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HUGH RODMAN LEAVELL LECTURE AWARD 2006

"GLOBALIZATION, POVERTY AND HEALTH"

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The first words I say should express the deep gratitude I have to the World Federation of Public Health Associations for having given me the privilege of being the Leavell Lecturer in this XI World Congress and VIII Brazilian Congress on Collective Health.

This award means a lot to me. First, I received it from the largest and most important public health association in the world. The Federation brings together more than seventy national associations of all around the world that congregate health professionals working on national health services, universities, as well as on public health academies, schools and institutes and on so many other institutions that are extremely important for the health of their countries' populations. I was introduced to the Federation through a dear friend of mine and one of the most extraordinary supporters of the global public health, Margaret Hilson, who I wish now to render homage to.

Second, I'm honored to receive this award because it is named 'Hugh Rodman Leavell', one of the public health and preventive medicine professors that most influenced my thinking from back when I started my career until today. Leavell was Professor Emeritus of the Harvard School of Public Health and co-wrote with E. Gurney Clark a seminal book for the doctors of my generation: *Preventive Medicine for the Doctor in His Community*. On that book, they established the basis for the natural history of disease and for one of the most widely known and creative explanatory models of the health-disease process. They helped us organize our thinking and understand and distinguish the different levels of applicability of health promotion and disease prevention measures – the greatest objectives of public health and its professionals. He has served the World Federation as Executive Director for many years. Leavell is thus here very rightfully honored and immortalized with this award by this very own Federation.

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Public health, both as a knowledge area and a social practice, has faced gigantic challenges throughout its history. The late twentieth century and the beginning of this millennium have challenged us with two defying processes: globalization and poverty. On a daily basis, these two phenomena deeply influence the health of the populations. The health of the populations is the first and most important objective of public health and public health professionals. That is why, therefore, we should try to better comprehend these phenomena so they can be better tackled.

GLOBALIZATION AND POVERTY

The planetary or global economy, strictly speaking, has existed since the end of the sixteenth century, a time when the great discoveries and European exploration of Africa, Asia and the Americas were first being made. The European colonialist expansion caused both positive and negative social and economic consequences over the newly found territories as well as over the European population itself.

For most authors, however, *globalization* is a social, economic and cultural process that has been established over the past two or three decades of the twentieth century. Among its characteristics (which have never been so explicit) are:

- an increase in the international trade of goods, products and services;
- transnationalization of mega corporations;
- free circulation of capital;
- privatization of the economy and a decrease in importance of governments and nation-states;
- the fall of protectionist commercial barriers and the regulation of international trade according to the rules of the World Trade Organization (WTO);
- facilitated transit of people and goods among countries;
- the expansion of communication by the emergence of the so-called information society and the ease with which people communicate due to the invention of several communication devices, one of which, the internet.

Numerous authors and organizations of the United Nations have criticized the process. The “short twentieth century”, the expression coined by the historian Eric Hobsbawm (1995) to describe the recently finished century, brought us an extraordinary “revolution in transport and communication that has practically annihilated time and distance”. In this immense approximation between unequal cultures and economies, the globe becomes the “basic operational unit, and older units such as ‘national economies’, which are defined by the policies of territorial states, change into [mere] impediments to transnational activities”.

The World Commission on the Social Dimension of Globalization, established by the International Labor Organization (ILO, 2004), insists that “the

current process of globalization is generating unbalanced outcomes, both between and within countries. Wealth is being created, but too many countries and people are not sharing in its benefits (…). Many of them live in the limbo of informal economy, without formal rights and in a swathe of poor countries that subsist precariously on the margins of the global economy. Even in economically successful countries some workers and communities have been adversely affected by globalization."

The Commission alerts that "these global imbalances are morally unacceptable and politically unsustainable". They stress "the unfairness of key global rules on trade and finance and their asymmetric effects on rich and poor countries", as well as "the failure of current international policies to respond adequately to the challenges posed by globalization".

What's being observed is that "market opening measures and financial and economic considerations predominate over social ones. Official Development Assistance (ODA) falls far short of the minimum amounts required even for achieving the Millennium Development Goals (MDG) is tackling growing global problems. The multilateral system responsible for designing and implementing international policies is also under-performing. It lacks policy coherence as a whole and is not sufficiently democratic, transparent and accountable. These rules and policies are the outcome of a system of global governance largely shaped by powerful countries and powerful players. There is a serious democratic deficit at the heart of the system. Most developing countries still have very limited influence in global negotiations on rules and in determining the policies of key financial and economic institutions" (OIT, 2004). This can be illustrated by the failure of the Doha Round at the World Trade Organization.

According Nobel Prize Winner in Economy in 2001, Joseph Stiglitz, it was the developed countries who profited from globalization. Countries whose internal savings and technological development, together with strong protectionism – which goes against the golden rule of trade liberalization established by them apparently only to others –, made them the privileged addressees of the world's wealth.

