Globalization, development and health: a political economic perspective on the global struggle for health

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Introduction

Fourteen thousand women die every day giving birth. Their deaths, largely from bleeding or sepsis, are almost all preventable. Overwhelmingly they come from poor families and live in low and middle income countries. Their deaths provide a measure of the tragedy of the global health crisis but the crisis could be equally measured in terms of farmers' suicides, occupational injury, violence or deaths through lack of access to health care. The broad dimensions of the global health crisis have been well documented (see for example, recent World Health Reports). The purpose of this chapter is to briefly explore the economic and political dimensions of this crisis; focusing, in particular, on the links between the conditions for global health and the prevailing regime of global economic governance ('globalization').

Our focus is on the economic dimensions of globalization and their implications for health. Health systems and pathways to better health are shaped, in large degree, by the economic environment and the social structures and political forces which govern the economy.

Our focus on global economics and health should not discount the other dimensions of crisis reflected by our colleagues in other chapters of this text, such as environmental destabilization, the crisis of inequality, despair, violence and militarism. Absolutely, "economic causes for women's deprivation have to be integrated with other social and cultural factors to give depth to the explanation (1)."

The preventable deaths of 14,000 young women every day reflect the way the global economy works. We argue in this chapter that the global economy is in crisis

and that the contemporary consequences of this crisis are born largely by the peoples of the Third World. We argue that the economic policies implemented to protect the rich world from the crisis exacerbate the existing health care crisis for low income countries.

There are three main parts to this chapter.

1. First we focus on economic history. We review the development of the global economy since the end of the Second World War, highlighting the high growth rates of the long boom (1945-1975) and the slowing pace of growth since then.
2. In the second part of the chapter we examine the political structures which support and maintain prevailing global economic relationships. Understanding globalization as a regime of global governance provides a useful framework for analysing how an unfair and unsustainable global economy is maintained and for thinking about political strategies through which it might be reformed.
3. Lastly, we review a number of key episodes over the last 60 years which highlight the links between globalization and Third World health. We show how the changing policies for managing the global economy have shaped the policies and discourses of health development.

We close by presenting some broad conclusions about the relations between globalization and health and a role for advocacy that is becoming increasingly more critical. If in fact women's health is to be improved by political action and public policy, we have no choice but to return to the links between global economic crisis and its various manifestations. These include, first, seeing how the local struggles for health are framed by the wider economic and political environments and factoring the big picture into our local strategies. Second, is the importance of building solidarity, shared analyses and vision across geography, class and culture. Third, is identifying the new forms of struggle that are called for by the contemporary structures of globalizing economic governance. With our improved understanding, another world will be possible!

Part I. Globalization and economic crisis: an historical perspective

The decades since the end of the Second World War fall into three periods:

- the 'long boom' and the dominance of Keynesianism (1945-1975);
- the emergence of stagflation and the rise of monetarism (1975-85); and
- the looming threat of structural over-production and the rise of neo-liberalism (1975 onwards).

Any such periodization involves over-simplification. The progressive improvement in living standards associated with the long boom continued (for many) into the 1980s and 1990s and the threat of structural over-production commenced well before the mid 1970s. However, these three periods provide a framework for tracing the main dynamics operating at the global level over the last 60 years and are briefly summarized. (For further reading around the contemporary global economy see 2,3,4,5).

The long boom (1945-1975)

The 30 years from 1945 to 1975 were characterized by high annual growth rates and relatively short recessions (6). Two major factors contributed to this. On the demand side was the huge need for reconstruction after the war and the pent up consumer demand after so much hardship. On the supply side was the huge industrial capacity which had been built up during the war, much of which could be converted to producing for the civilian market.

In addition to these post-war factors the development of the internal combustion engine, associated with cheap oil, contributed greatly to increasing productivity in many different sectors of production.

This economic regime has been described as Fordism, a regime of mass production, mass employment and mass consumption. Metaphorically this refers to Ford employees being paid enough in wages to actually buy a Ford motor car. The significance of the metaphor as a descriptor of a broader economic configuration is the concept of workers as consumers and the significance of mass employment and high wages sustaining mass markets.

