World Federation of the Catholic
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Associations de Médecins Catholiques

A Just and Ethical Response to the Impact of Globalization on Healthcare

Rev. Dr. Stephen Fernandes

INTRODUCTION

Globalization is a gift with unlimited potential for both good and harm. When it is based on social justice, globalization can contribute to the economic liberation of the non-industrialized world. But when human dignity, human rights and justice are ignored, globalization may further widen the enormous chasm between the world of privilege and the world of poverty.[1] Globalization is a process that is changing the nature of human interaction across many spheres, particularly those of politics and institutions, economics and trade, social and cultural life, and the environment and technology.[2] It is changing the temporal, spatial and conceptual boundaries that separate individuals in society. Today, it indicates a shift from a world economy based on national market economies to a borderless global market economy. This shift to a new aggressive, competitive global economic order is the result of a global economic policy of liberalization, a global financial system, and a transnational production system, based on a homogenized worldwide law of value.[3] The free flow of trade and money around the world has brought economic growth for the fortunate in the largest and strongest economies but has also created widening gaps in wealth and health between, and within, countries. These polarizing forces have intensified in the past decade, creating a hundred million poor within the rich "core" in addition to the 1.3 billion people in the "periphery" who exist on $1 a day or less.[4] Hence, a global market economy requires a global ethic with just social conditions and in the service of humanity.

Can globalization, including its impact on health, help to eliminate world poverty? The World Bank estimates nearly half the 6 billion people in the world are poor and of these 1.1 billion people (one-sixth of humanity) live in extreme poverty.[5] Asia leads in numbers, but Africa has the largest proportion, namely, nearly half its population. In India itself, 250 million of its citizens live in dire poverty. More than 8 million people around the world die each year because they are too poor to stay alive.[6] The British Prime Minister in his introduction to a recent government White Paper said, that 'making globalization work for the world's poor is a moral and ethical imperative.[7] The fundamental question is whether we can develop a new global economy that is based on justice and respect for human life and human dignity. It is crucial to determine the impact of a country's trade, industries, academic and research resources on global health. Leaders of pharmaceutical and biotech industries are challenged to demonstrate their commitment to social justice by exploring creative ways of expanding the highly effective drug and development systems to adequately meet some of the needs of the world's poor who do not have the financial resources to access drugs.[8]

The question of justice in health care has become one of the most crucial issues in the area of biomedical ethics. There has been a longstanding tradition of understanding and concern for justice within the Catholic moral community, which has in recent times been given an impetus by the Second Vatican Ecumenical Council and the Encyclicals of the Popes.

Official Catholic teaching recognizes the right to medical care. In *Pacem in Terris*, Pope John XXIII affirmed "that every person has the right to life, to bodily integrity, and to the means which are necessary and suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care and finally the necessary social services".[9] In *Populorum Progressio*, Pope Paul VI reaffirmed this teaching.[10]

For centuries, health was chiefly a private matter, and each person took personal responsibility for it. There was no collective understanding of the need to have a general interest in the health of everyone, and so the poor were left to suffer in agony. In the last two centuries, with the growing awareness of the concept of human rights, the right to health care slowly established itself among the fundamental human rights. It is from this time onwards that *health care was linked to the dignity of the person* and his/her quality of life, irrespective of economic considerations.

In this paper, keeping in mind the impact of globalization, the ethical challenges of a just healthcare system are exposed along with a search for a correct response. Then a model healthcare system which considers the impact of globalization, is proposed. Only a global policy which has global ethics as its foundation, will lead to a more humane social order. But can such a global social order which bind the global markets within the ethical and political framework of a global policy be achieved at all? The discussion concludes with the appeal to each one of us to demonstrate compassion and love to all those in need of health care.

2.0. HUMAN DIGNITY AS FOUNDATION OF THE RIGHT TO HEALTH CARE

Today, our conception of health gives rise to numerous demanding issues of justice. The foundation of the right to health care depends upon two main factors. The first issue addresses the persons for whom health care justice must be ensured. Do persons who are sick and suffering have a right to health care? On what basis can health care be considered as a basic human right? The second issue focuses upon a framework for decision making. On what foundation or basis can one make *decisions* in a just way about matters pertaining to health care?

