Part I

1 An introduction to global health policy

Kelley Lee, Suzanne Fustukian and Kent Buse

Globalisation is among the most discussed, and is undoubtedly one of the most disputed, terms to have come into common parlance in recent years. Scholarly and popular writing about globalisation has grown exponentially over the past decade or so, spurred by often heated debates over whether or not the process is actually occurring, to what extent, for what reasons, in what forms and with what consequences. Economic globalisation has initially received the lion's share of attention, but recognition of the political, social, cultural, technological, environmental and other aspects of globalisation has rapidly grown in more recent years.

It is in the latter context that this book, which explores how health policy-making is being affected by forces broadly defined as globalisation, was conceived. Health is an important sector of most economies and a core area of social policy. For example, total expenditure on health as a proportion of Gross Domestic Product (GDP) is as high as 14 per cent in the US and is over 10 per cent in a number of additional OECD (Organization for Economic Co-operation and Development) member countries. Public expenditure on health as a proportion of total public expenditure varies widely between countries, with India and Indonesia spending 3.9 and 3.0 per cent respectively, and Andorra and Argentina spending 38.5 and 21.6 per cent respectively (WHO 2000a). As such, the health sector has been the focus of much policy reform effort over the past two decades, to coincide with shifting ideas worldwide about the welfare state and the role of the public and private sectors in health care financing and provision. Ultimately the subject of health policy is a universally relevant one. Global health has featured prominently on the agendas of the major international political conferences of the 1990s, and has recently been framed as a security issue in the US and at the UN Security Council. Moreover, we are all concerned with our own and others health status, and the factors that optimise it. The health status of individuals and populations is a significant barometer of social progress, broadly reflecting the sustainability of current, and prospective, forms of how we order our lives both locally and globally.

Attention to the links between globalisation and health has increased rapidly since the mid 1990s, initially spurred by concerns over perceived changing threats to national and human security. These concerns have widened, as understanding of the diverse and uneven impacts of globalisation on human health has grown, to include international trade agreements, global financial and trade flows, and global environmental change. Accompanying this attention have been efforts to explore the implications of these challenges to existing institutions and practices of health governance – how should collective action be taken to mediate the positive and negative impacts of globalisation on human health?

The purpose of this book sits between seeking to better understand the impacts of globalisation and finding ways forward to strengthen health governance. We are especially interested in the changing actors, processes and contexts of policy-making, along with the actual policies adopted. In many ways, these four components are intertwined with each other. Yet it is useful to analytically tease them out in relation to how globalisation is impacting on each of them. Selected areas of health policy have been focused on, with a particular emphasis on low- and middle-income countries (LMICs), to illustrate the impact of globalisation on health policy-making. The areas covered are by no means exhaustive, however, and the issues they raise in relation to health policy-making are not exclusive to these countries and regions. Indeed, one of the key messages of this volume is that no population group is immune from the health-related causes and consequences of globalisation.

The impacts of globalisation on health

An appreciation of the diversity of impacts that globalisation is having on health is rapidly growing, resulting in a variety of initiatives seeking more detailed understanding of these impacts and designing effective policy responses to them. These initiatives, in turn, have led to the term 'global health' which is being increasingly recognised among scholars, policy-makers and practitioners as distinct from 'international health', although the difference is not always made sufficiently clear. Indeed, both terms are variably defined and frequently used interchangeably, and there is consequently confusion between them.

International health is a familiar and longstanding term that broadly refers to health matters that concern two or more countries. Alternatively, within the development community, international health usually refers to health matters relevant to the developing world. While all sorts of public and private sector actors (both individuals and groups) may be involved in international health, it is the primacy of the state and state-defined

actors that distinguishes international health. For example, the regular transport of infectious diseases such as plague by trade ships from Asia to western Europe from the twelfth century onwards led to the adoption of maritime quarantine systems by Italian city states and later other European countries, as the foundations of the modern surveillance and control systems. The practice essentially excluded a suspect ship and its passengers from landing at a port of call for a given time until it was granted plague-free status by local authorities. The important feature of this system, which Carmichael (1997) describes as 'an undeniable stimulus to the growth of the modern bureaucratic state', is its efforts to shore up the territorial boundaries of the state against a health threat. If somehow the threat could be kept at bay outside of the given state's borders, the population within would remain safe.

