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Neither Science Nor Shamans: Globalization of Markets and Health in the Developing World

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INTRODUCTION

An important aspect of the economic gap between developed and developing countries is the huge disparity in the health conditions experienced in the rich and poor parts of the world. The physical and economic burdens of diseases affect peoples in the developing world more significantly than they do those in developed countries. In its 1999 *World Health Report*, the World Health Organization (WHO) stated that “[d]espite the long list of success in health achieved globally during the 20th century, the balance sheet is indelibly stained by the avoidable burden of disease and malnutrition that the world’s disadvantaged populations continue to bear.”¹ While WHO and other international organizations have tried to reduce the “health gap” between developed and developing countries,² experts point to much evidence that the health gap still remains of daunting and, in some cases, worsening proportions. WHO argues that populations in developing countries now face not only continued threats from infectious diseases but also growing epidemics of non-communicable diseases, such as lung and heart disease.³ The continued presence of the global health gap becomes more worrisome when arguments that the processes of globalization are increasing, rather than narrowing, the gap are considered.

The claim that the globalization of markets, laws, and culture adversely affect the health of peoples in developing countries deserves specific attention when analyzing perspectives on globalization from developing States because the health area provides excellent material for evaluating the differential

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1. WORLD HEALTH ORGANIZATION, *THE WORLD HEALTH REPORT 1999: MAKING A DIFFERENCE* 13 (1999) [hereinafter *WORLD HEALTH REPORT 1999*].

2. *Id.* (“Reducing the burden of that [health] inequality is a priority in international health.”).

3. *Id.* at 13-17, 19-20.

impact of globalization in international relations. Analyzing the health-globalization relationship proves, however, to be a very complex business because both “health” and “globalization” are complicated concepts. Health, for example, is a composite value: to achieve a condition of individual health requires multiple inputs from multiple sources at the personal, familial, local, national, and international levels.⁴ Thus, the points at which the processes of globalization can affect the health of a person or society are many. Likewise, the processes of globalization are many and complex, ranging from formal international legal structures, such as the World Trade Organization (WTO), to the subtle influences of the globalization of certain cultural images and practices on individuals’ decisions about diet, sexual behavior, and health care.

This Article explores the health-globalization relationship to contribute modestly to thinking about globalization from the perspective of the developing world. Much of my attention will be focused on the impact of the globalization of markets on public health and health care in developing countries because it is in this area that much sound and fury has already developed about globalization and its champions. Part I briefly outlines the health gap between developed and developing countries to provide some empirical context for the analysis that follows. This outline includes not only data on the relative burdens of infectious and non-communicable diseases in developed and developing countries, but also looks at the “health transition” strategy that was designed to close the health gap between rich and poor countries.

Part II examines some of the claims being made about the adverse effects that globalization is having on public health and health care in developing countries. Central to these claims is a health-oriented critique of liberal or neo-liberal economic thinking perceived to be animating the institutions and rules regulating the world economic system. In caricature, the critique asserts that health in developing countries is being sacrificed on the alter of neo-liberalism in a ritual that benefits the rich. Interestingly, the critique focuses more on the policies of the World Bank and International Monetary Fund (IMF) than on those of the WTO. In this focus can be found a divergence between developed States’ concerns with public health threats spreading to their shores through international trade, and developing countries’ concerns

4. *See id.* at 6 (noting the multisectoral determinants of health).

with the impact of “structural adjustment programs” and general global economic competition on national public health and health care.

Part III moves into the theoretical realm by asking whether liberal or neo-liberal economic thinking, applied globally and locally, adequately values health as an objective. This line of analysis brings to the forefront controversies about the so-called “human right to health,” one of the economic, social, and cultural human rights. In this context, we face the uncomfortable accusation that liberal thinking and its manifestations in globalization processes foment violations of a basic human right. My analysis suggests, however, that much of the problem rests not with neo-liberal economic thinking, but with the concept of the “right to health,” a concept that packs more rhetorical punch than policy or legal guidance for States or international organizations.

Part IV focuses on a different aspect of the health-globalization relationship that is central to future thought and action: the future of traditional medicine in developing countries. Any project to improve health conditions in many developing countries, particularly those in Africa, has to confront how to meld modern, Western approaches to diseases with the approaches of traditional cultures. Such melding could take different forms. It could be a medico-paternalistic (or medico-imperialistic, depending on your viewpoint) effort designed to educate the ignorant about the scientific understandings of ill-health. It could be a cultural relativistic approach that denigrates “Western” medical-health strategies in the context of traditional cultures. No matter the approach, I argue that this melding process will be affected, for better and for worse, by the globalization of Western economic and cultural norms that ultimately affect health decisions of individuals and governments. In other words, “traditional medicine” will cease to be a useful concept in the global era, not because Western medicines and medical technologies become universally available in developing countries, but because the traditional *cultures* themselves are eroding and will continue to erode under the onslaught of the globalization of Western economic culture.

I conclude by arguing that on the horizon is a future in which people in developing countries may find themselves in the worst of all possible worlds from a health perspective: they will not have access to Western medical care and standards of public health, and they will have lost their faith in traditional medicine and its cultural underpinnings. This situation represents a double cultural alienation and a crisis for global public health and any concept of the right to health.

I. THE HEALTH GAP BETWEEN DEVELOPED AND DEVELOPING COUNTRIES

Despite the proclamation in 1946 of the fundamental human right to health in the WHO Constitution⁵ and the efforts of the WHO to achieve “health for all,”⁶ health conditions greatly differ between developed and developing countries. Historically, infectious diseases wrought the most serious morbidity and mortality damage in most societies. Industrialized countries in Europe and North America began breaking the grip of infectious diseases in the late nineteenth and early twentieth centuries primarily through basic improvements in sanitation, personal hygiene, and public health.⁷ The discoveries of effective vaccines and antibiotics in the second half of the twentieth century further advanced health in the developed world.⁸ Public health experts and scientists argued that developed countries had passed through a seminal health transition: from the stage where infectious diseases were the leading cause of premature death, to the stage where chronic diseases, such as various heart diseases, lung disease, and cancer, imposed the greatest health burdens.⁹

As became clear in the post-World War II period of decolonization, developing regions of the world were far from passing through the health transition already experienced by developed societies. While vaccines, antibiotics, and other Western medical breakthroughs were increasingly available to governments and people in developing countries through national and international programs,¹⁰ massive problems remained in terms of basic sanitation and public health that would take decades more to overcome. The goal of developed States, international health organizations, and health-related non-governmental organizations (NGOs) was to move developing countries

5. WORLD HEALTH ORGANIZATION CONST. preamble, *opened for signature* July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185.

6. See International Conference on Primary Health Care, *Declaration of Alma-Ata*, Sept. 12, 1978 (visited Sep. 5, 1999) <<http://www1.umn.edu/humanrts/disabled/alma-ata.htm>> [hereinafter Declaration of Alma-Ata].

7. See David P. Fidler, *The Globalization of Public Health: Emerging Infectious Diseases and International Relations*, 5 IND. J. GLOBAL LEGAL STUD. 11, 26 (1997) (noting that “[i]mprovements in public sanitation and hygiene within European and North American cities during the late-nineteenth and early-twentieth centuries have had significant impact on the spread of infectious diseases”).

8. *Id.* at 27.

9. WORLD HEALTH REPORT 1999, *supra* note 1, at 13 (observing that there has been a “20th century revolution in health” and that “[t]his epidemiological transition results in a major shift in causes of death and disability from infectious diseases to noncommunicable diseases”).

10. Fidler, *supra* note 7, at 28.

through the health transition to the point where infectious diseases were under control and non-communicable diseases posed the biggest health challenge. The shift in emphasis from infectious to non-communicable diseases would be a sign of economic, public health, medical, and social development in developing countries.

Recent analysis of the state of public health in the world demonstrates that most developing countries have not passed through the health transition. As WHO observed in its 1999 *World Health Report*, “[t]he populations of developing countries and particularly the disadvantaged groups within those countries remain in the early stages of the epidemiological transition.”¹¹ While health conditions have improved in many developing countries, as life expectancies have generally increased and infant mortality rates generally decreased, infectious diseases remain the leading cause of premature death.¹² In some respects, the infectious disease problem in developing countries is getting worse, as evidenced by the spreading and deepening of the HIV/AIDS crisis,¹³ the continued death and illness caused by water-borne diseases such as cholera,¹⁴ and the development of antimicrobial resistance in killers such as malaria, pneumonia, and tuberculosis.¹⁵

Developing countries face, however, a growing crisis with non-communicable diseases at the same time they face the continued, and in some areas increasing, threat of infectious diseases. WHO sees on the horizon a global pandemic of non-communicable diseases related to tobacco consumption that has the potential to surpass even the burden of infectious diseases in developing countries.¹⁶ In addition, WHO has warned of the development of a global obesity crisis which will further adversely affect health in developing countries through obesity-related non-communicable

11. WORLD HEALTH REPORT 1999, *supra* note 1, at 20.

12. *Id.* (noting that “infectious diseases are still the major cause of death” in developing countries).

13. For statistics on the global HIV/AIDS crisis, see UNAIDS, *AIDS Epidemic Update: December 1998*, at 2 (1998) (visited Nov. 11, 1999) <<http://www.who.int/emc-hiv/december1998/wadr98e.pdf>>. UNAIDS estimates that “[m]ore than 95% of all HIV-infected people now live in the developing world” and that “[t]he epidemic has not been overcome anywhere . . . and the epidemic is frankly out of control in many places.” *Id.*

14. *See, e.g., Cholera in 1997: Summary*, 73 WKLY. EPIDEMIOLOGICAL REC., July 3, 1998, at 201 (noting “dramatic cholera epidemic affecting the countries in the Horn of Africa”).

