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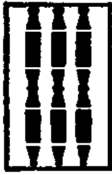

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"*Globalization and Global Health*"

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GLOBALIZATION AND GLOBAL HEALTH

(Giovanni Berlinguer)

1. *Which globalization*

There is much talk of globalization nowadays. Globalization of finances, of just-in-time information, of ethnic migrations, of criminal organizations, of scientific knowledge and technology, of power systems, of production and human labour.

Globalization may either be praised as an opportunity for the economic and cultural growth of all peoples, or criticized as to how it is managed, by whom, in which directions. Yet it is unrestrainable, most of all because it corresponds with the present phase of historical development across the world and because it can fulfil many requirements of the human beings.

The true question to be asked therefore is not whether globalization is good or evil, whether we should foster it or slow it down, but rather: which globalization, to what ends ?

In this paper I will try and provide a partial answer to the question, observing reality from through the prism of health and safety, considered as individual well-being, as essential condition freedom, as a collective interest. My starting point shall be the threat of diseases, outlining some aspects of modern history. I will briefly mention both the results achieved, and the (relative) regression of the last few decades. I will describe damages and hazards as they are accumulating on a global scale - infections, environmental degradation, drug addiction, violence. My conclusive remarks will be mainly of political and moral nature.

2. *Globalization of diseases*

Globalization of disease, namely the spreading of the same clinical entities all over the world, dates back to the year 1492. The discovery (or conquest) of America, a turning point in history, meant also the microbial unification of the world, the transition from separation of peoples and diseases to mutual communication.

Until then, differences in environmental conditions and nutritional patterns, in social and cultural organization, in the presence or absence of biological agents and vectors of transmissible disease had brought about markedly different epidemiological trends in the Old and in the New World.

Indeed, there were no such things as smallpox, measles and yellow fever in the Americas, while syphilis was unknown of in Eurasia and Africa. The first time syphilis broke out in an epidemic in the Old World was as late 1495, when Naples was conquered by the French armies of Charles VIII. This is why the Italians named it "mal franzès" and the French "mal napolitain". When it reached the Far East, the Japanese named it "Portuguese illness", and so on and so forth. The tendency to blaming "others" for epidemics goes a long way back in history. Black Death in Europe was blamed upon the Jews, cholera in New York on the Irish, poliomyelitis in Brooklyn on the Italians, nor should we forget that the first definition of AIDS expressed by the CDC (Center for Disease Control) in Atlanta on identifying the disease was "homosexuals acquired immune deficiency", and the responsibility was often attributed to Haitians.

Since 1492, the new illnesses had a devastating impact on populations where natural immunity was altogether inexistent, particularly on the American continent, and they rank among the causes of the largest genocide in the whole history of mankind. One of its primary causes. And yet, a number of historians maintain an exclusive focus upon this actor, related to the then uncontrollable relationship between micro-organisms and human biological defences. This overshadows the other causes, which are to be found in the loss of identity, of security and power of the New World peoples, in deliberate extermination, in the deadly conditions of slaves working the mines, in the disruption of balanced nutritional patterns, in the psychological and cultural breakdown that weakened resistance to disease and actually caused suicide epidemics.

The microbial unification of the world therefore dates back to the XVI century. Three long centuries were still to elapse for mankind (peoples, governments, culture and science) to recognize the existence of common

risks, to declare the fundamental rights of each and every human being, and to start coping with such risks in a cross-boundary effort.

3. *The earliest globalization of health and safety*

Only in the XIX century was the idea established that the free market, such a strong factor of economic progress, should not be all-embracing. Human beings, first of all, had to remain outside its reach, otherwise everybody's safety and dignity would be jeopardized. On that basic understanding, rules and prohibitions against slavery were first laid down, and in time accepted world-wide.

Only in the XIX century did the three pre-conditions develop for an effective action against transmissible diseases, which in all countries were by far the most important cause of death: the knowledge of their causes, the identification of appropriate prevention and therapy, and the will for international action.

