Managing globalisation for health

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Dr. Olive Shisana
CEO and President, Human Science Research Council designate (August 1 2005)

Abstract

The increasingly interdependent world poses severe challenges to communities around the world. The high density of the population leads diseases to spread much faster than ever before. While communities are physically separated by seas, roads, mountains or rivers, they have become too close and interdependent because of efficient transport, communication and trade systems that allow pathogens to travel and infect people much more easily than ever before, thus allowing for globalisation of infectious diseases. Globalisation has also made it easier for the increase in non-communicable diseases. Efforts are underway to manage these through the establishment of global goals, drawing of international health regulations, negotiation of international agreements, financing of health services, and reducing determinants of health. Although globalisation brings with it major challenges, it also permits the global community to manage its impact for the benefit of health. Only when global players work closely with member countries can the negative effects of globalisation be managed and the health of people improved.

In 1997 I stood before some of you in Jakarta and spoke on global health trends and health potential, focusing on successes we had achieved by the middle of the 20th century and challenges to the global community. I argued that significant advances had been made in health: life expectancy had increased, infant mortality had dropped, smallpox was eradicated, the standard of living had improved, but that there were between and within regional and country disparities in access to the proven technologies for improving health. I also presented some of the global health challenges such as the ageing population, the emergence and re-emergence of infectious diseases such as HIV/AIDS, TB, malaria and Ebola, and the increase in use of substances such as tobacco and drugs. I concluded by arguing for including health promotion within the paradigm of primary health care, and urged health promoters to be advocates for world peace, to rid the world of poverty, to support health sector reform to create supportive environments for people to be healthy, and to get ready for the next millennium and enter it with appropriate policies, programmes and plans of action.

Here we are in Bangkok now facing the challenges of the 21st century, which have their roots in the last two decades of the 20th century. Many of the successes we celebrated in Jakarta are now being reversed. Life expectancy in developing countries, which was 63, has now declined to the 40’s. Infant mortality is now on the increase because of AIDS. Smallpox has been eradicated, but as the world was about to destroy the remaining vaccines, the potential for its use in attacks against states suggested that it is possible for the disease to re-emerge. Disparities have increased; standards of living for the poor have fallen, with nearly a billion people living in slums, mostly in the developing countries, notably Africa.
At invitation of WHO, again, I am back, but now to speak on the subject of managing globalisation for health. The draft Bangkok Charter alludes to major challenges such as globalisation, environmental changes, urbanisation, political and demographic transitions, new and emerging and re-emerging diseases and advances in medical science and information technology. These challenges, though global, have local impact on the health of populations. What is exciting is that attempts are being made globally to tackle these challenges and mitigate their impact. This paper presents some of the challenges globalisation has brought to health and also the opportunities that it brings to provide better health for many.

Globalisation

Although globalisation began at least as early as the 14th century when the Mandigo king of Mali sailed to the America prior to the arrival of Christopher Columbus in the 15th century (Van Sertima, 1976), it has been accelerated because of trade between countries, efficient transportation of goods and services, and information technology (Chen and Narasimhan, 2003).

The increasingly interdependent world poses severe challenges to communities around the world. With six billion people in the world diseases spread much faster than ever before. While communities are physically separated by seas, roads, mountains or rivers, they have become too close and interdependent because of efficient transport, communication and trade systems that allow pathogens to travel and infect people much more easily than ever before; this is termed globalisation of infectious diseases.

Globalisation of infectious diseases is possible partly because of massive human movement across borders. In 2002, more than 700 million international tourist arrivals were registered (World Tourism Organisation, 2002) In the US alone, 400 million international tourists arrived by air, sea and road in the same year (Wilson, 2003). Such large numbers of people arriving in a country within such a short space of time brings with it cultural and social change, as well as multiple opportunities to introduce new and old pathogens. Examples in history of globalisation of infectious disease, which led to decimation of populations as a result of the arrival of human beings who brought with them diseases which local people had no immunity to, are abundant. The extinction of the one million Taino people due to small pox that was associated with the arrival of colonialists such as Christopher Columbus in the Caribbean Island of Hispaniola; the devastation from small pox of the Aztec and Inca kingdoms of Mainland South and Central America, reducing the population from 25.2 million in 1518 to 1.1 million in 1605 (Barnet and Whiteside, 2002). In all between 25 million and 50 million people died of small pox resulting from human travel; or the “Spanish Flu” epidemic that killed 60% of the population of Nome, Alaska and also 80-90% of the Samoan population; the spread of plague from Asia to Europe leaving death and destruction; or small pox and TB spread from Europe to Africa leaving shrunken populations are all examples that clearly demonstrate that globalisation, if not managed properly, can bring with it death and destruction of significant parts of populations. This is further discussed below.