15. WORLD HEALTH REPORT 1999, *supra* note 1, at 22 (stating that “antimicrobial resistance is a worrying phenomenon since it could have great adverse effects on the control and treatment of diseases such as pneumonia, tuberculosis, and malaria”).

16. *See id.* at 67 (stating that “on current smoking patterns, by the third decade of the next century, smoking is expected to kill 10 million people annually worldwide—more than the total of deaths from malaria, maternal and other major childhood conditions, and tuberculosis combined. Over 70% of these deaths will be in the developing world”).

diseases.¹⁷ Developing countries thus confront what WHO calls a “double burden”¹⁸ for public health in the new millennium: continuing or increasing burdens from infectious diseases and increasing sickness and death from non-communicable diseases.

Not only has the “health gap” between developed and developing countries not disappeared, but it has also changed its nature. Previously, the gap was basically measured in terms of the burden of infectious diseases; countries were supposed to make the transition away from infectious diseases toward non-communicable diseases. Today and in the future, the gap is and will be measured in terms of the burdens of both infectious and non-communicable diseases. Any future “health transition” strategy now must aim to reduce the burdens of both infectious and non-communicable diseases—a public health undertaking of enormous proportions. The scale of the challenge can be glimpsed by briefly noting that it requires governments in developing countries (with international assistance) to improve basic sanitation and public health systems, make better use of antimicrobial treatments to prevent the development of resistant pathogens, and alter individual behavior patterns that produce morbidity and mortality, such as tobacco consumption, promiscuous sexual behavior, illicit drug use, and poor dietary habits. Where the economic resources to undertake such massive and expensive public health endeavors will originate remains a mystery.¹⁹ The mystery becomes even more forbidding when we begin to factor in the public health and health care implications of the globalization of markets and culture.

II. GLOBALIZATION AND HEALTH IN DEVELOPING COUNTRIES

Public health and health care in developed and developing countries have not escaped the impact of the processes of globalization. In fact, experts have identified the phenomenon of the “globalization of public health,” under which States are losing the ability to protect the health of their publics from

17. World Health Organization, *Obesity Epidemic Puts Millions at Risk from Related Diseases*, Press Release WHO/46, June 12, 1997 (visited Sep. 12, 1999) <<http://www.who.int/archives/inf-pr-1997/en/pr97-46.html>>. See also World Health Organization, *Obesity: Take It Seriously, Deal with It Now*, WHO Feature No. 190, Mar. 1996 (visited Sep. 12, 1999) <http://www.who.int/ncd/feat_190e.htm>.

18. WORLD HEALTH REPORT 1999, *supra* note 1, at 14.

19. WHO argues that “financial resources for health lie overwhelmingly *within* countries Only a tiny fraction of resources for health in low and middle income countries originates in the international system—development banks, bilateral development assistance agencies, international nongovernmental organizations, foundations and WHO.” *Id.* at 83.

disease threats.²⁰ The loss of the ability to provide for public health because of global forces is, of course, a matter of concern for developed as well as developing countries. But, as in other areas of globalization, the impact on developing countries is of a different magnitude in the health context because the health threats are greater and the financial, technological, and human resources to deal with them are smaller.

The relationship between globalization and health is complex; but it is necessary, even at the risk of oversimplification, to clarify how the processes of globalization adversely affect health in developing countries. From the broadest perspective, the adverse health effects from globalization in developing countries arise from structural imbalances in the international system that the processes of globalization exacerbate. The structural imbalances can be glimpsed through four features of globalization: (1) increases in international trade; (2) structural adjustment programs maintained by international financial organizations; (3) increases in international trade in services and in transnational investments in service industries; and (4) the international regime on intellectual property.

A. Increases in International Trade

In literature on the globalization of public health, the contributions of international trade in goods to the global spread of diseases are often highlighted.²¹ Increases in international trade in food provide opportunities for food-borne pathogens, toxins, and potential carcinogens to spread to new populations.²² The increased scale of tobacco exporting by the major transnational tobacco conglomerates fuels the consumption of tobacco in

20. See, e.g., Fidler, *supra* note 7; Gill Walt, *Globalisation of International Health*, 351 LANCET 434 (1998); Derek Yach & Douglas Bettcher, *The Globalization of Public Health, I: Threats and Opportunities*, 88 AM. J. PUB. HEALTH 735 (1998); Derek Yach & Douglas Bettcher, *The Globalization of Public Health, II: The Convergence of Self-Interest and Altruism*, 88 AM. J. PUB. HEALTH 738 (1998); Vincent Navarro, *Comment: Whose Globalization?*, 88 AM. J. PUB. HEALTH 742 (1998).

21. See Fidler, *supra* note 7, at 31; Yach & Bettcher, *The Globalization of Public Health, I, supra* note 20, at 737; David P. Fidler, *Trade and Health: The Global Spread of Diseases and International Trade*, 40 GERM. Y.B. INT'L L. 300 (1997).

22. See, e.g., F. K. Käferstein et al., *Foodborne Disease Control: A Transnational Challenge*, 3 EMERGING INFECTIOUS DISEASES, October–December 1997, at 503. In the late 1990s, a number of high-profile situations have arisen in which States have acted to block the spread of infectious diseases or carcinogens through international trade, including the trade restrictions adopted by countries in response to bovine spongiform encephalopathy in the European Union, the “chicken flu” outbreak in Hong Kong, the Nipah virus outbreak in Malaysia, and dioxin contamination of poultry from Belgium.

developing countries, leading to more non-communicable disease problems.²³ Some experts claim that neo-liberal free trade agreements, such as the General Agreement on Tariffs and Trade (GATT), WTO, and North American Free Trade Agreement (NAFTA), contribute significantly to the public health threats related to increases in international trade.²⁴ The globalization of the markets for food products places stress on public health in developed and developing States.

The health threats from increased international trade are not, however, identical for developed and developing States. Much of the worry about international trade spreading food-borne pathogens has been generated in developed countries because they fear the importation of infections from developing regions of the world.²⁵ This worry reflects the infectious disease gap between developed and developing countries. The globalization processes of trade have become transnational pathogen superhighways. The concern, from the perspective of developing countries, is whether the policing of this microbial traffic by developed States and international trade organizations deals fairly with developing countries.

Under existing international trade law, States have the sovereign right to restrict trade to protect human, animal, and plant life and health.²⁶ This right is, however, subject to scientific and trade-related disciplines. Trade-restricting health measures must be based on a risk assessment and be supported by scientific evidence.²⁷ In addition, scientifically justified trade-restricting health measures have to be "necessary," in the sense that they are the least trade-restrictive measures possible.²⁸ Given the scientifically

23. See WORLD HEALTH REPORT 1999, *supra* note 1, at 71 ("In the past few decades, transnational tobacco conglomerates have made tremendous inroads into the markets of poor and middle income nations in Africa, Asia, Eastern Europe and Latin America."). On globalization and the tobacco problem, see Derek Yach & Douglas Bettcher, *Globalization of Tobacco Marketing, Research, and Industry Influence: Perspectives, Trends and Impacts on Human Welfare* (visited Aug. 23, 1999) <<http://www.who.int/toh/TFI/globalization.htm>>. For analysis on the link between trade and tobacco, see Allyn L. Taylor, *An International Regulatory Strategy for Global Tobacco Control*, 21 YALE J. INT'L L. 257 (1996); Fidler, *supra* note 21, at 305-08, 316-17, 351-53.

24. See, e.g., CHRIS MCGINN ET AL., PUBLIC CITIZEN GLOBAL TRADE WATCH, NAFTA'S BROKEN PROMISES: FAST TRACK TO UNSAFE FOOD (1997).

25. David P. Fidler, *Mission Impossible? International Law and Infectious Diseases*, 10 TEMPLE INT'L & COMP. L.J. 493, 500 (1996) (arguing that "the attention being generated on E[merging] I[nfectious] D[isease]s comes mainly from the developed world, which fears the spread of infectious diseases from the developing world").

26. DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES 122-23 (1999).

27. *Id.* at 138-46 (analyzing the science-based disciplines of the WTO Agreement on the Application of Sanitary and Phytosanitary Measures [hereinafter SPS Agreement]).

28. *Id.* at 150-51 (analyzing the "necessary" requirement in the SPS Agreement).

legitimate public health worries about pathogenic microbes spreading from developing to developed regimes through international trade, this body of international trade law seems tailor-made for developed countries to restrict trade from developing countries. For example, in November 1998, Zimbabwe's Deputy Minister of Health and Child Welfare "reported that African meat exports to the EU are being rejected due to weak food control systems in African countries."²⁹

Under the WTO, this regime for sanitary and phytosanitary (SPS) measures has mainly, however, been the subject of dispute between developed countries, as illustrated by the *Beef Hormones Case* (United States and Canada v. European Union), *Australian Salmon Import Case* (Canada v. Australia), and *Japanese Agricultural Products Case* (United States v. Japan).³⁰ The WTO's SPS regime has not, to date, been used extensively by developed countries against developing countries. This evidence of inactivity is not to imply that all is well with the SPS regime under the WTO from the perspective of developing countries. While developed countries seem willing to litigate SPS disputes, developing countries have not challenged trade-restricting health measures of developed countries that violate international trade law. A good example of such measures can be found in the European Union's (EU) ban on the importation of fresh fish from East African countries after these countries suffered cholera epidemics in late 1997 and early 1998.³¹ WHO and the U.N. Food and Agriculture Organization (FAO) both made it clear that trade restrictions, such as those imposed by the EU, were not appropriate in dealing with cholera.³² Despite the lack of a legitimate scientific and public health justification for its import ban, the EU kept it in place for six months, causing millions of dollars in damage to fishery

29. *Meaty Trade Issues*, 2 BRIDGES WKLY. TRADE NEWS DIG., Nov. 16, 1998 (visited Sept. 27, 1999) <<http://www.newsbulletin.org/bulletins/getbulletin.CFM?SID=>>.