More recently, even the World Bank, in its World Development Report of 2006 (World Bank, 2005), finally admitted that market forces and free trade will not solve the problem of poverty in the world or even reduce it to bearable levels. The report itself affirms that "only equity is capable of increasing our capacity to reduce poverty."

Internal and foreign debts, trade barriers and the protectionism of industry and agriculture in richer countries (which hinder the developing countries' primary and industrial goods) are the roots of the enormous fiscal crisis presently faced by developing countries and of the increasing social debt they have with their people. Almost all taxes collected in these countries, as well as international loans granted by the IMF under strict conditions, are used in postponing debts acquired in adverse conditions in the past, often under non-democratic and corrupt governments. These debts increase under abusive interest rates which are

imposed unilaterally by the international financial capital. Consequently, programs destined to fight poverty and other social programs end up underfinanced and ineffective (Buss, 2002).

One of the most harmful aspects of globalization are the brutal attacks promoted by the international speculative capital on more fragile national economies of poor or middle-income countries. The action of the so-called *hot money* has injuriously affected social budgets in poor countries, including that of health. The daily circulation of speculative, non-productive capital in the world is of around 1.8 trillion US dollars (Tobin Tax Initiative, 2005). This capital has no nation and, therefore, no responsibility over people or countries and should be controlled both nationally and internationally as a way of avoiding its global and local perniciousness. In his recently released book, the economist John Williamson, who coined the expression *Washington Consensus* to name the set of recommendations for Latin America regarding economic reforms (which has defined the conceptual basis of the globalization process as we understand it today), recognized that it is imperative to control capital flow in the so-called emerging markets.

Besides producing bad economic results, the international division of production and labor that took place with globalization also led to important social, environmental and sanitary consequences. As to labor, the transfer of unemployment from developed to developing countries (due, in great part, to protectionist policies and agricultural subsidies in richer countries) is observed. Economic activities with higher risks to workers and the environment or that produce dangerous waste (the so-called “dirty industries”) have been transferred to poorer countries, whose legislations protecting the worker and the environment are more tolerant.

Moreover, the unsustainable pattern of urbanization, industrialization, waste generation and energy consumption in more developed, rich and industrialized countries possesses a destructive influence over the environment, which includes climate consequences such as the progressive global warming. The results are losses in food production, desertification, the pollution of air, soil, rivers, aquifers and oceans, the depletion of woods and forests and the unrecoverable damage to biodiversity.

Recently, United Nations University specialists warned that within five years the world is going to have at least fifty million of the so-called “environmental refugees” (O Globo, 12/10/2005), that is, people that had to leave their houses and/or their lands because of tornadoes, tsunamis, earthquakes, long-lasting droughts, deforestation, desertification and other natural disasters. Many of these people are “refugees in their own countries”. The causes of most of these natural phenomena are uncontrolled economic activities that affect the environment. Shortly after the disasters, survivors show weaker health and social and economic conditions that favor diseases to appear. Therefore, I understand that these “new refugees” are among the new public health problems, whose responsibility belongs national and local governments and to the United Nations – in the event of a global

problem. We – public health specialists and health professionals and administrators – should provide the care these people deserve.

The responsibility for the terrible social and economic results of globalization should be attributed not only to developed countries and to international financial corporations and organizations, but also to the political and economic elites and governments of many underdeveloped countries that have a low level of social commitment and are often corrupt.

The low quality of politics and governance of many governments of developing countries causes the wasting of resources and the ineffectiveness of environmental protection and health promotion, disease prevention and health assistance initiatives – if they exist. Generally speaking, the actions of social, environmental and sanitary programs in these countries are vertical, unarticulated and often drained by corruption.

On the other hand, even though the aid provided by foreign countries and the easing of exportations for poor countries (aiming at improving their trade balance) are necessary measures, they are also insufficient for these countries to finally launch their development. That happens because what they gain through foreign trade is not equally distributed among the poor population of these countries, thus remaining totally concentrated on the hands of few, generally the hands of nationals or trans-national export corporations.

These factors have a different impact in different individuals and populations. They are cast-aways from the benefits of globalization and yet vulnerable to its costs. Moreover, the benefits they get from public policies in the health field are very limited.

GLOBALIZATION AND POVERTY

Poverty is a multidimensional concept (as well as a multidimensional real situation in life). In the past, the notion referred exclusively to the income of the individual: the poor are those who live with less than 1 USD a day, adjusted to the purchase power of the country or region. Even though the wealth of the world – which is presently estimated in 20 trillion USD per year – continues to grow, around 1.2 billion people live with less than 1 USD a day (in a situation categorized as of “extreme poverty”) and half of the people in the world live with less than 2 USD a day (World Bank, 2002). In Sub-Saharan Africa, almost half of the people live with less than 1 USD a day, while 37% of the population (or 448 million people) live in similar conditions in South Asia. In Latin America and the Caribbean, 222 million people are poor, out of which 96 million, or 18% of the population, are indigent (CEPAL, 2005).

