

HIV/AIDS and Globalization

What is the epidemic telling us about economics, morality and pragmatism?

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ABSTRACT

Disease epidemics have been related as both cause and effect to increasing integration of human economies, societies and cultures throughout history.

It is well known that infectious disease is not equally distributed between different societies and different sections of the same society. This clear on a global scale where disparities in exposure to infection and access to public health provision and health care are acute.

There is a debate as to the meaning and effects of “globalization” as well as about whether it is “new” and, if so, in what ways. This paper briefly examines (a) the history of disease in relation to globalization; (b) the meanings and importance of “globalization”; (c) where and how the HIV/AIDS epidemic fits into the picture; (d) some of the theoretical and ideological implications.

1. Disease, Globalization and Integration

William McNeill (1977) was among the first to draw our attention to the role of epidemic disease in human history. Many subsequent authors have noted its importance, and most recently Jared Diamond (1998) has informatively discussed its role in the increasing integration of human society and economy over the past 13,000 years (which may be another way of talking of “globalization”). Scott and Duncan (2001), argue that the “Black Death” in medieval Europe and other plague events must be understood as events affecting “metapopulations”, a term used by ecologists to describe “populations of populations” (Scott and Duncan, 2001, 13). They note that the term is not usually applied to human populations but that it is appropriate in relation to studies of spatial heterogeneity of disease “where individuals can be either infected or uninfected, an example of the interaction between demography and disease” (Scott and Duncan, 2001, 13). HIV/AIDS is a global pandemic affecting the ultimate metapopulation – the entire human community. Its distribution is unequal: spatially in terms of countries and parts of countries; socially, in terms of social and cultural groups; and economically, in terms of income and wealth classes. The evidence on this is not at all clear but some patterns seem to be apparent (see for example Carael, 1995; Over, 1998; Ainsworth and Semali, 1998; Filmer 1998; Farmer, 1999; and more generally on the relationship between ill health and inequality, Wilkinson, 1996).

2. Globalization: Health Promoter or Health Hazard?

There are numerous definitions of globalization (Went, 2000). They emphasise different aspects of the process and in so doing express different evaluations and ideological stances. For example¹:

- The intensification of global linkages across a wide sphere - across transnational corporate business structures, international finances, people mobility (migration, tourism), global cultural exchange, global environmental issues, and technology and electronic communication.
- Globalization not only refers to economic processes or the development of economic institutions, but also describes the interconnection between individual life and global features; the process of increasing economic, political, and social interdependence and global integration that takes place as capital, traded goods, persons, concepts, images, ideas and values diffuse across state boundaries. Routes of globalization are in the industrial revolution and laissez-faire economic policies of the last century.
- Globalization and liberalization are a fast, new express train and countries have been told that all they need to do was get on aboard...those that fail to get aboard will find themselves marginalized in the world community and world economy.
- Globalization is not a new phenomenon (the 16th and late 19th centuries are both characterized by the development of communication, transportation, and production systems) but the present era has distinctive features. Shrinking space, shrinking time and disappearing borders are linking people's lives more deeply, more intensely, more immediately than ever before (Human Development Report 1999, 1)

The term refers to some or all of the following phenomena:

- Global markets which are more closely and immediately linked, de-regulated and accessible to more people than hitherto;
- Tools of communication such as cell phones and the internet which enable the creation and maintenance of more flexible and responsive networks of communication – both financial and non-financial.
- New “actors” and “agents” which transcend national boundaries, for example the World Trade Organisation. Such agencies may have or claim to have authority over governments. Indeed the role and potential for action of nation states – with the exception of the largest and most powerful, the US – may be questioned by the existence of such global organisations. Some multinational corporations have global reach and more economic power than many states. Some NGOs are able to mobilise globally in opposition to and independently of states.

¹ These definitions are taken from a very useful discussion on the internet by Tamara Hattar, Debra Berliner, and Flavio Casoy, dated October 17, 2000 and entitled Globalization: Health Promoter or Health Hazard?

3. How does globalization affect health?

There are two broad views of how globalization affects health.

- There is a view which sees the increased interdependence attendant upon globalization resulting in an increased willingness of nations to work together in pursuit of improved health because this would serve their rational self-interest. This offered an optimistic analysis of the health benefits of globalization to poor countries and to poor communities in rich countries. These included: increased trade, easier diffusion of new technologies, and – at a cultural-political level - acceptance and application of common human rights throughout the world. This view argues that increased pace of cross-national exchanges should facilitate diffusion of technological innovations such as new and effective contraceptive methods, techniques for enabling access to clean water, inexpensive refrigeration, efficient transport and communication technologies, and new and effective systems for prevention and treatment of infectious disease.

