THE JEFFREY SACHS PROJECT

Environment, Poverty and Healthcare on a Global Scale: What Can One Person Do?

A Student Dialogue

February 26, 2003

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The Echo Foundation offers these resource materials and collections of essays as an inspiration to you who share the next generation. We challenge you to search each day for opportunities to weave lessons of compassion, respect for all people and ethical decision making into every subject area; to teach children not to be indifferent to the suffering of others and to take a stand for justice; to believe in themselves, that they too have the power to make a difference…indeed, that is their moral obligation to do so.

Stephanie G. Ansaldo
President

The Jeffrey Sachs Education Project

Environment, Poverty, and Healthcare on a Global Scale: What Can One Person Do?

"This country is now so rich, and has so many rich parteners in Europe and Asia, that we wouldn't have to do much, relative to our income, to accomplish an enormous amount of good. How many more tragedies willwe suffer in this country before we wake up to our capacity to help make the world a safer and more prosperous place, not only through military might but through the gift of life itself?"

– Jeffrey Sachs, *The Washington Post*, 2001

Foreword

Sustainable development is a concept that emerged two decades ago to encourage solutions for global problems such as human rights violations, environmental degradation, and economic injustice. It is a topic that warrants study, discussion, and introduction to the national conscience. Sustainable development provides for community economic development while preserving the environment throughout our country, we are obliged to promote effective stewardship of the resources in our environment.

The AIDS epidemic is crippling nations, especially in Africa, Lack of awareness and resources creates a perpetual cycle of embittering conditions. It is time that we stand up and do our part to address the scourge. Millions of lives can be saved by giving proper attention and funding to the effective treatments now available.

Poverty levels in developing countries are astonishing. Many countries are poor not only in economic terms, but also in the areas of health and technology. Disease and lack of opportunities exacerbate the already dire economic situation facing many in the world. Affluent countries need to provide technological as well as financial support so those developing countries may empower themselves without our assistance in the future.

Jeffrey Sachs, Director of the Earth Institute at Columbia University, is well versed in all of these areas. Dr. Sachs has served as economic advisor to a number of countries, and was Chairperson of the Commission on Macroeconomics and Health of the World Health Organization during 200-2001. He was a featured participant at the World Summit on Sustainable Development (WSSD) held in Johannesburg, South Africa from August 26 to Spetember 4, 2002. Dr. Sachs and the Earth Institute at Columbia University are making a real difference in our awareness of critical global concerns. With great hopes for the future of our world, we can faithfully place confidence in leaders like Jeffrey Sachs who can steer us from the darkness that we could enter as a civilization, into the light of a new era of responsible living.

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The Jeffrey Sachs Project:

Environment, Poverty and Healthcare on a Global Scale: What Can One Person Do?

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Prof. Jeffrey D. Sachs

Director, Earth Institute at Columbia University
Professor of Sustainable Development
Special Advisor to UN Secretary General Kofi Annan

Biographical Information

Jeffrey D. Sachs is the Director of The Earth Institute and Professor of Sustainable Development at Columbia University and a Research Associate of the National Bureau of Economic Research. He was formerly Director of the Center for International Development (CID) and Harvard Institute for International Development (HIID), and the Galen L. Stone Professor of International Trade at Harvard University. In January 2002 Professor Sachs was appointed by Secretary General Kofi Annan as his Special Advisor on the Millennium Development Goals. During 2000-2001, he was Chairman of the Commission on Macroeconomics and Health of the World Health Organization, and from September 1999 through March 2000 he served as a member of the International Financial Institutions Advisory Commission established by the U.S. Congress. Sachs serves as an economic advisor to governments in Latin America, Eastern Europe, the Former Soviet Union, Asia and Africa. He also serves as Co-Chairman of the Advisory Board of The Global Competitiveness Report, and has been a consultant to the IMF, the World Bank, the OECD, and the United Nations Development Program. In February 2002 Nature Medicine stated that Sachs "has revitalized public health thinking since he brought his financial mind to it." He was cited in The New York Times Magazine as "probably the most important economist in the world" and in the December 1994 Time Magazine issue on 50 promising young leaders as "the world's best-known economist." In 1997, the French magazine Le Nouvel Observateur named Professor Sachs as one of the world's 50 most important leaders on globalization. His syndicated newspaper column appears in more than 50 countries around the world, and he is a frequent contributor to major publications such as the New York Times, the Financial Times of London, and the Economist Magazine.

