Globalisation & Healthcare Mission

"The benefits of globalization are potentially enormous, as a result of the increased sharing of ideas, cultures, life-saving technologies, and efficient production processes. Yet globalization is under trial, partly because these benefits are not yet reaching hundreds of millions of the world's poor, and partly because globalization introduces new kinds of international challenges as turmoil in one part of the world can spread rapidly to others, through terrorism, armed conflict, environmental degradation, or disease, as demonstrated by the dramatic spread of AIDS around the globe in a single generation." [1]

Globalisation & The Poor

"The poor you will always have among you." [2]

Jesus' comment to Judas was not just a statement of fact, but also an indictment. Poverty is as real and horrifying in our day as it was in the first century, but the scale has grown beyond all imagining.

Consider these few stark facts:

- The growth of the world economy doubled in the twenty five years before 1998
- Yet around 1.3 billion people live in grinding poverty (income < US$ 1 per day)
- Developing world population numbers 4.4 billion
- Significant proportions of this population lack
  - Sanitation (3/5)
  - Clean water (1/3)
  - Health care (1/5)
  - Enough dietary energy and protein (1/5)[3]

Economic disparities both within and between countries have grown over the past decade, and incomes are lower in real terms in about 100 countries. According to the International Poverty and Health Network (IPHN), the link between economic growth and health is not automatic. Poverty is multidimensional. Improving the average health of a nation may widen inequalities, with the rich getting healthier, and the poor getting less healthy[4].

There are broadly speaking two main schools of thought on the impact of economic globalisation on the poor. These can be separated roughly into the anti- and pro-globalisation lobbies.

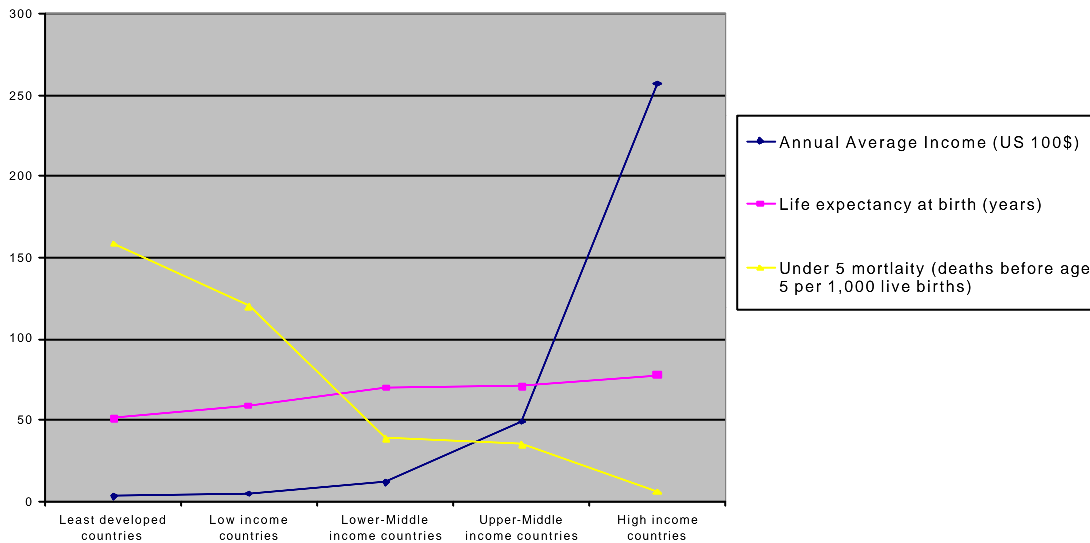
The first school holds that economic globalisation is inherently unjust, that it perpetuates the rich poor gap by forcing poor nations to trade on the rich nations' terms. Thus for example a cup of coffee in your local Starbucks may cost you £1.75, but the coffee producer in Latin America or Africa will only see 5p of that as international coffee prices plummet due to (mainly Western led) market pressures.

Naomi Klein[5] is the guru of this school, and with George Monbiot and many others has helped pave the ideological way for the anti-globalisation movement that has been so evident at recent G8 and World Trade Organisation [WTO] meetings.

The other school, typified by the WTO and the World Bank, etc. argues that only though trade liberalisation can the poor by positively affected by 'economic uplift'. In fact, the cause of world poverty, they argue is *too little* globalisation rather than too much[6,7]

The one point at which both the schools of though would broadly agree is that wealth affects health (see figure 1).