New and emerging diseases
Towards the end of the last century there was a resurgence of infectious diseases in developed and developing countries. More than two dozen viruses or bacterial diseases emerged and those diseases resistant to antibiotics have spread globally at alarming rates (Heymann, 2003). The diseases that are likely to spread globally are HIV, Avian influenza (spread to humans), dengue, hepatitis C, variant of the mad cow disease, West Nile Virus (Wilson, 2003), SARS, herpes simplex, other sexually transmitted infections and hepatitis B. The HIV/AIDS epidemic is one major example of a disease that has engulfed the globe in less than two decades, though at varying speeds per region. Cholera has spread in Peru and Latin America, plague in India, dengue fever in Asia, Ebola virus in Africa, West Nile fever in the USA, mad cow disease in Britain, TB in many parts of Africa and SARS in Asia. Developed and developing countries are all affected by the spread of these communicable diseases. Some of these diseases are spreading because of the ease of transport of people, goods and services across countries. The dengue fever-carrying mosquito has found its way to the Americas; SARS has found its way to as far as Canada; while HIV has spread across the globe leaving 20 million deaths, and 38 million people still living with the disease. Today HIV/AIDS is a threat to human security, reduces human development and affects the economy (Shisana, Zungu-Dirwayi and Shisana, 2003). These are the effects of globalisation. But the world is not standing by idly and watching the impact of globalisation of infectious diseases.

Efforts are underway to manage globalisation of infectious diseases through the establishment of global goals, drawing of international health regulations, negotiation of international agreements and financing of health services, and improving determinants of health.

The global community decided to unite in their efforts to tackle globalisation of infectious diseases. Under the leadership of the United Nations and its agencies, such as UNAIDS, WHO, UNICEF, UNFPA and UN-Habitat, 191 member countries of the United Nations pledged to attain eight Millennium Development Goals (MDGs) by 2015. Five of these goals are in the health area; they are reducing child mortality, improving maternal health, reversing the spread of HIV/AIDS and malaria, and ensuring sustainable environmental health. They also address those determinants of health such as reducing the proportion of people without sustainable safe drinking water, and improving the lives of at least 100 million slum dwellers. To ensure that these goals are implemented, the member states pledged to establish a global partnership for development with the objective of developing further “an open trading and financial system that is rule-based, predictable and non-discriminatory” that includes a “commitment to good governance, development and poverty reduction - nationally and internationally” (UN Millennium Development Goals). While these efforts are laudable, very few resources have flown from the North to the South countries, nor within the South countries, to help attain these goals. Most of the donor countries have not increased their donor contribution to 0.7% of their GDP to assist needy countries of the South, and many countries in the South do not contribute their share of spending to reduce poverty and improve education, health and social development, opting instead to spend on arms. Hence the MDGs are unlikely to be attained. The recent decision of G8 to scrap the debt of very poor countries and reroute the dividends to priority health problems will go a long way to releasing funds for the South governments to use to attain these MDGs, but only if all countries who
are owed do not “make it more difficult for 18 of the world's poorest countries to be granted 100% debt relief” (Watt, 2004, p1). Debt relief, coupled with the existence of the Global Fund for HIV/AIDS, TB and Malaria, the Global Alliance for Vaccines and Immunization, with contributions from public and private sources, such as mega-private foundations like the Bill and Melinda Gates Foundation, are excellent sources of income aiming to manage globalisation of communicable diseases.