The preamble of the WHO Constitution holds the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions. The concept of a right to health care as a human right emphasizes social and ethical aspects of health care as these aspects are embodied in principles underlying all international human rights.[11]

The very concept of rights stems from the inherent dignity of every human being. The use of rights language in connection with health emphasizes that the dignity of each person must be central in all aspects of health, including health care. The dignity of all must be respected, and in particular, the dignity of society's most vulnerable persons, the poor, the ethnic minorities, the disabled and the mentally challenged. At the heart of the *Ethical and Religious Directives*[12] is the recognition of the inviolable dignity of each and every human being. At the very beginning of the document, the *Directive* states that "Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of human life from the moment of conception until death". "The dignity of human life flows from creation in the image of God (Gen 1: 26), from the redemption by Jesus Christ (Eph 1:10; 1 Tim 2: 4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15: 42-57)".[13]

It is because of the Catholic Church's commitment to the inviolable dignity of each human being that she insists upon the right of all not to be denied access to health care, especially those who are weak and vulnerable.

3.0. ETHICAL CHALLENGES OF A JUST HEALTH CARE SYSTEM

In this section, we will focus on the burning ethical issues of health care that are likely to preoccupy biomedical ethics for the next decade. There is need to take note of the fact that health care as it has developed in the First World today is not even conceivable in developing countries like India and Bangladesh. In developing countries the government does not have sufficient funds reserved for health care. What it does have are primary health services which have their own problems and moral issues. Distributive justice, in order to be more affordable and accessible to the masses, cannot achieve its objective, unless one studies the following five parameters in health care: i) accessibility ii) efficiency iii) quality iv) equity and v) sustainability. Though these issues have to be understood from the perspective of both the First World and the developing World, the concerns of the developing countries will be highlighted.

3.1. Accessibility of Health Care: A Human Rights Issue

Access to health care must exist irrespective of the paying capacity of the individual. Often the access to health care is reasonable but the exorbitant user fee prevents the poor to use such services. Hence, the affordability or paying capacity of the individual should be taken into consideration in the calculation of the payments to be made for health care. One way to ensure this is through direct progressive taxation and charges. Another way to ensure a universal access healthcare system is to motivate every State to foster a rights based health policy and healthcare system. Right to healthcare is a fundamental social and economic right mandated by the International Covenant for Economic Social and Cultural Rights (ICESCR). In this era of globalization in which the global capital alliance grows tremendously, there is a need to respond to it

with a strong global labour alliance, so that the common citizens of this world are able to reclaim their human rights including health rights.

Globalization is persuading pharmaceutical, insurance and healthcare companies to make health services a tradable commodity. The World Trade Organization (WTO) through the General Agreement on Trade in Services (GATS) is creating extra pressure for the privatization of public services, especially healthcare. India has one of the most privatized healthcare systems in the world and the recent patent laws passed in India have put access to medicines and healthcare beyond the reach of the masses. The Journal of Health Affairs has indicated that illness and medical bills caused half (50.4%) of the 1,458,000 personal bankruptcies in India in 2001. Further, the study indicated that medical bankruptcies affects about two million Americans annually. Imagine the disaster it would have on developing countries in Asia which are aggressively pushing for unregulated privatization in healthcare.[14]

3.2. Global Financial Solidarity needed to improve Efficiency of Health Care:
The health care policy in a country has to focus on all the aspects of a person's well-being, and in particular the promotion of good health and preventive care. Good health is an important contributor to productivity and economic growth. In this regard, a health policy should aim for efficiency in its results. For every per capita income spent by the Government or private institutions on health care, what is the health improvement that is taking place for the concerned persons? One can measure efficiency by studying the life expectancy, the infant mortality, the control of communicable diseases, the improvements in water supply and sanitation, and the like.[15] However, it is not sufficient just to know the increase in life expectancy or decrease in infant mortality, but for every percent increase/decrease (or point percent increase/decrease), it is crucial to know how much money was spent and the extent to which the individuals who received the health care actually benefited.

Further, are there any ethical criteria to decide whether a certain percentage of a country's Gross National Product (GNP) is adequate or not for its expenditure on health care? Some argue that the amount of expenditure set aside for health care should be sufficient enough to assure the *basic minimum* for a dignified human existence.

Though cost-containment may not be taken as the fundamental and dominant norm to decide upon society's expenditure on health care,[16] some form of cost-containment policy, would morally justifiable under certain carefully defined conditions of economic necessity.[17] Thus, the social justice considerations of the wider community and the moral considerations of providing efficient care are to be taken into account by the fiscal authorities in making a budget for health care services. In other words, the decision of restricting financial support for health care should not be taken solely for political motives or be the result of the market-driven forces.