30. See WTO Appellate Body Reports on (1) EC—Measures Concerning Meat and Meat Products (Hormones), WTO Doc. WT/DS26/AB/R & WT/DS48/AB/R (Jan. 16, 1998); (2) Australia—Measures Affecting Importation of Salmon, WTO Doc. WT/S18/AB/R (Oct. 20, 1998); and (3) Japan—Measures Affecting Agricultural Products, WTO Doc. WT/DS76/AB/R (Feb. 22, 1999).

31. See Commission Decision 97/878/EC, 1997 O.J. (L356) 64; Commission Decision 98/84/EC, 1998 O.J. (L15) 43.

32. World Health Organization, *Director-General Says Food Import Bans Are Inappropriate for Fighting Cholera*, Press Release, WHO/24, Feb. 16, 1998 (visited Nov. 11, 1999) <<http://www.who.int/inf-pr-1998/en/pr98-24.html>>; Food and Agriculture Organization, *Import Ban on Fish Products from Africa Not the Most Appropriate Answer*, Press Release PR98-21E, Mar. 25, 1998 (visited Nov. 11, 1999) <http://www.fao.org/waicent/ois/press_ne/presseng/1998/PREN9821.HTM> [hereinafter FAO].

industries in East African countries.³³ Yet, to my knowledge, none of the affected East African countries attempted to use the WTO's SPS regime to bring the EU in line with international trade law. Many reasons potentially explain this reticence to use the WTO on the part of African countries; for example, any case brought would not have been resolved before the EU import ban was scheduled to be lifted under its original terms (i.e., six months). The usual remedy under WTO law is for the offending Member State to bring its measures in line with international trade rules, but the offending ban would have been lifted long before any WTO panel would have addressed the issue. The EU in this case violated the SPS regime in connection with developing countries with impunity.

More worrisome, because it directly affects health in developing countries, has been the use of international trade law and international trade institutions to open developing country markets to tobacco exports from developed country companies. In the 1980s, the United States vigorously used international trade law and GATT institutions to pry open developing countries for the tobacco exports of U.S. tobacco enterprises.³⁴ In the *Thai Cigarette Case*, the United States succeeded in convincing a GATT panel to strike down a Thai ban on the importation of foreign tobacco products.³⁵ The United States claimed that the ban violated the national treatment principle in GATT (Article III) and could not be justified under the GATT provision allowing contracting parties to protect human health (Article XX(b)).³⁶ The GATT panel agreed with the United States that the ban violated the national treatment principle because it allowed Thai, but not foreign, tobacco products to be sold and because the ban was not the least restrictive trade measure available to the Thai government to achieve its public health objective.³⁷ The United States' tobacco trade offensive in the 1980s coincided with dramatic increases in the consumption of tobacco products in developing countries.³⁸

Underneath the international trade lawyering was the long-term strategy of Western tobacco companies to find new markets because their existing, lucrative markets in developed nations were stagnating and facing future

33. FAO, *supra* note 32 (stating that fish exports from "Kenya, Mozambique, Uganda and Tanzania to the EU amounted to around 55,000 tonnes in 1996 worth \$230 million. The EU is their most important market for these products").

34. See Taylor, *supra* note 23, at 264.

35. See Thailand—Restrictions on Importation of and Internal Taxes on Cigarettes, Nov. 7, 1990, GATT B.I.S.D., (37th Supp.) at 200 (1990).

36. *Id.* at 206-07.

37. *Id.* at 223, 225-26.

38. Taylor, *supra* note 23, at 264.

decline. Developing countries made ideal emerging markets because they did not have the sophisticated public health and regulatory systems that were increasingly making tobacco companies' lives in developed countries difficult. In addition, Western tobacco companies could effectively sell their tobacco products by packaging them as Western cultural products; buying Marlboro cigarettes was one way to sample Western lifestyle. The cultural linkage in the tobacco conglomerates' strategy also received a boost from the end of the Cold War and the collapse of communism because liberalism and the ways of the West had triumphed and faced no universal challengers for the hearts, minds, and pocket books of people living in developing countries. The dramatic turn of developing countries toward free-market economics paralleled that of civil societies as individuals increasingly desired what the West offered for consumption, both philosophically and culturally. Western tobacco companies succeeded in riding the waves of international trade law, liberal triumphalism, and globalizing Western culture in penetrating the markets and lungs of millions of people in the developing world.

Another feature of the increased globalization of markets through international trade is the concern that processed food exports from developed countries adversely affect the dietary habits of peoples in developing countries. This concern links with the warnings from WHO about the global obesity pandemic.³⁹ Public health experts have traditionally viewed obesity as a health problem in affluent countries. While some traditional practices of cultures in developing regions foster the development of obesity,⁴⁰ this health problem has affected mostly rich countries. Now WHO is worried that the globalization of markets for processed food products may contribute to negative changes in the dietary habits of peoples in developing countries.⁴¹ As with tobacco consumption, these dietary transformations also represent part of the globalization of Western culture as some people's lives in developing countries begin to look more like the sedentary lifestyles established in the West than the traditional habits and patterns of the native culture.

39. World Health Organization, *Obesity Epidemic Puts Millions at Risk from Related Diseases*, *supra* note 17.

40. World Health Organization, *Obesity: Take It Seriously, Deal With It Now*, *supra* note 17 ("In some traditional societies, pressure is exerted on women to gain weight and remain overweight during their reproductive lives.").

41. On the globalization of the markets for processed foods, see U.S. Department of Agriculture, *Globalization of the Processed Foods Market* (visited Sept. 27, 1999) <<http://www.econ.ag.gov/epubs/pdf/aer742/index.html>>.

From the perspective of health in developing countries, the globalization of markets has negative aspects, as it has made products available to people that adversely affect health. In addition, the consumption of these products also represents consumption of Western culture—"Taste Marlboro Country" and "Drink the Real Thing." The globalization of markets plays a significant role in the increasing threat of non-communicable diseases related to tobacco consumption and poor dietary practices occurring in developing countries today.

But the globalization of markets through international trade has not greatly decreased the burden of infectious diseases in developing countries because the transnational flow of goods has done little to ameliorate the underlying problems of poverty that continue to stimulate pathogenic microbes. Generally, the persistence of poverty suggests that many developing countries have not had much success in fostering economic development through participation in the international trading system. While some Asian countries, once considered developing, have advanced to the ranks of industrial, affluent countries through export-driven strategies, many developing countries, particularly in Africa, have not achieved such trade-based economic development. In fact, some evidence suggests that Africa has fallen behind as the globalization of markets has accelerated world-wide economic growth. In 1980, African exports represented 5.9 percent of world exports; but, in 1996, that share had fallen to 2.3 percent.⁴²

These figures suggest that Africa has been marginalized in the world trading system in the past twenty years. Such marginalization contributes to the continued lack of economic development in African countries, and thus to the kind of social conditions that provide opportunity for infectious diseases. Why this marginalization of African countries has occurred is a complicated matter that I do not have time to explore thoroughly here, but some factors include African reliance on primary commodity exports, fluctuating world commodity prices, protectionist import policies and regional trade agreements in developed regions of the world, and the internal policies of African governments (such as protectionism against imports). The Trade and Development Centre, a joint venture of the World Bank and WTO, has argued that "the most critical factor responsible for Africa's poor trade performance, is the protectionist policies adopted by most African governments

42. Trade and Development Centre, *Country Studies: Africa* (1997) (visited Sept. 10, 1999) <<http://www.itd.org/issues/africa0.htm>>.

themselves.”⁴³ The policy implications of this view, of course, are that African governments need to further liberalize their economies to international trade in order to boost economic development. Increased economic development would reduce poverty and improve the ability of African governments to address public health problems. In this pattern of reasoning, we can see neo-liberal economic assumptions embedded in the health transition strategy.

I do not mean to imply that liberal or neo-liberal economic assumptions were always embedded in thinking about the health transition strategy because this strategy came of age during the Cold War when debates about the proper path to economic development were rife in international relations. My point is twofold: (1) that the health transition strategy assumes economic development will occur in developing countries; and (2) that, in the era of the globalization of markets, neo-liberal economic thinking dominates discourse about how developing countries can achieve economic development. As the position of the Trade and Development Centre makes clear, the neo-liberal view of the continued lack of economic development in developing countries faults the internal, protectionist policies of African governments, not the structure and dynamics of international trade law and globalized markets. The failure to experience the health transition is, in other words, largely self-inflicted. In addition, the logic of this neo-liberal position suggests that African countries' lack of preparedness for the emergence of non-communicable diseases is also largely self-created.

My discussion of the impact of increases in international trade contains, thus, two images: (1) the globalization of markets threatening health in the developing world through the spread of products and cultural practices that increase non-communicable diseases; and (2) the failure of developing country governments to adopt appropriate, neo-liberal domestic reforms to partake fully in the globalization of markets, resulting in continued poverty and inability to address existing infectious or emerging non-communicable disease problems. One image shows health in the developing world as the victim of the globalization of markets; the other image depicts health in the developing world as victim to government policies that prevent people from enjoying the full economic benefits of international trade and the globalization of markets. Neither is a completely accurate view of the situation, but I am more interested in what both images actually agree on—that the globalization of

43. *Id.*

markets involves radical transformations of traditional cultures. I come back to this point in Part IV, when I analyze globalization's impact on traditional medicine.