However, after the critical work of Nobel Prize Winner in Economy in 1998, Amartya Sen, it was clear that a universal poverty line could not be established and applied to everyone the same way, that is, without taking personal characteristics

and circumstances into account. Sen (1999) pointed out that the analysis of poverty should also concentrate on the capacity the individual to take advantage of his/her opportunities, as well as other aspects such as health, nutrition and education, which reflect the individual's basic working capacity in a society. The power health promotion has to perform actions among the poor and the strategies of individual and collective 'empowerment' rest in observations like this.

On the other hand, it is necessary to state that the poor are precisely those living in worse social, environmental and sanitary conditions. They also have more difficulty in accessing public services and, specifically, health services. In fact, numerous studies conducted around the world show that people with lower incomes are precisely those who, despite being underprivileged, have worse access to adequate housing, potable water, sanitation, food, education, transportation, leisure, stable and risk-free jobs as well as to health services.

POVERTY AND HEALTH

Disparity in wealth exists between countries and regions as well as between the rich and the poor within each country. Table 1, for example, shows the differences in health between the countries grouped by level of development. It shows evident losses in the indicators for the poorer and less developed countries.

Table 1. LIFE EXPECTANCY AND MORTALITY RATES, BY COUNTRY DEVELOPMENT CATEGORY, (1995–2000)

Development Category	Population (1999 millions)	Annual Average Income (US dollars)	Life Expectancy at Birth (years)	Infant Mortality (deaths before age 1 per 1,000 live births)	Under Five Mortality (deaths before age 5 per 1,000 live births)
Least-Developed Countries	643	296	51	100	159
Other Low-Income Countries	1,777	538	59	80	120
Lower-Middle-Income Countries	2,094	1,200	70	35	39
Upper-Middle-Income Countries	573	4,900	71	26	35
High-Income Countries	891	25,730	78	6	6
Memo: sub-Saharan Africa	642	500	51	92	151

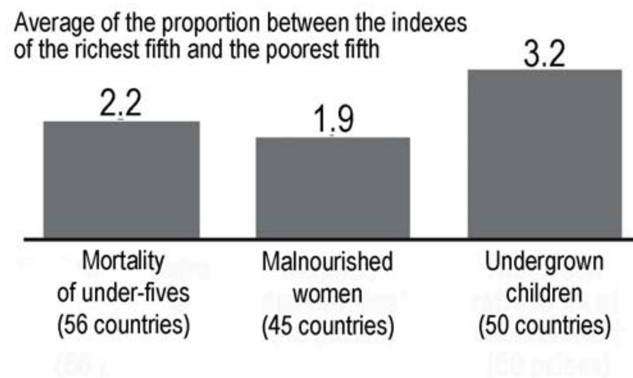
Source: Human Development Report 2001, Table 8, and CMH calculations using World Development Indicators of the World Bank, 2001.

The difference in life expectancy at birth reaches 28 years between richer and poorer countries; the infant mortality rate is 100 per 1,000 live births in less developed countries and only 6‰ in high-income countries; the difference in the under 5 mortality is even higher: 159 per 1,000 live births in less developed countries and 6‰ in high-income countries.

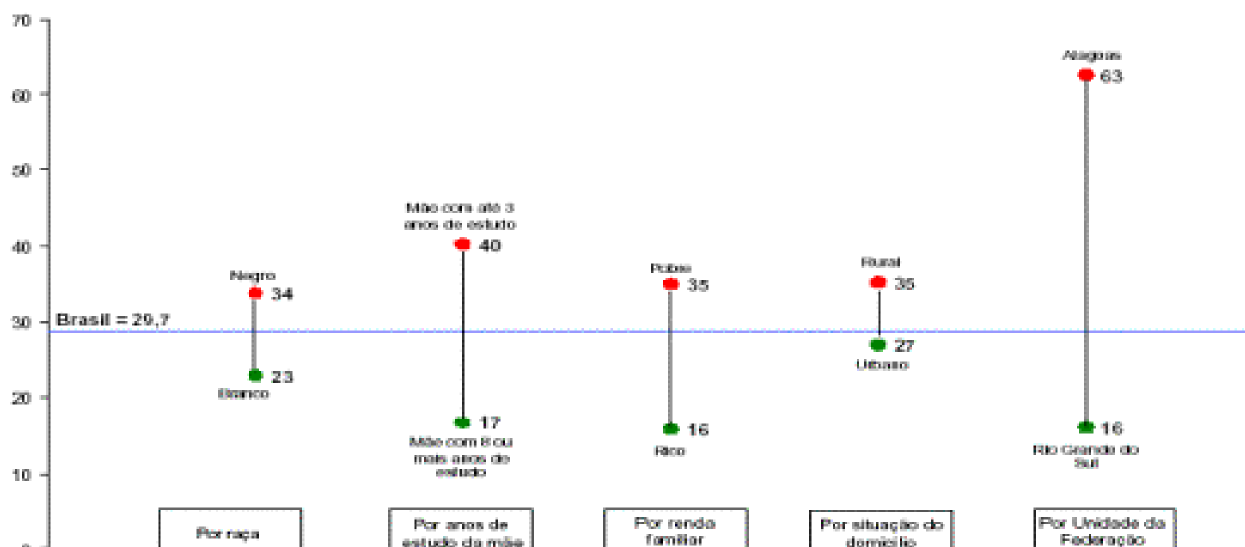
Health inequalities between rich and poor people within poor countries also increased. Such inequalities occur as to health and nutrition levels (morbidity,

disabilities and mortality), as well as in terms of access to social and health services.

