Debate

Health, equity, justice and globalisation: some lessons from the People's Health Assembly

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Can you imagine a world in which the spread of globalisation meant the world becoming a more just and equitable place? This seems like an impossible dream. All the indications are that the current forms of globalisation are making the world a safe place for unfettered market liberalism and the consequent growth of inequities. This economic globalisation is posing severe threats to both people's health and the health of the planet.

While the recent debate about globalisation is new its negative health impact is not. For instance on the Australian continent the indigenous peoples have suffered severe and ongoing health consequences of the European invasion of their lands 200 years ago. These have been so severe that they have come close to an actual and cultural genocide. At the start of the 21st century one of the major threats to global health comes from the transnational financial interests who speculate against the world currencies and multinational companies that are gaining more and more control over world production and trade.[1] These interests have little stake in a healthier or more just world and their modus operandi must be recognised as one of the major threats to world health in this new century. This commentary will describe some of the deliberations of a recent gathering of public health activists, the People's Health Assembly, which examined the health impacts of globalisation, particularly the impact of global trade regimes and considered what can be done to change its character and impact.

The People's Health Assembly

The People's Health Assembly, held in Savar, Bangladesh from the 5–9 December 2000 was attended by 1500 from 93 countries. The People's Health Assembly was deliberately constituted to ensure fair representation of people from poor countries and people from NGOs and grass root perspectives. The People's Health Assembly potentially represents the beginning of a powerful global popular movement focused on combating the devastating impact of economic globalisation on health. The meeting was powerful because it resulted from collaboration between eight NGOs, included perspectives from rich and poor countries and was careful to link analysis to lived experience. After five days of discussion the delegates unanimously adopted the People's Charter for Health,[2] which has the potential to take over the mantle of the World Health Organisation's Alma Ata Health for All 2000 document. The document builds directly on that document and explicitly seeks to take its philosophy and make it relevant to the public health issues of the 21st century. It does this by outlining the global health crisis, details six principles and then sets out a call to action. Much of the philosophy is in accord with the HFA 2000 document but in addition it calls for radical change in global trading patterns and relationships and clearly fingers the practices of multinational companies as a threat to health. Examples are:

This Charter calls on people of the world to

- Demand transformation of the World Trade Organisation and global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the south in order to protect public health. Such transformation must include intellectual property regimes such as patents and the trade related aspects of intellectual property rights (TRIPs) agreements.
- Demand the cancellation of third world debt.
- Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- Demand effective regulation to ensure that TNCs do not have negative effects on peoples' health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- Demand that national governments act to protect public health rights in intellectual property laws.

This charter deserves to be read, discussed and debated by public health professionals and activists. It offers a wake up call and warning that something is rotten in the global way of doing business. Before adopting this charter the assembly considered the nature of global inequities and the ways in which they are maintained.

Global inequities and how these are maintained?

One of the most devastating features of the economic globalisation identified at the People's Health Assembly is the growing inequities within and between countries resulting from

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two decades of a "greed is good" mentality. The UN Human Development Report (1999) compares the size of the income of the fifth of the world's people living in the richest countries and that of the fifth in the poorest. The ratio had changed from 30 to 1 in 1960, to 60 to 1 in 1990 and to 74 to 1 in 1997. The world's 358 richest billionaires have a combined net worth of US$760 billion, which is equal to the total assets of the poorest 45% of the world's population.[3] The overall consumption of the richest fifth of the world's people is 160 times that of the poorest fifth.[4]

In our complex world there are obviously many factors contributing to these inequities. The traditional research tools of public health are not very powerful when it comes to analysing the various contributions. Political science offers us more powerful and relevant tools to unpack the factors behind the inequities in our globalised world. An initial analysis immediately indicates that the power relationships behind globalisation are complex, confusing and, at times, contradictory. The People's Health Assembly discussion and background paper and presentations and debate at the assembly suggest three main reasons for the maintenance of global inequities.

1 THE IMPOSITION OF STRUCTURAL ADJUSTMENT PROGRAMMES (SAPS) BY FINANCIAL INSTITUTIONS SUCH AS THE WORLD BANK AND THE INTERNATIONAL MONETARY FUNDS (IMF)

SAPs have cut employment and investment in the social sectors, removed protection to local industries, barriers to outflows of funds and removed labour regulations. Institutions have been weakened by the rapid privatisation of services and decreasing government control and accountability. While these policies have had an adverse impact on some sections in rich countries, their impact on poor countries has been more devastating. Carpenter,[5] commenting on the impact of neoliberalism, notes that it has "made serious inroads against all forms of collectivism, fostering the expansion of the market and the erosion of state regulation of social life". Rao and Loewenson[6] note that, while these SAPs promised poor countries economic growth, in sub-Saharan Africa per capita income, as a whole is now lower than it was in 1960. A longitudinal study in Zimbabwe has indicated the deleterious effects on health of structural adjustment policies in that country.[7]