B. Structural Adjustment Programs and Health in Developing Countries

Structural adjustment programs (SAPs), used by the World Bank and the IMF in making loans available to developing countries, have become very controversial in the 1990s. The World Bank and IMF use SAPs to restructure the economies of developing countries that are suffering severe economic problems. As a condition for receiving further loans, a developing country often has to promise the World Bank or IMF that it will undertake fundamental structural adjustments in its economy. These adjustments involve removing barriers to exports and imports, deregulation of the economy, reduction of budget expenditures, and increasing the attractiveness of the economy to foreign investors. The World Bank and IMF believe that SAPs promote the building of the appropriate economic conditions and institutions that will generate and sustain economic development, and integrate the developing State's economy with the global economy. SAPs are based on the liberal or neo-liberal model of economic growth and development.

Critics have attacked SAPs as being bad for people in developing countries.⁴⁴ While these criticisms often encompass many economic and social sectors, the impact of SAPs on health in developing countries has been a frequent target of SAP critics.⁴⁵ In caricature, health-based critiques of

44. See, e.g., *War on Structural Adjustment Programmes!* (visited Sept. 3, 1999) <<http://parsons.iwww.org/~iw/nov/stories/women-imf.html>> (NGO participants at 1995 International Women's Conference in Beijing stated that "we declare war against all IMF-dictated Structural Adjustment Programmes (SAPs). These programmes have traumatised whole continents, torn apart the social fabric of entire societies and are wreaking havoc on the lives of billions of people worldwide, especially women."); J. Munoru, *IMF and World Bank Policies*, AFRICAN PERSPECTIVE, Nov. 14, 1998 (visited Mar. 26, 1999) <<http://www.africanperspective.com/html10/imf.html>> (arguing that in Zimbabwe SAPs "have been a disaster for the workers, peasants and young people"); *Statement of the Local Civil-Society Steering Committee of the Structural Adjustment Participatory Review Initiative, SAPRI, on the Serious Situation in Ecuador*, Mar. 11, 1999 (visited Mar. 26, 1999) <<http://www.igc.apc.org/dgap/saprin/eccris.html>> (arguing that "[a]fter 18 years of 'stabilization and adjustment' policies, the results continue to be catastrophic for the poor, and the failure of structural adjustment couldn't be more evident").

45. See, e.g., Emma Curtis, *Child Health and the International Monetary Fund: The Nicaraguan Experience*, 352 LANCET 1622 (1998) (analyzing negative impact of SAPs on health in Nicaragua); Carol Riphenburg, *Women's Status and Cultural Expression: Changing Gender Relations and Structural Adjustment in Zimbabwe*, 44 AFR. TODAY 33 (1997) (arguing that women's health in Zimbabwe is in jeopardy because of SAPs); Imogen Evans & David Westaby, *Structural Adjustment Too Painful?* 344

SAPs blame them for sacrificing public health and health care on the altar of neo-liberal economic policy. The budgetary changes imposed through SAPs force developing country governments to cut back expenditures on public health and health care systems. Often users' fees are imposed on patients in an attempt to cover costs no longer borne by the government, but the poor often cannot afford to pay such fees.⁴⁶ The SAP-driven macroeconomic changes, the general argument goes, reduce both the quality of and the access to health services. While adverse health consequences of SAPs appear throughout populations, particularly vulnerable groups—such as women, children, and persons with HIV/AIDS—suffer the most. The adverse health impact of SAPs in developing countries undermines fulfillment of the human right to health proclaimed in the WHO Constitution⁴⁷ and international human rights documents.⁴⁸

These worries about SAPs connect with more general concerns about the globalization of markets, public health, and health care. At a general level, the health-focused criticisms of the policies of the World Bank and IMF are concerned about the power these international financial organizations wield in developing countries. This power directly relates to the triumph of liberalism over communism, as the World Bank and the IMF prescribe the detailed, neo-liberal economic conditions for developing countries to receive further international loans. Many people in developing countries also believe that the general liberalization of (1) international trade encouraged by GATT/WTO, NAFTA, and other neo-liberal international trade agreements; and (2) the legal regime regulating foreign investment encouraged by bilateral

LANCET 1377 (1994) (arguing that SAPs wreaked havoc on the health and welfare of people in sub-Saharan Africa); Angela M. Wakhweya, *Structural Adjustment and Health*, 311 BRIT. MED. J. 71 (1995) (criticizing SAPs for making health worse for rural people in Africa); John W. Peabody, *Economic Reform and Health Sector Policy: Lessons from Structural Adjustment Programmes*, 43 SOC. SCI. MED. 823 (1996); A. D. Kiwara, *Structural Adjustment Programmes and Health: Gender Implications* 20, Paper Presented at TGNP Seminar (Aug. 24, 1994) (arguing that SAPs "have real negative consequences on the health of society, but more so on women because of their disadvantaged position in society").

46. See, e.g., JEAN LENNOCK, PAYING FOR HEALTH: POVERTY AND STRUCTURAL ADJUSTMENT IN ZIMBABWE 20-22 (1994) (criticizing the increase in users' fees in Zimbabwe as a result of a SAP).

47. WORLD HEALTH ORGANIZATION CONST., *supra* note 5 ("The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.").

48. See, e.g., European Social Charter, Oct. 18, 1961, art. 11, 529 U.N.T.S. 89, 104; International Covenant on Economic, Social, and Cultural Rights, Dec. 16, 1966, art. 12, 993 U.N.T.S. 3, 8; Banjul Charter on Human and Peoples' Rights, June 27, 1981, art. 16, 21 I.L.M. 58, 61; United Nations Convention on the Rights of the Child, Nov. 20, 1989, art. 24, 28 I.L.M. 1456, 1465; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, Nov. 14, 1988, art. 10, 28 I.L.M. 156, 164.

investment treaties, places extraordinary pressure on governments of developing countries to reform fiscal and economic policy priorities. In order to trade and to attract foreign investment in a world of intense global competitive forces, developing country governments have to compete for business and investment for their citizens and enterprises. The need to compete forces these governments to transform, sometimes radically, social and economic priorities in order to advance free market economics. One of the priorities suffering under the disciplines imposed by globalized markets is government-sponsored health programs. In addition, some people fear that the radical economic changes, produced by a developing country joining the globalization scramble, erode traditional economic structures closely linked with indigenous societies and cultures. Even absent direct pressure from international financial organizations through SAPs, developing countries face economic development challenges that result in health, the right to health, and traditional cultures being sacrificed on the altar of globalized neo-liberal economics.

Combining these conclusions with the analysis on increases in international trade in Part II.A above, the neo-liberal economic structure and the dynamics of the globalized world economy look very hostile toward health in developing countries. Developed countries' use of international trade regimes and the trade liberalization they encourage to export unhealthy products to developing countries has led to increases in non-communicable diseases, without significant positive impact on the burden of infectious diseases. SAPs required by international financial organizations and general competitive pressures from global markets for goods, services, and capital force developing countries to reorganize their public health and health care systems to accommodate the global market, which results in the undermining of public health resources and the right to health.

C. International Trade in Services and Service Investments

Another aspect of the globalization of markets with the potential to affect health in developing countries is the increase in international trade in services and investments in the service sectors. These phenomena accentuate problems already raised in this Article, but it is worthwhile to spell them out more clearly. International investments in service industries include fast-food restaurants, and U.S. fast-food companies have been rapidly expanding their

global investments in the last decade.⁴⁹ The first wave of fast-food investment expansion went into developed countries in Europe and Asia; the second wave into “transition economies” in Eastern and Central Europe; the third wave is now breaking on the economies of developing countries.⁵⁰ From a health perspective, the penetration of U.S. fast-food into the diet and lifestyles of developing country societies forms part of the concerns about the emerging epidemic of obesity-related, non-communicable diseases. In addition, U.S. fast-food restaurants market more than unhealthy food; they market this food as part of the selling of U.S. culture. A trip to McDonald’s in a developing country is more than a quick meal; it is part of tasting a lifestyle and culture vastly different from the ones surrounding the customers. During a trip to South Africa, I was told that many poor people save money specifically to buy a meal at a McDonald’s restaurant. While perhaps this thrift is (mis)directed at acquiring a tasty meal, more is involved with this phenomenon than the consumption of food. The cultural features of this type of behavior factor into the growing problem of obesity-related, non-communicable diseases.

Another important phenomenon to note is the increase in the international trade in health services.⁵¹ More and more people are seeking health services in other countries,⁵² and health service providers are increasingly marketing their services to foreigners as well.⁵³ Developed countries currently dominate the provision of cross-border health services,⁵⁴ and developing countries are

49. For example, McDonald’s now “operates more than 24,500 McDonald’s restaurants in 116 countries on six continents.” *25 Fascinating Facts About McDonalds’s International* (visited Sept. 27, 1999) <<http://www.mcdonalds.com/surftheworld/facts/index.html>>.

50. See, e.g., *id.* (noting McDonald’s first investments in Europe, Japan, and Australia were in 1971, while its first investment in Africa was in 1972).

51. Mario Marconini, *Domestic Capacity and International Trade in Health Services: The Main Issues*, in *INTERNATIONAL TRADE IN HEALTH SERVICES: A DEVELOPMENT PERSPECTIVE* 55, 55 (Simonetta Zarrilli & Colette Kinnon eds., 1998) [hereinafter *INTERNATIONAL TRADE IN HEALTH SERVICES*] (noting “the expansion which has occurred in the last few decades in the [health services] sector’s international trade”).

52. *Id.* (noting “a considerable increase in the global demand for health services”).

53. David C. Warner, *The Globalization of Medical Care*, in *INTERNATIONAL TRADE IN HEALTH SERVICES*, *supra* note 51, at 71, 75 (“There has been a rapid growth in international marketing by medical facilities in Europe, the United States, and elsewhere.”).

