: This may require additional funds to assure competitive salaries; more importantly, it requires the revaluation of such staff and the identification of the malaria control program as an essential component of national development planning during structural adjustment.

- Reestablishment of universal access, without user fees, of blood slides to diagnose cases present via patient self-referral: User fees in this area generate few financial resources but sabotage the malaria control program and send the mistaken message that malaria control is elective, rather than an essential service and national commitment.
- Valuation of decentralized planning and mobilization of local resources for malaria control not only in rhetoric but in practice through training local staff, on-going evaluation of local models by national health authorities, and the designation of local leaders on the basis of ability rather than personal or political relations: Central authorities must use routine malariometric indicators as management tools each month to monitor and improve the capacity of and learn from the initiatives of local leaders.
- Recognition of the great potential resource available for malaria control in local volunteers: Traditional volunteers as well as new constituencies can be called upon to facilitate the collection of blood samples to diagnosis cases, the administration of directly observed antimalarial therapy, the promotion of prevention (via bednets and breeding site reduction in the peridomestic environment, for example), community health education (to recognize symptoms and complete treatment), and the identification of effective local strategies to reduce transmission (such as focal mass drug administrations, residual sprayings, and adulticides). Decentralization creates enhanced opportunities to mobilize volunteers in affected areas, but such mobilization will not occur without national leadership and the reestablishment of an espirit de corps of public service and social solidarity.

None of these priorities are necessarily inconsistent with structural adjustment. Nor are they particular to one kind of political regime—some combination of these priorities were in effect in each of the governments, from the right to the left, which Nicaragua has experienced over the last 40 years. Yet without reevaluation of the measures and revision of the goals for structural adjustment, it appears that these priorities will continue to be left out and preventable epidemics of malaria will continue to occur.

APPENDIX 1.
Important Dates

1947	Malaria Eradication Program Established during Somoza dictatorship
1979	Revolutionary war brings leftist Sandinista (FSLN) party to power
1981	Mass Drug Administration carried out nationally
1983-89	Contra War interrupts malaria control activities
1990	Centrist Chamorro coalition government elected
1996	Rightist candidate Alemán elected to presidency

THE POTENTIAL CONTRIBUTION OF CIVIL SOCIETY

THE POTENTIAL ROLE OF TRANSNATIONAL CIVIL SOCIETY IN HEALTH DEVELOPMENT IN THE AMERICAS:

Lessons From the NGO Revolution in International Law and International Relations

David P. Fidler

An express purpose of the Seminar on Health & Human Development in the New Global Economy is to seek to explore how groups from transnational civil society in the Americas can "enhance their capacity to influence the formulation of public health policies." The pursuit of this goal is timely as the World Health Organization (WHO) has also been emphasizing the important role that transnational civil society and non-governmental organizations (NGOs) play, and need to play, in improving global public health.[1] The Seminar's goal also echoes the historical contributions made by private groups, foundations, and individuals in

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[1] See, e.g., WHO, *A New Global Health Policy for the Twenty-First Century: An NGO Perspective—Outcome of a Formal Consultation with Nongovernmental Organizations held at WHO*, [Geneva 2 and May 1997], WHO/PPE/PAC/97.3 (1997) [hereinafter WHO, *A New Global Health Policy for the Twenty-First Century: An NGO Perspective*]; WHO, Concept Paper and Proposal for the Initial Stage of the Global Health Watch (GHW) (unpublished paper); and Dr. Gro Harlem Bruntland, *Speech to the Fifty-First World Health Assembly*, WHO Doc. A51/DIV/6, May 13, 1998 (stating that WHO "must reach out to the NGO community" and that she plans to "convene a conference with the NGO community to draw up new guidelines for our cooperation [and] to establish new mechanisms for interaction with civil society in Member States.").

fighting diseases around the world.[2] More generally, this objective also connects the Seminar to the growing awareness of the importance of non-State actors, especially NGOs in international relations in the late twentieth century.[3] Rather than looking specifically at what NGOs can do for health development in the Americas, my paper analyzes the perceived revolution in the role of NGOs in international relations and international law for lessons useful to the Seminar's objective of enhancing the involvement of transnational civil society in the making of public health policy in the Americas.

I believe that the goal of enhancing the role of transnational civil society in health development in the Americas should be pursued within a global perspective, which is why looking at the global phenomenon of NGO involvement in international affairs is useful. Public health problems today are no longer strictly local, national, or regional. Public health officials and academic experts believe that the globalization of public health is taking place.[4] While the globalization of public health is a complex phenomenon, it teaches the basic lesson that a global perspective is needed in dealing with public health problems, whether those problems involve infectious diseases, tobacco control, or any other health issue. Health development in the Americas not only is influenced by the globalization of public health but also affects the dynamics of such globalization. The role of transnational civil society in health development in the Americas should be seen as a global role not just as a task restricted to protecting the public health of people in the American hemisphere.

A focus on transnational civil society's responsibilities in bettering local, national, regional, and global health provides one way to bring global perspective to the ambitions of this Seminar. This Seminar seeks to harness the perceived global power of transnational civil society witnessed in other contexts to the objective of bettering public health in the American hemisphere. Much of what my paper explores are global lessons relevant to a regional setting. But, in applying global lessons regionally, we should not build mental, political, or legal walls that prevent us from retaining a global perspective on public health problems. Although we meet with a regional focus, our deliberations are, and should be, global in nature and ambition. Believing that the American hemisphere, or any country within it, can protect itself while not worrying about the rest of humanity would be regressive and ultimately fatal to health development in the Americas.

Exploring the role of transnational civil society in international relations today involves asking many kinds of large questions, such as "Why have NGOs become so important in international relations and

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2 See Neville M. Goodman, International Health Organizations and their Work pp.369-387 (2nd ed. 1971) (analyzing history of some "voluntary agencies in the international health field").

3 See generally Peter Willetts, *Transnational Actors and International Organizations in Global Politics*, in THE Globalization of World Politics (John Baylis and Steve Smith, eds. 1997), at 287, 298-303 (analyzing NGOs as political actors in international relations).

4 See, e.g., Derek Yach and Douglas Bettcher, *The Globalization of Public Health, I: Threats and Opportunities*, v 88 American Journal of Public Health p.735 (1998); Derek Yach and Douglas Bettcher, *The Globalization of Public Health, II: The Convergence of Self-Interest and Altruism*, v 88 American Journal of Public Health 738 (1998); Gill Walt, *Globalization of International Health*, 351 The Lancet p.434 (1998); and David P. Fidler, *The Globalization of Public Health: Emerging Infectious Diseases and International Relations*, 5 Indiana Journal of Global Legal Studies p.11 (1997).

international law?", "How have NGOs become important?", "What does the NGO revolution tell us about the future of sovereignty in the era of globalization?", "How does the NGO revolution compare with the revolution in the power and influence of other non-State actors, such as transnational corporations?", etc. In the limited space available to me, I cannot do justice to such an enormous topic; but I set my task at least to bring to the global discourse at this Seminar some lessons from the NGO revolution in international law and international relations.

The NGO Revolution in International Relations and International Law

Referring to the growing importance of NGOs in contemporary international relations and international law as a "revolution" is somewhat misleading because NGOs have been playing a prominent role in international relations and international law for over two hundred years.[5] The political, moral, and legal roles shouldered by NGOs in international affairs have been evolving over centuries rather than flaring up recently to dazzle those interested in humanity's future. But evolution and revolution can co-exist, particularly when specific changes in the nature of international relations transform the dynamics of human interaction. How people perceive NGOs today is different in radical ways from earlier periods of international history, so it is important to understand both the continuity of NGO involvement and the historical moments when that involvement is transformed.

A. Looking Back: NGOs in History

In a detailed overview of NGO involvement in international governance from 1775 to the present, Charnovitz divided such involvement into seven historical periods:[6]

Emergence	1775-1918
Engagement	1919-1934
Disengagement	1935-1944
Formalization	1945-1949
Underachievement	1950-1971
Intensification	1972-1991
Empowerment	1992-?

Charnovitz's analysis demonstrates not only the historical pedigree of contemporary NGOs but also the great diversity of areas in which NGOs influenced the policies of governments and international

5 See Steve Charnovitz, *Two Centuries of Participation: NGOs and International Governance*, 18 Michigan Journal of International Law 183 (1997) (beginning analysis of NGO involvement in international affairs in 1775).

6 Id. p. 190.

organizations.[7] Charnovitz provides examples from peace societies, labor associations, business organizations, transportation groups, women's groups, human rights advocates, and environmentalists. The history of NGO involvement in international relations and international law reveals NGOs as important actors in the shaping of international policies and international legal regimes.

Those familiar with the history of NGOs in the public health field will find none of this surprising. Non-governmental efforts in the medical and health fields span the history of NGO involvement in international relations.[8] Private groups have since the nineteenth century been involved in delivering medical and public health services to peoples all over the world. NGOs, most famously the International Committee of the Red Cross, have been involved in advocating for new international law to improve the health of threatened individuals.[9] Private foundations, such as the Rockefeller Foundation, have long contributed to scientific research in the public health field and the dissemination of the fruits of this progress globally.[10] NGOs formed to combat specific disease scourges, such as the International Union against Tuberculosis, which was formed in 1920.[11] Public health-related NGOs became involved with international health organizations from their earliest days in the twentieth century.[12] Looked at with historical perspective, Article 71 of the WHO Constitution, which allows the Organization to "make arrangements for consultation and co-operation with non-governmental international organizations," is not as novel as it might first appear.[13]

While Charnovitz's seven historical periods were not elucidated with public health as the focus, they serve as a rough-and-ready template for the historical experiences of NGOs in the public health area. NGO involvement in international health policy emerged at the same time public health emerged as an international issue—in the period after the first International Sanitary Conference in 1851. The period of intensification corresponds to the period in which various international health organizations were created (e.g., Pan American Sanitary Bureau (1902), Office International de l'Hygiene Publique (1907), Health Organization of the League of Nation (1923), Office International des Epizooties (1924)). The general international political problems of the 1930s affected all NGO activities, including NGOs working in public health, producing the period of disengagement. Public health NGOs had the opportunity to formalize relations with the new WHO under Article 71 of the WHO Constitution, so Charnovitz's period of formalization also applies to the public health context.

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7 See generally id.

8 See Goodman, International Health Organizations and their Work, at pp. 369-387.

9 See John F. Hutchinson, Champions of Charity: War and the Rise of the Red Cross (1996) for a history of the Red Cross movement.

10 See Goodman, International Health Organizations and their Work, at pp.377-382 (describing work of the Rockefeller Foundation).

11 See International Union Against Tuberculosis and Lung Disease, at <http://www.who.int/ina-ngo/ngo/ngo126.htm>.

12 See, e.g., League of Nations, Health Organization 19 (1931) (reporting that in 1924 the Health Organization of the League of Nations "was requested by the Yugoslav Government and the International Union Against Tuberculosis to take up the problem of tuberculosis.").

13 WHO Constitution, art. 71.

What is perhaps less clear is whether public health-related NGOs can be said to have undergone the period of underachievement identified by Charnovitz for the general NGO situation. The 1950-1971 period of underachievement corresponds with public health improvements all over the world, as public health experts and scientists began believing, for example, that science had conquered infectious diseases.[14] I do not have sufficient empirical evidence to evaluate to what extent public health-related NGOs "underachieved" in the decades following WHO's creation.

Similarly, whether Charnovitz's 1971-1991period of intensification fits the experiences of public health-related NGOs is not clear to me. Within this period, of course, is the creation and implementation of the original Health for All policy, which may have stimulated an intensification of NGO efforts around the world on the key aspects of this policy initiative, such as primary care.[15] On the other hand, this twenty-year period also encompasses the heyday of complacency and premature triumphalism in scientific and public health communities about infectious diseases.[16]

I am on more solid ground agreeing with Charnovitz's framework that public health-related NGOs are now in a period of empowerment. As WHO's involvement of NGOs in the formulation of the new Health for All policy suggest,[17] WHO sees NGOs as allies in the battle to improve humanity's health. Director-General Brundtland has also emphasized the importance of tapping NGO involvement in the new directions she intends to take the Organization.[18] Other factors, such as the revolution in information technologies, also contribute to the empowering of NGOs in the public health context at the end of the twentieth century.[19]

B. What is the NGO Revolution?

This historical background forces me to explain more precisely what I mean by the "NGO revolution" in international relations and international law. The history of international relations shows that NGO involvement and influence in international affairs is not revolutionary. In addition, Charnovitz's analysis points to a cycle of NGO impact on international governance, the movements of which flow from

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14 See Laurie Garrett, The Coming Plague: Newly Emerging Diseases in a World Out of Balance 30 (1994) (noting in the 1950s and 1960s that "[f]ew scientists or physicians of the day doubted that humanity would continue on its linear course of triumphs over the microbes").

15 WHO recognized this spark provided by the Health for All policy when it wrote that NGO contributions to international health "was further vitalized by Alma-Ata in 1978". WHO, *A New Global Health Policy for the Twenty-First Century: An NGO Perspective*, p. 4.

16 Such complacency is believed to be one factor behind the emergence and re-emergence of infectious diseases. See Institute of Medecine, Emerging Infections: Microbial Threats to Health in the United States pp.108-110 (1992) (discussing complacency as factor in emergence of infectious diseases).

17 See WHO, *A New Global Health Policy for the Twenty-First Century: An NGO Perspective* (reporting results of WHO consultations with NGOs on draft Health for All policy).

18 See Dr. Gro Harlem Brundtland, *Speech to the Fifty-First World Health Assembly*, WHO Doc. A51/DIV/6, May 13, 1998 (expressing her desire to reach out more to the NGO community).

19 See David P. Fidler, *Microbialpolitik: Infectious Diseases and International Relations*, 14 American University International Law Review 1 (1998) (discussing importance of new information technologies to global society participation in infectious disease control).

dramatic changes in the international system.[20] Perhaps it is more accurate to say that revolutionary changes in the nature of international relations have produced this new period in which experts perceive NGOs to have a growing influence in international affairs. These revolutionary changes are (1) political, (2) economic, and (3) scientific and technological; and each is discussed more below. What the confluence of all these major changes produces is the need by States, intergovernmental organizations, and vulnerable people for more NGO activity in the public health area. In other words, the demand for NGO involvement has increased because major transformations have taken place or are taking place in international relations.[21] Many people assume that more NGO involvement in international affairs is a good thing; but, when we consider the nature of the problems producing increased demand for NGO participation, the NGO revolution rings with more somber tones.

Political Changes. Charnovitz noted that major political changes in international relations drive the cycle of NGO participation in international relations. The number and activities of NGOs always seem to increase after the end of major wars. The increase in prominence of NGOs in the 1990s comes in the wake of the end of the Cold War.[22] With the end of the political dynamics produced by a bipolar international system and ideological struggle on a global scale, international relations became a less hostile milieu for NGO involvement in the great issues of the day. Although many NGOs were active during the Cold War, particularly in the area of human rights, their participation always took place against the backdrop of American-Soviet global political, military, and ideological competition. Further, NGO activities also became part of this competition dynamic between the superpowers as human-rights NGOs became useful weapons for the United States in its struggle with the Soviet Union.

The end of the Cold War triggered a number of important political transformations in the international system that have produced more opportunities for NGOs.[23] First, the American-Soviet clash, which had colored every aspect of international relations during the Cold War, disappeared, which created different dynamics for the pursuit of bilateral and multilateral diplomacy. The somewhat rigid bipolar structure of international relations collapsed, leaving in its wake a world transformed with new potentialities.[24] Issues, such as human rights, that were once overshadowed by the ideological battle between the superpowers, gained new life once the shadow vanished.

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20 See Charnovitz, *Two Centuries of Participation*, at pp.268-270 (analyzing the cyclicality of NGO impact from 1775 to 1992).

21 Charnovitz explains the cyclicality of NGO activities over time through the "needs of governments". See id. at 269. He includes also the needs of intergovernmental organizations in the demand for NGO activity. While the needs of governments and intergovernmental organizations are important, the needs of individuals and groups of people not well-served by governments and intergovernmental organizations must also be part of the "demand" factor for NGO involvement.

22 Id.

23 Crockatt argued that "the end of the cold war was a major historical turning point as measured by changes in the international system, the nation-state, and international organizations." Richard Crockatt, *The End of the Cold War*, in The Globalization of World Politics (John Baylis and Steve Smith, eds. 1997), at 89, 91. The same can be said of the impact of the end of the Cold War on NGOs and transnational civil society.

24 Id. p. 90 (the end of the Cold War "marked the end of the broadly bipolar structure, based on US-Soviet rivalry, which the international system had assumed since the late 1940s.").

Second, the end of the American-Soviet struggle decreased the importance, and perceived importance, of military power in international relations.[25] The Cold War engendered a depressing menagerie of nuclear and conventional warfare strategies and arms races, evidencing the overriding importance of national security and military power in the affairs of States. As the cause of the burning interest in military power dissipated with the end of the Cold War, people engaged with international affairs began to look at "national security" differently. Thus, we have seen experts discoursing on the protection of the environment as an issue now germane to concepts of national security. The Directors-General of both WHO and the Pan American Health Organization (PAHO) have both discussed global health threats in terms of national security.[26] The political changes caused by the end of the Cold War have produced the room needed for such arguments to be made and taken seriously. NGOs can play a larger role in this type of environment because the issues that come forth in this milieu tap into the strengths NGOs offer.[27]

Third, the end of the Cold War was also the end of the ideological struggle between liberalism and communism.[28] With the global triumph of liberal political philosophy came benefits for NGOs. As a political philosophy, liberalism encourages the political activity and participation of non-governmental actors, be they individuals or associations.[29] Democratic systems of government, and the rule of law that undergirds such systems, provide hospitable climates for NGOs, national and international, to attempt to influence national and international policy. Thus, to understand the growing role of NGOs in international affairs today, it is important to comprehend not only that the Cold War is over but also who won the Cold War. NGOs would not be having the impact they have today if communism had prevailed in the Cold War because that ideology proved hostile and deadly to political activism of the wrong kind.

The political transformations in international relations from the end of the Cold War were thus structural (i.e., the end of rigid bipolarity), substantive (i.e., decreasing importance of military power in the affairs of States), and ideological (i.e., the triumph of liberalism). While human affairs remained divided into sovereign States and thus an international system, the nature of those States and that international system had changed in revolutionary ways with the end of the Cold War, laying the groundwork for a new era in NGO involvement in international relations. These political changes affected

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25 Id. p. 103 (many believed that "the end of the Cold War would bring a 'peace dividend' both financial and political. Nations could now afford to expend fewer resources on military and foreign policy, and devote it to domestic growth.").

26 George Alleyne, *Health and National Security*, 30 Bulletin of the Pan American Health Organization 158 (1996); and Hiroshi Nakajima, Global Disease Threats and Foreign Policy, 4 Brown Journal of World Affairs 319 (1997).

27 See Charnovitz, *Two Centuries of Participation*, p. 270 ("Because many of the salient issues of the 1990s— for example, the environment, human rights, and intellectual property— have traditionally entailed NGO activity, it is not surprising that NGOs are busier than ever on these issues at the international level.").

28 Crockatt, *The End of the Cold War*, p. 91 (arguing that a key feature of the Cold War was "ideological conflict between capitalism and communism").

29 See David P. Fidler, *Caught Between Traditions: The Security Council in Philosophical Conundrum*, 17 Michigan Journal of International Law 411, 413 (1996) ("Liberalism refers to a body of thought the core of which is the liberty of the individual. Unlike realists, liberals view individuals as important actors in international relations . . .").

the "supply" side of NGO activity in the post-Cold War world by making it possible for NGOs to meet the demand for their increased participation caused by the economic and scientific and technological changes examined below.

Economic Changes. The buzz-word of the 1990s—'globalization'—attempts to capture the essence of the economic changes perceived to have happened with the end of the Cold War. Although globalization affects more than economic affairs, it most prominently affects the economic realm. At the risk of oversimplifying a complex phenomenon, globalization in the economic realm constitutes a denationalization of markets for goods, services, and capital.[30] Companies trading goods, services, and capital today largely act on the basis of "global markets" as opposed to formerly dominant notions of distinct national markets.[31] Experts perceive that the globalization of markets undermines the authority and sovereignty of States while empowering non-State actors, most prominently transnational corporations (TNCs).[32]

The political changes outlined in the previous section contributed to the globalization of markets because the political fallout from end of the Cold War produced new market opportunities for TNCs. Regions of the world blighted by the superpower competition became "emerging markets" for TNCs and governments trying to promote the exports of their companies. Liberalism's triumph also meant the triumph of capitalism; and free market policies, such as free trade and liberal investment policies, came to dominate the international economic agenda.[33] The collapse of the ideologically-divided bipolar international system created the potential for the global extension of the liberal framework of international trade, the General Agreement on Tariffs and Trade (GATT). This global extension took place through the Uruguay Round and culminated in the creation of the World Trade Organization (WTO).

Other aspects of the liberal international economic agenda and framework have grown in importance as well in the post-Cold War period. After many years of communist and developing countries implementing policies hostile to foreign investment, developing States and countries in transition to

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30 Jost Delbrück, *Globalization of Law, Politics, and Markets—Implications for Domestic Law—A European Perspective*, 1 Indiana Journal of Global Legal Studies 9, 10 (1993) (defining globalization as "the process of denationalization of markets, laws, and politics"). For other definitions of globalization, see Jan Aart Scholte, The Globalization of World Politics, in The Globalization of World Politics (John Baylis and Steve Smith, eds. 1997), pp. 13, 14-15.

31 See Gordon R. Walker and Mark A. Fox, *Globalization: An Analytical Framework*, 3 Indiana Journal of Global Legal Studies 375, 380 (1996) ("The key feature which underlies the concept of globalization . . . is the erosion and irrelevance of national boundaries in markets which can be truly described as global.").

32 See, e.g., Willetts, *Transnational Actors and International Organizations in Global Politics*, p. 293 (arguing that the "extensive transnationalization of major companies" has substantially diminished "two of the most fundamental attributes of sovereignty, control over currency and control over foreign trade").

33 See Roger Tooze, *International Political Economy in an Age of Globalization*, in The Globalization of World Politics (John Baylis and Steve Smith, eds. 1997), at 212, 226-227 (arguing that since the end of the Cold War, capitalism "has 'been the only game in town' as far as the arrangement of economic and political life are concerned" and that "the ideological basis of capitalism has been further reinforced and legitimated").

democracy and capitalism have adopted liberal foreign investment policies.[34] The roles of the World Bank and the International Monetary Fund (IMF) have also increased in the era of economic globalization in both domestic economies and the management of the international economic system.[35]

The globalization of markets has clearly empowered TNCs as non-State actors.[36] In fact, economic globalization puts the growing prominence of NGOs as non-State actors into perspective. NGOs are not the only non-State actors helped by the end of the Cold War. Comparing TNCs and NGOs as non-State actors in the new world order, it is clear that TNCs have more power and influence than NGOs. The awesome power TNCs wield today creates a troubling situation for NGOs. At the risk of doing injustice to the richness of history, NGOs in the past largely targeted governments and intergovernmental organizations for political and legal action. Today, NGOs have to confront States, intergovernmental organizations, and TNCs in their efforts. In addition, States and intergovernmental organizations also pay attention to TNCs because of the political and economic power these non-State actors possess. In the era of globalization, the challenges facing NGOs are perhaps more complex and in some ways more difficult than those faced in the past.

These economic changes in international relations affect the "demand" side of NGO involvement in international affairs. While the globalization of markets has brought benefits to many countries and their peoples, it has also created problems that require political and legal action. One of the consequences of economic globalization is the perceived weakening of the State to deal with economic and social problems. As economic power shifts from States to TNCs, governments are under increasing pressure to provide regulatory and economic environments attractive to TNCs.[37] Too often this dynamic contributes to environmental problems, labor issues, human rights concerns, and health difficulties. In connection with emerging infectious diseases, I have argued that "the development of the global market has intensified economic competition and increased pressure on governments to reduce expenditures, including the funding of public health programs, leaving states increasingly unprepared to deal with emerging disease problems."[38] Similar concerns exist about the impact of structural adjustment policies required by international financial organizations as conditions for loans (discussed in detail elsewhere in the Seminar). Intergovernmental organizations are also negatively affected by the rise of TNC power because "TNCs

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34 See Ralph H. Folsom and Michael W. Gordon, International Business Transactions 587-88, 766-67, 773-75 (1995) (discussing liberalization of foreign investment laws in the 1980s and 1990s).

35 See Caroline Thomas, Poverty, Development, and Hunger, in The Globalization of World Politics (John Baylis and Steve Smith, eds. 1997), pp. 449, 455 (noting that the World Bank and IMF have pursued economic liberalism after the end of the Cold War).

36 Willetts, *Transnational Actors and International Organizations in Global Politics*, p. 293 ("The growth in the number of TNCs, the scale of their activities and the complexity of their transactions has had a major political impact. . . . TNCs have the ability to evade government attempts to control financial flows, to impose trade sanctions or to regulate production. . . . The sovereignty of most governments is significantly reduced.").

37 Id. p. 294 (discussing TNCs use of "regulatory arbitrage" that puts pressure on governments' efforts to regulate economic behavior).

38 David P. Fidler, *Globalization, International Law, and Emerging Infectious Diseases*, 2 Emerging Infectious Diseases 77, 78 (1996).

also make intergovernmental relations more complicated."[39] In short, economic globalization increases the number and types of social and economic problems that require NGO involvement to address. With the perceived weakening of the State by globalization, such NGO participation in international relations is now more important than ever.

Scientific and Technological Changes. The revolutionary political and economic changes in international relations discussed above have produced increased demand for and supply of NGO involvement in international affairs. Scientific and technological changes contribute to both the demand and supply aspects of NGO participation in international relations as well. Science has helped experts identify new global problems requiring international action and NGO involvement, and technological changes have helped NGOs move to a new level of activity and effectiveness in the face of mounting demands for global political and legal action on pressing issues.

Scientific advances have long had impact on international relations, perhaps most famously represented by the development of nuclear weapons. Science has sparked and shaped the development of many different international legal regimes. The biggest scientific impacts in this regard have come in the environmental and health areas, where scientific evidence prompted States and intergovernmental organizations to take political and legal action against environmental and health problems. Particularly in the environmental field, NGOs have been prominent in using scientific developments and evidence in advocating for international environmental law. Environmental NGOs often possess a scientific capability that rivals or even surpasses that of governments and intergovernmental organizations. Such scientific expertise is useful to governments and intergovernmental organizations, and helps NGOs secure a seat at the diplomatic table. Transnational scientific expertise in the form of "epistemic communities" have been very influential in constructing international environmental regimes. Science has, thus, been important in the identification of many global problems, especially in the environmental context, that NGOs have mobilized to address. Science has helped increase the demand for NGO activity. The corresponding use of science and scientific expertise by NGOs has helped them increase the quantity and quality of the input they supply in the diplomatic efforts to deal with global problems.[40]

Technological changes work a similar double effect on NGOs. The revolution in information technologies has greatly facilitated the globalization of markets for goods, services, and especially capital.[41] This revolution has, thus, contributed to the economic and social problems the globalization of markets exacerbates or creates, which is also a contribution to the demand for NGO involvement in global issues.

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39 Willetts, *Transnational Actors and International Organizations in Global Politics*, p. 293.

40 See, e.g., Owen Greene, *Environmental Issues*, in The Globalization of World Politics (John Baylis and Steve Smith, eds. 1997), p. 313, 325 (in the negotiation of international environmental agreements, "transnational 'knowledge-based' communities of experts with shared understanding of the problem and preferred policy responses (i.e., 'epistemic communities') have proved particularly influential.").

41 See Walker and Fox, *Globalization: An Analytical Framework*, p. 382 (noting that "the most important factor in the globalization of financial markets is technological change.").

At the same time, the information technology revolution has improved the ability of NGOs to monitor the behavior of governments and intergovernmental organizations, to communicate with governments and intergovernmental organizations on global problems, and to network among like-minded NGOs on coordinating responses to particular challenges.[42] Information technology gives NGOs greater potential to deal with the growing and often massive local, regional, and global problems seen today all over the world. Transnational networking among NGOs is not new, as it has been a feature of NGO involvement in international affairs from the earliest days.[43] But new information technologies put in the hands of NGOs powerful resources, the possibilities of which are still unfolding.

Summary of the Factors Behind the NGO Revolution. Political, economic, scientific, and technological changes have created both an increased demand for NGO participation in international affairs as well as increased ability for NGOs to try to meet such demand. The NGO revolution sensed in the post-Cold War world represents, thus, a complex phenomenon that comprises structural changes in the international system, decreasing relevance of military power in international affairs, ideological transformations within and among States, the globalization of markets, the growth in power of TNCs, the weakening of governments and intergovernmental organizations in the face of economic globalization, and scientific and technological advances. The NGO revolution is a mixed blessing because the increased opportunities for NGOs are often connected with worsening political, social, economic, and environmental problems around the world and with the decreasing ability of governments and intergovernmental organizations to deal effectively with such problems.

Power and Norm-making Shifts in International Relations

The NGO revolution needs to be seen in the wider context of the general changes to international relations in the era of globalization. From the perspective of the development of international law, it is important to understand how power and the making of international norms has shifted in the post-Cold War world, and how NGOs sit in relation to these two shifts. International legal rules are a complex tension between particular norms and the exercise of power. Unfortunately, there is often a gap between the norms contained in international law and how States exercise their power. Historically, NGOs have been active in the formulation, adoption, and implementation of norms through international law.[44] NGO legal energy has been largely channeled through States and intergovernmental organizations. This traditional pattern of NGO influence in international affairs is breaking down under the stress imposed by the political, economic, scientific, and technological forces at work in the post-Cold War period.

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42 See Willetts, *Transnational Actors and International Organizations in Global Politics*, p. 303 ("The improved communications make it more likely that NGOs will operate transnationally and make it very simple and cheap for them to do so.").

43 See Charnovitz, *Two Centuries of Participation*, pp. 191-212 (variously noting the transnational quality of NGO movements in the 1775-1918 period of NGO emergence).

44 See id. pp. 198-208 (describing NGO efforts in the period of NGO emergence to promote new international legal regimes).

A. Power Shift

Power in the Cold War era, and previous historical periods of international relations for that matter, predominantly remained with States. National power is what really counted, and usually military power occupied the central position in analyses of a nation's power. The dominant international relations theory during the Cold War, realism, focused on national power and emphasized the military aspects of a nation's strengths and weaknesses.[45] While theories of economic interdependence brought renewed attention to the economic aspects of national power, they did not replace the military focus of realism until the Cold War was over.

The globalization of markets, and the perceived weakening of State sovereignty, contains a profound shift in how we look at power in international relations today. One aspect of this shift is the elevation of economics in evaluating a nation's power, and the downgrading of military considerations. More interesting is the shift in the loci of power. The rise of TNCs in the era of the globalization of markets reflects a shifting of power from States to non-State actors. The traditional realist framework, with its emphasis on States and State conflict, increasingly seems anachronistic when power is today wielded by non-State actors on a global scale. Further, the type of power wielded by TNCs is not military power but economic power. These shifts force us to reconsider the nature of power and power-holders in international relations.

Many people lament the growth of TNC power in the era of globalization because such power is unaccountable and contributes to many political, economic, social, and environmental problems. Such laments should not, however, make us deaf to the profound nature of this power shift. We have moved from an international system dominated by States fixated on military power and the potential for war to a situation in which military power and war have faded somewhat from the picture. The new power-holders, TNCs, seek profit globally rather than military advantage or war. From a classical liberal perspective, the aggregation of power in the hands of private individuals and the weakening of the power of the State is something to celebrate rather than lament. In other words, as a historical matter, the power shift from States to TNCs is actually a progressive rather than regressive feature of international relations in the era of globalization.

B. Norm-Making Shift

While NGOs have long been involved with promoting new international norms and rules of international law, intergovernmental organizations have been the traditional source of new norms and rules of international law in the twentieth century. The central norm-making function of the intergovernmental organization is illustrated through Charnovitz's periods of NGO disengagement and underachievement, lasting roughly from 1935 until 1971. Starting with human rights, and accelerating with environmental protection, NGOs started to play a larger role in global norm-making. Rather than

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[45] See *generally* on realism Scott Burchill, *Realism and Neo-Realism*, in Theories of International Relations (Scott Burchill and Andrew Linklater, eds. 1996), at 67; Timothy Dunne, *Realism*, in The Globalization of World Politics (John Baylis and Steve Smith, eds., 1997), p. 109.

international norms being just a reflection of the international society of States, today norms are increasingly influenced by transnational civil society, or global society. As with power, the norm-making process is shifting away from State-centered approaches to more complex processes involving non-State actors.

While I have referred to NGOs as major players in this norm-making shift, TNCs also affect what norms are adopted because they exercise power. The well-known controversy over "free trade vs. the environment" in the WTO captures a clash over norms for international relations. Including TNCs in the norm-making equation serves to emphasize a key point: non-State actors increasingly affect the making of norms in international affairs.

C. The Complex NGO Role in the New World Order

The power shift from States to TNCs, and the norm-making shift from intergovernmental organizations to non-State actors, creates a complex role for NGOs in the new world order. This role contains old and new features. The old features include traditional NGO efforts to influence States to change their policies nationally or to support reform initiatives inside intergovernmental organizations. In addition, NGOs still have the well-understood role of working with intergovernmental organizations to effect change in international policy and law. Today, however, NGOs also face the task of dealing with the power of TNCs. Some of this task comes through convincing States and intergovernmental organizations to adopt and implement rules that better regulate TNC power, but some of this task comes in challenging TNCs head on. NGOs are increasingly involved in this type of pressure on TNCs, as illustrated by controversies stoked by NGOs over the treatment of labor by TNCs and over TNC environmental practices (e.g., the Greenpeace Brent-Spar incident). Where States and intergovernmental organizations fail to deal adequately with the growing power of TNCs, NGOs find a role in seeking to balance and ameliorate the power of TNCs in global affairs.

Another new feature of the NGO role in the new world order is the global scope of this role. The political, economic, scientific, and technological changes that have transformed human interactions by breaking down traditional territorial barriers also break down barriers between civil societies. To respond to the demand for NGO activity caused by the processes of globalization, NGOs cannot maintain parochial outlooks on the problems they confront. The globalization of public health engenders, for example, the globalization of civil society and its advocates, the NGOs.

The future NGO role in international relations will also be complex because of the nature of the problems confronting human societies. Whether the issue is human rights, environmental protection, or public health, NGOs face problems that cut across a wide spectrum of political and economic activity. NGOs will need multidisciplinary capabilities to undertake action on many of these problems. Public health is a good example of these types of multisectoral challenges. Many public health problems arise out of other social or economic ills that have to be addressed as part of a sophisticated public health strategy. WHO has been criticized for failing to appreciate the multisectoral nature of public health

problems because it has traditionally approached problems through a narrow "medical-technical" strategy. Just as WHO is now emphasizing the need to have multisectoral capabilities to deal with global health problems,[46] NGOs will increasingly be required to adopt similarly diverse and complex strategies.

The NGO Revolution and International Law

The contemporary prominence of NGOs in international relations has produced new thinking in connection with international law. While NGOs have long been involved in pushing for, shaping, and implementing international legal regimes, their importance encourages some scholars to argue that traditional notions of international law need to be changed to accommodate better the role of NGOs in international law and relations. Traditionally understood, only States are subjects of international law. As intergovernmental organizations and then individuals (through international human rights law) became subjects of international law, the traditional framework changed. Some scholars now argue that NGOs should also be considered subjects of international law, which would further alter the traditional framework.[47] In fact, including NGOs as subjects of international law would portend a revolution in the way we think about law globally. International law would cease to exist because the application of rules of law to States, intergovernmental organizations, individuals, and associations of individuals would constitute "world law" or "global law" rather than law predominantly applying between States. Allott has argued that "the great task of the coming decades is to imagine a new kind of international social system, . . . and to imagine at last a new kind of post-tribal international law, which extends to the level of all humanity the wonder-working capacity of law."[48] The emergence of NGOs is one of the "deep currents" that Allott identifies that may be moving humanity in the direction of global law. Taking the step to include NGOs as subjects of international law is very controversial, but it is nevertheless part of the international legal landscape for NGOs in the era of globalization.