2 UNFAIR TERMS OF TRADE BETWEEN RICH AND POOR COUNTRIES WHICH MEAN THAT THE ECONOMIC SITUATION OF POOR COUNTRIES IS UNABLE TO IMPROVE

Most significantly increasing external debt means that a significant share of the income of poor countries is used to pay back their debt with often crippling interest rates. It is also evident in the practices of the World Trade Organisation, which codifies and consolidates the unequal terms of trade. This is shown in the TRIPs regime that, among other things allows patenting of seeds. TRIPs poses a threat to genetic resources, sustainable agriculture, food security and the wellbeing of farmers. Increased patent protection will lead to increasing prices and reduced access to medicine and supports monopoly control. Similarly the GATT agreement results in the use of science and standards setting as a mechanism for maintaining unfair trading practices. Lang[8] notes that the UN Codex Alimentarius Commission (the international food standards body) is subject to undue influence from industry representation that also results in discrimination against poorer nations. Legge[9] observes that the structured unfairness of the economic globalisation of the past two centuries is not an accident. He says that it is "a direct consequence of the economic policies of the last two decades which have restructured the world economy in ways that favour the interests of the rich capitalist metropolis". Currently the terms of world trade are extremely favourable to transnational companies and the richer countries in the world where they are based. This has lead to an increasing disillusionment in the process of globalisation from commentators in third world countries where the lack of tangible benefits and sense of progress is ever more evident.[10]

3 THE ABILITY OF THE WORLD TO LIVE WITH AND ACCEPT THE MASSIVE INEQUITIES IN THE WORLD AS IF THEY ARE PART OF SOME NATURAL ORDER

Yet these inequities are social, political and economic not biological in origin. From a public health perspective they can be tackled if only we would imagine and then create the political, economic and social arrangements that would make trade fair, inequities reduce and so improve health. The New World Order of economic globalisation preaches that these inequities are a necessary part of life if the world's economy is to flourish. A trickle down effect will ensure that eventually the benefits of the New World Order are spread. This is not happening. So public health practitioners in rich countries have a responsibility to pose the question of how we can make the impact of economic globalisation on health a top public health issue in the 21st century.

What is to be done?

One of the tasks the organisers of the People's Health Assembly set was to work out a plan of action for improving global health. That this proved difficult is not surprising. The sheer speed of the global economic changes that are affecting health make effective responses difficult to formulate. As soon as one strategy is developed there are a new set of threats to respond to. This is very clearly the case with HIV/AIDS in Africa where the growth of the epidemic is formidable and the pricing policies of multi-national pharmaceutical companies mean treatment choices are very limited for those living in poor countries.[11] Additionally the role of the state is changing. Public health practitioners once looked to the state to provide the regulation of markets and the public health legislative and implementation infrastructure in which to conduct their work. Now,

however, the role of the state is being marginalised and there is a proliferation of non-state actors in the health field.[12] The role of the World Health Organisation is being questioned as it is seen to have lost global leadership and become increasingly impotent.[13] A massive effort is required from the public health community to debate, discuss and analyse the health crisis caused by globalisation and then to develop strategies, based on principles of social justice, to establish a world where health for all is a reality rather than a receding dream. This journal is contributing to this debate with the publication of this and related articles. Below I offer three areas in which action is needed. These are presented as a starting point for discussion.

GOVERNMENTS THAT INTERVENE

Markets will not spontaneously change the terms of world trade to favour poor people. Encouraging them to do this is the responsibility of government. Historically public health has been successful when societies have used the benefits of economic growth for the common good as Szreter's[14] analysis of 19th century Britain has highlighted. Part of the recent economic globalisation has been a retreat from state intervention. The SAPs sold to poor countries and the neo-liberal regimes imposed in rich countries have been based on a roll back of the state. For the sake of equity and public health this roll back must be reversed. Navarro and Shi[15] consider the political context of inequalities and health through an empirical study of the policies of different political traditions in the advanced OECD countries between 1945–1980. Their analysis indicates that political traditions more committed to economic and social redistributive policies are more successful at improving the health of populations. The work of Kawachi *et al*[16] and Wilkinson[17] also suggests that equity is good for health. Equity does not result from unfettered markets but rather in societies in which governments have a commitment to redistribution. Countries that have achieved this redistribution are rich social democracies such as Sweden and poorer countries such as China, Cuba and Sri Lanka that have achieved high average life expectancies without high levels of economic wealth.[18]

Khor[19] notes that a review of structural adjustment policies and of the liberal "free market" model in general shows that a reconceptualisation of development strategies is required and that alternative approaches are needed. This needs to be done in a way that is socially equitable and allows an integration of environment with economics. The governments of rich countries have to take responsibility for ensuring a more environmental sound future as they are responsible for causing most environmental problems and have the resources and economic capacity to reduce their output and consumption levels.