54. Orvill Adams & Colette Kinnon, *A Public Health Perspective*, in *INTERNATIONAL TRADE IN HEALTH SERVICES*, *supra* note 51, at 35, 49 (noting that “cross-border trade in health services flows chiefly from North to South”); Gustaaf Wolvaardt, *Opportunities and Challenges for Developing Countries in the Health Sector*, in *INTERNATIONAL TRADE IN HEALTH SERVICES*, *supra* note 51, at 63, 63 (noting that “it is predominantly developed countries that are taking advantage of the opportunity to provide health services in a globalized market”).

emerging markets for high-tech medical services, such as telemedicine.⁵⁵ Some developing countries are, however, starting to market their health services to potential consumers in both the North and the South.⁵⁶ Within this burgeoning activity in the globalization of health services, many issues arise that concern those worried about health in developing countries. One concern is that the globalization of health services may increase the flow of trained medical personnel from the developing to the developed world.⁵⁷ Another is that governments will encourage “health care exports” at the expense of public health and health care for the domestic society.⁵⁸ Participating in the international trade in health services could also accentuate the already heavily criticized penchant of developing country governments to invest in modern, high-tech hospitals and other health care resources that are not appropriate for the health problems facing most of the society and that end up benefitting only the elite and powerful.⁵⁹ Even telemedicine, which many see as offering great benefits for health in developing countries, has its long term downside in that it could perpetuate developing countries’ health dependence on the developed world. In addition, telemedicine might be largely geared toward Western-style health care services that do not address the most serious health threats facing the majority of the populations in developing countries.⁶⁰

More generally, the liberalization of international trade in services has produced opportunities for insurance companies in developed countries to penetrate new markets.⁶¹ As insurance companies seek new customers in developing countries, governments may find it easier to move away from

55. See generally Salah H. Mandil, *Telehealth: What Is It? Will It Propel Cross-Border Trade in Health Services?*, in INTERNATIONAL TRADE IN HEALTH SERVICES, *supra* note 51, at 79.

56. Wolvaardt, *supra* note 54, at 63 (noting that “a limited number of developing countries such as Cuba, India and Jordan are currently competing at a significant level”).

57. Adams & Kinnon, *supra* note 54, at 36-39 (analyzing movement of persons supplying health services).

58. Wolvaardt, *supra* note 54, at 68 (noting dangers of international trade in health services including (1) a brain-drain of health care professionals; (2) an outflow of financial resources through cross-border flow of patients; and (3) the creation of a two-tier health care system with foreign patients receiving higher quality care).

59. Adams & Kinnon, *supra* note 54, at 46 (expressing the concern that a foreign commercial presence in the health sector through hospitals or health insurance programs would likely only produce gains for affluent segments of populations in developing countries).

60. See Mandil, *supra* note 55, at 93 (cautioning that telemedicine is not “more important or more effective than tackling the basic causes of poor health: poverty, lack of clean water, basic nutrition and sanitation”).

61. See generally J. François Outreville, *The Health Insurance Sector: Market Segmentation and International Trade in Health Services*, in INTERNATIONAL TRADE IN HEALTH SERVICES, *supra* note 51, at 111.

universal systems of health care coverage to a privatized system in which many people insure themselves for health care costs. Thus, liberalized international trade in health services has synergy with the pressures many developing country governments face in reducing public expenditures. The fear is, of course, that the privatization of health care systems, made easier by the availability of private health insurance, undermines the principle of universal access to health care.

Increased international trade and investment in health and other services plays an important role in how globalization affects health in the developing world. Even more than trade, the international trade in services is dominated by developed countries and the benefits for developing countries of this trade are not always clear, as indicated above by the analysis of international trade in health services. Cross-border investment in certain service sectors, such as fast-food, may contribute to the growing problem of diet-related, non-communicable diseases in developing countries. International trade in health services may weaken national public health and health care systems in developing countries by shifting resources and policy priorities away from the real threats to health in the country. From the perspective of developing countries, the growth in international trade in health services looks like a “trickle down” health policy: the changes clearly benefit those with resources, with the hope that the ripple effects of the benefits will eventually flow to the poor. However, legitimate doubts may be raised about the propriety of such an approach.

D. Intellectual Property and Health in Developing Countries

Another prominent feature of globalization that affects health in developing countries is the emerging international legal regime protecting intellectual property. Developed countries, led by the United States, have pushed the protection of intellectual property rights near the top, if not to the top, of the agenda of the global trading system. In the GATT/WTO system, developed countries succeeded in conditioning WTO benefits for trade in goods on Member States' accepting obligations to accord intellectual property rights greater protection through the mandatory Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).⁶² This linkage of trade

62. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, LEGAL INSTRUMENTS—RESULTS OF THE URUGUAY ROUND vol. 31; 33 I.L.M. 81 (1994) [hereinafter TRIPS].

benefits to intellectual property protection has forced many developing countries to change their approaches to intellectual property rights; prior to TRIPS, for example, many did not recognize patents on pharmaceutical products.⁶³ Some States “fear that TRIPS requirements for intellectual property rights could lead to a higher cost burden for newer, patent-protected essential drugs, further reducing access to health care.”⁶⁴ Given that “one-third of the world’s population has no guaranteed access to essential drugs,”⁶⁵ further reduction of access because of TRIPS constitutes a public health concern for developing countries.

Western pharmaceutical companies have, for example, been severely criticized by many NGOs working on their pricing policies for HIV/AIDS therapies that have proven successful in the United States and Europe. With ninety-five percent of the world’s HIV-infected people now living in the developing world,⁶⁶ most of the people affected by this pandemic do not have access to successful therapies because they are too expensive.⁶⁷ Part of the expense flows from the intellectual property rights that pharmaceutical companies hold over the drugs in question. The same fears arise in connection with any future development of an effective HIV vaccine. Pharmaceutical companies (and their government backers) in the developed world defend the rigorous protection of intellectual property rights because such rights make it economically possible for new drugs to be developed in the first place. Without the monopoly right accorded by a patent, a pharmaceutical company would be much less likely to engage in innovative research and development.

The controversy about the need for access to HIV/AIDS therapies in the developing world and the pharmaceutical industry’s fierce protection of intellectual property rights has come to a head on the issue of compulsory licensing of patents by developing countries as they attempt to deal with their HIV/AIDS epidemics. Compulsory licensing would involve the government of a developing country issuing licenses to local firms to manufacture lower

63. Bernard Pécoul et al., *Access to Essential Drugs in Poor Countries: A Lost Battle?*, 281 JAMA 361, 365 (1999) (noting the importance of TRIPS “because many developing countries do not fully acknowledge patent protection rights for pharmaceuticals”).

64. World Health Organization, *WHO to Address Trade and Pharmaceuticals*, May 22, 1999 (visited Sept. 10, 1999) <<http://www.who.int/inf-pr-1999/en/pr99-wha13.html>>.

65. World Health Assembly, *Revised Drug Strategy*, WHA 52.19, May 24, 1999 (visited Sept. 16, 1999) <http://www.who.int/wha-1998/WHA99/PDF99/e_reso.pdf>. For a general analysis on the problems in developing countries with access to essential drugs, see Pécoul et al., *supra* note 63.

66. UNAIDS, *supra* note 13, at 2.

67. *AIDS in the Third World: A Global Disaster*, ECONOMIST, Jan. 2, 1999, at 42, 42 (“The poor cannot afford to spend \$10,000 a year on [HIV/AIDS] wonder-pills.”).

cost, generic versions of expensive, patented HIV/AIDS drugs. Many HIV/AIDS activists have been calling for developing country governments to use compulsory licensing as a way to help increase access to HIV/AIDS therapies. TRIPS allows for compulsory licensing of patents in certain situations,⁶⁸ but Western pharmaceutical companies and important developed countries, such as the United States, vigorously oppose compulsory licensing of pharmaceutical patents.⁶⁹ When South Africa and Thailand made legal moves to allow compulsory licensing for patented HIV/AIDS drugs, the U.S. government quickly put diplomatic and economic pressure on both governments to turn them away from compulsory licensing.⁷⁰ When South Africa refused to change course, dozens of Western pharmaceutical companies challenged the compulsory licensing law in South African courts.⁷¹

The tension between the protection of patent rights and compulsory licensing complicated WHO's adoption of a revised drug strategy. In January 1998, WHO's Executive Board recommended that the World Health Assembly adopt a resolution that urged WHO Member States, *inter alia*, "to ensure that public health rather than commercial interests have primacy in pharmaceutical and health policies and to review their options under the Agreement on Trade-Related Aspects of Intellectual Property Rights to safeguard access to essential drugs."⁷² The World Health Assembly sent this resolution back to the Executive Board in May 1998 because the controversy it generated prevented its adoption.⁷³ The Revised Drug Strategy resolution adopted in May 1999 by the World Health Assembly urged WHO Member States, *inter alia*, "to ensure that public health interests are paramount in pharmaceutical and health policies; [and] to explore and review their options

68. TRIPS, *supra* note 62, art. 31.

69. See Merrill Goozner, *Third World Battles for AIDS Drugs*, CHI. TRIB., Apr. 28, 1999, § 1, at 1 (quoting a representative of the Pharmaceutical Research and Manufacturers Association as calling compulsory licensing "a form of patent piracy" and "stealing;" and quoting Assistant U.S. Trade Representative for Intellectual Property Issues as stating that the U.S. government is "negative toward compulsory licensing").

70. *Id.*

71. *Id.*

72. World Health Organization Executive Board, *Revised Drug Strategy*, Jan. 27, 1998, § 1(2) (visited Sept. 16, 1999) <<http://www.who.int/gb/pdfangl/angr24.pdf>>.