Again at the risk of oversimplification, arguments in favor of subject status for NGOs usually build on the limited entitlements that NGOs already have under the United Nations system and within specific international legal regimes.[49] These limited entitlements reflect the important role NGOs play in the formulation and implementation of international law today. In addition, these arguments are bolstered by the fact that "NGO influence has far exceeded that indicated by their tentative formal standing in international institutions."[50]

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46 See, e.g., WHO, *Intersectoral Action for Health: A Cornerstone for Health-for-All in the Twenty-First Century Report of the International Conference*, WHO/PPE/PAC/97.6 (1997).

47 See, e.g., Stephan Hobe, *Global Challenges to Statehood: The Increasingly Important Role of Nongovernmental Organizations*, 5 Indiana Journal of Global Legal Studies 191 (1997); and Peter J. Spiro, New Players on the International Stage, 2 HOFSTRA Law & Policy Symposium 19 (1997).

48 Philip Allott, *The True Function of Law in the International Community*, 5 Indiana Journal of Global Legal Studies 391, 413 (1998).

49 See, e.g., Hobe, *Global Challenges to Statehood*, pp. 199-207 (analyzing the legal framework for NGO activities).

50 Spiro, *New Players on the International Stage*, p. 26.

While appealing to some, making NGOs subjects of international law remains fraught with problems. One basic problem is how to define which NGOs to include as subjects of international law.[51] Another is that it makes little sense to make NGOs subjects of international law without making TNCs subjects as well. The increasing strategy of NGOs to target TNCs directly using standards developed in international law perhaps suggests that we are moving towards a system of global law where private parties hold each other responsible for global activities.

Also, the sheer diversity and abundance of NGOs creates problems for thinking about giving them international legal personality. Giving an entity rights and duties under international law is a very serious matter, and it is not clear that many NGOs really deserve international legal personality. Thinking about giving NGOs international legal personality raises questions of the legitimacy of NGOs. To broaden the entitlements of NGOs under international law will require filtering mechanisms to assure the legitimacy of NGO participation; and, at the moment, those filters are States and intergovernmental organizations.

Finally, there is a process problem in giving NGOs international legal personality. At the moment, international law is made exclusively by States. States thus would have to agree formally that sovereignty is not what it used to be and allow NGOs subject status under international law. The likelihood of this happening soon are dim. States, either individually or through intergovernmental organizations, have historically increased and decreased NGO participation instrumentally—hence the demand and supply analysis used earlier. I would imagine that States, being the creatures that they are, prefer (at least for the foreseeable future) to continue to use NGOs as instruments of their desires rather than inviting them into the club of full subjects of international law.

Lessons for the Role of Transnational Civil Society in Health Development in the Americas

The preceding analysis offers some general lessons for plans to increase the role of transnational civil society in health development in the Americas. I want to emphasize that these lessons are not strategic or tactical because they do not focus on what a NGO should specifically do to promote health development in the Americas. How NGOs influence international law and relations is fairly well understood. Charnovitz identified, for example, seven functions NGOs serve in their activities: (1) gathering intelligence, (2) promoting policy alternatives to decision-makers; (3) prescribing behavior through participation in the formulation of regulatory regimes; (4) invoking publicly how State behavior deviates from established norms; (5) applying international legal rules in specific disputes; (6) terminating existing rules that do not serve the common good; and (7) appraising the extent to which international policies and legal regimes achieve their objectives.[52] I do not want to try to apply these specific functions to NGO activity in the American hemisphere because others at the Seminar will be providing detailed,

[51] On defining NGOs, see Hobe, *Global Challenges to Statehood*, pp. 193-195.
[52] Charnovitz, *Two Centuries of Participation*, pp. 270-273.

country-specific analyses of the potential role of civil society and transnational civil society. I also want to emphasize that applying lessons from the global NGO context to health development in the American hemisphere connects rather than separates NGOs in this region to the global perspective needed to deal with the globalization of public health.

An initial, and perhaps fundamental, lesson is that NGO involvement in international relations has to be understood in connection with the nature of international affairs. The structure and dynamics of international relations significantly affects how transnational society can operate as a global actor. The rise and fall of NGO involvement identified by Charnovitz means that the current era of "empowerment" is not necessarily a permanent change for NGOs. While "NGOs are here to stay,"[53] what role NGOs play remains subject to the great political and economic forces flowing in international relations. Thus, complacency about the place of transnational civil society in global affairs would be dangerous to the cause of improving health globally.

Complacency is also dangerous because the structure and dynamics of contemporary international relations produce great demand for NGO involvement. Part of the dark side of NGO empowerment is the need for NGO participation because of State and intergovernmental organization failures to confront adequately local, regional, and global problems. Globalization exacerbates these failings by weakening States and empowering non-State actors, particularly TNCs. Indeed, to think of the current period as one of "empowerment" for NGOs, when the growing power of TNCs is considered, seems surreal. Greenpeace's ability to bring Royal Dutch Shell to heel in the Brent-Spar incident is not uniformly shared by NGOs working in most areas, including the area of health development. Most of the participants in transnational civil society activities face daily the "David and Goliath" problem—only today the situation is more sobering as TNCs emerge as another Goliath with which to do battle.

More positively, the contemporary era does offer transnational civil society increasing opportunities to deepen its role in the dynamics of international politics. Successful efforts to deepen involvement will enhance the prospects that NGOs will be less vulnerable to cycles in their influence. This deepening is particularly important in the field of global public health. In connection with infectious diseases, I have identified a set of dynamics for what I call microbialpolitik, or the international politics of dealing with pathogenic microbes.[54] Part of my analysis of *microbialpolitik* includes the argument that global society has become part of the dynamics of the politics of international infectious disease control.[55] Global society's role in microbialpolitik most noticeably appears in the form of privately led efforts to connect individuals all over the world electronically for cooperative efforts on infectious disease control (e.g., SatelLife and ProMED-mail).[56] I believe that these non-governmental efforts have given global society a

53 Id. p. 282.
54 See Fidler, *Microbialpolitik*; and generally David P. Fidler, International Law and Infectious Diseases (1999).
55 Fidler, *Microbialpolitik*, at 28-37.
56 Id. at 31-33.

political role in international infectious disease control that NGOs previously did not have. Instead of infectious disease control being simply a matter within States, among States in the international system, and in international organizations, it is now a matter of concern for global society; and global society joins States, the international system, and international organizations as players in infectious disease control.

Because this model of the dynamics of *microbialpolitik* is based on a structural analysis of international relations, it can be applied more generally to the international politics of health development. What this means is that transnational civil society has the opportunity to solidify its place in the dynamics of the international politics of public health. Such a solidification will require accelerating the changes in the nature of health-related NGOs in developing countries. Walt observed that:

> Historically, non-government organizations in the health sector were apolitical providers of welfare and relief to the poor. They were largely service deliverers, and often provided an essential service in rural areas under-served by government. They were predominantly from the developed world, staffed and run by expatriates.[57]

This traditional health-related NGO model is already undergoing change,[58] but it must be accelerated to capture the opportunities now presenting themselves to transnational civil society in the era of the globalization of public health.

While seeing transnational civil society carving itself a place in the dynamics of international health politics is useful, the model presented above also reveals how difficult and complicated the task will be for NGOs. NGOs have to target States and their internal policies, the interactions between States in the international system, and the policies and programs of intergovernmental organizations. In addition, it must be remembered that NGOs do not occupy transnational civil society alone, but that TNCs also are non-State forces in the international politics of public health. The only hope that NGOs have to meet these daunting challenges is to network transnationally. This is why initiatives such as Global Health Watch and the networking proposals to be discussed at this Seminar are very important to the future dynamics of the global politics of public health.

Because NGO impact on international relations is often measured through law, either national or international, we need to consider more specific legal lessons to apply to the role of transnational civil society in health development in the Americas. The first lesson is that law is important to the role transnational civil society has to play in the era of the globalization of public health. The relevance of international and national law to human rights and environmental protection and the work of NGOs in these areas does not need debating. Unfortunately, the relevance of national and international law to the

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57 Gill Walt, Health Policy: An Introduction to Process and Power 117 (1994).
58 Id.

mission of public health needs emphasizing. International law as a feature of international public health has historically been neglected, and it is only in the 1990s that it has received serious attention, starting with Allyn Taylor's seminal 1992 article.[59]

A growing body of scholarly literature now exists that examines the intersection of international law and global public health.[60] In its new Health for All policy, WHO has also placed emphasis on the importance of international law. These developments suggest that NGOs working on public health issues need to pay attention to international law.

In some areas, this lesson would not greatly advance matters as many health-related NGOs are very aware of international law.[61] Human rights is perhaps the most prominent area of international law utilized by NGOs in the public health context. Much of the international human rights discourse in the public health area came out of the AIDS pandemic and the violations of human rights caused by government policies against persons infected with HIV or suffering from AIDS.[62] The new WHO Health for All

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59 Allyn L. Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 American Journal of Law and Medecine p. 301 (1992).

60 For a general treatment of international legal issues and health, see Taylor, *Making the World Health Organization Work*; Katarina Tomesevski, *Health*, in United Nations Legal Order, Vol. 2 (1995), p. 859; Maureen Bezuhly, Mark E. Wojcik, and David P. Fidler, *International Health Law*, 31 The International Lawyer p. 645 (Summer 1997); Derek Yach, The Emerging Role of Public Health Law in the New Health Policy for the 21st Century, presented at the International Conference on Global Health Law, New Dehli, India, December 1997; Allyn L. Taylor, Globalization and Public Health: Regulation, Norms and Standards at the Global Level, Background Paper for the Conference on World Health Cooperation, 1998; Maureen Bezuhly, Allyn L. Taylor, Mark E. Wojcik, and David P. Fidler, *International Health Law*, 32 The International Lawyer p. 539 (Summer 1998); David P. Fidler, *The Future of the World Health Organization*: *What Role for International Law?*, 31 Vanderbilt Journal of Transnational Law p. 1079 (1998). For analysis on infectious diseases see David P. Fidler, *Globalization, International Law, and Emerging Infectious Diseases*; David P. Fidler, Mission Impossible? International Law and Infectious Diseases, 10 Temple International and Comparative Law Journal P. 493 (1996); Bruce J. Plotkin, *Mission Possible: The Future of the International Health Regulations*, 10 Temple International and Comparative Law Journal p. 503 (1996); Bruce J. Plotkin and Anne-Marie Kimball, *Designing the International Policy and Legal Framework for Emerging Infectious Diseases*: First Steps, 3 Emerging Infectious Diseases P.1 (1997); Allyn L. Taylor, *Controlling the Global Spread of Infectious Diseases: Toward a Reinforced Role for the International Health Regulations*, 33 Houston Law Review p.1327 (1997); David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 Minnsota Law Review p.771 (1997); David P. Fidler, *The Role of International Law in the Control of Emerging Infectious Diseases*, 95 Bulletin de l'Institut Pasteur p.57 (1997); David P. Fidler, David L. Heymann, Stephen M.Ostroff, and Terry P. O'Brien, *Law and Emerging and Re-Emerging Infectious Diseases: Challenges for International, National, and State Law*, 31 The International Lawyer p.773 (Fall 1997); David P. Fidler, *The Globalization of Public Health: Emerging Infectious Diseases and International Relations*, 5 Indiana Journal of Global Legal Studies P.11 (1997); David P. Fidler, *Trade and Health: The Global Spread of Diseases and International Trade*, 40 German Yearbook of International Law p.300 (1997); David P. Fidler, *Legal Issues Associated with Antimicrobial Drug Resistance*, 4 Emerging Infectious Diseases p.169 (1998); Fidler, Microbialpolitik; David P. Fidler, *Legal Challenges Posed by the Use of Antimicrobials in Food Animal Production*, 1 Microbes and Infection p.29 (1999); and Fidler, International Law and Infectious Diseases. On global tobacco control, see Allyn L. Taylor, *An International Regulatory Strategy for Tobacco Control*, 21 Yale Journal of International Law p.257 (1996); and Fidler, *Trade and Health*.

61 WHO, *Health for All in the 21st Century*, WHO Doc. A/51 (1998), at para. 52 (stating that WHO "will develop international instruments that advance global health, and will monitor their implementation; it will also encourage Member States to apply international laws.").

62 See, e.g., Katarina Tomasevski, Sofia Gruskin, Zita Lazzarini, and Aart Hendriks, *AIDS and Human Rights*, in AIDS in the World (Jonathan M. Mann, Daniel J. M. Tarantola, and Thomas W. Netter, eds. 1992), p. 537; Sofia Gruskin, Katarina Tomasevski, and Aart Hendriks, *Human Rights and Responses to HIV/AIDS*, in AIDS in the World II (Jonathan M. Mann and Daniel J. M. Tarantola, eds. 1996), p. 326; and Lawrence Gostin and Zita Lazzarini, Human Rights and Public Health in the AIDS Pandemic (1997).

policy also stresses the importance of human rights to global health policies.[63] In addition, NGOs around the world have impressed on WHO the need to advocate for health as a human right, the so-called "right to health."[64]

The relevance of international law to the role of transnational society in health development goes beyond international human rights law. As globalization proceeds, a number of international legal regimes affect public health, including international trade law, international intellectual property law, international labor law, and international environmental law. I have described WHO facing an "international legal tsunami" because of all the international legal issues it will have to confront,[65] and I think that this tsunami also bears down on health-related NGOs and poses a difficult challenge for transnational civil society in promoting health development.

In the public health context, national law is also very important, and forms part of the legal context of transnational civil society activity on health development. Unfortunately, national public health law has not received much more attention historically than international law on public health. WHO conducted a pilot study in 1997 in 37 WHO Member States that revealed a global lack of capacity on public health law.[66] The pilot study concluded that WHO had to provide leadership in building public health law capabilities in WHO Member States, particularly in the developing world.[67] NGOs also face the problems created by the lack of public health capabilities in many countries around the world and should play a role in trying to remedy this problem.

The increased attention on international law and the growing awareness of the need for better national public health law underscores the importance of law not only to WHO's future but also the future of transnational civil society's efforts on health development. An upcoming event signals that national and international legal issues are appearing on the global public health reform agenda. The University of Durban-Westville and the South African Medical Research Council are sponsoring in November 1998 an International Colloquium on Public Health Law in Durban, South Africa. A wide spectrum of issues will be discussed at this Colloquium, including (but not limited to) international law and global public health, the environment and public health law, trade and public health law, poverty and public health law, HIV/AIDS and public health law, and human rights and public health law. The agenda of this Colloquium provides a glimpse of the many and complex legal challenges facing States, intergovernmental organizations, and transnational civil society in the era of the globalization of public health.

Very important to understanding the legal aspects of global public health concerns is that international and national laws are interdependent levels of law. Improving capabilities to handle

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63 WHO, *Health for All in the 21st Century*, para. 2 ("Respect for human rights and the achievement of public health are complementary.").

64 See WHO, *A New Global Health Policy for the Twenty-First Century: An NGO Perspective*, p. 17.

65 Fidler, *The Future of the World Health Organization*, p. 1107.

67 Aude L'hirondel and Derek Yach, *Develop and Strengthen Public Health Law*, 51 World Health Statistics Quarterly pp.79, 84-86 (1998).

67 Id. p. 86.

international and national legal challenges has to be seen as an interdependent task, not two isolated ones. In presenting the results of WHO's pilot study, L'hirondel asked: "What would be the use of a framework convention on tobacco if countries have absolutely no capacity to adopt and implement domestic legislation in accordance with this convention?"[68] This interdependency also affects how NGOs approach international and national law in their efforts at health development.

To provide a way to think constructively about this legal interdependence, I have developed the concept of *global health jurisprudence*. What States, intergovernmental organizations, and NGOs face is the challenge of crafting a global health jurisprudence—"that body of rules, strategies, and procedures that allows law in all its forms to support public health."[69] As I have written:

> The objective of developing a global health jurisprudence is to identify legal concepts, standards, and approaches that best promote public health. The world's diversity will ensure that any global health jurisprudence remains complex, but the concept of global health jurisprudence seeks to generate a common discourse about the relationship between law and health. This discourse will emanate from treaties, international regulations, international recommendations and standards, international soft law norms, customary international law, national statutes and administrative regulations, and cases settling disputes.[70]

I believe that the concept of global health jurisprudence provides a way to keep the global nature of public health problems always in perspective. Because national and international law on public health are interdependent, working with law in the context of globalization of public health requires moving from the global to the local, and from the local to the global, both of which demand re-thinking traditional distinctions between national and international law.

But global health jurisprudence also captures the interdependence of national systems of law and the need to keep such interdependence in mind. National legal reform undertaken without consideration of the global consequences of such action clashes with the spirit of global health jurisprudence. For example, the proposed settlement in the United States between state governments and U.S. tobacco companies violated the essence of global health jurisprudence because the settlement contained nothing that suggested the participants understood or cared about the global nature of the tobacco pandemic. The proposed settlement looked at tobacco consumption as a "United States" only problem without regard for the U.S. tobacco companies efforts to penetrate the markets and lungs of millions of people in

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68 Aude L'hirondel, An Initial Assessment of the Needs for Capacity in Public Health Law, presented at the International Conference on Global Health Law, New Delhi, India, Dec. 5-7, 1997.

69 Fidler, *The Future of the World Health Organization*, p. 1117. This article develops global health jurisprudence in more detail. I also use the concept of global health jurisprudence in Fidler, *Legal Challenges Posed by the Use of Antimicrobials in Food Animal Production*; and Fidler, International Law and Infectious Diseases, pp. 303-309.

70 Id.

the developing world.[71] Similarly, failure to take needed national legal action can threaten health in other countries, as illustrated by the legal challenges posed by dealing with the development of antimicrobial resistance:

Because antimicrobial resistance is a global problem, national legal reforms taken in one or a few countries would suffer if other countries did not take similar actions. For example, since drug-resistant pathogens travel easily in today's world, national legal reforms to rationalize antimicrobial use in a few countries might be subverted if such misuse is not curtailed in many other countries. The creation of new international legal duties would likewise be undermined if such duties were not translated into national law. Thus, any legal strategy against antimicrobial resistance must be pursued at both national and international levels.[72]

I believe that WHO and NGOs have to foster the development of global health jurisprudence as advocates for world health because "[g]lobal health jurisprudence will not spontaneously appear for the benefit of human health."[73] In this respect, health-related NGOs will be following in the footsteps of NGOs that have done so much to develop labor standards, human rights, and environmental legal norms at both national and international levels. I believe that the concept of global health jurisprudence should become a focus of NGO networks on global public health. This concept's development will require the intensification of legal activity among NGOs, between NGOs and intergovernmental organizations, and between NGOs and States.[74] In short, global health jurisprudence can become a strategic element in transnational civil society's solidification of its role in the global politics of public health.

Conclusion

Reflecting on the NGO revolution in international relations and international law to find general lessons for transnational civil society efforts on health development in the Americas produces a kaleidoscope of political, economic, scientific, technological, and legal issues. This Seminar's express purpose of enhancing the capacity of groups from transnational civil society to influence the formulation of public health policies seeks to tap into the perceived global power of NGOs witnessed in other fields of human endeavor. Drawing from this well of information and inspiration brings us into contact not only with issues specific to NGOs but also with the unfolding transformations in the nature of human interaction. These transformations contain the potential for good and evil, thus coloring ambitions for increased activity by transnational civil society with hope and fear. NGO involvement in international relations throughout history suggests that NGO activity is necessary but not sufficient for human betterment.

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71 See Taylor, *An International Regulatory Strategy for Tobacco (*analyzing efforts of U.S. and British tobacco companies to sell tobacco products in the developing world).

72 Fidler, *Legal Issues Associated with Antimicrobial Drug Resistance*, p. 175.

73 Id.

74 Id.

It is, thus, fitting that this Seminar aims to launch in the Americas a renaissance for transnational civil society in the health development area. This aim also underscores the need to encourage the empowerment of health-related NGOs on a global scale. No one at this Seminar needs lecturing on the public health problems crippling human betterment in the developing world and the pitfalls of approaching these problems with anything less than a global vision. In the era of globalization, human responses to public health problems require more than ever the discipline and determination of private individuals and groups linked locally and globally in pursuit of health for all.

CIVIL SOCIETY PARTICIPATION

Dev K. Ray

Health systems in many countries across the world continue to be in a state of crisis. Inadequate resources, inaccessible and unresponsive services, and dissatisfied users and providers are some of the major problems encountered. Developing countries carry 90% of the global burden of disease, yet it is in these countries that the problems are often the most severe. Scarce resources are being used inefficiently with vital programs and services seriously underfunded. Excessive bureaucracy, lack of transparency and accountability, and corruption plague all levels of the health services. The growing dissatisfaction with public health services among users is leading to a rapid increase in private funding and delivery of health care. The actual health outcomes of private services are a moot point, but clients appear to prefer the higher responsiveness shown by private clinics to their needs.

In this context, active participation of civil society in health assumes great relevance. The involvement of civil society in health has long been advocated as a means of improving health systems performance. Civil society here refers to non-governmental and not-for-profit actors—individuals, groups and institutions—who have the potential to make significant contributions at various levels of the health system. While professional medical associations fall within this category, they have thus far dominated the process of setting health agendas. Of much greater interest are individuals and groups that are more representative of the lay community and who have usually played a marginal role to date. In this paper, I first review the rationale for participation. Then I shall distinguish between the rhetoric and the reality in the

last few decades. Some major reasons for the failure to meet expectations will be discussed. One ongoing experience will be examined. I will end by highlighting some major lessons and the outlook for the future. Much of the paper focuses on developing countries although I have touched on the experiences of developed countries since important lessons and parallels can be drawn.

Rationale for Participation

The "market" for health care is not a perfect market and has built-in biases. First, provider/consumer links are skewed from the point of information sharing. Providers of health care exercise a high level of control over their negotiations with consumers and in deciding the nature of treatments. Secondly, it is the providers who usually dictate where and when care is to be provided, and the opening hours of clinics and health centers seldom reflect the preferred choices of patients. Thirdly, health professionals primarily control the planning and implementation of health services, while consumers do not exercise any marked influence. The only area where consumers seem to exercise their choices is in selecting the type of care and their preferred provider.

Lay participation in setting and implementing health agendas has been seen as a means to improving the quality of decisions because priorities and the consequent resource allocations will conform more closely to community needs. Participation is also viewed as way to increase commitment to implementation by enhancing accountability and transparency in the health services. The community touts lesser corruption, increased efficiency and improved discipline within the health services as potential benefits of active participation.

There is also a major political dimension to civil society participation. Calls for participation are based on specific notions of citizenship in a democracy. The push for participation may come from both ends of the political spectrum with very different motivations. The 'new' right is concerned with reducing the power of the centrist state, checks on bureaucracy, and stronger consumer rights. In contrast, the left is mainly concerned with equal opportunities and access—in particular, the empowerment through involvement of disadvantaged groups.[1] The future of the nature and extent of civic participation will be driven in part by political shifts between, on one hand, a highly participatory society with an emphasis on collective obligations and, on the other, a representative democracy with a limited role for the citizen emphasizing individual freedom of choice.

However, the use of different terms are themselves subject to interpretation. Community involvement and participation have usually centered on organizing and tapping the resources of a collection of people at the local or grass roots level. Thus, much of the effort goes into organizing and educating these groups and creating structures, which sometimes have quasi-governmental status such as village health committees or district development committees. By civil society, however, we mean a multitude of

1 Taket A., Curtis S. *Health & Societies: Changing Perspectives*. Arnold. 1996.

institutions, voluntary associations and networks—women's groups, trade unions, chambers of commerce, farmers' and traders' cooperatives, neighborhood associations, religious based organizations and so on.[2] Thus these are already formed groups—often oriented towards specific issues or interests—that can be supported but need not be created. We shall talk about both approaches, realizing that it is a continuum and no strict separation of the two concepts is possible.

Rhetoric for Participation

The rhetoric of civic participation in the health system is very widespread. Community involvement is one of the principal elements of the WHO Health for All (HFA) strategy. In the Alma Ata conference in 1978, primary health care (PHC) was stated to be the key to attaining HFA targets and that, inter alia, it "requires and promotes maximum community and individual self-reliance and **participation** in the planning, organization, operation and control of primary health care…."[3]

The Global strategy for Health for All by the year 2000 adopted by the World Health Assembly in 1979 presented a mandate for social control of health systems. It was bold in its scope and ambition. There were a few instances of communities that had become empowered in health issues but these were isolated cases on small scales. But there was no known precedent for large government-run systems working harmoniously in partnership with numerous empowered communities.

The third evaluation of progress towards HFA goals carried out in 1997 indicates that almost all countries appear to consider community involvement important in building effective and sustainable primary health care.[4] At least in policy, there is an explicit commitment to community involvement.

In advanced countries, calls for ensuring public participation in planning and implementation have translated into several mandates and legislative initiatives. For example, the Congress in the USA enacted the National Health Planning and Resources Development Act to create Health Systems Agencies with consumer majorities on their governing bodies. In general, most advanced countries have created mechanisms to provide for community inputs to policy development.

The Reality

Before looking at the actual progress made towards genuine participation, it may be worthwhile to have a quick overview of the different possible types of participation. A central dimension is the degree of participation, which is well summarized by Arnstein in his ladder of participation.[5] He distinguishes eight degrees of participation ranging from control by citizens through partnerships to non-participation

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2 *Our Global Neighborhood*. The Report of the Commission on Global Governance. Oxford University Press. 1995.

3 World Health Organization. *Alma ATA 1978.* Primary Health Care, *Health For All* series #1. World Health Organization. Geneva. 1978.

4 World Health Organization. *Evaluation of the implementation of the global strategy for Health For All by 2000: 1979-1996.* WHO/HST/98.2. World Health Organization. Geneva. 1998.

5 Armstein S.R. "A ladder of citizen participation." *Journal of the American Institute of Planner* 35, 216-24, 1969.

where citizens are passive recipients of care. Different levels of participation may operate simultaneously in different parts of the health services. The types of participants and their roles, rights and responsibilities are also important considerations. The process of participation, in terms of the enabling mechanisms and structures, has a direct bearing on its effectiveness. A necessary element of the process is facilitating access to participation, such as access to relevant and timely information presented in simple understandable terms and creating appropriate environments for meetings.

Civic Participation: The 1970s

In the 1970s, several experimental projects were underway to bring basic health services to marginalized populations. Many of these projects envisaged community involvement often through use of locally recruited community health workers. Community organizations created in the course of these projects served to assess local needs, set priorities, provide the health worker and link health activities to larger development goals.

International agencies such as WHO and UNICEF showed growing interest in these projects and concurrent acceptance of the crucial role of community involvement. As described before, one of the aims of the global strategy for HFA was to get governments to introduce, replicate and institutionalize active community participation. The decade ended with high expectations, ambitious plans and a generous outpouring of donor support.

Civic Participation: The 1980s

In the early 1980s, many countries attempted to mobilize communities for PHC. One common route was to:

- require community leaders to form a local health committee;
- to get this committee to appoint a health worker and then;
- to train the health worker for delivery of certain basic services; and
- to support and supervise activities from the nearest health service station.

In some countries, a degree of active community involvement was indeed achieved. Benefits included increases in immunization coverage, higher attendance at PHC units and enthusiastic participation in public health campaigns.

But in other countries, very little progress was made. A few failed to mobilize communities in any significant way. Others found it difficult to sustain community inputs. A particular problem was the interface between the health system and communities. The peripheral health workers were inadequately trained to engage in the complex process of facilitating community participation. They also lacked the time and resources

to effectively support community health workers. In general, a common recurrent pattern of promising initial activities followed by failure and lack of sustainability was evident by the end of the last decade.[6]

The health service staff had not internalized the philosophy of civic participation. In fact, many health personnel had a negative attitude towards community involvement. Logistical support for sustaining participation structures was grossly inadequate. There was little evaluation of community participation and monitoring indicators were generally lacking.

Civic Participation: 1990 to Present

The 1990s have been a time of fiscal crisis and belt tightening by governments of many poor countries. Real resources for health have been squeezed. Health care costs have been a major concern for rich countries as well. This has been one of the major driving factors of the health sector reform process.

Decentralization of health responsibilities and budgets is taking place up to the regional level and beyond in several countries. In a few instances, decentralization has moved to the community level. In general, participation by the community appears to be linked to tapping community resources in addition to economic development, democratic traditions and a culture of cooperation. Decentralization is often viewed by the population as shifting responsibility downward in order to deal with resource shortages and the growth of private sector.

Increased cost recovery has been another common feature of the reform process. The shift of costs to individuals and households has increased community concern and participation in some places. A growing private sector has reduced involvement in other countries.

In developed countries, a large number of community-based interest groups are very active in shaping health policies. These groups are often well organized and well funded with clear mission statements, objectives and work plans. In addition to local operations, they operate at the regional and national levels through alliances and coalitions.

The overall experience of developed countries regarding citizen participation has been mixed. The Health Systems Agencies in the United States created by legislation have been criticized for reducing real participation to tokenism. In the UK a variety of mechanisms exist to provide a lay voice in policy development, but studies show little success in reaching decisions that contradict local professional or administrative decisions. Experiences from elsewhere also suggest that the medical establishment often sets the terms for debate. On the other hand, where innovative and proactive approaches to facilitating participation have been adopted, a higher degree of lay participation is evident.

Countries in transition, i.e. former communist states, face a peculiar problem of some resistance in the community to being mobilized. This reflects in part a residual distrust of governments and the shock of radical economic and social changes. Among developing countries, a variety of approaches are currently being used, e.g. local committees including cooperatives and women's groups; partnerships with NGOs,

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6 World Health Organization. *Community involvement in health development: Challenging health services*. WHO Technical Report Series #809. World Health Organization.

schoolteachers, religious leaders, private sector, etc.; and district health teams. Some countries have witnessed an intensification of this aspect, e.g. Bangladesh, Myanmar, Chad, Uganda, Indonesia etc. Some, such as Sri Lanka, note a trend of decreasing enthusiasm with modernization and increased individualism.

In addition, almost everywhere, it has proved difficult to mobilize urban communities. Cultural heterogeneity, mobile populations and breakdown of traditional structures are some of the factors responsible. Although harder to organize along a geographical dimension, urban communities can be mobilized along other dimensions such as common occupations. Trade unions, religious associations and local NGOs could be the main partners for health services in urban settings. In general, in most developing countries, barring a few localized successes, civic participation in health is limited to token representation at various levels.

Reasons for Failure to Meet Early Expectations

Some major reasons for the failure to progress in involvement of civil society include:

- resistance in the health establishment, often within the ministries of health, to sharing power and resources with partners;
- domination of proceedings by the relatively resource-rich and articulate professional associations and provider representatives at the expense of other participants;
- informed and educated communities are still an exception rather than a norm;
- lack of skills among health service staff at various levels on how to initiate and manage the participation process;
- unrealistic time frames (developing structures for community participation is a complex and time consuming process);
- growing private funding and delivery of health care; and
- donor disenchantment in 1980s and early 90s with initial experience with PHC and a shift to 'blueprint' and vertical approaches wherein communities are basically instructed on what to do.

Experience in mobilizing civil society in developing countries is somewhat limited but recent experience in Zimbabwe suggests that, with an active promoter, it can be done. The following example illustrates the experience.

The Experience of Zimbabwe[7]

In 1980, Zimbabwe embarked upon an ambitious social development program with an emphasis on equity. Investments made in health in that decade produced significant reductions in overall morbidity

[7] Loewenson R. Personal communication. 1998.

and mortality, and also narrowed health gaps among different social groups. However, in the 1990s, the combined effects of AIDS, drought and poor economic performance have reversed some of the gains. There is currently a large gap between demand and resources available for health care as well as considerable public and professional dissatisfaction with the state of health services.

In this context, constituent groups gathered recently to collectively share experience and information on health, to analyze the situation and put forth strategies to address problems as seen by their members. The civic groups involved are primarily membership organizations, mainly national but with some local groups. Groups represented include private and public formal workers, small scale farmers, informal sector workers, youth, women, churches, AIDS patients, environmentalists and others (the combined membership of which totals 3.5 million).

An initial core of seven civic groups already involved in health carried out a survey of the membership groups active in Zimbabwe. The intent was to determine their health related activities and views on the main issues in the health sector. The results of the survey were clustered into 14 sets of membership views. Technical papers were commissioned to obtain background information on those views. The survey results, along with relevant technical information, was fed back to the civic groups. The civic groups agreed to form a network organization called the Community Working Group on Health (CWGH). The CWGH has been interacting with the health sector to ensure that community views are an input to policy development and implementation. The CWGH has summarized and submitted community views on priorities and strategies for the health sector to the national government. It had disseminated to professional and public groups a position paper on health financing as part of advocacy to enhance resources for health. It has also initiated dialogue at local level between health care providers and civic groups.

A recently completed analysis of this experience has suggested that the process for forming participatory structures should be supported by empirical evidence on current views and practices of the different social groups involved. Their own expectations of and views on how to structure participation are important if such structures are not to be dominated by articulate political or professional interests.

Lessons Learnt

What lessons have we learnt from the past experiences in community involvement/participation? First, community means different things to different people. To some, it is the unit that is closest to the grass roots and to others it is the representative institutions and groups.

Second, the importance of civil society participation is acknowledged but rarely pursued by governments. It is often the pressures generated by the civic groups that lead to recognition by formal governance structures.

Next, the civil society itself is often fragmented and does not act in cohesion. The organized groups are often formed around particular themes and their interests revolve around such themes to the exclusion of others, e.g. employment for trade unions, women's status for women's groups, etc.

Also, the empowerment of civil society in forming a cohesive, strong voice has its own perils. Some of the groups are corruptible and motivated by material gains, as examples of some booming non-governmental organizations show. Others are theme oriented. To bring them together implies some selection on the basis of certain criteria and the existence of a self-appointed catalyzer. Moreover, the cohesive voice may be powerful but in seeming opposition to the formal institutions.

Fifth, there is also the danger that once an institutionalized civil society for health is formed, it may assume all the characteristics of the current formal health system. It may become medicalized, and professionals may become the dominant partners.

Future Directions

Whatever potential dangers may exist, one must go forward in mobilizing civil society in the interests of health development and to represent the voice of consumers. However, in the same way that civil society derives its strength from collectivity, there is a need to form networks of institutions and groups within and between countries. Networking is currently in fashion but is costly in terms of time and resource commitments. It is the task of governments to identify potentially strong and committed groups—groups that are socially conscious and active. Such groups can form the nucleus of national networks of civil society.

At the international level, regional and interregional networks are also needed to share experiences and learn from best practices. International organizations have a role in the formation and sustenance of such networks. Working through these networks will also avoid the potential problem of offending particular Ministries of Health.

If transparency and accountability of the health system is to be achieved, working with communities is as necessary as working with civil groups. Without the latter, formal health systems may remain mute in the face of population demands and needs.

DEMOCRATIZATION, HEALTH CARE REFORM, & NGO-GOVERNMENT COLLABORATION:

Catalyst or Constraint?

Alberto J. F. Cardelle

During the 1980s, the traditional, state-centric health care delivery systems that had dominated Latin America collapsed as a result of the regional economic crisis. By 1995, concerned with the economic performance and sustainability of health care delivery systems and following the advice of international financial institutions, 34 of the 38 countries in Latin America and the Caribbean had begun implementing health care reform projects. The economic crisis had exposed the imbalance and mismanagement plaguing the regional health systems and further constrained the states' ability to remedy the systems inequality and inefficiency (Musgrove 1992). Reflecting the major trends in the political economy of the hemisphere and responding to the new consensus regarding the diminished role of the state in Latin America, health care reform in the region has decentralized the delivery of health care. In addition, it has enhanced the role of the private sector in the delivery of services. Simultaneously, a regional democratization process has expanded the number of organized civil society groups, compounded the complexity of civil societies, enlarged the number of political interest, and promoted the demand for greater respect for social rights and citizenship.

