Globalization and health viewed from three parts of the world

Some health implications of globalization in Thailand

Chitr Sitthi-amorn,[1] Ratana Somrongthong,[2] & Watana S. Janjaroen[3]

In recent years Thailand's economy has become increasingly dependent on international forces (*1*). With this exposure have come advances in health care technology and improvements in living standards, as well as increasing disparities between social groups (*2*) and exposure to health risks from other parts of the world (*3, 4*).

Prior to 1997, when the economy was strong, there was intense competition for a share of the health market. Resources were invested in speculative markets with potential for large expansion. Private hospital beds increased from 8066 in 1982 to 21 297 in 1992 and 34 973 in 1996. The number of specialized doctors in private hospitals increased, leading to shortages in the public sector (*5*). The culture of free enterprise brought with it an enlarged middle class, insurance coverage for hospitalization, tax incentives for private health care, heavy investment in advanced health technology for private sector use, and an internal "brain drain", at the expense of public health (*5, 6*). Aggressive promotion increased the demand for expensive imported medicines and procedures (*7, 8*). The cost of medical care for civil servants and state employees has quadrupled in the last seven years, reflecting the lack of adequate governance in the health care business sector (*5, 9*). Meanwhile the share of the underprivileged in the country's overall wealth was decreasing (*4*). The slump of 1997, followed by devaluation of the baht, and recession with its concomitant negative health impact, reflects the country's overdependence on cheap labour and foreign investment, and consequent inability to control and protect its own economy.

[1] Dean, College of Public Health, Chulalongkorn University, 10th floor, Institute Building 3, Soi Chulalongkorn 62, Phyathai Road, Patumwan, Bangkok 10330, Thailand. Correspondence should be addressed to this author.

[2] Academic staff, College of Public Health, Chulalongkorn University, Bangkok, Thailand.

[3] Associate Dean, College of Public Health, Chulalongkorn University, Bangkok, Thailand.

Ref. No. **01-1315**

Direct health effects

Perhaps the most important direct effect of globalization on health in Thailand is unequal access to medical care by different social groups. The rise in imported sophisticated technologies has increased costs and necessitated new training. An analysis made in 1996 found that the average cost of medical care per admission was 1558 bahts for health cardholders (rural) and 9981 bahts for civil servants (privileged), a sixfold difference (*10*). If these facilities were treating similar diseases, explanations are needed for the huge variation. The economic gap might create demand unrelated to need and distort market competition. The organization of health service delivery was obscure, and there were no rules governing the payment of providers. Unequal access to care was reflected by unequal health status (*2*). Infant mortality in the poorest regions was twice as high as in the richest ones.

Second, there are increasing problems of environmental pollution. These include inadequate treatment of raw sewage (for instance, in tourist areas), and the notorious air pollution in Bangkok and other big cities (*11*). Environmental degradation and disruption of the ecosystem have led to frequent floods and changes in disease vector behaviour. The construction of a dam in the North-eastern region, financed by a loan from a development bank, has caused natural disasters affecting food production (*12*).

Third, concerns about new infections and the resurgence of old ones have been on the rise. International trade and travel are shaping the patterns of epidemics. The plague scare in India had worldwide reverberations. The nipah virus outbreak in Malaysia caused concerns in Thailand (*13*). Cholera epidemics can inflict enormous costs on a country and this results in attempts to hide them by calling the disease "severe diarrhoea". The costs associated with controlling HIV infection continue to rise. Fears of foot and mouth disease have affected meat consumption. The control of new dangers of this kind will require global cooperation but many aspects of control have to be country-specific.

Fourth, globalization has brought with it unhealthy lifestyles. Health has been damaged by the promotion of fashionable drugs, foods and other consumer products such as tobacco, alcohol, melatonin and Viagra. Fifth and finally, globalization brings with it many concerns about health ethics. For instance, the options for genetic manipulation and the patenting of the technologies will have direct and far-reaching effects on health and social well-being.

