Globalization and Health Effects in SAARC Region
Evolving a Framework of Analysis

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Abstract
Globalisation has evolved out of a gradual progress of progressive integration of the world economies through falling trade barriers, greater exchange and mobility of capital and labour. The process further facilitated by a number of developments in international cooperation, emergence of international institutions and the continued advances in information and communication technologies also paved the way for global governance. The new globalisation environment has driven several developing countries with a sizeable public sector to adopt policy reforms including macroeconomic and financial stabilization policies, creation of market-oriented environment and more space for the private sector. This goes hand in hand with increasing internationalization of goods, services, labour and capital, and exchange and exposure of human beings for development oriented programmes. However, such a process is likely to have far reaching effect on health - both direct and indirect particularly in developing countries, where health attainments are low and majority of population lacks resources to finance their healthcare needs. The dynamics, mechanism and pathways through which the process of globalisation affects the health sector is not yet clear as their linkages are complex and influenced by several key set of endogenous and exogenous factors.

This paper while focusing on the SAARC region (South Asian Association for Regional Cooperation), discusses different channels

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and their dynamics through which the process of globalisation affects the health sector. An attempt is made to evolve an analytical framework for assessing the health effects in a comparative basis and explore both direct and indirect effects of globalisation on health. The SAARC region is selected as globalisation induced policies particularly in these countries are being questioned on grounds of - rising healthcare cost, WTO compliance costing too high to the domestic industry and economy, and increasing infectious diseases associated with international travel and migration. These issues are further discussed in the light of accessibility, efficiency, and quality of healthcare delivery, geographical inequalities, heavy burden of private healthcare financing, and fiscal stress faced by governments in these countries. This analysis assumes importance if health objectives set forth in the Millennium Development Goals (MDG) have to be realized in the SAARC region.

I. The Context

Globalization seen in the historical perspective has evolved out of a gradual process of progressive integration of the world economy through falling barriers to trade, enhanced exchange, and greater mobility of capital and labour. These trends while providing market-orientation were further facilitated by the emergence of economic co-operation among various countries and international institutions, the economic collapse of the former Soviet Union, the macroeconomic imbalances in several countries particularly in the 1980s, and the emergence of the European Union (EU). The rapid advances in information and communication technologies (ICTs) and their digital convergence has also complemented the globalisation process by cutting down drastically the delay and distance along with providing a far greater access to information, which is not only rapid and cheap, but 'symmetrical' too, that is more and more people can access vast information, whenever and wherever they need it.

Globalization is neither a simple economic phenomenon nor a traditional concept of internationalization. It is a process of integration, which enables an intermeshing of social groups in almost all spheres, be it economic, social, religious, political, legal and cultural. Economic integration involving an increasing

interaction of inputs, factors and final product markets across countries enhances the role of multinational corporations (MNCs) in international economy[1].

In fact globalization requires conscious human decisions to bring in a general direction of change towards market-oriented environment (Petras and Veltmeyer, 2001). It works out by bringing the world together through socio-economic integration, and changes in the 'mindset', initially, at the key decision-making level among those who matter in influencing attitudes and orientations, and then gradually percolating down at the grass root level paving the way for an evolution of a 'global mindset' (Arora 2002).

Globalization is also different from the usual notion of internationalization as it works towards crossing the boundaries of national economies to establish a single global economy. The interactions decisively affect national economic activity beyond the power of the national government, usually without even its knowledge. In such a situation action becomes a matter of complex negotiation rather than simple fiat while making politics widely dispersed and complex. The old agenda of planning becomes entirely utopian (Harris 1999).

Globalization has prompted the developed countries to claim that the world has become a global village requiring regular interactions, and de-politicized institutions with harmonized and universalized rules and standards, and changes in developmental trajectories suggesting globalization path as the only successful development model. In addition, the different facets of globalization including world wide media coverage, expansion of trade, foreign direct investment (FDI) and financial markets, migration, rise of internet, crime and terror, and globalization of environmental problems have created a greater demand for international coordination and also the legitimacy of international organizations. The use of globalization as an instrument of multilateralism has further created a basis for global policies and governance frameworks needed in the areas of trade, development, finance and international peace and

security, as well as in other social and technical fields. Declarations and covenants arising out of this multilateral system legitimise global governance, which no individual state, however powerful, can match. Thus, as global integration trends grow, the need for changes in the policy framework and their internal coordination and management both at the national and international levels paving the way for global governance not necessarily under UN flag simultaneously grow.

This background of globalization helps us to derive the following key points worth considering in the context of evaluating its impact on the health sector:

(i) Globalization is a reality now and it is being demonstrated as more or less the *necessary foundation* for productivity, growth and development.

(ii) Globalization process, world governance, and changes in nation-state development policies and allied institutions, all go together.

(iii) The national economic environment has to be changed by making conscious efforts towards market-orientation by launching policy changes at all levels to realign the forces of market versus state in order to create market oriented environment and more space for the private sector over the period. This requires *state's quantitative withdrawal* from all economic spheres to give more space to the private sector. This will have serious impact on the political economy structure of the country.

(iv) Domestic business have come under *strong pressures* as the pattern of competitiveness has undergone a serious change with n*on-price factors* like product quality, brand name, packaging, and delivery, and after sales services. Firm's performance if not more have become equally important consideration as the price is[2]. *Comparative advantage* has become the necessary

condition of business sustenance whether it is for the domestic economy or exports[3].

Such a process of globalization, no doubt, has promoted open societies and open economies along with encouraging a relatively freer exchange of goods, ideas and knowledge, and creativity and entrepreneurship in some parts of the world along with contributing towards awareness of rights and identities enabling social movements to strengthen democratic accountability. According to World Development Report 2003, over 200 million people came out of poverty in a single decade in East Asia. Global conscience, at least theoretically speaking, is emerging more than ever before to the income inequities, poverty, gender discrimination, child labour, health hazards and environmental degradation.

During the course of globalization, general economic risks of the developing countries have become more real. The fundamental problems of poverty, unemployment, exclusion, inequality and corruption are still widespread. The future of open markets is increasingly in question with global terrorism rising and global governance reaching a critical juncture. At present, the process of globalization lacks means to keep the balance between democracy and markets, because market success and failure have tended to become the ultimate standard of behaviour, and promotes the attitude of 'the winner takes all'. This in turn, weakens the fabric of communities and societies.