Another attempt to curb the continued globalisation of infectious diseases is the development of international regulations, such as those recently amended at the World Health Assembly; allowing for the listing of notifiable communicable diseases without interfering with trade and travel. WHO has also taken a decision to dispatch its staff to countries experiencing epidemics without the approval of countries; an action prompted by accusations that some of the countries were hiding information on the spread of SARS for fear of deterring tourists (Store, Welch and Chen, 2003). This strategy has been successful because the member countries were part of making the decisions reached at the World Health Assembly. In cases where WHO did not adequately consult member countries, few have implemented the international goals. A clear example is that of the 3 X 5 initiative aiming to provide 3 million people living with HIV/AIDS antiretroviral therapy by 2005. This was rejected by countries such as South Africa, who argued that they were not consulted when the goal was set up, and most donor countries did not contribute funds to ensure that the goal was achieved, forcing WHO to publicly acknowledge that the 3X5 goal would not be attained.

The effects of global environmental changes

Global environmental change has an impact on the health of populations, not only where the source of environmental pollution is located but several thousand kilometres away. However, it is important to indicate that the evidence in this area of the debate is not as crisp as that evident in the globalisation of infectious diseases. It is also fraught with controversy in interpretation of the evidence and hence in reaching agreement among countries and subsequent implementation. What is clear is that those activities that contribute to global climate changes and ozone depletion originate largely from outside of many of the developing countries. For example, only about 2% of global carbon emissions originate out of the African, Pacific and Caribbean countries (McGranahan, et al, 1999) and yet stratospheric ozone damage could increase to 11% at the mid-South latitudes, which would significantly increase exposure to harmful ultraviolet radiation, which in turn is associated with skin cancer, eye problems (cataracts), and probably immune system suppression (cited in McGranahan, et al., 1999).

The effects of global warming are probably not going to be uniform across regions. Predictions of the greenhouse effects such as melting of polar ice caps, severe storms, flooding of coastlines leading to possible submersion of a third of the world’s population are of concern (in Bond, 2003).

The human induced greenhouse effect emanates from a number of sources such as the burning of fossil fuels (industrial and automobile) and solid waste which emit carbon dioxide and methane; municipal landfills which produce methane; and the production of foams, refrigeration and airconditioning, which emit chlorofluorocarbons.
Individuals can do a lot to reduce the emissions. Changes in life style and consequent reduction in purchase and use of the goods that produce these gases that harm the environment are likely to be more effective than getting some governments to agree to regulate the private sector’s production of these gases. The next example is evidence that governments are at times reluctant global partners in managing the global health.

The world community has taken note of the potential damage that may emerge from human activity that may lead to the greenhouse effect by getting agreement on the Kyoto Protocol, which aims to reduce emissions of six greenhouse gases. But such agreements are often not so easy to implement. Although more than 170 countries have signed the treaty, some of the main countries responsible for the greatest amount of total carbon dioxide emissions in 1990 have not yet ratified the agreement. Although the agreement called for 55 countries that contributed 55% of the total carbon dioxide emissions in 1990 to ratify the Kyoto Protocol, the US, which contributed 36.1% of the pollution in 2001, is still unwilling to ratify the protocol. For any agreement to be effective it is crucial that countries be united in its implementation. This is one example where the critical global players refuse to act to prevent pollution that is produced locally but has global impact. The decision of the European Union to relax the targets for emission as a means of getting the support of highly industrialised countries was taken in an effort to encourage reluctant greenhouse gas emitters to ratify the agreement. It is critical that international agreements aiming to reduce the adverse effects on health are binding. The Kyoto Protocol is not binding, as there are no consequences for non-compliance. The only hope, we are told is when every citizen takes action to add his/her part in changing lifestyle and reducing the emission of greenhouse gases (Bond, 2003).

A good example of global health management that has an impact on non-communicable diseases is the first international health treaty, the Convention of Tobacco Control of 2003. Tobacco consumption is now a huge problem in developing countries. For far too many years the Tobacco companies had a right to advertise and recruit new smokers, including children. The global community decided to act to prevent this. Under the Convention countries can now restrict tobacco advertisement, prevent smuggling of tobacco products and prevent indoor pollution. Because this Convention was negotiated with countries through the World Health Assembly that involved those responsible for ratifying it, it was no surprise that 40 countries ratified it within the first week open for signature, causing the Convention to come into full force (Store, Welch and Chen, 2003). This is evidence that countries can stand together, under the leadership of WHO, a global player, and take global decisions with local implications.