73. See World Health Assembly, *Third Report of Committee A (Draft)*, May 15, 1998 (visited Sept. 16, 1999) <<http://www.who.int/wha-1998/pdf98/ea41.pdf>> ("The Committee decided to refer resolution EB101.R24 on 'Revised drug strategy' back to the Executive Board, to be further considered . . . , taking into consideration the discussions of this matter in the Committee and in a drafting group.").

under relevant international agreements, including trade agreements, to safeguard access to essential drugs.”⁷⁴

Opposition to compulsory licensing is also connected with concerns about the potential misuse and abuse of antimicrobial drugs in developing countries. Lack of control over the prescription and distribution of antimicrobial drugs has contributed to the irrational use of such drugs and the resulting development of antimicrobial resistance. In connection with the use of antimicrobial drugs for both human and animal health purposes, many developing countries have inadequate or non-existent regulatory controls over antimicrobial use.⁷⁵ Antimicrobial resistance in such diseases as tuberculosis and malaria has resulted from the undisciplined use and misuse of pharmaceutical drugs in developing countries. With some strains of HIV already developing resistance to HIV/AIDS therapies,⁷⁶ concern exists that widespread compulsory licensing of HIV/AIDS therapies in developing countries could increase the potential for the development of resistant strains of HIV.⁷⁷ While some developing countries may have the public health infrastructure to administer HIV/AIDS drugs properly on a large scale, the historical problems encountered in the developing world with the irrational use of antimicrobials suggests that compulsory licensing of HIV/AIDS therapies might have a significant long-term downside.⁷⁸

Another controversial feature of intellectual property rights relates to the historical practice of Western pharmaceutical companies exploiting for global profit therapeutic remedies developed by traditional healers in developing societies.⁷⁹ Typically, a Western pharmaceutical company finds a compound of therapeutic value in traditional medical practices, takes the compound back to its headquarters, refines its chemistry, and patents the research and

74. World Health Assembly, *supra* note 65, § 1(2)-(3).

75. David P. Fidler, *Legal Issues Associated with Antimicrobial Drug Resistance*, 4 EMERGING INFECTIOUS DISEASES 169, 172 (1998); David P. Fidler, *Legal Challenges Posed by the Use of Antimicrobials in Food Animal Production*, 1 MICROBES AND INFECTION 29, 31 (1999).

76. See Luc Perrin & Amalio Telenti, *HIV Treatment Failure: Testing for HIV Resistance in Clinical Practice*, 280 SCIENCE 1871 (1998); Maureen Bezuhy et al., *International Health Law*, 31 INT'L LAW. 645, 658 (1997).

77. Goozner, *supra* note 69 (“As part of its campaign to forestall widespread compulsory licensing, the drug industry is raising concerns that poorly monitored use of the latest HIV inhibitors might create resistant strains of the virus.”).

78. For a detailed analysis of the factors producing drug resistance in developing countries, see Iruka N. Okeke et al., *Socioeconomic and Behavioral Factors Leading to Acquired Bacterial Resistance to Antibiotics in Developing Countries*, 5 EMERGING INFECTIOUS DISEASES 18 (1999).

79. See, e.g., Naomi Roht-Arriaza, *Of Seeds and Shamans: The Appropriation of the Scientific and Technical Knowledge of Indigenous and Local Communities*, 17 MICH. J. INT'L L. 919 (1996).

development, giving it the opportunity to reap monopoly profits without returning anything to the society from which the knowledge originally came.⁸⁰ Critics of this behavior provocatively call it “biopiracy”⁸¹ and “biocolonialism;”⁸² many developing countries have taken actions to prevent Western pharmaceutical companies from “stealing” indigenous knowledge without fair return for the investment of the indigenous society.⁸³

The biopiracy controversy is important in terms of the impact of intellectual property rights on developing countries, but it is also important in what it tells us about Western attitudes toward traditional medicine. Western pharmaceutical companies have viewed traditional medicine through utilitarian lenses: what can we learn from traditional medicine that can be transformed into modern, scientific therapies that make profits from patients in the developed world? Traditional medicine has, thus, historically been treated by Western pharmaceutical companies as a commodity, or a natural resource of the periphery, to be exploited for the benefit of health in the core. The resulting pharmaceutical products, protected by the international law on intellectual property, are then exported back to developing countries, where they largely benefit the rich and powerful because of their intended medical purpose or cost. The cultural significance and health importance of traditional medicine in many developing countries does not factor into this utilitarian perspective or the international law on intellectual property,⁸⁴ and the commodification of traditional medicinal knowledge tends to produce pharmaceutical products that are too expensive to benefit health in developing societies significantly or are irrelevant to the major health threats facing these societies.

80. Keith Aoki, *Neocolonialism, Anticommons Property, and Biopiracy in the (Not-So-Brave) New World Order of International Intellectual Property Protection*, 6 *IND. J. GLOBAL LEGAL STUD.* 11, 49 (1998) (noting that “invaluable biological and cultural resources flowing out of the countries of the South as ‘raw materials’ into the developed nations of the North where they are magically transformed in the laboratories of pharmaceutical and agricultural corporations into protected intellectual properties whose value is underwritten by provisions of multilateral agreements such as TRIPS”).

81. See, e.g., VANDANA SHIVA, *BIOPIRACY: THE PLUNDER OF NATURE AND KNOWLEDGE* (1996).

82. Aoki, *supra* note 80, at 52.

83. See K. S. Jayaraman, *India Seeks Tighter Controls on Germplasm*, 392 *NATURE* 536 (1998); Ehsan Masood, *Old Scores Surface as African States Face New Opportunities*, 392 *NATURE* 540 (1998); Ricardo Bonalume Neto, *Brazil’s Scientists Warn Against ‘Nationalistic’ Restrictions*, 392 *NATURE* 538 (1998).

84. *But see* the ongoing debate about expanding intellectual property rights to cover indigenous knowledge and its products analyzed in Roht-Arriaza, *supra* note 79, at 953-58; Rosemary J. Coombe, *Intellectual Property, Human Rights & Sovereignty: New Dilemmas in International Law Posed by the Recognition of Indigenous Knowledge and the Conservation of Biodiversity*, 6 *IND. J. GLOBAL LEGAL STUD.* 59, 77-82 (1998).

III. GLOBALIZATION OF MARKETS AND THE HUMAN RIGHT TO HEALTH

As mentioned in Part II, one strategy frequently used to counter the perceived adverse health consequences of the globalization of markets is an appeal to the human right to health. Some believe that the imposition of neo-liberal economic policies on developing country governments through SAPs forces them to violate the right to health by cutting back spending on public health and health care.⁸⁵ Some argue that the international intellectual property regime's restriction of access to essential drugs violates "a basic human right."⁸⁶ The "right to health" argument is powerful rhetorically, and many people working in health sectors in developing countries passionately believe that every individual has a fundamental right to health. Thus, the globalization of markets becomes an enemy of the basic human right to health, particularly in connection with developing countries.

Unfortunately for these arguments and passions, the human right to health remains an amorphous concept. No one is really sure what it means.⁸⁷ In December 1998, WHO's Director-General defined "health security" as encompassing a right to health care, food, water, shelter, education, and a safe environment.⁸⁸ The problem with this kind of definition is that it suggests that the right to health means a right to almost everything. As one commentator argued, "if the right to health covers everything, then it means nothing."⁸⁹

Even more problematic is the manner in which the concept of the right to health is actually enshrined in international law. The right to health is an economic, social, and cultural right—one of the "second generation" of human rights.⁹⁰ As contained in international human rights agreements, State parties accept the obligation to realize progressively the right to health while taking into account their economic circumstances.⁹¹ An individual's enjoyment of the right is dependent on, or relative to, the State's economic resources. This

85. See arguments about adverse health impacts of SAPs cited *supra* note 45.

86. See *Statement of Consumers International delivered by Ellen æt Hoen on Agenda item 13 of the 52nd World Health Assembly: Revised Drug Strategy*, May 22, 1999 (arguing that "[a]ccess to essential drugs is a basic human right").

87. FIDLER, *supra* note 26, at 181 ("Lamentations about the difficulty of determining the content of the right to health populate the literature on the right to health.").

88. World Health Organization, *Director-General Sets Out WHO Stance on Health and Human Rights*, Dec. 8, 1998 (visited Sept. 12, 1999) <<http://www.who.int/inf-pr-1998/en/pr98-93.html>>.

89. Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 53 (1994).

90. FIDLER, *supra* note 26, at 179-80.

91. For an analysis on the principle of progressive realization and the right to health, see *id.* at 183-85.

principle of progressive realization connects the right to health to economic development. Thus, like the health transition strategy, the right to health carries within it the requirement for sufficient economic development to support well-funded public health and health care systems. Through the primary health care (PHC) strategy, launched with the Health for All by the Year 2000 policy in 1978,⁹² WHO attempted to create public health strategies geared toward the socioeconomic conditions in developing countries. Despite some progress, the PHC strategy has not had the impact on health in developing countries originally hoped.⁹³ The lack of widespread economic development in the developing world, combined with the failure of public health strategies designed to improve public health in developing countries, has left the right to health empty in the lives of people in developing countries.

A serious problem with using the right to health to criticize neo-liberal economic policies and the globalization of markets is the conspicuous failure to provide an alternative model of economic development. Fulfillment of the right to health depends on the presence and effective use of economic resources; thus, support for the right should be accompanied by ideas related to how the country creates and utilizes economic development. I do not mean to imply here that neo-liberalism and economic globalization are the only possible policy avenues available to States and international organizations. But it is frustrating to hear wonderful rhetoric about the right to health being violated when the rhetoricians often have not thought it necessary to address how a government in a developing country should go about creating economic development. As noted earlier, supporters of neo-liberal models of economic development fault governments, rather than globalization, for the lack of economic development in developing countries. From this perspective, the failure to realize progressively the right to health is, like the failure to experience the health transition, largely self-inflicted. Again, we reach a stage of finger pointing about the underlying problems burdening the health of peoples in the developing world.