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The need for states to respond to stronger civil societies within a context of fiscal constraint has led to development schemes characterized by new alliances. Collaborative projects between non-governmental organizations (NGOs) and governments have emerged as important strategies in the process of state reform. Although the opportunities for NGO-government partnerships in health care have increased, the success of these new arrangements is affected by myriad national and local factors that determine the degree and sustainability of the collaboration.

The paper examines the experiences of 20 different projects promoting NGO-government collaboration in Guatemala, Chile, and Ecuador. It is divided into three parts. The first part reviews the global trends within which the policies are being implemented and assesses the degree to which different factors, such as civil society-state relations, democratization, state reform, and international pressure, have served to catalyze or constrain policies promoting NGO-government collaboration. The second part analyzes how the goals, objectives, resources, and planning processes associated with the implementation of collaborative projects influenced project sustainability. The third section identifies the different ways in which NGOs and governments collaborate (for example, funding, coordinated planning, and training) and examines how each affects the project's outcome. The paper concludes with a set of policy recommendations for the implementation of future collaborative projects.

Global Trends

The Evolution of NGOs and Their Relations with the State

The NGO sector associated with the delivery of social services such as health evolved in three stages or generations (Korten 1987). The first generation of NGOs lasted from colonial days to the 1960s. It was characterized by organizations charged with providing relief and welfare services designed to address the short-term needs of the population. The first NGOs were closely associated with the Catholic Church, which was the strongest institution in Latin American civil society. These organizations were charitable in nature and employed an "assistantialist" approach—providing housing for the homeless, soup kitchens for the indigent, and free hospitalization for the poor. (Hospitals were the venue of care for the poor, while the wealthy received care at home.)

A second generation of NGOs emerged during the 1960s and was dominated by groups that emphasized a technical, modernization approach to development. The shift in logic, from charity to technical assistance, helped NGOs become significant recipients of international aid. Their growing professionalization made aid agencies more responsive to using them as vehicles of development.

The third phase of NGO development came during a period of growing political repression and collapsing state-centered industrialization in the 1970s and early 1980s. It accelerated the formation of NGOs desirous of influencing national policies in favor of the poor, providing services that weakened states could not, and helping to open new political spaces in the face of growing repression. It was during this phase that the NGO sector and popular sector movements began to work more closely together. This

spurred NGO involvement in popular education, community organizing, and consciousness raising. The coupling of the popular movements and NGOs was a significant factor in the sector's orientation toward the state. With these new objectives, NGOs developed a strong sense of autonomy. During the third phase, NGOs championed themselves as the antithesis of the state, which relies on the legitimate use of force and coercion, and of the private for-profit sector, which responds to profit-maximizing incentives (Macdonald 1997).

Observers have noted that had NGOs aligned themselves more closely with the labor movements that emerged in the region during the period of populist governments, they would have necessarily developed more collaborative tendencies. The social movements, on the other hand, refused this kind of neo-corporatist framework and eschewed the conventional politics of interest mediation, political parties, and elections. By identifying themselves closely with the popular movements, NGOs rejected political negotiation in favor of collective claims and personal liberation (Foweraker 1995). This was clearly evident in the countries of Central America, where many NGOs became important political instruments for insurgent social movements. At the same time, it is important to note that many NGOs did not follow this evolutionary path, but instead remained within the developmentalist approach and continued to provide high-quality technical assistance to international development organizations and even the state.

The personnel who came to staff the NGOs at this time were a significant factor in determining the NGO sector's positions vis-à-vis the state. NGOs became a refuge for professionals from the public sector and academic centers. This migration not only assisted the rapid professionalization that allowed NGOs to become powerful group within civil society, but also reinforced the sector's anti-state posture. Many NGO personnel had been forced to abandon previous positions by an increasingly coercive state and, therefore, fiercely defended the NGO sector's autonomy (Cox 1992).

While the NGO sector was gaining strength, the public sector was losing both capacity and institutional strength. For some in the public sector, NGOs were responsible for diverting international aid away from stare programs and challenging the authority of the state by strengthening the collective action of a multitude of groups within civil society. NGOs were also seen as fueling a growing international scrutiny of the state in Latin America.

In many instances, NGOs felt that collaboration with the state could compromise funding from independent sources. From the state point of view, NGOs were judged according to their former and current political program. Today, in countries like Guatemala and El Salvador, NGOs are closely identified with the opposition groups they supported during the period of civil war. The state's reluctance to collaborate is directly related to this association. In order to alter the existing competitive relationship, significant incentives and guarantees must be assured.

Democratization

In countries in which non-democratic regimes limited the political space available for civil society to express its collective ideas and demands, NGOs served as a crucial forum for the expression and

articulation of those political and social interests (Jelin 1997). NGOs performed a critical role in the processes of democratization because the traditional forms of political organization had very little room for political action under non-democratic governments. They mobilized civil society into new organizational structures that increased both subnational and international pressures on non-democratic governments. It was in this spirit that the first attempts at NGO-government collaboration emerged. The onset of democratic regimes and the presence of powerful NGOs were viewed as an opportunity for governments to integrate civil society, increase participation, and improve social services. Indeed, in many countries, NGOs became integral partners in the reconstitution of democracy. NGOs that were part of the opposition became active participants in the electoral processes in the countries, in the writing of constitutions, in the creation of new governments, and in designing new social service systems.

Yet, as countries in the hemisphere continued to exhibit rising economic and social inequality and the breakdown of democratic institutions (legislatures, the judiciary, political parties), advocates of democratic institutions began to demand a broader definition of democracy. No longer were electoral processes enough. Rights of citizenship had to be guaranteed. Proponents argued that alliances among the dominant political, economic, and social groups were limiting democratization (Amini 1996). Advocates of more institutionalized democracy claim that greater levels of participation of institutions of civil society such as NGOs are required in order to hold the state accountable.

Despite the success of early NGO-government collaboration during the reemergence of democratic governance, it has been during the recent process of expanding the right of citizenship when collaboration has been most difficult. Collaboration during these processes requires new structures of governance and public administration, including collaborative decision-making bodies and arenas that allow for consultation between NGOs and the public sector. There has been a recurring assumption that the decline of authoritarianism and the rise of electoral processes would precipitate a shift in the anti-statist position of social movements and NGOs to one more open to collaboration with governments. Yet, the evidence points to the possibility of a different outcome (Diaz 1997). It seems that as the process of democratization advances, there is a parallel decline in civil society participation and in the number of NGOs. As part of a counterintuitive process, this occurs in part because authoritarian regimes provide environments conducive to the creation of NGOs as a matter of necessity. In times of authoritarian regimes, NGOs are havens of democracy and, therefore, find a new broad base of support. In contrast, as the new democratic regimes pursue electoral legitimacy and battle to institutionalize themselves, the rationale behind NGOs becomes less compelling, and NGOs find it more difficult to articulate their goals and objectives.

Case Study: NGOs in a Pacted Democracy

During the authoritarian regime of General Augusto Pinochet in Chile, among the most active organizations in the opposition were the NGOs working for women's rights. Organizations such as the *Colectivo Mujer Salud y Medicina Social* and the *Centro de Estudios de la Mujer* were active in the struggle

for democracy. Following the victory of President Patricio Aylwin in 1990, these NGOs were viewed as integral groups that could continue to motivate the social participation of civil society. The new government was hopeful that "the work of the NGOs in the previous phase (struggle for democracy) [would] continue in this next phase and that NGOs [would] continue serving as a conduit of international solidarity and support" (Jiménez 1996). The democratic government of President Aylwin issued a document entitled "Policies for Private Development Corporations and NGOs" in which it was stated that

> …the new government recognizes the value that these organizations [NGOs] have in the promotion of development and it therefore promises to respect their autonomy, support their institutional development and in those areas where it is possible, and establish working agreements so they may cooperate with the implementation of public policy.

This period of opportunity resulted in very concrete manifestations of collaboration, including the creation of a department specifically dedicated to NGO-government collaboration within the Ministry of Development and Planning (MIDEPLAN), and a new agency of the executive branch, the National Service for Women (SERNAM), a coordinating body aimed at promoting programs for women. The Ministry of Health (MINSAL) along with SERNAM and the Pan American Health Organization (PAHO) funded a project aimed at improving the quality of health services for women. The project combined the resources and services of the state via MINSAL and SERNAM and the expertise of NGOs working on women's issues. The project provided these NGOs with project funding in order to design and implement new service delivery models targeting women, analyze the existing needs of women in the country, design and evaluate health policies and their impact on women, and examine the existing legal framework regarding women's rights. Between 1991 and 1993, the program funded 10 different projects throughout the country, which resulted in the development of important health policies and a strong relationship between the state and NGOs. Yet three years later, many of the NGOs were disillusioned with the process. Most felt that the democratization process had weakened them. While during the period of authoritarian government NGOs were the primary beneficiaries of international aid, now more aid went directly to the state, leaving the state as the primary contractor of NGOs. This forced NGOs to respond to the state's programmatic agenda instead of having the opportunity of developing their own programs. In addition to losing direct contact with international financing, the international perception that Chile had undergone an economic recovery had led to an overall decline in international aid.

NGOs have also suffered from a diminution of staff. Many of the people, who came to NGOs from the public sector or academia to elude political repression, have moved back to the public sector. Another important factor, according to the NGOs, is the increasing role played by technocrats within the government. As the state moves to strengthen its institutional structures, it has emphasized greater technical efficiency in policymaking, leading to a technocratic style of policymaking. According to the director of a consortium of NGOs working on women's health issues, this new technocratic bureaucracy

is not conducive to collaboration because NGO-government collaboration requires a process of social and political dialogue, which, in turn, requires a significant investment in time and resources. Since the short-term rate of return for collaboration is minimal, given the level of negotiation and compromise required, collaboration is an unattractive strategy to technocrats. NGOs in Chile also feel that the pact between the authoritarian regime and the Chilean democratic forces generated a self-imposed censorship among groups within civil society against criticizing and making demands upon the state. The confluence of these factors constrained the type of environment required for NGOs and the state to collaborate.

State Reform

With guidance from international financial institutions (IFIs) and the Paris Club of donor countries, Latin American countries responded to the economic crisis of the 1980s with austere economic stabilization programs. Structural adjustment programs aimed at curbing inflation, decreasing fiscal deficits, shrinking the state, liberalizing the economy, and privatizing state enterprises followed stabilization programs. The traditional state-centric health care delivery system in the region, despite some successes, collapsed during the economic crisis. As a result, state revenues dedicated to public health programs and capital investment fell from a regional average of 9 percent in 1980 to 5 percent in 1985. The crisis exposed the health system's imbalance and mismanagement, while the rapid debt accumulation that triggered the crisis further constrained the state's ability to address the system's inequality and inefficiency. Proponents of the need for fiscal austerity saw the health sector as an integral component for the overall reform and economic development of the state, since the health sector's lack of financial viability presented a threat to the broader economic structural programs. Investments in health began to be seen as essential in order to ensure a productive workforce. Communicable diseases such as HIV/AIDS and tuberculosis cumulatively account for millions of years of lost life annually, and health sector expenditures in the hemisphere account for an average of 11 percent of gross national products (GNPs), representing a considerable economic component of productivity and employment (PAHO and ECLAC 1994). In response, a regional health care reform "fashion trend" emerged. Reform programs were undertaken or planned in 34 of the 38 countries in Latin America and the Caribbean.

Health care reform in Latin America and the Caribbean has resulted in decentralizing health care delivery and has increased the role of the private sector in the delivery of social services by altering the way the system is financed. The delivery of health services is being decentralized to regional health entities, municipal governments, and local health entities, municipal governments, and local health systems. Proponents of decentralization claim that local entities will increase responsiveness to local needs, improve access of the poor to health services, and increase management adaptability and flexibility. This has meant that these local structures are charged with the delivery of services, purchase and allocation of resources, contracting and management of personnel, selection of technologies, design of programmatic interventions, and coordination of both governmental and non-governmental entities providing health care.

The new health care financing schemes are designed to provide the decentralized health entities

with a more efficient, streamlined funding mechanism. Under the existing financing scheme, service has been segmented according to where patients access their services. The social security system is responsible for workers in the formal sector, whose employers pay into the system (about 15 percent of the population), while the central Ministry of Health provides care for the remainder of the population (with a small percentage of the population using the private health care market). Within each of these structures, the respective institutions finance and administer the funds, and they provide health services to their target populations in a vertically integrated system in which each institution is the sole participant.

In the health systems envisioned in various reform proposals, the entire system (especially ministries of health services) would be open to more institutions in the hope of diversifying the providers and increasing competition. Under these new systems, the Ministry of Health and Social Security would regulate and finance services, while the administering of the system and the provision of the services would be provided by decentralized institutions of the national government, by local government entities, or by private entities.

Both the decentralization of the health care system and the new financing schemes being established are designed to open the system to a greater number of private providers. It is expected that by aggregating private decisions, the market represents "public interests" better than the political realm, which is affected by personalism, clientelism and populism (Mahon 1995). In advancing the role of the overall private sector, the health care reform processes promote a greater role of the private non-profit (NGO) sector in the region. The expectation is that the limited technical and organizational capacity of the new decentralized health entities, as well as the pressure to contain costs, will persuade the entities to contract with private sector groups such as NGOs that have experience in delivering services locally.

In general, health care reform has increased the opportunities for NGO-government collaboration. Most importantly, reforms have lifted the financial and administrative barriers that prevented NGOs from serving as contractors. Under these systems of open competition, the opportunities for collaboration are strengthened by the market advantage NGOs enjoy over other private sector entities. NGOs have experience in providing health care services in the regions that are being decentralized. They have a good reputation with international donors and communities, and they usually provide a wide array of social services such as community organizing and participatory health education and training, which go beyond the services found in a "basic package of services" financed by governments.

Paradoxically, reform programs also limit collaboration because they emphasize a contractual type of NGO-government collaboration for the provision of more efficient and cost-effective social services. This is in contrast to the perspective and interest of NGOs, which seek a broader-based relationship—one in which NGOs can continue their work as strong advocates for the basic needs of the population and in which they may truly collaborate. The reform context favors considerations of efficiency, emphasizing NGO program management and administration. Less attention is paid to the qualitative dimensions of collaboration and the possibility of a greater role of the NGOs in project planning and design. The importance placed on "collective goods" by NGOs makes them more likely to provide such

needed services as free care to the poor, public health services, and popular education, but these are services that the new reformed health systems will not finance. Under health care reform, collaboration is not only defined but also implemented and governed through economic and market strategies (contracts, bids, capitation reimbursement, basic package of services, and so on). Additionally, the contract regime usually reimburses the entities after the provision of services, in many instances months after the NGOs have provided the services. This requires NGOs to continue to underwrite a considerable amount of their activities. The emphasis on pecuniary considerations also includes greater emphasis on complex financial and administrative procedures and reporting mechanisms. This, coupled with the limited institutional capacity and weaker financial foundations that characterize NGOs, makes it difficult for NGOs to collaborate with the state through a "contractual regime." The fragile economic foundations of NGOs limits their capacity to participate as equal partners in traditional bidding processes, reimbursement procedures, procurement practices, and contractual restraints.

Case Study: NGO and Health Care Reform

In cases where economic reform measures have been vigorously implemented, as in Chile, policies promoting collaboration have failed to produce collaborative relationships that satisfy the needs of both sectors. NGOs such as Fundación Cristo Vive (FCV) and La Caleta are what can be considered the "new proto-typical NGO," in the sense that they are subcontractors of the ministries of health. These NGOs are among the few service-providing NGOs that have made the transition from international aid recipient to government contractor. The shift has required that these two NGOs strengthen their financial and administrative capacity.

In the case of FCV, the organization was forced to secure funding beyond the government contract so that they could have the financial flexibility required to cover their operating expenses, since the government required 12 to 18 months to reimburse the NGOs for the services rendered. The organization has also found itself subsidizing many services because it provides services beyond those covered by the government contract. This also means that they begin to attract patients outside their target population (the population for which they are paid) because of their growing reputation. FCV has had to integrate its reporting system and preventive health care program with that of the state, forcing it to modify its administrative system and increase its personnel. According to organization officials, the new contracting system has also increased competition among providers. While previously the organization was more likely to coordinate and collaborate with other clinics and NGOs, now each clinic is in competition for patients and funding, thus making it less likely to coordinate and cooperate with others in the provision of services.

In a similar vein, organizations like La Caleta, a small NGO specializing in substance-abuse treatment and intervention programs, have found it difficult to sustain their activities because government contracts in specialized health care areas have tended to be short-term and renewable through competitive bidding processes. This has meant that the organization has found it difficult to carry out long-term planning

because it never knows what resources it will have at its disposal. For three months at the end of every contract, the organization is also required to re-compete for funds, increasing the need for an administrative capacity able to produce sophisticated proposals and financial reports.

The International Health Regime

A common underlying factor running throughout these national and global trends has been the role played by international organizations. International financial institutions, intergovernmental cooperation organizations, and bilateral aid agencies form part of a powerful international health regime capable of affecting the policy agendas of sovereign nations. The capacity of international organizations to impact national development policies with regard to the role of NGOs in national development has been evident for some years. After the collapse of the state-centric systems and the rise of authoritarianism, donors worked on the assumption that NGOs were more effective than the public sector in delivering social services to the poor. NGOs therefore acquired the reputation of being reliable alternatives for the disbursement of international cooperation aid in places where donors had lost confidence in the public sector. In Chile, for example, the number of NGOs grew by 87 percent after the 1973 coup, due to the international community's growing skepticism regarding the public sector. The influence of the international community in the rise of the NGO sector is reflected in the dramatic increase in the international aid being channeled through NGOs. NGOs channeled US$0.9 billion in 1970, US$1.4 billion in 1975, US$4 billion in 1985, and in 1990, NGOs channeled US$5.2 billion in the area of health alone and about 20 percent of all "official development assistance" (World Bank 1993; Bebbington and Thiele 1993). More recently, causal evidence of the role played by the international regime in the implementation of state reform is detectable in the synchronized fashion in which health care reform policies have been implemented across the majority of the countries of the region. Policies promoting the greater involvement of NGOs in the delivery of health care portray similar patterns, given that nearly 20 countries in the region have implemented similar policies within the last five years without any apparent groundswell of support in favor of greater NGO collaboration from within the countries.

A great part of the interest in NGOs in health emerges from the recent interest by the World Bank, the Inter-American Development Bank (IDB) and the Pan American Health Organization (PAHO) in promoting greater civil society collaboration. This interest is evident in the growing role the World Bank, previously somewhat uninterested in non-state actors, is granting NGOs. In 1988, for instance, only 6 percent of the organization's projects included NGO-government collaboration, while in 1994, the projects in the hemisphere that involved NGO-government collaboration accounted for 50 percent of the organization's projects portfolio (Malena 1995). Over the last few years, these organizations have begun to recommend liberal democratic governance as an important condition for the sustainability of economic reform and growth. Since the early 1990s, the multilateral organizations are no longer prescribing or making loans contingent upon economic reform, but rather are emphasizing the implementation of strategies promoting democracy, decentralization, community participation, and respect for civil liberties (Vacs 1994).

As a result, most, if not all, of the major international multi- and bilateral organizations have instituted an initiative encouraging NGO-government collaboration. These organizations have been promoting such collaboration using different strategies, which include the strengthening of NGOs, the creation of NGO networks, and the inclusion of NGOs in aid programs. These organizations have also employed NGOs as a mechanism to improve their ability to deliver technical cooperation and assistance. NGOs have been used to help the organizations better identify the needs of communities, give representation to underserved populations, and channel resources to isolated groups. These organizations have emphasized the inclusion of NGOs in the process of policy formulation and social development by facilitating the creation of suitable mechanisms that foster the collaboration between NGOs and the state. The idea is to establish channels of representation so that the society as a whole may be ensured participation in the health policy process. PAHO has actively supported the inclusion of NGOs in the health reform debate and in the reform process in countries such as Belize, Guatemala, Ecuador, and Chile. The basic strategies for these objectives include the promotion of systematic work alliances for program planning and execution, taking into account the institutional comparative advantages of NGOs and governments.

The influence of the international community is also illustrated in the declarations and documents presented at international intergovernmental summits. Initiative 17 of the Plan of Action of the 1994 Miami Summit of he Americas, states "... health care reforms will include decentralizing services, reorienting budgetary allocations to favor the poor, developing new, financial mechanisms and encouraging greater use of NGOs." (Summit of the Americas, 1994) In the program of action of the International Conference on Population and Development, Chapter 15 is dedicated to partnerships with the NGO sector and states that "governments and intergovernmental organizations should integrate NGOs and local community groups into their decision-making..." (UNFPA 1994).

Until now, the projects funded by international organizations seeking to create an enabling environment for NGO-government collaboration have produced intense but unsustainable projects. International organizations influence national policymaking and therefore transmit their policy preferences using two major mechanisms. First, organizations use their financial leverage via loan and aid conditionality in order to compel states to implement specific policy packages. Many of the health care reform loans arranged by both the World Bank and the IDB will have specific requirements for NGO involvement. A second mechanism, a dense network of policymakers who permeate both national institutions and transnational organizations, allows policies to become part of the technocratic consensus within the network. In many cases, policymakers move with ease from positions within international organizations to positions within the national governments and vice-versa. That allows these policies to become important components of reform packages. Yet while these policy-influencing strategies can precipitate the rapid implementation of policy packages (because they are usually linked with aid and financial resources), they are difficult to sustain because once the financial incentive ends, policymakers are less committed to the policy objectives. This contrasts approaches in which the incentives and the proponents of collaboration are internal and, therefore, can count on long-term political commitment.

Case Study: The World Bank, NGOs, and Government

PACT, an international consortium of NGOs, worked closely with the Association of Service and Development Institutions (ASINDES), a Guatemalan consortium developed in the late 1980s, at a time when the NGOs decided on a strategy of closer collaboration with the state. In the early part of the 1990s, the World Bank approached the government of Guatemala with the idea of creating a Social Investment Fund (SIF), an autonomous public entity designed to promote local development initiatives through financial support of projects carried out by community groups, local governments, NGOs, and other private groups. At that time, ASINDES was the largest NGO consortium group with a stated strategy of greater cooperation with the state, and it agreed to participate with the World Bank and the government in negotiating the SIF. ASINDES viewed such participation as a way of influencing national development strategies, diversifying and increasing the NGOs' financial base, increasing coordination among NGOs, and proving the strength and effectiveness of the NGO sector. For the Christian Democratic government, the negotiations would work toward the fulfillment of government promises of decentralization, create effective mechanisms to address poverty, increase the faith of foreign donors in the state, gain the World Bank's stamp of approval so as to attract more foreign funds, and respond to pressure from the Bank to work with NGOs.

From January 1989 to March 1990, six different World Bank missions came to Guatemala to help the government and NGOs develop mechanisms that would allow for NGO participation in the SIF. Throughout this 18-month period, there was close collaboration among the parties and even an agreement by which ASINDES would provide 1.5 million quetzales (from other funding) to support SIF non-NGO projects. After the last World Bank mission, negotiations fell apart, the government accused the NGOs of reneging on agreements of NGO support for the SIF, and the NGOs accused the government of politicizing the SIF. In the absence of an outside source like the World Bank to mediate and provide incentives, the collaboration fell apart even before it entered the programmatic stage. According to evaluations, the process failed to create a sustainable environment where the three actors were able to work together within a cooperative decision-making model. The incentives for the government to depoliticize and for the SIF to allow nonpolitical control of the fund and greater NGO involvement were not strong enough. There was little internal support within the government for collaboration. As stated earlier, a primary motivation for the government to participate was to satisfy international pressure, but that did not translate into a real desire to increase the collaboration with civil society.[1]

Some Preliminary Conclusions on Global Trends

Efforts to promote greater NGO-government collaboration in Latin America and the Caribbean have been working under the assumption that, within an environment dominated by health care reform and democratization, heightened levels of NGO-government collaboration would automatically emerge.

[1] While some of the information for this case study emerged from interviews with ASINDES, most came from PACT 1990.

Although the opportunities for NGO-government collaboration in health care have increased as a result of political and economic reforms, competing influences have actually hampered their implementation. Therefore, it is overly simplistic to talk about a direct causal effect between state reform, democratization, and greater NGO-government collaboration. There is a considerable delay in the appearance of collaboration after the implementation of democratization and economic reform policies, in part because these catalyzing factors are double-edged—creating opportunities but failing to construct an enabling environment for the collaboration of NGOs and the government.

The specific historical relations between the government and NGOs in a particular country is a significant factor that can be a barrier to collaboration, despite the easing of tensions as a result of democratization. One of the primary roles the NGO sector views itself as playing is as an arena for discussing issues regarding civil society vis-à-vis the state. The fact that the NGO sector grew rapidly when political space was curtailed, and that it still seeks to play an important role in demanding transparency and accountability from the state, lead to a situation in which NGOs find it necessary to defend their autonomy and independence.

Democratization has produced significant social and institutional changes that have permitted once illegal and marginalized groups as well as social movements to enter the national political and social arena and obtain legal incorporation. Yet the process has not automatically led to the integration of these marginalized sectors or groups into the political process. Democratization has broken down many of the existing relationships that sustained these marginalized groups. Democratization in some ways has weakened the social base from which NGOs emerged without truly creating a secure and coherent means of participation in the new political system.

The space available for integration into the national political, economic, and social space is usually crowded out by more mainstream social movements and groups, thereby leading to similar or even greater levels of marginalization and exclusion for other NGOs and social movements.

Economic reform has replaced the existing unsustainable welfare functions of the health sector with neoliberal reforms that have allowed for contractually based systems of collaboration between civil society groups and the state, leading in some instances to more efficient systems and better quality of services. Nonetheless, the problems that plagued the previous state-centered system—an inability to provide equitable access to health care services, which in turn increased costs and inefficiency—have not been addressed by the market forces introduced by neoliberal reforms. The health care reform processes being introduced are market-based systems without the incentive for contractors to implement programs that address issues of inequality. The contractual bases of collaboration promoted by reform actually constrain the NGO sector's expertise in providing collective and social goods.

The influence of international organizations is also double-edged. They rapidly create incentives for governments to view NGO-government collaboration as favorable policy and a strategic alternative. Unfortunately, they fail to create long-term and sustainable motivations that allow for the formulation of permanent state policies.

The Implementation Process

The implementation of NGO-government collaboration redefines the state-centric social contract between the public sphere and civil society. The process, in addition to the influences created by global trends, is affected by the political conflict that arises as institutions that are threatened by the new relationship resist changes to the existing social contract. The successful implementation of collaborative projects in this context requires skillful statecraft. The implementation process becomes as important as program content, in which poorly designed, executed, and funded implementation plans negatively impact the quality of the collaborative project. The following analysis looks at four basic implementing conditions that serve as a checklist against which to score the quality of the implementation process. These include the level of time and resources available for implementation; the degree of consensus on the validity of the policy; the level of interdependence, communication, and coordination of the implementing actors; and the presence of a coherent implementation process (Hogwood and Gunn 1984).

Level of Time and Resources Available for Implementation

Funds are often readily available during the initial phases of NGO-government collaborative projects. Problems tend to arise when complementary counterpart funding, especially from the ministries, is required. In Chile, between 1991 and 1993, international and bilateral organizations financed a program designed to generate NGO-government collaboration in the extension of primary care services. The program funded 90 NGOs in 86 communities throughout the country. The services offered by the funded NGOs ranged from general community health to specialized services in mental and occupational health. Dr. Roberto Belmar, the director of primary care services for the Ministry of Health at that time, believes that the project was successful because the NGOs' flexibility allowed them to pool resources from other projects, while their social embeddedness permitted them to mobilize additional resources, resulting in programs that would have otherwise cost the ministry many times more. However, as the international funding for the program diminished and the health care reform emphasized privatization and contractually based relations with NGOs, the shift in priorities made collaboration less intense. By 1996, only l0 percent of the 90 NGOs that the Ministry of Health funded in the early 1990s maintained a relationship with the public care system. In Ecuador, Dr. Patricio Abad Herrera, the second of three ministers of health during the administration of former President Sixto Durán (1991-1996), supported efforts to increase NGO-government collaboration. Dr. Abad developed a strategy for increasing collaboration and established a unit directly under his administration to coordinate the efforts. Because of a decrease in state expenditures on health (from 8 percent of the national budget in 1994 to 4 percent in 1996), the efforts and the unit were reduced upon his departure.

The experiences in Chile and Ecuador demonstrated intense periods of collaboration because of a significant initial injection of funds. In Guatemala, collaborative projects were slow in developing, but they still exist today and show a greater chance of sustainability than the projects in Ecuador and Chile.

The Ministry of Health in Guatemala has been involving NGOs in the implementation of Sistemas Integrales de Atención en Salud (SIAS, Integrated Systems of Health Delivery). SIAS are the new administrative local-level entities of the Ministry of Health promoted by the health care reform process. These are allowed to contract NGOs to deliver health care and, after 10 months of implementation, five major NGOs were already contracted. The Guatemala experience is an example of collaboration being implemented with funds controlled by the Ministry of Health (mainly from loans from the international financial institutions destined for health care reform).[2]

The limited evidence from these experiences shows an inverse relationship between initial external funding and long-term project sustainability. The problem is not that efforts are poorly funded from their initiation. On the contrary, the influx of initial funds, usually from international sources, while producing initial intensive collaboration, fails to secure sustainability in the absence of complementary domestic funds.

Agreement Upon the Validity of the Policy

If the implementing agents of a policy or a program of activities do not agree with the validity of the theory upon which the policy is based, its implementation is difficult. All of the cases observed in this analysis show an initial lack of consensus among the diverse set of implementing actors on the validity and the goals of collaboration. Importantly, the reservations concerning the policy were not based on political considerations per se, but many of the technical personnel within the ministries of health had serious reservations regarding the capacity of the NGO sector.

Personnel from the Chilean Ministry of Health's maternal and child health program feel that the same attributes that make NGOs attractive to international donors make them problematic for the public sector. Dr. René Castro of the Chilean Ministry of Health explained that while NGOs' effectiveness emerges from their small scale, this same characteristic makes them unable to expand their scope of work to a wider scale or to “scale up” their projects. Therefore, despite even the greatest efforts by NGOs, their inability to broaden their scope makes them ineffective partners for the Ministry of Health, which is responsible for the delivery of care to an entire nation. According to Castro, NGOs are more of a drain on the ministry than an asset because of the need to subsidize their work continuously.

Personnel from the Ministry of Health in Guatemala highlighted their frustration with a lack of NGO compliance with national health plans. According to ministry officials, the NGO sector's reliance on external sources of funding makes it difficult for NGOs to follow guidelines established by the national institutions (in many instances, private international donors encourage the NGOs to remain autonomous of the Ministry of Health) since they are more accountable to international donors than to national entities. Officials in Guatemala are very sensitive to this issue, given the country’s more than 300 NGOs. Officials complain that this has led to isolation, duplication of services, and a squandering of a good part of the international assistance since the activities are uncoupled from other national-level interventions. This

2 For more on SIAS and its effects, see Icú as well as Verdugo in this volume.

perception is not without some merit. There is significant evidence that NGOs do not have a monopoly on flexibility and client-centered behavior. The presence of undesirable traits cannot be assigned to either the public or private sector; instead, the divide runs across both sectors (Tendler 1997).

Even within the international organizations that promote greater collaboration between sectors, there is no consensus on the comparative advantages of the NGO sector. In a collaborative paper by staff from the International Monetary Fund (IMF) and World Bank, the authors analyzed strategies promoting popular participation using social choice and public choice theory (Gerson 1993). Among the paper's conclusions are assertions that organizations like NGOs are unlikely to represent broad public opinion and that close NGO-government collaboration may actually diminish social participation. In addition, the paper states that social participation is a commodity that might not always yield sufficient benefits to justify the costs. Officials from other international organizations, including PAHO, find NGOs to be difficult counterparts because of the nebulous distinction between their social and political roles and argue that collaboration with NGOs can limit democratic representation and social participation.

Levels of Interdependence, Communication, and Coordination of the Implementing Actors

The process of implementing any policy is long and involves an intricate progression of events and linkages, any of which may derail the process. The more complex the dependency and the relationship among the different implementing actors, the greater the difficulty in implementing the policy. With regard to NGO-government collaborative projects, the programmatic area that the collaboration is intended to address will be a strong determinant of the ease of implementation. The public sector's functions in health include (1) development of health policy, (2) research, (3) regulation, (4) education and training, (5) provision of clinical services, and (6) implementation of public health initiatives. Each of these functions occurs at different levels of the state administrative structure and results in varying degrees of dependency.

If schematically depicted as a multilayered box, with the outer layers corresponding to the provision of public health interventions and the inner layers representing the health policy environment, the interdependency and overlap of areas of authority among the actors, as well as the difficulty related to program implementation, increase as the program being implemented addresses activities in the inner layers.

The more enterprising the collaborative project (the more policy-oriented the work), the greater the interdependency among the decision-making actors; and the greater the overlap of the areas of authority, the more negotiation required and the greater the difficult in implementing the project.

Health System Activity and Actors Involved

In the policy-making realm, there is less space for complementarity of tasks, so any collaboration in this area is dependent upon formal institutionalized coordination with a greater number of public sector entities. The more periodic and short-term the area of collaboration (vaccination campaigns, for example), the less interdependency among relevant actors, less impact on the different jurisdictions of the institutions, and a greater likelihood that the NGO-government collaboration will succeed.

FIGURE 1. Public Health Programs Governed by the Ministry of Health

An example of this escalating interdependence was evident in Ecuador in the collaborative project between Fundación Sol Mayor and Health Area Nine (a health area on the outskirts of Quito). The director of the local health area, Dr. Jorge Albán, realizing that many of the patients were accessing their health care from the local curanderos (traditional healers), decided to coordinate the efforts of the formal health system with the Fundación Sol Mayor, which had a project with the local curanderos. The resulting project integrated the services of the curanderos and the physicians so that physicians working in the local health area and curanderos referred patients to each other. Although Dr. Albán and the Fundación Sol Mayor characterized the collaboration within the local health area as a success, their efforts to develop policy promoting this coordination at the national level were fiercely opposed. According to Dr. Albán, the collaboration was easy at the local level because it was negotiated between two local entities. However, as soon as the project tried to influence policy, it made contact with the sphere of influence of a multitude of actors, which made the development of the policy a highly political process. For example, the Ministry of Justice opposed any policy recognizing the curanderos because collaboration with "non-western" medical practices is prohibited by the statutes still on the books. The same held true with the national medical association, which felt that a legitimization of the curanderos devalued their role as physicians.

The Presence of a Coherent Policy

The lack of a rational and coherent policy represents a major barrier not only to the implementation of collaborative projects but to the enactment of health care reform. Health care reform advocates claim that the traditional health system needs increased efficiency, cost effectiveness, and quality, and that these may be attained by rationing state resources while increasing the power of the private sector. In contrast to the interventionist approaches advocated by the state-centric model, the neoliberal foundations upon

which much health care reform is based encourage countries to reduce the rote and size of the public sector and increase that of the private sector. The concrete manifestation of the strategy is a process of unchecked decentralization and privatization with little coherence and rationality. This is an understandable consequence given the inherent contradiction in a strategy that asks public sector entities to support, fund, and press for measures that are going to reduce their own power and sphere of influence. What emerges is a declared process of decentralization and rationalization, without a guiding coherent state policy. Since NGO-government collaboration is embedded in these health care reform policies, collaborative projects also often lack a coherent process and system capable of instituting an effective implementation process.

The experience of the Fundación Eugenio Espejo (FES) in Ecuador highlights the effect of this contradiction. As part of the health care reform process, FES worked with the Ministry of Health to set up a collaboration that allowed the NGO to administer a local health area (Tabacundo, Ecuador). FES, the Ministry of Health, and PAHO implemented a project by which FES would coordinate the health services of the area's multi-institutional delivery system (ministry services, UNICEF projects, UNFAP projects, church programs). Although officials in the higher echelons of the ministry agreed to the program, the project was never supported by the local health director, the other institutions, and the area's health personnel. The director resented the loss of control, the health personnel viewed the project as "low-intensity privatization," and the other NGOs saw it as a threat to their autonomy. Although certain sectors of the ministry had supported the project and even provided funding, the ministry as an institution could not compel the local entities to collaborate, and after the first year the project collapsed. Ministry of Health personnel explained that without any explicit state policy, there was no leverage for them to support the NGO over other public sector employees who, through strikes and protests, could not only exact significant political costs but who also represented the interests of the public sector more than did the NGO.