While the dynamics of the long boom were primarily rooted in the industrialised world there was some 'trickle down' to the developing countries. Increasing production in the rich world raised the demand for agricultural products and minerals sourced from developing countries. Newly independent Third World countries commenced the process of industrialization using various forms of protection to allow local manufacturers to produce goods for the local market (substituting for imports and therefore described as the 'import substitution' approach to economic development). A small number of these countries were able to complete this process and achieve strong industrial economies, notably the 'Asian

tigers'. (The circumstances of the Cold War created particular conditions which facilitated the industrialization of Korea, Taiwan and the post-war rebuilding of Japan.)

Stagflation and the rise of monetarism (1975-85)

The long boom was replaced during the 1970s by stagflation, a combination of prolonged recession associated with rising inflation. The economic slowdown of the late 1970s reflected a combination of a cyclical slowdown (the cyclical over-production of the normal business cycle) and the emergence of structural over-production (defined as global productive capacity exceeding effective demand).

Thus, economic policy makers faced two problems: economic slowdown and inflation. The economic slowdown of the late 1970s suggested the need to stoke the economy (which might have suggested low interest rates) but the need to control inflation suggested the need for high interest rates. The 'fight inflation first' slogan prevailed and the policy makers implemented high interest rate policies which gradually led to the control of inflation but which deeply exacerbated the recession.

The debt trap: set (in 1973) and sprung (in 1981)

Following the first OPEC (Organization of Petroleum Exporting Countries) oil price rise in 1973, the oil producers were flush with cash; more cash than they could spend or invest so much of it was deposited in commercial banks. The banks sent salesmen around the world lending money at low and even negative interest rates. Interest rates are 'negative' when they are lower than the prevailing rate of inflation; effectively paying people to borrow. Much of this lending was to private corporations, particularly in South America, but generally with government guarantees which meant when the debt crisis was sprung the governments were held accountable for repaying and servicing these debts. In Africa most of the lending was directly to governments. Some of the borrowing during this period was well directed but much of it went to projects which were corrupt or aggrandizing or was directed to support the sales of corporations from the North. One notorious example was the borrowing by a friend of Ferdinand Marcos in the Philippines to construct a nuclear power station (on a tectonic fault). The power station has never produced any power but the people of the Philippines continued to service the debt until very recently.

In the early 1980s, under the 'fight inflation first' policy, interest rates escalated (to a peak of 17% in the US in 1981) imposing repayment and servicing burdens that many poor countries could not carry; particularly, in the context of economic recession. We return to the debt trap later in this story.

Structural over-production (1975 to the present)

The third phase, from around 1975 to the present, we characterize as 'the looming threat of post-Fordist crisis'. With increasing productivity, fewer and fewer workers are needed to produce goods for the global market. With the greater use of low wage production platforms and low paid casual employment in the rich world, discretionary spending of those who are employed is more and more constrained. The crisis which threatens is a crisis of structural over production; "over production" meaning that productive capacity exceeds effective demand; "structural" because it reflects the structural changes to patterns of global production and consumption; "post-Fordist" because it represents a de-linking of high wage mass employment in mass production from mass consumption.

The global economy is too complex to be summarized simply in terms of one dominant dynamic, in this case the looming threat of post-Fordist crisis. Against this negative dynamic of crisis we can also discern the continuing influence of the (Fordist) dynamic which underscores the long boom; under-employed labor plus capital and technology producing new goods and services for new markets which are themselves motivated by the wages and business expenditure of the new production.

The emergence of China as the global factory since the 1980s epitomizes the continuing significance of the Fordist dynamic. China's explosive growth has involved under-employed labour coming together with capital and technology to produce goods and services that those employees can now buy with their wages, which therefore stokes further consumption continuing the process of capital accumulation. China's economic growth and its industrialization may stand as a metaphor for the continuing significance of the Fordist dynamic in India, Brazil and other regions.

Nevertheless, despite China and India, the threat of productive capacity outpacing effective demand and precipitating economic crisis remains real with increasing

numbers of people excluded from employment because of productivity growth and excluded from consumption because they are unemployed or underemployed.