3.3. Accreditation Body needed to ensure Quality of Health Care:

In healthcare, quality provided decreases costly medical errors. Measuring quality efforts in healthcare is essential to the overall performance of any healthcare organization. Quality of care not only means well-defined standards and good practices but also satisfaction of the client. Some doctors practicing in the private sector are accused of prescribing excessive, expensive and risky medicines and of adhering to unjustified use of technology for diagnosis and treatment. Most people give their unquestioned trust to their physicians and the hospitals to which they go to for treatment. However, in the recent years there are a growing number of incidents that raise questions about the quality of care. For example, the cover of *Time* magazine on 22 January 1996 pictured a doctor with a gag in his mouth together with a nine-page cover story about a mother's fight to survive cancer when her HMO forbade her physicians to prescribe a course of treatment that was covered by insurance.[18] In 1996 a survey was conducted at L.M.T.G. Hospital (popularly called Sion Hospital) in Mumbai, with a view to improve the public health system.[19] A large number of the patients (71.4%) were from the city's slums, chawls or streets. The survey showed that 3.2% of the patients were not provided beds, 19.5% were not provided with linen and 16.3% were not given hospital clothing. Less than half the respondents approved of the hospital food. One of the startling findings of the survey was that fact that as many as 41.8% of the patients spent more on the daily expenses of hospital care than their entire household earnings in a day.[20] Medical expenses force the poor into a debt-trap, with poverty leading to illness and illness leading to further poverty. Can certain parameters be laid down to check the medical errors, infection rate in hospitals and other such factors so that quality care can be improved? Can an accreditation body access hospitals for compliance to standards, ensure proper patient care and assist in upgrading standards of hospitals?

3.4. Equity in Health Care: The Just Distribution of Healthcare Resources to All

Equity is an important consideration in the just distribution of health care. It is based on the principle of non-discrimination.[21] Unfortunately there exists gender biases and discrimination between the urban and rural population.

Women in developing countries are often in poor heath and overburdened with work. They are very tired, most are anemic, many suffer from malnutrition and parasitism and chronic ill health from lack of personal attention and adequate health care, especially during pregnancy and childbirth. Early marriage, repeated childbearing, ignorance, poverty and manual labour, all have deleterious effects.[22] It has been estimated that every sixth death of a female infant in India, Bangladesh and Pakistan is due to neglect and discrimination. In India alone this would amount to over 3,00,000 girls per year.[23] For example, in one region of India, girls were four times more likely to suffer from acute malnutrition and 40 times less likely to be taken to hospital.[24] In Bangladesh, the typical girl receives 20 percent fewer calories than her brother, is more likely to be malnourished and is likely to attend school for only one or two years. The school drop-out rate for girls is twice as high as that for boys.[25] There are of course other types of discrimination that

flow from the inferior status of women and have an influence on women's health. Education helps women to face life with confidence and be more involved in health care decisions. Educated women are more likely to stand up for themselves and their health needs.

The discrimination between the urban and rural population is yet another reason for a disparity in a just allocation of health care resources. In India, the rural people constitutes 75 percent of India, but resource allocation for health is only 25 percent.[26] A proliferation of medical equipment and technologies in urban areas has led to excess capacities and the consequent irrational use of these technologies. In developing countries, governmental health services are inaccessible to a big section of people, especially those living in rural areas. People are being forced to take recourse to private health services. These services, including the most basic medical care, especially in the backward and remote villages, are sparsely available; and if available, they are exploitative. Further, many private practitioners in the rural areas are not appropriately qualified. The emerging alternative is to provide immediate relief to those in need, through the development of rural community health projects. The success of these initiatives is very minimal since the resources available are limited and the root causes of the illnesses (such as malnutrition, lack of drinking water, inadequate sanitation and environmental degradation) are not tackled.[27]

The 1978 Alma Ata Declaration was the first international effort to mobilize global commitments to reduce inequalities in health status between and within countries. The declaration encouraged governments to strengthen primary health systems and assume responsibility for an acceptable level of health for their people.[28] In India, after the Alma Ata Declaration, saw the rapid expansion of rural primary health facilities. But despite these developments, governmental policy pronouncements and international resolutions, the wide gap in the health status of those in village and urban areas continue. Ill health means loss of daily wages or even loss of work. Chronic illness or hospital care may call for liquidation of assets or even pledging a child in dire cases. Between 1986 and 1996, those sick but not availing treatment for financial reasons increased from 15 percent to 24 percent in rural areas.[29] Evaluation reports of the department of rural development also indicate that health expenditure, particularly for hospital treatment, is the second major cause of rural indebtedness.[30] Such evidence indicates to us the nexus between ill health and deprivation, namely, that the poor become ill and illness makes them poorer.[31] Can an effective public policy that ensures access of health services in rural areas be designed and implemented? Some solutions could include the change in the attitude of the health care professionals to the rural people, public health policies and health budgets, the integration of a holistic approach to health care with modern medicine, adequate facilities and trained staff in rural areas, health education, and a search for an appropriate model for health care. A suggested model is given below.