Sachs is the recipient of many awards and honors, including membership in the American Academy of Arts and Sciences, Harvard Society of Fellows, and the Fellows of the World Econometric Society. He is a member of the Brookings Panel of Economists, the Board of Advisors of the Chinese Economists Society, and several other organizations. He received Honorary Degrees from St. Gallen University in Switzerland in 1990, the Universidad del Pacifico in Peru in 1997, Lingnan College of Hong Kong in 1998, Varna Economics University in Bulgaria, and Iona College of New York in May 2000. Professor Sachs has delivered the Lionel Robbins Memorial Lectures at the London School of Economics, the John Hicks Lectures at Oxford University, the David Horowitz Lectures in Tel Aviv, the Panglaykim Lectures in Jakarta, the Okun Lectures at Yale and many other distinguished lecture series. In September 1991 he was honored with the Frank E. Seidman Award in Political Economy, and in June of 2000 he received the Bernhard Harms Prize in Kiel, Germany.

During 1986-1990, Sachs was an advisor to the President of Bolivia, and in that capacity helped to design and implement a stabilization program which reduced Bolivia's inflation rate from 40,000 percent per year to the current rate of 10 percent per year. Sachs is also one of the architects of Bolivia's debt buyback program of 1988, which was the first case of a debt reduction program in the 1980s, and which successfully cut Bolivia's commercial bank debt by

half. The Bolivian buyback became an import milestone in resolving the developing country debt crisis. During 1988-90, Sachs also advised the Governments of Argentina, Brazil, Ecuador, and Venezuela on various aspects of financial reform.

In 1989, Sachs advised Poland's Solidarity movement on economic reforms, and at the request of the Solidarity leadership, prepared a draft program of radical economic transformation. After August 1989, he advised Poland's first post-communist government on the introduction of radical economic reforms in 1990 and 1991. In January 1999, Sachs received the Commanders Cross of the Order of Merit of the Republic of Poland, a high Polish national honor bestowed by the President of the Republic of Poland.

From the Fall of 1991 through January 1994, Sachs led a team of economic advisors for Russian President Boris Yeltsin on issues of macroeconomic stabilization, privatization, market liberalization, and international financial relations. He founded a non-governmental research unit, the Institute for Economic Analysis, in Moscow.

In 1991, Sachs advised the Slovene Government on the introduction of a new national currency, and in 1992, advised the Estonian government on the introduction of a new national currency. In both cases, the successful monetary reform enabled these countries to end a hyperinflation and reestablish monetary stability. During 1991-93, he also advised the Mongolian Government on macroeconomic reforms and privatization.

In 1990, Sachs met with Pope John Paul II as a member of a group of economists invited to confer with the Pontifical Council on Justice and Peace in advance of the Papal Encyclical Centesimus Annus. They met again in 1999 in Sachs' capacity as the Economic Advisor to the Jubilee 2000 movement.

In January 1998, Sachs was the first foreigner in the 43-year history of Japan's Liberal Democratic Party to be asked to deliver a keynote address at the LDP national convention.