Some Preliminary Conclusions on the Implementation Process

Although the model from which these preconditions were derived is a linear, top-down approach to policymaking, the application of the four factors selected to the process of implementing NGO-government collaboration actually highlights the nonlinearity of the process. In reality, the implementation of collaborative projects is an interactive and reciprocal process in which policymakers and proponents of collaborative projects may adapt and modify strategies as well as the policy-making process itself. As the cases analyzed demonstrate, the process is not exclusively top-down and allows for a variety of implementation mechanisms, including informal and extra-institutional processes. Regardless of the direction of the process, these four factors were a source of friction in all the attempts at implementation. Attempts to increase the role of NGOs represent a significant alteration of the status quo. The conspicuous conflicts between the public sector and NGOs have been embedded in the institutional behaviors of each sector, and for the NGO sector it has even served as the raison d'être behind the existence. This level of institutional discord requires that collaboration advocates take the political and institutional reality that

governs the state and civil society relations into account when implementing cross-sectoral collaborative projects. These are conditions that proponents of greater collaboration need to integrate into project implementation plans and are examples of why implementation plans are as critical as the programmatic contents of the projects.

Outcomes and Mechanisms of Collaboration

This component of the analysis attempts to identify the correlation between the mechanism employed to operationalize the collaboration and the success of the project. The existing literature indicates that the linkage mechanism is a significant determinant of the sustainability and impact of the collaboration program. In experiences in other fields (education and agriculture), linkages that employ mechanisms such as contracting tend to be short-term and result in low levels of satisfaction. This contrasts programs that employ a more structural mechanism, such as planning bodies with public-private sector representation, which lend themselves to higher levels of success because of their institutional nature (Bebbington and Thiele 1993).

Based on the examples of NGO-government collaboration observed in this analysis, the modes of operationalizing the collaboration can be classified as either operational linkages or structural linkages. Operational linkages refer to modes of collaboration based on activities in which personnel from both sectors are actively involved. These include professional activities, such as training, research, conferences, and collaborative project planning committees. Structural linkages are modes of collaboration more administrative in nature, such as resource allocation systems (in which NGOs are contracted or are government grantees), units within state agencies with the goal of coordinating NGO activities, and policy-making committees with both NGO and government representation.

Table 1 is a roster of the NGOs involved in the collaboration analyzed in this research, along with the collaborative mechanism used in each case. The table also describes two outcome indicators—one measured by the ability to sustain the project at least 18 months beyond the life of the original project funding, and a second by the satisfaction of both the public and private sector personnel involved in the project. This was measured using a battery of questions to measure individual satisfaction with the extent of the collaboration and its accomplishments. In the last column, the expressions describing the modes of collaboration for those projects that showed positive outcomes in both categories are highlighted.

The most revealing information in Table 1 is the positive correlation demonstrated between the eight cases of NGO-government collaboration that demonstrated positive outcomes and the presence of collaboration mechanisms that lacked professional activities, collaborative project planning committees, and policy-making units with co-representation (ACE).

Interpreting the Results

In interviews, government officials argue that in order to collaborate with NGOs, governmental entities must be able to verify the professional and technical capacity of the NGOs and be able to hold NGOs

accountable. NGO officials, by contrast, look for mechanisms that allow them to retain autonomy and recognize their long experience. It appears that modes of collaboration that in some way increase the contact among the personnel of both sectors give those involved a greater sense of control. Professional activities,

TABLE 1: NGO Collaboration

Countries	NGOs	(A) Professional Activities	(B) Resource Allocation	(C) Planning Units	(D) NGO	(E) Decision making bodies	Outcome measured Satisfaction/ Sustainability	Isolation of the determining factors
Chile	La Caleta		+			+	negative/ positive	
	CEMS	+	+	+		+	positive/ positive	A B C D E
	CORSAPS	+	+	+		+	positive/ positive	A B C D E
	Fundación Cristo Vive		+			+	negative/ positive	
	COMUSAMS	+	+	+		+	positive/ positive	A B C D E
	Hogar de Cristo	+	+	+		+	positive/ positive	A B C E
	Fundación Sol Mayor			+			negative/ positive	
Ecuador	Fundación Eugenio Espejo			+	+	+	negative/ positive	
	CEPAR	+		+		+	positive/ positive	A C E
	CIUDAD	+		+		+	positive/ positive	A C E
	CARE/Ecuador	+		+		+	positive/ positive	A C E
	CEPAM	+					negative/ negative	
Guate-mala	Médicos Descalzos	+		+		+	positive/ positive	A C E
	ATI	+				+	negative/ positive	
	ASINDES	+		+		+	negative/ negative	

collaborative project planning, and policy-making units with co-representation are conducive to alleviating the apprehensions of both sectors. Arenas of dialogue, debate, and exchange allow the government to supervise and hold the NGOs accountable and provide the NGOs with a minimum level of exchange that allows them to feel that they are retaining their autonomy and that their contribution and experience is respected.

The negative correlation between "resource allocation" mechanisms and satisfaction is significant. The presence of resource allocation was not a sufficient or even necessary factor in making collaboration outcomes positive. This finding is critical, since many of the international initiatives promoting collaboration concentrate their efforts in providing the state with funds to finance NGOs. The experience of NGOs like Fundación Cristo Vive (FCV) and La Caleta in Chile shows that the financial difficulties involved with receiving funding from the state, either because of reimbursement problems or the short-term nature of the contracts, negatively impacts the NGO sector's satisfaction with collaboration.

A second interesting correlation is the minimal role that formal NGO coordinating units played—another mode of collaboration prompted by international organizations. In Ecuador, for example, the NGO tied closely to the NGO unit (the Fundación Eugenio Espejo) collapsed entirely because of the disappointment that resulted after the NGO unit was given little support and status. The presence of NGO units, in and of themselves, is not enough. Instead, positive outcomes require contact among differing levels of the bureaucracy in various institutions and not just contact between the NGOs and the governmental NGO unit.

This seems to indicate that the NGOs interested in collaboration perceive the state's openness to using the NGOs' professional experience in training, sharing planning responsibilities, and decision-making as even more valuable than the allocation of state resources. An example of the importance played by units of co-representation is the experience of Hogar de Cristo (HDC) in Chile. HDC is one of the oldest NGOs in the country and counts on a broad-based presence throughout Chile. The organization has centers throughout the country and is a very successful philanthropic organization, receiving much of its operating budget from private contributions. Although the organization is not the typical post-1973 Chilean NGO and was not a major organization in the pro-democratic movement, it has maintained very close contact with the state through an advisory board that includes people from the organization, politicians, and government bureaucrats. Médicos Descalzos, a Guatemalan NGO established in 1990 to research and promote the use of medicinal plants, has also been able to establish and sustain a successful relationship with regional health officials in the province of Quiché without initially receiving funding from the state. Local ministry officials initiated the relationship so that the NGO would not only provide services to the patients, but train ministry personnel in the use of medicinal plants. The collaboration has been highly successful, with the NGO now included in the strategic planning sessions of the local health services. Among the most successful public-private collaborations in Ecuador is that between CIUDAD, an NGO concerned with urban issues, and the health secretariat of the municipality of Quito. Without the need for a formal agreement or any transfer of funds between the two institutions, the NGO and mid-level civil servants at the municipality designed, developed, and implemented a computerized

epidemiological surveillance system for the capital city. After the program had been developed and tested, it was presented to municipal and ministry officials. CIUDAD officials attributed the success of the project to the confidence that had been built up between the state civil servants and CIUDAD personnel in everyday programs as well as in planning sessions.

Policy Recommendations

Despite the perception that Latin American health care systems were state-centric, the reality is that by the 1980s the state was a weak and disinterested actor in health policy. Governments and NGOs in the region often have an adversarial relationship embedded in the political, religious, and ethnic polarization that has dominated the region's sociopolitical structure. Although the opportunity for comprehensive NGO-government collaboration could have been an instrumental mechanism through which the state-centered system could have been made more flexible, responsive, and efficient, the polarized political landscape that governed the region in the 1970s and 1980s made the collaboration impossible. Yet, with the end of the Cold War and its accompanying ideological currents, the emergence of the proponents of democratic market economics were able to seize health care reform processes and champion the benefits of decentralized, market-governed health care systems.

Under the current model of health care reform, NGOs reemerge as private sector entities that can improve the system's efficiency and effectiveness, and collaboration is defined, implemented, and governed through market strategies (contracts, bids, per capita reimbursement, and so on). The cases explored in this analysis show that democratization processes and decentralized health care systems in and of themselves were not enough to create an enabling environment for NGO-government collaboration. The merits of democracy and market capitalism have been agreed upon, and sometimes followed, but the mechanisms and institutions by which to generate and maintain greater NGO-government collaboration have been given very little priority. The attempts at NGO-government collaboration have lacked appropriate resources as well as established administrative practices characteristic of good governance. It is through good governance that states put mechanisms and procedures in place that facilitate NGO competitiveness, including contractual and reimbursement procedures that are sensitive to the NGO sector's financial, technical, and administrative constraints and bidding and contracting systems that allow the NGO sector to use its expertise not only in the implementation of projects but also in the planning and designing of programs.

The cases also demonstrate the need for bureaucratic commitment and institutional learning. The potential benefit of decentralization is visible in the successful collaborative efforts that have emerged at the local level, but at the same time its limitations are evident in the difficulty encountered in sustaining efforts and replicating them in a context devoid of institutional state support. The lack of a bureaucratic commitment and the loss of accumulated knowledge as a result of frequent bureaucratic reshuffling does not engender cohesive governmental structures and policies, which are the precursor of effective

government-NGO collaboration. Greater collaboration between the sectors depends upon the will demonstrated by the state to promote actively and create an enabling political and economic space for the NGO sector to interact with government. An active, participatory, and collaborative non-governmental sector requires a determined, active, and guiding state that is willing to modernize through a participatory and inclusionist process.

The evidence in this analysis points to three pillars upon which successful NGO-government collaboration may be developed and implemented. The first is the need for a broad-based commitment to the policy, that is, a belief in the validity of the theory underlying NGO-government collaboration and in the cause-and-effect relationship of the policy. The second is an adequate system of procedures and processes able to guide the financial and programmatic relationship between NGOs and the state. The third is the critical role played by the structural mechanism of dialogue and debate that allows both sectors to air contested matters and to compromise. These three pillars are attainable through various mechanisms of good governance.

Broad-based commitment to policy is a component that emerges from an inclusion of various levels of bureaucracy in the development and implementation of the policies. Both top-down and bottom-up approaches of policymaking are inadequate in and of themselves. The policy in either approach encounters significant barriers from the mid-level bureaucracies. Some advocates promote a process of "cluster implementation," in which the process does not focus either on top-down or bottom-up approaches (Walt 1994). Instead, policy, is implemented by choosing strategic clusters at the three levels of bureaucracy: the macro or political will level; the local-level bureaucrats or the micro-level; and the mid-level bureaucrats, which include local area health directors, regional health directors, and ministerial division heads. The approach is enhanced by instituting policies through a system of open dialogue and debate among different levels of bureaucracy and by focusing the policy implementation on the attainment of specific programmatic outputs. The governmental sector should institute and implement policies not for the sake of political cover but for the attainment of very concrete programmatic outputs whose progress can be measured in the short and long terms. The process of consultation allows for all levels of government to agree to the availability of political, financial, and technical resources for the implementation of the policies. This strategy requires more effort at the early stages of policy implementation, but the political gains in terms of reduced intergovernmental conflict outweigh the initial investment. Hence, the state needs to accompany the rhetoric of stated policy with the required effort at the initial stages of policy implementation.

Collaboration mechanisms that respect the uniqueness of NGO characteristics are critical. Among the most destabilizing factors in the contracting and granting system between NGOs and the state is the myth that contracting operates according to market principles. This results in under-investment in the NGO sector, short funding cycles undermining fiscal stability, and a predominant concern with efficiency and cost-cutting that puts pressure on service quality (Smith and Lipsky 1993). Instead of retaining this belief, the practice of collaborating with NGOs through contracting and grant-making needs to be

recognized as a social service delivery system and viewed as a public investment. Among the strategies governments may use to help alleviate the poor performance of contracting regimes are the following (Magnussen 1993):

1. Extend funding cycles to three-to-five-year grants and contracts: This would allow NGOs to improve their financial stability and long-term strategic which in turn would allow them to secure and hold personnel and staff.
2. Build contingency funds into the contracts: In other words, allows NGOs to make a minimal "profit" as a buffer against temporary setbacks and for times in between contract periods in which the organization has few sources of income.
3. Provide NGOs with tax incentives that facilitate their importation of necessary technology and equipment and the purchase of infrastructure resources such as land, buildings, and other capital investment components: This is important because NGOs cannot use their contracts as assets in seeking mortgages and loans.
4. Develop accountability measures that satisfy public sector regulations (such as strict financial reporting and annual audits), respect the autonomy and independence of the NGOs, and respond to the administrative limitations faced by NGOs—yet that are based on programmatic outcomes: This would not only reduce regulatory interference and allow NGOs to exploit their advantage of efficiency, but it would also protect the interest of the NGOs to respond quickly and thoroughly to community needs.
5. Provide NGOs with small one-time grants that recognize their contributions as laboratories for the invention of social services: These grants would allow NGOs to pursue independent research and practice, which not only help the organizations retain their programmatic autonomy but also contribute to the production of knowledge in the social service sector.

Arenas of dialogue allow for controlled and constructive debate and compromise. The social service sector is an integral component of the relation between the state and civil society. This exchange is a reciprocal process that requires give and take, which recognizes the obligations both of civil society, and of government. This requires participation, protections, and privileges. The establishment of arenas of dialogue makes decision-making transparent, allowing the goals and objectives of policies to be made clear to all the actors involved. Policy decisions should be undertaken after consultation with sectors of civil society, providing accessible and reliable information. The arenas of dialogue allow the NGO sector to provide input into the policy-making process. Even if these bodies are only consultative in nature, they allow NGOs to voice their experience, present empirical data, and put forth philosophical arguments to policymakers. These arenas of dialogue also provide a vehicle through which the strong historical antecedents that have governed the two sectors' adversarial relationship can be taken into account and discussed. The implementation of policies or of funding regimes that do not recognize these historical antecedents will be unable to establish a well-founded collaborative relationship.

Some of the countries of the hemisphere are rediscovering democracy, while others are discovering it for the first time. This is occurring simultaneously with a retrenchment of the state and a championing of the private sector. The challenge facing the countries of the hemisphere is to find a formula that allows them to balance the social responsibilities of the state with the efficiencies of the private sector. NGO-government collaboration has emerged as a mechanism to attain this equilibrium, but this relationship requires a third factor, namely, the inventiveness of the NGO sector. It is with this goal in mind—the pursuit of a balance among the state, the market, and civil society that these recommendations are made. The state is responsible for its citizens; the private sector provides efficiency; and the NGO sector is more caring and inventive. Conversely, the state needs to become more efficient; the private sector, more caring; and the NGO sector, more accountable. Future paths to development lie in the balance of these three arenas, and international organizations must work to exploit the advantages and minimize the disadvantages inherent in this new framework.

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GOVERNABILITY & GOVERNANCE:

Toward Health and Human Development

Juan Antonio Casas, Rita Delia Casco, Cristina Torres-Parodi

"Medicine is a social science; and politics nothing but medicine on a grand scale."
Rudolph Virchow (The Medical Reform, 1848)

"If a free society cannot help the many who are poor, it cannot save the few who are rich."
John F. Kennedy, 1961

Historical Background: Public Health and Social Medicine

The theory and practice of public health incorporate the essential elements of the State's responsibility to protect and promote population health. This approach implies addressing the underlying economic and social determinants of health and disease, as well as the informed participation of the population being served (Beaglehole, 1997). There is, then, a close relationship between public health and the exercise of political power, which in human development literature is now expressed through the terms "governability" and "governance."

Within the historical background of this conception of the social and political determinants of population health is the German Medical Reform Movement of the mid-nineteenth-century, of whom the most significant protagonists were Rudolf Virchow, Rudolph Leubuscher, and Solomon Neumann. Encouraged by the

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democratic and anti-monarchical surveys of 1848 in Prussia, the first issue of the weekly The Medical Reform, published by Virchow and Neumann, proposed as its fundamental thesis that:

> The "Medical Reform" comes into being at a time when the overthrow of our old political institutions is not yet completed, but when from all sides plans are being laid and steps taken toward a new political structure. What other task could then be more natural for it to undertake, than that of participation in clearing away the old ruins and in constructing new institutions?… In this situation medicine cannot alone remain untouched; it too can no longer postpone a radical reform in its field (Rosen, 1979).

Their awareness of the relationship between medicine and social problems was expressed in Virchow's rhetorical but effective phrase that heads this article: "the characterization of medicine as a social science." The discussions at that time clearly show that this formulation summarized certain well-defined principles, among them:

- population health is an object of unmistakable social responsibility, and society has an obligation to protect and ensure its members' health;
- economic and social conditions have an important effect on health and disease, and such relations should be a topic for scientific research; and
- social and medical measures are required to promote health and combat disease.

In Virchow's words:

> The democratic state desires that all its citizens enjoy a state of well-being, for it recognizes that they all have equal rights. Since general equality of rights leads to self-government, the State also has the right to hope that everyone will know how through his own labor to achieve and maintain a state of well-being within the limits of the laws set up by the people themselves. However, the conditions of well-being are health and education, so that it is the task of the state to provide on the broadest possible basis the means for maintaining and promoting health and education through public action…. Thus it is not enough for the state to guarantee every citizen the basic necessities for existence, and to assist everyone whose labor does not suffice for him to acquire these necessities; the state must do more, it must assist everyone so far that he will have the conditions necessary for a healthy existence (Rosen, 1979).

The advocates of the 1848 Medical Reform Movement promoted a very broad conception of public health objectives, indicating that one of its principal functions was to study the living conditions of various social groups and to determine the effects of these conditions on health. Advocates understood that the

very words "public health" revealed a political character and that public health practice necessarily involved intervention in political and social life to identify and eliminate obstacles that hindered the normal operation of life processes and the attainment of population health.

In light of the failure of the 1848 revolution in Prussia, the Medical Reform Movement ended, and its weekly publication was interrupted. Nevertheless, a century-and-a-half later, the ideals and concepts that inspired the Movement have not lost their novelty or relevance. The last editorial of *The Medical Reform* seems formulated for our times and our world:

> The medical reform that we had in mind was a reform of science and society. We developed its principles... [and] every moment…will find us occupied in working for them and ready to fight for them. Our cause remains unchanged; it is only the field of activity that changes (Rosen, 1979).

Governability and Democratic Governance in Latin America

> By the end of the 1980s in Latin America, the concept of "governability" began to be used not only in reference to the exercise of government, but also in reference to the conditions required for governments to be able to perform their duties effectively, legitimately, and with public support. Some Latin American authors relate governability "to the authorities' ability to channel the interests of civil society into the interaction that exists between both sectors, and therefore, to the legitimacy of the first: the government" (Tomassini, 1993). Others have pointed out that "Governability depends on the way in which a given society—a specific political system—manages to articulate and adequately resolve all the tensions occurring within its environment" (Fernandez, 1996).

At the same time, in the Anglo-American literature, the term "governance" has been used with similar connotations, although also with some noteworthy distinctions that explain its connection to health. Referring to the binomial concept of governability/governance, Roberto Espíndola affirms:

> With the use of democratic governance we attempt to assert not that a society is governable, but that such society is capable of governing itself with the consensus of its members. A dictatorship may be a type of governable society, but it does not show the presence of democratic governance (Espíndola, 1997).

The concept of governability itself gives special importance to the notion of a society divided and organized into potentially conflicting institutions in which the State is responsible for defining the public interest. It is certainly possible to speak of non-democratic governability, if by democracy we understand "a system in which [incumbant political] parties [can] lose elections," or a system of institutionalized

uncertainties (Przeworski, 1991). In the context of Latin American democratization, the concept of democratic governance refers to a new relationship between the State and civil society.[1] The latter cannot be passive in the search for solutions, nor can it only be seen as a source of demands or conflicts that the State should serve by means of a vertical exercise of power. The very process of building democracy involves a transformation of civil society, which is increasingly becoming an important non-state public sphere.[2]

During this century, the Latin American State has been characterized by neo-corporate forms of integration in which corporate interests identify themselves with the public sphere at the same time that the State bureaucratic administration is intensified. At the threshold of the next century, this scheme is entering a crisis because it is acknowledging that public issues are not synonymous with corporate issues; the recognition of this inconsistency is one of the tenets of the Latin American State Reform Movement. New forms of direct or participatory democracy are being tested, as evidenced by the emergence of social movements (environmentalism, feminism, ethnicism, etc.) and in the varied forms of citizen participation. Likewise, spaces are being created for the production of social services, mainly for education and health, through non-profit institutions. Bresser Pereira clearly delineates between corporate interests and non-state public interests:

> Civil society then acquires a new definition, as a non-state public space, which must be differentiated from forms of corporate interests representation. Public, in the end, is what belongs to all and for all, while corporate refers to the interests of certain groups, which, although ultimately legitimate, are not necessarily public (Cunill Grau, 1997).

The concept of "governance" attempts to incorporate this new role and character of civil society.[3] In 1990, a World Bank publication entitled "Governance and Development" appeared which argued that the concept of "governance" is vital for the creation and maintenance of an environment that promotes strong, equitable development and constitutes an essential complement to good economic policy.[4]

The InterAmerican Development Bank (IDB) has also prepared and disseminated a conceptual framework describing the relationship between development and governability. This framework proposes

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1 Civil society includes a tightly women tapestry of diverse organizations and institution such as NGOs, syndicates, community organizations, families, tribes, religious groups, civic clubs, foundations, political parties, cooperatives, cultural groups, sports associations, environmental groups, professional associations, academic and research institutions, consumer groups, and local service and communal organizations.

2 For an excellent discussion of the relationship between democratization and new civil society in Latin America, see Cunill Grau.

3 The term appears for the first time in a World Bank report titled "Sub-Saharan Africa: From Crisis to Sustainable Growth: A Long Term Perspective Study" (World Bank 1989).

4 The World Bank defines governability as the form in which power is exerted in the administration of economic and social resources of a country in favor of development, which encompasses three different aspects: a) the form of the political regime, b) the process in which the authority is performed in the administration of economic and social resources of a country in favor of the development; and c) the government's capacity to design, formulate, and implement policies and perform functions.

that development "depends on the existence of relationships between the State and the civil society to make the legitimacy, efficiency, and stability of the government feasible in an ample sense" (Tomassini, 1993). Governability, then, is not only related to strengthening the government's capability to formulate and apply economic policies, manage the budget, and execute investment proposals. It is also linked to "the maintenance of the rule of law, the lawfulness of public deeds, the election of political regimes, the legislative role, the administration of justice, the management of regional and local interests, public safety and terrorism control" (ibid.). In order for the government to perform its basic tasks legitimately, firmly, and efficiently, civil society must be included in the process of reaching consensus. There can be no governability without civil society participation.[5]

For the UNDP, the concept of governance not only includes the State but also extends beyond it by including the private sector and civil society, thereby incorporating three critical development areas (UNDP, 1997). The State creates a propitious environment and legal framework; the private sector generates employment and income; and civil society facilitates political and social interaction by mobilizing its agents to participate in economic, political, and social activities. According to the UNDP, governance may be understood as

> . . . the exercise of political, economic and administrative authority in the administration of a country matters at all levels. This includes the complex mechanisms, processes, and institutions whereby the citizens articulate their interests, mediate their differences and exercise their legitimate rights and obligations (UNDP, 1997).

Governance is, among other things, participatory, transparent, and accountable. It is also effective and equitable, and it promotes the rule of law. It ensures that economic, political, and social priorities are based on a broad social consensus and that the voices of the poor and the most vulnerable are heard when allocating resources for development.

In short, we understand "governability" as the State's *capability* to coalesce the various interests of its members, and to articulate and adequately resolve tensions created within its jurisdiction. "Democratic governance" refers to the *complex mechanisms*, *processes*, and *institutions* by which these interests are

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5 In light of this discrepancy in the definition of the concepts of "governability" and "governance," many Latin American authors agree that: a) in English only the word "governance" exists, from which many assume the concept of governability has been taken, and b) that the empirical uses of the concept of "governance" indicate that the term is utilized in reference to the capacity to govern steadily and effectively, or to the viability of the government. In this regard, it is worth noting that the concept "governability" was used in 1975 by Michael J. Crozier, Samuel P. Huntington, and Joji Watanuki in their report *The Crisis of Democracy: a Report on the Governability of Democracy to the Trilateral Commission*. In that report, it is stated that the governability problems in Western Europe, Japan, and the United States "came from the growing gap between some fragmented and increasing social demands and some governments' increasing wanting of financial resources, authority and institutional frameworks and capacities that the new type of collective action demands." Additionally, in many English publications the concepts "governance" and "good governance" are used to refer to good government, or good administration and a corollary of this conception is the emphasis on institutional capacity building and development. Obviously, in this case, "governance" and "governability" are two different things.

articulated and mediated, and by which citizens exercise their legitimate rights and duties through political, economic, and administrative authority to manage a country's issues at all levels; it requires the effective participation of civil society, the private sector, and the State itself.

With respect to the central topic of this analysis—that is, the relationship between health and the concepts of governability/governance—both concepts are necessary and useful since they allow different scenarios and actors to participate in the process of defining priorities and allocating resources to improve health. As will be seen further on, the historical governability crisis characterizing Latin American States has been attributable in part to their inability to build what Espíndola calls "a community of opportunities and objectives," that is, a scheme in which political citizenship is accompanied by social and economic citizenship (Espíndola, 1997).

The 1990s economic liberalization and globalization of finance in Latin America have not reduced the abysmal differences between life opportunities available to the great majority of Latin Americans who survive in unacceptable conditions of poverty, and those enjoyed by the wealthy minority who avail themselves to the new benefits. When a high proportion of the population lives in poverty, a large sector of society can become alienated from democratic life, without any material reasons to share the objectives nor to accept the rules of the game obeyed by those who have access to much greater opportunities. Espíndola sees acceptable living conditions as necessary for participation:

> . . . citizenship is not divisible, and by depriving an elector access to education, health, housing, work, sanitation, and adequate food, such elector is deprived of his/her qualifications as a participant and as a citizen (Espíndola, 1997).

Guaranteeing the entire population opportunities required for health—understood not only as access to health care services but also to the social, economic, and environmental conditions required for human development—is a pressing task for most of the region's countries if they intend to create conditions of governability (CPHA, 1997).

However, building democratic governance in the region's new circumstances implies adapting the ways in which society responds to the demands for basic medical care, environmental protection, epidemiological surveillance, health promotion, and other components that form the essential functions of public health (Sapirie, 1996). As we will see further on, the unification of the non-state public sector, or civil society, and a strong private sector with a state modernization process requires us to rethink the concepts of sectoral management and the exercise of State power in relation to personal and environmental health services.

Governance requires economic, political, and administrative support. Economic support includes the decision-making process that affects the economic activities of a country and their relation to other economies, which have important implications for equity, poverty, and quality of life. Political support refers to the decision-making process for policy formulation. Administrative support is the policy implementation system (UNDP, 1997).

Concepts such as management and sectoral "steering," although valid regarding management of State institutions' own resources (known as administrative governance), may be insufficient to analyze the new setting where emerging non-traditional civil society actors become increasingly prominent partners in defining public welfare, and the private sector assumes a growing role in the delivery of services and resources (PAHO, 1997, La cooperación…).

Governance in health—when determining policies and priorities for allocating societal resources as a whole within the economic and political spheres—requires a strategic vision in which leadership is shared, leading roles are agreed upon, and sectoral proposals are submerged in broader processes and agendas than those of past public management.

The complexity resulting from this expansion of actors is intensified by the addition of two increasingly important dimensions in which health action scenarios are generated: at the sub-national level, the decentralization of State activities including its responsibility for providing health services; and at the supra-national level, the impact of globalization and the emergence of new economic and political integration schemes, which have important consequences for health, as will be seen further on. This dynamic situation requires a new vocabulary and conceptual framework to account for new demands, to direct the acquisition of skills to strengthen governability in our societies, and to build participatory and democratic governance mechanisms for promoting health.

Globalization, Governability, and Health

Governability is high on the Latin American development agenda, which has been strongly threatened by a series of phenomena that reveal the State's lack of financial resources, institutional frameworks, authority, and skills required to face the growing social demands. These phenomena include: a) the foreign debt crisis consequent to the replacement of the Import Substitution Model; b) globalization; and c) State reform.

a) The Foreign Debt Crisis and its Impact on Health

During the three decades after World War II, the Latin American and Caribbean Region adopted the industrialization strategy based on import substitution. This model was intended to reduce the import coefficient and develop the State's own industrial production. During the 1950s and 1960s, economic growth was generated by active State intervention in the economic and social spheres. However, this model prevented the development of competitive and open markets and was unable to eliminate the income disparities in most of our countries. The model's weaknesses contributed to the 1973 increase in oil prices, which forced the countries of the region to resort indiscriminately to foreign debt. Between 1973 and 1982, the cumulative foreign debt of Latin America multiplied by ten-fold and, in 1982, when Mexico announced it could not pay the debt service, the debt crisis—and the new development model—began in Latin America.

> To help countries pay the debt service, the International Financing Institutions (IFIs) induced Latin American countries to adopt a series of economic policies called structural adjustment packages, whose design is attributable to the so-called "Consensus of Washington," a group consisting of the International Monetary Fund, the World Bank, and the United States Treasury Department. These structural reforms emphasized "fiscal discipline and public expenditure control, improvement of tax systems, liberalization of financial systems, better exchange rate management, opening of commercial regimes, incentives to direct foreign investments, privatization of public companies, deregulation of economic activities, and state downsizing" (Tomassini, 1997).

As predicted, the introduction of this new economic model in the 1980s created enormous economic and social tensions, which coincided with the transition of most authoritarian regimes of the region to democratic governments. Hence, in the 1980s and 1990s, Latin America was shaken by tensions produced by both economic and political changes. While economic structural adjustment programs resulted in social exclusion, political reforms attempted to establish mechanisms to allow the inclusion of other, often destabilized, political actors. Thus, two contradictory forces came face to face, endangering the fragile Latin American democracies and exacerbating the situation of increasing ungovernability in most Latin American countries.

Consequently, in this last decade, the region has experienced escalating violence levels. Guerrilla movements have recurred or been strengthened in some countries and, in addition, almost all Latin American cities have become dangerous. Murder indices, which were already were six times higher than the world average, have increased while kidnappings as well as other violent acts are commonplace (OPS, 1998; Sachs, 1998).[6]

While social exclusion destabilized and undermined some traditional civil society organizations, others were strengthened as this same process forced them to seek innovative ways to associate. New civil society groups appeared that began to channel citizen participation in economic and social activities in order to influence public policies and ease access, particularly for the poor, to public resources. These new organizations and forms of association within civil society aim to become the counterweight and balance to public authority.

The new development model has generated moderate economic growth, but has not resulted in achieving human development or in eradicating poverty (CEPAL, 1997). These programs have increased unemployment, particularly among low- and unskilled workers and older public servants, and their impact on poverty, health, and development are unknown (Tomassini, 1997).

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6 This growing violence has been accompanied by an escalation of private spending on security, which frequently contributes to greater crime to the extent that the private armies become paramilitary groups. In total, the region spends between 13 and 15 percent of the GDP on security (both private and public), while it spends less than 7 percent on health services.

Structural programs have intensified the inequities in Latin America and the Caribbean, which has been characterized as the region of the world with the greatest inequality in wealth distribution. This, in turn, causes severe differentials in access to and financing of health services, and in the health status of different population groups (Casas, 1998). These programs have both enlarged the gaps in health conditions between high and medium income groups and worsened the health of the most vulnerable groups, such as the children of rural and urban fringe areas. They have also undermined the well-being of poorer rural and urban sectors (OPS, 1998). Despite major progress in the last two decades, the number of people in the region living in extreme poverty has constantly increased and now exceeds 100 million (UN, 1997).

Another remarkable disparity is the utilization rate of services between sexes, to the detriment of women, particularly those in poorer groups (Casas and Dachs, 1998). Moreover, widely disparate access to health care financing functions as a powerful regressive mechanism and reduces access to services for those who need them the most. Adjustment programs also liberalize labor markets in order to spur competition, resulting in an erosion of basic labor laws, sanitary measures, and safety regulations, as well as reduced access to childcare and maternity leave (World Health Globalization...)

Indications of the growing gaps in health conditions in the Americas were presented in the most recent PAHO report on Health in the Americas (OPS, 1998).

In Argentina:

- Since 1994, the number of people living in poverty in metropolitan Buenos Aires has increased, an effect linked to an increase in unemployment, food prices, and the number of families living in precarious dwellings.
- Infant mortality in the city of Buenos Aires in 1995 was 13.1 per 1,000 live births, while in other Provinces as El Chaco and Formosa the levels are more than 30/1,000.

In Bolivia:

- In 1992, 70% of the households were classified as poor due to inadequate access to basic education, health, and housing. Only 17% of the Bolivian population are considered to meet their basic needs.

In Brazil:

- This country has one of the largest socio-economic disparities in the world, and between 1960 and 1990, the proportion of national revenue received by the poorer half of the population decreased from 18% to 12%, and that of the richest 20% increased from 54% to 65%.
- Although mortality levels in Brazil have declined significantly in recent decades, part of this success is off-set by the increase in male mortality in the age group 15-29 years due to external causes, most of which is attributable to violence, especially homicide.

- There is a marked inter-regional disparity in health, with an infant mortality rate in the Northeast of 64/1,000, which is 2.5 times greater than the South's rate of 25/1,000. Because the infant mortality rate tends to diminish as the mother's education increases, the rate is ten times higher in children of non-educated mothers than in children with college-educated mothers.

In Colombia:

- The principal health problem in the population is that of injuries due to the endemic violence of the society. Of the violent deaths, 59.7% occurred among people between 15 and 34 years old, with men experiencing a violence rate ten-fold above that of women and a homicide rate fifteen times that of women.
- There are many hypotheses for this very high incidence of violence; however, its principal determinant seems to be persistent socio-economic disparities, which are exacerbated by the structural distortions resulting from the country's entry into the global economy through drug trafficking.

In the Dominican Republic:

- Infant mortality varies according to the mother's educational level. Here, it is 85/1,000 in the case of uneducated mothers and only as high as 20/1,000 among mothers with some level of higher education.

In Ecuador:

- 63% of the population lived at some level of poverty in 1995, compared with 54% in 1990. It is estimated that 30% of the population lacks access to basic medical care.

In Guatemala:

- 75% of the population lives in poverty, with 58% in extreme poverty. Both poverty and extreme poverty are higher in the rural areas, and 91% of the indigenous population lives in extreme poverty.

In Peru:

- The risk of death in children under one year old is five times higher among children of the two poorer quintiles than among children of the richest quintile. Between the same groups, the rate is seven times higher for children between one and five years old.

In Trinidad and Tobago:

- Between 1980 and 1988, poverty rates increased from 3.5% to 14.8%, and current rates are estimated at 22% of the population; half of these families are classified as extremely poor, and the severity of poverty is worse in urban areas.

These descriptions clearly show that, in matters of health and human development, the Region of Latin America and the Caribbean is still far from being what Espíndola calls "a community of opportunities and objectives," where political citizenship is accompanied by social and economic citizenship (Espíndola, 1997). The growing socio-economic disparities and the resulting inequities in health conditions represent one of the principal threats to the governability of the region's countries. The model of economic growth adopted in Latin America has not yet improved living conditions for the great majorities living in poverty. If no investments in human capital are made by protecting and promoting public health, and if social capital is not increased by developing participatory, collective, and democratic governance and institutional life, then the financial and physical capitals alone will be insufficient to generate sustainable economic growth, governability, and human development.

b) Globalization and its Impact on Health

Globalization is a process of progressive internationalization of economic activity. It implies, among other things, harmonizing market rules, reducing trade barriers, forming an international capital market by eliminating foreign exchange and capital controls, investing directly, increasing the number of companies that operate in many countries, disseminating information and knowledge at ever-increasing speeds, and making inexpensive and effective communication technology available (Castells, 1997).