This process of globalization is likely to have far reaching impact on the health sector in developing countries, particularly the SAARC region. Determinants of health range widely to include income and wealth, education, peace and security, and environmental conditions are likely to be influenced during the globalization process especially in public sector dependent economies. In addition, globalization induced policies, as stated above, are in question due to their likely adverse effect on the poor, the domestic industry and economy, and burdening the health systems with infectious diseases associated with international travel and migration particularly if

the existing problems with respect to accessibility, efficiency, quality of healthcare delivery and inter-regional inequalities in healthcare financing continue to persist.

Therefore, it will be a worthwhile attempt (i) to identify the channels and their dynamics through which globalization affects the health sector in order to evolve an analytical framework for assessing the health effects in a comparative basis; (ii) to use this framework to explore both direct and indirect effects of globalization on health, (iii) to sketch out the broad contours of policy changes in the context of given socio-economic context of these countries, so that health effects of globalization are optimized, if not fully, at least to some extent. The focus of this paper is on the South Asian Countries constituting SAARC (South Asian Association for Regional Cooperation) given its economic peculiarities; some of which are discussed below.

II. SAARC Region

(a) Socio-Economic Profile

The SAARC region was established in December 1985 by Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka to promote the welfare of the people of South Asia through accelerated economic growth, social progress and cultural development in South Asia.

Up till 1970 all SAARC countries struggled with massive poverty, food shortages, heavy disease burden and high illiteracy rates. However, the last two decades have seen significant rise in real income and reduction in poverty levels. The economies of the SAARC region shifted away from being dependent on agriculture to increasing emphasis on modern

urban-based industries and service sectors. Initiation of economic reforms during 1990s, particularly in India, Pakistan and Bangladesh has put these economies on the higher growth trajectory path. During 1997-2001, except Pakistan and Nepal all other SAARC countries have recorded more than 5 per cent annual growth in GDP (Table 1, given below).

Table 1. Socio-Economic and Human Development Indicators for Countries in SAARC Region

Indicator	ndia	akistan	anglad esh	epal	ri Lanka	hutan	aldives	AARC**
Population (million) 2002	050	50	44	4.6	9	.2	.31	390
Gross national income per capita (US $) 2002	87	08	51	30	73	95	182	60
GDP annual growth rate 1997-01	.5	.3	.4	.7	.3	.6	.1	.2
Poverty - % of population below $1 (PPP) per day consumption , 1995-97	4.2	1	9.1	7.7	.6			1
Population living below the national poverty line (%), 1990-2001	8.6	2.6	9.8	2	5			1.4
Share of income/consumption - Poorest 20%	.9	.8		.6				E
Share of income/consumption - Richest 20%	1.6	2.3	1.3	4.8	2.8			E
Life expectancy at birth 2001 (Rank among 177 countries)	3.7 (122)	0.8 (127)	1.1 (126)	9.6 (130)	2.5 (62)	3.0 (125)	7.2 (112)	3.2
Human Development Index* 2002 (Rank among 177 countries)	.595 (127)	.497 (142)	.509 (138)	.504 (140)	.740 (96)	.536 (134)	.752 (84)	.584
Adult literacy rate (% ages 15 and above) 2002	1.3	1.5	1.1	4	2.1	7	7.2	7.2

* The composite human development index is based on four indicators namely, life expectancy at birth, adult literacy rate, school enrolment ratio, and per capita income in PPP US$. For details see [UNDP 2004]. NE – Not estimated.

** SAARC average is weighted according to share of each country in the total population of the region.

Source: World Development Report 2003; Human Development Report 2004; Research and Information System for the Non-Aligned and Other Developing Countries 2004.

It is important to note that despite the sustained average annual growth rate of above 5 per cent over the last two decades, this region continue to suffer from many health problems, and in the global context, lags behind all other regions of the world, both in its income and in human development levels. South Asia is by now the poorest region in the world - its per capita income of US$ 309 is much below the US$ 555 of Sub-Saharan Africa and is only one-third of the average of US$ 970 for all developing countries (Human Development Report 2004). Further, there are notable differences regarding socio-economic and political, epidemiological and demographic transitions among these countries. Characterized by large income disparities and 43 percent of its population living below the poverty line, South Asia's economy exhibit sharp dualism with traditional village farming coexisting with modern agriculture, traditional handicrafts with a wide range of modern industries, and a multitude of support services. SAARC, tragically, is the world's only region, which has failed to tap the potential for social-cultural exchange and economic cooperation, with the continuation of war and cold war in the region between India and Pakistan. Intra-SAARC trade is dismally as low as 4% and the collective share of the region in world trade was just 1%.

Despite spectacular economic growth accompanied by noticeable social change reflected in the spread of basic education and literacy levels, the gains from development have not trickled down to the poor. For instance, in terms of composite human development index (HDI), the rank was as low as 142nd (out of a list of 177 countries) for Pakistan, 140th for Nepal, 138th for Bangladesh, 134th for Bhutan, 127th for India with Sri Lanka and Maldives were placed much better at 96th and 84th position, respectively. Although there is an improvement in overall HDI over time, the relative position of SAARC countries has not changed much. The gap between HDI and income rankings was more noticeable for India and Sri Lanka whereas between HDI and life

expectancy at birth for Sri Lanka and Maldives. Interestingly, Sri Lanka with relatively lower level of GDP has exceptionally done well in the region by achieving higher levels of longevity and human development.

(b) Demographic profile

The demographic landscape of the SAARC region has seen unprecedented changes over the last 100 years. First half of the 20th century recorded a slow population growth due to frequent famines and epidemics, such as, plague, cholera and influenza. A high population momentum in SAARC region was noticed during the second half of the 20th century while experiencing second stage of demographic transition. The population growth rate accelerated and India (which accounts for three-fourths of the region population) doubled its population between 1961 and 1991 and crossed one billion mark in 2001. India, Pakistan and Bangladesh are respectively the second, seventh and ninth most populous countries of the world. While accommodating about 23 per cent of the global population on just 3 percent of the world's area making it the most densely populated part of the world with about 263 people for every square kilometer. More people are born in South Asia every year (27 million) than the total population of all the Scandinavian countries (Denmark, Finland, Norway and Sweden). As a matter of fact the population of South Asia exceeds the total population of 50 of the smaller UN Member countries.