Sachs' research interests include the links of health and development, economic geography, globalization, transition to market economies in Eastern Europe and the former Soviet Union, international financial markets, international macroeconomic policy coordination, emerging markets, economic development and growth, global competitiveness, and macroeconomic policies in developing and developed countries. In 1987 and 1988, Sachs directed a large-scale research project at the NBER on the international debt crisis, which is published under Sachs' editorship in a four-volume series, Developing Country Debt and the Economic Performance, University of Chicago Press, 1989. From 1990-92 he directed a project on economic reform in the Soviet Republics and in Eastern Europe for the United Nations University, World Institute for Development Economics Research (WIDER), in Helsinki, Finland. He is now directing a major research program on global public health and economic development as Chairman of the WHO Commission on Macroeconomics and Health.

Sachs has published more than two hundred scholarly articles, and has authored or edited many books. His NBER volume, Economics of Worldwide Stagflation, co-authored with Michael Bruno, was published in 1985, and his books Global Linkages: Macroeconomic Interdependence and Cooperation in the World Economy, co-authored with Warwick McKibbin, and Peru's Path to Recovery, co-authored with Carlos Paredes, were published by The Brookings Institution in

1991. Sachs' textbook on Macroeconomics in the Global Economy, co-authored with Felipe Larrain, was first published in 1993, and has appeared in German, Spanish, Russian, Chinese, Japanese and Portuguese. His account of Poland's reforms, Poland's Jump to the Market Economy, was published in Fall 1993 by MIT Press. In 1994, the two volumes on The Transition in Eastern Europe, co-edited with Olivier Blanchard and Kenneth Froot, were published by the National Bureau of Economic Research and The University of Chicago Press. In 1995, Sachs published, with the BBC, a Russian-language book on Russia and the Market Economy. The John M. Olin Critical Issues Series on The Rule of Law and Economic Reform in Russia, which Sachs co-edited with Katharina Pistor, was published in Spring 1997 by Westview Press.

Sachs was born in Detroit, Michigan, in 1954. He received his B.A., summa cum laude, from Harvard College in 1976, and his M.A. and Ph.D. from Harvard University in 1978 and 1980 respectively. He joined the Harvard faculty as an Assistant Professor in 1980, and was promoted to Associate Professor in 1982 and Full Professor in 1983.

August 15, 2002

http://www.earthinstitute.columbia.edu/about/director/index.html

Newsweek

Fighting Poverty, Fighting Aids

Jeffrey Sachs, An Economist, Links Global Wealth To Global Health

DEC. 30, 2002
BY GEOFFREY COWLEY

Jeffrey Sachs is an economist, not an evangelist. But give the man 10 minutes behind a microphone, and a scholarly symposium starts to feel like a revival meeting. "Ladies and gentlemen," he tells a hushed hall after describing how AIDS sufferers die in Malawi for want of $1-a-day drugs, "this plague is *exploding*. Its consequences will make the world *quake*. Rich countries could *stop* the devastation. And most are still looking away."

Sachs is not the first to sound this alarm, but he speaks with special authority. As the newly appointed director of Columbia University's Earth Institute, he heads a huge interdisciplinary effort to help poor countries build sustainable economies. Sachs also chairs blue-ribbon panels for the World Health Organization, advises U.N. Secretary-General Kofi Annan on development issues and circles the globe pleading with policymakers to support the fledgling Global Fund to Fight AIDS, Tuberculosis and Malaria. In the coming year he'll work closely with Dr. Allan Rosenfield, the dean of Columbia's Mailman School of Public Health, to seed new treatment and prevention programs throughout Asia and Africa. He'll also help government ministers in China, India and other high-risk countries to improve overall health services.

From Sachs's perspective, controlling AIDS is not only a moral imperative but also a practical necessity. Disease is as much a *cause* as a consequence of poverty and political unrest, yet the world's richest countries now spend just $6 billion a year in health-related development assistance. A Sachs-led WHO commission concluded last year that by raising that commitment to $27 billion by 2007 and $38 billion by 2015, donor nations would save 8 million lives every year--while improving a third of the world's prospects for prosperity.