The threat of crisis is made more urgent by compensatory policies adopted by corporations and governments which tend to exacerbate the threat of over-production and make the crisis more likely. In the corporate world the threat of crisis is manifest in terms of reduced sales and reduced profitability. The common compensatory strategies include:

- mergers and acquisitions (maintaining market share but further reducing productive employment),
- increasing market power (e.g. gaining monopoly control over supply or through intellectual property strategies) supporting the successful corporation but exacerbating under-consumption through increasing prices;
- cutting wages (maintaining sales through cheaper prices but further reducing wage based consumption);
- replacing labour with technology (further reducing the flow of wages into consumption);
- transferring production to low wage platforms (maintaining sales through cheaper prices but further reducing the flow of wages into consumption);
- expanding the boundaries of the market place (commodifying family, community and government functions previously conducted outside the marketplace); and
- keeping prices low by transferring the costs of production to the environment (through unregulated pollution) and to the workforce (through lack of occupational safety or financial compensation for occupational injury and disease).

The threat of structural over-production is understood in the policy world in terms of falling growth rates which elicit a range of policy responses many of which also further exacerbate the risk of crisis (or impose greater burdens on those already suffering their effects). These policy responses may in fact be similar to those used within the corporate arena, but may also include:

- cutting taxes (reducing the corporate and executive tax burden to compete for new investment in the global market place but also reducing the financial capacity of government to ameliorate the impact of crisis);
- outsourcing and privatising government functions (providing new investment and market opportunities for under-employed capital but also transferring the costs of government services from tax payer to user);
- forcing repayment of debt from Third World countries (supporting the profitability of the banks and maintaining living standards in the North and propping up the value of Northern currencies thereby keeping the prices of imported goods in the North low);
- forcing Third World countries to open their markets to Northern manufacturers.

Some of these corporate and policy responses might tend to restore the conditions for sustainable growth. However, most of them further reduce demand, through reduced employment and reduced wages. Many of these responses also have adverse consequences in relation to the environment (illustrated by the reluctance to reduce greenhouse gas emissions); in relation to family and community life (the commodification of family and community functions); and the decay of social infrastructure.

Rise of neo-liberalism (1980 to 2000)

Despite some developing countries having achieved economic growth over the last 30 years, for many countries the conditions for health development for the poorer sections of the population have been sacrificed in order to maintain living standards in the North.

This is not the story told in the mainstream financial press or by the politicians meeting each year at the World Economic Forum in Davos. They speak of the importance of free trade, reduced taxes, free markets and small government. This story about the superiority of markets and the dangers of government is commonly described as the new liberalism or neoliberalism.

The term neoliberalism is a reference to the rise of economic liberalism during the early development of capitalism in Europe. Liberalism here meant freedom of commerce, in particular the lifting of royal monopolies sanctioned by the king in return for a share of the rent. The new liberalism borrows from this history but in very different conditions.

The underlying logic of the new liberalism is about the greater efficiency of free markets compared with planned and administered program delivery. In many respect the new liberalism was an ideological campaign about the general superiority of markets over governments; it argued for small government, deregulation, reduced reliance on planning and for program design to follow market principles. It is noteworthy in relation to to health development that the commitment to the free market did not extend to intellectual property where monopoly power has been progressively shored up. (See Part III for examples, specifically sections on Access to Expensive Drugs and Agriculture.)

Part II. Globalization as governance

Our purpose in this chapter is to understand how global health conditions are shaped. Our focus so far has been on economic relationships including the flows of goods and services around the world and the corresponding (reverse) flows of money. We have explored briefly some of the system relationships between these flows which we can be described in terms of 'dynamics': the dynamic of Fordist stability and the dynamic of post-Fordist instability. An appreciation of these economic dynamics is necessary to understand the ways in which the conditions for global health are determined through the global governance of economic relationships.

The economic 'system' we have described is a simplification of a much more complex world. Other conceptual systems applied to the same world will reorganize our experience in different ways; often in ways that will add new insights to our understanding of the problems we face and possible directions. A focus on governance, as opposed to the stocks and flows of 'the economy', can enhance our understanding of the conditions which shape global health and possible strategies for change. Key components include:

- empires, big powers and nation states;
- transnational corporations and their peak bodies;
- international institutions and conventions;
- non-government organizations (local, national and international);
- constituencies and movements;
- information (e.g. knowledge, discourses, ideology and the organizations which support the generation, flow and engagement of knowledge and discourse; and
- pathways of social change.

