

Pandemics In The Age Of Globalization And Lessons For Low Income: A Focus On The Coronavirus Pandemic

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Abstract: The challenges of pandemics have been a recurring one in human history as it has posed a threat to continued human existence. Yet as a result of human resilience man has always had to improvise and overcome these challenges as individuals and more so as collectives. Globalization has been a very strong force particularly in the 21st century and has gone on to shape the way people interact and in this case manage outbreaks of global pandemics such as the coronavirus pandemic. The paper focuses on the dynamics and intricacies underlying the impact or effect of global pandemic in the era of heightened globalism and interaction between low income economies and developed societies. It aims to underscore how health sectors in low income countries have fared in the face of the crisis amidst globalization. It finds that these countries are truly better off developing domestic policies and strengthen their respective institutions. It recommends amongst others that countries should look inwards and find solutions to such threats and by so doing the global community can become more fortified.

Keywords: Pandemic, Age of Globalization, Lessons for Low Income Economies

I. INTRODUCTION

For millennia epidemics and pandemics of varying degrees have threatened the annihilation of the human species and our collective existence, through the Grace of the Almighty, our sheered resilience and instinctive collectivism we have been able to overcome these threats. The implication of this therefore is that collectivism, multilateralism and globalism are not only tools in the propagation of achieving shared economic prosperity but also of attaining global security in the face of threats such as rising health concerns in cases of global pandemics.

Globalization could refer to the phenomenon of shrinking world economies and its component sectors into smaller spheres by removing or subduing trade barriers in a bid to allow for ease of flow or movement of person, goods and services and knowledge. It could also be seen as a process whereby national and international policy drafters and governments advance the course of domestic deregulation and

external liberalization. This trend known as globalization became even more widespread with the domestication of policies of liberalization, deregulation and privatization within domestic and local territories, which in force led to the acquisitions across borders by multinational firms.

This trend or phenomenon of globalization has had significant impact in virtually all facets of life, from economic to social and even political systems. It has undoubtedly had a complex influence on health sectors across national boundaries particularly in the face of global pandemics. An Understanding of the nexus between globalization and health will no doubt require an in-depth reconciliation of the correlation and mediating effect of income growth and distribution, economic instability largely created by income inequality or a huge gap in wealth distribution – be it at the domestic level or within the international system – the availability or otherwise of health facilities and other social services, and other related factors such as stress and access to basic health care.

This paper therefore attempts to underscore the existing concerns of the impact globalization has on healthcare particularly in times of pandemic and to draw submissions on whether concepts such as multilateralism, intergovernmentalism and collectivism can be galvanized in the face of a global pandemics such as the Covid19, or that the fate of globalization will be left hanging in the balance and sovereign entities left to fend for themselves in the face of a global crisis.

II. GLOBALIZATION AND HEALTH

Globalization as stated earlier should have a direct bearing on health, this relationship as stressed above is often more than not complex in nature and its effect on one another we did say is mediated by some factors which should inter alia; income growth and distribution and the availability of health infrastructure albeit, it is arguable that if globalization is indeed meant to achieve the mandate of interconnectedness then these issues should resolve themselves in the face of ease of movement of goods, services, people and technology across borders. It therefore means that going by the conceptual intent of globalization, health infrastructure development and the human capacity to man them should be spatially distributed across board from developed climes to low income countries, in a bid to mitigate unforeseen cross border threats such as an outbreak of a global pandemic like the case of Covid 19.

However this is not the case. Health status in most cases today is affected by the initial conditions of each reforming country. i.e. the size and specialization of its economy, the availability and distribution of assets, it's human capital and infrastructure, and the quality of its domestic policies. This therefore leads us to submit that globalization can only in fact present actual health benefits where systems have been made efficient and effective by local governments, which then circles back to the question of; why then the need for globalization where local authorities are meant to develop proper infrastructure for it to sufficiently thrive? The above argument is made in light of the fact that it has been observed that global market forces for example works efficiently only in settings where domestic markets are competitive and non-exclusionary, where regulatory institutions are strong, asset concentration is moderate, access to efficient public health service is widespread, social safety nets are in place, and rules of access to global markets are non-exclusionary, Cornia (2001). This argument tries to portray a scenario where it is only under the above 'conditions' that globalization can thrive and hence where these conditions are set globalization therefore tends to play its role of reducing opportunistic behaviour, reward efforts and entrepreneurship, captures economies of scale in production, increases employment opportunities and improves welfare by raising earnings and also reduces the prices of consumer goods. The argument here therefore is that an expanding, symmetrical and 'non-discriminatory' global market can help to incorporate into the world economy only those developing nations that have created for themselves sound human and physical infrastructures but possess narrow domestic markets. The benefits of such a global market to them will also mean that it

can facilitate the spread of North to South transfer of investment, health and other technologies and knowledge. In essence, those developing countries that have not sufficiently created a system that is efficient and where all of the above qualities are lacking will have limited benefits if at all any from the globalization process which in the view of the paper seems selective and discriminatory and opposed to the very ideal which the globalization proponents advocate.