Many of the health issues that policy-makers face today remain, strictly speaking, international health issues. The threat of food-borne diseases from increased international trade, for example, in principle could be addressed by improved national, regional and multilateral regulation of food production and trade. Increased risk from infectious diseases as a result of highly mobile populations, at least those affecting individuals who enter and leave countries legally, could (theoretically) be regulated by customs authorities and public health officials at points of entry into a given country. In practice, as a number of chapters to this volume demonstrate, this is difficult to achieve given the limited capacity of many LMIC governments.

However, international health becomes global health when the causes or consequences of a health issue circumvent, undermine or are oblivious to the territorial boundaries of states and, thus, beyond the capacity of states to address effectively through state institutions alone. The illicit drug trade is conducted in a highly covert way, using global transportation, communications, banking and financial infrastructures to directly challenge law-enforcement authorities worldwide. As Stares (1996) argues, the illicit drug industry has its own geographical rationalism of closely linked producing and consuming populations. The health effects of environmental degradation, such as global climate change or the Chernobyl nuclear accident, can also transcend state boundaries and directly challenge the capacity of the state alone to address its causes and consequences.

Global health is also concerned with factors that contribute to changes in the capacity of states to deal with the determinants of health. The global economic crisis of the late 1990s is recognised as having had profound impacts on public sector expenditure on health programmes such as family planning and basic health services (UNFPA/Australian National

University 1998). Cheaper and more widely available transportation technologies, for example, have led to a significant increase in the number of people crossing national borders each week. While the sheer volume of international population movements challenges the logistical capacity of public health officials to cope with screening of travellers for health risks, the global movement of more vulnerable groups, such as economic migrants, refugees or trafficked individuals, places the inadequacy of international health (both conceptually and operationally) in starker relief.

One of the first premises of this book is that the scope of global health is expanding as a consequence of the processes of globalisation. Globalisation can be defined as 'processes that are changing the nature of human interaction across a wide range of spheres including the sociocultural, political, economic, technological and ecological' (Lee 2001). These processes are global, in the sense that at least three types of boundaries hitherto separating human interaction – spatial, temporal and cognitive – are being redefined. These are discussed in greater depth in Lee (2001) but can be summarised briefly as follows.

Spatial or geographical boundaries, in particular the territorial borders of states, are becoming relatively less important as a consequence of globalisation. Perhaps more accurately, a reterritorialisation of geographical boundaries is occurring by which globalising processes are redefining geographical space in alternative and innovative ways. For example, global civil society, virtual communities and cyberspace increasingly defy the logic of territorially defined geography, giving rise to the importance of, on the one hand, aterritorial social arrangements and, on the other, competing loyalties and identities (Scholte 2000). Transnational activities such as foreign-exchange trading and the Internet have become deterritorialised in the sense that geographical location matters little. Other transnational activities, although not deterritorialised as such, have intensified to such an extent that they are transforming societies around the world. Most fundamental of these is the 'global shift' of the world economy, which, through the interrelated actions of transnational corporations (TNCs) and states, is affecting local communities around the globe (Dicken 1998).

In the health field, this reterritorialisation of human interactions is impacting on both cause (health determinants) and effect (health status). As discussed above, globalisation in the economic, political, social, cultural, ecological and technological spheres of human activity needs to be taken into account as part of the broader determinants of health. The impacts of these processes of change, in turn, are leading to new patterns of human health and disease that do not necessarily conform to, or are revealed by, national boundaries alone.

This reconfiguration of the geography of health determinants and status, along with other geographies (e.g. financial resources, production and trade, cultural identity), has called into question traditional ways in which we categorise health needs. The familiar dichotomy between developed and developing countries has long been recognised as overly crude but broadly useful in distinguishing the needs and realistic options of countries of different levels of wealth. Global health issues are thus those that are not confined to a specific country or groups of countries, but are transborder in cause or effect; this suggests that the ways in which we conceptualise the geographical boundaries of the world, and the health issues related to them, need to adapt to processes that are transborder in nature.

Importantly, this does not mean that we should ignore the often stark inequities in impact that are being experienced within and across population groups. While global health, by definition, makes all individuals and groups potentially vulnerable given their transborder nature, those who have the necessary resources, skills and mobility to reduce or avoid the costs of globalisation are at a clear advantage over those who do not. Most agree that there are winners and losers arising from the processes of globalisation. The proportion of winners to losers, and the long-term distribution of costs and benefits among them, remain highly disputed. Supporters of neo-liberalism maintain that benefits will eventually 'trickle down' to more and more people, raising the overall standard of living for all (World Bank 2000). Others, however, disagree that these trickle-down benefits are occurring sufficiently or fast enough. Bauman (1998), for example, argues that a minority of extraterritorial elites are enjoying a disproportionate share of the benefits of globalisation, while the bulk of the world's population, a 'localised majority', bears the brunt of its risks and problems. Similarly, Coburn (2000) writes that 'the links between globalisation and health initially stemmed from concerns within the health sector that economic globalisation in its present form is having adverse impacts on human health, in particular worsening equity and health status within certain vulnerable populations'. Measures to redistribute costs and benefits more directly are thus advocated, such as the Jubilee 2000 initiative on debt relief or the Tobin Tax, to generate resources for addressing global health inequalities.