In the 1999 *World Health Report*, the WHO Director-General advocated supporting health sector development through what she called a “new universalism.”⁹⁴ The essence of new universalism appears to be reliance on

92. See Declaration of Alma-Ata, *supra* note 6.

93. See Allyn L. Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J.L. & MED. 301, 302 (1992) (arguing that “[s]ince WHO initiated the Health for All strategy [in 1978], disparities in health standards between rich and poor nations have increased and health spending in most developing nations has declined”).

94. *Message from the Director-General*, in WORLD HEALTH REPORT 1999, *supra* note 1, at xv.

market forces to produce the economic resources needed for the government to provide universal access to health care. The Director-General seemed to recognize the dominance of liberal and neo-liberal economic thinking by acknowledging that health sector reform “will take place in a context of increased reliance on the market forces which have increased productivity in many sectors of the world economy.”⁹⁵ She also noted that “[m]arket mechanisms have enormous utility in many sectors and have underpinned rapid economic growth for over a century in Europe and elsewhere.”⁹⁶ The new universalism rejects, however, using market forces to provide health services because “[n]ot only do market-oriented approaches lead to intolerable inequity with respect to a fundamental human right, but growing bodies of theory and evidence indicate markets in health to be inefficient as well.”⁹⁷ She noted that “the very countries that have relied heavily on market mechanisms to achieve the high incomes they enjoy today are the same countries that rely most heavily on governments to finance health services.”⁹⁸ The primary role of the private sector in the new universalism is to supply drugs and equipment to health service providers and to invest in new drugs and technology to improve health.⁹⁹ But it is the public sector that has “the fundamental responsibility of ensuring solidarity in financing health care for all.”¹⁰⁰

The extent of this fundamental responsibility is not clear, however, as the Director-General warned governments cannot attempt “to provide and finance everything for everybody.”¹⁰¹ The new universalism “recognizes that if services are to be provided for all then not all services can be provided.”¹⁰² New universalism maintains that “[t]he most cost-effective services should be provided first.”¹⁰³ The breadth and depth of the fundamental responsibility to finance health care for all would seem to depend on the level of economic development of the country in question, which itself depends on the breadth and depth of the country’s reliance on market forces and integration with the global economy.

Whether the path to the progressive realization of the right to health involves neo-liberalism, socialism, or WHO’s new universalism, it will be a

95. *Id.* at xiv.

96. *Id.* at xiv-xv.

97. *Id.* at xiv.

98. *Id.* at xv.

99. *Id.*

100. *Id.*

101. *Id.* at xiv.

102. *Id.* at xv.

103. *Id.*

globalized path. The use of the right to health, and agitation by members of transnational civil society for its realization, represents the globalization phenomena itself. Global networks of NGOs, linked in the common cause of the right to health and utilizing new information technologies to build solidarity and exert influence, constitute creatures of globalization. The enterprise is very distant from concepts of health in traditional cultures in developing countries and constitutes a threat to traditional medicine. Further, the scale of economic development needed to support the WHO Director-General's definition of "health security" and her concept of "new universalism" cannot be achieved except through connecting a national economy to global markets for goods, technology, services, and capital. In short, new universalism seems to admit that realistic and progressive fulfillment of the right to health in developed, and especially developing countries, requires the globalization of markets.

Do supporters of the right to health and new universalism have to cut a Faustian bargain with the neo-liberal globalization of markets? New universalists and right-to-health critics of neo-liberalism's version of the globalization of markets may believe in the possibility of a kinder, gentler globalization. New universalism seeks not only to harness the wealth-producing forces of free markets, but also to protect public health and health care systems from adverse consequences of free market activities. Even new universalism's version of globalization will not, however, be kinder and gentler for traditional cultures in developing countries. New universalism would involve significant transformations of traditional practices, customs, and mores because it would require radical action internationally, nationally, and locally to stimulate market-inspired economic reforms and to address systematically the burdens of infectious and non-communicable diseases.

IV. GLOBALIZATION AND TRADITIONAL MEDICINE

The assertion that the serious pursuit of the right to health would undermine traditional cultures in developing countries may not trouble some people committed to improving health in developing countries. In the global era, the concepts of "health" and the "right to health" are intertwined with Western scientific and technological approaches to human illness. This particular outlook may be defensible in terms of what Western science and medical technology have offered and potentially promise to offer

humankind,¹⁰⁴ but it does not deal with a very practical problem at the heart of health problems in many developing States, particularly in Africa. According to WHO, “[m]ost population[s] in the developing countries still [rely] mainly on indigenous traditional medicine for satisfying their primary health care needs.”¹⁰⁵ In these societies, traditional medicine often has no connection at all with Western conceptions of illness and health because it is encapsulated in belief systems alien or antithetical to modern, Western thought. From one perspective, the large-scale use of traditional medicine in developing countries only serves to emphasize the extent of the failure of national and international health policy to improve health conditions along Western models.¹⁰⁶ It further serves as an illustration of the relative isolation of these societies from the processes of globalization and their benefits.

This rather skeptical view of traditional medicine is currently not in vogue. In fact, international and national public health experts are attempting to formulate ways to meld traditional and Western forms of medicine to improve health in developing countries. The reality that most people in developing countries only have access to traditional medicine is not seen so much as a failure, but as an opportunity to build a more effective and culturally sensitive approach to public health and health care. Experts believe that a melding strategy offers promise in developing countries for public health and health care generally¹⁰⁷ and in connection with specific disease

104. See *Message from the Director-General*, *supra* note 94, at vii (stating that “[r]emarkable gains in health, rapid economic growth and unprecedented scientific advance—all legacies of the 20th century—could lead us to a new era of human progress”).

105. World Health Organization, *WHO's Policy and Activities on the Traditional Medicine* (visited Sept. 13, 1999) <<http://www.who.int/dap/trm0.html>>.

106. See, e.g., Bernard Hours, *African Medicine as an Alibi and as a Reality*, in *AFRICAN MEDICINE IN THE MODERN WORLD* 41, 46 (Centre of African Studies ed. & Christopher Fyfe trans., 1986) (arguing that “the rediscovery of African medicine . . . works chiefly as an institutional alibi, designed to mask the inadequacies of existing policies, in the hope that health problems will be solved by introducing some more or less imaginary dimension”); Komla Tsey, *Traditional Medicine in Contemporary Ghana: A Public Policy Analysis*, 45 *SOC. SCI. MED.* 1065, 1065 (1997) (arguing that “[i]n Ghana, as in most African countries, the rising cost of Western medicine means that individuals and . . . governments are increasingly turning to traditional medicine as an affordable alternative”).

107. See, e.g., World Health Organization, *supra* note 105 (stressing “the need for the governments of the countries interested in the use of traditional medical practice to give adequate support to engaging traditional medical practitioners in primary health care teams”); L. Thikhoi Jonathan, *Traditional Versus Modern Medicine: The Case for a Collaborative Approach to Primary Health Care*, in *ETHNOMEDICINE IN SOUTHERN AFRICA* 9, 16 (National University of Lesotho Journal of Research ed., 1993) (“It is . . . imperative that the two systems of medicine [modern and traditional] are brought together under one umbrella for the benefit of the people they are intended to serve.”). For an analysis on the policy debate about integrating traditional and modern medicine in health policies of developing countries, see MELVYN FREEMAN & MMATSHILO MOTSEI, *IS THERE A ROLE FOR TRADITIONAL HEALERS IN HEALTH CARE IN SOUTH AFRICA?* (1990); EDWARD C. GREEN, *INDIGENOUS HEALERS AND THE AFRICAN STATE: POLICY ISSUES*

problems.¹⁰⁸ This melding strategy raises many interesting questions, many of which draw attention to the relationship between globalization and culture. Earlier, this Article pointed out globalization's potential to erode cultures in developing countries. The intimate connection between traditional medicine and its nurturing culture might, thus, find itself in the eye of globalization's cultural hurricane. Whether traditional medicine can survive globalization to contribute to improved health in developing countries remains to be seen, but the future for traditional medicine may not be bright, despite the resurgence of interest in traditional medicine.

Underneath the growing attention to traditional medicine as a feature of global health policy are some worrisome issues. The globalization of markets has not greatly accelerated the advance of Western-style public health and health care in much of the developing world. In fact, as analyzed earlier in this Article, many people think the globalization of markets is harmful to health in developing countries. In addition, the globalization of markets has had, and promises to have, an even greater impact on traditional cultures in developing countries as economic policies and individual lifestyles increasingly follow patterns already established in the West. Traditional cultures are mutating or dying without access to the full political, economic, and scientific benefits of the adopted Western culture. The health context provides an interesting lens through which to look at this phenomenon, particularly in connection with the future of traditional medicine.

Despite its importance in many developing countries, traditional medicine is under stress from three major sources. The first source of stress is the long-standing realization that governments in developing countries have to regulate traditional medicine to prevent traditional healers from committing fraud, inflicting injury, spreading disease, and causing unnecessary deaths.¹⁰⁹

CONCERNING AFRICAN INDIGENOUS HEALERS IN MOZAMBIQUE AND SOUTHERN AFRICA (1996).

108. See, e.g., World Health Organization, *Report of the Consultation on AIDS and Traditional Medicine: Prospects for Involving Traditional Health Practitioners*, WHO/TRM/GPA/90.1 (July 23-27, 1990); EDWARD C. GREEN, AIDS AND STDs IN AFRICA: BRIDGING THE GAP BETWEEN TRADITIONAL HEALING AND MODERN MEDICINE (1994); Edward C. Green, *The Participation of African Traditional Healers in AIDS/STD Prevention Programs* (visited Sept. 9, 1999) <<http://www.yg.cchs.usyd.edu.au/IHN/green1.htm>>.

