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THE IMPACT OF ECONOMIC GLOBALISATION ON HEALTH

ABSTRACT. The analysis of the impact of economic globalisation on health depends on how it is defined and should consider how it shapes both health and health policies. I first discuss the ways in which economic globalisation can and has been defined and then why it is important to analyse its impact both in terms of health and health policies. I then explore the ways in which economic globalisation influences health and health policies and how this relates to equity, social justice, and the role of values and social rights in societies. Finally, I argue that the process of economic globalisation provides a common challenge for all health systems across the globe and requires a broader debate on values, accountability, and policy approaches.

KEY WORDS: economic policy, ethics, globalisation, health, health policy, international organisations, trade

As the term 'globalisation' is often used loosely any analysis of the impact of economic globalisation needs to begin by clarifying what is implied by globalisation. Economic globalisation incorporates three processes at supranational levels that influence policies at national levels. Firstly, there is the mobility of capital, goods, services, and labour and the role of transnational actors, such as transnational corporations and nongovernmental organisations, in the international economy. The second process is that of global economic integration and the impact of global economic actors and legal agreements on nation states and their capacities to regulate the private sector and prices of goods. Economic globalisation thus also covers issues of regulation, rights, risks, and responsibilities. Thirdly, globalisation is part of an ideological process that justifies particular economic policies or forms of 'neoliberalism.' This ideology is geared towards economic liberalisation and shapes the ways in which both international and national organisations and actors influence the views and nature of national public policies in the name of globalisation. These three levels of our definition of globalisation aim to

cover the economic impacts and actors; the questions of rights, risks, and responsibilities (and how these are defined); and finally the relationship between particular economic and other policy priorities.

The first set of processes is the most commonly discussed and tends to dominate the discourse in the economic sphere, although quite frequently all three processes are seen as interlinked. The analysis of the social impact of globalisation has also gained new emphasis as reflected, for example, in the World Commission's work on the Social Dimension of Globalisation.[1] The debates on the benefits, costs, and importance of economic globalisation are argued mostly within the framework of the first set of processes.[2,3] The second set of processes relates more to debates on global governance and to the analysis of the impact of trade and investment agreements.[4–7] The third set of processes determines which particular economic policy approaches and priorities become important as part of domestic policymaking. [8,9] The three processes do not necessarily cover all aspects of economic globalisation, but identifying them helps in explicating different policy issues and mechanisms of influence. While it is possible to separate these economic globalisation processes, in practice very few analyses of globalisation focus exclusively on only one of them.[10–12]

The impact of economic globalisation is likely to differ between countries and regions, and reflect the orientation of national health policies within a particular country. National health policies and health outcomes have always been influenced by international and global developments. Examples include migration and trade and more recently the international health policies and programmes of the World Health Organisation (WHO), UNICEF, and international nongovernmental organisations. Epidemics have also always been a part of international debates; rarely respecting national boundaries. Thus, international influence cannot be limited merely to economic globalisation.

The impact on health and health outcomes must be distinguished from the impact on health policies. Health outcomes are important, but in the context of health systems, they cannot be the sole concern. Such an exclusive approach would undermine the role of health protection and the responsibility of health systems for the health security of citizens. Many health protection measures do not produce health outcomes directly, but their absence may result in increased risk of epidemics or illness. Health systems aim to cure illness, but they also provide care for those who cannot be cured and alleviate

suffering and pain. A focus on health outcomes may overstate factors important for people to stay healthy, but undermine factors that are important when people fall ill.

Health outcomes can be seen as the ultimate result of health policies. However, as health outcomes are determined by many social and policy factors that are beyond the reach of direct health policy measures, it is necessary to address health policies in their own right. Health policies depend on the nature and traditions of public policy within a country and on the extent to which public policy measures, equity, and cost-control mechanisms are considered health policy priorities. The impact of globalisation will therefore differ depending on national circumstances, regulatory aims, and capacity. At least in the short-term, some aspects of globalisation (such as global regulatory measures on trade-related intellectual property rights and trade in services) may be more important for public health policies and health care system financing than they are to health outcomes.