Will that dream come true? While pressing ahead with Middle East war plans that could cost $100 billion or more, the Bush administration pledged less than $1 billion last year to helping poor countries fight AIDS, TB and malaria. Sachs doesn't doubt that priorities will shift as the pandemic grows. The issue that worries him--and it's a big one--is how long the awakening will take.

Op-ed Article by Jeffery Sachs, March 2002

Blantyre, Malawi – The sight was shocking. Peering into the medical ward of Queen Elizabeth Hospital was like peering into a corner of hell. AIDS has overtaken the hospital.

Seventy [ercent of the medical-ward admissions are AIDS-related, but the hospital lacks the proper medications to treat the sick. So the patients come to die in ever increasing numbers, far beyond any capacity to manage.

Two to a bed; sometimes three to a bed. When the beds overflow, the next wave of the dying huddle on the floor under the beds, to stay out of the way of families, nurses, and doctors passing through the wards. The constant low-level moans and fixed gazes of emaciated faces fill the ward.

These patients are dying of poverty as much as they are dying of AIDS.

In the next corridor is an outpatient service that offers AIDS drugs. Four hundred or so patients are successfully being treated with antiretrovirals. They are the tiny fraction who can afford to pay approximately $1 per day out of pocket for the medicines.

The treatment has been successful. CIPLA, the Indian generics producer, supplies the drugs; the patients take them twice a day and they get better. No great complexity, no unusual complications of toxicity, no struggles to achieve patient adherence to the drug regimen, Just a doctor prescribing medicines, and his patients responding.

A few miles away, one sees the implications of the dying fields that Africa has become. A village in Malawi is like a great orphanage, in which a few elderly and wizened grandmothers look after the children of their dead and dying sons and daughters.

Enter a village and suddenly one is surrounded by dozens of children, a handful of elderly, and almost nobody of working age. On the day of our visit, it turns out, the few remaining men are off to a funeral. The grandmothers talk softly of their lost children as their orphaned grandchildren squat quietly nearby.

One grandmother shows us the rotting, bug-infested millet that she will use to make the gruel that keeps her and her wards barely alive. A beautiful young girl proudly tells us that she is in the second grade. She wants to go to college, says her grandma. To make it, she will have to beat forbidding the odds.

The rich world is an accomplice to the mass deaths in Africa. Why aren't U.S. leaders visiting hospitals, villages and health ministries in Africa to ensure the United States is doing all it can do to stop the deaths? Why aren't U.S. leaders talking to African doctors?

We are spending tens of billions of dollars to fight a war on terrorism that tragically claimed a few thousand American lives. Yet we are appending perhaps 1/100 of that in a war against AIDS that kills more than 5,000 Africans each day.

A report of the Commission on Macroeconomics and Health of the World Health Organization shows that a tiny share of rich-country income – one penny of every $10 of GNP – would translate into 8 million lives saved each year in the poor countries.

The rich world is running out of excuses. Every misconception we've heard about treating AIDS patients – that the drugs don't work in Africa, the patients wouldn't adhere to "complex" regimens, that the doctors aren't qualified or can't be trained – has been matched by similarly lazy misconceptions about foreign assistance.

We've been told that any aid would be wasted, that debt relief would be squandered by corruption. We've been told that it's not "cost-effective" to spend a tiny fraction of our own income to save millions a year, as if it's cost effective to let a generation die, to allow the collapse of Africa's tottering health care system, and to stand by as tens of millions of children are orphaned.

Debt-relief foes in Congress have warned that the benefits of debt cancellation would never reach the poor. We found the opposite. In each country that we visited on this trip – Malawi, Uganda, Ghana – the government is pursuing a meticulous and transparent process to ensure that budgetary savings from debt relief are actually channeled into urgent social sectors. The problem is not waste or corruption, the problem is that the extent of help from the U.S. and Europe is so meager in the face of the enormous crisis.