Indirect effects

These direct effects are complemented by indirect ones, which include the economic crisis in Asia. Among many other things, it led to a rise in suicides, malnutrition, abandoned children, low birth weight, and a rise in deaths from preventable diseases such as acute respiratory infections, diphtheria and measles (*14, 15*). These adverse effects were partly due to decreased use of the health services (*14*). Increased poverty and unemployment also led to rising rates of crime, prostitution, migration and drug trafficking (*16*).

Response

These brief notes may be enough to indicate the need for an active response to globalization, rather than mere observation and speculation. In the first place, the world needs a clearly recognized moral authority to uphold the principle of equity in health and social justice (*17*). This authority has to be translated into norms and standards, accountability, measures for resolving conflicts and responding to emergencies, and a mandate to implement them. It needs to focus on key aspects of globalization which have implications for health. These include international capital volatility, drug trafficking, migration, protection of the environment, disease surveillance, and the indifference of market forces to marginalization, famine, suffering and oppression.

Next, the existing international institutions have to be reoriented. They have to re-examine their specific contributions to the overall well-being of the world. To do this they need to give full recognition to the changing context in which they are now working, and to the other actors involved. They must clearly define the roles of all concerned, and establish true partnerships for equitable cooperation, free from the domination of particular countries and companies.

Finally, national institutions have to be reoriented. They have to work out new partnerships between civil society, industry, government and other actors. An important goal here is to empower the public and specific groups in society to make rational choices and to demand accountability from those entrusted with implementing them. Thailand has been through a political transformation highlighted by the drafting of a new constitution. Its current health reform effort focuses on harmonization of living standards, rights, environmental protection, and equity between groups. ■

Acknowledgement

The document was written with partial support from Thailand Research Funds.

1. **Sitthi-amorn K.** *Thailand economic crisis and challenges related to economic structure, politics and governance*. Bangkok, Infinity Press, 1998.
2. **Sitthi-amorn C, Janjaroen W.** The bubble in Thailand's health care system; need for reform and major issues. In: Hung PM et al., eds. *Efficient, equity-oriented strategies for health: international perspectives*. Melbourne, McKellar Renown Press, 2000.
3. *Health research for development: the continuing challenge*. Discussion paper for International Conference on Health Research for Development, Bangkok, 10–13 October 2000.
4. *Regional consultative process, Asia*. Disscussion paper for International Conference on Health Research for Development, Bangkok, 10–13 October 2000.
5. **Bureau of Policy and Plan, Ministry of Health.** *Health in Thailand 1995–96*. Bangkok, Veterans Press, 1997.
6. **Chaudhary V.** Chile's economic boom fails to improve health care. *British Medical Journal*, 1992, **305**: 1113.
7. **Tangcharoensathien V, Supachutikul A.** *Compulsory health insurance development in Thailand*. Paper presented at the International Conference on Economics of Health Insurance in Low and Middle-Income Countries, Antwerp, Belgium, January 1997.
8. **Barnett A, Creese AL, Ayivor ECK.** The economics of pharmaceutical policies in Ghana. *International Journal of Health Services*, 1980, **10**: 479–499.
9. **Barraclough S.** The growth of corporate private hospitals in Malaysia: policy contradictions in health system pluralism. *International Journal of Health Services*, 1997, **27**: 643–659.
10. **Supachutikul A.** *Situation analysis on health insurance and future development*. Bangkok, Thailand Health Research Institute, 1996.
11. **Chretnut GL, Ostro BO, Vichit-Vadakan N.** Transferability of air pollution control health benefits estimates from the United States to developing countries: evidence from the Bangkok Study. *American Journal of Agricultural Economics*, 1997, **79**: 1630–1635.
12. Pak Moon Dam: Pak Moon has a lot to teach the state. *Bangkokpost*, 10 April 2001.
13. *Nipah virus in Malaysia*. Communicable Disease Control Network, Ministry of Public Health, Thailand, 10 April 2001 (http://www.cdcnet.moph.go.th/cdcweb/nipa.htm).
14. **Tae-Arruk P.** *Impact of economic crisis on health of the Thai people*. Bangkok, Health System Research Institute, 2001.
15. **Choprapawon C, ed.** *Health situation of the Thai people*. Bangkok, Health System Research Institute, 2000.
16. **Woodward A, Kawachi I.** Why reduce health inequalities? *Journal of Epidemiology and Community Health*, 2000, **54**: 923–929.
17. **Berlinguer G.** Health and equity as a primary global goal. *Development*, 2000, **42**: 20–21.