Finally, it is important to address the social justice dimension of health and health policies. Concern about the impact of globalisation has a particular focus on equity.

THE IMPACT OF ECONOMIC GLOBALISATION ON HEALTH OUTCOMES

The general assumption in the sphere of economic policies is that as long as globalisation increases economic growth it will improve well-being and health. An increase in average income is expected to provide better access to food and health care. This is the basis for the claims that the impact of economic globalisation is beneficial.[13,14] However, in many ways, the situation is clearly more complex than one in which more economic resources yield better health. Trade agreements in the field of intellectual property rights and trade in services, as well as economic and public policy reforms, influence health and the health policy context much more than is usually anticipated in analyses of the overall impact of globalisation. Furthermore, the view that globalisation equals more resources for everyone is increasingly being challenged. Doubts about the benefits of economic globalisation for developing countries have been recognised and debated at length. They are slowly becoming part of a global political agenda in the context of the World Trade Organisation (WTO) negotiations, the United Nations Conference on Trade

and Development's (UNCTAD) emphasis on national policy space, and the International Labour Organisation's (ILO) work on the social dimensions of globalisation. More recently, critical accounts of the expected benefits of globalisation even in the developed world have been raised amongst economists.[15]

Concern over the spread of infectious diseases has been a part of the international trade framework for a long time and in practice provided the impetus for the establishment of the predecessor of the WHO.[16,17] The increasing mobility of people and goods is expected to create new dimensions in the long recognised problems of communicable disease. However, economic globalisation requires more than adequately functioning public health measures to ensure the quality of goods. It also requires a functioning health care system in order to respond to communicable disease outbreaks, as the SARS epidemic made only too clear. Such systemic adaptations can be seen as an indirect benefit of globalisation. While communicable diseases remain a crucial issue within the context of trade policy and the mobility of people, goods, and services,[18–20] other concerns about economic globalisation as a broader process have been raised in relation to food security and determinants of health for noncommunicable diseases.

Existing global food supplies are sufficient to meet the nutritional requirements of all people, but there remain concerns over the environmental sustainability and distribution of global production.[21] Both positive and negative implications of the trade in agricultural products have been traced to the liberalisation of trade and reform of agricultural policy. Two types of ethical concerns need to be disentangled: Firstly, insufficient or impartial liberalisation of trade in agricultural products, including inequities related to unfair trade practices; and secondly, ethical concerns related to the impact of the trade liberalisation process as such on agricultural products, food security, and market actors, as well as to the relative position of consumers, different types of farmers, and the food industry in a more liberalised trade regime.

In the case of unfair trade practices, nongovernmental organisations (such as Oxfam) have drawn attention to the extent of agricultural dumping and subsidies in developed countries, which is also illustrated by the WTO dispute settlement case on sugar.[22–24] World Bank estimates currently suggest that substantial benefits could be gained from further liberalisation of trade. The Bank argues that freeing all merchandise trade and agricultural subsidies would boost

global welfare by nearly $300 billion per year by 2015 and that developing countries would enjoy a disproportionate share of 45% of the total gain, almost two-thirds of which would be due to agricultural liberalisation.[25] However, the impact is expected to differ between different groups of developing countries, with the least developed countries benefiting the least from the reduction in subsidies. Of the 46 least developed countries, Food and Agricultural Organisation (FAO)[26] analysis has shown that 31 are net importers of both food and agricultural products and will be hurt by the rising agricultural prices that will result from liberalisation by developed countries. The benefits of liberalisation will accrue to the relatively well-to-do developing countries in Latin America and Asia. The FAO argues that while there is a case for transferring some of the agricultural subsidies currently given to farmers in the Organisation for Economic Cooperation and Development (OECD) countries to net importers of food and agriculture in the developing world, it must be acknowledged that unqualified assertions that these subsidies are hurting the poor countries are not grounded in facts. The FAO analysis further states that while there is a strong case for removing agricultural protection and export subsidies on efficiency grounds, the claim that the change will bring net gains to the least developed countries as a whole is at best questionable and at worst outright wrong.