During 1950-75, the population in SAARC countries grew by more than 2.2 per cent. In the later period, only Sri Lanka has experienced a much slower population momentum whereas the population of India, Pakistan and Bangladesh continued to boom. Overall population of the region would be growing at 1.4 per cent during 2002-15 whereas the rate for Sri Lanka is just 0.7 per cent. The rapid transition from high to low fertility for Sri Lanka was quite unexpected. Fifty years ago, women from this region were marrying at young ages and having an average of six births during their lifetime and, even by the early 1970s, the corresponding figure was five births. Today, Sri

Lanka has achieved the population replacement level (total fertility rate touching 2.0). Sri Lanka is being considered as a demographic success story in the region.

In 1950, the region had very young population; almost two-fifths of them were under age 15 years. Over time, only Sri Lanka has recorded a significant decline in the share of children (from 40 per cent in 1950 to 25 per cent in 2002) primarily due to faster decline in fertility rate. On the other hand, population aging is being experienced both in Sri Lanka and India. Except Sri Lanka, the population dependency ratio is continued to remain high for the SAARC countries (Table 2).

Table 2. Population change in SAARC Region

Indicator	Year	India	Pakistan	Bangladesh	Nepal	Sri Lanka	Bhutan	Maldives	SAARC*
Population (million)	2002	1050	150	144	25	19	2.0	0.3	1390
	2015	1246	204	181	32	21		0.4	1688
Annual population growth rate (%)	1975-02	2.0	2.8	2.4	2.3	1.3	2.3	3.0	2.0
	2002-15	1.3	2.4	1.8	2.0	0.7	2.5	2.8	1.4
Urban population (%)	2002	28.1	33.7	23.9	14.6	21.1	3.2	28.4	27.9
Population under age 15 years (%)	2002	33.1	41.5	38.3	40.2	25.1	41.8	33.1	34.7
Population age 65 and above (%)	2002	5.1	3.7	3.2	3.7	6.9	3.3	2.2	4.8
Dependency ratio	2002	62	82	71	81	57	76	66	65
Total fertility rate (births per woman)	1970-75	5.4	6.3	6.2	6.8	4.1	5.9	6.0	5.6
	2000-05	3.0	5.1	3.5	4.3	2.0		3.3	3.3

* SAARC average is weighted according to share of each country in the total population of the region.

Source: Human Development Report 2004; World Health Report, 2004.

(c) Mortality Decline and Improvement in Longevity

The decline in mortality in many developing countries was experienced after World War II as modern medicines and health practices were introduced and public awareness about health increased. During the 1950s and 1960s, many infectious diseases such as malaria, cholera and tuberculosis were increasingly brought under control with the importation of Western medical technology, particularly antibiotics and the spread of knowledge about the factors associated with 'good health'. Coupled with these advances were the general improvements in the socio-economic conditions of the masses, including those related to sanitation and hygiene, which accompanied poverty reductions. Consequently, the crude death rate in SAARC region declined from around 25 in 1950 to 8 by the end of the 20th century. Currently, as compared to crude birth rates, there is not much differential in death rates between SAARC countries. The decline in fertility followed at much later stage. The evidence suggests that the demand for children (fertility rate) was also higher when infant and child deaths were high. Of the world infant deaths in 1996, India, Pakistan and Bangladesh accounted for 21.9 per cent, 5.6 per cent and 4.8 per cent respectively. The infant mortality rate was highest in Bangladesh, followed by Pakistan; and for India it was around 71 per 1000 live births. However, there is not much difference in child mortality rate for ages 1-4 among these three countries. Surprisingly, the probability of dying among male babies was higher than their female counterparts in Bangladesh, whereas the pattern was reversed in the case of child mortality. There is a widespread prevalence of malnutrition among pregnant women and lactating mothers in these countries. The low birth weight of babies also contributes to the chances of survival.

The WHO indicator of healthy life expectancy (HALE) after adjusting for morbidity and disability losses in the population suggest that longevity among Sri Lankans is higher by 7 to 9 years than Indian, Pakistani or Bangladeshi people (Table 3). Interestingly, a comparison of the gap between life

expectancy at birth and HALE suggest that all the SAARC countries have very similar disease burden (ranged between 7.5 and 8.7 years).

Table 3. Key Health Status Indicators in SAARC Region

Indicator	Year	India	Pakistan	Bangladesh	Nepal	Sri Lanka	Bhutan	Maldives	SAARC**
Infant mortality rate (per 1,000 live births)	1970	127	120	145	165	55	156	157	128
	2002	87	83	61	76	17	64	18	66
Under-five mortality rate (per 1,000 live births)	1970	202	181	239	250	100	167	155	203
	2002	93	107	87	91	19	74	27	92
Maternal mortality ratio (per 100,000 live births)	2002	540	500	380	540	92	420	110	516
Healthy Life Expectancy (HALE)*	2002	53.5	53.3	54.3	51.8	61.6	52.9	67.8	53.7
Life expectancy lost (years)	2002	8.5	8.1	8.3	8.3	7.7	8.4	8.3	8.7
Children under 5 underweight for age (%)	1995-02	47	38	51	47	23			47
Low birth weight babies (%)	1998-02	30	19	50	21	12	15	12	29
People Living with HIV / AIDS Adult ages 15-49 (%)	2003	.79	.11	0.1	.49	0.1	0.1	.06	
Malaria cases (per 100,000 people)	2000		58	0	3	,110	85	.	2
Tuberculosis cases (per 100,000 people)	2002	344	379	347	371	53	305	56	353

** SAARC average is weighted according to share of each country in the total population of the region.

Source: Human Development Report 2004; *World Health Report, 2004.