Some health implications of globalization in the United Kingdom

John Wyn Owen[1]

The British Prime Minister in his introduction to a recent government White Paper said, "Globalization creates unprecedented new opportunities and risk" and the White Paper goes on to state that "making globalization work for the world's poor is a moral imperative and a first-order priority for the British Government" (*1*). At the highest level of government, then, globalization, including its impact on health, is seen as a policy imperative, albeit outward-focused, helping to eliminate world poverty.

[1] Secretary, The Nuffield Trust, 59 New Cavendish Street, London WIG 7LP, England.

Ref. No. **01-1308**

The Nuffield Trust, an independent charitable foundation established in 1940, was one of the organizations in the United Kingdom to ask at an early stage — in the context of its programme on "the changing role of the state and the machinery of government for health policy" — whether globalization was extending to health and health care. In 1997 the Secretary of the Trust addressed the Annual Meeting of the Association of Academic Health Centers in Palm Springs on this subject, and in 1998 the Trust supported a delegation drawn from the Royal Colleges, the National Health Service, universities, senior policy-makers, key opinion-leaders and mass media to attend a trilateral conference (UK, USA and Canada) in Washington DC. At the conclusion of the meeting the UK participants saw the need to stimulate UK and international action on globalization and health because of the moral and ethical imperatives for action rather than for primarily national or bilateral interests.

On returning to the UK, the group became the Steering Group for the "Global Health A Local Issue" policy review — an analysis with a view to action — which culminated in a national conference funded by the Trust and held jointly with the Royal College of Physicians on 31 January 2000. The framework adopted was based on the work of Dr Kelley Lee. It describes globalization as a process that is changing the nature of human interaction across many spheres, particularly those of politics and institutions, economics and trade, social and cultural life, and the environment and technology. It is changing the temporal, spatial and conceptual boundaries that separate individuals in society. During the programme 14 seminars and workshops were held and 18 papers were presented (*2*), covering: health and the environment; economy, trade and aid; social and cultural factors; institutional and political issues; uncertainty and global health risks; local perspectives of global health; working with industry for global health; and development of a framework, including a practical model for UK action on global health.

The conference endorsed the framework, following which a number of significant events have taken place: a UK Partnership for Global Health was established; a web site and network contact was established for those interested in the field to exchange contributions (*3*); members of the Partnership contributed to the UK Foresight Report, particularly on trade and health (*4*); members of the Partnership did the research for the UK White Paper on the implications of globalization for the health of the poor, women's health and the caring professions; and a Centre for Health, Environment and Climate Change was established at the London School of Hygiene and Tropical Medicine.

Further areas for policy analysis

Globalization and health is now a priority area for government in the UK. The Nuffield Trust, through its network of influence and its programme of grants, fellowships, seminars and conferences, has played a leading role in bringing this about. Alongside others, it has raised the awareness of senior ministers, policy officials, community leaders, researchers and the Royal Colleges about these issues. It will continue with further research and policy analysis in areas such as those listed in the box. The Nuffield Trust and the UK Partnership for Global Health are also keen to pursue the notion of an international award for responsible globality by international public and private sector organizations through responsibility auditing for health.