According to Sharma,[27] the net trade position of the developing countries as regards food and agricultural trade has worsened between 1990–1994 and 1995–1999, due to the sharp increase in food imports and despite marked increases in agricultural exports. But most arguments on removing subsidies and promoting a level playing field are based on the assumption that liberalisation of agricultural trade will provide overall benefits.

On the other hand, ethical issues also arise in relation to the liberalisation of trade as a more systemic process. This is reflected in the concern that large transnational actors may be more able to benefit from liberalised trade. There are substantial constraints for developing country small producers actually to compete in agricultural markets, since large producers are more able to reap the benefits of capital investments in technology and other measures that increase output and lower prices. Corporations are the traders, not countries. Further analysis of competitive advantage is needed here, analysis that takes account of the political economy of production, trade, and consumption, as well as of how the benefits and costs of liberalisation

are divided between farmers, consumers, and corporate actors (both between and within countries). One example is the presence of large agribusiness actors and their bargaining power and influence on lowering producer prices and accumulating profits higher up in the value chain of the final products.[28–30]

Changes towards poorer and unhealthier diets due to marketing and promotion of food and drinks through globalisation, aggravated by urbanisation,[31,32] are generally adverse but are not uniformly negative. In some places, changes in diet may counter unhealthy local practices. Nonetheless, the aggressive marketing strategies of transnational commercial actors producing processed food and drinks (for example Coca-Cola's distribution of free refrigeration equipment in schools and leisure facilities, that increase the consumption of soft drinks)[33] have the capacity to reshape consumption substantially and are at the core of globalisation processes. In the context of infant health and the promotion of breast feeding, a shift to the use of infant feeding products has created problems that are reflected in international regulatory initiatives concerning the promotion of infant foods. Between 1988 and 1997, foreign direct investment in the food industry increased from U.S. $743 million to more than U.S. $2.1 billion in Asia and from U.S. $222 million to U.S. $3.3 billion in Latin America, far outstripping the level of investment in agriculture.[34]

Increasing mobility of goods tends to include goods hazardous to health – namely, alcohol, tobacco, and drugs. Consumption that may be good for economics is not necessarily good for health. Empirical findings support the expectation of increased domestic consumption of tobacco as a result of increased trade, and suggest that less wealthy countries may be more vulnerable than wealthier countries to the impact of trade liberalisation.[35] The impact of globalisation on consumption of health hazardous products is also related to how public policies may be implemented and the extent to which access to health hazardous products or advertising them are restricted.[36]

THE IMPACT OF GLOBALISATION ON HEALTH POLICY

The impact of globalisation on health policy is broader than its effect on health outcomes. Increased mobility of goods and services may complicate the practice of health policy and require stronger emphasis on public health measures. But the real issue concerns the terms on which health policies can be applied in the context of

globalisation. The more individualised and market-led health policies are, the less likely it is that economic integration will interfere with health regulations. Thus the impact of globalisation on national health policies strongly depends on the extent to which such policies regulate or restrict interests and priorities of commercial actors or markets in a more general sense.

The impact of economic globalisation on health policies is mediated through three main interactive levels: legal agreements and legal frameworks; shifts in economic resources, terms, and conditions; and knowledge and information transfer about optimal and appropriate strategies. In the sphere of economic influence, the bargaining power of international financing institutions is more limited with less indebted countries or with big powers, such as China or India. In the case of smaller and more indebted countries, the role of international financial institutions is often much larger, as they have both indirect and direct influences through the negotiation of lending and debt.

The role of international financial institutions in the sphere of globalisation has been under increasing criticism from both inside and outside the Bretton Woods organisations.[37–39] International financial institutions have influenced health policies by altering the scope of public budgets (health budgets in particular) and through policy prescriptions proposed for sectoral reforms in health, social services, or as part of a broader public sector reform.