Studying selected health indicators in the poorest countries in the world, Gwatikin *et al* (2003) (*apud* Carr, 2004) showed (see Figure below) that the under 5 mortality was 2.2 times higher among the poorest fifth of the world as compared to the richest fifth; malnutrition among women was 1.9 times higher; and the rate of undergrown children was 3.2 times higher.



In Brazil, my country, studies show that, as in many parts of the world, infant mortality is related to family income, the mother's level of education, housing conditions, the place in which the child and the family dwell and their social conditions.



This way, among black people (and skin color is a *proxi* of the Brazilian social situation), the average infant mortality rate is 34 per 1,000 live births versus 23‰ in the white population; 35‰ among the poor and 16‰ among the rich; 40‰ among mothers with less than 3 years of education while only 17‰ among mothers with 8 or more years of education; 35‰ among the rural population against 27‰ in the urban population; and 67‰ in a poorer northeastern state versus 16‰ in a richer southern state.

There are also differences between the rich and the poor as to the use of health services. Studies conducted in 50 poor countries between 1992 and 2002 show that the use of oral rehydration therapy is 1.3 times higher among the rich when compared to the poor; vaccination in children is 2.3 times more frequent; attendance to three or more antenatal care is 3.1 times higher among the richest fifth; the use of modern oral contraceptives is 4.4 times higher. The rich also have 4.8 times more births attended by skilled health personnel.

The differences in *Per capita* total expenditures on health are also impressive, as shown in the figure below. Less developed countries spend an average of eleven dollars *per capita* per year, against two hundred and forty-one dollars in middle-income countries and around two thousand dollars in high-income countries.

Per capita health expenditures, by countries' level of income, 1997

Level of income	*Per capita* health expenditures, US$
Less developed countries	11
Other low income countries (GDP per capita less than US$760 in 1998)	23
Medium-low income countries (GDP per capita more than US$761 and less than US$3,030 in 1998)	93
Medium-high income countries (GDP per capita more than US$3,031 and less than US$9,360 in 1998	241
High income countries (GDP per capita more than US$9,361 in 1998)	1,907

To conclude, this data show that globalization has made countries poorer and increased poverty, exclusion and social and economic inequalities. These inequalities are heavily echoed over the health of individuals and the population as a whole.

GLOBALIZATION AND DISEASE

One of the most noticeable aspects of globalization affecting health is the possibility of trans-nationalizing transmissible diseases (particularly new or re-emerging diseases). Since international traveling has been facilitated and trade intensified, a series of microorganisms can be easily transported through people, animals, insects and food from a country to the other, that is, from any point of the globe to another. Recent examples include the spread of *SARS* and of the *Dengue* and *Bird Flu viruses*. Interpersonal transmission of *viral hemorrhagic fevers,* as in the recent cases of *Marburg* and *Ebola* hemorrhagic fevers in Africa, is one of the major doorways for epidemics (now facilitated by fast international air travels). This emphasizes the necessity and the importance of strengthening the global networks of surveillance and diagnosis in health managed by the WHO and partners around the world.

A well-known case is the *Aids virus*, which possibly originated in a remote region in Africa and spread throughout the world over the last 20 years. Migrating birds can also be accounted for the global spread of infectious diseases, such as the *Bird Flu* and the *West-Nile Virus. Salmonellosis* and *E. coli* infections have often been related to the contamination of fresh or industrialized food circulating between countries. Among the so-called "old" diseases (which re-emerge in one region and spread throughout the world) are *polio*, which had a the recent outbreak in African and Middle Eastern countries due to flaws in vaccine coverage; *cholera*, whose epidemics affected 75 countries in the last 40 years and produced, over the last two years, over 50 thousand cases and 2 thousand deaths in Angola only; *yellow fever*, which reappeared in African Countries; and new versions of old diseases, such as the *drug-resistant tuberculosis*. The increase in *resistance to*

antibiotics of some species, which facilitates their global spread, should also be taken into account.

I am also speaking of sexual tourism and its consequences. Many countries in the underdeveloped world depend economically on international tourism. The globalized tourism industry tolerates the sexual trade of children, adolescents and adults of both sexes. Many destinations in the world are sought today for opportunities related to sexual tourism. These places include Brazil and many Caribbean, Asian and African countries. The globalization of sexual trade entails the spread of sexually transmissible diseases and the psychological and emotional damages that result from the sexual abuse of children, adolescents or even adults.