The first example of such action was smallpox immunization. A long-standing practice in Asia based on serum from healed smallpox blisters, it came into Europe through a notice from Turkey, where female healers successfully induced an attenuated disease in children, thus giving them permanent immunity. That practice failed to spread in Europe, probably because of the "epistemological blindness" and professional haughtiness of the European physicians, safe in the belief they had nothing to learn from persons they considered as intellectually underdeveloped on three different grounds, being females, being quacks-doctors, and being Turks. Immunization gained ground in Europe, and then spread all over the world, only when Jenner re-invented it, improved on it and showed how effective it was on a large scale.

The decades spanning from the late XIX to the early XX century were the most successful in the fight against epidemic diseases. A number of microbes were discovered, agents of widespread and lethal infections such as tuberculosis, plague, cholera, as well as their transmission, through arthropods or through polluted food and water. Sera and vaccines were introduced. Many cities and towns were reclaimed to prevent epidemics. Bills were voted to bring down working hours from 14-12 gradually to 8 hours a day, to provide protection to pregnant workers and to limit child labour. Social insurance and various forms of collective protection of health were developed. Nations agreed to co-operate against the transmission of disease across the planet, and the International Epidemics Office was created, the first seed of a world health agency.

It is of some interest to point out that many biological agents and vectors of epidemic disease were discovered by medical officers, or military scientific commissions following the drum of colonial armies. The plasmodium of malaria in Northern Africa, the role of fleas and rats in the transmission of plague in India, Aedes aegypty as vectors of yellow fever in Central America at the opening of the Panama canal are significant cases in point. These researches were encouraged also because disease would strike down armies and settlers along with the local population, and new medical insight was indispensable for continued conquests and exploitation. But its benefits did spread everywhere, including (to a lesser extent) the local populations

The interplay of a number of factors and the convergence of widely different interests resulted, for the first time in history, in a constant regression of the "eternal" scourge of mankind. It paved the way to increasing life expectancy in the human species, a phenomenon which occurred with large variations in time and space over the planet - thus maintaining substantial inequalities among peoples and social classes - but in the end it is a remarkable social and biological progress in our century.

Our century brought also in its wake two world wars, genocides, violence, local wars beyond number. But the judgement of a historian such as Toynbee holds true: "The XX century shall be essentially recalled not so much as an epoch of political conflicts and technical inventions, but rather as the time when human society dared to think about health care of the whole human species as a practical objective within its reach".

4. *The regression during recent decades*

But I am not sure about the most recent decades being so positively recalled. This is a pervasive feeling, largely based upon facts: the slackening of health progress, the growing differences and inequalities in health and safety standards among nations and within most nations, the surrendering of so many hopes. It also reflects the orientations prevailing in many countries and internationally, which I we can sum up in four main points.

1. Owing to its own weakness and to the declining commitment of national governments, the World Health Organization has lost its leadership in health policies across the world. Power and influence have shifted on to the World Bank and the International Monetary Fund, which are becoming (not for ever, I hope) the real health leaders, especially for developing countries.

2. The notion of health as a corner stone of economic growth, as a multiplier of human resources, and most importantly as a primary objective of such growth, has been replaced far and wide by an opposing notion. Public health services and health care for all are now perceived as an obstacle, often as the hardest obstacle, hindering public finance and the wealth on Nations, so much so that reduction in health expenditure (not rationalization, which is imperative everywhere!) has become one of the top priorities for all governments.

3. The model of primary health care as fundamental for the prevention and treatment of diseases has been abandoned. The trend is now towards dismantling the whole machinery of public health. Even in countries with minimal resources, priority is given to costly technologies to the exclusive benefit of very few happy few. Community services are increasingly replaced by private insurance - which in the US turns out to be the most expensive and least equitable system of health delivery - and the State is only made responsible for the poor: in brief, a step back to XIXth Century Europe!