Globalization is also related to the progressive emergence of networks and facilitation of networking organizations that proliferate contacts, share experiences, and strengthen the learning process. Globalization expands a government's ability to learn from other countries' experiences when formulating and implementing its own policies. This process has been described as eliminating borders and unifying the world through transnational companies, which are creating global production and a global capital market to finance their activities (Informe sobre creación, 1996).

Among the effects of globalization, we may mention the following:

- the economy has disengaged itself from the traditional production factors, such as financing capital, natural resources, and labor, and adopted factors based mainly on knowledge and technological change;
- the structure of the basic economic unit, the enterprise, has changed; and traditional organization and management structures based on centralized direction and control have been substituted with more flexible and decentralized forms;
- new linkages have arisen for knowledge, technology, information, publicity, communication, marketing, and financing;
- there is growing specialization, which fragments the work force into multiple specialized groups; and
- globalization and the technological revolution produce combinations of factors that reduce employment possibilities, particularly for manual laborers (ibid.).

Globalization strains the bases for governability. On one hand, pressure from supranational and transnational companies erodes the State's sovereignty and debilitates its identity and autonomy when these companies intervene and mediate in national matters and press for the establishment of uniform international laws; on the other hand, globalization demands that political leaders and civil service develop new perspectives on the utilization of knowledge, attitudes, and abilities. In others words, globalization imposes the need for reinventing leadership and civil society, and for re-forming the State (Prats).

Likewise, globalization and the technological revolution that accompanies it present many challenges to the democratic process. In the case of Latin America and the Caribbean, despite the fact that globalization multiplies the number of political actors, the different political sectors continue to be unequally represented. Another side-effect of globalization and the technological revolution is that these processes allow a small (wealthy) minority to significantly increase its income, while the vast majority fights to maintain a steady income, and many others see their income decline considerably which causes great insecurity. Additional risks are caused by a larger and more structurally embedded poverty, the growing marginalization of major sectors of the population, and the disunification of the work force (Bezanson, 1998).

Globalization also creates health risks and opportunities that transcend national borders. Free trade and the technological revolution have facilitated the dissemination of health advances, such as effective contraceptive methods, techniques to obtain safe drinking water, low refrigeration costs, and new therapeutic agents to effectively treat diseases such as leprosy, schistosomiasis, trachoma, onchocerciasis (river blindness), and other diseases (Roemer and Roemer, 1990). Likewise, the potential benefits of modern information and communication technologies abound, so much so that they are becoming more accessible to governments, groups, and the public in the region's countries. Their use could spread to the field of telemedicine, interactive health networks, communication services among health operators, development of human resources, continuing education, and distance learning (Yach and Betcher, 1998).

The globalization of trade and transport also carries risks and opportunities for public health. One of the principal threats to health is the spread of infectious diseases among countries. This is not, of course, a new phenomenon. What is innovative is that in the last decade of the 20th century, travel volume and speed have magnified that risk and facilitated the "globalization" of infectious agents. Free trade has facilitated the production, processing, and distribution of food by transnational companies and, although this tends to reduce the price of consumer products, it also holds the potential to increase health hazards. Traffic of tobacco, alcoholic beverages, and psychoactive drugs constitutes a health threat, as does dumping unsafe or ineffective pharmaceutical products. For example, global tobacco consumption has increased substantially due to tobacco conglomerates' aggressive marketing directed primarily to the general populations of developing countries and to women and teenagers globally. If the trend continues, by the year 2020, more than 10 million people will die of diseases related to tobacco consumption—a great deal more than the 3 million at the beginning of the 1990s (World Health Globalization. . .).

Moreover, in some Latin American countries such as Argentina, Brazil, and Mexico, free trade and

health sector deregulation has increased the price of medicines. Imperfections in the international trade of these products, the small price elasticity of many, and the low price of these products before trade barriers were eliminated explain to a great extent the systematic price increases of these goods in recent years. This has a non-negligible impact on "the population access to these goods, as well as on the balance between income and expenses of medical social security entities responsible for the financing and delivery of health services" (Katz et al., 1997).

Still, social exclusion is undoubtedly the greater risk that globalization carries. A large number of people lose their jobs, and subsequently their political and social participation in the community decreases. The insecurity created by a fear of poverty and unemployment moves people to protect themselves through hostility and even violence directed toward those who are considered intruders, thus forcing marginalized groups into a situation of even greater vulnerability than they were before.

Diminishing citizenship participation in community activities and the loss of confidence among community members has a serious impact on social capital. Unlike human capital—or physical capital—social capital is a public good created as a by-product of social relations. It refers to "features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions" (Putnam, 1993). Evidence demonstrates a strong relationship between poverty, health, and the exhaustion of social capital. The dislocation of a group and their lack of participation in community activities are important factors in predicting certain diseases. Empirical data show a strong relationship between a lack of confidence among members in groups or communities and an increase in their total mortality indices due to coronary heart disease, malignant neoplasms, cerebrovascular diseases, and infant mortality (Wilkinson, 1996). These data also indicate that investment in social capital is strongly and negatively correlated to disparities between the rich and poor. That is, reducing investment in social capital is one way by which growing inequities in income levels exercise their effect on the mortality index (Kawachi et al., 1997).

c) Impact of State Reform and Modernization on Health

Reform of the State is part of the IFIs' second package of measures proposed to developing countries, in recognition that their original programs and projects failed due to institutions' inability to execute them (Gestures Against Reform. . . , 1998). In this second generation of reforms, the concept of governance is introduced into previous projects that promoted efficiency, effectiveness, and transparency in public finances, tax systems, customs systems, and the ministries of economy. The World Bank also tries to promote accountability by establishing information systems that permit quick access to information for decision-making, programming, etc., as well as for rendering accounts (World Bank, 1992).

However, that approach to State reform does not take into account the fact that rendering accounts is not possible without a civic culture that demands it, a feature that requires the active participation of civil society organizations to monitor the public authorities' performance.

Just as the structural reforms of Latin American economies monopolized public discussions in the 1980s, the topic of State reform and modernization dominates public debate at the end of the century.

Such a focus is justified because the countries' efforts to balance democratic regimes, market economies, and growing popular demands are being increasingly hindered, according to the IDB, by "the traditional structure of state institutions, the State's precarious management modalities, inappropriate public policies, and obsolete legal frameworks" (BID, 1994).

One of the principal challenges the region's governments currently face is the growing social dissatisfaction generated by frustration, especially among the poor, over the failure of the first and second generation structural reforms. Even the Latin American authorities, frustrated by the pace of the reforms, rush to find measures that will allow them to speed economic growth and increase the provision of social benefits.

As a consequence of the hard-learned lessons from the debt crisis, the changes in their economies as well as in the world economy, the impact of globalization, and the reaction of those sectors struck hardest by these changes, the countries of the region have come to understand that economic growth does not automatically translate into human development nor into the elimination of inequities. This recognition highlights the need for incorporating the social, economic, and State reforms into a single, integrated development agenda.

Developing an integrated agenda implies supporting the processes to transform and modernize the economies; strengthening the State's ability to satisfy its basic responsibilities (social and macroeconomic policies, regulations, justice, etc.); consolidating the rule of law as a requirement for the efficient operation of a market economy; creating the normative guidance and institutional conditions to ensure long-term stability as well as juridical and political safety; reinforcing democratic institutions; and strengthening civil society as a necessary condition for a democratic system and for sustainable and equitable development (Sexta Cumbre de Presidentes, 1996).[7]

The reform process is changing the State's role, transforming its dimension, the character of its interventions, and its relation to different economic and social agents. Notwithstanding the progress of Latin American countries in the last ten years, problems still persist that, if not addressed, could endanger the sustainability of the new development strategies and the solidification of democratic systems (BID, 1997).

Solidification of democratic institutions, along with creation of open, efficient, and competitive market economies, maintenance of social cohesion, and reduction of inequity are challenges that require selective decisions and actions. Experience teaches that, in the long run, the success of economic and structural reforms depends on the support of strong political coalitions and determined leaders to change the status quo. However, as a societal feature, governability does not depend solely on the capabilities of governments and those who are governed, but also on the prevailing values, attitudes, and mental models in the society. Hence, every program meant to strengthen governability and governance should extend beyond State reform and modernization to encompass civil society. Governability and governance, then, require reinventing not only the State but also the civil society (Prats).

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[7] This new conception of the reforms has been called "The Consensus of Santiago" since the Latin American dialogue on governability and effective participatory democracy apparently started at a summit of Latin American and Ibero-American leaders held in Santiago, Chile, in 1996.

State reform should be directed toward eliminating inequities and strengthening social justice; to this end, the State's minimum role should consist of striving to guarantee:

- Protection of people's life and physical integrity, as well as property;
- Public infrastructures and minimum services to ensure human dignity (drinking water and sanitation, electricity, and roads);
- Quality in basic and professional education for the entire population;
- Food safety and basic health for the entire population;
- A system of assistance and basic social security; and
- Environmental integrity for future generations.

Similarly, the State should create and promote opportunities for participation in productive activities, especially among the neediest, through employment and by supporting the development of small and medium-sized companies; by banning discrimination against ethnic minorities; and by nurturing diverse cultures in an effort to integrate the national identity (Instituto Internacional, La Reforma…)

In short, the level of governability of a given country depends, on one hand, on the quality of its institutions, its social capital, and its political culture; and on the other hand, on the ability of representatives of organizations and movements to contribute to the formation and implementation of policy. Thus, strengthening governability and building democratic governance should first be directed toward reforming the institutional environment of public action.

The quality of public intervention does not depend only on public institutions' organizational capabilities and the abilities of their representatives to formulate and implement public policies, but also on the incentives and restrictions under which public entities operate. It is important to improve the qualities of institutions and their representatives, but by itself, institutional development is insufficient. Hence, the purpose of State reform should not be that a public institution "be effective and efficient, but that it function so as to induce efficiency in the markets and justice in societies…" (Instituto Internacional, Desarrollo…).

Governability/Governance and Health Sector Reform

a) The Health Reform Objectives

Health systems throughout the world are involved in a profound transformation process. The universal process of economic liberalization, globalization, and State modernization is evident in the Latin American and the Caribbean health sectors through the health systems reform movement. In general, the express purpose of these processes is to improve the health level of the entire population regardless of the diversity among countries. The reforms stem from certain fundamental objectives, including the following:

- Promoting equity in health status, as well as the access, use, and financing of services;
- Improving the quality of care, both on a technical level and from the patient's perspective;
- Increasing efficiency of health expenditures, resource allocation, and management;
- Ensuring sustainability, both in terms of public support and financing; and
- Promoting participation of the private sector in planning, management, provision, and evaluation of both health services and their financing mechanisms (OPS, 1997).

However, there is a real danger in that the progressive extension of the market approach to health system reform may erode the provision and allocation of resources to cover the care requirements of the most neglected populations of the country. Rational measures and interventions are needed to improve efficiency in the provision of services, which will increase resources available to serve the neediest. Until now, experiences both within and outside the Americas indicated that health reform processes have principally resulted in cost containment and the creation of new opportunities for gain rather than an increase in quality and coverage of basic services (Evans, Going…, 1997; Evans, Coarse Correction…, 1997).

Additionally, it should not be forgotten that the health sector is responsible for executing a set of basic functions to promote and protect people's health, and that, as members of and participants in their society, citizens have an inalienable right to receive these guarantees and services. In order for the State to effectively fulfill this health promotion and protection role at both central and local levels, it must develop and strengthen up-to-date normative, legal, and regulatory frameworks. This would facilitate effective collaboration between the public and private sectors—including civil society—to protect public health, especially for the most vulnerable populations.

Among the minimum health services citizens have the right to expect are

- Epidemic prevention and control of prevalent diseases;
- Protection against environmental risks;
- Trauma and disability prevention;
- Promotion of healthy behavior and mental health;
- Effective response to disasters and sufficient assistance in the recovery process; and
- Assurances of health care services quality and access.

In order to fulfill these minimum demands made by the population, health reform necessarily should serve the following support functions for the development of a health system:

- Development of epidemiological information systems as well as health and documentation services, including database networks on health statistics; epidemiological surveillance; and dissemination of scientific, technical, and bibliographic information in health that are accessible to the entire population and to organizations.

- Development of national policies for technological research and development that include health technology assessment and adaptation.
- Development and training of human resources from and for the health sector, including creation of national networks for public health training of national and local leaders, both for intra- and inter-sectoral management.
- Development of participatory community systems for planning, monitoring, and evaluating health services as well as other components of well-being that affect people's health through mechanisms similar to the Healthy Communities Movement.

In performing these essential functions, the sectoral reform process, which is intended to encourage democratic and participatory forms of governance, should introduce new modalities for delivery of the basic services described above. For example, evaluation of health status and health determinants should allow State, private sector, and civil society responsibilities to interlace with each other. Epidemiological surveillance systems should include social participation in researching environmental risks, behavioral risks, and socio-economic determinants of health.

At the local level, democratic governance in health requires designing and implementing epidemiological surveillance systems and health situation analyses. These tools should instruct local services managers to involve community agency representatives in the assimilation and dissemination of information used to define priorities and select interventions.

Methods and standards for the preparation of Community Health Profiles should be made available to political authorities as well as to local citizenship leaders. Profiles should systematize and update information on people's health status, determine health needs, identify health risks, evaluate health outcomes, and assess the cost and effectiveness of health services.

Additionally, integrated epidemiological and health information service systems should be shared with public and private services, care providers, financing or buying entities, and the community itself, so that various interest groups and entities may monitor and evaluate the status of health and health services. Transparency in health information is a fundamental quality for encouraging and channeling social participation to identify priorities, and for planning and mobilizing public and private resources for health.

Using transparency to facilitate participation requires promoting, on a national scale, mechanisms for collaboration and health information dissemination among private sector and civil society actors interested in health protection and the promotion of well-being. It also implies opening the state health apparatus to increase accountability in health-related matters. This process, in turn, requires recognizing and respecting the multiplicity of forms of participation. These can range from self-help community activities and the formation of social support networks, to the constitution of formal bodies that represent entities of the State, private sector, and civil society, and can assume partial or total responsibility for managing public resources allocated to health services.

Finally, in light of the globalization of health and disease determinants, it is necessary to develop a

supranational level of civil society consultation and involvement for the purpose of analyzing health conditions globally.

b) The Reform Process

Health sector reform implies a redefinition of the State's sectoral role. In Latin America, health sector reform has been associated with the decentralization of health services and local systems, and with the attempt to confront inequalities in access to services through universal standardized or focused benefits. Moreover, as Sachs has observed, reform tries to improve "the efficiency and quality of the benefits, and seeks to increase sector productivity through reforms in management, promotion of synergies among the public and private health systems, control of costs escalation and regulation of private medicine" (CEPAL, 1997).

Reforms are complex processes that involve new actors and speakers and demand greater supervision through strategic performance evaluation systems. The success of health reforms depends on attaining a level of consensus sufficient to generate political and social support. An integrated approach should take into consideration the growing leadership of civil society, so that health-sector reform and the strengthening of civil society are mutual and complementary processes.

Civil society participation in health-sector reform processes is invaluable and should be central to the process. Without a broad national consensus or the appropriation of health topics by political and business leaders, political parties, civil society organizations, and the media, it will hardly be possible for the region's countries to effectively engage in such a large and important enterprise. This participatory aspect of formulating and implementing reforms should be subject to closer evaluation and analysis when following-up on the health reform process in the region, especially in monitoring the impact of new financing schemes, management decentralization, or equity levels in access to basic services among income, gender, and ethnic groups.

Creating democratic governance in the health sector reform process should also address the following issues:

- Health sector priorities should be based on a broad consensus of society, and the voices of the poor and the most vulnerable should be heard when allocating sector resources. This implies that health sector reform cannot be conceived nor implemented only by the public and private entities that provide health care services to the population. Reform should be designed to take into consideration the interests and needs of the population—particularly the poor—and the interests and positions of the private sector and civil society organizations that provide health services to the population. It should be coordinated with the State sub-sectors whose tasks may have an influence on health.
- The reform process should be based on a systemic and structural concept of people's health, conditioned by factors that affect human development. It must be linked to measures directed toward increasing employment, eradicating poverty, expanding education opportunities, improving quality of life—particularly in the areas related to food safety, nutrition, housing, and sanitary conditions—-and raising the status of women.

- The systemic character of countries' health problems implies that health policies should take a comprehensive approach by addressing the participation of other sectors. Ministries of Health should be capable of drafting health policies and interventions in cooperation with the Ministries of Finance, Education, Social Welfare, Trade and Economy, Agriculture, etc., as well as with the Legislative and Judicial branches.
- Restructuring the Health Ministries should extend beyond personnel downsizing and separating the service delivery functions from those of financing. Strengthening management functions and sectoral regulation requires, among other things, a public administration and civil service capable of attracting highly skilled, competent, honest, and well-remunerated personnel. A career civil service should be developed that depends on merit-based recruitment and promotion, and incentive-based compensation (UNDP, 1997). It would also need a more efficient, effective, and transparent administrative apparatus for managing public health services and mechanisms for accountability to the citizenship and civil society. In the health sector, the State role should be mainly to formulate policies and programs, define regulatory and financing frameworks, and establish and facilitate interactions between the various actors who intervene in the delivery of health services. This requires a renewal of institutional and managerial health policy.
- To strengthen equity and social cohesion in the region, it is necessary to promote civil society involvement and leadership by supporting the development and proliferation of leaders, entrepreneurs, and social managers, and by facilitating the redistribution of roles between State and civil society. Exercising democratic governance implies political and social interactions to mobilize groups into participating in economic, political, and social activities. Civil society organizations can act as surveillance mechanisms to alert and defend citizens against excesses in the exercise of governmental power, as well as to help groups affected by market decisions and weaknesses.
- The health systems and services decentralization process should contribute to building democratic governance in the health sector and strengthen existing social, group, and civic networks by disseminating health information through communication mechanisms. In a larger sense, decentralization should help strengthen sectoral governability and governance and create social capital. It is necessary to create spaces and mechanisms to enable civil society organizations to participate, through different forms of association, in the management or co-management of public health services, and in the execution and/or monitoring of regional, national, or municipal health programs and projects.

In short, health sector governability implies democratization of the reform process and formulation of health policy. Hence, health sector reform should begin with a comprehensive analysis of population health, and it should be directed toward developing democratic governance in the health sector and contribute to governability.

Governance in the health sector is linked to democratization of public administration in general but also encompasses the civil society and the private sector. This, in turn, imposes a responsibility on the national institutions that oversee sector management to exercise leadership in the reform process and in the formulation of health policies.

Most health ministries of our countries lack the resources and institutional capability required to assume that leadership.[8] New personal and institutional capacities are required, including:

- proper management in the multicultural context;
- creation and management of information and consultation networks;
- creation of a vision and strategic management;
- negotiation with other actors within and outside the health sector;
- establishment of interdisciplinary teams;
- management of conflicts; and even more importantly
- capacity to maintain the necessary credibility for directing experimentation and learning processes (Prats, 1998).

Poverty and growing social inequities, including those present in health conditions and access to basic services, threaten the governability of Latin American countries. In the transformation process that Latin America has undertaken, these persistent inequities stretch societies' weak social fabric, encourage social disintegration, and endanger democracy and the accomplishments in stabilizing principal macroeconomic parameters. "Neither democracy, nor the market will be sustainable with the current levels of poverty, inequality, uncertainty, and the lack of hope for many sectors" (Instituto Internacional, Desarrollo…).

Conclusion: Implications for International Cooperation in Health

In a recent article on the future of capitalism and globalization, Jeffrey Sachs insists on the need to address the subject of disparities in health and nutrition between the North and the South as one of the most necessary interventions for protecting the future of global capitalism (Sachs, 1998).

International organizations such as PAHO, WHO, the development banks, the bilateral cooperation agencies, and others who form the world health system (WHS) (Frenk et al., 1997) provide technical and financial cooperation to national governments to support their efforts to deliver basic services to the population, particularly to the poor and the marginalized. At the same time, they increasingly perform coordination and supranational health regulation activities. According to several authors who have

[8] A symptom of the growing difficulty that governments of the region face in health sector management is the progressive reduction of the average duration of a minister of health mandate in Latin America and the Caribbean in the last ten years, around 18 months.

recently thought about the role of these institutions in the globalization of health, the core functions of this system should be differentiated from what are commonly called support functions.[9]

The former functions—the essential functions—are those that, in the context of health globalization, are directed toward promoting international public goods with positive externality, such as health research, data and health information bases, technical standards, and actions to monitor and control the negative externalities represented by environmental risks, exchange of unhealthy goods, dissemination of pathogens, etc.

In the words of Jamison, Frenk, and Knaul:

> Core functions are an attempt to solve the global analogue of "market failures"—i.e., the situations in which costs and benefits of an action are not reaped exclusively by the individual agent, in this case, the nation state. Supportive functions, by contrast, are intended to compensate for "government failures"—i.e., scenarios in which a government cannot fulfil its responsibilities independently. The ultimate goal of supportive functions is to help countries move from dependence to independence, whereas the goal of core functions is to help them move from independence to interdependence, which represents a higher level of international cooperation—and the only way to meet the challenges of the global era (Jamison et al., 1998).

The fundamental objective of WHO's essential activities, then, is to contribute to health governance on a world scale, providing an institutional and regulatory framework to reduce health hazards that multiply in the context of globalization. International cooperation in health support activities, on the other hand, is necessary where there is a lower level of State-nation governability. In contrast, the support functions of international cooperation and health are necessary where there is less development of governance of the national states and of the health sector itself. These functions are also necessary in order to protect governability on a global scale, which is threatened, as Sachs points out, by the growing disparities between rich and poor that the global adoption of the capitalist model has generated.

The corollary of this conception is that strengthening national governability and sectoral governance should be part of the support activities in international cooperation in order to progressively reduce and ultimately eliminate the "government deficiencies" on the national level and the "market deficiencies" on the international level.

In most cases, this implies strengthening democratization of health policy formation and promoting transparency, effectiveness, and efficiency in health services administration. It also implies that the WHS should be equally concerned with strengthening effective mechanisms of political governance of the health sector in the democratization of health policy formation and the management or co-management of primary health services.

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9 For this discussion, see: Frenk, et al., "The New World Order and International Health," *BMJ* May 10 1997; 7091:314. Jamison, et al., "International collective action in health: objectives, functions and rationale." The Lancet 1998: 351:514-17. Mogedal, Sigrun, "Supportive Functions of International Health Organizations," DIS, Centre for Partnership in Development. Yach D., Bettcher D., "The Globalization of Public Health, I: Threats and Opportunities," *American Journal of Public Health*, May 1998; 88(5):736.

Within the scope of constructing democratic governance, health sector reform and democratization imposes on WHS institutions the responsibility to provide technical cooperation and training. This applies not only to areas traditionally related to managerial development (administration, finances, accounting, etc.), but also in those areas linked to strengthening global governability and sectoral governance in health. All this activity implies an organizational culture change, not only nation-wide and in the local institutions responsible for the sector governance, but possibly also within the cooperating organizations at the international level.

In conclusion, we postulate the following intervention areas, in which the technical and financial cooperation from WHS institutions should help strengthen health governance and governability in the region's countries, and correct and eliminate "government deficiencies" in the health sector. Among them are:

- The promotion and formation of effective leadership for change, which implies the capacity to translate political vision into sustainable programs that guarantee governability of the nation and democratic governance;
- The development of capacity for strategic planning and the establishment of accounting systems and mechanisms;
- The establishment of expedient and reliable information systems necessary to formulate policies and to monitor programs and projects;
- The creation of coordination and consensus-building mechanisms between the institutions responsible for steering the health sector and for other State powers, particularly the legislative and judicial branches, the private sector, and civil society organizations;
- The creation of laws and mechanisms to form and strengthen political and administrative management to permit and promote the freedom of civil society organizations to participate in the formulation of policies and health services management; and
- The establishment of mechanisms necessary to provide, on a timely basis, information to civil society groups that will facilitate their participation in the surveillance, co-management, or management of health programs and projects.

The sector's large and small objectives are no longer under a single institution. Health sector management should extend beyond the traditional handling of organizational resources. It should involve inter-sectoral or inter-organizational management of the discovery of opportunities and of change.

We who work in the countries of Latin America and the Caribbean to develop the New Health Reform would do well to re-examine the precepts of those who spoke of medical reform a century and a half ago. For Virchow and his followers, the social and political character of public health was evident. The biomedical health model, which arose as a consequence of the century's enormous progress in science and knowledge, has not brought equity in health. The benefits of this knowledge are not distributed equally in our societies. The prevalent health problems of our peoples continue to be those

determined basically by educational level, by environmental conditions, by economic and social opportunities, and by access to basic services, nutrition, work, and decent housing. In order to identify and address the basic determinants of population health, it is necessary to build a new holistic health model, in which the biological, psychological, and social character of human beings integrated into a vision that is respectful of their diversity, complexity, and human dignity.

Let us recall Virchow, who in 1848 at the request of the Prussian Government, investigated an outbreak of tuberculosis among miners in Silesia. The scientist concluded that the epidemic was caused by the abominable living conditions of the miners and their families and that these would not change unless a representative democracy and social justice were established in the country.

Health reform in Latin America, if understood as a process of attaining equity in health, also cannot be effective until it becomes an arena for creating governability, consolidating democratic governance, and augmenting the social capital that is so needed for sustainable human development in the Region of the Americas.

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OPPORTUNITIES & RISKS PRESENTED BY GLOBALIZATION: COUNTRY CASE STUDIES FROM THE PERSPECTIVE OF CIVIL SOCIETY GROUPS

NOTES ON GLOBALISATION & THE ENVIRONMENT FOR WOMEN'S REPRODUCTIVE HEALTH IN THE ENGLISH-SPEAKING CARIBBEAN:

The Guyana Example

Jocelyn Dow and Andaiye

The Cairo Conference and the New Commitments to Women's Reproductive and Sexual Health[1]

A main objective of the 1994 Cairo International Conference on Population and Development and later, the 1995 Fourth World Women's Conference in Beijing, was to write an agenda for the global development and empowerment of women. At Cairo, women fought successfully against strong, well-financed lobbies from the dominant religious bodies to ensure not only that the right to choose the timing and spacing of one's children, agreed upon at the 1992 Earth Summit in Rio, would be the minimum basis of the Cairo Programme of Action, but also that women's health, especially our reproductive and sexual health, would be guaranteed in future programming, and the concept of population control with timebound targets would become a crudity of the past.

In a chapter on "Gender Equality, Equity and Empowerment of Women," the Cairo Programme relates women's empowerment to sustainable development rather

[1] Wherever appropriate, the word "women" should be read as "women and girls".

than fertility reduction. It calls for women's enhanced decision-making capacity and the transformation of power relations between men and women in the private and public spheres, with issues in the private sphere including an end to violence against women and girls as well as increased male responsibility for reproductive work and health. The Programme also urges encouragement of women's grassroots, community-based and activist organisations. Using the World Health Organization's broad definition of reproductive health, it envisages a corresponding model of reproductive and sexual health services that is integrated, comprehensive, and incorporated into primary health care programmes. While it does not include abortion as a requirement of women's reproductive and sexual health and rights, it identifies "unsafe abortion" as a public health issue.

In principle, Cairo also integrated the need for financial and other resources at a macro level with the delivery of health services. What it did not do was question how these resources would be made available in the context of a globalised economy where the shift to market arrangements for public health contradicts the goal of timely and accessible comprehensive health care for women who are poor. Like the later Beijing Conference, Cairo was also weak on the question of transferring resources for implementation to poor countries and weak on challenging the unchecked rule of the market or the unjust terms of globalisation. Caribbean women participated actively at Cairo (at all the United Nations conferences, from Rio to Beijing, we have had an influence far exceeding our numbers), with a clear position that the global economic context was hostile to women's well-being, especially women from poor countries. This brief presentation will use the example of Guyana to indicate some of the effects of globalisation on the ability of a small, poor country to find the financial and human resources to honour the promises of Cairo; rather than offer you the statistics of women's poor reproductive and sexual health in Guyana, we want to describe the environment in which women must struggle to improve it.[2]

Globalisation and the Availability of Financial Resources for Health Care in Guyana

The Guyana market, like the markets of other developing countries and countries "in transition," is being restructured for the global economy by International Monetary Fund (IMF)/World Bank Structural Adjustment Programmes (SAPs): after a first programme which was cut short at the beginning of the 1980s, this process has been continuously underway in Guyana since 1988. SAPs have had a particularly harsh effect in Guyana because the context in which they were implemented was a huge state sector, massive debt, an economy and infrastructure near collapse, and a population divided and in dispersal. Thus, while SAPs led to seven years of macro-economic growth (from 1991 to 1997), the economy continues to be characterised by heavy public debt, high unemployment, an inadequate physical and social infrastructure, a critical shortage of skilled workers, and widespread poverty. Its capacity to continue growing is at risk. Like

[2] For sources of information on reproductive and sexual health in Guyana, see references at end of document.

other Caribbean countries, it faces uncertain preferential access to the European Union market for its sugar and rice, arising from World Trade Organisation (WTO) rules which prescribe equal access by each country to markets regardless of their size, strengths and weaknesses.[3] In the first half of 1998 the economy declined by 2.7%, partly because of political/ethnic unrest in the capital following December 1997 elections and because of bad weather, but also because of developments in the globalised economy—a fall in the price of exports and the impact of the Asian crisis on Guyana's markets for timber and other natural resources.

In direct relation to health and health care provision, our economic dilemmas translate in the following ways:

- In spite of some improvement in SAPs' conditionalities and recent increases in social sector expenditure, Guyana has just US$52 per capita per year to spend on health, including government, donor agency, parastatal and private sector resources. This compares to US$160 for Jamaica, US$250 for Trinidad &Tobago, and US$700 for Barbados.
- Because it is impossible to invest adequately in human resource development and the physical infrastructure for Primary Health Care, money continues to flow to more costly, central, and higher level facilities, with the inevitable result that patients bypass their local clinics and medical personnel. There is no primary health care unit in the Ministry of Health, and partly as a result, no explicit national family planning programme and only inadequate reproductive health education in the schools. The major responsibility for work in these areas is borne by small non-governmental organisations.
- Especially in public medical facilities, wages are abysmally low, with the result that many nurses, for example, work daily shifts in both the public and private sectors; since July 1998, a staff nurse in the public sector has earned G$18,304, or between US$120-130, per month. There is a frighteningly high migration rate among nurses.
- Access to health care is sharply uneven, and for poor women, gaining access can be time-consuming, energy-consuming and costly. This is because of inadequate health facilities, especially in rural and hinterland areas, cost recovery in the public sector, and increased reliance on private local facilities. Formal arrangements by the Ministry of Health for the treatment of Guyanese in neighbouring CARICOM countries are so inadequate that endemic delays can have fatal consequences. The majority of Guyanese are unable to use local or Caribbean private facilities because the level of poverty in the country, while officially falling, is still very high (43% of the total population; 80% of the hinterland population).

The inadequate provision of funds to the health sector, which is directly related to early conditionalities of restructuring, is clearly a critical barrier to improved health services. This remains

[3] This is the same rule under which the United States challenged preferential European Union access for Caribbean bananas under the Lome Convention.

true even with Guyana's participation in the Highly Indebted Poor Countries Initiative, part of a debt forgiveness package negotiated with the Paris Club which offers the country savings on debt payments for a programme-specific package centred in the social sector. Not only is the increased allocation to health it provides inadequate to the size of the task, but also Guyana no longer has the human resources we need to effect a transformation in the provision of health care (or in other areas). This is partly because of low wages, but also because of the depletion of what we will call our social and cultural resources. In a variety of areas related to women's reproductive and sexual health—including access to contraceptives and to information on contraception, the prevention and treatment of breast and cervical cancer, the AIDS programme, and the monitoring of the implementation of the Medical Termination of Pregnancy Act of 1995—the problem is not only a lack of financial resources, but also a lack of what people call "technical" resources.

Globalisation and the Availability of Social and Cultural Resources for Improved Health Care

Globalisation, as we know, is more than an economic phenomenon; it is shaping and reshaping populations, cultures and politics. Within and across nations, it is helping to develop its own opposites: fragmentation and dispersal. Its economic and social effects (e.g., increased job insecurity and growing ethnic competition and conflict) are acting against the capacity of poor people to mobilise in their own defense. In Guyana, just as the economic fault lines of the country predated the introduction of SAPs but were sharpened by it, the same is true of our social and cultural fault lines:

- material conditions fuelling ethnic polarisation and the domination of political space by ethnic polarisation;
- the fragmenting of families and communities under the pressure of internal and external migration;
- the increased recourse to personal violence, especially against children and women;
- the phenomenal growth and spread of illegal immigration and drug industries and relatedly, of violent, armed crime;
- the rise of casual lawlessness and conversely, the weakening of a sense and practice of legitimate entitlement;
- a precipitous fall in functional literacy (89% of out-of-school youth are at a low or moderate level of functional literacy);
- and the fragility of civil society.

We want to look at just two aspects of these conditions as they affect reproductive health care—gender inequity and the level of involvement of civil society in health planning.

If we return to the Cairo Programme of Action we see that it called for the transformation of

male/female relations in the public and private spheres, including increased male responsibility for reproductive health and work as well as decreased violence against women; women's greater participation in decision-making; and the encouragement of grassroots women's organising. Caribbean Women's Analysis for the Beijing conference (our consultations were region-wide and involved both governments and NGOs) contested the usual view of the Caribbean as a place with near gender equity (or where women are dominant) and identified three critical areas that are product and producer of women's subordination in this region: the extraordinary burden of unwaged, reproductive work that women bear, at the heart of which is child and family care (one activist says we should add "man care"); the unequal relations of men and women in emotional and sexual relations, reflected in high levels of sexual and other physical violence against women and in their low levels of decision-making on reproductive and sexual issues; and the low participation of women in public decision-making.

As the effects of globalisation and trade liberalisation bite deeper into our small nation states, the situation in all three areas worsens, since all are shaped by crisis. In some territories (for example, Trinidad and Tobago) violence against women is of epidemic proportions. In relation to the burden of unwaged work, it is now broadly accepted that SAPs as policy are predicated on the increased exploitation of (mainly) women's unwaged and (low-waged work), and that they do in fact increase that work as the price of individual and family survival. This is why when we look at changes in the structure of health services we need to look not only at the public/private redistribution, but also at the redistribution from the public sector to the household, NGO and community sectors, all of which run largely on women's unwaged work. In countries like ours where the gender division of labour remains sharp, SAPs have an especially negative effect on women's time and health. A major area of "job growth" is the low-income, insecure, informal sector, including the sex industry. Where access to public decision-making is concerned, a side effect of the shift from a strong government sector to the private sector as "the engine of growth," is a shift from the sector where women were beginning to occupy positions of leadership (i.e., in the civil service) to a sector dominated by men.

The view that Caribbean women's rights are expanding because we are even more visible in the workplace than we have historically been, and have even greater responsibility for family survival, is a view of "empowerment" which we completely reject.

In Guyana, weaknesses in civil society, including worsening of the domination of political space by race/party, in part fed by differential impacts of SAPs; and lack of space for a healthy civil society to grow), are clearly reflected not only in women's organising, which reveals race/party divisions, but also in organising by both women and men on health issues. Both patients and medical personnel seem to have developed a "culture of low expectations" and a kind of fatalism. The low level of popular organising on health is especially marked in relation to health advocacy, and there is little awareness of movements developing elsewhere for health as wellness, for alternative therapies, in favour of patients' rights, and against the old fixed hierarchies between doctor/nurse and doctor/patient.