Another issue related to the process of globalization is the increase in wars and conflicts caused by economic and territorial disputes between countries and between groups or ethnicities within nation-states. This has produced thousands of deaths and injuries and post-conflict physical, emotional and psychological disabilities, which mostly afflicts young individuals, the major victims of conflicts. Mutilations caused by injuries, landmines or by deliberate action on prisoners, exploration and abuse of women for revenge and the genocide of children and the elderly are among the many war crimes seen in recent years. State terrorism and terrorism effected by specific groups is one of the major causes of this tragic statistic.

One of the most significant consequences of wars and conflicts is the devastation of infrastructure, that is, the destruction of health and sanitary services as well as of the environment, which affects the health of the people (and indirectly, yet strongly, of entire populations). Governments redirect money from social programs, such as education and health, to the financing of the military, which hinders people's access to these essential services and worsens health conditions.

The 20th century was one of the most violent periods in human history: conflicts directly or indirectly caused the loss of around 191 million people, half of which were civilians (Rummel [1994] *apud* OMS, 2002). The last years of the 20th century and the first years of the 21th century sadly indicate a tendency of an increase in these harmful events.

Globalized violence has forced thousands into migrating from conflict areas or has caused them to become political refugees. Numerous studies show that human groups that are taken by force from their original homes present worse physical and mental health conditions in their new place of living (Buss, 1992).

The globalization of drug trafficking (cocaine, heroin, marijuana and synthetic chemical drugs) has immensely expanded the use of drugs in almost all societies, causing dreadful consequences on the health of drug users. Moreover, international drug trade is associated to international gun trafficking. This is an explosive combination with astonishing consequences, as shown by the World Report on Violence and Health (WHO, 2002).

One of the paradoxes of the current process of globalization is that, despite the fact that the history of mankind is in a stage in which agricultural technology has the ability to produce an abundance of food products, hunger is still very prevalent in the world and causes parts of the planet to undergo a true genocide. FAO (2004) warns that no less than 852 million people suffer from chronic hunger and malnutrition, and that they are the cause of death of 5 million children every year and cost billions of dollars in productivity losses and decreases in national incomes. These tragic statistics are paired by the information that currently, every year, 20 million babies are born underweight, what most of the times happen because of malnourished mothers.

In Sub-Saharan Africa – currently the world region that is most affected by poverty and further results of poverty – FAO (2004) estimates that no less than 33% of the population are considered malnourished – a rate that reaches to 55% in Central Africa and around 40% in Southern and Eastern Africa. Besides urgent foreign aid for tackling the cruel situation of these countries (such as at least Niger and Malawi at the time this article was written), specialists agree that the problem can only be confronted by means of technical and financial cooperation, as well as through investments in water, the sustainability of ecosystems and in enhancing people's capacities.

Another important consequence of globalization over health is the market-oriented sectorial reforms, extolled by international organizations (World Bank, 1993). These reforms have led to more health inequities. There is no space for public health or for health promotion in these reforms. The only aspects spoken of are the medical care of individuals and how to finance it. The same applies to the imported models for training human resources – which are ill-adjusted to the country's cultural patterns and national health systems. That's why it is imperative that we support the exchange of this reform proposals for another one seeking to implement egalitarian and solidary public health systems – which should take the *health of the population* into account and not only *do business with disease*.

THE OPPORTUNITIES OF GLOBALIZATION

Globalization has positive aspects, however. If we remember the last half of the 20th century, for example, right after the traumatic experience of World War II, we will see that the creation of the United Nations, which comprehends the World Health Organization, represents an important step towards international dialogue, peaceful coexistence of nations and cooperation for the progress of all people and countries in the world. (Despite that, there was a great deal of deception and a big loss of trust in the United Nations, which caused member States, organizations and people to demand a broad reform of the system).

In the 90's, a guideline for organizing a set of large thematic conferences – which would be carried out by the sectorial organizations respectively responsible for each theme – was established within the United Nations, "in order to prepare the world for the 21st century". The major conferences are listed below.

1990's UNITED NATIONS CONFERENCES

1990 – World Summit for Children
1990 – World Conference on Education for All
1992 – United Nations Conference on Environment and Development
1993 – World Conference on Human Rigths
1994 – International Conference on Population and Development
1995 – United Nations Fourth World Conference on Women
1995 – World Summit for Social Development
1996 – United Nations Second Conference on Human Settlements (Habitat II)
1996 – World Food Summit
2000 – Millennium Summit: Millennium Declaration and MDG
2002 - World Summit on Sustainable Development
2005 – World Summit: 2005 Outcomes

These conferences have produced important reports with substantial recommendations, which if had been taken into account and implemented by countries and even by the UN itself, could have already caused an expressive political, social, economic and environmental development for the world as a whole. The major problem is that these recommendations express contradictory political interests and have, thus, not been implemented – which make them mere internationalist rhetoric.

In the year 2000, closing the series of conferences that took place in the previous decade, the United Nations organized the World Summit, in which all Member-States made a new global commitment to development, with an all-encompassing perspective taken from the agreements that had been reached due to the global conferences. The policy thrust was reflected in the Millennium Declaration (United Nations, 2000). The Millennium Development Goals (MDG) are presented in the figure below.

