

Globalisation and health

by Steve Fouch

Treating the world as one huge marketplace brings new opportunities for sharing ideas and technologies, experiencing different cultures, and developing highly efficient modes of production. But anti-globalisation rallies show that not everyone is pleased. Globalisation can increase the gulf between rich and poor and is currently producing a world where an increasing number of people live in absolute poverty. And poor people all too often have ill health. This file assesses the health impact of economic globalisation.

Globalisation is based on the idea of free trade between nations. It has crept into our language just as rapidly as it has affected our lives. Just look at what we wear, eat and use. Fashion clothing comes from countries like Mauritius or Pakistan; tea from Kenya or Sri Lanka; bananas from the Windward Islands. Your watch could have been made in Japan or Hong Kong. Phone a call-centre help-line and it is increasingly likely to be answered in India.

The world is effectively right on our doorstep. You can travel by train from London to Paris in less than three hours, or take a plane and be in Australia within 24 hours. You can write a document and have it on a colleague's desk anywhere in the world in a matter of seconds.

This choice and ease of access, however, is only available if you can afford it. Those who are rich stand to reap the benefits of globalisation and gain more wealth, while the poor just fall further behind. Indeed, poorer people in rich countries are starting to suffer as unskilled and semi-skilled jobs are moved to countries where people work in bad conditions for poverty wages.

Part of the cause of this imbalance is the structure of so-called 'free trade'. Through the World Trade Organisation (WTO), International Monetary Fund (IMF) and World Bank, Western industrialised nations have encouraged

developing countries to remove import tariffs on goods and allow foreign industries to compete with domestic ones on equal terms. In theory everyone trades on the same footing.

In practice this seldom occurs. For instance, in 2001 Mali opened its cotton industry to free trade, but that industry is now dying. This is mainly because the United States subsidises its own large but expensive cotton industry. American farmers claim payments so they can meet the high standards of health and safety that they are required to keep. But the subsidies are so generous that they can ship their cotton to Mali and still sell it cheaper than Malians can produce it. This pattern is repeated throughout the developing world, where the USA and European Union have created unequal competition with poor nations.^{1,2,3}

The consequence is greater poverty. Those who rely on local production for export abandon their farms and find work in the cities. Their country then loses out on tax revenues, and cannot put as much money into its health and social infrastructure. These health and education cuts are then further compounded by the amount of money developing countries have to give in debt repayments to Western governments and financial institutions.⁴ The poor then live malnourished in

squalid shantytowns and inner city slums that breed disease.

In about 100 countries, incomes are lower in real terms than ten years ago, so that around 1.3 billion people live in grinding poverty with incomes less than one US dollar per day. This is despite a 100% growth in the world economy over the 25 years between 1973 and 1998.

How we trade affects the health and wellbeing of literally billions of people.

Poverty and ill health

The forces that shape poverty and health are complex, and in a globalised world they touch us all. Jesus' comment that there will always be poor people,⁵ was not just a statement of fact, but also an indictment. Globalisation means that not only are the opportunities immediately on our doorstep, but so are the responsibilities. While there are poor people, the rich have a duty of care.⁶

Although poverty was horrifying in the first century, the scale has now grown beyond all imagining. Of the 4.4 billion people living in developing countries, three-fifths lack sanitation, one third have no access to clean water, one fifth have no form of healthcare or enough dietary energy or protein,⁷ and

the number of undernourished people is climbing by 5 million a year.⁸

The WHO's 1995 annual report states that poverty was the main reason why babies weren't vaccinated, children caught dysentery from infected water, and people could not get drugs and other treatments.

Solving the problem is not simple. According to the International Poverty and Health Network just making a country richer does not automatically improve everyone's health. Improving the average wealth of a nation may widen inequalities, with the rich getting healthier, and the poor getting less healthy.⁹ This is because new wealth tends to go to the 'better-off', and newly improved healthcare services often become more costly.¹⁰

Furthermore, new wealth is often created at areas of rapid industrialisation where controls are lax, and the new factories cause a rise in industrially related illnesses.¹¹ This can be seen in places like China or the sweatshop factories of the Philippines and Vietnam. There is ample evidence that the industrialisation of the developing world is leading to economic growth, but at the cost of people's health.¹²

On top of this, governments seldom allocate health resources equitably because those with wealth or education have power can demand what they need. Consequently, while most countries allocate about 30% of their public expenditure to health and education, this is normally weighted towards the rich. For instance, in India the richest

20% receives three times the subsidy in curative healthcare than the poorest 20%, and while 60% of all Moroccans have access to clean water, this applies to only 11% of the poorest fifth.¹³

That said, increasing income can improve things like life expectancy and under-five mortality. A wealthy nation can have better health facilities, allowing more people to access healthcare. Wealthier people can also eat better, live in better housing with clean water and sanitation, and can pay for healthcare, either directly or through taxation.