Guyana is not unique in the English-speaking Caribbean; it is the English-speaking Caribbean at

the extreme of its present dilemmas. Our relation to global capital has long been defined by small size interacting with a geographic location in the "backyard" of the United States and our plantation history. Today, we face a threat of marginalisation that is masked by the kind of indices used in UN measurements of human development and gender empowerment, and by our real achievements. But the issue goes beyond the Caribbean: our problems, while specific in their details, are generally true of small, poor countries where women's struggle for expanded rights, including our rights to reproductive and sexual health, must take place under the pressure of terms of globalisation which threaten our survival.

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THREE RESPONSES TO THE COMPREHENSIVE HEALTH SYSTEM REFORM BY CIVIL SOCIETY IN GUATEMALA

Hugo Icú

General Framework

The Health Sector Reform process and the Comprehensive Health Care System (SIAS) are framed in a context of lack of information, continuation of the war against popular organizational movements, and atomization. These circumstances have conditioned the inability of civil society to react quickly to the reform. Instead there has been a lack of knowledge, uncertainty, and doubts about the proposal, a serious situation in regions where the mechanism used has not been dialogue but rather pressure, authoritarianism, and threats from Ministry of Health authorities. These circumstances are gradually being overcome, in part due to the organized response of civil society. Here, three civil society organizations are described in terms of their membership, missions, visions, responses, and actions. ASECSA was established in 1978, and works with more than 70 partners around Guatemala to promote community health in rural and poor urban areas through primary health care. Instancia Nacional, established in 1997, is a coalition of NGOs, Churches, Health Workers and Community Groups advocating for healthy policy at the national level. The Chimaltenango Coordinating Committee, also established in 1997, operates at the provincial level and includes 23 health NGOs. Its activities include negotiating health reform, advocating for reforms that are culturally sensitive and include community participation, and holding public institutions accountable for provisions set forth in the nation's constitution.

The following timetable chronicles the recent health reform proposals and the ensuing response by civil society.

- **The Centro de Investigaciones Económicas Nacionales –** CIEN (the National Economic Research Center) published the general outline of the SIAS in its economic letter of July 1995, entitled "Health Services for all Guatemalans."
- **May 1996 –** Signing of the "Socioeconomic and Agrarian Situation" agreement between URNG and the government. A few days later, more information was published on health sector reform framed within this peace agreement.
- **Early 1997 –** Signing of the first agreements with NGOs in Alta Verapaz and Chiquimula during the first months of 1997.
- **March 1997 –** ASECSA held its National Seminar with the participation of 60 Community Programs. They analyzed the SIAS and expressed their dissatisfaction on several aspects of the same.
- **July 1997 –** ASECSA held its National Seminar with the participation of 90 Community Programs to study more closely the SIAS. The need to seek an alliance with the Church and other organizations became obvious.
- **September 1997 –** Creation of the Coordinadora Departamental de ONGs de Salud (Health NGOs Provincial Coordinating Committee) in Chimaltenango.
- **December 1997 –** The SIAS was analyzed with the Guatemalan Episcopal Conference. First meetings with NGOs from the Western part of the country.
- **February 1998 –** Creation of Instancia Nacional, formed by NGOs, the Church and grassroots community groups.
- **April-June 1998 –** Constitution of Coordinadoras Departamentales (Provincial Coordination Committees) in the provinces of Petén, Alta Verapaz, Baja Verapaz, Quetzaltenango-Retalhuleu, Totonicapán and San Marcos. Instancia Nacional developed a Strategic Plan and an Operational Plan.
- **July 1998** – National Seminar sponsored by ASECSA, with the participation of Instancia Nacional.
- **August-September 1998 –** Strengthening of various Coordinating Committees. A forum was held on the peace agreements and the health situation in Petén. The Provincial Coordination Committees participated in the development councils.
- **October 1998 –** Creation of the Movimiento Nacional de Promotores de Salud (Health Workers' National Movement) represented by 57 health workers from different regions of the country.

I. ASECSA: Health and Development with Community Participation

Promoted by the Community Health Workers Regional Committee, ASECSA was established in Guatemala in 1978. A year later it was approved by the Ministry of Government through governmental agreement of May 15, 1979, with both annual and 5-year work plans. ASECSA is a civil, non-governmental,

social and not-for-profit organization that contributes to public health through its work in primary health care. The organization comprises 71 social organizations and programs that are formal partners, and operates with direct and continuous participation of another 40 programs considered informal partners.[2]

ASECSA has grown both in the kind of work it does and in its geographical reach and its presence is felt in the multiethnic, multilingual and multicultural social fabric of Guatemala in 18 provinces of the country. The associated programs are located in different parts of the country. They comprise health clinics, rural health centers, health workers' groups, cooperative groups, associations, and parish programs. All of these programs have an impact on the poor Mayan, Garífuna and Ladino populations.

Our mission is to be an institution with a social vision that advises, educates and raises the level of awareness in comprehensive community health and to gain international, national and governmental recognition and credibility. We promote community health in rural and poor urban areas in the majority of the country's provinces, seeking to improve the quality of life of the population through Local Comprehensive Health Programs. We also hope to continue the process of improvement and self-management—modern and technically oriented—promoting and strengthening community programs to improve the conditions and the well-being and health of the population it serves.

II. Instancia Nacional de Salud[3]

Instancia Nacional was established in March 1997 and comprises 30 NGOs, 12 Pastorales de Salud (Church-sponsored health units) and 5 Health Workers and Midwives Groups, representing different regions of the country. Its purpose is to strengthen, modify, and adapt the health sector reforms through the development of methodological strategies and actions to improve and adapt the health system and policies of the country.

Mission

"We are Instancia Nacional, an organization integrated by NGOs, Churches, Health Workers and Community Groups working for the health of the Guatemalan population. We promote and protect the right to Comprehensive Health through the analysis and development of proposals related to the Guatemalan health system and policies with the objective that the entire population, especially the most vulnerable, enjoy better living conditions and access to adequate and quality health services."

Work Priorities

1. Consolidation and Strengthening of Instancia Nacional
2. Health Policies Analysis and Proposals
3. Influence and Negotiations on Health Policies

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2 See Annex 1 for a list of participating organizations.

3 "Instancia Nacional de Salud" may be loosely translated as "National Petition for Health".

Main Actions Carried Out

1. Expand membership in Instancia Nacional, seeking representation from all the regions
2. Strengthening of Coordinadoras Departamentales
3. Initiation of a communications network
4. Meetings and workshops to analyze and develop proposals on the health reform and its components
5. Monitoring SIAS execution in several NGOs
6. Search for strategic alliances
7. Dialogue and negotiation with the MSPAS (Ministry of Public Health and Social Welfare) at various levels

Statement Issued by Instancia Nacional

Agreements and Proposals Originating from the first National Meeting of NGOs and Pastorales de Salud on the Health Sector and Comprehensive Health Care System (SIAS) Reform

Background

Since the 1980s, Latin America has been subject to structural reforms based on development trends imposed on public and private management. These reforms have led to the implementation of competitive market models, the privatization of goods and services, the downsizing of the State, social participation in the co-management and surveillance of public management, democratization and decentralization.

The Government of Guatemala—as well as many countries of the region—complying with conditions imposed by multilateral agencies to have access to technical, technological and financial resources for the development of the Health Sector, and driven by neoliberal politicians, is undergoing a reform process. This reform process, in general, does not differ much from what has happened in other countries.

This document is the outcome of the meeting of NGOs and Catholic Church Pastorales de Salud that met on March 16 and 17 in Chimaltenango to analyze and propose principles and actions to the Reform of the Health Sector and the Comprehensive Health Care System (SIAS) promoted by the government. The clauses, decisions and proposals agreed are as follows:

Considering:

1. The political and social changes that took place in the country during the 1944-1954 decade brought about changes in health services including, among others, the creation of the Ministry of Public Health and Social Welfare (MSPAS) and the Guatemalan Social Security Institute (IGSS). These changes were part of a national socioeconomic modernization project to benefit

the general population. However, the impact that these institutions have had on health has been limited in view of the national development model that has been adopted, which concentrates on the economic rather than on the social aspects of development. This has led to a deepening of the poverty suffered by the population and the resulting political conflicts that have recently concluded the internal armed conflict that lasted more than thirty years.

2. As a result of such a development model, health services have been of poor quality, low coverage and have been concentrated mainly in the urban centers, especially the capital city. Health services have not taken into account traditional medicine, and care has been mainly curative rather than preventive. Health services have been operating with very low State financing (because priority has been given to other governmental expenditures not related to development) thus contributing to the high morbidity and mortality of the population (mainly maternal and child).
3. The NGOs, the Catholic Church and Evangelical Churches, aware that said situation affects most of the poor and excluded population, in a joint historical effort took the initiative of providing preventive and curative health services based on respect for the communities' organization, culture and their development process.
4. In light of the precarious historical development of the health institutions, the reform of the Health Sector is imperative. This reform should be comprehensive, democratic, participatory and responsive to the cultural, social, economic and political reality of Guatemala. We consider that the Health Sector should be the basis for the consolidation of peace and the incipient democratic process of the country.
5. The Government is currently promoting a Health Sector Reform that includes the Comprehensive Health Care System (SIAS). In its conception and development, the SIAS has not taken into account the opinion of the communities, health workers, NGOs and Churches.
6. The foregoing approach forced the NGOs and Catholic Church Pastorales de Salud to meet and organize to analyze the governmental proposal for the reform of the Health Sector and the SIAS. To this end, they have shared experiences and developed joint proposals to enrich, modify and adapt this proposal on the basis of their historical experience and the work they currently carry out on behalf of the health of the communities they serve.

Resolve:

1. To create Instancia Nacional of NGOs and Churches to unify criteria and actions for the Health Sector Reform and to develop negotiation proposals for the development and implementation of the Health Sector and SIAS Reform promoted by the government, with a view to improving and adapting it to the national reality.
2. To encourage community groups, NGOs and Churches to form and strengthen local and provincial coordinators to consult, analyze, and develop proposals on the Health Sector and SIAS Reform.

3. To maintain communication and consultation channels among communities and health workers as well as local, provincial and national coordination levels on the proposals and actions related to the SIAS.
4. To forge alliances with other sectors of civil society for the democratization of the Health Sector Reform and the defense of the right to health.
5. To carry out a deeper analysis of the legal consequences, operational health techniques, financial, administrative, and organizational aspects for the communities, health workers, NGOs and Churches that decide to participate in the SIAS.
6. To appeal to the Government to take into account our proposals with regard to the components of the SIAS, as follows:

Proposal:

A. Technical Health Component

A.1. To expand the basic health package to take into account a comprehensive view of the health problem, with special attention to Traditional Medicine, Oral Health, Mental Health, and the relation between Culture and Health, and with sufficient emphasis on health promotion, prevention, recovery, and rehabilitation.

A.2. That the SIAS include aspects on public health, community health, and intersectoral actions that are essential to improve the health status of the disadvantaged populations of the country.

A.3. To include mechanisms to inform and consult community organizations, NGOs and Churches on the Health Sector and SIAS Reform.

A.4. That the content and methodology of the SIAS take into account the experience in community work of health workers in NGOs and Churches.

A.5. That the Ministry of Public Health and Social Welfare (MSPAS) assume total responsibility in its role as leader, regulator, financier, and executor of health services to guarantee the continuity of health services independently of the participation and/or presence of NGOs.

B. Administrative and Financial Component

B.1. To clearly establish State guarantees and resources available for the implementation and continuity of the SIAS through the creation of a stable fund legally formalized at each provincial level and based on the domestic GDP.

B.2. To establish the social criteria to define what organizations or institutions can provide or how they can manage health services, and to standardize the conditions for organizations that are contracted as providers or administrators of health services, for example in relation to per capita expenditures and overhead, among others.

C. Organization and Participation Component

C.1. That the standards and regulations of the SIAS explicitly include respect for the autonomy and voluntary participation of community groups, NGOs, and Churches.

C.2. That flexibility is allowed for changes or adjustments in the development and implementation of the SIAS in accordance with the geographical area or the form of work and philosophy of NGOs and Churches.

C.3. That in granting jurisdictions and in the development and implementation of the SIAS, attention be paid to the historical experience and the presence of community organizations, NGOs and Churches to prevent the SIAS from becoming an overpowering and vertical institution.

C.4. That community organizations, NGOs, and Churches participate in the constitution and operation of health councils at the municipal, provincial, and national levels where decisions should be made by consensus.

D. Legal Component

D.1. That community groups, NGOs and Churches collectively negotiate their participation in the SIAS, with the objective of standardizing the conditions, responsibilities and rights of the counterparts in the agreements to be signed.

D.2. To negotiate the content of the agreement for the benefit of the population that is targeted for the health actions.

D.3. To expand the terms of the agreements or contracts (more than the 12 months established by the MSPAS), so that political changes do not affect the management process and the delivery of public and private services generated through the SIAS.

D.4. That beneficiary communities have full participation in the evaluations and criteria on the renewal of service contracts.

D.5. Availability of legal advisory services to analyze the agreements and the new Health Code to guarantee respect for the right to health and the work of the different communities, organizations and institutions.

The foregoing is hereby attested by the organizations and institutions that participated in the Workshop, which are listed below:

III. Chimaltenango Coordination

Established on September 30, 1997, the Chimaltenango Coordination comprises 23 Health NGOs from the Chimaltenango Province.

Actions

- Halt pressure from the Ministry of Health in the implementation or administration of the SIAS
- Negotiation and dialogue
- Education and joint training activities between NGOs and MSPAS to analyze the SIAS
- Creation of municipal and provincial negotiation committees
- Proposal to the MSPAS on the SIAS.

The last action, the Proposal to the MSPAS, follows in its entirety, and serves as an example of how civil society can organize to increase political pressure for healthy public policy.

Proposal of the Chimaltenango Coordinating Commitees of NGOs to the MSPAS

Proposal on the SIAS Prepared by the Coordination of NGOs and the Health Workers from the Province of Chimaltenango

During the last eight months, the Coordinator of NGOs of Chimaltenango has been involved in an analysis and negotiation process with the Ministry of Public Health and Social Welfare (MSPAS). As part of this process, a workshop on the Comprehensive Health Care System (SIAS) was held in February as well as a workshop with Chimaltenango rural health workers in May of this year.

Our proposal on the SIAS is based on the important conclusions reached at both workshops to continue with the negotiation process. It is hoped that both parties respect the agreements arising from this process and that those agreements become the framework within which the NGOs decide whether or not to participate in the SIAS. Moreover, we wish to express our support for the clauses, agreements, and proposals of Instancia Nacional, the NGOs and Churches involved in health-related actions.

Below are the proposals of Chimaltenango health workers and NGOs on the development and implementation of the SIAS.

Technical Health Component:

1. Respect for the communities' cultural values through the integration of traditional and natural medicine in the basic health package.
2. Reformulation of the basic health package to make it as comprehensive as possible, incorporating traditional and natural medicine, oral health, mental health and other therapeutic alternatives such as acupuncture and acupressure.
3. Community participation in the development of the basic health package to adapt it to their reality.
4. That health personnel working in the SIAS be familiar with the sociocultural context of their corresponding work area.
5. Adjustment of the number of families per promoter, in accordance with the local reality.

6. Reformulation of the responsibilities and working hours of community and institutional personnel on the basis of an analysis conducted with the participation of community health workers, NGOs and the Ministry of Health.
7. Increase the number of institutional personnel per 10,000 inhabitants, especially physicians, to provide better quality care and certification of those services presently proposed in the SIAS.

Organization and Participation Component:

1. That all decision-making levels at the Ministry of Health be willing to negotiate the content and implementation of the SIAS.
2. That community health workers (health workers and midwives) participate in the negotiations with the MSPAS and in the selection of NGOs to work in the SIAS.
3. Implementation of provincial and municipal health councils with the participation of health workers, midwives, and NGOs of recognized acceptance and experience in the provision of social services.
4. That all decisions in the health councils are adopted by consensus.
5. That the determination of jurisdictions takes into account comprehensive criteria and the opinion of the communities involved as well as existing local organizations.
6. That all the selection steps are undertaken in the qualification of an NGO as provider or administrator of health services.
7. That provincial and municipal health councils be organized, systemized, and regulated in a participatory manner and by consensus among the Ministry of Health, NGOs and Community Health Workers.

Legal Component:

1. Respect for Article 98 of the Constitution of the Republic that provides for community participation in the planning, execution and evaluation of health services.
2. That the agreements clearly define the commitments and the responsibilities of the Government as well as accountability mechanisms in case of noncompliance, taking into account, among others, the following: worker-employer problems, emergencies and financing.

Administrative and Financial Component:

1. To create a national health fund, legally established by states and municipalities, with relation to the GDP, and with a sense of growth.
2. To standardize the conditions for NGOs that become health services providers or administrators.
3. To review the criteria used for the selection of NGOs, among other things to take into account their acceptance and experience within the communities where they will work as health service providers or administrators.

4. That communities and community health workers be informed about the amount and use of the economic resources allocated for the SIAS at the provincial, municipal and local levels.
5. That community personnel working in the SIAS be paid in accordance with their responsibilities and real labor time used to perform the tasks required by the SIAS.
6. To include expenditure categories within the budget such as management costs for strengthening NGOs and community organizations working in the SIAS.

ANNEX 1: Health Programs Associated with ASECSA

1. Alianza para el Desarrollo Juvenil Comunitario
2. Asociación Guatemalteca de Refugiados (AGRUMS)
3. Asociación de Asesoría a Proyectos (ADAPD)
4. Asociación San Cayetano
5. Asociación de Promotores de Salud y Desarrollo Socioeconómico
6. Asociación Salud para el Pueblo
7. Asociación Adecomaya Achí
8. Asociación Cultural Mam
9. Asociación Konojel Junam
10. Asociación Bola de Oro
11. Asociación de Promotores de Salud Paya Grande
12. Asociación de Promotores y Comadronas de Salud Rafaeleña (APCOVSAR)
13. Asociación Salud y Desarrollo
14. Asociación de Promotores Rurales de Xalbal
15. Asociación de Promotores "Unión Maya Kakchiquel"
16. Asociación de Desarrollo Integral (ADI)
17. Asociación Maya Pro-Salud
18. Asociación de Desarrollo Integral "María Maya" (ADIMM)
19. Asociación de Desarrollo Comunitario Cakquichel (ADECCA)
20. Asociación de Salud y Desarrollo Comunitario "Nuevo Amanecer"
21. Centro de Educación y Recuperación Nutricional "EMMANUEL" CERNE
22. Clínica Menonita
23. Clínica El Novillero
24. Clínica Maxeña
25. Clínica Parroquial San Juan Chamelco
26. Clínica Samayac
27. Comité de Servicio Presbiteriano Kanhabal
28. Conferencia Evangé1ica Aguacateca de Desarrollo Integral (CEADI)
29. Cooperativa Manos Unidas

30. Cooperativa El Recuerdo
31. Coordinadora Cakchiquel de Desarrollo Integral (COCADI)
32. Diócesis de El Quiché
33. Dispensario Parroquial Hogar del Niño Solidario
34. Dispensario Parroquial San Agustín
35. Dispensario Parroquial María Egan
36. Dispensario Santa Elizabeth Seton
37. Dispensario Parroquial Indigenista
38. Dispensario Parroquial Telemón
39. Esclavas del Sagrado Corazón de Jesús
40. Fundación Kaslen
41. Fundación ULEU
42. Grupo de Artesanos La Moderna
43. Promotores de Salud Comunitario Voluntario
44. Hermanas de Raxhuja
45. Parroquia San Martín
46. Parroquia Santa Cruz
47. Parroquia Nuestra Señora del Rosario
48. Parroquia Cristo Nuestra Paz
49. Parroquia San Antonio de Padua
50. Parroquia Fray Bartolomé de las Casas
51. Parroquia San Marcos
52. Pastoral de Salud Colomba
53. Programa de Salud y Desarrollo Integral (PSADI)
54. Programa de Salud Lancetillo
55. Programa de Salud Cristo Crucificado
56. Programa Diocesano de Promotores
57. Programa de Promotores, Diócesis de Huehuetenango
58. Programa de Salud San Pedro Mártir
59. Promotores de Salud, San Lucas Tolimán
60. Dispensario Parroquial Bethania
61. Promotores de Boloncó
62. Proyecto Acualá 513
63. Proyecto Ixin Acualcá
64. Tecnología para la Salud
65. APROSADC Sipacapa
66. Rixin Tinamit
67. Promotores de Nueva Esperanza
68. Asociación Nuevo Amanecer
69. ACODI MAN Ostuncalco
70. RECOMAK
71. Promotores de Salquil Nebaj

ANNEX 2: Health Programs Associated with Instancia Nacional

ORGANIZATION	Province
1. Asociación Guatemalteca de Servicios Médicos	Guatemala
2. CARE	Guatemala
3. Llegando a Todos	Guatemala
4. Fundación Berhorst	Chimaltenango
5. Renacimiento	Chimaltenango
6. ASECSA	Chimaltenango
7. Provincial Coordination of NGOs	Chimaltenango
8. ASECSA	Baja Verapaz
9. ASECSA	Petén
10. COMADEP	Petén
11. ASECSA	Cobán
12. Pastoral de Salud Parroquia El Calvario	Cobán
13. Pastoral de Salud Parroquia El Estor	Izabal
14. Pastoral de Salud Parroquia Jocotán Clínica Bethanea	Chiquimula
15. Pastoral de Salud Verapaz	Cobán Alta
16. Pastoral de Salud	Huehuetenango
17. Pastoral de Salud	Quiché
18. Pastoral de Salud	Totonicapán
19. Pastoral de Salud	Sololá
20. Pastoral de Salud Vicariato del Petén	Petén
21. Pastoral de Salud	Quetzaltenango
22. Asociación Pies de Occidente	Quetzaltenango
23. ACUMAN	Quetzaltenango
24. ECOMADI	Quetzaltenango
25. Clínica Maxeña	Mazatenango
26. Cooperativa El Recuerdo	Jalapa
27. ESFRA	
28. Proyecto Microregional	San Marcos
29. Centro Integral de Atención a la Mujer	San Marcos

THE RISKS INVOLVED IN HEALTH SECTOR REFORM & THE ROLE OF CIVIL SOCIETY IN GUATEMALA:

Moving from a War-time Economy to a Market Economy

Juan Carlos Verdugo

Guatemala is experiencing one of the most important moments of its history. The political resolution of a 30-year armed conflict and incipient opening of the political process has sparked varying degrees of optimism about the country's future.

Nevertheless, this future in search of peace, democracy, and respect for human rights is threatened when we consider many of the changes taking place in the country, justified by its third democratically elected civil government to fulfill the conditions of the Peace Accords.

One such troubling aspect involves the current health sector reform promoted during the 1990s, which is both the corollary to and formalization of the historical exclusion and inequity that mark the health services and the health situation of the population.

This article addresses this topic from an approach that considers broader social processes, and views health reform as a process for restructuring the relationship between the State and civil society, which is closely related to the level of equity that can be achieved by the health sector in the future. In short, civil society faces a total restructuring of public, private, and mixed public/private health sector organizations, which involves a reassessment of the roles of the State and the market with respect to health care.

State Modernization in the 1990s and Implications for Health Sector Reform

During this century, at least five trends in health policy can be identified, promoted by different government administrations. The first three of these can be attributed to very well-defined historical periods, while the last two have taken place as part of the democratic transition and State modernization under way in the country since 1986.

Since before the October Revolution that gave way to the decade known as the "Springtime of Democracy" (1944-1954)—which came to an abrupt halt due to U.S. intervention—health policy was linked to maintaining the labor force employed in foreign enclaves and in the national system of coffee plantations ("latifundios nacionales") to produce coffee for export.

During the revolutionary years, the Arévalo and Arbenz Administrations took steps to promote a nationalist-capitalist project in which the main objective was to modernize the economy and make headway in the creation of a welfare State, in view of the recognition of social and labor rights and the need to create institutions to ensure these rights be honored. Also during these years, the Ministry of Public Health and Social Welfare (MSPAS) and the Guatemalan Social Security Institute (IGSS) were founded, and other important social reforms were enacted.

The impact that these two health institutions might have had on health conditions, together with education, housing, labor, and other policies, was diminished in the post-revolutionary period with the advent of a series of military dictatorships (1954-1986). These administrations promoted what the Economic Commission for Latin America and the Caribbean (ECLAC) referred to as "development concentrated in the economic sphere and marked by social exclusion."

As a consequence of this anti-development model, the state health sector was virtually abandoned, a fact reflected in low coverage levels, poor quality of services, the employment of a biological approach to health, and the inability to put measures in place that would have a real impact on the health conditions of the population. The changes occurring in the health sector during these years were described as "additive reforms" by Fielder, who emphasized the role played by cooperation agencies, mainly the U.S. Agency for International Development (USAID), in achieving small changes within the health system.

Since 1982, although more so since the establishment of the first civil government in 1986, the country has embarked on a transition process brought on by the deepening of the national economic-social crisis, as well as the exacerbation of the political-military conflict, which occurred during the final years of the 1970s. All this took place within the framework of the international economic crisis, the globalization process, the initial implementation of structural adjustments in most of the countries of the Region under the tutelage of international financial organizations (i.e., IMF, World Bank, and IDB), and the dominance of neoliberalism.

In short, after 1982, a series of complex reorganization processes developed within the country's power blocs, especially the economic and military sectors. This was accompanied by the reformation of the political doctrines and projects of these sectors. Consequently, over the past two decades concepts

such as transition to democracy, decentralization, the targeting social funds, the importance of civil society organizations, and subsidiarity or the modernization of the State, have taken on real meaning as two dominant projects have come to the forefront. The first of these is national stability as conceived by the military, while the second is neoliberalism, the product of coinciding interests of international financial agents and the factions involved in the modernization of the country's economic sector.

Although state modernization was not widely emphasized until the early 1980s, the concept arises out of the different economic, political, and social objectives of the political project to which they respond—objectives that are based on a permanent reconstitution of the power bloc directing or regulating state policies.

It is precisely during these same years that health sector reform rose to importance on the national agenda and, although based on a technical approach to health, its rationale was subject to the various aforementioned political projects and thus, to dissimilar modernization processes.

With respect to the 1980s, then, we can identify the following trends in health sector reform.

Health Sector Reform as a part of Subsidiary/Counterinsurgent State Modernization

The first reform trend, which occurred between 1986 and 1990, responded to a health policy that was linked with a great deal of difficulty to a project promoted jointly by the Army and the Christian Democrats. This reform was based on and originated from two not antagonistic visions of what state modernization should entail: the Army's vision of a developmental-counterinsurgency model, in which the State should play a key role in achieving national stability through complex social structures and investments as well as military security; and the Christian Democratic Party's model based on state subsidiarity and the social economy of the market. The two visions were fused to promote a type of state modernization that can be qualified as a "subsidiary counterinsurgent" model, in which the State's central role was to seek national security by promoting development through organizing society around state structures (i.e., Urban and Rural Development Councils at the national, regional, provincial, municipal, and local levels).

During this governmental period, structural adjustment measures were implemented by the Christian-Democratic government in a disorganized and improvised manner, largely due to the conflicts generated through the ideas and activities promoted by the Army and the Christian Democrats.

During this period, there were no significant advances in health policy formulation or implementation, owing to many internal problems within the techno-bureaucracy, uncertainty as to where changes should be made, and the lack of political will and genuine interest by the party in power to restructure the health sector.

Generally, the decentralization proposals put forth by this administration were known for leaving decision-making to the MSPAS and continued to posit a key role for the State in the delivery, administration, and financing of health services. Moreover, the new state structures that it tried to implement, such as the Health Council (Consalud) or the "Cápsula Distrital," a package presented as a

part of the PREN and the Master Plan for Institutional Development of the MSPAS, were vertical mechanisms for the integration of health workers that limited the participation of these human resources to the coordination and delivery of health services, while excluding them from taking part in decision-making. During these years, state financing averaged only 1% of the gross domestic product (GDP), while other expenditures, such as those allocated to the military, the public debt, and to institutional support sectors, continued to receive priority. Moreover, it is important to mention that a business boycott was staged to protest an attempt by the government to impose a progressive tax reform that would have financed the development-oriented strategy and state interventions of this period.

Generally speaking, the counterinsurgent perspective views services as being largely responsible for maintaining an authoritarian relationship and fomenting a sense of mistrust toward the various health activities of civil society organizations. Oftentimes, both community health workers and health promoters have been direct targets of state repression, as were professionals working in that field. In addition, government programs, such as "Channeling" (health census) were used for the surveillance and control of the population.

With the advent of the second civil government in 1991, the actions and vision of this management strategy began to lose strength, despite the fact that the Minister of Health adopted some of the ideas of his predecessors with respect to ministerial action.

Health Sector Reform as Part of Neoliberal State Modernization

During the 1990s, civil governments increasingly aligned with the policies of international financial organizations and, to the extent that national conditions have permitted, support has been building for the implementation of a neoliberal program. However, structural adjustments in Guatemala have kept their distance from, or are even in conflict with, the proposals of that model. More specifically, such adjustments tend to result in an imbalance between the economic and social spheres. Without going into great detail, these structural adjustments can be characterized as unbalanced or asymmetrical, as progress occurs only in relation to aspects that do not compromise the interests of the dominant economic sectors. In this sense, liberalization, openness, and economic transformation occur slowly and intermittently, while privatization and social reforms move forward without resistance, due to the absence of social or political power that would maintain a greater balance within, enrich, or halt government measures.

The advent of the current government, in addition to the Peace Accords that it ratified, marks a turning point in the process. Here, discourse and action begin to diverge, creating a dual agenda. While the current government publicly embraces democracy, respect for human rights, and compliance with the conditions set forth in the Peace Accords as its primary objectives, it has worked to implement a package of neoliberal social reforms, which in most cases are neither debated nor publicized. In effect, the Government Program 1996-2000 includes what amounts to a neoliberal project in terms of its diagnoses and proposals for governmental management, and health policy is no exception.

With respect to health, from 1991-1992 the government began to embark on a neoliberal health

policy with its Basic Health Sector Study and later commissioned proposals by consultants financed by the Inter-American Development Bank (IDB). In 1993, the country committed itself to health reform through an IDB loan that follows guidelines laid out by the World Bank in its World Development Report 1993, Investing in Health, and the different administrations between 1991-1998 have had to assume the commitment to fulfill the credit conditions agreed upon with the IDB in order to receive the progressive loan disbursements.

At present, the Health Code has already been approved. This reform is known, especially at the first level of care, as the Comprehensive Health System (SIAS). In recent years, other international agencies have joined the reform movement and, with the exception of some conflicts, have had a synergistic effect on the process.

Rationale and Brief Characterization of the Reform

The Health Sector Reform, or SIAS, is supported by a series of technical arguments, such as the demographic and epidemiological transition and the search for equity, efficiency, and effectiveness in the health system, or as a part of the conditions of the Peace Accords. With respect to the first level of care, civil society organizations are viewed as part of a program to increase coverage for the population unable to access these services. Accordingly, these organizations are being called on to take action on behalf of the poor, signing work agreements with the State that would hold them responsible for the health-disease process of some 10,000 or more inhabitants (per district) at the first level of care.

However, the scope of the reforms goes beyond this as their implications exceed aspects that are purely technical in nature. Thus, they become a forum for restructuring the relationship between the State and civil society, and between the State and the market. Accordingly, it is not only a technical process, but is also ideological, political, economic, cultural, and social; and has a broad impact on society's relationships and operations. In short, the reforms provide another opportunity to contribute to the construction of a society based on the market, private property, freedom of choice, and individualism.

Essential Elements of the Neoliberal Model and its Economic Rationale

Viewed from an ideological perspective, neoliberalism stems from the idea that the limits of the market should be expanded to include all goods and services entering the marketplace and, moreover, to limit state interventions that are considered inefficient, ineffective and counterproductive. Accordingly, the concept of health as a social or human right for which the State is responsible, becomes blurred through the general marketing (purchase/sale) of health services.

With respect to material goods, it is clear that economic interests at the international and national levels are attempting, insofar as possible, to turn the health care industry into a sound business and to reduce state redistribution mechanisms. In countries where significant marketing of health care services occurs, this sector's share of the GDP is very significant (see Laurell).

From a political standpoint, the attempt to modify power or political relationships by introducing contractual or market mechanisms involves a radical change in the social order and in the relationships between the State and civil society. Attempts to implement the market rationale in the health sector, as in other spheres of national life, requires the establishment of an order based on neoliberal values or principles. With respect to these attempts, democracy is understood as the individual's freedom of choice and competition in the market, while the common good is understood as the sum total of individual goods. Thus, society is faced with the concept of limited democracy and a weakening of elements such as solidarity, economic redistribution, the common good, justice, and equity.

With regard to program content and government responsibility for health, in 1993 the World Bank underscored the importance of following an economic rationale based on concepts such as public goods (in a restrictive sense), large externalities, market imperfections, the cost-effectiveness of actions, and targeting programs to the poor.

Guatemala has been very faithful to these proposals, basing its actions on strict dogmas such as the belief that the country had at one time created a welfare state or, at best, widespread paternalism in health. However, it is enough to recall that social security coverage has never risen beyond 15%, and that MSPAS coverage of the total population has been no higher than some 35%.

The Reform Process and its Strategies

According to the IDB definition of "reform" from 1993, the main lines of the reform process, which have continued with the current government, consist of restructuring the MSPAS and IGSS; improving MSPAS' coordination and steering role in the health sector; instituting changes in financing and budgeting; and including a component for expanding coverage.

These elements correspond to the strategies implemented as part of the social policies designed to facilitate structural adjustments. In sum, these include: a reduction in health expenditures and the targeting of the poorest sectors of the population; decentralization that puts privatization mechanisms in place for the production and management of services; and privatization of these services that establishes stable forms of financing for the purchase of private health care services by eliminating social security monopolies and the subrogation of state services. An additional component of this last strategy seeks to enhance the private sector's capacity in order to offer services that meet the needs of the growing market, through state subsidies to health enterprises or health facilities.

Changes at the MSPAS center on redefining its sectoral role and emphasizing its steering and regulatory role, while leaving the provision/management of health care services to the private sector. Emphasis is placed on health as a private good that should continue to be the responsibility of families through self-care; of communities through self-management and sustainability; or of individuals through payment for services. The changes instituted in the sector have been political, legal (the new Health Code and its regulations), administrative, and financial in nature. With respect to the individual levels of care, the modifications are summarized in Table 1.

TABLE 1: Modifications at the Three Levels of Care

Level of Care	Reform Measures/Actions
First Level	• Privatized delivery and management of health care services
Second Level	• Budgetary management and allocation based on production, efficiency, and effectiveness • Inclusion of basic packages for each level, to be financed with public and private funds
Third Level	• Fee for services • Search for other sources of financing

With respect to the third level of care, some measures have been instituted, including increases in hospital fees for services, particularly in some specialized areas such as ophthalmology and cardiovascular surgery. And while some attempts have been made to place responsibility for hospital administration in the hands of boards of trustees, little progress has been made in this area. In addition, the availability of basic packages at the second and third levels has not been publicized.

The first level of health care in the SIAS program has achieved more systematic reforms. Accordingly, more is known about this level and some experience has accumulated. The proposal for this level involves contracting nongovernmental organizations (NGOs), churches, cooperatives, and community committees, among other entities, to provide and manage health care services. Moreover, in cases where organizations do not possess administrative capacity, other private organizations can step in and assume responsibility for administering their funds. These service administrators can be organizations or institutions similar to the providers or any other private entity with administrative capacity, such as an oil company, cable company, etc.

To this end, the government has divided the population of each province into districts of 10,000 inhabitants, offering them to organizations for coverage. The provisions in the contracts with respect to the services to be provided by private entities include the organizational model at the community level, the health care model, the basic package of services, the type of personnel qualified to perform services, the necessary inputs, and a per capita budget that ranges from Q28 to Q32 per person (equivalent to US$5).

The organizational model employed in the community should include a volunteer malaria worker, a volunteer health guardian (community health worker) for every 20 families, and a community facilitator for every 20 health guardians. At the institutional level, an institutional facilitator is available for every 8 community facilitators, as well as a nursing auxiliary and a roving physician for each district. Accordingly, 10 salaried staff members and at least 160 volunteers, including health guardians and malaria workers, provide health care in each district. The latter category receives a monthly per diem of Q50.00 to attend

training meetings. In other words, the result is a health system based primarily on volunteer staff that carries out a series of well-defined tasks. Accordingly, this volunteer staff assumes a high level of responsibility in terms of the community and the MSPAS.