In a small room in Uganda, the intermingling of beauty and unnecessary suffering touched us more deeply than we could have ever imagined. A singing troupe of HIV-infected individuals, all likely to die in the next few years for lack of access to life-saving meds, sang to us with great power, charm and bravery of their struggles.

Rock star Bono, traveling with our group, reached for his guitar. With haunting beauty, he responded with his magnificent ballad, "I Still Haven't Found What I'm Looking For." The Ugandans swayed rhythmically to his pure and gripping tones. The tears flowed freely.

The U.S. complicity in Africa's mass suffering, unless reversed, will stain our country. Africa is the place where we will confront our own humanity, our morality, our purposes, as individuals and as a country.

Jeffery Sachs is director of the Center for International Development at Harvard University's Kennedy School of Government and chairman of the Commission on Macroeconomics and Health of the World Health Organization. Sonia Ehrlich Sachs is a pediatrician. This article first appeared in *The Boston Globe*. <SPAN style="FONT-

About the Earth Institute

The Earth Institute at Columbia University is the world's leading academic center for the integrated study of Earth, its environment, and society. The Earth Institute builds upon excellence in the core disciplines--earth sciences, biological sciences, engineering sciences, social sciences and health sciences--and stresses cross-disciplinary approaches to complex problems. Through it research training and global partnerships, it mobilizes science and technology to advance sustainable development, while placing special emphasis on the needs of the world's poor.

Examples of research conducted under the auspices of the Earth Institute include:

- The impact of climate variability and change on economic development, through focus on such issues as El Niño. Climate modelers and forecasters identify where El Niño's impacts are likely to be most severe, while others provide socio-economic analysis of potential impacts, and work with the international community to prepare for El Niño-related disasters.

- A four-city study on sustainable development: Focusing on Accra, Ghana; Fortaleza, Brazil; Chennai, India, and New York City, the Earth Institute and local partners study the intersection of environment and development to deepen understanding and to develop appropriate policy responses.

- Uses of science and technology to alleviate poverty and improve health. How existing knowledge and new research can be harnessed in support of the United Nations Millenium Development Goals to reduce poverty and improve health, especially for the world's poorest people. This research incorporates natural resource management, and improved agriculture coupled with preservation of biodiversity, and efficient health care delivery systems.

A Collaborative Forum for Teaching, Learning and Outreach

Columbia University's excellent core disciplines and basic research gain an added dimension from the mission and programs of the Earth Institute. The Earth Institute provides opportunities for cross-disciplinary learning for undergraduates and graduate students, as well as communicating its message to the international academic, governmental, and policy-making communities.

A number of new initiatives enable the Earth Institute to strengthen its educational mandate:

- A new Earth Institute Fellows program, attracting two or three of the most talented post-doctoral researchers in each of five core disciplinary areas: earth sciences, ecology, engineering, social science, and health science for two years of post-doctoral research and teaching.

- At the graduate level, while building more linkages with existing masters and doctoral degree programs, the Institute will develop a Ph.D. program in social sciences that focuses on sustainable development.

- On the undergraduate level, the Institute will expand awareness of issues surrounding sustainable development by mounting high profile seminars, lectures and other educational programs, and by offering undergraduates place-based research and learning opportunities.

In addition to these new initiatives, the Earth Institute at Columbia will continue its many education and outreach programs for professionals and the public, including training, curriculum development, web-based communications, and participation in conferences and other professional forums.

The Earth Institute Centers

The Earth Institute at Columbia includes several research and teaching centers, each contributing to the Institute's central mission:

Lamont-Doherty Earth Observatory, the leading research center in the world examining the planet from its core to its atmosphere, across every continent and every ocean. From global climate change to earthquakes, volcanoes, shrinking resources, environmental hazards, and beyond, LDEO scientists continue to provide the basic knowledge of earth systems that must inform the difficult choices needed to maintain the health and habitability of our planet. Within LDEO, some groups exist that encourage specialized interdisciplinary research, such as the Center for Hazards and Risk Research and the Rivers and Estuaries center.