Our purpose here is not an exhaustive and systematic description of the structures of global governance. Rather we introduce the governance perspective and highlight some of the critical components which are of particular importance to the nexus between globalization and health.

Empires, big powers and nation states

Historically, global governance has been the work of empires, in varying degrees of tension with other empires, nation states and other political forces. The dominant imperial power in the present era is the USA and it uses a range of instruments to fulfill its governance responsibilities.

In many respects, however, the global economic regime governs itself and the role of the governors is merely to adjust the settings from time to time. Markets are self sustaining mechanisms which, within a particular framework of regulation (7), reproduce the economic flows and relationships we have discussed above. The rules that characterize this regulatory regime at the global level are formalized and administered by a range of international institutions and conventions which generally mediate the interests of the big powers and big corporations.

The health implications of this 'market autonomy within a particular regulatory framework' perspective can be seen in the eclipse of Keynesianism and rise of monetarism in the early 1980s. Keynesianism, with its focus on tax policy and government expenditure, provided space for redistributive policies and public investment in social infrastructure (8). The rise of monetarism and the neoliberal philosophy of 'small government' weakened the support for such social policies and created the conditions for widening global inequalities with familiar implications for population health.

International institutions and conventions

The main groups of institutions which would need to be considered in any account of the global governance of health would include:

- United Nations system, especially WHO, UNAIDS, UNICEF on the health side and UNCTAD and UNDP on the economic side;
- various 'public private partnerships' in health (e.g. GFATM, GAVI);
- the Bretton Woods Institutions (the IMF, WB and WTO); and
- the conventions and agreements which set the 'legal framework' internationally (e.g. WTO agreements, various declarations on economic, political, cultural and social rights, Kyoto Agreement, the International Health Regulations, Framework Convention on Tobacco Control).

The various 'public private partnerships' such as the Global Fund for AIDS, TB and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI) are a relatively late addition to this range of governance institutions. Much of the pressure for the emergence of the global partnerships has been the need to mobilize corporate charity (differential pricing) to alleviate the medications crisis in the developing world and head off the risk of more profound reform to the global intellectual property regime (9).

These various players do not operate in a vacuum. Beyond the empire, the nation states, the transnationals and the international institutions are the more diffused constituencies whom the principal players both lead and follow. We can describe these constituencies in terms of nationalities, ethnicities, classes, castes and religions although these overlap complexly. In terms of understanding the global economy it is useful to think in terms of countries; the countries of the North and the South, or the center and the periphery. However, class alliances (and those of race, language and religion) cut across national boundaries and are also useful descriptors. Cross national solidarities are also framed by religion, language and race. Reich (10) has pointed to the rise of the global middle class with a sense of shared identity and cultural solidarity arising from similar educational experiences and greater international travel (owing to links with government, transnational companies and universities).

The idea of social movements which cross national boundaries provides further insights into the agency of these more dispersed constituencies. The People's Health Movement (as an illustration of global social movements generally) is based on a shared consciousness and solidarity arising from a common recognition of, and opposition to, the disease burden arising from globalization.

Information, knowledge and discourses and the organizations which support their generation, flow and engagement

Any account of governance structures must also include the information dimension (including knowledge, discourse and ideology,) and the organizational structures which support the generation and dissemination of knowledge; the flow of discourses and the engagement of ideologies. We may characterize the information dimension of global governance in terms of:

- information (e.g. population statistics, intelligence, news)
- knowledge paradigms (e.g. traditional, technicist, interpretive);
- discourses of health and economics (e.g. neoliberalism, free trade, comprehensive primary health care, cost-effectiveness packages); and
- ideologies (e.g. neoliberalism, liberal democracy, market fundamentalism, religious fundamentalisms, community empowerment).

The organizations which support the generation, flow and engagement of information, knowledge, discourses and ideology include:

- academic and other research centers (e.g. London School of Hygiene and Tropical Medicine and the Harvard University School of Public Health, the World Bank);
- media organizations (e.g. News Corporation, BBC, VOA);
- discussion platforms (e.g. UN, the OECD and the World Economic Forum, and the World Social Forum);
- markets; in particular, the financial markets and the financial media.

