

# In this month's *Bulletin*

## Globalization is good for you

Non-globalizing countries suffered an 18% fall in GDP in the 30 years from the 1970s to the 1990s, whereas in globalizing countries the GDP grew by 104%, according to Dollar (pp. 827–833). Increased trade has no correlation with changes in inequality. The proportion of the population in Viet Nam who are poor declined from 75% in 1988 to 37% in 1998, as that country opened up to foreign trade. Conclusion: global economic integration can be a powerful force for increasing incomes and hence improving health and other aspects of welfare. However, for that potential to be fulfilled, complementary policies within developing countries and further improvements in international architecture, for example in intellectual property rights, are required.

## Globalization is bad for you

Among other ill-effects, globalization has caused a series of banking-financial-currency crises followed by recession and a steep rise in poverty rates, Cornia points out (pp. 834–841). The rise of income inequality has been universal in the former Soviet Bloc, almost universal in Latin America, common in the OECD countries and frequent in Asia. In a study of 18 developing and transitional economies, policy changes towards liberalization and globalization are followed by rising inequality in 13 of them. Conclusion: for many countries, premature, rapid and unconditional globalization is likely to generate immediate costs in efficiency and welfare that would worsen growth performance and health outcomes.

## The outlook from three spots on the globe

In **Kerala, India** (pp. 892–893), good organization has achieved for US\$ 28 per person per year public health status comparable to that of the United States, where it costs US\$ 3925 per person per year. The challenge now is to attract more investment without sacrificing the welfare gains of the past, and without a market takeover of health, which could price out the poor. In the **United**

**Kingdom** (pp. 890–891) a nongovernmental research and policy organization is exerting its influence on the government to seek ways to make globalization work in favour of health in developing countries rather than against it. In **Thailand** (pp. 889–890) globalization is associated with problems: unequal access to medical care, environmental pollution, exposure to new and resurgent diseases, and unhealthy lifestyles figure prominently. A new international authority is needed to monitor and mitigate these ills. Far-reaching reform in existing international and national organizations is also needed.

## Globalized information in India: opportunities and constraints

Chandrasekhar & Ghosh (pp. 850–855) confront us with this dilemma: investing in information and communication technologies appears to be the main opportunity for cutting health care costs dramatically while improving their quality. But in developing countries excessive emphasis on these technologies would divert resources from much more crucial expenditure on education, without which the digital divide would rapidly widen.

## Exotic globalized food in Tonga: mutton flaps and chicken parts

Evans et al. found that food preferences and perception of nutritional value are less influential than prices when it comes to doing the food shopping (pp. 856–862). Health education on diet-related diseases is thus of little use without corresponding economic conditions. One possible solution would be to follow the example of Fiji and ban the import of fatty foods. However, as a full member of the World Trade Organization, Fiji is under threat of complaint by New Zealand. Another solution would be to promote sustainable indigenous fishing and farming activities. Both solutions could be upheld under Article XX of the General Agreement on Tariffs and Trade, which favours “measures ... necessary to protect human, animal or plant life or health”. All you

need is a handful of good international lawyers, patience and, of course, money.

## The globalization of public health

The globalization of infectious disease could be said to have begun in about 500 BC. Fidler explains how, nevertheless, modern public health measures to control it only began in Europe in the 14th century (pp. 842–849) with the introduction of quarantine, a 40-day period of compulsory isolation for ships, to avoid contagion. Systematic international cooperation to control global health risks is a quite recent development, not really beginning till 1851, with the first International Sanitary Conference. There European states discussed cooperation on cholera, plague and yellow fever control. In the years that followed, the diplomacy agenda included trade in narcotics and alcohol, occupational health and cross-border pollution. Today's familiar pattern of national self-interest attempting to outmanoeuvre international needs was set between 1851 and 1951. It is time to get out of that trap.

## Global public goods and bads

Recent special initiatives such as the Global Alliance for Vaccines and Immunization (GAVI) and the Global Health Fund to fight AIDS and other communicable diseases in Africa are merely emergency measures, Kaul & Faust explain (pp. 869–874). They propose a broader framework for action. On the principle that the best way to take care of oneself is to take care of others, they recommend strong investment in global public goods, one of which is international disease control. This should be a major item on national budgets. It would also provide against “global public bads” such as cross-border pollution, smuggling, and drug-resistant strains of existing diseases. Rich countries should begin the process. A global research council should be set up to manage health-related knowledge. Disease-specific managers should be appointed to facilitate cross-border and cross-sector partnerships. Everyone would gain from this approach. ■