So, which comes first, health or wealth? Should policies aim to improve health so that wealth may follow, or improve wealth so that people can afford good health? Former head of the WHO Gro Harlem Brundtland argued that health creates wealth, and not visa versa. As people's health improves, so does their ability to earn a living, and the cost of medical bills falls. The nation as well as the individual benefits as good health reduces the economic burden of an overstretched health system and a large unproductive population. A report by the Commission for Macroeconomics and Health (CMH) suggests that if the basic health inequalities in the poorest nations of the world were met, over £113 billion per annum could be added to the global economy and the resultant economic uplift could take many nations out of poverty.¹⁴ Moreover, eight million lives would be saved each year.

The CMH calculates that this could be achieved if the developed nations gave a total of £19.4 billion per annum,

and the developing nations increased their spending on health by £27.4 billion. These are not unreasonable sums of money. Just consider that in November 2003 the US mobilised an additional \$87 billion (£53 billion) to fund the reconstruction and on-going military intervention in Iraq. This came on top of an initial outlay of \$71 billion for the first phase of the war.

The missing ingredient is not the ability to pay, but political willpower from not only developed nations,^{15,16} but also developing nations,^{17,18} where widespread corruption and the promotion of self-interest by political elites in some nations have perpetuated poverty. Nobel Prize winner Amartya Sen claims that there has never been a famine in a country that has a free press. He says that because democratic governments rely on popular support they cannot afford to ignore hungry people, and a free press will bring corruption and food shortfalls to the attention of government officials and the public.

All the same, recovering from a poor situation can be hard, because the lack of sound infrastructure can undermine even the best funded and intentioned healthcare initiatives.¹⁹

Alongside this, globalisation has introduced new challenges. Rapid movement of peoples searching for jobs in a world where multinationals move factories from country to country like pieces on a game board, means that there is a constant global flow of millions of workers. These vast, mobile populations are both vulnerable to disease and poverty, and also can be vectors for transmitting disease.

But did you know that:

- In sub-Saharan Africa, improvements in health have reversed in the past two decades.²⁰ Average life expectancy is only 51 years, and the incidences of malaria and TB are increasing.²¹
- In parts of central, southern and eastern Africa 30-40% of pregnant women are now HIV positive.²²
- Of the 50 million deaths occurring annually in the world, about 15 million are children under the age of five years.
- World-wide, four million children die every year from acute diarrhoea and four million from respiratory infections, both treatable conditions.
- Three million children per year die from the immunisable infections poliomyelitis, tetanus, measles, diphtheria, pertussis and tuberculosis.²³
- 529,000 pregnant women died in 2000 (one a minute), most during unsafe delivery. African women are 175 times more likely to die in childbirth than women in developed regions of the world.²⁴

The healthcare brain drain

This trans-global human traffic impacts health when those moving are trained healthcare workers. A mass exodus of staff from developing countries to the West has left many developing nations so short of healthcare staff that their hospitals can barely function.²⁵

Once again, the poor's loss is the rich's gain. For example, about 24% of

Further action and information

There is a range of organisations that address issues of globalisation, debt, poverty and health at both the hands-on and the advocacy/campaigning level. Here are three that may be worth looking into or getting involved with.

Tear Fund: funds relief, development, healthcare and carried out some campaigning work around Fair Trade. www.tearfund.org.uk

The World Development Movement: a purely campaigning organisation, focussing on changing UK and EU governmental policies and international institutions (especially the International Monetary Fund (IMF), World Bank and WTO). www.wdm.org.uk

Doctors Without Borders: Access to Essential Medicines Campaign advocating for changes to international rules allowing greater access to essential treatment by the poor, and encouraging research and development into treatments for the diseases of the developing world. www.accessmed-msf.org

doctors in the NHS were trained abroad, while the Zambian health service has lost 550 of the 600 doctors it has trained since independence in 1964. The doctor to population ratio in Uganda is 1:24,000,²⁶ in comparison with about 1:700 in England. Nurses in the Philippines are even training to work overseas and never practise in their own country. As a consequence some Filipino hospitals are functioning with one trained staff nurse to fifty patients, while in the UK it is more like one to ten.