Decline in death rate especially among infants and children in the region have led to considerable improvement in the life expectation at birth. During 50 years of independence, the life expectancy in India has doubled. Similar gains were also

noticed in Pakistan and Bangladesh. The success of immunization and related health programmes, often as part of maternal and child health care, coupled with continued improvements in living standards, are obvious factors in improvement in child and maternal survival (Table 4). Yet, despite these impressive declines, considerable scope remains for further improvements in the coming decades - as the recent years has witnessed only a marginal decline in infant mortality rates in India, Pakistan and Bangladesh.

Table 4. Select Health Access and Health Input Indicators for SAARC Countries

Indicator	ndia	akistan P	anglade sh	epal	ri Lanka	hutan	aldive s	AAR C*
One-year-olds fully immunized against tuberculosis (%), 2002	1	67	5	5	9	3	8	2
One-year-olds fully immunized against measles (%), 2002	7	75	7	1	9	8	9	8
One-year-olds fully immunized against DPT (%), 2002	0	63	5	2	8	6	8	1
Contraceptive prevalence rate (%), 1995-2002	8	28	4	9	2	1		7
Births attended by skilled health personnel (%), 1995-2002	3	20	2	1	7	4	0	7
Hospital beds (per 100,000 people), 1993-2000	9	65	0	7	74	61	6	4
Physicians (per 100,000 people), 1990-2003	1	68	3		3		8	9
Population with sustainable access to affordable essential drugs (%), 1999	-49	50-79	0-79	-49	5-100	0-94	0-79	E
Population Without Access to Sanitation (%)	9	39	7	3	7	1	4	3
Population Without Access to Safe Water (%)	2	12		9	7	8		1

* SAARC average is weighted according to share of each country in the total population of the region.

Source: World Development Report 2003; Human Development Report 2004.

(d) Healthcare System and Role of Public Sector

Over time the healthcare system in SAARC countries has expanded considerably with both public and private sectors playing critical role in delivery of primary and secondary health care. With some exceptions the major health needs of the public are catered for by the public sector. The major boost in infrastructure of the public health care system in SAARC region took place after they endorsed the Alma Ata declaration of 1978 - "*health for all by 2000"* initiative launched by the World Health Organization. Three tier public health infrastructure were created - 'primary health care centres' at village level with first referral unit, community hospital at sub-divisional headquarter as secondary units, and district hospitals and teaching and referral units representing tertiary care.

Along with this a significant public health campaign was launched for the first time, keeping in view local needs and WHO guidelines to meet the target. These included the expanded immunization programme to eradicate the prevalent infectious diseases; malaria, tuberculosis, diarrhoea and pneumonia control programmes; family planning programme, and many others such disease control programmes. Due to various socio-economic and political reasons, most SAARC countries (Sri Lanka as an exception) have failed to achieve desired health targets by 2000. Nevertheless under every government the "*health for all by 2000"* remained an official policy for the state-owned health system, which despite poor resources and mismanagement, provided a big relief to the people of SAARC region.

Entire public health care system in SAARC countries is financed through tax revenues. There is a mixed pattern in government health spending in the region. The share of public spending in India, Pakistan and Nepal is very low (ranging between 18 and 30 % of total health expenditure) whereas for Bangladesh and Sri Lanka, it is about half; and for Bhutan and

Maldives as high as 90% (Table 5). Both in terms of budgetary allocation and as percentage of GDP, the share of public spending has not been stepped up in India and Pakistan. Over time, fiscal crunch and mismanagement in the public sector contributed to a worsening of the health service provided. In the meantime a vibrant private healthcare sector flourished in South Asia. No doubt, it is efficient and equals Western standards, but unfortunately, it is run on purely business lines with no ethical values. It is totally unaffordable for the general public and has become one of the most successful businesses in India and Pakistan. The policies of successive governments failed to improve the public healthcare system.

Traditionally, it had been the policy of the government - on paper at least - to provide free health care. Health care utilization data for India for 1986-87 and 1995-96 indicate a considerable decline in the provision of free health services by the public sector agencies (Gumber 2002). This all changed when SAARC countries officially endorsed the free trade WTO treaties. Over the last decade, these countries have been undertaking economic reforms to pursue privatization, liberalization and globalisation. And health sector is not an exception as large-scale inefficiencies and mismanagement have been pointed out in the public sector hospitals. As a first step to check this mismanagement, hospitals have been given more autonomy and allowed to maintain their budgets. Consequently, there was an increase in the cost of treatment as free diagnostic tests were withdrawn and service charges were imposed, making the equity issue more serious (Gumber 2000).

Table 5. Selected Health Accounts Indicators in the SAARC Region

Indicator	ear	ndia	akistan	anglade sh	epal	ri Lanka	hutan	aldive s	AAR C*
Total Health Expenditure (THE) as % GDP	997	.3	.8	.9	.4	.2	.6	.5	.9
	001	.1	.9	.5	.2	.6	.9	.7	.8
Govt. Expenditure on Health as % of THE	997	5.7	7.2	3.7	1.3	9.5	0.4	1.9	9.2

	001	7.9	4.4	4.2	9.7	8.9	0.6	3.5	1.4
Private Expenditure on Health as % of THE	997	4.3	2.8	6.3	8.7	0.5	.6	8.1	0.8
	001	2.1	5.6	5.8	0.3	1.1	.4	6.5	8.6
Govt. Expenditure on Health as % of Total Govt. Expenditure	997	.2	.8	.7	.3	.0	0.1	0.9	.6
	001	.1	.5	.7	.1	.1	.5	0.3	.7
External Resources for Health as % THE	997	.3	.7	0.0	0.6	.2	2.1	.2	
	001	.4	.9	3.3	.4	.1	8.2	.9	.7
Per Capita THE (PPP $)	997	4	3	0	8	1	8	80	4
	001	0	5	8	3	22	4	63	0
* SAARC average is weighted according to share of each country in the total GDP of the region. Source: World Health Report 2003, pp. 171-75.									