4. The notion of the world health as indivisible – a milestone in the middle of this century, the founding principle of WHO itself - has been supplanted by a widespread belief, in Europe and the United States that our peoples could enjoy the best possible health separated from the suffering of other peoples. The same misconception is largely shared, within each country, by its rich and healthy social groups, unresponsive to the conditions of the underprivileged.

I am not pessimist about the future. I do believe that doctors, scientists, public bodies and NGOs, all those operating in the health sector, are bound by a dual pledge to human society: the pledge of secrecy to sick individuals putting their lives in our hands, and the pledge to speak out, to inform everybody on the threats looming ahead on the community's health and safety.

Therefore I would like to mention some processes, which are under way and which entail not only hazards but increasing damage to individual and collective health and integrity. They are diseases, or "social pathologies" provoking similar negative consequences in the human beings: the exacerbation of old infections and emergence of new ones; the impact of environmental changes on human health; drug traffic on a world-wide scale; destructive and self-destructive violence.

5. *Infections, old and new*

Mortality rates from infectious diseases were cut down so drastically in all countries of the world, that in recent decades the hope of a world unaffected by epidemics seemed within our grasp.

Most unfortunately the continued vulnerability of peoples to microbes and viruses was confirmed in the '70s and the '80s by the emergence and identification of the AIDS virus, which rapidly disseminated practically everywhere. And other facts followed it: the identification of new viral agents, so far luckily confined within specific geographic areas; the transmission across continents of diseases hitherto considered as persistent only in a few countries, such as cholera; the impact of malaria, killing victims by the millions every year in Africa and elsewhere in the South of the world; the recrudescence, growing virulence and increased morbidity for Mycobacterium tuberculosis, even in Europe and the US.

The usual explanation given for all such events is the exponential increase in the numbers of men and women travelling at top speed throughout the world. That is the truth, but not the whole truth.

BSE (Bovine Spongiform Encephalopathy) spread across the human population in the UK for the very simple reason that cattle breeders had fed their cows with sheep meat, viscera and brains. For the sake of gain, noble herbivores had been turned into carnivorous, opening the way to interspecific transmission of prions.

Tuberculosis is not only increasing because it is an opportunistic infection in AIDS patients, but also because poverty and urban marginalization are increasing as well, along with nutritional deficiencies, child labour, and the inappropriate and indiscriminate use of antimicrobial drugs that has induced the selection of drug-resistant strains.

If parasitic diseases as malaria still persist, that is also due to scanty investment in vaccine research and development. Comparing malaria to AIDS, investment ratio is one to ten, or less, the only objective difference between the two diseases is that the latter may kill both rich and poor.

And what about international travels? They are not only due to tourism, culture, work and business. In the last ten years 50 million men, women and children have been forcibly displaced from their home country as a consequence of famine, civil riots, putsch and wars: tragedies that in the course of history have been constant harbingers of disease.

All these events lead us to reconsider the so-called "epidemiological transition". It is usually defined to be a transition from infective diseases to chronic-degenerative, or rather to non-infectious diseases, as being the dominant phenomenon. This approach holds true for life and death statistics, but some further considerations are in order.

Item one, this analysis cannot be transferred to morbidity statistics.

Item two, the reappearance of old infections and the emergence of new ones should alert us to the fact that prions, viruses, microbes and parasites need no passport and no visa to cross national boundaries. "Ever since the world is becoming smaller as a result of modern means of communication ... human solidarity in the health domain cannot be neglected with impunity": it is a quote from Henry Sigerist in *Civilization and Disease*, written in 1943, that is 55 years ago.

Item three, if we move beyond mere description and seek a causation explanation, "epidemiological transition" is also (or primarily) the passage from *physiogenic* diseases, having mainly a natural origin, to predominantly *anthropogenic* diseases. For the latter, the origin lies within ourselves, human beings, in our actions and/or omissions, in the absence of foresight and solidarity in our thinking. Being anthropogenic, these diseases are neither fatal nor irreversible: we are able to modify them, to bring them under control.