Globalisation can be beneficial in increasing access to food. Many countries export food to those countries which, for a variety of reasons such as poor economies and drought, are unable to produce sufficient quantities for domestic consumption or even for those who import foods to add variety. With the importation of food, local inhabitants inadvertently acquire new risks. The imported foods may be overly processed, contain processed sugars; be high in fat content, and their consumption might contribute to development of chronic diseases of life style.

The trade policies that facilitate the establishment of fast foods, which are usually fatty, have enabled people to acquire new unhealthy tastes, especially among children.
This has led to changes in dietary habits. Instead of children eating low fat food with high fibre, many are eating over processed foods. With a combination of access to television and programmes that advertise these foods (such as McDonalds), children in developing countries are now becoming as obese as those in developed countries. They eventually begin to suffer from the same life style-related diseases, such as diabetes, cancers, hypertension and heart diseases; this comes on top of diseases related to poverty, such as diarrhoea, acute lower respiratory diseases, malaria, TB, HIV, and cholera. The double burden of communicable and non-communicable diseases is a threat to provision of public health services in developing countries, which barely afford to provide even basic care. But this is not limited to developing countries.

At the time of our meeting in 1997 the industrialised countries experienced diseases related to life style, such as hypertension, heart disease, cancer, diabetes and strokes, while developing countries were experiencing poverty-related diseases such as infectious diseases, malnutrition and maternal-related diseases. The world has changed dramatically. People in industrialised countries are now affected by both non-communicable degenerative diseases and communicable diseases. The poor and middle-income populations are affected by similar diseases. For the first time in the history of the United States, HIV/AIDS has surpassed the one million mark; new HIV infections are occurring in minority populations and, with the advent of antiretroviral therapy, people are living longer, suggesting that the pool of infected people is increasing. As this infected population ages, it is susceptible to non-communicable diseases such as hypertension, diabetes, strokes and cancers. These pose major public health challenges in the training of staff, cost of health care, and need for development of treatments for communicable diseases that are administered to those with non-communicable diseases.

Political and demographic transitions

The population continues to grow rapidly; with more than six billion people occupying this planet. Major changes have occurred in age distribution of populations; many of those resulting from changes in birth and death rates, which in turn are affected by standards of living. While birth and death rates have fallen in Europe, resulting in ageing populations, “six mega countries, India, China, Pakistan, Nigeria, Bangladesh and Indonesia continue to account for half the global growth of 77 million persons annually” (cited in Wilson, 2003). Industrialised countries of Europe and the United States have resorted to importing populations from developing countries as a means of increasing labour supply. Human beings cross these borders carrying pathogens and behavioural patterns that spread or promote diseases from their countries of origin to the new home countries and vice versa. It is now possible to find developing countries to train their staff in specific areas and send them to other countries to earn money and send remittances to their home countries. Examples are Cuba, which trains doctors, or the Philippines training nurses to work outside and generate foreign exchange for the country. In other countries it is more common to find much-needed health workers migrating for work purposes to developed countries; for example South Africa loses too many nurses to the UK, USA, Saudi Arabia and New Zealand; it loses doctors to Canada, UK, and dentists to the UK; while Nigeria has lost more than 21 000 doctors to the USA, leaving many Nigerians with inadequate access to medical practitioners and specialists. Another challenge is
that health professionals also migrate within the region, attracted usually by better salaries in neighbouring countries. Poorer countries experience severe shortages of health professionals, while middle-income countries are able to replace health professionals who have migrated with a pool from neighbouring countries.

Health ministers at the World Health Assembly and regional committee meetings of the World Health Organisation continue to attempt to find ways to reduce brain drain; but there are no easy answers. The political climate at home, unpleasant working conditions, poor economic environments and poor salaries are some of the factors that “push” health professionals from their countries. It would be wrong to bar health professionals from migrating to greener pastures because it is their human right to cross borders and seek better opportunities. The developed countries often give incentives that are hard to refuse as a means of attracting health professionals in developing countries. It is for this reason that the Ministers of Health in Africa have mandated the Switzerland-based International Office of Migration to register Africans in the diaspora. They are encouraged to be registered in the database so that they can be contacted to participate in a development project in their country of origin (International Office of Migration).

Advances in medical sciences and information technology

Globalisation has not only brought challenges, it has also created opportunities. Scientists are now able to work together in person or through telemedicine or email to find treatments or cures for diseases. The advent of internet has accelerated access to scientific information. Electronic journals are now available to scientists across the globe; they now are able to use evidence-based medicine to diagnose, treat and rehabilitate their patients.