Even in urban areas the picture is not rosy. The determinants of health in these areas include the extent of squatter settlements and slums, the availability of low-cost housing, the employment

situation, the purchasing power of those having low wages, the water supply and sanitation facilities[32], the communication and transport infrastructure, and the literacy level. The gap between the rich and the poor in developing countries is yet another cause for unjust distribution of health care. The poor spend a disproportionately higher percentage of their incomes on health services than the rich. On an average, 12 percent of income is spent by the poor on health care as against 2 percent by the rich.[33] The poor delay seeking treatment to avoid expenditure and nearly one-fifth do not avail of treatment for financial reasons. Borrowing and interest-bearing loans are important financial sources of health care for the poorest. One episode of hospitalization can wipe out family assets.[34] Last but not the least, environmental racism (the dumping of environmental wastes or governmental ignoring of pollution in areas inhabited by the poor) has been documented.[35]

Further, can expenditure of very huge amounts of money on procedures which benefit only a few people be justified when a minimum amount of care is not provided for others in society?[36] Other people whom we cannot name, suffer from similar problems and die, away from our attention. Such inequalities in the distribution of health care resources go against the principle of distributive justice.

3.5. The Sustainability of the Medical System:

Any health care system that wants to gain credibility must be sustainable over a period of time, at the local level, state level and even national level. A sustainable model is concerned with the demand for health care as well as its affordability in order to be viable.

3.5.1. Solidarity lacking in the Market Model

In the market model of health care delivery, the parties involved, namely, the doctors and the patients, measure and judge their own destinies independently of each other. Each of them buys and sells freely so as to gain maximum satisfaction for oneself. The efficiency or cost reduction which the market is said to achieve, is a value and social goal worth striving for.[37] A great drawback of this model occurs when poor persons lack adequate resources to buy health care in the market. The result is that this competitive model does not guarantee minimum standards of care.[38] Other factors such as scarcity of health care resources and inadequate information where patients hardly understand the quality or cost of alternative treatments, prevents people from making proper choices about the competing providers of health care.[39] This market model, is based on a fundamental individualism and on a political and cultural vacuum. It assumes that each individual has the necessary capacity to take care of himself or herself. But the sick and injured are not in a position to do this.[40] Besides, the common good is not the goal of the shared social concern by the members of society. The market model cannot ensure sustainability in developing countries. Since the poor cannot afford to buy sufficient health care, the government should provide for health services and other security schemes which are essential to patch up the defects in the market model.

3.5.2. Primary Health Services Reaches Out to the Marginalized:

Developing countries like India do not have a self-sustaining model of health care. Even in the recent budget, less than 1 percent of the GDP was kept aside for health care. Primary Health Services is suggested as an alternative model of health care in developing countries such as India, the challenge is to provide adequate health services to all is an almost impossible task. Any attempt to eradicate ill-health should be pursued side-by-side with the mutually supportive objectives of eliminating hunger, poverty, inequality and ignorance, and against a backdrop of socio-economic transformation which will give effective power to the poor and underprivileged groups to demand for their basic rights.

This model of providing primary health services is based or rooted in the community. It goes beyond the curative aspects of health and integrates promotive, preventive and curative aspects. It gives up the overemphasis which the present system places on large urban hospitals and creates small community hospitals or health centers in villages. Here, community participation in the community health programmes is encouraged. Further, home based domiciliary care where community health workers pick up early uncomplicated signs and symptoms, and treats them with basic essential drugs, is now gaining much acceptance. This reduces the need for rarely available doctors and nurses and also reduces hospitalization costs. The challenge lies to educate community health workers to run more of domiciliary based care. Today, in a situation of rising population and difficulty to control diseases, the only probable solution to improve the health scenario is to involve the community in providing health care. Here, the key is community participation where people work in partnership with those who are able to assist them, identify their problems and needs, and take responsibility for concrete action.

3.6. The Global Commercial Interest in Health Care:

The health crisis faced by the developing world is one of the greatest human tragedies of our time. Six million people a year die from epidemics of diseases such as TB, AIDS, and
malaria, and very many do not have access to even the most basic healthcare. This is primarily an economic issue and must be tackled from a global perspective. Large parts of the populations of developing countries often do not have access to food and clean water, let alone quality healthcare. Widespread corruption, lack of governmental spending, substandard and counterfeit medicines produced by the pharmaceutical companies make poor health endemic for the world's poorest people. Most of the 1.2 million qualified doctors in India gravitate towards private practice. The crème gets absorbed in high-tech hospitals, leaving the public health sector to the lower rungs. Some doctors payback their medical school fees from the earnings squeezed out from patients within a few years of their careers. Besides, very often the financial incentives of the doctors are aligned with the financial interests of the pharmaceutical companies. One really questions whether the medical treatment is done in the best interest of the patients. In this regard, UN Secretary-General Kofi Annan has called for a large-scale mobilization of resources in order to reach out to developing countries.[41]