The impact of globalisation may be more important for health policy options in terms of resources than has been anticipated. The general assumption has been that tax competition and increasing economic globalisation will result in pressures for smaller public budgets and more limited resources for health. However, some aspects of economic globalisation actually increase the need for resources. For example, commitments in relation to the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) have direct implications for the cost of pharmaceuticals. The TRIPS agreement was never a carefully negotiated and balanced agreement in which the needs of other sectors (such as health or environment) were addressed, but instead was essentially a corporate driven process.[40,41] In terms of ethics, this also raises concerns over the ways in which the current use and interpretation of intellectual property rights sets commercial rights in the context of human rights and how this relates to the rights to health and access to health care. The formulation of intellectual property rights as 'rights' has created the opportunity to frame their interpretation in terms of individuals and

a human right of authors and inventors in the context of Article 27.2 of the Universal Human Rights Declaration and Article 15.1 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[42]

While TRIPS related debates on pharmaceuticals have been discussed primarily in the context of promoting the interests of developing countries, the underlying separation is between commercial industrial interests and public health policy interests. The cost of pharmaceuticals has been rising not only in developing countries, but also in the developed world.[43] While TRIPS alone does not explain or account for the state of health or even access to pharmaceuticals in many countries, it does have significant relevance for how health policy and research and development are financed and implemented. Focusing merely on the poorest countries obscures the essential problem that research and development efforts in a private sector environment are not driven by public health or health policy priorities, but instead are geared to commercial priorities. This core problem is reflected in growing concerns over the limited interest of the pharmaceutical industry in investing in antibiotics due to their low profitability.[44] Some of these systematic issues have now been raised in the context of new proposals for a global research and development treaty to address the failures of current policies.[45]

TRIPS is not the only trade agreement of importance to health policy. The Agreement on Sanitary and Phytosanitary Measures (SPS) has implications for standard setting and the ways in which public health regulatory measures may or may not be implemented in the context of trade in goods. While the WTO agreements allow public health regulatory measures, they nevertheless influence the ways in which these measures can be implemented and the grounds on which they are evaluated. WTO approved standards only relate to the end product and have little role in the regulation of production processes. The problems with respect to WTO and regulation in the areas of environment, labour, and health also highlight the problematic relationship between trade agreements and global governance. The crucial issue is that global governance in these fields should take place through the ILO and the WHO, which are the appropriate forums for labour rights and regulatory measures on public health and standard setting.

The WTO Agreement in the field of services is relevant to health services. While the main impact in the field of trade in goods has been in relation to standard setting and public health, the potential impact

of the General Agreement on Trade in Services (GATS) is far broader, extending to the regulation of service provision. In the context of the GATS, governments may have the freedom to define which services they want to bind and include in the GATS, but after they have bound sectors, their leeway and freedom to operate is limited. While countries are free to change their commitments, these need to be 'compensated' by providing other commitments. The general protection clauses relating to 'public services' are also narrow. According to legal reviews, they do not cover services which are contracted out.[46, 47]

Growing attention has been drawn to the mobility of professionals. The human resources crisis in the health care sector of many countries has become more acute, as professionals move across regions and countries in order to improve their wages and working conditions.[48,49] However, the mobility of health professionals is not a new phenomenon nor is it associated only with trade agreements. Trade agreements will likely increase this mobility, but so far very little has been agreed in this area. The mobility of health professionals seems to be more important in the context of commonwealth countries with special reference to the United Kingdom.[50,51] Health and the provision of health care are also viewed as business opportunities for countries that have developed a private hospital sector and see the potential for trade in health services. The globalisation of health care may also open up further business opportunities through the provision of surgical operations, interventions, and treatments which relate to ethically problematic aspects of care, such as cloning or buying organs as part of transplantation surgery.

The role of trade agreements is important, but in practice can be more limited when compared with the importance of particular policy prescriptions. International consulting and advice often provide the basic framework in which health systems are analysed and core policy issues are articulated. Trade agreements are also more relevant to those health systems that have substantial contracting out and private sector collaboration. In many ways, changes in the organisation and financing of health care have been strongly influenced by the assumed benefits of corporatisation of hospitals, contracting out services, introducing user charges, and introducing competition to the health care sector. Thus, it is not surprising that the role of policy advice has been discussed in the context of health care reforms.[52] Health care reforms over 20 years have been the major framework of reform and policy change in health systems. Substantial shifts towards privatisation, contracting out, and user cost-sharing have been introduced

through sectoral reform policies and programmes. The role of the OECD has been brought up in the context of the 'globalisation' of health care reform processes.[53] However, the role of the OECD, WHO, or ILO is only based on the understanding of expert knowledge, whereas aid organisations and actors, such as the World Bank and the International Monetary Fund (IMF), have much more policy leverage through the mechanism of financing.