Figure 1



The graph[8] shows how increasing income has a measurable impact on basic health indicators such as longevity and infant and under five's mortality. If a nation is wealthy as a whole, it can (theoretically) afford better health infrastructures, so more people can access adequate healthcare. If people are wealthier, the theory goes, they can afford to pay for healthcare (either directly or indirectly through taxation) so they become more healthy. More fundamentally, they can afford to eat better, and can afford better housing and sanitation.

In practice, increases in national wealth often tend to benefit the health of those who are already wealthy more than benefiting the poor. New wealth tends to congregate around those already better off rather than reaching the poor, while healthcare services, as they improve become more costly - both factors tending to disadvantage the poor[9].

However, health also affects wealth. As people's overall health improves, so their ability to earn a living improves, and the drain on their incomes of medical bills is reduced. This also affects the wealth of the nation as a whole because the drain caused by an overburdened health system and a large unproductive population is reduced. A recent report[10] suggests that if the basic health inequalities in the poorest nations of the world were met, over US$ 186 billion per annum could be added to the global economy and the resultant economic uplift could take many nations out of poverty. More significantly, eight million lives would be saved each year.

To achieve this the report calculates that all the developed nations need to give a total of US$ 27 billion per annum ($_c$£19.4 billion), and the developing nations increase their spending on health by US$ 38 billion ($_c$£27.4 billion). If we consider that the US mobilised $40 billion in a few weeks to fight the war in Afghanistan, or that the costs of the proposed health development programme are equivalent to $25 (£18) per person per year in the developed world, it becomes apparent that the missing ingredient is not money but political willpower. Again, on this both schools of thought would agree, although the pro-globalisation group would point out that the lack of political will (or, indeed infrastructure to sustain development of health services) on the part of the governments of many developing nations is equally a part of the problem[11].

The focus of the pro-globalisation development agenda is primarily economic and at the macro level. For example, a recent initiative (The Global Health Initiative [GHI]) which came out of the World Economic Forum [WEF]) seeks to get businesses to tackle the health needs of both their employees and the communities in which they operate – on the basis that investing in health will yield economic benefits in the long-term. This initiative is being seen as major driver in the international fight against HIV, Malaria and TB[12].

Opponents of economic globalisation argue that this is naï ve, as the major causes of poverty in the developing world are these self-same businesses, and that 'enlightened self-interest' will never ultimately

benefit the poor. As Christians, accepting the doctrine of the fall the admonitions of Amos and Isaiah, we would probably broadly agree with this point.

In response, as the WEF was meeting in New York in February of this year, an even bigger gathering in Porrto Alegre, Brazil was looking at how to tackle corporate power on behalf of the poor. One clear example of this is the issues of Intellectual Property Rights (IP) for pharmaceuticals. IP rules mean that developing countries that manufacture or purchase cheaper versions of many drugs (most topically, HIV Anti-retrovirals) are breaking international law. A recent campaign and international court ruling has encouraged the WTO to allow generic drugs to be manufactured at low cost in developing nations, and has forced the pharmaceutical companies to begin to supply drugs at cost to developing nations[13].

This however has not tackled the chronic under-investment in developing drugs that primarily benefit people in the developing world (e.g. treatments for common tropical diseases such as sleeping sickness, Leishmaniasis or Chaga's disease). The capitalist economic model encourages pharmaceutical companies to invest primarily in drugs that will be profitable, i.e. those that treat primarily western conditions[14]. Therefore, it is more profitable to invest in drugs that correct male sexual dysfunction, for example, than those that will effectively control the current epidemic of drug resistant malaria. A recent report shows that many leading pharmaceutical companies spend less that 1% of their research and development budgets on the major illnesses of the developing world[15].

The anti-globalisation school, having realised how powerful companies are in affecting the health and wealth of nations, are increasingly targeting the practices of trans-national business rather than governments to seek justice for the poor.[16]

Economic globalisation is a hot topic as either the cause or cure for world poverty, and thus of health inequalities. However, it is not the only factor

Globalisation and Global Health

Globalisation in its wider sense also has a major impact on health, and always has done. The movement of people through trade, exploration, world mission and (latterly) tourism, has ensured that many infectious diseases are moved from one corner of the globe to another – hence the devastation wrought on the native Amerindians by 16th century Spanish explorers carrying small-pox, and more recently the rapid spread of HIV and AIDS. These movements are also tied in with wealth and poverty. The poor increasingly move into urban areas looking for work as rural economies collapse (e.g. as a result of the fall in coffee and cocoa prices in recent years), making them vulnerable to infectious diseases, waterborne illnesses (most slums lack good sanitation and clean water) and diseases usually thought of as diseases of affluence such as cardiovascular disease and cancer (smoking - a habit imported from the West, and supported by international tobacco firms who pump a large part of the advertising budget into the developing world, is a growing health problem among the world's poor, especially in cities)[17]. Meanwhile, wealthy sex tourists from the West have introduced HIV and other STDs (most notably in Haiti and Thailand), and are now acting as vectors to bring those diseases back to the West[18].