In the views of the pro-globalization school of thought; those countries that have been able to meet the domestic conditions which they term as opening up which in turn allows them access international markets at unlimited pace, the argument is that these economies have been able to manage a judicious mix of unorthodox domestic policies on the one hand and globalization on the other hand. The end result of this is that it has contributed tremendously to rapid growth, a rise in living standards and gains in health status of the country. In respect to the above postulations the examples of China, India, Costa Rica and Vietnam and most of the Asian Tiger countries have stood out distinguished, Cornia (2001). One is rather perplexed and amused that countries in this bracket could be identified as a product or achievement of globalization and even so particularly by western philosophers. The argument goes further down the prism that in several of the developing economies growth has been stalled and improvements of their health sectors; personnel and infrastructure have been stunted by premature, unselective and poorly sequenced 'globalization'.

III. GLOBALIZATION AND PANDEMIC: LESSONS FOR LOW INCOME ECONOMIES

The elimination of import tariffs and export taxes is famous for the reduction in revenue. Furthermore, in a world of mobile capital and immobile labour, developing countries that wish to attract foreign capital always end up in downward bidding and in times of health crisis such as the covid19 pandemic are left alone and constrained. This above situation driven by globalization often leads to a reduction in the rates and progressivity of income tax, the concession of tax holidays, and the granting of various industrial subsidies in low income economies. In addition, globalization leads to the informalization of the economy through outsourcing and subcontracting of everything including health infrastructure by large corporations. Most hospitals, for example, relies on a cascading chain of over 10 000 micro-subcontractors for hospital consumables. This renders revenue collection more difficult. Employment in microenterprises, especially in the informal sector, has increased at high rates in developing countries over the last 20 years. The proportion of this type of employment in the nine largest Latin American countries reached in the early-mid 1990s 58%, and the corresponding values for sub-Saharan Africa, North Africa and Asia were 74%, 43%, and 62%, respectively (Sainz & Young; 2000).

There is little evidence that tax competition leads to an increase in capital inflows which invariably has an effect on the health sector. However, there may be more evidence that it affects revenue levels and the ensuing ability of the state to provide a modicum of health services and social security.

Evidence on this matter from specific countries is, however, scarce. The world development indicators of the World Bank revealed that public spending on health in low-income countries remained constant and constrained (1.12% of GDP in 1990 and 1.13% in 1996), while that on education dropped from 3.43% to 3.25% over the same period. In contrast, the situation in middle-income countries showed a clear improvement for education and a modest one for health. The picture varies substantially between regions. In the liberalizing economies in transition, of which the Russian Federation is a good example, public health expenditure has fallen both as a share of a rapidly shrinking GDP and in per capita terms. There are other examples of drops in public health expenditure (e.g. China) but there are as many others in which it has been sustained, for instance in some countries of Latin America.

Globalization also has an effect on health status through the impact of international trade agreements such as TRIPS (trade-related aspects of intellectual property rights). TRIPS is part of the 1994 World Trade Agreement, which, on the face of it, makes access to essential life-saving drugs impossible for low income countries, regardless of their level of public health expenditure. Indeed, trade expansion is dominated by international rules that provide protection for 20 years to new discoveries. This restricts the possibility of producing or importing essential drugs. In addition, even in the cases in which TRIPS allows parallel imports of cheap generic drugs, trade pressures by the large countries where the major pharmaceutical companies are based limits access to affordable drug imports (Wilson et al: 1999). The case of HIV/AIDS drugs is an example of distortions in the international norms being partly responsible for delaying the fight against this lethal disease in many poor countries. Conscious of the risks involved in new trade agreements such as TRIPS, the World Health Assembly in May 1999 mandated WHO to monitor the health consequences of international trade agreements. This is the same case as with the covid19 pandemic, as low income countries are seen to be on the verge of losing substantial amount of lives as a result of lack in health consumables that are required to manage the pandemic outbreak.

IV. HEALTH IMPACT OF GLOBALIZATION AND THE FATE OF LOW INCOME ECONOMIES

With slow growth and frequent rises in inequality, health improvements during the era of deregulation and globalization decelerated perceptibly, especially during the 1990s. In many parts of Africa and countries of the former Soviet Union there was total stagnation or a sharp regression. The infant mortality rate, a key indicator of overall health in developing countries, fell more slowly over the period 1960–98 than in previous decades, despite the massive increase in the coverage of low-cost, lifesaving public health programmes (vaccination coverage rose from an average of 25% to 70% between 1980 and the end of the 1990s) and the spread of knowledge about health, nutrition, and hygiene among parents. More detailed national data often portray a worse health picture than that indicated in this paper, which is mainly based on estimates of some time ago by the United Nations Population Division.