3.6.1 The Role of Pharmaceutical Companies – Profit Maximization or Service?

Pharmaceutical industries are called to play a crucial role in providing effective health care. But one wonders whether they are attempting to reduce healthcare costs and/or seeking to improve the quality of the drugs manufactured? For example, there is a huge explosion of drugs in the Indian market, with over 60,000 formulations. Some of these drugs are banned in India itself but continue to be marketed even after getting a stay order from the courts. Since legal proceedings take a number of years, and so doctors continue to prescribe them. Some of the drugs are banned in other countries but continue to be used in the Indian market. There are also some drugs in the market which are spurious or of sub-standard quality. The Government takes a long time to test samples of drugs and declare whether they are substandard or not. Drug testing (for FDA approval) should be limited to public institutions that have no financial stake in them. Many of the health claims made on the advertising material of pharmaceuticals has absolutely no basis in scientific fact.[42] There is also an effort by pharmaceutical companies to minimize any discussion on *disease prevention* and rather focus on *disease symptom* treatment.[43] The cost of prescription medications too is rising mainly due to the large amounts of time and money that drug manufacturers spend in competitive research and development to produce new drugs or develop redundant drugs. Though some of the costs are recovered through Government grants, the rest of burden falls on the consumer. One also hears sad stories of how drug manufacturers cease to produce certain medication that are useful in poor countries where little profit can be made.[44] Thus, it appears that pharmaceutical companies are far more interested in generating profits than actually improving human health.

3.6.2. The Glivec Case in India: Wither Distributive Justice

The astronomical rise in the price of Glivec, the blood cancer drug[45], began when the Indian Patent Officer granted the exclusive marketing rights (EMR)[46] to Novartis A.G., a multinational based in Switzerland. The EMR which is the first such granted in the country, gave Novartis the right to be the only company that could produce and market the drug in India. Of the 24,000 people afflicted by the leukaemia every year, 18,000 succumb to the disease, mainly because they cannot afford to buy even the generic drugs. Novartis began enforcing the EMR and began restraining companies such as Cipla, Ranbaxy and Sun from manufacturing, selling, distributing or exporting the drug. Now, once these generic manufacturers stopped producing Glivec, the price of the drug rose form from approximately Rs 10,000 (equivalent to US $ 200) for a month's requirement to around Rs 1,20,000 (equivalent to US $ 2,400).[47] The Glivec case is seen as an example of what is to come, viz., the dangers of a product patent regime. Is there a way out so that the poor can have the drug at an affordable price?

4.0. The Yeshasvini Health Scheme: A Healthcare Model for Developing Countries

The classic rural scenario is an Indian farmer who needs Rupees Five Thousand (that is, One Hundred Ten U.S. Dollars) for an operation. As a logical step, he would approach a village money lender who would charge him an exorbitant rate of interest. Once in a debt trap, he would under-

go physical and emotional harassment from the moneylender. Hence, there are so many suicides among farmers. Health experts, both in India and the world over had unanimously agreed that the main problem in villages was due to the lack of quality hospitals, quality doctors and medical equipment.

However, the research findings of the Narayana Hrudayalaya Foundation, Bangalore and the Asia Heart Foundation, Kolkata correlated with the observations made by Dr. Amartya Sen[48], namely, that the root cause of the massive health care problem that India faced was not the lack of infrastructure but the lack of the paying capacity of the working class and the poor. It was this startling discovery that gave birth to the Yeshasvini Health Scheme. It began with a health care scheme for the rural masses of Karnataka, enabling them to have quality healthcare for a nominal amount of Rupees Five (that is, eleven cents) per month. The programme began to become a successful venture of the Co-operative Department of the Government of Karnataka, India. It provided over 1.7 million farmers and their families with quality health care, including costs of critical operations.[49] The Yeshasvini Health Scheme entirely depended on numbers to keep it afloat. Working around the axiom that it costs Rs. 10,000 for a life saving operation, the Yeshasvini Health Scheme was open to a large number of people because, among the 1.7 million members only a few thousand members are usually the ones with diseases. The other members are generally healthy members who pay for the treatment of the rest of the diseased members. In the first 7 months of its launch, 5,000 farmers underwent various types of operations and 23,500 farmers had out-patient medical consultation, entirely free for just Rupees Five (that is, eleven cents) per month. That is the amazing power of a self-funding health scheme in action.