The UN Millennium Development Goals

Goal 1: Eradicate extreme poverty and hunger

- Reduce by half the proportion of people living on less than a dollar a day
- Reduce by half the proportion of people who suffer from hunger

Goal 2: Achieve universal primary education

- Ensure that all boys and girls complete a full course of primary education

Goal 3: Promote gender equality and empower women

- Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015

Goal 4: Reduce Child Mortality

- Reduce by two thirds the mortality rate among children under five

Goal 5: Improve maternal health

- Reduce by three quarters the maternal mortality ratio

Goal 6: Combat HIV/AIDS, malaria and other diseases

- Halt and begin to reverse the spread of HIV/AIDS
- Halt and begin to reverse the incidence of malaria and other major diseases

Goal 7: Ensure environmental sustainability

- Integrate the principles of sustainable development into country policies and programmes; reverse loss of environmental resources
- Reduce by half the proportion of people without sustainable access to safe drinking

water

- Achieve significant improvement in lives of at least 100 million slum dwellers, by 2020

Goal 8: Develop a global partnership for development

- Develop further an open trading and financial system that is rule-based, predictable and non-discriminatory, includes a commitment to good governance, development and poverty reduction – nationally and internationally
- Address the least developed countries' special needs. This include tariff-and quota-free access for their exports; enhanced debt relief for heavily indebted poor countries; cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction
- Address the special needs of landlocked and small island developing States
- Deal comprehensively with developing countries' debt problems through national and international measures to make debt sustainable in the long term
- In cooperation with the developing countries, develop decent and productive work for youth
- In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries
- In cooperation with the private sector, make available the benefits of new technologies – especially information and communications technologies

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The goals were subdivided into 18 measures and 48 indicators. Health is directly related to at least 18 of these indicators, whose 1990 values should be improved (WHO, 2005).

The conclusions of WHO's recently conducted evaluation should inspire us into reflection and action:

- If the state of affairs observed in the last five years continue most poor countries of the world won't be able to meet the modest established goals of reducing infant mortality and mortality among under-fives. Moreover, the goals for the measles vaccine coverage of children under one year of age are also not going to be met.
- Maternal mortality is only being reduced in countries that already have low rates. In high-rate countries, rates have either stabilized or increased.
- A few indicators related to the offer of health services have improved more favorably. Those are: the proportion of women receiving care by trained professionals during labor; the use of insecticide-covered mosquito-nets in areas with a high prevalence of malaria; and the improvement of the coverage of assisted treatment to tuberculosis.

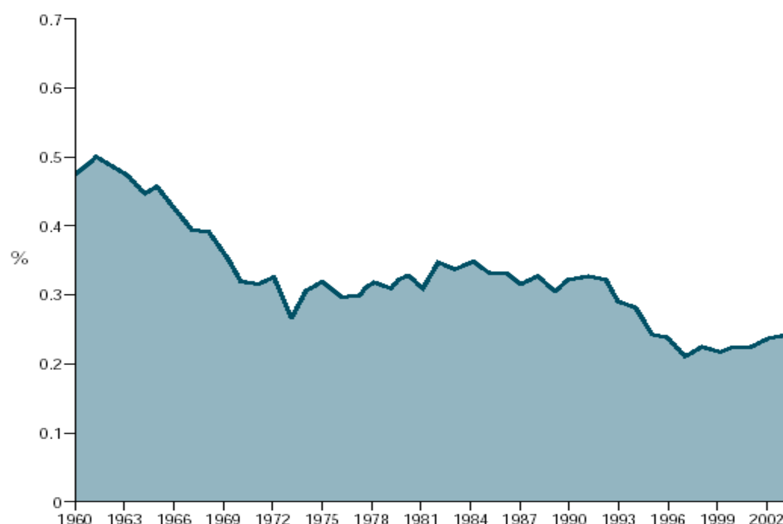
The first seven Goals include commitments that ought to be met primarily by the developing countries in order to gradually work towards providing universal access to minimum levels of wellbeing. Goal 8, which is to "develop a global partnership for development", encompasses both a series of developed countries commitments to support the efforts of developing countries and a number of elements intended to redress international asymmetries and thus benefit developing nations, including the official development assistance and a trade/financial system capable of providing viable workouts for debt overhangs.

Richer countries established that they needed to invest 0.7% of their national income in aid in order to attain the Millennium Goals. However, the percentage of internal wealth that richer countries send to poorer countries was halved in the last 40 years, going from 0.48% between 1960-1965 to 0.24% today (OXFAM, 2004).