Goddard Institute for Space Studies at Columbia University, the only urban laboratory of the National Aeronautic and Space Administration (NASA). GISS is a climate research center that models and monitors earth systems. In addition to research, GISS plays an important teaching function, running educational programs at more than twenty universities, schools, and organizations in the New York metropolitan area.

Biosphere 2 Center, The 250-acre Arizona center devoted to deepening understanding of earth systems vital to informed leadership of the planet. Its 3.5 acre, glass-enclosed, research laboratory allows systems-level research on the science of sustainability. Academic programs in earth systems for high school, undergraduate and graduate students as well as educational programs for 180,000 annual visitors and local school children, are part of the Center's continued commitment to public outreach and education.

Center for Environmental Research and Conservation, a consortium of five leading science and education institutions: Columbia University, the American Museum of Natural History, The New York Botanical Garden, the Wildlife Conservation Society, and Wildlife Trust. The Center employs a wide array of resources to train the next generation of environmental leaders charged with conserving Earth's biological diversity.

Earth Engineering Center includes about 20 engineering faculty members, in addition to specialists from several Columbia schools as well as other universities and environmental organizations. Part of the historic Henry Krumb School of Mines and closely linked to its new academic program in Earth and Environmental Engineering, the Center is uniquely equipped to meet the challenges of managing planetary resources in the 21st century.

International Research Institute for Climate Prediction aims to improve quality of life and environmental sustainability through the use of climate prediction science. From climate forecasting and modeling to fishery management, IRI researchers focus on where climate fluctuation and public policy intersect. Encouraging societies to make climate a routine part of regional planning and decision-making, the IRI collaborates with communities to better manage the challenges posed by climate fluctuation.

Center for International Earth Science Information Network creates distributed data and information resources, provides users with new types of interactive analysis and visualization capabilities, and conducts research about human interactions with the environment as well as about the management of data and information. By combining these activities in a single organization, CIESIN redefines what it means to be a data center in the information age.

Laboratory of Populations, a joint venture of Columbia University and The Rockefeller University in the City of New York that uses demography, epidemiology, ecology, statistics, and mathematical modeling to detect and measure the continual changes that occur in populations. The Laboratory studies continue to provide insight into population increase/decrease, the spread of diseases in households and communities, and the social structures that are essential to human health and well-being.

Center for Global Health and Economic Development, a collaboration between by the Mailman School of Public Health and The Earth Institute at Columbia University, mobilizes programs in health sciences to help poor countries address the burden of disease. This new, multi-disciplinary academic program will link researchers with field-based organizations to document successful strategies and pass the best practices to a new generation of global health leaders.

Center for Globalization and Sustainable Development focuses on the human dimensions of what is needed to bring the developing world more fully into the global community on a road toward sustainable development. Projects in developing countries range from encouraging competitiveness and private sector development to globalization and trade policies, children and education, natural disaster policy, and political conflict resolution.

The Columbia University/UNESCO Joint Program on Biosphere and Society, the first joint partnership between Columbia University and the United Nations, assists local communities around the globe in adapting to rapid environmental and societal change. The program also aims to promote sharing of information between societies facing similar challenges.

The Center for the Study of Science and Religion, an interdisciplinary, inter-school, collaborative forum for the examination of issues lying at the boundary of scientific and religious ways of comprehending the world. The center will help social scientists incorporate religious experiences and rituals in models or predictions of human behavior, and will have a particular focus on the science involved in social planning, scientific research policy, and strategies for the protecting the future of the planet.

The Center for Economy, Environment & Society integrates economic research with environmental and social sciences. The center is developing a Ph. D. program in environmental economics, and delving into research about topics such as the economics of climate change,

environmental risk management, the economic aspects of conservation, and the environmental and social responsibility of corporations.