6. *Medical alert for the environment*

A risk of irreversible damage however exists. It concerns the environment. Many changes in the environment led to better health and sanitation: urban reclamation, for one, was a determinant factor in the fight against oro-fecally transmitted diseases, just as increased agricultural productivity (making proper use of chemistry and biotechnologies) was essential to free many peoples from hunger.

In recent decades, however, many damages have appeared, as a result of air, water, soil and subsoil pollution, of depletion of natural resources, of declining quality of life in large and crowded urban centres.. Especially in the metropolis of poor countries, the striking contrast between the ostentation of wealth and the increased poverty is one of the main causes of dissatisfaction and even of crime.

Even more alarming are the risks for the future. *The New York Times* has published on December 1st, 1997, an appeal to physicians and to everybody highlighting the possible effects of *global warming*:

"1. Increased illness and deaths from heat waves and air pollution, particularly in urban areas, with the elderly, infants, the poor, and those with chronic heart and lung disease the most at risk.

2. Increased injuries and deaths from extreme weather events.

3. Increased outbreaks and spread of some infectious diseases carried by mosquitoes, including viral encephalitis, dengue fever, yellow fever, and malaria.

4. Increased outbreaks of some water-borne diseases such as childhood diarrheal diseases and cholera.

5. Decreased availability of drinking water from the effects of drought, flooding, and rising seas.

6. And perhaps of greatest concern, damaging effects to organisms on land and in the oceans that could compromise food production and alter the functioning of ecosystem services that provide the life support system for all life in this planet."

On signing their appeal, scientists frankly recognized that "there are many uncertainties in these forecasts, and that some of the health effects here described may be less severe than anticipated". Two considerations, however, are in order.

The first is of a practical nature. Even when the severity of damages is unpredictable, we do already perceive many of them. And above all, here comes the crux of the question. Is it possible to avoid action when, even if there is still uncertainty about the magnitude of some developments, one thing is for sure: in case of inaction on our side, they shall undoubtedly become irreversible ?

The second consideration is of a moral nature. The consequences of already established damages and risks of environmental changes quite often fall far away from the primary originators; they also involve yet unborn human beings. Under these conditions, damage/benefit and risk/benefit analyses are out of the question. We face an extremely asymmetrical relationship: benefits accrue to some, while damages and risks are or will be shared by others. Even the golden rules of ethics seem insufficient. We may rather rely upon the "responsibility principle" as stated by Hans Jonas, involving both an ethics of proximity and an ethics of distance, where the frame of reference is *the world space* and *the time of future generations*. It implies a power of prediction and prevention which can only operate on a global level, and which needs deep changes in public ethics and the law, and in world governance.

7. *Two routes for drug traffic: South to North and North to South*

Drugs are a fundamental risk for the present generations, particularly the young. Psycho-physical damage resulting from drug abuse is often connected with the presence of organized crime, often multinational in scope. It stimulates drug consumption, channels its huge profits often recycled through banks into legal business and contributes to political corruption.

Awareness of the health and safety risk of drugs has started a heated debate, centred on possible conversion of production in opium and coca-exporting countries. A second focus of debate is the strategy of "damage containment", intended to separate as far as possible the intrinsic effects of drug addiction from an increase in criminal activity as well as from irreparable health hazards, such as the dissemination of AIDS through heroin-infected needles. A third focus relates to a possible legal use of "soft drugs" and to the controlled use of heroin.

In these debates, the need for individual and collective security clashes sometimes with the feelings of solidarity for drug addicts; and practical necessities, ideological bias and value systems often prove difficult to reconcile.

I will only draw attention to a largely unnoticed fact. The United Nations has set up a special agency to cope with the problem. Paradoxically - and the only plausible explanation involves power relations in the international community and in the mass media - the alarm and all proposed actions are exclusively targeted against coca, opium and related products: harmful and even lethal drugs, no doubt, which grow in the poor countries in the South of the world and threaten the rich countries in the North. Not a word is said about alcohol and tobacco, which are produced and above all distributed by the North, and are now invading the South of the world through the multinational corporations.