The idea of an information dimension of global governance (including knowledge, discourse and ideology) opens up a huge field for description, analysis and strategy. This is not the place for such a discussion but we can illustrate the importance of this dimension by simply mentioning two examples:

- the promotion of 'cost-effective packages of interventions' as the basis for the World Bank's approach to health sector reform; and
- role of progressive websites in supporting popular movements around health issues.

Since 1993 the World Bank has promoted the principle of cost-effective packages of interventions as the basis for health system planning. In essence this approach assumes a multitiered health system with the middle class relying on insurance and private providers and the minimal packages constituting a safety net for the poor. In promoting this model, a huge infrastructure of data and information has been built up dealing with burden of disease and cost-effectiveness evaluations of interventions. There is a certain logic to much of this argument, and it has a place in the range of disciplines from which the health planner draws. However, in the context of the broader economic perspective of the Bank, this body of data, techniques and ideas has a particular ideological function as well, namely to legitimise an unfair and unstable economic regime; the ideological message is that improved health is possible within this regime.

A counter illustration of the importance of the information dimension of global governance concerns the role of progressive websites in supporting popular movements around health issues. This is particularly clear in relation to the various campaigns around the medications crisis (e.g. the Treatment Action Campaign in South Africa, the Novartis campaign in India and the support for the Thai use of compulsory licensing) and in exploring alternatives to the prevailing intellectual property regime.

Pathways of social change

An account of global governance which is designed to support the struggle for health needs to go beyond simply describing the structures of global governance. Our main focus in the preceding discussion has been on the policy decisions and structures which maintain the existing regime. We also need a framework for thinking about the pathways through which change occurs and the pressures for change and the ways in which the strategies of the people's health movement might drive change. This is a big field; too big to be properly addressed in this chapter.

However, in the following section we shall review a number of key struggles in health development and seek to draw out of these some principles of activist practice.

Part III. Globalization and health

Our purpose in this chapter is to explore the links between population health and globalization (which we are using to denote the prevailing regime of global economic governance). We began with an overview of the dynamics and transitions of the global economy since the Second World War and proceeded from there to present a framework for analyzing the political regime through which the global economy is governed (and which so powerfully shapes population health).

In this part we give examples of the impact of the economic regime on health development.

Primary health care

In many countries under colonial rule, health service development had been largely restricted to the urban centers. This pattern was in many cases continued after decolonization, leaving the rural majority poorly served. However, during the 1960s several countries were experimenting with more comprehensive approaches to health care, moving away from hospital and doctor-based care in the cities to the provision of basic health services in the rural areas. There was also new attention given to appropriate workforce strategies and more focus on community mobilization for prevention. This approach became known as primary health care (PHC) and was formally enshrined in and endorsed by the Alma-Ata Conference and Declaration (11).

Alma-Ata was a reaction against top down vertical programs and urban centered health service development. The Declaration called for greater attention to the needs of rural populations and for greater reliance on heath workers with basic training who were accountable to local communities but who were properly supported by clinical and prevention specialists based more centrally (12).

The Alma-Ata Declaration went well beyond a narrow medical or disease-centered model, recognizing that sustainable economic development was a critical condition for health development in the Third World. Alma-Ata refers explicitly to the 1974 call by the Non-Aligned Movement for a New International Economic Order, a governance regime that might facilitate the sovereign economic development of poor

countries. Alma-Ata was driven in large part by the spirit of the Non-Aligned Movement with support and facilitation from the leaderships of the WHO and UNICEF. By this time Dr. Halfdan Mahler was the Director-General at WHO. Mahler was a committed advocate for the PHC approach although there remained divisions within WHO who were still oriented to the vertical disease focus (13).

In some ways Alma-Ata was the last hurrah of the hope and confidence of the Non-Aligned Movement. The Long Boom had petered out, monetarism was on the rise and the debt trap had been set. Within a few years many developing countries were facing recession and economic restructuring under the control of the IMF. The IMF did not regard health development as particularly important; the debt had to be serviced and if that meant dismantling health services and terminating food price subsidies then so be it.