In all it does, the Earth Institute at Columbia remains mindful of the staggering disparities between rich and poor nations and the tremendous impact that global-scale problems -- from the AIDS pandemic to climate change to extreme poverty in much of the developing world -- will have on all nations.

Says Director Jeffrey Sachs of the Institute's mandate: "Our generation has the tools to understand these massive problems and to mobilize our knowledge and resources -- and those of the generation we teach -- to create a life of shared prosperity and responsible environmental stewardship."

http://www.earth.columbia.edu/about/about.html

A Global Fund for the Fight Against AIDS

by Jeffrey Sachs
April 7, 2001
Reprinted from the Washington Post

AIDS has become the greatest killer epidemic in modern history, and it may be the worst ever by the time it comes under control. Yet, with effective treatments now available at low prices, and global attention as never before, we can actually fight the scourge and save millions of lives in the process. A few moments of thinking could change history.

The key step would be to add $1.5 billion to this year's budget targets for fighting AIDS in Africa, the epicenter of the disease. Sen. Bill Frist (R-Tenn.) has led a valiant effort this week to begin the process, sponsoring an amendment to the budget bill calling for $200 million more in fiscal year 2002 and $500 million the following year. This an important start but not yet enough.

The needed $1.5 billion should be deposited in a global trust fund with leadership of the World Health Organization and UNAIDS, with critical scientific support of the National Institutes of Health, Centers for Disease Control and other relevant organizations. The U.S. contribution would be augmented by $3 billion from donors in Europe and Japan. The path-breaking Gates and Rockefeller foundations are also committing support to the battle.

The money would be made available to finance increased AIDS prevention and treatment, especially anti-retroviral therapy, in the poorest and hardest-hit countries. A rough estimate is that $1.1 billion would go for treatment at the start and perhaps $3 billion for prevention and care of orphans created by them pandemic, as well as treatments other than anti-retrovirals. Another $400 million should be added for massive training and buildup of medical infrastructure.

In later years more people would come under treatment, and five years from now the total cost might rise to around $7.5 billion, with a U.S. share of perhaps $2.5 billion.

Americans would not shrink from the $5 per American that prevention and treatment would cost this year. Even if the price tag rose to $10 per American in future years, it would seem a small price to pay for keeping 5 million people alive.

Many Americans, of course, are skeptical about the effectiveness of foreign aid. Yet in the case of disease control, and AIDS treatment in particular, America's financial help would translate into dramatic, rapid and easily observable benefits. More than 100 of my colleagues at the Harvard Medical School and the School of Public Health this week spelled out how this can be accomplished according to sound scientific, medical and public health standards. Experts such as these in national agencies and academic centers would help to ensure the success of the global effort, as opposed to the amateurism that has sometimes characterized assistance programs.

The biggest risk is not coldheartedness on the part of the Bush administration or Congress but simple inattention as Congress and the president wrangle over our fiscal future. There is also a nagging but mistaken doubt in political circles that AIDS is just too big and costly to address. It's time for these doubts to be put to rest by the evidence.

http://www.ksg.harvard.edu/news/opeds/sachs_global_fund_aids_wp040701.htm

Survey Finds China's AIDS Awareness Is Lacking, Medicine Scarce in India, Conference Is Also Told

By David Brown Washington Post Staff Writer Tuesday, July 9, 2002; Page A02

BARCELONA, July 8 -- People in China know very little about AIDS, with nearly three-quarters unaware that the disease is caused by a virus or able to describe how they can avoid becoming infected, according to the first attempt to measure the country's knowledge about HIV. About one in six Chinese has never heard of the disease.

In India, the other sleeping giant in the AIDS pandemic, the number of infections with human immunodeficiency virus (HIV) has increased tenfold in a decade, with a huge share of cases found in rural, entirely monogamous women who have scarcely left their villages. In the meantime, almost no one on the subcontinent is receiving life-sustaining antiretroviral therapy, even though Indian manufacturers of generic drugs are rapidly becoming the suppliers of choice to the developing world.