Areas for research and policy analysis

- The impact of globalization on the determinants of health in the UK.
- The impact of the UK (its trade, industries, academic and research resources) on global health.
- Health as a foreign policy imperative in the UK. The likely effect of the UK 2001 budget announcement of the government's intention to establish a Global Health Fund with WHO and to introduce a new and special tax credit to help companies contribute to the relief of disease around the world and provide an incentive to accelerate research on the killer diseases in the poorest countries. This was discussed at the G8 meeting in Genoa (July 2000) and incorporated in the communiqué (*5*), announcing the establishment of a new global fund to fight HIV, AIDS and tuberculosis.
- Further integration of domestic and development policy objectives for health. The formulation of a UK Global Health Strategy, building on the government's practice of ''joined-up government''.

Peter Hain, in his book *The end of foreign policy* (*6*) sketches out a vision for new diplomacy to reflect interconnectedness and the new global interests that have taken shape alongside more traditional national ones. "Perhaps foreign ministries will be named Departments of Global Affairs as the concept of 'foreign' becomes ever harder to define." The task requires the specialized skills of all government departments and the committed and innovative involvement of nongovernment actors in business and civil society. "In the process we will see an end to traditional foreign policy and the evolution of a new foreign policy based upon global linkages recognizing natural limits and embracing global responsibility: a foreign policy for a world in which there is no longer any such place as 'abroad'." ■

1. *Eliminating world poverty: making globalisation work for the poor.* London, Stationery Office, 2000 (*White Paper on International Development, Cm 5006*).
2. www.nuffieldtrust.org.uk/health2/global.htm
3. www.ukglobalhealth.org
4. www.foresight.gov.uk
5. www.g8itali.it/_en/docs/XGKPT170.htm
6. **Hain P.** *The end of foreign policy. British interests, global linkages and natural limits.* London, Fabian Society, Green Alliance and Royal Institute of International Affairs, 2001.

Some health implications of globalization in Kerala, India

K. R. Thankappan[1]

The Indian State of Kerala with a per capita income of around 1% of that of the wealthiest countries, has achieved good health comparable to theirs. For example the infant mortality rate for Kerala in 2000 was 14/1000 live births (*1*) compared with 7/1000 for the USA (*2*). Life expectancy at birth was 76 years for women and 70 for men in Kerala; in the United States these figures were 80 and 74 respectively (*2*). However, Kerala's per capita expenditure on health was only US$ 28 whereas that of the USA was US$ 3925 (*3*). The most important reasons for this good health in Kerala are probably the following: its high level of female literacy (87%); access to health care (e.g. 97% institutional deliveries); a good public distribution system (PDS), which provides essential food items at subsidized rates (the system covers 96% of the population); political commitment (40% of the state budget went to the social sector till recently — 15% to health, and 25% to education); good communication and transport (newspapers, telephones, rural roads); land reforms (land distributed to the poorest and the landless) which helped reducing inequality in land and income; and Christian missionaries who started schools and hospitals, mostly in rural areas (*4*). Overall, the achievements of Kerala seem to result from a relatively fair distribution of wealth and resources across nearly the entire population of the state (*5*).

Globalization as promoted by the World Trade Organization (WTO), the World Bank, the International Monetary Fund and the transnational corporations has created a new world order. One of its major impacts is increasing inequality, which is detrimental to Kerala's health achievements. The Indian government initiated a major economic reform in June 1991 to increase economic growth. Social sector expenditure declined considerably during the first few years of this reform, resulting in stagnation in the development of public sector facilities.

In spite of the high demand for health care, the Kerala government could not increase its hospital beds substantially, for lack of resources for the health sector. During the 10 years from 1986 to 1996, public sector hospital beds in Kerala increased by only 5.5%, from 36 000 to 38 000, while in the private sector there was a 40% increase, from 49 000 to 67 500. Furthermore, the quality of the public health sector decreased because the financial restrictions affected supplies, including drugs, more than the salaries of the well-organized and militant employees (*6*). Taking advantage of this situation, the unregulated private sector in Kerala opened many hospitals with high-tech equipment, thereby increasing the cost of health care. For example, in 1995, 22 out of the 26 computerized tomography scan centres in the state were in the private sector (*6*) and even the small remainder in the public sector is decreasing now. The introduction of user charges in the public hospitals as part of the reform process increased the out-of-pocket expenses of those using public health facilities.