The requirements which led to the success of the Yeshasvini self-funding health Scheme were[50]:

1) A minimum of 10 lakh members.
2) The members should have come together for some other reason than healthcare, like a co-operative society, a teachers association, a grameen bank or the like.
3) A monthly premium of Rs. 10-15 should be collected for the whole year and deposited before the launch of the scheme. If the membership fees were to be collected on a monthly basis, the logistics would amount to more than the actual cost of the premium.
4) The premium must be deposited in the account of the charitable trust that will be the regulatory body for implementing the scheme, and a third party administrator should be given the responsibility of managing the scheme, on a day-to-day basis.
5) Recognized hospitals should offer comprehensive packages for the operation, which will be paid by the Yeshasvini Health Scheme. Patients should be exempted from additional charges if he/she develops complications that requires additional stay and treatment. The hospital should not directly charge the patient, irrespective of the duration of stay in the hospital.
6) Yeshasvini is successful primarily because of benevolence of the recognized hospitals

Can such a model or scheme be proposed for the developing countries?

5.0. CONCLUSION: GLOBALIZATION CALLS FOR A GLOBAL ETHIC IN HEALTHCARE

A health care system which neglects the poor, impoverishes the social order of which we are constituted. Sixty four years ago Henry Sigerist claimed that "the chief cause of disease is poverty".[51] Research on the relationship between race, class, poverty, and health consistently shows the same pattern.[52] Providing medical treatment to the poor is at the heart of the Catholic mission in health care. Health care that reaches out to the marginalized is an expression of social solidarity. The question of social justice in health care is: Are we willing to care for the needs of the downtrodden of society? Financial access to medical care is becoming a benefit only to the healthy and the economically advantaged. Many middle-class and all poor families are not in a position to afford health insurance. Thus, the challenge today is to make health care available to all those socially disadvantaged who need it.

There is an increasing need today to provide social action programmes to provide health care for the poor. Medical schools are to be encouraged to establish programmes in their hospitals to focus both on caring for the poor and at the same time education the medical students. To keep all these programmes functional, the medical schools and hospitals could be aided by public funding from institutions such as Medicare and Mediaid. For example, the students of St. John's Medical College, Bangalore, India, are encouraged to work in needy rural areas after the completion of their training to be doctors. It has started a rural service system built into the admission of the medical students called the "rural bond". All the MBBS students execute a bond to serve in a medically underserved area for at least two years after they complete their training. Our Catholic doctors can be instruments of promoting the values of respect for life, medical ethics, effective communication, and understanding the dynamics of rural family life.

When there are limited resources for the number of patients who require them, how should the selection be made? Could the criteria of age, contribution to society or merit be used as the basis for selecting some and rejecting others? A just procedure would be to i) Decide on medical grounds as to those most likely to benefit from the procedure and ii) Select from this group, randomly or by lot, those who are to be treated.

The unfettered market ideology commodifies and commercializes human life and everything it touches –without moral underpinnings, without human values and without humane intentions and aspirations. The process of globalization should embrace a spirit of global compassion and solidarity for suffering humans in order to achieve the common good of all. Only a sound global ethic which focuses not only on economic imperatives but also on justice and social responsibilities will give globalization a human face. We must be ready to say NO to the many disvalues of a globalized economy and work for a better and more human living. There can be no global peace without global justice in healthcare.

ENDNOTES

[1] Nary Gordon, Poverty, Globalization and Healthcare, 01 February 2000.

[2] The Nuffield Trust in 'Global Health: A Local Issue'' policy review on 31 January 2000. See www.nuffieldtrust.org.uk/health2/global.htm

[3] M. Ould-Mey, Global Adjustment: Implications for Peripheral States, *Third World Quarterly*, 15:2, 1994.

[4] United Nations Development Programme. *Human development report*. New York, Oxford: Oxford University Press, 1997:9, 116

[5] World Bank defines extreme poverty as living on an income of less than one U.S. dollar a day.

[6] Jeffrey D. Sachs, How to End Poverty in Time, 14 March 2005, pp. 31-40.

[7] *Eliminating world poverty: making globalization work for the poor.* London, Stationery Office, 2000 (*White Paper on International Development, Cm 5006).*

[8] Nary Gordon, ibid. The current drug development model is designed to meet the needs of the privileged few of the global population who can afford to purchase these drugs.

[9] John XXIII, Encyclical Letter, *Pacem in Terris*, (Peace on Earth), 11 April 1963; AAS 55 (20 April 1963): 257-304. See no. 11.