Temporal boundaries, the way in which we perceive and experience time, are also changing as a result of globalisation. For the most part, globalisation has been characterised by an acceleration of the pace of our lives, a feeling of time compression created by what has become possible technologically and aspirationally. As Gleick (1999: 9–10) writes:

> We are in a rush. We are making haste. A compression of time characterizes the life of the century now closing ... We believe that we possess too little of it [time]: that is a myth we now live by. What is true is that we are awash in things, in information, in news, in the old rubble and shiny new toys of our complex civilization, and – strange, perhaps – stuff means speed. The wave patterns of all these facts and choices flow and crash about us at a heightened frequency. We live in the buzz. We wish to live intensely, and we wonder about the consequences.

The effects of this temporal change on health are again relevant to both the determinants of health and health status. Changes in certain health determinants can manifest more rapidly or operate within an altered timescale. Our destruction of the natural environment, for example, is happening at an unprecedented and accelerating rate with direct consequences for the survival of the human species (McMichael 1993). Lee and Dodgson (2000) observe that the seventh cholera pandemic began in 1963 and spread worldwide more quickly than the previous six. Furthermore, its duration of about 40 years is by far the longest cholera pandemic in history, eluding public health efforts to definitively contain it because of its capacity to re-emerge in different parts of the world as a result of such features of globalisation as human hypermobility, political instability and the food trade.

Third, globalisation has a cognitive dimension that concerns the thought processes that shape our perceptions of ourselves and the world around us. Wallerstein (1991) refers to a globalising cognitive framework that he calls 'geoculture', in which 'particular patterns of thought and behaviour – even language – inscribed in geoculture, are not only essential to ensure that the modern world-system functions effectively, but also provide much of its underlying legitimation' (Murden 1997). Globalisation is changing how thought processes are produced and reproduced, particularly through the spread of communication technologies in the mass media, research community and interpersonal communications (e.g. email), as well as what thoughts are being produced (e.g. values, beliefs, ideologies, ethics, cultural identity). There is disagreement as to whether these changes are integrating societies for good or bad. Liberal advocates of the 'global village' vision observe that: 'The world is becoming a single place, in which different institutions function as parts of one system and distant peoples share a common understanding of living together on one planet. This world society has a culture; it instills in many people a budding consciousness of living in a world society' (Lechner and Boli 2000: xiii). Others are worried that dominant western-derived values, characterised by rampant consumerism, materialism and individualism, are being replicated around the world:

> onrushing economic, technological, and ecological forces that demand integration and uniformity and that mesmerize peoples everywhere with fast music, fast computers, and fast food – MTV, Macintosh, and McDonald's – pressing nations into one homogenous global theme park, one McWorld tied together by communications, information, entertainment and commerce. (Barber 2000: 21)

Most overtly, the impact of the cognitive dimension of globalisation on health is its direct consequences for diet and life style. Since the end of the Second World War, populations in high-income countries have become less physically active while at the same time consuming increased fat and sugar levels. Smoking rates have declined in many high-income countries, although the health consequences after many decades of high rates of smoking are now being experienced. The result is a steadily rising incidence of obesity, coronary heart disease, certain cancers and diabetes. Importantly, these changes can be linked to the multi-billion pound marketing of particular life styles via the mass media and other channels of advertising, promotion and sponsorship. According to Wallack and Montgomery (1992: 205), processed foods, soft drinks, cigarettes, alcohol, drugs and toiletries account for 80–90 per cent of all international advertising expenditures. The aspirational messages that advertisers have conveyed for decades in high-income countries are becoming globalised, exported to the increasingly affluent in other parts of the world through global trade and production relations, information technologies (notably the mass media), and the liberalisation and privatisation of economies worldwide.