Household health expenditure in Kerala has increased over five times (517%) during a 10-year period of 1987–96. This increase was significantly higher (768%) among the poorest people than among the richest (254%). Even after adjusting for inflation the increase in health expenditure was about 4 times higher than the increase in consumer price index (*7*). The major reasons for this increase in health care costs are the increasing privatization of health care in the state, the increasing and often unnecessary use of technology, and a rise in drug prices. For example, Kerala has one of the highest rates of caesarean deliveries in the world now. Caesarean rates were reported to be 22% of all deliveries in rural areas and 34.5% in urban areas (*8*). The extra cost of caesarean deliveries in the state was estimated to be Rs 25 million (US$ 540 000) in the year 2000. Around 75% of the pregnant mothers had at least one ultrasonography test without any notable change in the management or outcome of pregnancy (*9*).

Another aspect of globalization is migration. Although there had been small-scale migration from Kerala to other Indian states and neighbouring countries since India's independence in 1947, large-scale migration started after the oil boom of the 1970s. The Kerala economy started to stagnate in the early 1970s owing to many factors, including high wage levels compared to those in other states, and well-organized and militant workers creating a less investor-friendly environment. The investors could easily start industries in other states, using cheap labour. Slow growth of the economy and the consequent high unemployment rate (3 times the Indian average) were the push factors for large-scale migration.

International migration has been increasing over the years. In 1998 there were 1.4 million Keralites residing in other countries and another 0.7 million in other states of India. In addition there were 1.65 million Keralites who came back to the state after residing in other countries or other states of India. There were an estimated 6.35 million households in Kerala in 1998, and 40% of them had at least one migrant (*10*). One of the major consequences of migration was the flow of remittances into Kerala, estimated at Rs 4717 million (US$ 876 million) or 10.7% of the domestic product of Kerala in 1998. The total amount of remittances was nearly 3 times the budget support to the state from the government of India (*10*). Better housing and commodities were some of the advantages the

[1] Associate Professor, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences & Technology, Thiruvananthapuram, Kerala, India 695 011 (email: thank@sctimst.ker.nic.in).

Ref. No. **01-1314**

families of migrants enjoyed compared to those of non-migrants. For example 54% of migrant households had a television set compared with 34% of non-migrant households. The respective percentages for refrigerators were 40 and 13 (*10*). Migration also helped to reduce inequality in the state because a large proportion of migrants were from the poorer classes (*11*). Although the remittances could not be effectively used to promote industries in Kerala there is some evidence of revived growth in the Kerala economy since 1991, mainly in the service sector. The annual growth rate of net domestic product in Kerala for 1991–97 was reported to be 6.05% compared to 2.88% during 1971–90 (*12*).

Kerala has always been a food-deficit state. This deficit has been corrected by an efficient PDS through a widespread network of ration shops in the state. The ration shops, school lunches and agricultural labour pensions were reported to benefit female-supported households more than male-supported ones, reducing one aspect of gender inequality in the state (*5*). During 1986–87, 37% of the rural Keralites depended on PDS for their purchase of rice, the staple diet (*13*). The PDS also worked as a price check in the open market. From 1997, however, as a consequence of the change in the policy of the government of India, arising out of the process of economic reform, it was decided to limit the PDS subsidy to those below the poverty line. Moreover, the hike in prices for PDS announced by the Union Finance Minister of India in his budget speech in February 2000 was described as "a severe blow to the PDS in Kerala threatening its very survival" (*14*).