By now, twelve Summits of SAARC have been held and the health sector continues to be an important issue of discussion as it was one of the original five areas of cooperation decided by Member States discussed under the broad heading - Health and Population Activities. The Technical Committee on Health and Population activities set up in 1984 deals with maternal and child health, primary health care, disabled and handicapped persons, control and combating major diseases in the region such as malaria, leprosy, tuberculosis, diarrhoea, rabies and AIDS. Member States have taken a number of initiatives for strengthening efforts to combat problems posed by resurgence of communicable diseases such as malaria, TB, waterborne diseases and the emergence of HIV/AIDS as major health hazards along with making arrangements for training, research and activities with regional approaches to combat major diseases[4].

III. Globalization and Health: Key Linkages

Globalization, no doubt, has promoted open economies

and to some extent societies, too along with encouraging a relatively freer exchange of goods, ideas and knowledge, and creativity and entrepreneurship in many parts of the world. World Bank estimates suggest that more than 200 million people came out of poverty in a single decade in East Asia. Better information and communications have contributed towards awareness of rights and identities, and enabled social movements to strengthen democratic accountability. The diffusion of new knowledge and technology and easing of the trade restrictions can enhance disease surveillance, treatment and prevention, foreign investment in health services and even the medical tourism. The Australian government has already introduced a medical visa for those seeking health care in Australia. The emerging global conscience about gender rights and empowerment, income inequities, poverty, gender discrimination, child labour, and environmental degradation can have tremendously positive health effects. It is argued by many that when women gain control over household income, they, being more family oriented, invest more in their children's education and health, which benefits their own family as well as the community at large.

Let us also not forget that during the globalization process, the fundamental problems of poverty, unemployment, exclusion, inequality and corruption in developing countries continue to be widespread. The future of open markets is increasingly in question with global terrorism rising and global governance reaching a critical juncture. At present, the process of globalization lacks means to keep the balance between democracy and markets, because market success and failure have tended to become the ultimate standard of behaviour, and promotes the attitude of "the winner takes all". This in turn, weakens the fabric of communities and societies. All these aspects directly and indirectly influence the health outcomes particularly in the developing region like the SAARC given the fact that determinants of health are widely multidimensional ranging from income to education to national and international peace to environmental conditions to national and international efforts; because as defined in the preamble to the constitution of

the WHO, health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[5].

It also needs to be underlined that while globalization policies and structural changes in the health sector going hand in hand, the globalization and health linkage are getting increasingly intertwined. Three observations deserve mention.

- Both globalization and health consequences are greatly influenced by a number of other factors like the socio-economic and development policies, and the political will with which these policies are implemented, technological developments, economic pressures, changing ideas and increasing social and environmental concerns. All these get interconnected defying cause and effect relationship during the course of time to affect the health resources, healthcare systems and health achievements. For instance, one finds a two-way relationship between income and health. A high income nation can provide better health infrastructures for its people, who in turn can afford not only to pay for their healthcare directly or indirectly through taxation, but they can also afford to spend more on better and healthy living. However, health also affects income levels. With improved overall health of the community, the ability of individuals to earn more also improves, their medical expenditures decline, and the income of the nation improves, as the country has to spend less on providing healthcare infrastructure to unproductive population. It is equally important to note that both these are influenced by the forces of globalisation.

- Globalization effects are mediated by a number of factors like expected income growth, improvement in income and wealth distribution, poverty reduction and the initial conditions related to the level of development, the on-going growth pattern and its quality, accompanying economic policies facilitating this growth, the level of human capital development and the infrastructure available of the reforming country on the one hand and the changing international

economic scenario marked by the emerging new pattern of world trade, the global governance assuming a tangible role in managing the world economy on the other[6].

- Health has got multiple determinants, which get interconnected both endogenously and exogenously making the treatment complicated by resistance, lack of resources, and poverty. The key determinants like the healthcare infrastructure and its accessibility, income, education, safe water and sanitation, lifestyles, employment, workplace and environmental health, and supportive social relationships (sometimes called 'social capital') - all these are affected by domestic public policies that, in turn, are increasingly getting interconnected and affected by international developments, trade agreements and global governance. This complexity gets further confounded as the distinguishing line between environmental, health and quality standards is gradually disappearing. For instance, in the food sector what may be described as quality standard for food may also fall in the category of environmental standards [Jha 2001]. In addition, new challenges arising from managing the aging to debates over euthanasia, and the right to end life and gene patenting along with the old scourges of Malaria and Tuberculosis, which are being globalized further complicate the situation. Many would argue that as technical interventions improve and populations' age, new issues about ethical, financial, and human resources must be addressed, not just nationally, but globally. All these would further add complexities to health and its determinants.

Despite the complexity of the interconnections that exist between globalization and health, it is more or less clear that the health sector and allied policies of the nation-states affect the health system and health outcomes directly, whereas globalization induced effects on growth, poverty and environment, changes in public policies and pattern of trade in goods and services (including trade in legal and illegal substances and in military arms), flow of capital, and movement of people affect indirectly. These points are worth considering further.

Direct health and related policies of the countries no doubt explicitly influence the health outcomes in the developing countries, but these very policies are subject to change now. Globalization while challenging the established development paradigm (Arora, 2002) has induced a number of changes in the policy perspective of the health sector, too. The earlier notion as envisaged in the initial years of independence (in India, for instance), which prevailed for long that the provision of basic public health services would be provided free of cost is no longer appreciated particularly since the early 1990s with globalization becoming the reality. An impression is being created around as if privatisation and the trade treaties for international rules for health, and other essential public goods are the only solution for whatever problems exist today with health care provision particularly in the developing countries. It needs to be kept in mind that the public systems for health care arose in most countries because private systems proved inadequate and inequitable.

Changes in trade liberalization lowers tariffs (taxes) on imported goods, thereby reducing the amount of revenue that governments have to spend on social sectors like health, education, and environmental protection. Trade agreements though do not directly lead to health care privatization, but they do change the mindset to prevent any future expansion of the public system. For instance, as privatization trends grow and get consolidated, access and quality of the healthcare system is adversely affected; because health care professionals find the private sector more attractive and are pulled away from the public system; and two, patients who have the paying capacity and wish to spend move to the private sector depriving the public health system both from revenues to be deployed for improving the quality and/or the expansion of the public system. This can distort not only the investment pattern, but can lead a very regressive system as private investments will flow in services meant for the affluent, and disproportionately benefiting the wealthy.