PHC debates and legitimation crisis

As early as 1979 there were voices (14) calling for a return to the orthodoxy of narrow vertical programs (now re-named as 'selective primary health care'); perhaps recognizing that in the conditions of the time the resources necessary for the implementation of comprehensive PHC were not going to be available. From the point of view of donors (Western governments and philanthropies) the practical challenge was about getting outcomes for the aid dollar. The choices appeared to be either waiting for basic health system infrastructure to be developed or investing in more limited disease-centered and maternal and child health (MCH) programs which at least offered the promise of achievable outcomes. With the rise of AIDS/HIV and the weakening of basic health services associated with structural adjustment, the preference of the donors to return to vertical programs was consolidated. Advocates of vertical programs saw themselves as accepting the *real politic* that comprehensive PHC was not happening; they commonly depicted the advocates of comprehensive PHC as unreal ideologues.

The advocates of comprehensive PHC had two problems with this position (15). Their first objection was that for many diseases narrow vertical programs simply do not work; smallpox was the exception rather than the paradigm case. Effective prevention and management of conditions like TB, malaria and AIDS/HIV require a wide range of generic programs and services which are either not provided under the

vertical programs model or are duplicated specifically for this condition. The second issue motivating the advocates of comprehensive PHC was a concern that fraying livelihoods (e.g. loss of markets and jobs, malnutrition, loss of access to education) and the decay of services under the pressure of economic restructuring (e.g. reduced budgets, user charges) was actually adding to the disease burden of poor people in poor countries; indeed was now one of the most serious threats to health those communities were facing. Particularly for women, the impact on health from job loss and denial of education has been demonstrated to be particularly significant (16). From this point of view the effect of arguments for selective PHC and vertical programs was to obscure the damage being done by economic restructuring and to project the view that health could be improved despite these influences, thus legitimating an unfair regime.

The human cost of illness is a major motivating factor for health activists; 200,000 women died in childbirth during the writing of this chapter. Primary health care practitioners confront the immediate, local and personal issues which affect their communities but they can also work with those families and communities to make sense of the upstream factors which reproduce those patterns of pain and to consider ways of more effectively engaging with the structures and forces behind them. In many communities, poverty and lack of health care facilities are compounded by gender inequality. "The prevailing belief in this area [Sub-Saharan Africa] is that the role of a female in society is to marry, have many children, raise the children, and look to her husband for guidance in all matters. Even as we train more clinical officers and try to improve our medical services to women, we must remember that the environment we work in does not allow the women themselves to have a voice in their choices of health care or where and when they will seek medical help (17)."

Access to expensive drugs

High prices for life-saving drugs (and denial of access for millions who would benefit from them) is a further illustration of the way neoliberal globalization impacts on health. High prices for essential medicines is partly a consequence of the global intellectual property regime administered under the WTO through the TRIPS agreement. However, this case also shows the role of big power bullying and even how international organisations such as the WHO can be suborned. It also shows

how civil society working through South North partnerships can effect change. The key issue at stake in these struggles has been whether and when generic manufacturers might be authorised to create cheap versions of life-saving drugs.

As early as 1991 the US Trade Representative (USTR) was putting pressure on Thailand because it authorized the manufacture of drugs still under patent in the US through its government production facilities (18). Thailand had also modified its patent laws to require advanced notice of new drug approval applications and to make the information provided to the regulators available to generic manufacturers prior to patent expiration in order to accelerate their introduction to the marketplace. The US pharmaceutical lobby maintains a global watch over such threats and the USTR acts promptly on the urging of big pharma (also a big contributor to politicians' election funds). The USTR threatened Thailand with Super 301, a US trade law which authorizes the US to implement trade sanctions against any country which is found to be harming the interests of US corporations. Similarly Brazil has been subject to threats and pressures by the USTR on behalf of big pharma because of its policies of compulsory licensing and local production of anti-retrovirals.

Perhaps the highest profile case was the South African case from 1998 where 38 large pharmaceutical companies took the South African government to court (in South Africa) arguing that the legislative provisions for parallel importation of anti-retrovirals (sourcing public purchasing in the cheapest overseas market and bypassing authorized local representatives) contravened South African intellectual property laws. The legal issue was never decided. The case created such an international political storm that in April 2001 the companies withdrew their complaints and agreed to pay the costs of the defendant. The defeat of the drug companies in South Africa involved a massive struggle in South Africa (led by the Treatment Action Campaign) and the organization of a massive global protest (led by MSF and resourced by CPTech). The drug companies withdrew because they were bringing into disrepute the intellectual property rights upon which they depend and which are integral to the capitalist system itself. It was a battle about legitimacy and they lost.