- Contrastingly, the pessimistic view sees globalization as a phenomenon which because of the increasing loss of sovereignty by nation states means that states are less willing to pool resources. The result might be less co-operation and more protectionism, increased competition and insistence in maintaining those spheres of influence that still seem intact. In addition, the increasing concentration of the international pharmaceutical industry has been an important factor. The more ready availability of large profits from treatments of disease in rich countries and communities has meant that – for example – there has been markedly less attention to the needs of communities and countries which have lower ability to express their needs through markets. It has been argued (Thomas 2001) that pursuit of an HIV/AIDS vaccine has been of less interest to big pharmaceutical companies. These stand to profit more from development of treatments than vaccines. The debate about the TRIPS agreement and generic versions of anti-retroviral drugs before, during and most significantly after the XIII International AIDS Conference in Durban, 2000, is indicative of the kinds of challenge we confront in trying to ensure access to drugs through market mechanisms. The fate of the Global Fund for TB, Malaria and HIV/AIDS which was an outcome of the UNGASS meeting in 2001 still hangs in the balance as the rate of commitment from the main donor countries remains disappointing.

4. Neo-liberalism and global health

Although neo-liberal economic ideologies and the World Bank have not always been identical, they have certainly been very close during the past twenty years. The World Bank has had a profound influence on health provision in poor countries as the largest external financier of health activities in low and middle income countries. It has also been a major voice in national and international health policy debates and an important contributor to health policy research. Over the past two decades, the Bank has addressed the following three main health policy issues:

1. Systemic reform.
2. Targeting public sector investment.
3. Encouraging donors and governments to operate within the framework of the first two.

The thrust of these strategies was to emphasise the role of the market in health care provision. Government's role was to be mainly regulatory, by supervising the marketplace, insurance legislation, ensuring “acceptable” levels of access.

Criticisms of the Bank’s policy include the view that this is an approach which:

1. ignores the social ethics of health care and defines health services as commodities to be delegated to the market sector of an economy.
2. ignores the provision of public goods such as immunization and public sewage;
3. generally seeks to shift the larger burden of curative services to the private sector, which makes it available to foreign investment.

5. Individual health, public health and wellbeing

“Health” is not simple. It is a cultural artefact. It appears to be a quality of our body. That is where we feel unwell, where the symptoms of disease are experienced. It appears “natural” that we should see health, or its opposite: sickness, as an individual, isolated experience for which we take individual responsibility. The underlying metaphor is of a machine that we either maintain or neglect. Such ideas link with broader notions in western thought concerning the importance of the individual and his/her responsibility for her/his actions. This is where it links to markets which are also sometimes seen as interactions between “individual” economic agents. This is not the only way to see the issue. Consider the following two problems:

- is health really the issue or is there something broader called “well-being” which questions the purely individual and bodily nature of “health” and places more emphasis on the social and economic origins of “ill-being”?
- Do we need to understand the idea of “the individual” differently? This is not to suggest that individuals do not exist or have significance. It is to point out that the centrality of the individual as an acting and responsible entity is a product of western history and experience. Others, elsewhere, see things differently, placing the social nature of the individual centre-stage.

Amartya Sen² is an important commentator on these issues. His approach to problems of poverty and well being starts from the use which people get from their lives, how they are able to express and/or present themselves in the world. To understand the injustice of inequality, we need to see how economic, social, institutional and cultural structures stunt people's abilities to gain access to the resources which enable them to function as full human beings.

Sen's 'capability' approach focuses on the opportunities for choice open to people, rather than on the final outcomes they achieve. Potentially, this approach offers a way of limiting the need for contestable judgements about the nature of well-being as it notes that there can be a variety of limits to opportunity, different from one society to another. These ideas are important because they move away from the dominant western account of health and poverty as aspects of the individual. They involve a much broader perspective that spans cultures.

Sen's is a cross-cultural perspective. It allows a variety of interpretations of what it means to be a person and to have an identity. It engages with issues beyond the western cultural tradition and conflicts with the currently dominant emphasis on "the market" and "the private" in considering the provision of public goods and services.

These ideas were foreshadowed in the work of Karl Polanyi (Polanyi, 1945). Polanyi's view was that in past societies the market mechanism was closely integrated with other aspects of social relations. But in "the west" it became separated, "disembedded", and thus uncontrolled and unmoderated by considerations of values other than price. In its most extreme manifestation, "the market" is today held up by many politicians and philosophers as the best and only "rational" way to decide on the allocation of goods and services, including health and welfare.