The reform of IGSS health programs (maternity, common illnesses, and emergencies) is part of the health sector reform and complements the changes occurring in the MSPAS. The social security proposal includes three substantive elements: capitation; the private administration of funds; and the freedom of workers to choose the company that administers their funds and provides them with a certain degree of health services coverage. These elements are based on the separation of pension and health care programs, as well as the elimination of health care monopolies. In addition, it is hoped that private insurance or methods of prepaid insurance will be generated for specific economic groups such as those working in the informal sector, salaried employees, or migrant agricultural workers. This set of measures, while justified in terms of competition between private and public social security and freedom of choice, has a negative impact on the potential for achieving equity within the system or health sector, as will be seen further on. Moreover, the IGSS has increased the tendency to contract private health care services.

Dangers and Contradictions of the Reforms: Moving toward a Health Sector that Generates Inequity?

The reforms generate a variety of dangers or risks that are associated with the influences of the political, economic, technical, and social spheres and that are linked to a series of problems occurring within the transformation of the health services. Further on, this document will present arguments that the transformations under way in the sector are laying the foundations for a highly inequitable health system.

Minimal, Homogeneous, Targeted, and Inexpensive State Interventions in Health

The reforms appear to reduce state health interventions to a minimum. State delivery of services will be targeted and produce/finance only a basic package of services at each level of health care. In addition, special emphasis is placed on traditional medicine and self-care in health by families and communities with respect to the delivery of services.

The content of this basic package is related to the economic rationale discussed earlier and the definition of certain public health services based on the concept of public goods and large externalities, as well as some essential clinical services that are considered private goods. All should be highly cost-effective interventions.

All of the above makes it possible for us to point out some of the conflicts inherent in this model of care, which, as summarized below, are mutually exclusive:

- Basic package of services vs. the demand of the population for health services;
- Basic package of services vs. the right to health recognized in the Constitution of the Republic

(the State as the agent responsible for the promotion, prevention, recovery, and rehabilitation of the population's health, Article 94, Section 7);
- Basic package of services vs. significant epidemiological, cultural, ecological, and socioeconomic heterogeneity;
- Economic rationale vs. ethical content;
- Definition of the basic package of services based on indicators such as the total disease burden (TDB), measured in units called "disability-adjusted life-years" (DALY) vs. the impossibility of constructing or measuring them to reflect the reality in Guatemala;
- Selective health care model vs. the concept of primary health care;
- Targeting activities and financing for the poorest sectors vs. a society in which at least 85% of the population is considered poor;
- Interest in strengthening the role of the family/community and traditional medicine in health care when this has always been the case, given the low coverage of provincial services; and
- Work overload experienced by women of all ages vs. the recognition of their rights in the discourse of the government and the international financing organizations.

Economic Abandonment of Services by the State and Dubious Sustainability and Financial Equity of the Reforms

Although the government continues to proclaim its commitment to increasing public health expenditures, this is not reflected in its actions. Moreover, current health policy proposes increasing and diversifying alternative sources of financing as a part of its strategies, which would clearly have an effect on the quality and quantity of services that each private service provider offers to the population, depending on the particular combination of funds it has obtained. With respect to financing, the greatest potential danger is that the State will permanently reduce or maintain low levels of public health expenditure. Several contradictions or problems arise from the four alternative sources of financing proposed by the government (MSPAS, 1993a, 1993b, 1994, 1996, and IDB, 1993):

- Funds from donors and international cooperation agencies cannot permanently sustain health care services, due to their situational, cyclical, and conditional nature, which are subordinate to economic and geopolitical interests;
- Fees for public and private health services are a dubious source of sustainable financing, in view of the levels of poverty and extreme poverty of most of the Guatemalan population;
- Social funds created to compensate for structural adjustments are highly discretionary, temporary, targeted (to some part of the population that is not necessarily the poorest), and in decline; and
- The fund allocated to the municipalities (10% of the State income) is earmarked for a wide variety of expenditures.

Finally, we need only point out the potential danger for great disparity in the quantity and quality of services that public and private providers offer, based on the quality and combination of financing sources obtained by each. Very different services can be found within a single province or municipality. These services depend on a wide variety of factors, such as the user's ability to pay, the local management capacity of social funds or the funds provided by international cooperation, and the presence/absence of NGOs to secure financial assistance, among other things.

Limit the Role of the State as the Principal Coordinator of the Political and Social Spheres

In spite of the limited role historically played by the Guatemalan State in health care, various sectors of civil society continue to demand that it guarantee comprehensive and universal health care for the population. However, the population's demands and its pressures on the central government can be diluted or moderated by several of the financing and service delivery mechanisms operating under the current decentralization process:

- The gradual withdrawal of the State as a service provider and administrator, and its replacement by private organizations or institutions to meet the population's demands in this respect;
- The relations between the State and civil society with respect to the health sector reform or the SIAS are commercial/contractual and not political;
- The political, organizational, and participatory links or modalities of private service providers and administrators with the population may be of different types, although the commercial relationship (purchase/sale of services) with the community or users of the services is emphasized;
- The community is invited to implement decisions, but not in participate in the decision-making.

Lack of Coordination with New or Existing Pressure Groups

In its official statements the Government proposes action aimed at the functional re-education of personnel, the establishment of a university degree in administration, and the development of sectoral management, the improvement of training for personnel, and special training for personnel working in indigenous areas to adapt them to local needs (MSPAS, 1 993b-129).

At the same time, these proposals are aimed at introducing legislative and regulatory reforms to modernize human resources management (MSPAS, 1993b; 34); this requires modification of the Health Code, which is subject to the norms and regulations of the Civil Service Law, which will be also adapted for the purposes of state modernization (IDB, 1993; 6). The fundamental objective is the deconcentration of human resources, moving them from the metropolitan area outward (IDB, 1993; 3) as a result of the decentralization of the services.

The evident impact of this deployment of personnel is the considerable fragmentation of health workers, which would impede or hinder any collective action on their part. Under the health sector reform, each hospital, health center, or health post administered by the State or a private organization

would autonomously manage its personnel. Specifically, this involves the freedom of each organization to contract, set salaries, transfer, and terminate its own staff (i.e., see Governmental Agreement 8-95);

Hiring tends to consist of short-term service contracts. This is the case in both the public and the private sectors. In fact, SIAS agreements for service providers/administrators stipulates that contracts are to be offered for a period of 11 months and provide no employment benefits.

Preeminence of the Market Rationale in Health Sector Operations

Returning for a moment to the theoretical underpinnings of the current government project, the overriding concept governing the rationale behind health sector reform is the market, as expressed in the following points:

- The public/private link is established, favoring the mercantile or commercial mentality;
- Administrative modalities and budget allocations will obey the logic of domestic markets, where economic productivity, efficiency, and effectiveness dominate decision-making; and
- The State will limit itself to a steering role, establishing clear and stable rules, and regulating private sector service delivery, based on the market rationale.

These three points are complemented with actions such as the marketing of services; public or external funds to subsidize or contract companies, whether private or nonprofit; the opening of formal opportunities for greater participation by private services; and the use of the economic rationale as the basis for defining program contents that are to receive public funds.

Moreover, one of the contradictions associated with SIAS is to assume that NGOs are able to carry out an operation governed by the commercial rationale, when it is recognized that many of these organizations are guided by other precepts and institutional mystiques, or to assume that community dynamics and capacity can obey this logic and take charge of services. The danger is that business or commercial principles already govern some of these social organizations.

Problems and False Premises of Public/Private Mixes and Privatization

The topic of health does not escape the dogma of the market nor the current trends that consider privatization as the most efficient and effective alternative, capable of offering greater quality while curbing corruption, among other attributes, as compared with public or state-owned enterprises.

However, the private versus public dispute seems to be a false dichotomy, primarily when the facts bear out the appropriateness and importance of each of them with respect to different social and economic aspects of a society. Thus, instead of assuming a defensive position—often radical and dogmatic—regarding the role of the State or the market, we should focus our attention on what in society would better remain the responsibility of a redistributive system under public control, and what would fare better under a commercial rationale. In other words, there are no hard and fast rules in this regard, so each country

should identify, necessarily by consensus, the principles and institutions upon which it wishes to develop its society. To clarify the ideological dispute, some expert conclusions are provided below.

According to Bendiks, the advantages of privatizing services or leaving them to the public domain are unclear and will depend on the analysis of concrete experience. In addition, changes made with a view to privatization would have to be carried out with extreme caution, and only in some very limited areas involving social services with a low level of complexity and under close state supervision, which has not always proven successful (Bendiks 134,135).

With respect to the field of health, the empirical information and comparative analyses of public systems vs. the non-system of the market for health care, represented by the United States, overwhelmingly favor the former (Laurell).

The distinction of goods and services by attribute is useful for anticipating the potential problems stemming from the privatization of health care services. Type I attributes include goods and services that are easy to supervise, such as sanitary conditions, the ratio of patients to health personnel or the space required per patient. However, Type II attributes are difficult to supervise, such as the compassion or competence of medical or mental health workers (Brodking and Young citing Krasninsky, 1986; and Weisbrod and Schlesinger, 1986). Upon analyzing several cases, Brodking and Young came to the conclusion that the government can design objective and measurable standards for Type 1 attributes. However, companies, in their attempts to turn a profit and search for ways to cut costs, have a negative impact on Type II attributes, which cannot be controlled by the government or consumers (Brodking and Young, 1149).

Bendick agrees with the previous point, comparing private service contracts designed to carry out municipal functions. In general, functions that are predominantly direct, immediate, measurable, technical, and can be supervised (such as waste collection or street light maintenance), can feasibly be carried out by the private sector if it can perform these tasks with a greater degree of quality and at a lower cost than municipal services. However, companies contracted to perform social services of a complex, indefinable, and "subjective" nature obtain positive outcomes with far less frequency (Bendick, 128).

With regard to the comparison between private nonprofit companies and their public sector counterparts, Bendick points out that there are no rigorous comparisons. Thus, based on some studies, he concludes that the quality, precision, and costs are very similar. However, he concedes that private companies occasionally have an advantage in providing coverage to the population that public services are unable to cover, or in performing tasks that the public sector does not do well. Consequently, according to this author, private nonprofit companies can feasibly remain in charge of complex social welfare services in instances where the privatization of these services for profit might prove dangerous, in light of the impossibility of defining performance standards and objectives (Bendick, 137).

Based on the previous points, we can venture that the superiority of private over public services is not at all conclusive, as decisions involving services should consider existing experience in each specific field or domain of a society. Thus, such decisions should not be left to the precepts of irresponsible dogmas that may have repercussions for a country's future. For example, as Starr points out, there are

public sectors with serious problems attributable to manipulation of the political party in power, while by the same token, there are other highly prestigious, professional, and well-established public administrations (Starr, 55).

In the case of Guatemala, significant problems can be observed in the way privatization and public/private mixes are carried out. For example, with respect to the current SIAS, cases of "string-pulling" and political cronyism have been known to occur with respect to the signing of agreements and per diem payments to health promoters.

With regard to the quality and capacity of private service providers, the government has not developed any accreditation mechanisms to assess the quality of the services, nor has it designed an evaluation process for the reforms. Moreover, supervisory and regulatory mechanisms for private service providers/administrators have yet to be developed.

Imposition of a Community Health Model that Ignores other National Experiences

The dogmatism and vertical manner in which the SIAS and the health sector reform have been formulated and implemented have failed to take into account the existing body of experience in the country, amassed both by public and private institutions. Some examples follow.

Nine years ago in the province of Escuintla, the IGSS developed a model for first level health care that managed to break away from the traditional biological, individualistic, curative approach. The result was an intersectoral model for health promotion and disease prevention that included a community-based collective approach, etc. The first level of care in SIAS has significant problems in health promotion and concentrates on surveillance activities. In fact, the term "health promoter," the foundation of the community model, has been changed to that of "health guardian." In Escuintla, there have been attempts to replace this social security model with SIAS's model 61.

A significant body of historical community experiences exists, dating back to the 1960s and 1970s, especially those developed by the Catholic Church. Furthermore, community groups or grassroots organizations, such as associations of health promoters, have carried out community works emphasizing disease prevention and health promotion activities. The current SIAS ignores all these experiences, relegating them to a secondary status. If this situation persists, the country will lose much of the accumulated wealth of community health experience that has served a large portion of the population and has also established various degrees of coordination with respect to local realities.

An example of the previous point can be seen in the SIAS's persistence in embracing the idea of creating a health system based on volunteer workers, even though several years ago an assessment by historical community health organizations found this model to be unsatisfactory in the aftermath of the economic crisis of the 1980s, which plunged the population in rural areas into even deeper poverty.

The SIAS: an Unsustainable Health System

The sustainability of the reform process is one of the Government's priorities; however the Achilles'

heel of SIAS restructuring can be found in the two extremes of the health system. On one hand, most of the leadership at the MSPAS involved in directing the process is paid by the IDB; the high salaries received by these professionals could not easily be maintained for several years with public funding. On the other hand, at the community level, the system is almost entirely dependent on the commitment of volunteers working as health promoters or health guardians in exchange for a monthly per diem of Q50. The problem lies in the fact that because of the great demand imposed on these community health workers and the poverty in which most of these live, the prospect that they could work for many years is unlikely. Alternatively, community health workers could organize and demand an increase in per diem payments or wages for their work. However, this would render the SIAS community model unaffordable.

Toward a Health Sector Organizational Structure that Generates Inequity

The implementation of the neoliberal policy will continue to advance until it reaches equilibrium or a point of confrontation with the different political and social forces of the country. In the event that implementation of the neoliberal policy were to be fully achieved, we would have a sectoral organizational structure similar to that seen in Figure 1. In this figure, we can observe in a very general way, some of the effects that neoliberal strategies are going to have on health services, as previously discussed.

FIGURE 1. Organizational Structure of the Neoliberal Project in the Health Sector

MSPAS				AGROSALUD IGSS	PREPAID SERVICES AND PRIVATE HEALTH INSURANCE
MSPAS Services	NGO	Community Committee	Rural Health Insurance		
Uninsured Population				Beneficiary Population	
Poor income		High risk/ lower class	⇒	Medium risk/middle-lower class	⇒ Low risk/ middle and upper class
MINIMUM AND INEXPENSIVE CARE				CARE ACCORDING TO INSURANCE PLAN OR PREPAID SERVICES	
GREAT STRATIFICATION AND INEQUITY IN ACCESS TO HEALTH CARE					

In the past, the public health sector marginalized or excluded most of the population, and generally failed to provide efficient and quality services. With respect to the current policy, exclusion from comprehensive care has been formalized and is designed to increasingly cut back on state responsibility for health care, resulting in greater opportunities for private service providers. Hence, there emerges the need to redefine the role and content of care in each individual organization and institution, both public and private, operating in the health sector.

The new organizational structure results in significant stratification and inequality with respect to the population's access to services. Moreover, as López points out when referring to the neoliberal health sector reform promoted by the World Bank, the citizens' right to health is replaced by a system that classifies the population according to its indigent or consumer status (López, 1994; 53).

Thus, a polarity is established with respect to services, within which we would find a great diversity of modalities for the financing and production of public, public/private, and private services. One of the poles would be comprised of services aimed primarily at the poorer sectors of the population, with and without health insurance, and would be responsible for developing a basic package of services at all levels of care. This group would be comprised of the MSPAS and the IGSS, in combination with different private providers, such as those in the preceding figure, where Agrosalud and Rural Insurance are emphasized.

The other pole would be comprised of private and prepaid insurance that would be offered in combination with various service producers (hospitals, clinics, sanatoriums, etc.). The more affluent population would have access to these plans, choosing a specific health care plan according to its ability to pay. Stratification among the population that would exercise this option can also be found within this pole, given the diversity of existing plans.

Between the two poles there is a continuity of services that will either increase or decrease coverage, since access to coverage by the population to is a function of its variable ability to pay, and of a citizen's right to health.

Instead of searching for a single public health system, which has proven to be the most efficient and equitable system in the countries that have such systems in place, promotion of a non-system is under way, despite the fact that empirical evidence shows it to be more inefficient, ineffective, and inequitable. The best known example of this is the health care market of the United States.

The economic (cost-benefit) rationale fosters selective, targeted care with a welfare-style approach, casting aside the concepts of comprehensiveness and universality that are the foundations of the right to health as defined in the Constitution the Republic. Clearly, the cost-benefit criteria for implementing selective targeted actions cannot be the only grounds for developing health sector reform, as they are merely a good complement to a comprehensive and universal health system; their purpose is to intensify actions that are considered priority and not exclusionary (López, 1994; 54).

Some Reflections for Civil Society Action

Today, it has been posited that the central role of civil society is to build democracy and defend basic rights. However, the term "civil society" is so imprecise that, on one hand, it appears to say nothing, while on the other, it could be interpreted as the postmodern equivalent of terms like "the people" or "the masses," which communicate very little if our intention is to identify true potentialities and special features. However, we must concede that these three terms conceal of economic stratification processes, vast sociocultural disparities, and different political trends. This homogeneous discourse masks all of the contradictions and complexities that manifest themselves daily and historically in different dimensions or aspects. In the past, it was the workers—the proletariat; today, it is the ecologists, environmentalists, the NGOs, and women's and indigenous peoples' movements, among others, that conceptually occupy center stage in the struggle.

These efforts have come too far to return to the days of distributing leaflets, to the teleology of the political and social spheres. Today, conceptual humility and relativism appear to be the most intelligent position. However, this should not invite the lack of a position, or theoretical-practical opportunism or complacency. On the contrary, it should encourage the search for new questions and creative answers regarding the human and generic aspects of man and woman, where we find our raison d'être.

What, then, is civil society? What is its true potential? In order to reflect on and determine the boundaries posed by these questions, Gramsci's concept of political and civil society, as a means for explaining the nature, rationale, and structure of the State, helps to shed some light, making it possible to propose or demarcate the substantive aspects of these questions in the present. In an economic-social structure with a dominant State—that is, the preeminence of a political society—our capacity to propose new ways in which the State and civil society can relate to one another, provides us with an opportunity to forge a new historical bloc. However, what is to be the precise content of that historical bloc? This is the process that is presently underway and constitutes the core issue of the debate.

In health, this issue is expressed by the proposal to change the historical distance between the State (public sector) and the private sector. For the two to come together there must be new links between political and civil society— that is, between the State, in the strict sense, and civil society. Coordination, which has political, legal, economic, cultural, and social dimensions that determine what the content and form will be, will bring about that new relationship. Thus, health sector reform involves processes that are much broader than health alone, and therefore contributes to the construction of a given type of society.

Health Sector Reform as a Technical-Political Arena

Health sector reform is a process for transforming the dimensions previously indicated, but limited to the field of health. The reform, then, is the restructuring of the relationship between the State and civil society, and between the State and the market. This restructuring steadily progresses, taking advantage of

specific opportunities and times that, while largely determined by the formulators of the process and the powers that they exercise, are always influenced by social constructs.

Health policy does not mechanically transform the health sector at and between each level. Rather, transformation occurs as a result of reprocessing that policy. In extreme cases, a policy applied at the local or community level may have little to do with the original proposal generated at the central or ministerial level. This is a clear opportunity for the organizations and institutions of the sector that we classify as private or public/private and that maintain a strategic focus in their work. Accordingly, the following observations apply:

- The opportunities and timing of reforms are important, as they enable the different civil society organizations to avoid the risks and/or contradictions described previously, which require decisive action to promote democracy and the defense of citizens' right to health;
- The balance of forces achieved between the formulators of state policy and civil society will depend on the clarity of objectives and the strength amassed by each;
- Reform is always a work in progress. Accordingly, the new relationships, as well as the social, economic, cultural, and political identities arising from a reform will, in part, serve as the basis for immediate or future change;
- Reform, then, is an opportunity to fight for democracy, citizenship, and peace, in short, a small piece of the society that we wish to achieve.

Equity as a Social Construct

In the previous discussion, we established that equity is more a social outcome than a technical concept. In other words, it involves a historical and collective construction process that implies harmony, contradictions, and a relationship between the State and civil society.

Moreover, the social construction of equity in health is related to and determined by a general sense of equity regarding the different aspects or dimensions of society. These function as determinants of the health-disease process, medical practice and health, medical knowledge, and health policy or sectoral reform.

The search for equity in general and equity in health by civil society leads to the development of effective proposals for influencing structural adjustment programs and health policy/sector reform. The degree of a society's democratization appears to be directly proportional to the degree of equity achieved in that society.

In a complex and heterogeneous society with a history of great inequity, such as that of Guatemala, the recognition of and response to the varied health needs of the population poses a real challenge and will thus require greater political openness than has currently been achieved.

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NICARAGUA: THE STRUGGLE FOR HEALTH

María Hamlin Zúniga

Nicaragua, a small Central American country with a population of 4.2 million people, is one of the poorest countries in Latin America, second only to Haiti. It also is one of the most highly indebted nations in the world both per capita, with a foreign debt of US$6.1 billion dollars—equivalent to US$1,300 per capita—and in proportion to the value of the Gross National Product. Nicaragua is paying only on the interest of its debt, and these debt servicing fees are two-and-one-half times the recurrent costs in health and education together, and eleven times the recurrent cost in basic health services.

Health in Nicaragua today has deteriorated seriously as a result of the sweeping macroeconomic measures that are being applied by the Nicaraguan government in order to comply with the requirements of the International Financial Institutions (IFIs) and the donor countries. The application of the Enhanced Structural Adjustment Facility II, which will make Nicaragua eligible for the Initiative for Heavily Indebted Poor Countries (HIPC), requires, among other things, severe reductions in public expenditures, particularly in the social sector.

To understand the actual health situation in Nicaragua, we must examine what has occurred in the last two decades, characterized by war, a period of transition to peace, and the actual situation of accelerated impoverishment, misery, and social violence products of the new economic war.

The Revolutionary Period

During the 1980's the Nicaraguan Government was committed to the Alma Ata Declaration and was able to demonstrate the success of the principles of Primary Health Care. In 1979, the Sandinista National Liberation Front triumphed over the 40-year long Somoza dynasty. The new revolutionary government defined health as a right of all the people, and as the responsibility of the state and the organized population. During the decade of the 1980's, a National Unified Health System provided free and universal health care to broad sectors of the population. Both the commitment to Primary Health Care and the effectiveness of the community-based health campaigns were praised by the World Health Organization. Through massive immunization and education campaigns, community volunteers changed the concept of health from "health for a few of the elite" to "health for all." New facilities were constructed, personnel were trained, and an essential drug policy established. Great human and social capacities accumulated, making possible the improvement of living and health conditions in the population. As a result, polio was eradicated and health indicators, including child mortality, improved dramatically.

The Nicaraguan experience served as a model in the area of health and development to which others could aspire. However, it was not allowed to prosper. During the entire period, the Nicaragua revolution was subjected to a long and devastating counter-revolutionary war. This armed intervention was supported financially and ideologically by the U.S. Government. Although there was a growing need of funds for defense, the Nicaraguan Government continued to give priority to social programs, including health, education, and social welfare. Maintaining the services was not easy due to deliberate attacks against health and education workers, health facilities, and schools.

The Chamorro Period

With the people worn down by the experience of armed conflict, the elections in 1990 resulted in the defeat of the Sandinista Revolutionary Government. It was replaced by a broad-coalition government lead by Violeta Barrios de Chamorro. Her government, which promised an end to the war and restoration of economic stability, was supported by the U.S. and other countries interested in the integration of Nicaragua and the other Central American countries into the process of globalization. The new Nicaraguan government's economic cabinet was committed to the implementation of neo-liberal economic policies defined by the World Bank and the International Monetary Fund (IMF).

The Nicaraguan Constitution states that the Nicaraguan people have the right to health and that the basic conditions for health promotion, protection, and rehabilitation must be established. The Chamorro Government's National Health Policy, elaborated in 1993, recognized health is a basic right of the population, and stated that people should have access to integral health care. However, the policy stressed the opportunity for people to select their health services, opening the sector to private provision of health care.

The so-called "modernization" of the health sector in Nicaragua was financed by the World Bank, the Norwegian Government, and the Nicaraguan Government. It was characterized by a strategy of decentralization and reorganization including the proposal of a new public health law, with emphasis on Primary Health Care for the extension of services to the entire population. It also included a program to improve the quality of care, the participation of the community, and the modernization of information systems.

In this period, the conditions contributed to the increasing deterioration in the health of the population, in particular among children, principally and fundamentally because of the reduction and/or elimination of all subsidies for services and products of prime necessity, including medicines. Nevertheless, there still existed an accumulated human social capacity, which acted as a shock absorber that impeded a greater deterioration in the sanitary situation.

The Chamorro government began to initiate a wide-ranging process of transformation of the health system with a redefinition of the health model. This included the decentralization of services to the municipal level and the search for alternative financial support of the public sector, including fees for services. There was an enormous push in favor of both the private sector and of an optional social security system for those who could afford to pay. Rapidly, health was transformed from a "right of all people" into a "market commodity" no different than any other.

The Present Period (1997-1998)

Elections in October 1996 brought Dr. Arnoldo Alemán, leader of the Liberal Alliance, to power. He belongs to the Somocistas, the followers of Somoza—the military dictator overthrown by the Sandinistas in 1979. Most of the new government cabinet posts were filled with older (even quite elderly) Liberal Alliance members, many of whom did not even have the minimal necessary experience to carry out their work in the new economic scenario. In the first months of the Alemán administration, the Minister of Health called for the resignation of the directors of the ministerial departments, as well as the directors of 27 hospitals and the 17 SIAS (Regional Integrated Health Systems.) Most of the personnel being asked to leave were fairly young, well-educated persons, technically prepared and often recent graduates of the Masters Program in the School of Public Health. In an attempt to disarticulate citizen participation in health, the Minister disbanded the National Health Council, which had the broad participation of different sectors of civil society, as well as other entities incorporating citizen participation, including the local health councils, health commissions of different kinds, and the boards of directors of the hospitals.

During the 1990's, the World Bank, World Health Organization, and donor nations made considerable investments in the health sector. These included management training, support for the decentralization process, and in the renovation of facilities. Even though there have been adverse reactions to the changes in the policies of the Ministry of Health with regard to the modernization process, the government continues its own plan. In April 1997, another Minister of Health was appointed by the

President and the decentralization process was stopped. However, privatization of health services accelerated, as did the reduction of personnel at all levels. Fees for services and charges for medications increased.

The year 1998 has been conflictive in terms of the demands of the public health workers. During the four months from March through June, the Movement of Doctors for Salaries held a strike with work stoppages, demonstrations, and some 45-negotiation sessions with the government. Thirty-eight hundred of the 4,300 public health system doctors participated in the Movement, which emphasized the level crisis in a system where 44% of the doctors earn less than the equivalent of US$200 per month, and 22% earn less than US$100. Nurses earn the equivalent of US$60.00 per month. The government spends only US$14.56 per capita for health. Nicaraguan doctors have the lowest salaries in Central America. Initially the doctors demanded an increase of 1,000% in their reduced salaries, but they achieved an increase of only 100% with the promise of an additional raise of 50% in 1999. They also won raises for nurses and support personnel, the reinstatement of doctors who were fired during the strike, and the creation of a National Forum to discuss the modernization of the health sector.

In April, the Consultative Group for Nicaragua met in Geneva to discuss the foreign debt, the Enhanced Structural Adjustment Facility, and the compliance of the Nicaraguan government. Concurrent with the pressure to comply with the commitments made to the Consultative Group, a series of activities began in the Ministry of Health to advance the modernization of the sector.

In July, the National Health Council was reinstated with a swearing-in process covered by national media. The new council maintains its heterogeneity, with broad representation of civil society. Local health councils and directive boards of hospitals were also reinstated. Clearly some council and boards are fairly partisan, with representation of party members as well as the business sector. The beneficiaries of the services are not represented. Commissions with mixed representation of the government and civil society, such as the Breast-feeding, Maternal Mortality and SIDA Commissions have not been reactivated.

Also in July, the President of Nicaragua inaugurated a national consultation to present the plan for the modernization of the health sector. The Ministry is carrying out the so-called consultation with different sectors of the population. However, there are still no efforts directed toward children and youth under 25 years of age, which make up a total of 67% of the Nicaraguan population.

The latest event is the appointment of the Deputy Minister for Administration as the new Minister of Health. She is committed to the rapid reform of the sector through close collaboration with the local representation of the World Bank. The plan of reforms could mean the privatization of all health services, including general hospitals.

To reduce the budget of the Ministry, 1000 doctors have been offered “voluntary retirement”. Right now there are 3,799 doctors, or 1 per 1105 persons, but the majority are concentrated in the capital. With the reduction, the ratio will be one doctor for 1,500 persons. The cost of the retirement program for 600 specialists and 400 general practitioners will be financed by the Inter-American Development Bank at a cost of over US$4.4 million.

It is obvious that the demands of the international financial institutions, the donor countries, and the pressure to comply with the Enhanced Structural Adjustment Facility before the next meeting of the Consultative Group in February, 1999, will result in an intensive effort on the part of the health authorities to advance, at all costs, the reform toward modernization that is, privatization of the health sector in Nicaragua.

Structural Adjustment and the Pauperization of Nicaragua

The implementation of the Structural Adjustment Program in 1990 with the subsequent negotiation of the Enhanced Structural Adjustment Facility have been designed to reduce the extremely high foreign debt and close the fiscal gap.

The effect of the SAP has been dramatic in all spheres, especially in health and education. Subsidies have been eliminated from services and products of primary necessity. The extent to which health services reach the population has been reduced dramatically, and preventive initiatives such as "complementary food" programs have been abandoned. Coverage in women's prevention and promotion programs such as the "Uterine Cervical Cancer Control" for example, is known to have decreased and fewer women receive prenatal care.

Declining services are bound to adversely affect maternal mortality. According to registries in the Ministry of Health, maternal mortality in Nicaragua´s Region I (the northern region of Las Segovias) is extremely high: one in every 66 women of childbearing age dies during pregnancy, delivery, or the postpartum period. At the national level the maternal mortality ratio ranges from 159 to 300 per 100,000 live births, according to Nicaragua´s Women´s Health Network. However, there is under- reporting of deaths due to clandestine abortions. An unwillingness to admit that illicit abortions exists results in these deaths being reported as accidental pesticide intoxication or malaria treatment overdose.

In the period 1993–1994, there was serious deterioration in the economic accessibility to services and in the quality of health, sanitation, potable water and waste disposal services, as well as the programs available under the social security system. And for the period 1995–1997, there was an increase in the loss of the human social capacities to slow the deterioration of living conditions. This has produced an acceleration of the negative tendencies in health and nutrition indicators that coincide with the deterioration in the macroeconomic indicators affecting the social sector.

The Globalization Process

As well as the specific effects of structural adjustment, more general consequences of globalization, such as job insecurity and rising unemployment among the unskilled, also affect health.

In a widely publicized document, the United Nations Development Program proposed that the new Enhanced Structural Adjustment Facility should take into account the extreme poverty and

marginalization of over 80% of the Nicaraguan people. It suggested that the Enhanced Structural Adjustment Facility incorporate social adjustment as well as financial objectives in order to correct the dramatic deterioration of living conditions and the profoundly unequal distribution of wealth.

An alarming tendency is the increasing possibility of damage to the population's mental health, generated by tension and civil insecurity due to the socioeconomic situation. For example, morbidity and mortality due to violence have been increasing. Recent studies show that 60% of women in Nicaragua have suffered physical abuse, usually from their partners or close family members. According to police reports, the common denominators of this kind of violence are unemployment and the presence of alcohol.

Suicide has also become much more common. National Police statistics show that a total of 176 persons committed suicide in 1996, an average of 14.6 per month—a 33% increase over 1995. In 1997, 274 suicides were recorded: 23 cases per month. Most were males, with a proportion of 4:1 compared to women, and 70% of the cases were in persons under 34 years of age. From January to May of 1998, there was an average of 26.2 suicides reported each month. The principal causes of suicide related to depressive-emotional and/or economic problems.

The economic crisis and prevailing unemployment have also caused a significant jump in child labor. More than 367,000 children and adolescents in Nicaragua are workers. The government has no articulated policy for dealing with this issue. In 1997, it was estimated that 30,000 children were on the streets in different cities, where they were exposed to serious risks, including violence, abuse, and sexual aggression and drug addiction.

The Challenge for Nicaraguan Civil Society

Now that the Nicaraguan government has signed a new Enhanced Structural Adjustment Facility agreement, the citizenry is demanding the opportunity to participate actively in the decision making process. A variety of dialogues, and lobbying at the national and international level has been suggested.

In particular, organized responses have come from the non-governmental sector, including religious organizations. Alternative health centers are being established, offering programs designed to restore the social fabric within the country. The intention is to improve the population's quality of life and to provide integral health and education services at the local level. Such programs rely on the innovative, creative spirit of the Nicaraguan people.

What is now needed is for civil society, particularly the social movements, to participate in drafting Nicaraguan social and economic policies. Already they are using the Platforms of Action developed at the UN Conferences since 1990 to demand compliance with international agreements. Women and men are discussing alternative development plans and designing policy proposals. Activities cover a variety of fields including environment, education, health, sustainable development, food security, and population.

An important initiative is the Proactive Lobbying Group (Grupo Propositivo de Cabildeo, GPC) which has been formed by diverse organizations, federations, and groups of Nicaraguan civil society.

The intention of the group is to directly affect government policies and the international arenas where decisions are made about the present and future of the Nicaraguan people. These include the World Bank, the International Monetary Fund, the Consultative Group meetings, the Paris Club, etc.

Networking, especially among women, has been significant. For example, the Women's Health Network includes 54 different centers, and the Women's Network Against Violence Directed Against Women and Children involves nearly 200 groups. The Initiative for the Citizenship of Women is actively involving women from diverse sectors of society to develop education and advocacy programs around issues related to social and economic conditions, structural adjustment, human rights, as well as proposals for the generation of productive employment.

Thus, in spite of the major setbacks since the health achievements of the Sandinista revolutionary government, the resilient people of Nicaragua continue to organize and struggle for a society that is supportive of health and a quality of life for all.

A RESPONSE BY WOMEN TO THE RAPID DIMINUTION OF HEALTH & OTHER SOCIAL SERVICES

...As a Result of the Application of Neoliberal Economic Policies in Nicaragua

Dorothy Granada

Nicaragua is the second poorest country in Latin America. The gap between the rich and the poor grows rapidly, unemployment is increasing, the quality of life is failing rapidly, money spent on education has diminished, street crime and domestic violence are rising, malnourishment is endangering the future of children, and health care is out of the reach of most people. Eighty-two percent of Nicaraguans are impoverished and 44% live in misery.

The Nicaraguan Government is a willing player in the international economic system that fosters individualism and greed and abdicates responsibility for the welfare of its people. Following dictates of Structural Adjustment laid down by the International Monetary Fund and World Bank in order to service the foreign debt, for every US$5 spent on the External Debt, US$1 goes to social services and education. The Government is rife with accusations of corruption, some linked to drug trafficking.

The health policies of the government, in agreement with the Roman Catholic Church are anti-women. According to the dictates of the new Ministry of the Family, women are to abandon birth control and return to the home to be subservient to the

man, who is the only recognized head of a family. Of course, this is occurring in a context in which violence in the home, including sexual abuse of children and rape, is rising.

New government policies are making it more difficult for donations from non-governmental organizations and solidarity groups to enter the country as the government attempts to capture all humanitarian aid from international groups.

The result of this environment is that most of the country's children do not attend school and child labor is increasing, including in the sex industry. Mental illness and suicides are increasing with 192 suicides in the first eight months of this year, 24 of whom were between 10 and 15 years of age. Kidnapping, robbery and rape are on the increase. In the countryside around Mulukukú, there were 20 kidnappings in the first six months of this year. Thousands of ex-Contra and Sandinista combatants have not been integrated into civil society, continue to live by the gun, and are responsible for the majority of kidnappings and robberies. Some of the ex-Contras are used by the political far Right to harass and kill Sandinistas, especially around election times. The few police remaining are inadequate for the job of providing security and are increasingly involved in corruption and brutality. Vehicles are frequently stopped by armed robbers.