Public health arose from the realisation that individual health care would not ensure a healthy population in the face of massive social, economic and environmental problems. In the same way, a public health that does not encompass global issues of inequity is inadequate to address the health of human populations. A failure from national governments and international agencies to develop such responses will jeopardise health for all of us.

IMPROVE PUBLIC HEALTH GOVERNANCE

Closely related to the need for interventionist governments is the need for improved public health governance within countries and internationally. One of the main threats to establishing this is the industry quest, especially multinational interests, to influence and down grade measures taken to protect public health. A recent example from Australia illustrates the issues within countries. Australia has had a highly effective Pharmaceutical Benefits Advisory Committee that has worked over the past decades to ensure that drugs essential to public health are accredited under the national pharmaceutical benefits scheme and are, therefore, affordable. In February 2001 the Australian Government appointed a member to the committee who had close industry links. This led to an outcry and resignation of existing members because they feared the committee's independence and effectiveness was compromised.[20] Both nationally and internationally, it is vital to ensure that regulatory bodies are kept free of influence from industry because currently there is evidence that this does not happen.[21] The WHO should ensure that the systems it is responsible for do not become unduly influenced by industries that already hold considerable power in relation to public health regulators. The WHO should also seek to influence the agendas of the bodies governing world trade (most notably the World Trade Organisation) so that public health concerns are on the agenda of these bodies. Of course the WHO will need backing from UN member nations to do this but unless effective and independent public health governance can be instituted globally then existing inequities and threats to health will remain.

POPULAR MOVEMENTS AND ADVOCACY FROM PUBLIC HEALTH PROFESSIONALS

The economic global status quo will not change without opposition. The most effective form of opposition to the global institutions featured above is not clear. There are some signposts, however. A global mass movement, primarily orchestrated through the internet, was responsible for stopping the passage of the Multilateral Agreement on Investments (MAI) in 1998. The World Social Forum, held in Brazil in January 2001 as a counterpoint to the simultaneous World Economic Forum in Davos, Switzerland aims to strengthen alliances between NGOs, trade unions and other social movements.[22] Popular protests have also been seen in response to meetings of the WTO. The best known of these was in Seattle were scenes of riot police dealing with the protesters were flashed around the world. Similar protests were repeated in Melbourne in September 2000. Those speaking from established power

bases about these popular movements inevitably downplay the role of such protests and portray the protestors as undesirable and socially disruptive and threatening. Yet the protest role may be crucial in fuelling a debate about the desirability and equity of the New World financial order.

The People's Health Charter offers a challenge to public health professionals. It raises vital questions: Can we support the calls made in the charter for a fairer and more just world? Are we prepared to voice our support, to marshal the public health arguments in favour of this fairer world? And to do this in face of being told that we are "stuck in 1960s and 1970s thinking", out of touch of reality and too political and not scientific enough? Can we develop the passion necessary to fight the manifest inequities in the world?

There are already examples of health professional groups who are taking action in support of the issues. These include Medact, a UK based group, which is lobbying against the type of inequities described in this article or public health associations in the USA, Canada and Australia, which have developed policies critical of the health impacts of globalisation. But the very nature of globalisation requires an international public health movement that joins forces with other voices of protest (such as grass root health non-government organisations, progressive consumer groups, environmental organisations) and strengthens the advocacy voice against the growing power of multinationals and increasing inequities.

The People's Health Assembly was a very political affair. Most of the evidence presented at the assembly was qualitative in nature and based on stories of everyday life. But these experiences are backed by powerful statistics demonstrating the increased concentration of wealth and growing poverty. Behind these stories and statistics is a set of entrenched power relations. As public health professionals we can chose, through our silence, to support this status quo and thus be complicit in the damaging health effects. That stance is as political as the outspoken activists at the assembly were, because to do nothing is to collaborate in the current arrangements. Alternatively, we can ensure that our research and teaching considers the negative impacts of economic globalisation and encourages discussion about means of acting on the People's Health Charter. We can take opportunities (individually and through professional associations) to lobby governments about the need to tackle inequities and improve national and global public health governance. We can present the stark differences in health status between rich and poor countries as both a human rights and public health travesty. If we can't do these things then history will judge our contribution to public health in this new century as largely irrelevant.

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