The role of the World Bank and the IMF in health care reform processes in many countries has been implemented both indirectly, by limiting public investments and budgets and broader public sector reforms, and directly, through sectoral health care reforms. While the policy influence of epistemic communities (such as research institutions and networks) and international organisations is often exercised through interest group pressure, comparison, and persuasion amongst OECD countries, the role of international financing institutions is stronger in the developing world. The overall influence of the World Bank through proposed reform strategies, lending resources, and flagship publications is significant, even though its influence varies between countries and sometimes depends on the expertise of individuals. For example, the importance of the World Bank lending, advice, and policy influence has been evident in the context of pension reforms.[54,55] The application of loan conditionalities has been an important mechanism for inducing policy changes, but is no longer as visible and direct as it was in earlier structural adjustment policies and associated sectoral reforms. The Poverty Reduction Strategy Papers (PRSPs) currently used in the context of lending practices have been seen as a mechanism to enhance country ownership and participation. However, they have also been criticised on the grounds of embedded power relations and practice. Problems of participation by the Ministries of Health have been reported and it is unclear to what extent the potential of PRSPs has actually become realised in practice.[56,57] In the sphere of commercialisation and privatisation, the International Finance Corporation (IFC) has also been an active part of the World Bank, supporting commercial ventures in health care and thus promoting commercial policy approaches.[58]

THE IMPACT OF GLOBALISATION ON EQUITY ASPECTS OF HEALTH AND HEALTH SYSTEMS

The impact of globalisation on equity has been debated amongst global economists and should be discussed in the context of equity

between countries and within countries. The debate has been moulded by the pro-globalisation work of Dollar and Kraay, who claim that 'globalisation is good for the poor'.[59,60] Their work has been important in promoting liberalisation and the benefits of globalisation, but has been refuted by others, who have been critical of the data used, the selection of countries (for example, using China and India as prime examples of the benefits of globalisation), the use of population-weighted income of the 'globalizers', and of the validity of drawing causal interpretations from such data.[61–63] Rodrik has criticised the process of selecting the 'good' globalisers on the basis of trade, concluding that the beneficial effects of trade liberalisation on poverty have to be seen as claims based on faith rather than evidence.[64] A further critique deals with the assumption that the poor and rich benefit relatively as much in relation to their existing incomes, which implies that *relative* socioeconomic inequalities will – even according to the results of Dollar and Kraay – actually further expand.[65] In contrast, Milanovic argues that the record concerning inequalities and globalisation has been much worse in the last two decades than in the previous two decades; openness both makes income distribution worse before making it better and the effect of openness on national income distribution is dependent on the initial income level.[66–67]

The arguments on globalisation and inequality need to relate to the causes of poverty and inequality and to the ways in which globalisation may or may not influence them. According to the WIDER Institute study, traditional causes of inequality (such as land concentration, urban bias, or inequality in education) do not appear to be responsible for a worsening situation. Rather, what is crucial are 'new causes' linked to excessively liberal economic policy regimes and the way that economic reform policies are carried out.[68] Specific reference is made to the policy reforms undertaken by the international financial institutions, which have a redistributive impact on income within countries. In many cases, their influence has increased socioeconomic inequalities. The relationship and role of international financial institutions has been analysed both from inside and outside of the organisations. Their role in the process of economic liberalisation has been judged problematic and their reforms contributed to the widening of inequalities.[69–71]

In health systems, equity is often dealt with in the context of inequalities in health, in particular in health status and life-expectancy. Culyer and Wagstaff see these inequalities as the main reference

point for equity in health systems,[72] while others emphasise that equity is more multidimensional as a concept and health status is influenced by many factors beyond the powers of health systems.[73–74] Inequalities in health are strongly related to social inequalities. Reducing health inequalities through a health system therefore becomes increasingly difficult if social inequalities are increased as a result of globalisation. Paul Farmer has also argued that structural violence limits the realisation of civil rights and that civil rights cannot be protected in the absence of the protection of social and economic rights.[75] He goes on to suggest that it is in the context of globalisation, growing inequality, and pervasive transnational media influence that the new field of health and human rights emerges. He argues:

> It is time to take health rights as seriously as other human rights, and that intellectual recognition is only a necessary first step toward pragmatic solidarity, that is, toward taking a stand by the side of those who suffer most from an increasingly harsh 'new world order.'