Polanyi's perspective engages with a question that takes us beyond the conventional perspective of the "individual". While the western medical tradition deals with "individuals" and even dissects individual's complaints into "specialisms", this question locates individuals in their social field. It asks whether social relations can be considered as ends as well as means. In other words, whether social relations should themselves be considered as part of well being. If this were to be the case, then the social relations of making a living, living with other people, and rearing children, would have to be taken seriously as components of "well-being" in ways which are not currently the case in the "health" industry.

We live our lives in our minds but also through and in our bodies. We guard and worry about our health. *Our* health, *our* individual body, *our* well being or *our* ill-being. Medical doctors deal with our individual health. We pay them or make public provision for them to be paid. But is this really what health, well-being and ill-being are about? These questions confront us with the necessity to consider how we relate to each other in an era of increasing globalization.

These social relations are all-important aspects of public health inasmuch as the perspective that identifies "health" with "medicine" implies a much more

² These ideas have been developed in a variety of publications over the past twenty five years – see for example: Sen, 1985; Sen, 1997; Sen and Sengupta, 1983; Drèze and Sen, 1989. .

individualistic version of a “person” than does that which identifies “health” with “public health”. In the process, of course, the issue of whether or not social relations can be considered ends as well as means links once again to the notions of social cohesion, solidarity and public goods and their location and guardianship in a globalised world.

Social relations contribute to wellbeing³. They may be:

- ‘relational goods’ (Gui, 2000),
- goods which have characteristics of being “public” or “common” like, for example, transport infrastructure.

It may not be possible to supply the former category of good through markets, depending on whether a relationship, which is the good, is provided through a market. For example a foster parent provides care and support, a parent provides love as well. Can money buy love, can you cost a cuddle? The latter is not supplied or is under-supplied by markets because individuals and corporations have little incentive to supply those goods. Relational goods can be final consumption goods (i.e. valued for themselves) and/or intermediate goods (e.g. certain social relations may facilitate co-operation and trust). Social relations can be a source of value in themselves (Sugden, 2000, Bruni and Sugden, 2000). Social capital, social cohesion or community connectedness, make a huge difference to many facets of human life. Putnam (2000, 290) argues that “social capital makes us smarter, healthier, safer, richer and better able to govern a just and stable democracy.”

Such ideas are rich in their implications for thinking about public health in general. They also draw attention to some of the questions posed by the HIV/AIDS epidemic – perhaps the first global epidemic of which there has been a global political and public consciousness. The most important possibility that needs to be considered is that public health should be seen as a communal process. That it has elements of both a public good and a *relational good*: the good is consumed and enjoyed but the relationships through which it is provided are in themselves a “good”. This “good” is one which demonstrates care for others, an aspect of living with others. The problem is to develop an institutional locus for provision of such goods. These ideas about public health, health, medicine and the individual confront us with both challenges and opportunities in an era of “globalisation”. Discussion of these issues is – perhaps – one important “good” which might arise from the HIV/AIDS epidemic.

6. Irony and Pragmatism

It is ironic that at a time when the importance of past epidemics is increasingly recognised and discussed by historians, there is very little appreciation of how AIDS impact is already affecting many societies now and into the future. There is much talk of “emerging” and “re-emerging” diseases. HIV/AIDS is a harbinger of the global public health crisis.

³ Thanks to Richard Palmer-Jones, Cecile Jackson and Robert Sugden for their helpful discussion of these ideas in an unpublished document circulated in the School of Development Studies, 2000.

Epidemics such as HIV/AIDS and their impact do not take place in isolation. They need to be related to other events – changes in political regime, new ideas, global warming, the global distribution of power. We cannot deal with these events in isolation from each other. We live in a world where perception of inter-related multiple long-wave events must be on the agenda of every politician and policy-maker. We can no longer deal with issues piecemeal and sincerely claim that we have given them our full attention. As social scientists, we may engage with the AIDS epidemic for many reasons. Because it is an interesting phenomenon; because of a pressing desire to help those in distress now and in the future; because it makes a mockery of international development goals and prospects for progress in some countries; because resulting poverty may be a threat to the national security of the USA; or yet again because of a fear that “AIDS refugees” may flood the countries of the north in a search for treatment – a “therapeutic pilgrimage” which is a small but significant component of the enormous body of migration which characterises this period of globalization. It is clear that there is a premium on pragmatism as opposed to compassion. Pragmatism tends to capture resources. Social scientists may wish to explore further the links between pragmatism, self-interest, morality and public health. After all, economics was once described as a “moral” science!

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