[10] Paul VI, Encyclical Letter, *Populorum Progressio*, (On the Development of Peoples), 26 March 1967; AAS 59 (15 April 1967): 257-299. See nos. 6, 18, 22-23, 33.

[11] National Human Rights Commission in collaboration with Ministry of Health and Family Welfare, Government of India and WHO, South East Asia, "Regional Consultation on Public Health and Human Rights, New Delhi, 10, 11 April 2001, p. 118.

[12] National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, United States Catholic Conference, Washington D.C., 1995.

[13] National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Introduction to Part Two.

[14] Sujata Krishnamurthi, Right to Life: A Prerogative of the Wealthy? In The Human Rights Bi-Monthly, Vol. 4 Issue 4, November-December 2005, pp. 47-51.

[15] In India, life expectancy ahs gone up from 36 years in 1951 to 62 years in 1995. Infant mortality rate is down from 146 in 1951 to 71 in 1977. Crude birth rate has been reduced from 36.9 in 1970 to 26.1 in 1998. The Government of India claims that these gains have been due to the development of a rural health infrastructure with sub-centres for each 5,000 population, primary health centres for each 30,000 population and community health centres for each 1,00,000 population.

[16] See Victor Fuchs, *The Health Economy* (Cambridge: Harvard University Press, 1986), 356.

[17] Pellegrino, Rationing Health Care, 44.

[18] See Raymond G. Carey, *Improving Healthcare with Control Charts: Basic and Advanced SPC Methods and Case Studies*, ASQ Quality Press, Milwaukee, Wisconsin, 2002, p. xxvi. The *Chicago Tribune* printed a magazine insert in its Sunday edition with a story entitled, "When Doctors are a problem", alleging that about 5% of physicians, or about 31,000, have at some time put patients' health at risk. See B. Gavzer "When Doctors are the Problem", *Chicago Tribune*, 14 April 1996. The *New York Times* published a story about a little boy in a Houston hospital who died because the child received 0.9 milligrams of digoxin instead of 0.09 milligrams. The attending doctor missed the error in the amount of the drug, and no physician, nurse, pharmacist, or technician corrected it. See L. Belkin, "Who's to Blame? It's the Wrong Question", New York Times Magazine, 15 June 1997, sec. 6, 28-33.

[19] Centre for Enquiry into Health and Allied Themes (CEHAT), *Working Towards Right to Health and Health Care*, March 2001, p. 12-13.

[20] The average monthly household income was Rs 2,749 per month, and patients spent an average of Rs 2,533 before and Rs 1,555 after admission. This means that one-and –a –half times the monthly income of the entire household had been spent on medicines, investigations and doctors' fees.

[21] Equality of non-discrimination is a fundamental principle of human rights law, and prohibition of discrimination is a motif running through all of international human rights law.

[22] Patricia Smyke, *Women and Health*, Zed Books, London, 1991, p. 8.

[23] Sundari Ravindran, "Health Implications of Sex Discrimination in Childhood", World Health Organization/ UNICEF document, WHO/UNICEF/FHE86, 2, 1986, p. 12.

[24] *Women and Environment*, prepared and compiled by Annabel Rodda, forthcoming volume in the Women and World Development Series, UN/NGO Group on Women and Development, London, Zed Books.

[25] UNICEF, *Annual Report* 1989, p. 27.

[26] S.K. Subramanian, "Maternal Health for All" in *Religion and Society*, CISRS Publications Trust, Bangalore, Vol. 48, no. 4 (December 2003), p. 40

[27] CEHAT, *op.cit.*, p. 38-39.

[28] II and V of the Declaration of Alma Ata, 1978. The Alma Ata Conference recommended Primary Health Care (PHC), which aims at making health services accessible to all sections of society, with special attention to the needy and vulnerable. This approach places people's health in people's hands. It defined primary health care as follows: "Primary health care is essential care made universally acceptable to individuals and acceptable to them through their full participation and at a cost the community and country can afford".

[29] Savrekhshana, Government of India (GOI), March 2000.

[30] The other major factor of inequity in developing countries is societal prejudices. In India, for example, the Scheduled Caste/Scheduled Tribes (SC/ST) serve as an indicator for inequity. These people, because they belong to the SC/ST category, are often marginalized and thus face double the burden of social exclusion and poverty. (Various articles in the Indian Constitution provide for special protection to be extended to SC/ST, particularly in matters of education and employment).

[31] Rajiv Misra, Rachel Chatterjee and Sujatha Rao, *Indian Health Report*, Oxford University Press, New Delhi, 2003, 46.

[32] In Bombay, ? ths of the families live in a room or share a room with another family. Such a situation demands that attention be given to provision of water and sanitation

[33] NCAER Study of HDI, 2000.