The role of 'global' or 'globalism' in social policies has been most apparent in the context of neoliberal policies promoted by international organisations in the sphere of social and health policies.[76–77] The analysis of the ideology or discourse of globalisation is particularly important when it is seen as a process with no alternative. It is in this context that it influences other policy fields. Health systems distribute and redistribute resources as well as cross-subsidise risks. The emphasis on mobility and 'portability' of benefits, on the importance of savings and investments, and on the limits of public budgets as part of the implicit assumptions of globalisation shift the options for health policies towards a more commercialised and individualised organisation of care. Such changes have implications for the costs of care and equity, which are often analysed only in the context of public budgets, rather than in terms of the health system as a whole. These requirements for health policies result in pressure for health care systems based on individual insurance or personal health accounts, rather than systems that cross-subsidise and prioritise access to care for everyone through the use of public budgets.

CONCLUSIONS

I have predominantly raised critical questions about the impact of globalisation. However, in the context of equity and economic

globalisation, it is also necessary to draw attention to the expected benefits of greater interconnectedness between countries on the basis of increased trade and economic exchange. Such benefits are expected to decrease the chances of internal conflicts, political oppression, and disease epidemics within countries. The main question is whether or not economic interconnectedness is associated with mechanisms that enhance or decrease human security, equity, and health protection. The benefits from economic interconnectedness may be lost due to simultaneous processes decreasing human security, promoting a faster pace of change, reducing public resources, and increasing structural inequality, all of which may enhance the social ills that economic interconnectedness is expected to cure.

Globalisation is a challenging subject for any ethical analysis. In this article, economic globalisation and its impact on health have been explored in order to highlight different ways in which globalisation raises ethical concerns. While the discussion has not been comprehensive, it has provided a context for articulating broader ethical concerns about globalisation and health. The particular emphasis on ethics and public policies is too often replaced by a discussion of medical ethics, which is limited to the context of individuals and professional practice. It therefore fails to address the following ethical dilemmas of public policies:

(1) The ethical considerations of commercial rights and their interpretation, the nature and scope of social rights, the ethical aspects of the promotion of public or population health, and broad notions of protection and human security;
(2) The ethical basis of the current processes of economic globalisation and its relationship to social determinants of health, such as socioeconomic inequalities and vulnerability;
(3) The ethical dilemmas associated with the impact of economic globalisation on equity aspects of health systems and on their organisation and financing.

These are ethical issues that relate to public policies and the ways in which priorities are set. The emphasis on public policies and international aspects of ethical concerns also raises crucial questions about global policy priorities in the context of trade and health. Why should corporate rights to advertise unhealthy foods be protected and public measures to regulate this arena be subject to further scrutiny? Why should all products or providers of services be treated similarly if some are treating the environment and workers far better than

others? Why should intellectual property rights be more important than rights to health care and access to life saving pharmaceuticals? These are just a few of the ethical questions that emerge in relation to trade and health.

The impact of economic globalisation on health systems organisation and financing can be expected to grow. This is partly due to the magnitude of economic opportunities in the field, emerging global regulatory measures, and the significant and growing share of public and private budgets allocated to health care. The impact of economic globalisation on health policy cannot be understood merely in the context of traditional approaches to the mobility of goods across borders. It also needs to incorporate issues of intellectual property rights, domestic regulation of the trade in services, production of knowledge for aid and public sector reform, and the role of commercial actors in public–private partnerships and in lobbying for public policies at national and international levels. The process of economic globalisation provides a common challenge for health systems all over the world and requires a broader debate on values, accountability, and policy approaches.

NOTES

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