Globalization and Global Health

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ABSTRACT

Globalization shrinks the world. The world watches on television people dying of hunger or in extreme poverty conditions. Every year, 8 million children die before they reach the age of 5 from preventable diseases. “Exotic illnesses” cease to be so exotic, they can cross borders easily. Ebola, originally an African worry, in 2014 was an international threat. The revolution in information technologies enables us to witness the emergence of transnational epistemic communities exhibiting, measuring and explaining health and disease. Presently, the authors are more aware than ever of the health problems of people from far away countries, which decades ago were unknown and distant. The transparency and availability of this information exhibits, in a quasi-obscene way, an unacceptable world. A world that is willing to rescue banks and ignores the worst off – those people whose unlucky birth seals a never ending cycle of misery with almost no possibility of breaking it. This paper address the situation just described by asking: Are these new empiric circumstances reflected in the authors’ moral understanding of the issues? How should the world think of global health and their obligations towards people living in deprivation? How can the new empiric possibilities the global world offers be related to the implementation of such obligations? What are some of the challenges to the translation of new obligations to the present world? In addressing these questions, the paper argues that if the world seriously wants to address the obligations towards those in need, even if they are far away from the places they may need to work not only with ideal proposals such as the “new obligations” pointed by Singer and Pogge, but also with different transitional theories and non-ideal strategies in order to solve some of the big challenges the real world impose to theories.

Keywords: Globalization, Ideal, Illness, Poverty, Strategy Sick, Transitional, Vulnerable

INTRODUCTION

Globalization shrinks the world. We watch on television people dying of hunger or in extreme poverty conditions. Every year, 8 million children die before they reach the age of 5 from preventable diseases. “Exotic illnesses” cease to be so exotic, they can cross borders easily. Ebola, originally an African worry, in 2014 was an international threat. The revolution in information technologies enables us to witness the emergence of transnational epistemic communities exhibiting, measuring and explaining health and disease. Presently, we are more aware than ever of the health problems of people from far away countries, which decades ago were unknown and distant. The transparency and availability of this information exhibits, in a quasi-obscene way, an unacceptable world. A world that is willing to rescue banks and ignores the worst off – those people whose unlucky birth seals a never ending cycle of misery with almost no possibility of breaking it.

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This unfair and unequal picture of the world is a background we cannot deny. However globalization also offers another face: helping each other is easier than it was a century ago, for example, just a click in our laptop or tablet and we can send money to the other side of the world. In addition, there is an international architecture of human rights and international organizations as well as several non-governmental organizations (NGOs) that function globally and can make a difference for these populations. Are these new circumstances reflected in our moral understanding of the issues? How should we think of global health and our obligations towards people living in deprivation? How can the new empiric possibilities the global world offers be related to the implementation of such obligations? What are some of the challenges to the translation of new obligations to the present world?

In this paper I will work with the individual and institutional models represented by Peter Singer and Thomas Pogge. These philosophers come from different conceptual backgrounds, but they are both concerned with the global situation and poverty. They redefine our obligations to the global poor and its health. I will only sketch some of their main arguments because in the rest of the article. I will explore how to face a major challenge which is the difficulty of complying with those “new” obligations. I will use non-ideal strategies as a possible resource.

TRADITIONAL, INDIVIDUAL AND INSTITUTIONAL ARGUMENTS

As noted in the introduction, one problem is posed by the situation of poor people that die from preventable diseases and lack of access to health care, as children or women that die because of unsafe conditions at childbirth. And another situation is the one presented, by the risks entailed by certain transmissible illnesses (Ebola, swine fever, TB). They affect poor people but can also be a threat for other populations.

Different arguments can be given for one or the other case. Regarding poverty and global health the traditional view considers that alleviating poverty belongs to the realm of beneficence, to our feelings and our heart. It is an act of charity. Poor people are in an unfortunate situation but this is not unjust. They merit our sympathy and these nice feelings lead to charity or beneficence. The assumption is that we are not obliged to reduce extreme poverty. Thus, if there is a moral problem here it is our lack of generosity but not the violation of any moral principle or moral duty.

Regarding the second situation, globalization instead may lead to another argument besides charity. We should help these populations in order to prevent these illnesses from impacting other parts of the world (that is, can impact us). The rationale behind it is self-interest. We want to avoid that our countries “import” such threats. Not only self-interest is not even a moral principle - it is the rationale for actions done by convenience; but also if we follow this argument we will be committed to address only certain illness (mainly those that are transmissible and can cross borders) and not necessarily the most important threats to poor populations.

This second argument does not actually address global health; on the other hand, just appealing to charity is completely subjective. As previously said it depends on our good feelings, there are no moral requirements. The charitable may be praised but those who are not charitable are not condemned. Are there other ways of addressing the problem of global health? Can we think our obligations in this “shrinking world” where we are all interconnected with more stringent moral categories?

Certainly. There are other positions that provide another perspective to the problem. We can think of new obligations from at least two perspectives: an individual and an institutional one. From a consequencalist and individual perspective Peter Singer was one of the first philosophers to point out the shame of global poverty and our obligations towards the poor. In 1972 he wrote a remarkable article “Famine,