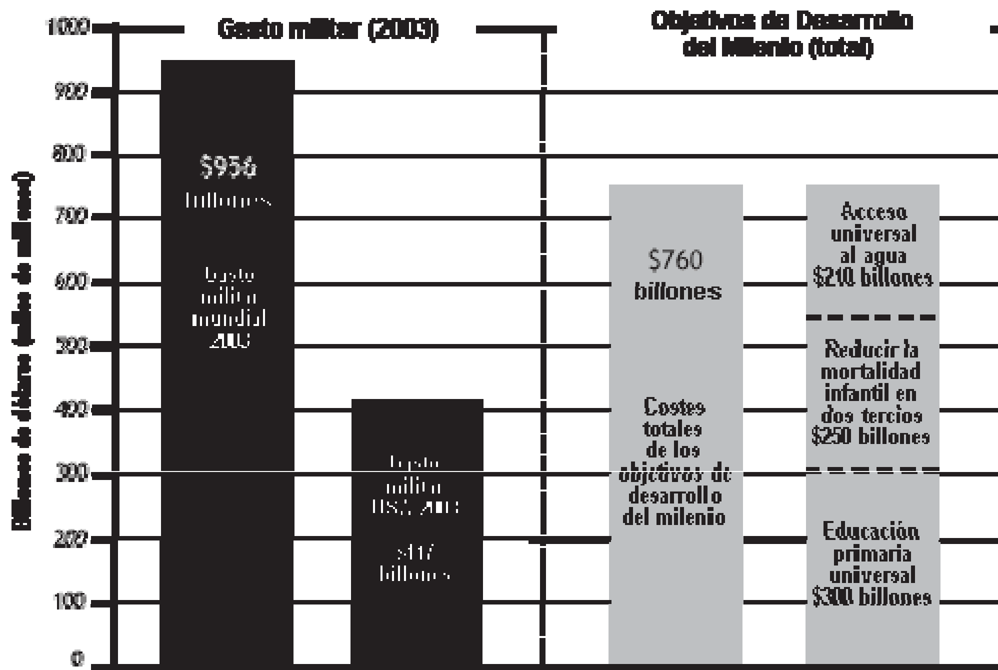
Therefore, it is clear that any contemporary national or international struggle will be related to the increase in external help from developed countries, at least to the amount agreed in the Millennium Development Goals. These modest goals would be achieved in case richer countries invested USD 80 per person per year in aid programs. It should be mentioned that this aid is equivalent to about 1/5 of the rich countries' defense budgets or half of what they spend in agricultural subsidies.

Figure 4: Governments spend less than ever on aid

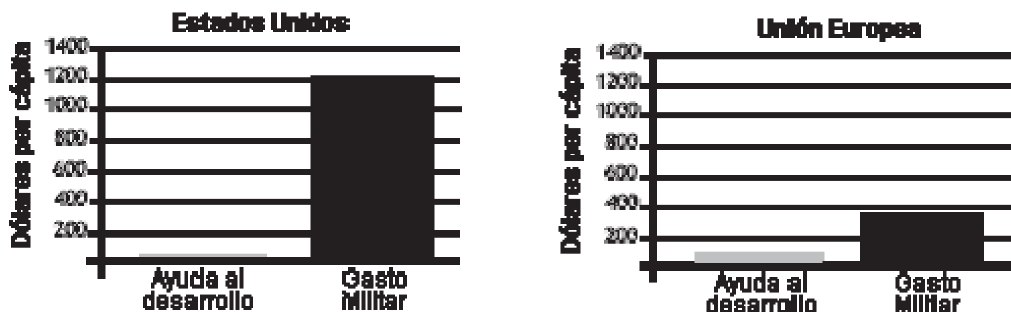
Net ODA as percentage of GNI 1960-2003, OECD countries



A propósito, a comparação entre gastos militares e ajuda oficial para o desenvolvimento é chocante, conforme nos mostram os Economistas por la Paz y la Seguridad (2006). O gasto militar no mundo, em 2003, foi de USD 956 bilhões, dos quais apenas os Estados Unidos gastou USD 417 bilhões. Para alcançar plenamente os objetivos de desenvolvimento do milênio seria necessário gastar não mais do que USD 760 bilhões nos próximos 10 anos, menos portanto do que o mundo gasta com armas em apenas 1 ano.



O gasto militar per capita nos Estados Unidos foi de USD 1,217.00 enquanto não passou de USD 46.00 para ajuda externa, dos quais apenas 23% para os mais necessitados. Ou seja, para cada 25 dólares de gasto militar americano apenas 1 dólar é destinado à ajuda externa, do qual apenas 23 centavos para os mais necessitados. Na União Européia os gastos militares foram de USD 358.00 *per capita* para a defesa e USD 61.00 para a ajuda externa. Stiglitz and Bilmes, economy professors respectively at Columbia and Harvard universities have presented a study with an estimate of USD 1 trillion expenditure for the Iraq War alone (Folha On Line, 10/01/2006).



The Commission on Macroeconomics and Health, created by the WHO in the year two thousand, emphasizes that investments in health – that expand the coverage of essential health services among the world's poor through a relatively small number of specific interventions – are fundamental for promoting economic development, reduce poverty and promote world security (WHO, 2001).