Globalisation has also contributed to the discovery of medicines to treat diseases. The pharmaceutical industries produce drugs needed by the poor, but which the poor cannot afford to purchase. The Trade Related Aspects of Intellectual Property Rights gave the pharmaceutical companies the right to hold on to patents for 20 years to recoup their research and development investment before generics could be produced. Indeed the profits were quite substantial. A report produced by a consumer watchdog, the Public Citizen in the USA, showed that the ten most profitable drug companies increased their profits by $4.8 billion or 20% from 1998 to 1999. These profits exceeded the profits of other Fortune 500 industries such as auto, oil, securities and airlines. Despite the reduction in prices and donations made for poor people to access these drugs, they are still unaffordable to many. The cost of ARV treatment at reduced price is around $200 annually, which is beyond the means of many who live on $1 per day. It is no surprise that only 7% of the people who need ARV have been able to access it.

With the globalisation of infectious diseases such as HIV/AIDS, it is critical that people have access to medicines at affordable costs. The patents remain an obstacle that the World Trade Organisation’s TRIPS agreement imposes on developed and developing countries to produce generic copies of the branded products. With access to technology, developing countries and NGOs no longer leave the interpretation of such global agreements as TRIPS to highly industrialised countries. The 1998 debate on the Revised Drug Strategy resolution, centering around the primacy of public
health over commercial interests, was led by southern African countries, who with the support of NGOs were able to educate the member countries and the world about the importance of the TRIPS agreement in accessing medicines. It was no surprise that at the following World Health Assembly member countries unanimously supported the Revised Drug Strategy. However, because the TRIPS agreement is negotiated at the WTO and not WHO, the health concerns do not take priority over commercial interest. But countries are still not taking advantage of the flexibility of the TRIPS agreement. Governments are allowed to authorise a third party to use the patent without the permission of the owner of the patent or without a license as long as the patent owner is paid adequate compensation. The TRIPS agreement does permit countries to establish administrative means to allow for production or importation of generic products from the competitive sector (Love, 2001).

Conclusion

New and emerging diseases are spreading globally at alarming rates. Mostly in developing countries, notably in Africa, standards of living for the poor have fallen and disparities increased. Although globalisation brings with it major challenges, it also permits the global community to manage its impact for the benefit of health. Only when global players work closely with member countries can the negative effects of globalisation be managed. It is crucial that the member countries who are to implement these agreements be thoroughly informed of the implications of the policy guidelines or agreements that are to be taken so that they can be partners, more so- equal partners. Further, affected member states of the South have to be involved from the beginning and partake in all discussions and brainstorming meetings that generate these global policies and agreements. To further improve the acceptance and, subsequently, the implementation of global strategies (eg. 3 by 5 initiative), these countries of the South will then become “from recipients of information to active designers of solutions’.

REFERENCES


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Dr Olive Shisana
President and CEO, Human Science Research Council

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Social science that makes a difference
Introduction

- 20th century successes in developing countries are now being reversed:
  - Life expectancy declining from 63 to 40’s.
  - Infant mortality on increase due to AIDS.
  - Small pox eradicated, but potential for use in attacks suggests possible re-emergence.
  - Disparities have increased:
    - standards of living for the poor have fallen-nearly a billion live in slums
    - Developing countries, notably Africa, hardest hit.
Globalisation of infectious diseases

- Globalisation has accelerated due to:
  - Multicountry trade, efficient transportation and information technology
  - With 6 bil. people in the world, massive across-border movement, diseases spread faster than ever before.
- In Aztec and Inca kingdoms, Taino people etc, between 25 mil. & 50 mil. died of small pox resulting from human movement.
New and emerging diseases

• >24 new viruses or bacterial diseases towards the end 20th century

• Diseases likely to spread include HIV, Avian influenza, Dengue, Hepatitis C, Mad cow variant, West Nile Virus, SARS, Herpes simplex, other STIs and hepatitis B

• Cholera- Peru & Latin America; Plague- India; Dengue fever-Asia; Ebola virus and TB- Africa; West Nile fever-USA; Mad cow disease-Britain; SARS-Asia; and HIV/AIDS across the globe

• Developed and developing countries are all affected by these diseases
Efforts to manage globalisation of infectious diseases are underway through:

- the establishment of global goals
- drawing of international health regulations
- negotiation of international agreements and
- financing of health services, and improving determinants of health.
Millennium Development Goals (MDGs)

- 191 UN member countries pledged to attain eight MDGs by 2015.