Tariff reductions for poor countries mean squeezed budgetary support and growing fiscal crisis in view of the rising non-development-non-plan expenditures. This brings in difficulties, both the Centre and the state governments to adequately cater to the changing health needs of the growing population. This has forced the governments to look for alternative options. It is more so because global trends towards increasing share of 'for profit' healthcare and its marketisation through an increasing influence of multinational corporations across societies are not only intense, but stand firmly consolidated.

The nation-states in order to realign their market versus state equation are undergoing fiscal retreat, which in turn adversely affect the social sector particularly health in two ways - by cutting down social expenditures particularly related to health and through cutting down fiscal transfers to different constituent regions, which in turn find it easier to reduce health expenditure because there exist neither industry lobbies nor political pressure groups to speak for the adversely affected poor sections of the population. Globalization induced international standards and commitments like World Trade Organisation (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) especially with regards to pharmaceuticals is supposed to ensure compliance to IPRs by protecting patents. However, TRIPS (unlike other WTO agreements) does not 'free' trade, rather it protects and validates intellectual property rights, majority of which are held by MNCs or individuals in rich countries.

The greatest indirect challenge to health probably occurs through global liberalization of trade, and the resulting movement of goods and services within a world economy. Although increased exchanges bring benefits, they also carry risks, such as the international trade in illegal products and contaminated foodstuffs, inconsistent safety standards, and the indiscriminate spread of medical technologies. Electronic media and the internet may provide opportunities for rapid communication, but they also allow, for example, the sale of prescription drugs that have not been approved by national drug-monitoring bodies.[15] Moreover, the binding trade rules

enforceable through multilateral institutions like the World Trade Organization limit the social and environmental 'regulatory space' of national governments, and undercut institutions that support public health and social well-being. Unfortunately, such institutions cannot provide for the basic needs relating to food, shelter, clothing, education and health of the poorest people and the poorest countries, and their technical requirements. Similarly, in the area of public health, the shift from national to global governance which began in the mid 19th century out of concern about infectious diseases have brought more compliance orders in developing countries and less technology transfers over the period.

In addition, TRIPS agreement is expected to increase sharply drug costs, which decreases the amount of public funding available for primary health care or other public programmes, and will add to the personal cost, as prescribed drug costs are not insured.

It is also argued that globalization affects *global* health through changes in economic growth, poverty, inequality and the sustainability of our environment, although the extent of this effect is yet unclear. During the past four decades, the world has become much more inequitable. The share of the poorest 20 per cent of world's people in global income now stands at a miserable level 1.1 per cent down from 1.4 per cent in 1991 and 2.3 per cent in 1960. In 1960, the richest 20 per cent of the world's population had incomes 30 times greater than the poorest 20 per cent. By 1990, the richest 20 per cent were getting 60 times more and by 1994, 78 times more. The assets of the 3 richest people are more than the combined GNP of all least developed countries. The assets of the 200 richest people are more than the combined income of 41 per cent of the world's people. A yearly contribution of 1 per cent of the wealth of the 200 richest people could provide universal access to primary education for all ($7-8 billion) (Human Development Report 1999, p.38). The least developed countries that make up about 10% of the world's population have halved their share of world trade. Such aggravating degree of inequality would have severe

repercussions on the health and well being of individuals by affecting world peace, migration, political instability, terrorism, violent conflict, and social unrest. The fall in life expectancy of Russian men (from 64 years in 1989 to 59 in 1993) resulted partly from a reduction in real income, increased stress, stress-related behaviour (e.g. alcohol consumption), and a breakdown in health services. Inequalities within countries have increased partly because employment opportunities have diminished and the labour market is rapidly changing. Though unemployment may be a short-term difficulty, as individuals adjust to demands for greater flexibility and technological competence in the global workplace, it may also signal 'the end of work' with repercussions deepening of inequalities between social groups. Low-income countries are affected similarly by changes in the global division of labour, which are altering the nature of work worldwide.

Trends to liberalize trade and increase privatization are also said to be associated with the destruction of the regenerative capacities of ecosystems on which future generations will depend. Excess carbon dioxide, methane, and other gas emissions are widely acknowledged to contribute to global warming. Climatic change will have both direct effects (ranging from respiratory disorders and infections caused by contaminated drinking water and food, to changed transmission of vector organisms) and indirect effects (through alteration of the range, proliferation, and behaviour of a large number of vectors, intermediate hosts, and the viability of infectious agents). Such changes affect population differently, depending on levels of poverty, age, nutritional status, and geographical location. The World Health Organization states that about 25 per cent of disease and injury worldwide is linked to environmental decline attributable to globalization, with 90 per cent of malaria deaths caused by rainforest colonization and large-scale irrigation schemes, which increase exposure to mosquitoes (WHO, 1997).

Globalization induced movements of personnel from one country to another no doubt benefit individuals in their short and

long-term personal promotion, but brings no short terms economic benefits to developing countries except in very few cases. With increasing economic openness while changing the scale and scope of cross-border flows of goods (including food and related products, services, and capital) not only allows some unscrupulous medical products to enter unsuspecting (Matowe and Katerere, 2002); but it also involves more frequent travelling and migration. This exposes communities to various health risks. The most dramatic example is of the HIV/AIDS epidemic - a deadly infectious disease spread through cross-border transmission, travel and migration.

Globalized tourism industry which is inseparable from the sexual exploitation of children, adolescents, and adults in third world countries (Buss, 2002), has aggravated the infectious diseases. Even the child health is endangered (indirectly at least) by the growth in economic activity by women if it is not accompanied by the development of adequate childcare infrastructure and nutrition levels (Cornia, 2001). The population-level health influence of tobacco marketing is another important example. China - the most quoted success story of economic reforms have shown that sexually transmitted diseases that were nearly eliminated in the 1960s have spread rapidly (Dollar, 2001).

In addition, the poor increasingly moving into overpopulated urban areas for 'push' and 'pull' factors expose themselves to infectious diseases, waterborne illnesses and conditions usually thought of as diseases of affluence such as cardiovascular disease and cancer. The alarming rise in smoking related illnesses is one important example.