UNICEF data for the European economies in transition show, for example, that in 15 countries the infant mortality rate was higher in 1994 than in 1990. In sub-Saharan Africa as a whole the 1999 mortality rate for children aged less than 5 years was higher than in 1990. In countries affected by large external shocks, sudden and large declines in household income have contributed to subtler but equally pernicious health outcomes. World Bank studies of the impact of the Mexican and Thai financial crises show that, even after the economies of these two countries recovered, health status was still affected. During the transitory but acute recessions, children were taken away from their schools, entered hazardous jobs or prostitution rings, or sustained permanent brain damage if they suffered from acute malnutrition. Especially in middle-income economies, acute and sudden economic crises, the ensuing sharp rise in unexpected unemployment, and job insecurity and income inequality have been major sources of depression and other mental disorders, alcoholism, domestic violence and stress-related deaths attributable to cardiovascular and violent causes and suicides (Marmot & Bobak; 2000). Large increases in inequality erode social cohesion, the control of deviant health behaviour and criminal activity, and mutual help among community members (Kawachi, Kennedy & Wilkinson; 1999). In turn, sudden and lasting increases in unemployment generate a loss of skills, cognitive abilities and motivation, and can be a source of acute stress by causing loss of self-respect, feelings of being unwanted, dependent and without a social role, and anxiety about the future (Sen, 1997).

These effects have been observed on a massive scale in the countries of the former Soviet Union, where a policy-induced sharp rise in unemployment and income inequality have reduced the ability of the state to tax the new elites and to provide law and order and a modicum of health care. The entire above scenario is very prevalent in today's low income economies where the struggle to subdue the current covid19 pandemic is very acute and has posed significant challenges to national governments. In the age of globalization and liberalization countries in low income bracket should be taken care of by the global community but just as with the above scenarios health infrastructure are faced with tremendous challenges and crisis.

A considerable psychological burden is placed on people disadvantaged in the transitioning economies; these are the people who constitute an underclass of mostly urban-based, middle-aged male workers, collective farmers and party cadres with limited education and skills, often unemployed, from broken families and migrant or ethnic minority backgrounds. The material deprivation of these people are exacerbated by the rage, humiliation, and hopelessness triggered by growing social segmentation and the perception that the new elites benefiting from liberalization have reached their positions through corruption and ascription.

The health impacts of these events are unprecedented. The idea of globalization is therefore not as rosy as it appears on face value. It therefore should be taken with a pinch of salt in comparison to the need for national sovereign governments to improve their health care facilities and infrastructures so as to shield their citizens in times of pandemic and outbreaks such as the covid19 pandemic.

V. CONCLUDING REMARKS

No doubt benefit have been derived from an expansion of global markets, international savings and technology transfers in a limited number of countries (mostly in Asia, particularly China) it must also be noted that all these are made possible only because of favourable domestic conditions in terms of human development and physical infrastructure, prudent macroeconomic policies, and selective, home-grown external policies. For example, China (Province of Taiwan) and the Republic of Korea, which achieved remarkable improvements in health status, integrated into the world economy through a mixture of outward orientation and unorthodox policies such as high levels of tariff and non-tariff barriers, public ownership of large segments of banking, patent and copyright infringements, and restrictions on foreign capital flows. The new wave of successful reformers, such as in China and Viet Nam, also improved living standards and health conditions by following a highly unorthodox two-track economic strategy, violating practically every prescription of the orthodox model. India, which has significantly raised its growth rate and life expectancy since the 1980s, remains one of the most protected economies. For most of the remaining countries, many of them in Africa and Latin America, globalization has not yet lived up to its promises, because of a combination of weak domestic structures and the persistence or even an expansion of global asymmetries for market access, such as protectionism in OECD countries, global financial crises, an unequal distribution of foreign direct investments and an endless list of new conditions on governance, patents legislation, veterinary norms, social clauses, etc. In these countries the last two decades have been characterized by a slower, unstable and increasingly unequal pattern of growth, and by a slowdown or stagnation in health gains despite the widespread expansion of highly efficient public health schemes, e.g. vaccination programmes and this example is very much present in the current crisis of covid19 where economies are struggling with sufficient PPE's for health workers and ventilators for patients.

What should developing countries do in the future? A return to outright autarky is certainly not the answer, but neither is unconditional and immediate globalization. The countries that have been excluded from the benefits of the global market undoubtedly have a genuine interest in strengthening their human resource bases, infrastructures and

macroeconomic balance. These measures, per se, can be expected to generate high health returns and to accelerate domestic growth. It is equally clear that, for many countries, some components of globalization, such as trade liberalization and technology transfer, could, in principle, increase efficiency, welfare and health. Yet it is doubtful whether, under the present increasingly restrictive rules of access to the international market, further liberalization and globalization would help these countries to improve their market position, economic efficiency and health status. Premature, rapid and unconditional globalization in these countries could be expected to immediately generate considerable costs in efficiency and social affairs that would worsen growth performance and health outcomes and erode the necessary political support for opening up to the world economy. Particularly for these countries, a gradual and selective integration into the world economy, linked to the removal of the major asymmetries of global markets and to the creation of new democratic institutions of global governance, is highly preferable to instant globalization.

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