However, even as big pharma was buckling in Johannesburg, the Government of Norway was hosting (April 2001) a meeting which included WHO, UNICEF, the World Bank, the global pharmaceutical giants and a small group of NGOs to discuss strategies to deal with access to expensive drugs by poor countries. The meeting considered all options including compulsory licensing but adopted the more conservative pharma-friendly option of differential pricing. This position was to be expected from the World Bank but from the WHO it was disappointing; perhaps a warning to those who might have expected more.

The conservatism of this position (differential pricing) was underlined seven months later when the WTO Ministerial Council meeting in November 2001 in Doha adopted the Doha Statement on TRIPS and Public Health. One the most significant agreements administered through the WTO is the Trade Related Intellectual Property Rights (TRIPS) agreement, in particular for its implications in relation to pharmaceuticals and in particular, retrovirals for AIDS/HIV (19). The principle underlying the Doha Statement was that public health should take priority over trade rules. The Statement affirmed the legitimacy of compulsory licensing and also addressed the barriers facing small countries unable to use compulsory licensing to meet their own needs because they did not have a domestic generics industry. The Doha meeting commissioned a process to work out the detailed rules and arrangements under which poor countries could use compulsory licensing for domestic or export purposes (to small countries without their own generic industry). In the years that followed the US mounted a rearguard action to prevent the use of the TRIPS Agreement to sanction compulsory licensing in developing countries.

Nevertheless the writing was on the wall with regard to the WTO as a compliant vehicle for US economic policy and the alternative strategy of multiple bilateral and regional 'free trade' agreements was being implemented at the same time. In Oct 2002, Bristol Myers Squib was defeated in a long-running case about the Thai Government's right to manufacture DDI (an AIDS drug) for local consumption. In the context of the Gore Bush presidential campaign and under sustained pressure from AIDS activists in the US the USTR under Clinton announced in 2000 that the US accepted Thailand's right to produce DDI within the terms of its own intellectual property laws. However, in 2003 negotiations commenced between Thailand and the

US towards a US Thai FTA with compulsory licensing, data access and extended IPRs on the table.

There is no sign of big pharma withdrawing from this issue. In early 2007, the Swiss giant Novartis commenced proceedings in the India courts seeking to overturn the decision not to grant a patent to imatinib (Glivec) on the grounds that it was not sufficiently innovative in comparison to existing drugs. The criteria for patenting new drugs will remain a tightly contested issue in future years.

Agriculture

While the TRIPS agreement is directly and explicitly relevant to health, the agreement which has the strongest impact on the health of people in developing countries is probably the Agreement on Agriculture (AoA). It allows the US, Europe and Japan to protect their domestic markets while forcing agricultural producers in developing countries to open their markets to manufactured and agricultural imports. Structural adjustment packages (SAPs) comprise a set of policies imposed by the International Monetary Fund on highly indebted countries seeking to borrow from the IMF as the lender of last resort. SAPs included cuts in public expenditure (on health and food subsidies), devaluation to make exports cheaper (but which made imports more expensive) and a reorientation of agriculture and industry around production for export. The prime purpose of the SAPs was to enable client countries to generate the export earnings needed to re-pay debts. While they were packaged in the language of economic development this was not their principal purpose. Indeed, in many ways the SAPs involved a process of de-industrialization and regression with respect to social and economic development. In a relatively small number of countries the SAPs were associated with economic growth and improvements in health and welfare despite widening inequalities. However, in most cases, particularly in Africa, structural adjustment have had a negative impact on health status and on health services.

After several generations of SAPs in which poor countries have been told to switch to producing the same range of agricultural commodities for export, the prices for these products have fallen below cost, leaving the farmers without subsistence and without income. The dumping of subsidized products into the cities of developing countries is a further blow to the farmers in the hinterlands.

While the rhetoric of the WTO is about ‘free trade’ it may be more useful to see it as driving towards a somewhat different objective, namely, to ensure that the transnational corporations of the rich world have access to the economies of the developing countries (without any real expectation of exposing the farmers of Europe, Japan and the US to international competition).