Furthermore, people moving to rural areas to escape war, famine, or overpopulation make themselves vulnerable to illnesses such as Leishmaniasis, Ebola, Kayasanur Forest Disease, etc. These are exacerbated by environmental damage – for instance Kayasanur Forest Disease (like Lyme Disease) is transmitted by ticks, whose normal hosts (small mammals and birds) were driven from their habitats due to extensive (economically driven) de-forestation, making populations near the affected areas vulnerable[19].

In short, the complex dynamics of human global relationships have a major impact on the social and environmental causes of disease, and on access to healthcare.

Moreover, we are naïve if we think this has no impact on life here in Britain. Global health issues are on our own doorstep. For example, AIDS, Malaria and TB, which are now endemic problems worldwide, are now hitting the UK. There are regular reports of TB outbreaks in schools[20], and there are concerns about the immanent arrival of malaria in coastal regions, where mosquitoes coming off cargo ships from the southern hemisphere are once again beginning to breed[21]. Meanwhile, AIDS is now one of the leading cause of death of young men and women in the Greater London Area – many of those affected are increasingly from the sub-Saharan African communities living in and around the capital.

In addition to these movements of people and disease, there is also a movement of cultural ideas. Western biomedicine is as culturally bound as any healthcare system[α]. This realisation, amongst others, has helped to undermine the standing of biomedicine in Western culture, so that in the post-modern West, eastern medical paradigms such as the Ayurveda and Traditional Chinese Medicine (TCM) are increasingly popular, offering an alternative to Western medicine for those who perceive it to have limitations in dealing with chronic illnesses in particular. The evidence-based practice of modern medicine is being challenged by some thinkers who argue that the whole scientific paradigm itself is wrong – thus further undermining the role of biomedicine in its heartlands of Europe and North America[22].

In developing nations, these Asian systems and numerous other local healing traditions compete with Western Christian medical services - often to the detriment of patients. In some cultures Western medicine is only used to treat certain conditions. Some cultures believe that your soul is lost or damaged if you die in a hospital so will not seek treatment for serious conditions. Others see Western medicine as useful only for treating certain acute illnesses or as a quick 'pick me up', and continue to use traditional healers for other complaints. Consequently, many people do not get treatment for easily manageable conditions until they reach crisis stage.

Furthermore, primary care and preventative medicine are affected by many religious and other cultural belief systems. For instance in some West African cultures it is believe that a man will lose his soul if his body is pierced by metal, hence a dangerously low uptake in vaccinations for boy children.

The failure in the past of some Western health practitioners to realise the interaction of local and Western health beliefs has added to the problem. Poverty is not the sole reason people do not come to the mission hospital or clinic for help[23].

Christian responses

"Heal those who are sick and say 'the Kingdom of God has come near to you'"[24].

*"Learn to do good, seek **justice**, **rescue** the oppressed, **reprove** the ruthless, **defend** the orphan, **plead** for the widow"* (emphases mine)[25]

"I have become all things to all people, so that I might by any means save some" [26]

Healthcare has historically been a key part of Christian Mission to the poor [27]. Jesus sent out the disciples with a mandate to heal the sick as well as to preach the gospel[28]. Healing is one of the marks of the Kingdom of God[29]. Yet today, global changes are impacting health as never before, and the issues being faced by those caring for the sick are far more complicated than even a generation ago[30].

For example one mission leader recently told me that his organisation's work in Africa was now so impacted by AIDS that they were having to refocus on HIV prevention and care, even though their primary emphasis has always been on church planting and training church leadership.

The relationships between poverty, health, trade, and culture are now better understood. In tackling the health problems being faced by the poor, how do we try and tackle the root causes? What is the role of Christian Mission in confronting the issues of economic justice that contribute to ill health? Is advocacy a part of mission?

Should we be campaigning on the IP issue, for example, ensuring that the poor get access to life saving drugs, as well as caring for those dying with AIDS? How can Christian businesses be a positive force in the health needs of the poor, and how might we work with them? Do we have something to say about the issue of HIV that can influence behaviours and attitudes positively? And how does our growing awareness of what is happening globally affect our understanding of our local situation?