Along with the replication of life style choices on a global scale, the cognitive dimension of globalisation is shaping policy responses that facilitate or hinder their health effects. Individual life style choices are being made within a broader context of global capitalism. Many of the issues raised by this book stem from concerns that cognitive exchanges within current forms of globalisation are undertaken within highly inequitable circumstances. Rather than a 'meeting of minds', health policy is being shaped foremost by a broader context of certain value systems, beliefs, aspirations and so on that seek to maintain a particular world order. This process is aptly captured in the French expression *pensée unique*, explained by Halimi (2000: 18) as follows:

> It is the ideological translation of the interests of global capital, of the priorities of financial markets and of those who invest in them. It is the dissemination through leading newspapers of the policies advocated by the international economic institutions which use and abuse the credit, data and expertise they are entrusted with: such institutions as the World Bank, the IMF, the OECD, the World Trade Organization.

This shifting cognitive landscape is clearly discernible in the health field where many of the policies discussed in this book derive. For example, Bettcher and Yach (1998) explore the ways in which public health ethics may be changing as a consequence of globalisation. Similarly, debates over how health should be defined are being reframed, from a concern with how to ensure health as a basic human right available to all and collectively provided, to health as a product whose attainment and consumption by individuals should be regulated by a marketplace. This shift is further reflected in the normative criteria, and resultant analytical tools (e.g. burden of disease, cost-effectiveness analysis), which are applied to translate certain values into decisions over, among other things, the allocation of limited health resources. The cognitive dimension relates to both how societies structure and deliver health care, from the underlying principles that guide health care to the specific technical interventions provided, and the deeper structural level which concerns how we act to mediate and direct globalisation towards agreed goals.

Collectively, changes to spatial, temporal and cognitive boundaries can be described as the dimensions of global change. Efforts to understand and respond effectively to these dimensions of change comprise the broad and growing fields of global health policy and governance (Lee 2001).

What is global health policy?

The focus of this book is on health policy and the ways in which globalisation is affecting how policy-making is being carried out in the health sector (and in other sectors and issue areas that impact on health). Health policy is broadly defined as 'goals and means, policy environments and instruments, processes and styles of decision-making, implementation and assessment. It deals with institutions, political power and influence, people and professionals, at different levels from local to global' (Leppo 1997). Global health policy can thus be understood as the ways in which globalisation may be impacting on health policy and, alternatively, what health policies are needed to respond to the challenges raised by globalising processes.

Interest in global health policy can be seen as an extension of a desire, in more recent literature on globalisation, to understand the knock-on effects of current neo-liberal and market-driven forms of globalisation, on public policy especially in relation to social policy. While much of the globalisation literature remains heavily focused on the economic and financial sectors (World Bank 2000), many of the policy areas neglected until recently are now being addressed. Initially, these efforts have come

from scholars in social policy who observe the often adverse effects that globalisation is having on the social sectors such as education, housing and health. Deacon (1997) argues, for example, that national social policy is increasingly determined by global economic competition and certain international organisations. Social policy must thus be understood in terms of global social redistribution, social regulation, social provision and empowerment (Deacon 1997). Alternatively, Kaul *et al.* (1999: 452) conceptualise the shortfalls of globalisation in terms of the undersupply of global public goods defined as exhibiting characteristics which are 'nonexcludable, [and produce] nonrival benefits that cut across borders, generations and populations'.

More recently, attention to the social sectors has come from economic analyses, prompted by externalities of the global financial crisis of the late 1990s, revealing the interconnectedness and mutual vulnerability of national economies and societies. As well as eliciting extensive reflection of the need to strengthen global economic governance (e.g. banking regulation) (Stiglitz 1999), the links between economic and social policy were brought more sharply into focus. As Reinicke (1998: 1) writes:

> without a greater effort to understand the origin and nature of the current global transformation and its implications for public policy, we will continue to react to events rather than act to shape the future course of world politics. Such passivity will leave our societies vulnerable to the risks that change will undoubtedly bring, while forgoing the gains that a more active policymaking could realize.

In relation to the health sector, concerns for nascent global public policy has initially centred on threats to national security or at least the security of high-income countries. In the context of reframing post-cold war foreign and defence policy, this perspective has focused on selected health threats such as infectious diseases, biological and chemical weapons, human migration, and illicit drug trafficking. The global health policy agenda in the US, in particular, has sought to channel the so-called 'peace dividend' to health risks arising from globalisation (Institutes of Medicine 1997; Raymond 1997).

Internationally, global health policy has been cast to emphasise the links between health and economic development led by the World Health Organisation (WHO). Recognising economic integration as a key driver of current forms of globalisation, WHO has strengthened its efforts to understand issues such as multilateral trade agreements, capital flows and macroeconomic policy and their implications for public health. In this respect, Director-General Gro Harlem Brundtland has frequently sought to argue that the protection and promotion of public health is a core requirement of sustainable globalisation (Brundtland 1999a).