Health sector in itself is passing through a transition causing changes in disease pattern load (Bhat, 2000). One, in almost all the SAARC countries, the healthcare problems are still dominated by communicable, respiratory and diarrhoeal diseases, and the high maternal, peri-natal and neo-natal morbidity rates. Under-nutrition, micronutrient deficiencies and associated health problems coexist with obesity and non-communicable diseases. In India, during the 1990s, while mortality rates reached a plateau,

there emerged a challenging dual disease burden. Communicable diseases have become more difficult to encounter because of the development of insecticide resistant strains of vectors, antibiotics resistant strains of bacteria; and the emergence of HIV infection for which there is no therapy (Government of India, 2002, Tenth Five Year Plan, Part II p.82). Two, with increased flow of information through print and electronic media, the active role of NGOs and campaigns led by grassroots organizations, the rising awareness and expectations of the people, stress on international health security, technological advances and improvements in access to healthcare infrastructure, people have become more right-conscious and both the demand and supply side perspectives are changed now. The adoption of the MDGs, and rising incidence of avian flu, animal diseases, and HIV/AIDS, SARS epidemic, and anthrax attacks in the United States have shown that international parameters enter the government agenda in a variety of ways

A Caveat

It is quite evident from the above analysis that globalization policies, particularly in the context of a developing SAARC region having substantial public sector has assumed the role of a great force of change, given its both direct and indirect but multidimensional inter-linkages with income growth and development, national policies, governance and institutions. The greater privatization, liberalization and deregulation of domestic economic activities requires realignment of the role of 'state' verses 'market' by reformatting macroeconomic policies to increase - international trade (in goods and services including banking, insurance, shipping, finance, education, and health care etc.) - flow of international capital especially of foreign direct investment (FDI) and technology and print and electronic media. These macro changes would affect the health resources, health systems and determinants through the changes in policies related to healthcare, drug, and demography meant for reducing demographic pressures, mortality and morbidity on the one hand and also through other policy changes as required to sign

international agreements related to TRIPs, TRIMS, and patents, and trade tariffs etc to meet international standards and commitments. These developments have to be seen in the background in which the national economy is getting formally global with the growth of the informal local economy, but social and political institutions remain largely local, regional and national. This may turn out to be unsustainable if social unjust and polarization continue to grow.

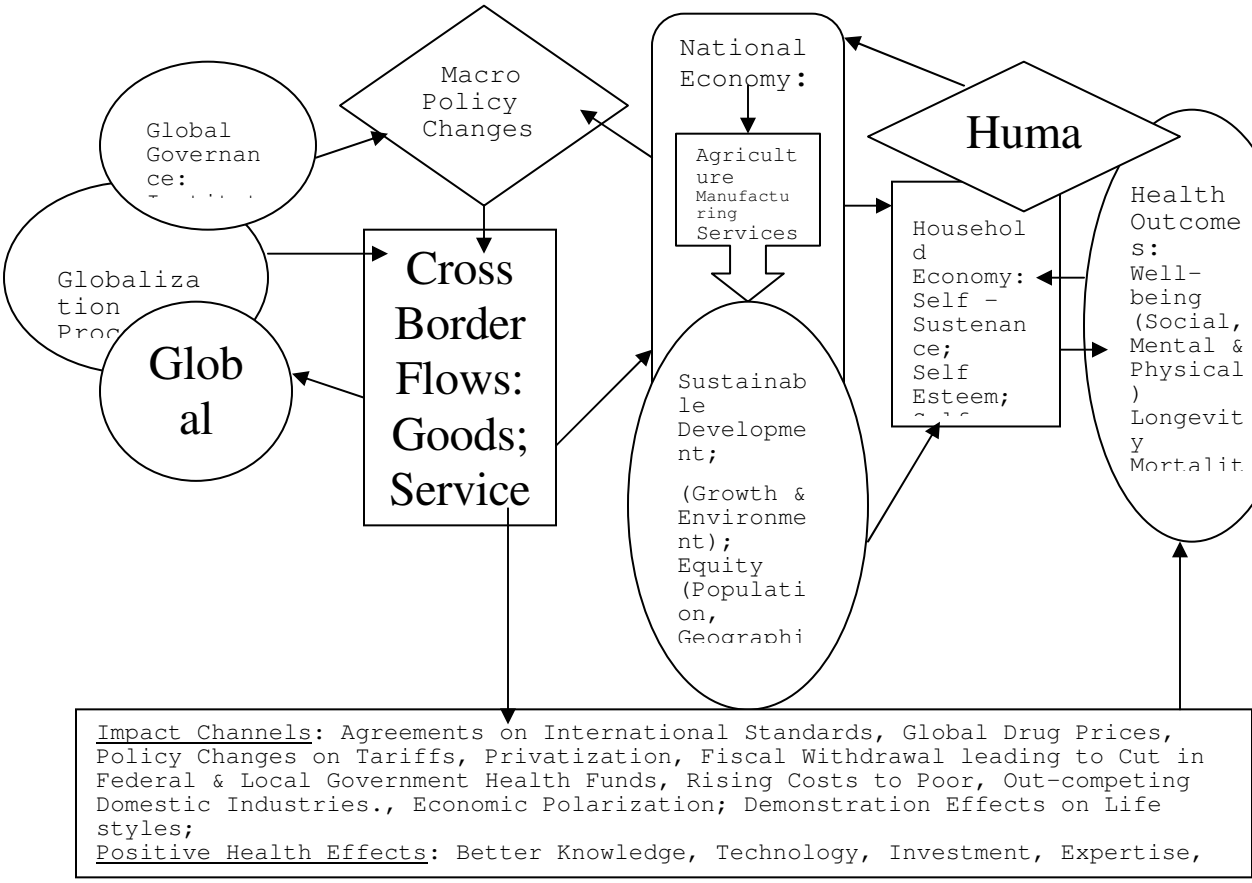
With multiplicity of changes taking place at the micro and macro levels ranging from healthcare requirements to health seeking behaviour to actual health outcomes on the one hand and globalization policies getting firmly established in the country and the world over, on the other, an evaluation of the health sector becomes critical and complex, more so because data are fragmentary and disparate in their reliability and scope (Sen et al., 2002). In this backdrop, there is a need to understand and evolve a kind of framework highlighting the channels of globalization process, which would affect the health sector as a whole and the health outcomes and consequences, more so in a region, which is diverse, and rapidly growing but health achievements are lacking.