109. See, e.g., Isaac Sindiga et al., *The Future of Traditional Medicine in Africa*, in *TRADITIONAL MEDICINE IN AFRICA* 175, 176-78 (Isaac Sindiga et al. eds., 1995) (analyzing need for legislation, registration, and licensing of traditional healers); GREEN, *supra* note 107, at 48-52 (analyzing the issue of legislation and traditional healers); World Health Organization, *supra* note 108, at 13 (arguing for legislation to regulate traditional medical practices); Salifou Dembélé, *Should Traditional African Medicine Be Regulated?*, 49 INT'L DIG. HEALTH LEGIS. 566, 566 (1998) (arguing that "co-existence between the rule of law and traditional systems of African medicine is . . . necessary").

Despite comforting rhetoric about the importance of traditional medicine and its importance in the daily lives of people in developing countries, the move to regulate it is a move to Westernize traditional medical practices by moving them onto a firmer scientific and legal basis. The move to regulate is also influenced by human rights concepts, again largely derived from the West, that frown upon certain traditional medical practices that are harmful to the body, such as female circumcision. Shorn of politically correct sentiments, the regulatory idea seeks to reform traditional medicine on scientific, public health, and human rights grounds prevalent in the West.¹¹⁰

The second source of stress for traditional medicine comes from attempts to link traditional and Western medicine together in improving public health and health care in the developing world. Much of the talk of melding traditional medicine and Western medicine is, at the end of the day, a utilitarian project to improve the penetration of Western health practices and technologies deeper into developing societies. The primary appeal of traditional medicine is practical, not cultural. As Green argued:

Perhaps the most powerful argument is that public health goals probably cannot be realized in Africa without some type of collaboration involving indigenous healers. The numbers simply are not there: the number and geographic distribution of Western-trained medical personnel, the number of clinics and hospitals in rural areas, and the amount of money available to ministries of health are all inadequate to meet existing needs. . . . Economic and manpower arguments in favor of collaboration can only become stronger in the foreseeable future.¹¹¹

Traditional healers are, thus, viewed as unavoidable conduits for the application of Western public health strategies and medical approaches in developing countries. Western-trained public health experts and physicians attempt to translate Western biomedical concepts into terms, symbols, and beliefs already prevalent in traditional medicine.¹¹² However, those in favor

110. An interesting development to watch in this regard is the attempt by South Africa to set up a statutory council to regulate traditional healers in South Africa. See Adele Baleta, *South Africa to Bring Traditional Healers into Mainstream Medicine*, 352 LANCET 554 (1998).

111. GREEN, *supra* note 108, at 38-39.

112. Green, *supra* note 108 (noting the need for "more effort to 'translate' biomedical concepts into locally familiar terms (language, symbols, metaphors)" and the attempt through AIDS/STD prevention

of collaboration between Western and traditional medicine do not usually hesitate to condemn traditional medical practices that cannot be co-opted as vessels for Western biomedical and public health knowledge.¹¹³

“Learning” from traditional healers also seems to include finding ways to improve Western health practices, primarily through new therapeutic compounds refined over the ages in traditional medical environments. As traditional medicine has come into vogue, sales and consumption of traditional remedies and resort to “alternative medicine” in developed and developing countries has increased.¹¹⁴ The Western interest in effective, traditional plant and herbal remedies, is a component of the allegations of “biopiracy” against Western pharmaceutical companies analyzed earlier in this Article. In addition, some experts have noted that Western efforts to modernize traditional plant and herbal remedies, through scientific research and development, tend to make such remedies “more expensive and thereby undermining ease of access often associated with traditional medicine.”¹¹⁵ While there is no hesitation on the part of Westerners to study and benefit from traditional remedies, concerns exist about sharing Western pharmaceutical products with traditional healers. One factor in the development of antibiotic resistance in developing countries is the misuse of antibiotics by unskilled practitioners, including traditional healers.¹¹⁶

The third source of stress is general cultural erosion. Traditional medicine belongs to ancient belief systems deeply embedded in many societies. The “world views” of these belief systems are not compatible with the world view that comes with Western science and medicine. Harnessing traditional medicine to promote Western public health and health care approaches is arguably a corrosive process because it undermines the foundations of traditional belief systems.¹¹⁷ While the traditional medical systems remain

programs “to teach biomedical concepts to traditional healers by using symbols, metaphors and etiological concepts already in use”).

113. See, e.g., Dembélé, *supra* note 109, at 567 (arguing that “the regulation of the practice of traditional systems of medicine could not promote . . . [dangerous] practices, despite the fact that they form part of the sociocultural background Certain procedures carried out by traditional practitioners deserve to be condemned in no uncertain terms and their ‘art’ expressly prohibited”).

114. See World Health Organization, *supra* note 105 (discussing rise in international use of herbal medicines and natural products).

115. Tsey, *supra* note 106, at 1073.

116. Okeke et al., *supra* note 78, at 19; GREEN, *supra* note 107, at 61 (noting “that there is great potential for misuse of medicines and related technology of biomedicine, in the hands of ‘untrained’ healers”).

117. See, e.g., GREEN, *supra* note 108, at 42-43 (arguing that “meddling with traditional medicine is fraught with unforeseen [sic] and possible negative outcomes. One does not have to be an anthropologist

part of daily life, the life force or energy behind them may drain away as collaboration with Western science and medicine deepens.¹¹⁸ More generally, the globalization of markets creates stress for traditional cultures as globalized trade, investments, urbanization, communications, and media encroach ever more into societies previously unconnected (and perhaps unconcerned) with the rest of the world. Once tempted by the allure of the global village, the ways of the local village never seem quite the same.¹¹⁹

One might challenge my sweeping assertions by pointing out the growing popularity of traditional medicine in African countries. Even more broadly, phenomena such as the “African renaissance”—a reawakening of traditional African culture—suggest that traditional cultures are not on the verge of extinction. However, the increase in popularity of traditional medicine and the resurgence of interest in traditional culture do not undermine the thrust of my arguments in the health context. Many commentators have pointed out the simultaneous unification and fragmentation of the world in the era of globalization.¹²⁰ Ethno-revivalism is, in many respects, a reaction to (or against) the cultural ramifications of globalization, and is thus linked to globalization as a phenomenon. In the health context, ethno-revivalism may be seen in the increasing popularity of traditional medicine; it is, however, open to question whether this popularity has or will have beneficial impact on health in developing countries. Perhaps the increasing use of traditional

to recognize that healers play a complex role and carry out complex, interrelated functions in their communities”).

118. Hours argued that collaboration between modern and traditional medicine: cannot conceal the different types of logic that underlie modern and African medicine. The first has a chemical or technical approach. But African medicine is concerned with power, with a struggle against the social disorders known as witchcraft. Thus, we cannot hope to achieve a synthesis, some simple, radical therapeutic syncretism. . . . Thrust into a system ruled by another logic, away from their own village and society, traditional practitioners are ineffective and powerless.

Hours, *supra* note 106, at 56-57.

119. The tension between the traditional and the modern was captured in the following excerpt from *The Irish Times*:

Although the roots of muti [a form of traditional medicine] lie deep in African traditional religion, it has learned to move with the times. South African blacks now live in an increasingly urbanised context, and the new wave of sangomas [a traditional healer] has swapped smoky huts and animal skins for high rise offices, sharp suits and framed certificates. But despite this new look image, the modern sangoma still makes his or her diagnosis by throwing animal bones on to the floor

....

Edward O’Loughlin, *It May Not Heal, But It Does Deter Burglars*, IRISH TIMES, Nov. 28, 1995, available in 1995 WL 12717654.

120. See, e.g., BENJAMIN R. BARBER, *JIHAD VS. MCWORLD: HOW THE PLANET IS BOTH FALLING APART AND COMING TOGETHER AND WHAT IT MEANS FOR DEMOCRACY* (1995).

healers reflects not pride in traditional culture, but desperation of people increasingly under threat from old and new diseases.

The stress placed on traditional medicine from the movement to regulate it, the plans to utilize it for better delivery of Western public health and health care, and general cultural erosion will eventually render the concept of "traditional medicine" less and less useful in the context of health in developing countries.¹²¹ In health and other contexts, worlds are literally colliding; it is also apparent which world has the greater mass and momentum to effectuate a change in the path it is following. The peoples of developing countries will not, however, be swept entirely up in the wake of globalization's impact as levels of economic development do not yet exist to support Western-style public health and health care.

CONCLUSION

Globalization in economic and other areas of human interaction has important consequences for the peoples of the developing world. Developing country societies entered the era of globalization burdened with health conditions far worse than in developed countries. The hoped-for health transition from infectious to non-communicable diseases did not take place. Instead, the health gap between developing and developed countries now involves developing countries facing enormous health problems with both infectious and non-communicable diseases, without levels of economic development needed to deal with either. The processes of globalization and their dynamics also contain aspects that appear to accentuate the health problems of developing countries, whether through increases in international trade, structural adjustment programs required by international financial organizations, changes in the nature and extent of international trade and investments in services, or the operation of the international intellectual property regime. While the human right to health is often used to argue against globalization and its health consequences, the underlying questions about how to develop a country economically to improve public health and health care are not usually addressed, let alone answered, in discourse on the human right to health. Finally, the interaction between the forces of globalization and traditional medical practices adds another worrisome

121. Some may assert, with some legitimacy, that colonialism and neo-imperialism destroyed what traditional medicine was really about long before globalization came into fashion.

wrinkle to the perspective of developing countries concerning globalization's impact on health in the developing world.

On the horizon for health in the developing countries may be the worst of all possible worlds: increasing disease burdens, continued lack of economic development, continued lack of access to Western public health and health care, and the erosion of the practices and the beliefs behind traditional medicine. Peoples in developing countries may, thus, suffer a double cultural alienation: falling short of the promises offered by Western science and falling away from the cultural identity represented by shamans. This situation portends great individual and societal discontent as globalization progresses.