World Health, the WHO journal, reports that "the greatest concern for tobacco in the world at the present time is the increasing consumption in developing countries. Tobacco market is declining by one per cent a year in the West, while increasing by a steady two per cent a year in the South ... The experts predict that cancer and other tobacco-related illnesses will break out in those countries before transmissible diseases are brought under control, so that the gap separating rich from poor countries will grow even deeper".

And what about national governments and international organizations? What are they doing?

The European Union, for a start, is making a big show of its two million dollar investment in the fight against tumours, particularly lung cancer. At the same time, the EU has allocated over two billion dollars to subsidize tobacco growing in Europe and its exports to other parts of the world. As to the United States, in the last few decades it "donated" 700 million dollars' worth of tobacco seeds to poor countries, with a pledge to later buy their leaves, within the framework of "Food for Peace" aid programmes. It also threatened trade sanctions against four Asian nations unwilling to give access to cigarettes manufactured in the US. For the

World Trade Organization, limiting the international sale of tobacco and cigarettes would be a gross transgression of free trade rules. When it comes to coca, opium and the like, the WTO sings a different tune.

I am not going to elaborate any further on that, since those facts are self-evident home-truths. Rather, I have three questions to ask:

1) When working in health education and promotion or wellbeing of our fellow people, are we allowed to forget that (possibly for the first time in history, certainly on such a global scale) we are facing powerful international organizations who, for their own interests, are actively promoting behaviours recognised as certainly harmful and often lethal ?

2) Are we supposed to think that dissemination of drugs calls for attention and prompt action only when criminal organizations are involved, whereas trade protection and penal impunity are due when we face industrial organizations, even though they have a more destructive global impact on human life and health ?

3) Finally, what about the United Nations, the WHO, the WTO, what about the governments both in rich and poor countries ? What are they doing to cope with these absurd inequalities, what are they doing to ward off this announced massacre, or at least to contain its ravages ?

8. *Violence and violences*

I am not going to introduce to you here the "epidemiological patterns " of violences. Suffice to say that in almost all countries they are the primary cause of death of adolescents and young people (especially males), that they destroy the life and damage the physical and mental integrity of millions of women and children.

Statistics are plentiful, usually only partial in scope, considering how difficult it is to work out a taxonomy of violences.

There are real and virtual violences: there is a reality of violence which is reflected in (and magnified by) violences as represented or imagined in virtual reality, which are being watched by TV and film viewers all over the world, most of all by children, every single day, many hours in the day.

There are violences which are judged as "without malice aforethought", such as industrial and road accidents, or accidents in the households, where however the standard notions of "negligence, imprudence, inexperience, lack of compliance with laws and regulations" seem insufficient. As a matter of fact, statistically measurable and predictable factors connected with economic interests are heavily involved,

such as for instance the manufacturing of cars whose key marketing and selling feature is to exceed speed limits existing in any country.

There are wilful violences, which arouse the strongest indignation in the public opinion: violences against the weak and by the weak; sexual violences and harassment as well, that at last recognised as a crime in a number of national legislation. Violences against children and against the elderly; hooligan violences, violences against animals. And finally, a comprehensive taxonomy should also trace back the roots and motivations of individual and collective violences.

All these phenomena cannot be medicalized, even though the medical professions is often called into question, for different and opposite reasons. Sometimes, even as actor or an accomplice to violences. In the Soviet Union psychiatry has been for decades an effective tool of political repression, and in Latin America military regimes had large numbers of physicians as accomplices in torturing prisoners. Reports of forced sterilization in Sweden, continued well into the Sixties, and of lobotomy being an admitted practice in large parts of Europe till recent times, bring home the same point: not only the Nuremberg Code, but the Hippocratic oath itself "*Primum non nocere*", are not universally applied.