- Five of these goals are in the health area;
  - reducing child mortality,
  - improving maternal health,
  - reversing HIV/AIDS and malaria,
  - ensuring sustainable environmental health,
  - addressing determinants of health such as
    - proportion of those without safe drinking water,
    - improving lives of at least 100 million slum dwellers.

- States pledged to establish “an open trading and financial system that is rule-based, predictable and non-discriminatory”
Attempts to achieve MDGs

- Few resources flown from North to South, nor within the South, to help attain MDGs.
- Most donor countries have not increased contribution to 0.7% of GDP to assist the South.
- Many countries in South do not contribute their share to reduce poverty, improve education, health and social development.
- Debt relief, the Global Fund for HIV/AIDS, TB and Malaria, the Global Alliance for Vaccines and Immunization, public & private sources aim to manage disease globalisation.
Attempts to achieve MDGs cont...

- The development of international regulations, listing of notifiable communicable diseases

- WHO staff dispatched to countries experiencing epidemics without the approval of countries - eg. SARS - (Store, Welch and Chen, 2003).

- Strategy successful because member countries part of decisions reached at the World Health Assembly.

- Where WHO did not consult adequately, few member countries have implemented the international goals.
The effects of global environmental changes

- Global environmental change impacts the health of populations
- Insufficient evidence, controversies in interpretation, has led to lack of effective solutions
- The non-uniformity of global warming
- The sources of the human induced greenhouse effect
- The failure of the Kyoto Protocol to reduce emissions of six greenhouse gases
- The success of the first international health treaty, the Convention of Tobacco Control of 2003
- Globalisation beneficial in increasing access to food.
The effects of global environmental changes - Cont...

- Trade policies facilitating the establishment of fast foods, have led to lifestyle-related diseases

- The double burden of communicable and non-communicable diseases a further threat to provision of public health services in developing countries

- The burden of non-communicable degenerative diseases, and communicable diseases in industrialised countries on the increase.
**Political and demographic transitions**

- Major changes in age distribution of populations
- Industrialised countries importing populations from developing countries to increase labour supply
- Human beings cross borders carrying pathogens and behavioural patterns that contribute to disease spread
- Developing countries such as Cuba & the Philippines, train doctors, nurses for export to generate foreign exchange
- The negative effects of “brain drain”. E.g. South Africa and Nigeria
- Initiatives from the Health ministers at the World Health Assembly, WHO and the Ministers of Health in Africa.
Advances in medical sciences and information technology

- Globalisation and advancing technology created new opportunities and mediums-telemedicine, internet, email

- Despite these, pharmaceutical industries still produce drugs that are unaffordable to the poor

- Patent rights prevent the production of cheaper alternatives- Trade Related Aspects of Intellectual Property Rights

- Reduced cost of ARV treatment around $200 annually, and beyond the means of many who live on $1 per day

- Only 7% of the people who need ARV have access to them.
Advances in medical sciences and information technology - cont..

- With the globalisation of infectious diseases such as HIV/AIDS, it is critical that people have access to medicines at affordable prices.

- With access to technology, developing countries and NGOs no longer leave the interpretation global agreements such as TRIPS to highly industrialised countries.

- But countries still not taking advantage of the flexibility of the TRIPS agreement.

- The TRIPS agreement, for example, permits countries to establish administrative means to allow for production or importation of generic products from the competitive sector (Love, 2001).
Conclusion

• New and emerging diseases are spreading globally at alarming rates.

• Mostly in developing countries and in Africa, standards of living for the poor have fallen, disparities increased.

• Although globalisation brings major challenges, it also permits opportunity to manage its impact for the benefit of health.

• Global players need to work closely with member countries to manage negative effects of globalisation

• Affected member states to be involved at all levels of discussions that generate global policies and agreements.

• To further improve acceptance and implementation of global strategies (eg. 3 by 5), countries need to move “from recipients of information to active designers of solutions”.

Social science that makes a difference