One very successful example of the good opportunities brought along by globalization is the effort being made toward child immunization in the poorest countries of the world, which is being put forward by the Global Alliance for Vaccines and Immunization (GAVI), an alliance between the World Bank, WHO, UNICEF, developed countries, private foundations (such as the most generous of them, the Bill and Melinda Gates Foundation) and other partners. GAVI has created a Vaccine Fund that supports basic immunization (DTP + polio), and the use of vaccines against hepatitis type B and Hib in 70 countries with a *per capita* GDP under USD 1,000. Six million children already received the DTP and polio vaccines (GAVI, 2005). However, at this point, I have to mention Ilona Kickbusch's protest in her 2004 Leavell Lecture, in which she said she thought it was outrageous for the global health governance that the world national governments would allow charitable institutions, such as the Gates Foundations, to have more resources allocated for health than the United Nations' own health organization, the WHO.

One recent and successful example of international mobilization (and also of its potential global impact in health promotion concerning non-communicable diseases and risk factors) is the Framework Convention on Tobacco Control, adopted in May 2005 in the 56th World Health Assembly. In September 2005, the New York Presidential Summit analyzed and adopted 32 proposals for international treatises. (WHO, 2005).

One of the most daring propositions regarding equity and eradication of poverty is to assure a minimum income to all people in a given country, a measure which is today being called *citizen's income* or *existence income*. (Suplicy, 2004). Renowned economists, politicians and institutions, such as of Keynes, Tobin, Friedman, Galbraith and Moynihan and the Basic Income European Network, under the leadership of Van Parijs, have defended this proposition (Suplicy, 2004). Just so as the idea does not seem just a theoretical formulation or a mere utopia, it should be mentioned that, in various moments of the 20th century, after the 30's, countries such as Denmark, the United Kingdom, Germany, Netherlands, Belgium, Ireland, Luxembourg, France, Portugal and several provinces in Spain have established more or less comprehensive citizen's income programs, with very positive results (Paugam [1998] *apud* Suplicy, 2004).

A similar proposition is being developed in Brazil and could stimulate both Brazil and other countries to perform concrete actions against poverty. It may be, therefore, as Amartya Sen (1999) said, used as a means of "overcoming economic freedom deprivation, which leads to the loss of social liberty".

There is already a way to control the circulation of speculative capital: taxing non-productive short-term international financial transactions (the so-called hot money) to create a world fund to finance global priorities (basic human and environmental needs) such as global warming, poverty, hunger and health. This fund could reach figures between USD 100 and 300 billion. A global initiative has been organized and seeks support from all citizens of the world in order to be implemented. It needs first to be approved in national parliaments and then

implemented by multilateral cooperation or by the United Nations. The tax is called "Tobin Tax" after Nobel Prize winner James Tobin of Yale University, who first introduced the idea (Tobin Tax Initiative, 2005).

The 59th World Health Assembly analyzed the Report of the Commission on Intellectual Property Rights, Innovation and Public Health and, after exhausting discussions, approved Brazil's and Kenya's proposal of preparing a mid and long-term plan for increasing resources destined to the research on health problems that affect the poorer unequally and for analyzing intellectual property rights for drugs and other input products used in tackling these problems.

In 2005, the WHO created the Global Commission on Social Determinants of Health seeking to devise evidence-based recommendations that inform the decision-making process on policies and global and national instruments to act upon the fundamental health determinants, which are essentially social (OMS, 2005a). In Brazil, the president has created a counterpart which I'm honored to coordinate (CNDSS, 2006). I have great expectations as to the accomplishments of this Commission, whose report will be analyzed in one of the next World Health Assemblies. This should produce a pact between countries to tackle such health determinants both globally and within each country.

There are a multitude of different initiatives around the world such as the ones previously mentioned. These initiatives have different attributes and focus on different aspects, in order to reduce poverty in the world, specific regions or countries or also to diminish the poverty of specific population groups such as women, children, elderly, etc. They also confront specific health-related situations or problems – such as hunger, malaria, Aids, other neglected diseases and so on. As public heath professionals, we are responsible for identifying these initiatives and give them support both globally and locally.

There is not, however, only one way to change the equation globalization ► poverty and exclusion ► worse health conditions into globalization ► equity and inclusion ► health. The only thing we can be sure of is that global solutions should be interconnected with national and local initiatives that are specifically oriented to confronting concrete expressions of globalization, poverty and the health-disease situation. E com este compromisso e esta luta, tenho a certeza que o mundo pode contar com a comunidade mundial de trabalhadores da saúde pública de todo o mundo e com a ação decidida da Federação Mundial e da Abrasco.

Como presidente eleito da Federação Mundial de Associações de Saúde Pública, comprometo-me a lutar e convido a todos os sanitaristas do mundo que se unam nesta luta contra a globalização injusta, a pobreza e a exclusão, contra a corrida armamentista e a violência, por um meio ambiente sustentável, pela eqüidade na saúde, pela paz e solidariedade entre todos os povos do mundo, para que alcancemos melhores condições de saúde e qualidade de vida não num futuro distante, mas hoje, aqui e agora!

Muito obrigado!

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