Since rice cultivation in Kerala was not profitable compared to cash crops like rubber and coconut, farmers converted paddy fields into coconut and rubber plantations. As a result of international trade agreements the importation of edible oil, coconut and rubber has been unrestricted since 1994. Although some import restrictions are still there, India's agreement to the WTO calls for the removal of all the remaining restrictions by 2005. Kerala is the state most affected by this liberalization because its major agricultural products are coconut and rubber. The price of 100 kg of rubber plummeted from Rs 5204 in 1995–96 to Rs 2994 (a 42.5% reduction) in 1998–99 (*15*). Rubber provides the livelihood of over 750 000 families in the state. The fall in prices of rubber and coconut has severely affected the economy of the state, which will have serious implications for the health of Keralites, especially that of farmers.

In conclusion, globalization challenges the foundations of the Kerala model of low cost health care, which is built on distributive justice**.** How can the people of the state face the challenges of globalization? The decentralization process, which the Kerala government started in 1996 by transferring power and money (40% of the state budget) to the local authorities presents a good opportunity to tackle at least some of the challenges of globalization. The potential for additional resource mobilization from the local community and from the migrants could be realized in the decentralized planning process. Transparency in programme implementation, together with the democratization of planning processes, will enhance people's participation.

There is enormous potential for further growth in the service sector in a well-educated society like that of Kerala. However there is a need to devise specific measures to make Kerala more investor-friendly and attract investment from within and outside the state including foreign investment for accelerated growth of income. This should be done without sacrificing the welfare gains of the past, and without a market takeover of health, education and welfare, which could price out the poor. ■

1. **Registrar General of India.** Sample registration system. *Sample Registration System Bulletin,* 2001, **35**: 1 (available from Registrar General of India, 2-A Mansingh Road, New Delhi 110 011).
2. **World Bank.** *World development report 2000/2001– attacking poverty.* Washington DC, The World Bank, 2000.
3. **Hypertension Study Group.** Prevalence, awareness, treatment and control of hypertension among the elderly in Bangladesh and India: a multicentre study. *Bulletin of the World Health Organization,* 2001; **79**: 490–500.
4. **Thankappan KR, Valiathan MS.** Health at low cost, the Kerala model. *Lancet* 1998, **351**: 1274–1275.
5. **Franke RW, Chasin BH.** Is the Kerala model sustainable? Lessons from the past, prospects for the future. In: Parayil G, ed. *Kerala – the development experience. Reflections on sustainability and replicability.* London, Zed Books, 2000: 16–39.
6. **Kutty VR.** Historical analysis of the development of health care facilities in Kerala State, India. *Health Policy and Planning*, 2000, **15**: 103–109.
7. **Aravindan KP, Kunhikannan TP, eds.** *Health transition in rural Kerala, 1987–96.* Kerala, Sastra Sahitya Parishad, Kozhikodu, 2000: 52–56.
8. **Thankappan KR.** Cesarean section deliveries on the rise in Kerala. *The National Medical Journal of India*,1999, **8**: 297.
9. **Hemachandran K.** *Burden cause and cost of cesarean sections in three city corporations of Kerala* (unpublished MPH dissertation 2001, available on request from Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, May 2001).
10. **Zechariah KC, Mathew ET, Rajan SI.** Impact of migration on Kerala's economy and society. *International Migration: Quarterly Review,* 2001, **39**: 63–85.
11. **Prakash BA.** The economic impact of migration to the gulf. In: Prakash BA, ed. *Kerala's economic development; issues and problems.* New Delhi, Sage, 1999: 134–149.
12. **Subramanian KK, Abdul Azeez E.** *Industrial growth in Kerala: trends and explanations. Working paper No. 310* (available on request from the Centre for Development Studies, Thiruvananthapuram, India).
13. **Nair KN.** Food security and the public distribution system in Kerala. In: Krishnaji N, Krishnan TN, eds. *Public support for food security: the public distribution system in India.* New Delhi, Sage, 2000: 314–330.
14. **Kannan KP.** *Food security in a regional perspective. A view from 'Food Deficit Kerala'. Working paper No. 304*, 2000 (unpublished paper available on request from Centre for Development Studies, Thiruvananthapuram).
15. **Government of Kerala.** *Economic Review 1999.* Thiruvananthapuram, State Planning Board, 1999.