[34] Misra, Chatterjee and Rao, *op.cit.,* 49.

[35] National Human Rights Commission, *op.cit.*, 120.

[36] In Illinois, Amy Hardin's family and friends raised $ 265,000 from private resources to pay for her liver transplant. See David Wessel, "Transplants Increase and So Do Disputes Over Who Pays Bills" in *The Wall Street Journal*, Vol. 73 (12 April 1984), 1, 24. In Florida, Billy Bostick received half a million dollars through the largesse of a Saudi Arabian prince to pay for a new heart and lungs. See *Raleigh News and Observer,* 13 June 1985.

[37] However, according to Daniel Callahan and others, "Despite the politically inspired, and not implausible, belief that competition among providers would reduce costs, it seems instead to have raised them". See Daniel Callaghan, *Setting Limits: Medical Goals in an Ageing Society* (New York: Simon and Schuster, 1987), p. 125.

[38] Brian Johnstone, *Justice*: *Lecture Notes for Students*, Accademia Alfonsiana, Rome, 1995, p. 21-22.

[39] Stanley Joel Reiser and Michael Anba, eds., *The Machine at the Bedside: Strategies for Using Technology in Patient Care*, (London: Cambridge University Press, 1984), p. 136,

[40] Joe Holland and Peter Henriot, *Social Analysis: Linking Faith and Justice*, (Washington: Orbis Books and The Center of Concern, 1980), p. 137.

[41] UN Secretary-General Kofi Annan has said: "The pharmaceutical industry is playing a crucial role to expand access to health in poor countries. However, the solution does not lie with the pharmaceutical companies alone. I am calling for a major mobilization of political will and significant additional funding to enable a dramatic leap forward in prevention, education, care and treatment".

[42] In a study carried out by the Institute for Evidence-Based Medicine in Germany, it was found that 94% of the information contained contained in the promotional literature sent to doctors by the pharmaceutical companies is either distorted or exaggerated. For example, the study quotes that treatment effects are exaggerated, study results are suppressed, and risks are manipulated. Many effects of the drugs are actually dawn from animal studies rather than human studies, even though the drugs are intended for human consumption. See Chris Gupta, The Medical Mafia Rules in *The British Medical Journal* 2004;328:485 (28 February), doi:10.1136/bmj.328.7438.485-a.

[43] In other words, *poor nutrition* and stale food leads directly to pharmaceutical industry profits. If you find a way to be extremely healthy, it does not create profits for anybody except you. In fact, if you used to be sickly and diseased and changed your lifestyle, and have consequently started consuming *optimum nutrition*, the pharmaceutical industry is losing a customer.

[44] An example is the drug melarsoprol, much needed in some African countries for the treatment of sleeping sickness, but out of production because it is not needed elsewhere and not profitable to the manufacturer. Cf. Donald G McNeil, "Drug Makers and the Third World: A Case Study in Neglect" in *The New York Times*, 21 May 2000.

[45] This anti-cancer drug is composed of the beta-crystalline form of the compound imatinib mesylate and is sold under the brand name Glivec, Imanib, Imalek, Temsab and Zoleta. The drug is used to treat people suffering from chronic myeloid leukemia (CML), a life-threatening form of cancer.

[46] The EMR was given to Novartis for a period of five years or until an order was passed on the patent claim in India, whichever was earlier.

[47] The generic version of the drug cost about Rs 90 (equivalent to US $ 2) per 100 mg capsule, and if four capsules are taken, it would cost Rs 360 (equivalent to US $ 8) a day. After Novartis got the EMR, the price of Glivec rose to Rs 1,000 (equivalent to US $ 20) per 100 mg capsule.

[48] Amartya Sen, *Poverty and Famines* (Oxford: Clarendon Press, 1981). Economist Amartya Sen won the Nobel Prize for this work. In it, he opined that the cause of the Bengal famine was not the shortage of food, but the lack of paying capacity among the rural masses.

[49] The scheme covered approximately 1,700 different types of operations which included critical operations of the stomach, gall bladder, bones, eyes, uterus, brain and heart at a nominal Rupees Five (eleven cents) per month. These operations would be conducted free of cost. The only exception would be the price of heart valves which are required in very few patients.

[50] See http://www.hrudayalaya.com

[51] Henry Siegerist, "Social Medicine" in *The Yale Review* 27, no. 3 (Spring 1938): 462-481; reprinted in *Moral Problems in Medicine*, ed. Samuel Gorowitz, et al. (Engelwood Cliffs, NJ: Prentice Hall, 1976), 468.

[52] Churchill, *ibid.*, 85.