Mulukukú

Mulukukú is a village of 5,500 located in the North Atlantic Autonomous Region of Nicaragua on the agricultural frontier. It is the center for 19 mountain communities with a population of approximately 25,000. The people are among the poorest in the country and lack work. The area suffered heavy fighting in the Contra war. The area is characterized by lack of security: many small farmers have abandoned their lands after being kidnapped (some more than once) and had to sell their animals to buy freedom. There is a new development in kidnapping after receiving ransom; some kidnappers are killing their captives.

More than half the village's children aren't in school because families cannot pay the fees. The government health clinic in Mulukukú has been without staff for most of the last nine years, and few medicines are sold. There is no electricity except individual generators; however, a central water system is being constructed with USAID funds. El Niño and changes in the area's weather have caused either drought or an over-abundance of rain, thereby losing many crops. Harvests are sold cheaply and goods that the campesinos need such as cooking oil, sugar, thread and medicines are rising in price.

Women in Cooperation

Mulukukú is a new community formed in the mid 1980's by persons displaced by the war. Ten years ago this month, Hurricane Joan destroyed the entire settlement. In the aftermath of the disaster, a group of forty women inspired by examples of cooperation in the Sandinista Revolution decided to work together for survival by forming a cooperative. Most of the women were widows or abandoned and all

had several children. With help through international solidarity, they built their homes, a factory to produce building blocks, and a carpentry shop.

At this time, the community was shocked by the suicide of Gladys, a 17- year- old woman who found herself with an unwanted pregnancy, swallowed more than thirty chloroquin pills and gave herself injections of unknown drugs. Through Gladys' death, the cooperative decided to develop a clinic where women could receive family planning and health care.

Women come to the clinic principally for gynecologic problems including Pap screen, pre-natal care and family planning as well as other problems such as infectious diseases including malaria and dengue. Many diseases, which had been controlled during the Sandinista Government, have now returned in force, including tuberculosis and childhood diseases preventable by immunizations. Children's principal problems are respiratory conditions, diarrhea and parasites, malaria and malnutrition.

The Clinic staff consists of six Health Promoters and two nurses. Twice a year, medical delegations visit, one of which is from UTMB and the First Presbyterian Church in Galveston. Workshops are offered to community health workers, 'Brigadistas' and midwives. Around the health work have grown other programs as women meet together to discuss their problems and identify their needs.

For instance, a micro loan fund lends between US$50 and US$100 to the most marginalized women, to assist in them in economic survival. In an effort to counter violence, gender training is offered to youth, men and women and to Barrio Coordinators, who are women elected in each neighborhood who receive training in how to recognize and respond to domestic violence. The Non-violent Men's Group of 50 men visits perpetrators of domestic violence, invites them to learn alternatives as well and mediates disputes in the community. The Legal Office assists and accompanies women with problems of domestic violence, property and support issues. Workshops are offered in Gender, Non-violent Conflict Resolution, and Human Rights among other topics.

Salvadora, my neighbor, is 48 years old; she has given birth to nine children and had three abortions. She arrived in Mulukukú displaced by the war. Salvadora never wore shoes, but now wears 'chinelas' the cheap plastic slippers of the campesina. Salvadora worked hard with the machete all her life and never learned to read or write. She has always loved her Roman Catholic 'capilla' and taught young children to sing hymns. After she arrived in the village with her family, she continued to again teach children to sing in her capilla. Salvadora joined a small group of women in our barrio who were learning to read and write. She also began attending gender workshops in the Women's Center. With the new knowledge of reading and writing, Salvadora was able to take on the responsibility of teaching catechism to the children in her capilla. The women of our barrio elected Salvadora as Barrio Coordinator. A 'Coordinadora del Barrio' is at the service of her neighbors. She provides accompaniment, support, and education and is especially alert to violence against women and children and has received training in this field. Salvadora has helped twelve women build composting latrines.

A few months ago, Salvadora borrowed US$100 from the Rotating Loan Fund of the Women's Center. With this she bought used clothes—'Ropa Usada Americana,' needles, thread, hair barrettes and

other small useful items, and travels into the 'montaña' to sell them. If the campesinos have no money, Salvadora trades for eggs, chickens and fresh cheese. These products of the campesinos, Salvadora then sells in the village.

When Salvadora received the loan, her companion left her. She came to the Legal Office at the Women's Center for help. A letter was written asking her companion to come for a meeting. At the meeting, Salvadora told her partner that, since she was working, he should return home and help in the house, look for fire wood, haul water and take care of the children when she was away working and attending 'estudios.' She stated that this was 'because I am an important person and you should help.' The man is back with his family and fulfilling his responsibilities.

Salvadora and other women of Mulukukú have learned that in organizing and with help from friends, they can rise out of the misery of their lives. The women refuse to be beaten and know that claiming and holding onto their dignity is a daily struggle.

THE EFFECT OF THE NEOLIBERAL ECONOMY ON EL SALVADOR

José Danilo Ramírez Martínez

El Salvador, the smallest country in Central America, has an area of 21,041 Km^2 with a density of 275 inhabitants/km. In 1996 its population reached 5.7 million, comprised of 2.8 million males and 2.9 million females. According to the 1994 UNDP Human Development Report, El Salvador placed 112 on the world scale of its Human Development Index, above Bolivia and below Morocco. At that time, we had fallen dangerously into the category of countries with low development levels. By 1996, El Salvador occupied the 109th position in human development, considered "medium development."

Women of childbearing age (CBF) and children under 15 constitute most of the Salvadorian population, constituting nearly 65% of the total population. This is the most vulnerable population because they are at greater risk of becoming ill and/or dying, and they also have less access to health services.

We are all aware of the revolutionary struggle process that went on for more than a decade in our small country and that culminated in January 1992, through the signing of the peace agreements between the rebels and the Government of El Salvador. During this time, the rural population suffered the most from the devastation of war—especially with respect to health services—because the Ministry of Public Health and Social Welfare had no access to the population that lived in rural areas. Additionally, there was no willingness on the part of the Government to serve this population because they were believed to be collaborating with the guerrilla forces. In fact, this

population and the vast majority of Salvadorians are those who traditionally have been marginalized from the socioeconomic benefits available to most of the urban population.

The signing of the peace agreements generated many expectations among these people; however, six years have elapsed since this great event took place and there is still no sign of a safe future. On the contrary, the measures implemented by the Government since 1994 have only brought an increase in extreme poverty. Those marginalized from all opportunities of collective participation in goods and services, both public and private, maintain that they have no hope of improving themselves in this country.

The Post-War Period

The dependent capitalist orientation of El Salvador—the violent, offensive capitalism that subjugates human dignity—has had a direct effect on the ways cities have grown, specifically at the expense of deforestation and the ever increasing and alarming loss of principles and values.

One example is the unplanned urbanization process, using and converting urban land into wealth and capital generation mechanisms for a small population at the expense of the majority. This affects not only the use of the land but has also served as the perfect mechanism to achieve the private appropriation of collective goods and has reproduced, at the local scale, the transfer of funds from the poorer to the richer. Proof of this is the non-realization of the Land Transfer Plan resulting from the peace agreements.

In our country the current economic situation is characterized by a trend toward deceleration of the economic activity and deterioration in the productive and purchasing capacities of the population. To a great extent this is the result of the implementation of "stabilization and structural adjustment" policies in recent years, a feature of the approach and interests of international financial agencies: the World Bank (WB), International Monetary Fund (IMF), and the Inter-American Development Bank (IDB).

Since the multilateral development banks resumed their lending programs to El Salvador in the 1990s, their country strategies have focused on the Structural Adjustment Program that seeks the liberalization of the economy (deregulation and opening of markets) and the redefinition of the role of the State (privatization and targeting). Deregulation implies divesting the State of any power to intervene in the market. This is carried out through the elimination of price controls, subsidies, regulations on investments, and regulations in the financial system. The opening of the economy implies establishing a "competitive" exchange rate (to attract investments), reduction of tariffs, and the promotion of exports and foreign investment.

Finally, there is the structural reform of the State to reduce its size and "make it more efficient" (to achieve the desired impact with less investment of resources). This is carried out by targeting social services to specific sectors (focusing on the most vulnerable groups) and removing from its responsibility those services that could be "efficiently provided by the private sector."

Health and Human Development in the Neoliberal Economy

Between 1991 and 1994, the World Bank disbursed two loans totaling US$125 million to initiate the Structural Adjustment Program in El Salvador. Similarly, the IDB approved a US$90 million loan in 1992 as part of the structural adjustment program (called "sectoral lending" by the IDB), specifically designed to promote the reform of the financial sector (privatization). In September 1987 the IDB approved another US$90 million sectoral loan for the public sector Modernization Program to promote the reform of the State, especially privatization.

In 1997, both the WB and the IDB revised their assistance strategies for El Salvador, adjusting them to reflect the events in the country. The current strategies are based on the principles and events in the country.

The strategies formulated in 1997, both by the IBRD and by the IDB for their programs in El Salvador, are framed under four central components:

1. Modernization of the State
2. Promotion of Local Development
3. Promotion of Private Sector Development and
4. Strengthening of Environmental Management.

The central focus of the effort is the Public Sector Modernization Program (PSMP), established within the context of the Structural Adjustment Program. The two Banks are co-financing the PSMP, and within that framework they seek to restructure the bureaucracy of the State to make it more efficient and reduce its costs; to divest the State of those assets and functions related to the provision of public services that the private sector can assume in a profitable manner; and to assist in the establishment of the institutional, legal, and regulatory frameworks that would promote private investment.

The WB proposes that the structural reforms in the social sectors (education and health), which are oriented to improve the coverage and the quality in the provision of services, will contribute in the long run to the reduction of poverty.

However, the Structural Adjustment Program in our country has taken a heavy toll on the rural population and the population marginalized from basic services. Theoretically, what was proposed to the people was "the need to go through a decisive adjustment to rescue the capital lost during the years of war, during which time the dependent capitalists would invest the proceeds from the IDB-WB loans. Then, once the economy spills over, the poorer of the poor would benefit from the strengthening of the social programs."

It was proposed that this could be accomplished fully, but what has actually happened is that the Banking sector has been strengthened and there has been a moderate increase in the domestic economy. The fact is that the economic increase has only favored a few, and the women and men of the communities have "adjusted"—since no improvement has been seen in the economic aspects, and even less in the social aspects.

With respect to social development, the Banks believe that in order to increase the productivity of the Human Resources supply it is necessary to invest in the education of human capital and in reducing poverty. Moreover, there are still no subsidies for the projects and beneficiaries for the legally recognized communities, i.e. legal entities.

With regard to health, the type of diseases and their timely treatment requires:

a) A preventive, educational, and curative basic approach.
b) Easy access to Basic Health Services, especially in rural and poor urban areas.
c) A comprehensive health care system that includes the development, promotion, protection, recuperation, and rehabilitation of the person.
d) The availability of safe water and an adequate environment.

The impact of the Structural Adjustment Program is often reflected by the users of hospitals and outpatient clinics. Following is a detail of the indicators for 1997:

Maternal mortality rate	= 86/100 000
Infant mortality rate	= 26/1000
Fertility rate	= 3.2 children/woman
Percent of cytology in childbearing aged women	= 36%
Childbearing aged women that use FP methods	= 22%
Prenatal check-up coverage	= 74%
Childbirth institutional care	= 60%
Tetanus toxoid in women with children under 1 year	= 72%
Post-natal control care	= 65.9%
Life expectancy at birth, 1995-2000	= 69, 43

Source: Health Situation in El Salvador, Information, Monitoring and Evaluation Unit, MSPAS, January-February 1998.

The impacts of the Adjustments, observed in the indicators above, are not really encouraging. Following the State Reform process, the World Bank and the IDB plan to initiate the financing of a comprehensive reform of the health sector; however, it is still not clear how the poorer will benefit. We believe that it is necessary and urgent to review the neoliberal economic model since it has demonstrated once again its ineffectiveness in the social sector—if what we seek is the economic and social development of man with dignity, equity, and solidarity.

Our institution, "Pro-Vida" of El Salvador, as supporter of the right to life with dignity, social justice and true democracy, and on behalf of the rural population that it represents, makes a call for the review of the Social Programs supported by international agencies. These agencies want to impose such programs on societies that have not even reached the minimal socioeconomic development but that survive on their hope for a new sun for our nation and the entire world.

HEALTH, BASIC SANITATION & THE GENERATION OF EMPLOYMENT & INCOME:

Paths to Sustainable Development

Vicky Schreiber

In recognition of the fact that all human beings have the right to a decent and healthy life, in harmony with nature, the UNCED Conference in Rio de Janeiro, 1992, called upon Governments and people to address the urgent and necessary tasks of eradicating poverty, to narrow, if not eliminate, the gaps that exist between rich and poor, North and South. In order to overcome this situation there must be a commitment on the part of the industrialized nations to reduce or eliminate unsustainable forms of production and consumption, through profound changes in their lifestyles. For the poor nations, this means avoiding the illusions of imitating the development path of others and seeking economic and social development which are based on the principles of sustainability.

However, despite the symbolic and concrete importance of this new paradigm, there is still a large gap between the defined objectives and attainment of desired results. Even though a solid unanimity exists regarding certain principles and objectives, there is still only a fragile consensus about the means for their fulfillment. Subsequent UN Meetings on Human Rights (in Vienna in 1993), Population (in Cairo in 1994), Social Development (in Copenhagen in 1995), Women and Development (in Peking in 1995), and Human Settlements (in Istanbul in 1996) continue to call for action and define numerous strategies, but headlines continue to demonstrate that

very little progress has been made. According to UNDP more than 2 billion people still do not have access to basic services, an adequate food supply or housing. Nine hundred million people are unemployed or under-employed, and this includes approximately 40 million people in the member countries of OECD (O Liberal, October 18th, 1998).

While Latin America, in general, has been able to weather the economic crisis which has deeply affected countries in Asia, the threat of economic recession is still present, and disparities between rich and poor in Latin America remain one of the major obstacles to overcome. Disparities in human development are also marked between rural and urban areas or even regions, as is the case for the Brazilian Amazon and Northeastern Brazil.

In Amazónia, poverty and environmental destruction, the debility of exercising political and social rights, the glaring contrasts between the resource wealth, and the living conditions of a majority of the region's population represent some of the more critical problems that must be faced.

Limits to Development

In order to characterize the Amazon Region and place it within the context of globalization and structural adjustment, the following gives an outline of the Brazilian case. Together with other Latin American countries, Brazil has been undergoing a process of restructuring in order to modernize the economy and build democracy.

In relation to the economy, this means implementing actions to increase competitiveness in the global economy through privatization programs and rigid application of global market laws. At the same time, through the democratic process the nation seeks to guarantee more equal distribution of the benefits of development and the full participation of its citizens in defining the future of the country.

Some regions of South-Central Brazil have been able to benefit from this process, but in general, due to the external debt, the State's capacity to intervene in public policy has been limited by a constant shortage of resources to invest in social and economic infrastructure, especially in regions as large as the Amazon. In addition, at the state and municipal level, old power structures still prevail and administrative structures are unprepared to face the growing social and economic problems.

In relation to civil society organizations, even though the numbers and kinds of organizations has grown to deal with both social and environmental problems, their actions are fragmented and they face the challenge of working with people who have little or no education, while their own capacity for organization is still in an embryonic state.

The private sector consists of only a few enclaves of large-scale mineral projects, which have failed to generate any substantial benefits for the regional society, and many small enterprises that have limited access to credit programs, modern technologies, and administrative procedures.

Besides these difficulties being confronted by public, private and civil society groups, international organizations also play a role in the region by financing diverse programs and projects. Even so,

coordination among the different groups is minimal and in many cases, due to a lack of understanding regarding the capacity of their regional partners, programs are not effectively implemented. Even more dangerous is the creation of the illusion that the transfer of resources from international sources will be sufficient to overcome the region's problems.

POEMA, Paths to Sustainable Development

POEMA-æPoverty and Environment in Amazóniaæwas conceived and created with the purpose of contributing to the generation and implementation of paths of sustainable development for Amazónia, with a context centered on the realities at municipal level. It is based on the perception that to make significant changes in the living conditions of Amazonian peopleæabove all, those of women and childrenæthe structural problems of the region must be dealt with effectively. These include the role of the government and civil society organizations and also the availability of innovative techniques and methods for solving the regions serious problems in the areas of health, sanitation, nutrition, family income, production, and environment degradation, to name a few.

The general objectives of POEMA are to:

- Provide incentives for the development of ways to mobilize and promote the self-reliance and organization of poor communities located in rural areas of Amazónia;
- Provide emergency strategies to meet the basic needs of vulnerable populations of the Amazon Region;
- Contribute to the identification and adoption of productive vocations for municipalities, taking into consideration their specific social, economic and ecological characteristics and promote the use of innovative, low cost and efficient technologies and methodologies;
- Provide basic information necessary to define priorities for plans, programs or projects at the municipal and state level, contributing to the integration of state and municipal administrative structures;
- Promote cooperation and exchange among programs in Amazónia, that have as their main objective: to overcome poverty and prevent destruction of the environment.

POEMA initiated its activities in pilot communities of three micro-regions of the State of Pará æ Marajó Fields, Lower Tocantins and Araguaia—whose macro-systems represent 40% of the total surface area of Pará and present marked differences from the point of view of their ecosystems, social, cultural and economic conditions, as well as the history of their occupation. POEMA began its activities in four selected communities called pilot communities: Praia Grande (in the municipality of Ponta de Pedras), Camurituba-Beira and Urubuéua-Fátima (in Abaetetuba) and Novo Paraiso (in São Geraido do Araguaia). POEMA's area of activity is expanding due to the demands from other areas and the replicability of its actions in other parts of the Amazon Basin.

Health and Human Development

Subsequent publications of the Human Development Report for Brazil by the United Nations Development Program and IPEA, in 1996 and 1998, tend to focus on the progress made by Brazil as a whole: Brazil had a Human Development Index of 0.394 in 1960 and 0.809 in 1995. But neglect to national statistics point out the stark contrasts which still exist between regions such as Sao Paulo and states in North-eastern and Northern Brazil, which still showed low Human Development Indexes (<0.7) and represent approximately 33% of the Brazilian Population (UNDP 1996).

In the Northern Region, 43% of the urban population is considered poor, and statistics for the rural population (approximately 50% of the population) are lacking. While improvements in education and income have contributed toward improving the Human Development Index for the nation as a whole in the last decades, in the northern regions life expectancy is low and infant mortality high due to a lack of basic services for health. While the Federal District of Brasilia has 1 doctor for every 225 people and the average for Brazil is 1/ 641, in the State of Pará, the ratio is 1/1094, with these doctors concentrated in urban areas (0 Liberal, 1998).

BOX 1.
Illnesses registered in the State of Pará, 1997

114,060 cases of malaria
39,565 cases of diarrhea
937 cases of infectious hepatitis
812 cases of dengue fever

Sources: SESPA, O Liberal.

The statistics in Box 1. give just some idea about the health conditions in the region. Studies carried out by POEMA in the pilot communities verified the high incidence of water borne diseases and those associated with poverty, and thus the program began to directly involve the community in preventive health programs. The methods and techniques passed on to trained community health agents are being transformed into the following practical actions: promotion of breast-feeding, control of disease through vaccinations, control of diarrhea and respiratory infections through the practice of basic hygiene, correct use of oral re-hydration therapy, pre-natal assistance, and basic first aid skills.

Basic Sanitation

The search for alternatives for basic sanitation, from the public health point of view, is an imperative in Amazónia, considering that about 60% of the illnesses treated in hospitals of the region are caused by the consumption of contaminated water. Given this alarming statistic, POEMA has striven to develop

and implement appropriate technologies for water treatment, supply systems, and waste disposal for low-income populations in both rural communities and those of the urban periphery that have no access to these basic services, as shown by the statistics below.

BOX 2.
Water Supply and Waste Disposal

Houses with Water Supply, Pará State		Adequate Waste Disposal, Pará State	
Pará	36%	Pará	2%
Brazil	75.4%	Northern Region	8%
Amapá	55.5%	Brazil	44%

Potable Water

This is always the most urgent need in Amazon communities. Providing this basic need is the first step in the implantation of a sustainable development proposal for Amazónia. The work is carried out in partnership with the communities, through collective forms of self-help, where the experiences of self-organization and community organization are indispensable for the success of this initiative.

BOX 3.
Lower Tocantins—the present situation

The infrastructure conditions of the region are precarious. There are very few houses connected to a sewage system, especially in the rural areas. The inhabitants of the Lower Tocantins end up using the water from streams, rivers or poorly built wells. All of them are vulnerable to diseases, which is one of the reasons why the micro-region has suffered from a cholera epidemic.

POEMA's actions in the area of sanitation are:

- study efficient and low cost, alternative technologies æ for example æ use of wind and solar energy to treat water through the production of chlorine " in loco," from a solution of water and salt in an electrochemical process; development of manual pumps which are easily operated and maintained; optimization of household water filter systems; solution for disposal of household waste water and sewage;
- implantation of demonstrative projects involving the communities and local authorities which includes monitoring the systems installed;

BOX 4.
Campos de Marajó, Praia Grande—Alternative Water Supply System

Without a water supply system, most of the inhabitants of Praia Grande used the water from shallow wells without any sanitary protection. Laboratory analysis showed the presence of fecal colliforms in the water used by these people.

With the implementation of a low cost water supply system, making use of alternative energies such as solar and wind energy, the problem was solved. The population started using the water from a deep well pumped by a windmill. The pump forces the water into a high tank. Then the water receives a solution of sodium hypochloride before it is distributed to the houses. The solution of sodium hypochloride is made in the following way: some water and common table salt are put under titanium electrodes full of energy (solar energy), turning this simple mixture into sodium hypochloride.

The water supply system of Praia Grande was built through community self-help and is managed by a committee of people who have received technical training.

- transfer of experiences and tested technologies to public institutions, non-government organizations, research centers, universities and community organizations through training programs and technical assistance.

Nutrition

Due to various factors in the different areas of the State of Pará, where POEMA carries out its activities, nutritional deficiencies have been detected especially among children. Traditional forms of agriculture (slash and burn, or shifting cultivation) result in loss of soil fertility and declining yields. Fisheries in the lower Tocantins have been affected by damming the river. Extractive activities are seasonal in nature, and so-called "modern agriculture" and mono-crops have been promoted in new colonization programs. The activities have all contributed to food scarcities among rural populations of the region.

Food Security and Sustainable Production

In collaboration with the small-holder farmers, three productive areas are being dealt with by the program. **Home-gardens** are being transformed into the family "supermarket", whether through the cultivation of vegetables and fruit, or by raising small animals or development of fish farming. **Cultivated fields** are being used and are transformed into agroforestry modules—"agriculture in layers"—where dozens of species are planted in consortium, to overcome problems such as seasonal production, and without the use of chemical fertilizers, which results in improved family incomes. The forest and rivers are managed and transformed into an ally to be preserved, as a genetic bank that can be enriched and may be used continuously by the small-holder, who is now able to maintain his property in a fixed location.

The greatest challenge of POEMA's work has been to develop an agricultural system that is economically viable and ecologically sound. In addition, such a system must be easily adopted by the rural families practicing subsistence agriculture. By integrating aspects of indigenous agricultural systems and technical-agronomic knowledge, the first model of the system "Agriculture in Layers" was obtained.

"Agriculture in layers" has the following advantages:

- Recovery of lands damaged by the "slash and burn" agriculture system;
- Year round harvests, because the species yield products in different seasons, overcoming the typical seasonality of monoculture;
- Strengthening of the biodiversity, decreasing the incidence of weeds and diseases;
- Elimination of the use of agrotoxins;
- Restraining the destruction of the forest provoked by shifting cultivation;
- Increase the possibility of vertical or value-added production;
- Improvement of the local population's diet and nutrition.

Agriculture in Layers

This method unites three types of knowledge: the technical-agronomic, indigenous, and the experience of rural producers. These "layers" or "strata" are formed by the plant species themselves. That is, there may be temporary herbaceous plants of about one meter high, like rice, beans, gherkin, pumpkin and watermelon, among others, in the first layer. Besides being useful for the nourishment of the farmer's family, these crops help to protect the soil and provide shade and organic material for other seedlings. In the second layer, the plants may reach up to 2 meters high, like manioc and tomato, but with the same function as the first layer. In this way, the layers "are built up" until the top layer, the only one with forest species, like the Brazil-nut tree, the sapodilla and the bacury, among others. The farmer himself chooses the species to be planted. He takes into account his own needs for food and income and local experience and research on the ecosystem and floristic composition.

Generation of Employment and Income

From the proposal to diversify production through agroforestry systems came the need for a strategy to make use of the products and sub-products generated by this system, which aim to increase incomes and generate employment opportunities in the communities involved in the program, thus improving human development.

Natural Products for Industrial Uses

The area for the processing of natural products develops scientific research and executes adequate projects and processes for the processing of natural products (fibres, oils, resins, latex, dyes) for industrial uses. This integrated workæagroforestry production in selected Amazonian regions and scientific researchæcreates the

foundation for an economy based upon the vocation of the rural communities. This in turn offers possibilities for the commercialization of their products and greater access to markets, generating income and employment. Mechanisms for the establishment of community-based businesses that involve partnerships among the business sector of Amazónia small-holder producers and national and multinational companies are promoted.

Food Processing

As the communities begin to produce food through the agroforestry activities, it becomes necessary to make better nutritional and economic use of the crops being cultivated. To incorporate these raw materials into the technological process, POEMA has developed the following objectives:

- Instill improvements in the processes for conserving food, which are being developed in the communities, to improve storage and reduce losses from spoiling;
- Develop technologies for using food produce proposed by the communities themselves, to improve the shelf life of the food crops produced by the small holders;
- Implant, with the support of institutions, associations, local council offices and municipalities, processing plants for produce which aim to make better use of these raw materials, and create opportunities for employment and generation of income in the communities;

Ethno-pharmacy

This is an area which has interfaces with agroforestry and food processing to make better use of plant species as medication or food by maintaining a constant supply of the raw materials which will be manipulated to produce remedies and food. This area has two main objectives:

- Pharmaceutical evaluations of the effectiveness and toxicity of the plant species already used for traditional medicine and that can be easily managed;
- Supply the scientific basis to use the selected species as pharmaceuticals, incorporating technology with traditional remedies.

Partnerships for Development

The following are just some examples of the partnerships which have resulted in sound development in Amazónia.

1. A cooperation agreement between Daimler Benz A.G./Mercedes Benz of Brazil and POEMA/UFPA, and the community enterprise PRONAMAZON has resulted in the following accomplishments:

   - a greater interest in natural materials with potential for industrial applications has been generated through the research component;

- a local enterprise has achieved self sufficiency and success in producing a manufactured natural product for the automobile industry through the transfer and adaptation of technologies for pilot processing and manufacturing units at the community level;
- with the growing demand for natural products as substitutes for synthetic materials, these initiatives are being expanded to involve additional communities engaged in value-added processing of coconut fibres and the manufacture of a diverse range of products for automobiles.

2. Cooperation Agreements with the State Government (SECTAM) for implementing alternative water supply systems, where the pilot experience will become part of government programs. Due to the demands of isolated, rural communities and the urgent need for safe drinking water, the low-cost technology for water supply developed by POEMA has been adopted by the state government, with funding available to benefit more than one thousand communities.
3. Local organizations, POEMA(R), State Government Programs (SECTAM/PED, Program for Professional Education Program for Decentralized Execution, SETEPS-PEP, and Pilot Program for the Protection of Brazilian Tropical Forests-PDA Demonstrative Projects) have been contributing to the establishment of community enterprises for food processing. Processing units for fruit pulps, dried fruit, palm heart etc. are being set-up in rural communities through joint commercialization and organization of associative companies and the support of government programs. The quality of products is being improved and the managerial and productive capacity of the local enterprises strengthened through training of rural producers in over 300 courses, involving small-holder producers for the period 1997-98.

Final Comments

As the interventions undertaken in conjunction with local communities and municipalities by POEMA are pilot programs in nature, their consolidation and adoption as part of government policies and programs will depend on the creation of a solid base of dialogue and cooperation with government institutions and working civil society organizations to make maximum use of available resources, and working together at all levelsælocal, national and internationalæto re-invent policies. The sustainability of the projects in social, ecological and economic terms will depend on the promotion of productive activities adapted to the specific socio-cultural and environmental conditions at the local level. Finally, the projects must seek partnerships between small-holder producers and businesses to take advantage of opportunities to promote the sustainable use of natural resources while promoting equitable relationships with the market, especially the growing tendencies and market niche for renewable, natural products.

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CONCLUSION

FINAL REMARKS

Alexandra Bambas

The contributors to this volume have explained some of the health, social, political, and economic effects of globalization from the perspectives of civil society, universities, and intergovernmental agencies, and have suggested responses and new strategies for addressing health concerns based on their experiences of challenges and successes. The lessons learned and models proposed during the seminar/workshop are applicable to those working not only in health, but also in the entire social sector. The primary lesson here, we believe, is one of process: learning how to mobilize and coordinate economic, political, social, and human resources in order to further equitable human development.

Consider the recent WTO Meeting in Seattle, Washington, USA in 1999. The failure of the meeting, in part due to public relations issues resulting from the civil demonstrations occuring outside of the meeting itself, marked a victory for those who have witnessed the unduly hasty attempts to integrate economies without care and human concern for its increasingly deleterious social effects. Thirty thousand people and dozens of groups took to the streets in common cause; they comprised steelworker and longshoreman unions, teamsters, international development groups, women's rights groups, minority groups, environmentalists, labor activists, peace activists and concerned citizens, gathered to defend national sovereignty, national labor and environmental protection laws, and the democratic process. The demonstration succeeded in suspending the talks and may even slow integration plans. But few believe that particular event will be a lasting solution—globalization will proceed.

More important than any immediate sense of victory for civil society, the events on the streets of Seattle serve as a prescient reminder of the ultimate ability of civil society to participate in affecting the process of globalization through organized local, national, and international response. This alliance demonstrated a powerful level of coordinated solidarity for sustainable human development and social protection, a result of careful planning. In preparation for this demonstration, discussion fora and workshops began the weekend before the WTO Meeting and extended through the week, and addressed many of the problems which have and could arise in the WTO agreements. This kind of coordinated solidarity must serve as a model not only for preventing the harmful effects of globalization but also for promoting positive, constructive action that capitalizes on the opportunities presented by globalization at local, national, and international levels.

As the role of the state has diminished, civil society has stepped forward to begin filling the void—often accomplishing the seemingly impossible with few or no resources. Whether this is a fair delegation of responsibilities is an important but different matter. No doubt the dialogue on this issue will continue, but responses are needed now, too, to preserve the various levels of human development already achieved.

In the complex global society in which we live, where "no one knows everything, but everyone knows something," broad and diverse participation is a necessary condition for positive and effective organization. Civil society as well as public institutions all over the world must practice coordinated solidarity through networking and ongoing communication. Awareness of each other's activities is not enough; we must now infuse our work with each other's strategies and goals. We must also build on and integrate our work with those historically powerful social movements whose effects continue to be felt through public awareness and the political will to support human development, such as the Health for All movement and the global recognition of Human Rights.

Civil society has taken many lessons from the limitations of state responses. Strict sectoral approaches to health and other social issues, in which the issue is conceptually, organizationally, and financially isolated, cannot fully succeed because the issues themselves do not operate in isolation. The efforts and effects of groups working in different areas of development are interconnected. Consequently, we must use multisectoral approaches while remaining mindful of the effects of our work on other sectors.

Civil society organizations are creating such intersectoral strategies for social development and providing models for professional character, flexible organization, the ability to synthesize information, continuous learning and capacity building, and enduring commitment to human development. Further, civil society must not only be active as a provider of services formerly administered by the state, but also remain mindful of its role as a representative of the People.

Good governance and governability are imperative, regardless of the present or future role of the State in relation to social services, if we expect each citizen to be treated as a valued member of society. The NGOs of the future will play an important role in the development of good governance and governability by promoting State accountability, transparency, dialogue, and responsiveness. As they mature, many NGOs are finding themselves in a position to support the State through capacity building, research, and information dissemination.

Despite the progress of NGOs in recent years and their increasing potential to support human development, NGOs need cooperation from other organizations in society. Universities and Intergovernmental organizations, for instance, not only have the various resources, infrastructure, and international relationships to support the work of civil society, but, as public service institutions, they also have a duty to do so. UTMB, PAHO, and WHO recognize the important contributions civil society can make to responsible leadership, and are beginning to coordinate work projects with them and establish ongoing dialogue and collaboration. Hopefully, these activities will not only contribute to the work of such organizations, but also will provide them new opportunities to benefit from other intergovernmental and governmental institutions as well as strengthen institutional cultures which respect and value these organizations' contributions.

GALVESTON DECLARATION ON HEALTH & HUMAN DEVELOPMENT IN THE AMERICAS

We, the participants in the Seminar/Workshop on: ***Health and Human Development in the New Global Economy: Experiences, Opportunities and Risks in the Americas***, (October 26th to 28th, 1998), jointly sponsored by the University of Texas Medical Branch-WHO Collaborating Center for International Health and the Pan American Health Organization/World Health Organization (PAHO/WHO): to examine the impact of the processes of economic globalization and inter alia technological changes on health development in the Americas, and to consider mechanisms by which groups from 'civil society' could influence the formulation of healthy public policies; and monitor equity in both health status and the distribution of health care resources;

Coming together from Non-Governmental Organizations and Universities from the United States, Canada, and many countries of Latin America and the Caribbean;

Sharing information and experiences about the current health and social situation, at local, national, regional and global levels; contemporary opportunities and inequities; ideas and aspirations for future improvement, reformation and fundamental change;

Recognizing that political, economic, technological and cultural processes of globalization, at the dawn of the Twenty First Century, are reshaping human interactions on all continents, by presenting new challenges and opportunities;

Acknowledging the manifold benefits of globalization, in increasing interdependent relationships among peoples, economic activity, and the spread of democratic governance; and the consequential encouragement of governments, inter-governmental and non-governmental organizations alike: to deepen their shared commitments to peace, prosperity and equity in human affairs;

Believing nevertheless, that the processes of globalization do contribute to widening inequities both between and within countries; and are having profoundly adverse impacts on, and posing formidable threats to, the health of peoples all over this hemisphere and indeed throughout the world, but especially in poor developing nations;

Believing also, that as we approach the new millennium, the complex dynamic between globalization and human health is deserving of urgent attention by governments, inter-governmental organizations as well as by groups in the civil society of all our countries;

Recognizing that the human right to health is enshrined in international law through various international instruments, and through the Constitution of the World Health Organization;

Agreeing that in this era of globalization, formulation and implementation of healthy public policies demands a reaffirmation and elaboration of this human right to health;

Believing that local, national, regional and international non-governmental organizations have a critical role to play in such reaffirmation and elaboration, through coordinated efforts to ensure that due recognition is given to the right to health both in the framing of policies and in the practices, equally of governments, inter-governmental organizations, and transnational corporations;

Agreeing that as an essential strategy in the promotion of human development in this era of globalization, we must deepen understanding for health as a human right and insist on strict adherence to the human right to health and to all related international norms;

I. Hereby declare our firm commitment to:

A. Work individually and collectively to raise levels of public concern for health at local, national, regional and global levels.

B. Create and strengthen existing effective networks among groups in civil Society at local, regional and global levels: to promote the adoption and maintenance of healthy public policies; and to concretize the human right to health in decisions affecting human development.

C. Cooperate with international organizations and governments in the monitoring of care resources their policies and practices in so far as the impact on the equity of both health status and the distribution of health; and in ensuring that the right to human health becomes central to all developmental public policies.

D. Enter into alliances with all civil society groups whose work in the areas such as human rights, labor standards and the protection of the environment is relevant to the promotion of human health.

II. Hereby request the University of Texas Medical Branch (UTMB)-WHO Collaborating Center for International Health in Galveston, Texas, to serve as the Coordinating institution: to enable us to fulfill our declared commitments.

Done October 28th 1998,
at Galveston, Texas.