The pressure on ‘developing countries’ to provide increased access to agricultural and food imports from the developed countries threatens the livelihood of hundreds of millions of small farmers, unable to compete with protected, subsidized, oil-based industrialized agriculture. Once again, the decreased earnings and employment have also resulted in reduced access to education and health care services.

Conclusion

So what conclusions can we draw from this review and what directions do they suggest? Our purpose in undertaking this review of global health and global economic governance over the last six decades was to draw out possible lessons and implications for people's health activists and for health policy and public health practice at the national and global levels. In this final section we discuss these possible lessons and implications.

Health activists need to develop their 'global economics literacy' to project clear narratives linking the disease burden carried by their communities with the structures, dynamics and flows of the current global economic regime and its governance. They also need to be able to read through the half truths of the establishment policy reports.

The impact of TRIPS on access to drugs for AIDS has proved a powerful introduction for many health activists to the workings of the WTO and the role of the WTO in regulating an unfair and unsustainable global trading regime. In terms of sheer burden of disease the Agreement on Agriculture (AoA) is probably the single most health-damaging instrument in the whole complex governance structure. Hundreds of millions of small farmers are being driven off their lands through the swamping of global markets by industrialized agriculture (heavily subsidized in the case of Europe, Japan and the US). Only a small proportion of these small farmers will find jobs in the cities. The health consequences associated with this loss of livelihood range from under-nutrition, to drug use and violence, AIDS and TB.

It is not wrong to attribute this 'burden of disease' to violence or AIDS but it doesn't tell the whole story. Behind violence and AIDS are the stocks and flows and dynamics of the global economy which is in turn sustained and reproduced by a governance regime which includes the WTO, the IMF, the US and the transnational corporates.

However, even for such powerful forces, their power is not unlimited. The success of the Treatment Action Campaign in South Africa in 2001 shows what mass mobilisation can achieve. It also shows the importance of global solidarity with MSF working with the TAC and CPTech working with the South African government.

The structures of global governance will be determined, in part, through contests over legitimation; how legitimate is the IMF, the WTO and the USTR in the eyes of various global constituencies. How legitimate is the World Bank in its advocacy for multi-tiered health care systems with minimal safety nets for the poor versus comprehensive PHC and health system capacity-building. There are real questions about models for health system development which need to be worked through but World Bank advocacy for vertical programming and 'cost-effective interventions' are partly about projecting the possibility that Third World health can be improved, for a relatively modest sum, without changing the economic dynamics of alienation and expropriation. How legitimate is this?

Health advocates need new ways of projecting the disease burden of poverty, despair, violence, displacement and conflict and of the underlying economic relations and structures of economic governance.

Comprehensive PHC, access to essential medicines and small farmers' livelihoods are important issues in their own right. However, they also provide case material through which to examine in more detail how economic dynamics and governance structures work at the global level. Global health policy advocates need to be able to advance a clear underlying economic analysis which makes sense of these issues.

The story presented in this chapter is not an over-riding and eternal truth about the global economy. It is an attempt to make sense of what is in truth impossibly complex. It is a story which knits together some of the salient features of the last sixty years of global capitalism, in particular focusing on the flow of resources and value between rich and poor countries. There is much scope for developing this story, perhaps accommodating more complexity, and for applying it in different ways to different parts of the system.

Another world is possible!

"Rise like lions after slumber
In unvanquishable number!
Shake your chains to earth, like dew
Which in sleep had fallen on you-
Ye are many, they are few!"(P Shelley, 1832; 20)

In December 2000 at a venue outside Dakha in Bangladesh the first International People's Health Assembly (PHA) was held with several thousand delegates representing over 50 countries. Out of the first PHA was formed the People's Health Movement (21) an international network of grass roots community health activists and policy advocates dedicated to demonstrating that 'another world is possible'. In July 2005, 1500 delegates participated in the Second People's Health Assembly in Cuenca, Ecuador. The growing strength of the People's Health Movement may be taken as a mark of the growing consciousness of the shared context among health activists world wide and the growing sense of solidarity and common purpose.

We have reviewed the interplay of economics and health at the global level over the past 60 years and drawn some conclusions about strategy for health activists working locally, globally and at all levels in between. Global health advocates need to keep the need for a fairer regime of global economic governance at the center of activist practice and health policy advocacy.

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