Medicine is also frequently called upon to bring remedy to violences: to provide treatment to their victims, and their perpetrators alike. The decision of some judges (but also the request of convicts of sexual offences) to resort to physical or chemical castration to prevent recidivist behaviour stirred up far-reaching discussions. Biological and behavioural sciences are called on to account for aggressive and criminal behaviour. This line of research may be fruitfully explored, but I for one do not believe that violences may be exclusively interpreted within the sociobiological category of "aggressive human nature". Such approach may possibly provide the scientific foundation for a better understanding of individual cases, but it does not and cannot explain time and space patterns of variation (usually on the upward trend) of global violence and of individual forms of violence.

Whenever violence breaks out anywhere in the world, against one gender or one ethnic group, against other ideas in the brains or a different colour in the skin, driven by ideological or national or religious beliefs or willing to take its revenge on the world at large - whenever violence comes out as organized or generalized crime, in the form of political oppression or as action and reaction - it is hard to imagine that any human being may think: "It is none of my business". That they may feel insulated, protected, sitting smugly in the double cocoon of insensibility and unresponsiveness.

Just as drug habits are transmissible by inducing drug consumption, so is violence transmissible, not only through the machinery of criminal organizations and sometimes the States themselves, but also along material and cultural paths - by imitation, by suggestion, by sensation, through the tensions and strains violence produces within individuals, social groups and whole peoples. Violence is transmitted as widely as infections, may be more rapidly. The basic difference is that no vaccines, no medicaments are available: violence is best counteracted by social and cultural antibodies.

I have a feeling that faced with violence (and drugs alike) the prevailing attitude is a selective rejection or acceptance, depending mainly by prejudice or bias. I believe that modifying this attitude is the essential preliminary condition for a global approach to the problem of violence.

9. *Some conclusions*

Globalization is not a dirty word, a wicked invention of neoliberism. Globalization is a positive tendency of the *Homo sapiens sapiens* species, in the present stage of knowledge and development. Any negative perception of globalization relates to its marked unbalance in terms of power and ultimate purpose. These are the features we are bound to change.

In terms of power, we cannot accept as unique authority that of the few nations (the 7 or 8 richest countries) who claim it is their right to decide for the whole world, and of the monetary institutions who claim that all human activity shall be subservient to their own interests. With a positive outlook, the aim is to pave the way to a "universal democracy" in which the voice of all peoples and of all interests is heard loud and clear, through intergovernmental organizations such as the UN and the WHO, and of the NGOs as well.

In terms of ultimate purpose, the fundamental human rights and the problem of equity should have pride of place - or at least they shall come back on the scene, after a long period of neglect. Health and safety pertain to this domain, as the right to life and a pre-condition for all forms of freedom.

Moral values such as universality, solidarity, justice, are often indicated as appropriate stimuli for this purpose: indeed, they are necessary but not yet sufficient. We shall also think in terms of mutual interest, of mutual advantage. Humanitarianism is a powerful force, but let's not forget another force, convenience, which is not necessarily always against it.

When the two of them come together, progress will be faster and last longer.

That is what happened at the beginning of our century. And yet, after the microbial unification of the world, after the separation of continents became communication, more than three centuries were to elapse before the first globalization of health and safety could begin in the recognition of mutual dependence. Sharing the risks I outlined in my four key points, we cannot afford waiting three more centuries, nor even three decades. The vital interest of peoples and of civil coexistence is at stake, along with the efforts of all the people concerned with health, safety, quality of life.

Short of a reversal of the present trend, we shall all face a deepening dual conflict between morals and daily practice. On the one hand, we shall be called on and forced to repair, however late and haphazardly, the predictable and preventable damages inflicted on human health and integrity. On the other hand, we shall do so with more sophisticated technical and scientific equipment, but under more stringent social and economic conditions, with dwindling resources and declining public support. It may even fall to ourselves to decide who is going to live and who will die, selecting individual patients. A bottomless pit, for professions and activities intended to foster and protect all human life.

If this is not to be the reality of the future (as it already is part of our present) we shall have to work hard. Starting from now.