Evolving a Conceptual Framework

The conceptual framework requires us to identify all the variables and parameters, and their linkages on the one hand, and the mediating factors which influence these linkages, on the other. The relationship is circular in nature. As shown in Figure 1, globalisation process operates through variables like cross-border flows, their size and pattern (goods and services; capital, portfolio investments and finance; labour, migration and tourism; entrepreneurship and technology), which influence national economy, which in turn affect health attainments. This process while increasing exchange and interdependence enhances interaction for global concerns and scope for global governance through international institutions like U. N., WTO, IMF, World Bank, WHO etc. on the one hand creates compelling reasons to

introduce macro economic changes in the domestic economy (lowering of trade barriers; removal of capital controls, disinvestments, privatization, foreign exchange liberalization) on the other.

Figure 1: Globalization Process and Health Linkages: A Conceptual Framework



These processes can be better illustrated with the help of Fig. 1. Globalization while influencing national economies gets itself influenced by a number of factors like nature of the world economy, technological developments, changing ideas about life styles, and socio-economic and political compulsions, global concerns about ecology, disease patterns, terrorism. These processes, globalization and changes in national policies together with global markets created by the spread of MNCs and global governance affect health attainments by affecting healthcare system, and individual level health risks. Health outcomes (physical, social and mental well being; ill health; and mortality, morbidity, disability, violence and social maladjustment) determine human development, which in turn can explain the health of the economy. The more dynamic and vibrant the economy is, more would be the influence on the world economy.

Conclusion

Globalization evolved out of a gradual process of progressive integration of the world economy is a real situation now and no country can afford to be out of this process. As global integration takes place the need for changes in the policy framework and their internal coordination and management both at the national and international levels paving the way for global governance not necessarily under UN flag simultaneously grow. This process, which operates through cross border flows of goods, services, capital, labour, migration and tourism etc. has got serious implications for health system and its determinants.

The diffusion of new knowledge and technology and easing of the trade restrictions while enhancing disease surveillance, treatment and prevention, foreign investment in health services and even the medical tourism have exposed the developing world including the SAARC region to serious health risks. Having sustained an average annual growth rate of above 5 per cent over the last two decades, this region still suffers from many serious health problems, and lags behind all other regions of the world while displaying wide range of variations in their

health outcomes. It is further brought out in this paper that though the link between globalization and health is very complex and circular, and there is a serious need to evolve a conceptual framework. It would help in (i) identifying the channels and their dynamics through which globalization affects the health sector and (ii) sketching out the broad contours of policy changes in the context of given socio-economic context of this region. This is going to be very important aspect if health objectives set forth in the Millennium Development Goals (MDG) have to be realized in the SAARC region.

Notes

[1] MNCs thus, can (a) integrate easily and efficiently the diverse economic and other activities through trade, finance, investment, technology transfer, (b) penetrate in any market and can relocate their manufacturing plants near the sources of cheap raw material or labor or markets, keeping in view their global interests, and (c) access foreign markets through many alternative routes, such as alliances, joint ventures, and sub-contracting without even requiring transfer of capital across international borders, and (d) organize their cross-national trade and capital flows in cross border value chains largely outside the control of national governments.

[2] As a result, the business has to ─ acquire competitive capabilities ─ cut down costs ─ achieve price competitiveness ─ improve quality, efficiency, productivity and services ─ all to be accounted for simultaneously and in an interconnected manner.

[3] As a result, the entire world of work and the production process witness an altogether different environment characterized by: (a) competitive environment, (b) “time-to-market" as the most important “competitive asset”, (c) heavy reliance on worker for his creativity, knowledge and ability to acquire new knowledge of their core employees; (d) rising pressure to rely on the external labour markets for inputs of temporary duration requiring highly sophisticated skills. Some of the examples are call centers, data conversions, medical transcription, back office operations, content-development, insurance claims processing etc. Thus there would be a change in the structure of labour sector.

[4] The SAARC Tuberculosis Centre (STC) established in Kathmandu in 1992, is playing an important role in the prevention and control of tuberculosis in the SAARC region by coordinating the efforts of the National TB Control Programmes of the Member States. A joint four-year SAARC-Canadian International Development Agency (CIDA) Regional TB and HIV/AIDS project was funded by CIDA to enhance he capacity of the STC to

coordinate the joint efforts of the SAARC Member States in meeting a major concern of the region – the combined toll of TB and HIV/AIDS. SAARC has signed an MOU with WHO in August 2000 for mutual cooperation in agreed areas to help Member States striving towards the goal of health for all. Under the MOU, collaboration with the STC and other institution in South Asia, particularly those active in the control of malaria, tuberculosis, and HIV/AIDS is being facilitated. WHO has declared STC as a WHO Collaborating Centre in this field. In April 2004, SAARC signed an MOU with the Joint United Nations Programme (UNAIDS). Under the MOU, SAARC and UNAIDS have agreed to mutually cooperate in agreed ways to help Member States to strive towards the goals for HIV/AIDS prevention, care and support for those infected and affected by HIV/AIDS and frame of common regional themes. In June 2004, SAARC also signed an MOU with the United Nations Fund for Populations Activities (UNFPA). Under the MOU the two organizations shall, through mutual consultation, endeavor to promote research, analysis, technical cooperation in areas of mutual interest such as population and development, women's empowerment, reproductive health including family planning, HIV/AIDS, education, migration and health education.

[5] Constitution of the World Health Organisation. 1946. http://policy.who.int/cgibin/om_isapi.dll?hitsperheading=on&infobase=basicdoc&record={9D5}&softpage=Document42. Accessed 27th February 2004.

[6] Developed countries are no longer importers of raw materials from less developed countries. MNCs have assumed a vital role both in quantitative and qualitative terms in integrating the diverse economic and other activities through trade, finance, investment, technology transfer and relocating their manufacturing plants near the sources of cheap raw material or labour or markets, keeping in view their global interests.

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