Furthermore, doctors, dentists, and other health professionals are now re-training as nurses to get work overseas that can pay ten to twenty times as much as salaries in the Philippines.²⁷

India is facing a growing shortage of doctors, again because many are leaving to work in the UK, the USA and Canada. The UK claims to run an ethical recruitment policy as regards skilled medics, but there is plenty of evidence that active recruitment goes on.²⁸

Almost 13,000 overseas nurses were registered in the UK in 2002. Over 40 per cent were from the Philippines and 14 per cent from India. A further 804 came from the European Union. Between 1997 and 2002, Britain took 6,739 nurses from South Africa, causing Nelson Mandela to appeal to Britain to stop poaching South African doctors and nurses. As a result, the Department of Health urged NHS trusts to cease actively recruiting in South Africa but did not formally ban the practice until 1999. That ban included the Caribbean nations, which had lodged similar protests,²⁹ and while NHS trusts are covered by this ban,

private health providers continue to use this source of ready-trained labour.

It is not just recruitment to the West that is the problem. Many doctors and nurses in developing countries work in urban and private practice. This leaves rural and public hospitals desperately short of staff, while those who can afford private fees have no shortage of health professionals to call upon.

There are potential solutions to this problem. Active links between medical schools across the economic divide could allow exchange without financial penalty.³⁰ Alternatively, developed countries that recruit doctors from developing nations could pay compensation for each doctor lost. The government could simply try harder to learn from other countries about making the NHS more efficient.³¹

Countries that benefit most from a globalised medical workforce should frame their own workforce policy in a manner that reflects global, not merely domestic, need.

Drug production favours the rich

As well as the so-called 'brain drain' the global economic arrangements limit poor people's access to essential medicines, especially for the 'three big killers' of AIDS, TB and malaria.

The WTO agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) ensures that pharmaceutical companies are protected

globally for a minimum of 20 years after they are patented. Because of the time it takes to get approval for use, this can mean that companies have only a decade of protected time to recoup the millions of dollars spent on research and development. Unfortunately it also means that over this decade the drugs are often too expensive for the world's poorest people.

There are potential solutions to this problem. A recent WTO agreement has sought to ensure that poor nations can import cheaper generic copies of life saving drugs in emergency situations - although what constitutes a life saving drug and an emergency is vague.³² Also, a few firms, in particular in Brazil and India, have made some of these drugs without licensing agreements, and sold them to developing nations at knock-down prices. In addition, the Canadian government has allowed its drug firms to sell generic versions of HIV antiretrovirals to poor nations under this agreement^{33,34} and many of the transnational pharmaceutical companies have started supplying their own drugs at cost to developing nations.³⁵

However, such apparent successes have not tackled the chronic under-investment in creating drugs primarily for people in the developing world (eg. treatments for common tropical diseases such as sleeping sickness, Leishmaniasis or Chaga's disease). Pharmaceutical companies focus their investment in drugs that will be profitable, which in practice means those that treat primarily Western conditions.³⁶ It is more profitable to invest in drugs that correct heart disease or male sexual dysfunction, than control the current epidemic of drug resistant malaria.

Consequently many leading pharmaceutical companies spend less than 1% of their research and development budgets on the major illnesses of the developing world.³⁷

A time to act for the poor

The Bible gives a strong indication that Christians must not ignore poverty and

oppression. The Old Testament has a strong ethic of fairness and justice in trade and treatment of the poor. In Isaiah 58, the prophet says that God condemns people who observe religious practice but have no concern for the poor. He talks of the need to free people from injustice and oppression and to share food, accommodation and clothing with those in need.

Likewise, other Old Testament prophets condemned the rich who oppressed the poor and needy in their midst³⁸ or who simply lived in prosperous ease and ignored them.³⁹ In the New Testament the apostles' concern for the poor is evident throughout⁴⁰ and James too speaks out against favouring the rich over the poor, or sitting back while others suffer.⁴¹

Jesus taught more about the right use of money than he did about prayer and concern for the poor was always at the heart of it.⁴² The apostle Paul urges us to follow Jesus' personal example in that 'though he was rich, yet for [our] sakes he became poor, so that [we] through his poverty might become rich'.⁴³ Indeed the Bible frequently comes back to the point that we cannot sit by and let others suffer while we have plenty - our material blessings from God are for the benefit of others, not just for ourselves, and we dishonour God when we hoard them.

Christians should lead the way in learning to do good, seeking justice, rescuing the oppressed and working to change oppressive systems.^{44,45} The Bible is clear that acting justly takes us in at least two complimentary directions. Firstly *to do* what is right (feed, clothe, shelter, heal, bring Good News, etc), and

secondly *to speak up* for what is right.

A Christian response to the issue of Globalisation and health must therefore be firstly to care for the needy, through Christian mission and development projects either working ourselves as health professionals, or supporting others who already do so, and secondly to engage with advocacy and activism to redress the policies and practices of companies, governments and international bodies that create conditions that cause inequality.

Sadly, some Christians see issues like trade and IMF economic policies as irrelevant, but they have a huge impact on the poor and should be matters of deep concern to us.

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