Healthcare mission is cross-cultural, so how do cultural beliefs and attitudes (of both healer and patient) impact healthcare provision? How do we as Christians and health carers seek to be respond sensitively and appropriately to local health beliefs and practices without compromising clinical efficacy, Biblical truth or our Christian witness? Should we not also look critically our own practice and health beliefs from a Biblical viewpoint, as well as examining other health systems from the same perspective (for example, is

---

[α] Being 'culture bound' does not imply arbitrary or unproven. Rather, in acknowledging that in all spheres of human activity culture is a factor and that beliefs and assumptions are not just based on 'hard evidence' but also on deeper cultural values and assumptions, we can understand how any activity we undertake is affected by the social and cultural environment in which it is undertaken.

the materialistic reductionism of much Western medicine any more or less Biblical than TCM, with its emphasis on treating body, mind and emotions as one)? How do we deal with cultures that treat Western biomedicine as 'alternative therapy'? How do we respond to the globalisation of alternative healing paradigms - are they all Satanic or superstitious or should we be prepared to selectively integrate some into our practice, and if so on what bases (clinical and spiritual)?

At the conference, our agenda will be to discuss these issues, and how they affect our work. The three main questions I feel we need to address are:

1. How does globalisation affect our individual mission situations?
2. What examples can we bring from the situations in which we work that might encourage and inform others facing similar issues?
3. Is there a wider, strategic response that we can take? Where might this intersect with the other Global Connections Fora?

Acknowledgements

Many thanks to Dr David Clegg for letting me use and quote from his draft paper on ‘The Impact of Globalisation on Global Healthcare’ which goes into more depth and breadth than I am able to do here, and from a more authoritative position.

Bibliography

[1] 'Investing in Health for Economic Development'. Report of the Commission for Macroeconomics and Health, December 2001
[2] John 12 v8
[3] 'WHO Bulletin Spotlights Serious Inequalities in Health' – Press Release WHO/6 26 January 2000
[4] Haines A, Heath I, & Smith R (2000) 'Joining together to combat poverty' – BMJ; 320: 1-2.
[5] Klein, Naomi (2nd Edition, January 2001) 'No Logo'. Flamingo; ISBN: 0006530400 1
[6] 'Globalisation: Is it at risk?' - The Economist, Feb 2 2002
[7] Annan, Kofi Financial Times, February 4 2002 – 'The Bottom Line is Hope: Companies must take the lead in ensuring that globalisation benefits the many, not just the few'
[8] 'Investing in Health for Economic Development' – Ibid.
[9] Haines, Health & Smith – Ibid.
[10] 'Investing in Health for Economic Development' – Ibid.
[11] 'Terrorism is Not the Only Scourge' – The Economist, Dec 22 2001
[12] 'World Economic Forum CEOs call for Greater Corporate Engagement Against AIDS/HIV, TB & Malaria' – World Economic Forum Press Release, Feb 2 2002, New York
[13] Financial Times, February 4 2002 - 'Campaigners set to focus on world's biggest corporations'
[14] Griffins, J (2002) 'Developing World Drugs' – Triple Helix, Spring 2002
[15] www.doctorswithoutborders.org/publications/reports/2001/fatal_imbalance_short.pdf
[16] Financial Times, February 4 2002 – Ibid.
[17] 'One in Five School Children Smoke in Developing Countries' – WHO Press Release WHO/51 14 August 2000
[18] Panos Dossier (1988), 'AIDS and the Third World' Chapter 8, p 88-91, The Panos Institute, ISBN 1-870670-04-3
[19] Hellman, C (1994) 'Culture Health & Illness', p 380 - 381
[20] 23 October, 2000, 'Sharp increase in tuberculosis' - BBC News On-line, http://news.bbc.co.uk/hi/english/health/newsid_986000/986406.stm
[21] Private communication with health workers in Kent.
[22] Glazer, S, (2000) 'Post Modern Nursing', www.thepublicinterest.com/current/article1.html
[23] Hellman, C (1994) 'Culture Health & Illness'
[24] Luke 10 v9
[25] Isaiah 1 v17
[26] I Corinthians 9, v22[b]
[27] Davey, T F (1985) Introduction to 'Heralds of Health', Edited by Stanley G Browne, pp 1 – 1. CMF/IVP ISBN 0-906747-17-1
[28] Luke 9 v1-2
[29] Luke 7 v20 - 23
[30] Clegg, D (2002) 'The Impact Of Globalisation On Global Health' – unpublished.