That was among the gloomy news presented today as scientists and activists attending the 14th International AIDS Conference discussed the state of the epidemic in the world's two most populous countries.

In China, HIV infection was for years confined to relatively small numbers of intravenous drug users on the country's southern border with Burma. It recent years, cases have been found elsewhere, spread not only by drug use but also by prostitution and, in one region, by procedures that infected a large number of peasants selling their own blood for money. Countrywide, the number of cases increased from 600,000 in 2000 to 850,000 last year.

In December 2000, China's State Family Planning Commission conducted a survey of about 7,000 people between age 15 and 50 in seven counties chosen to represent all stages of economic development.

Seventeen percent of people had never heard of AIDS. (Among farmers, the country's most common occupation, the figure was about 25 percent.) About 90 percent said they knew AIDS could be transmitted from person to person, but 85 percent were unaware it could be passed from mother to child; 81 percent didn't know it could be acquired by sharing needles; and 52 percent didn't know it could be transmitted by unsafe blood transfusions. Slightly over 75 percent were unaware that proper use of condoms could prevent infection.

"There are cases [of AIDS] in every province in the country, but I think the level of knowledge we found shows that people don't know how to protect themselves," said Deborah Holtzman, a sociologist from the Centers for Disease Control and Prevention (CDC) who helped analyze the data with the Chinese researchers.

The survey also found that only 8 percent of people reported using condoms as the form of contraception in their most recent sexual encounter. (Sterilization was the most common method.) Condom use is the central strategy to prevent sexually transmitted HIV infection.

The State Family Planning Commission reaches into virtually every Chinese village and historically has been the chief enforcer of the one-child policy promulgated for much (although not all) of the country's population. Holtzman said it expressed keen interest in the survey results and plans now to add HIV/AIDS education to its mandate.

In India, about 4 million people are infected, up from 400,000 in 1990. The true size of the

epidemic, however, may be larger, said Salim J. Habayeb, who until recently was the World Bank's lead public health specialist for South Asia. (There are currently about 40 million people infected with the virus in the world.)

"The numbers are not important; the trend is important. We are very concerned, and the worst is yet to come," he said. "It may not increase by 10 times in the next decade, but it will multiply several-fold at least."

There are now about two men infected for every woman, although that gap is narrowing. Most infections occur in cities among men who sojourn there for work, returning periodically to their village homes, where their families reside. Consequently, about 70 percent of India's infected have rural roots. About 90 percent of India's HIV-infected women are monogamous, married and have had only one sex partner in their life -- their husband.

"We should not use the word 'victim,' " Habayeb said, noting with asperity that the word is now politically incorrect in AIDS activist circles. "But this is the perfect scenario of a victim."

Habayeb said about one-third of India's states have good HIV control programs, one-third marginally acceptable ones and one-third poor ones.

At a news conference, I.S. Gilada, a physician and chairman of an organization called AIDS in India, said that while the country first needs much better HIV education and counseling, "we question why are not more people treated by the generic drugs that are produced in India."

Two Indian generic drug manufacturers, Cipla and Ranbaxy, are now the source of the cheapest antiretroviral drugs available in the world. A triple combination using stavudine, lamivudine and nevirapine now costs about $350 a year for purchasers in Africa.

Ironically, the three-drug combination sells for more than $350 in India because excise, sales and municipal taxes total about 25 percent of the drugs' price. (The excise tax on the drugs was recently dropped by the government.) In addition, said a Ranbaxy representative at the conference, there is no bulk purchasing of antiretrovirals in India, which would ensure the lowest prices.

In the first round of awards by the Global Fund to Fight AIDS, Tuberculosis and Malaria made last spring based on the quality of applications from governments and organizations, India received no money to buy antiretroviral drugs. There are estimated to be only a few thousand people taking the medicines in the entire country.

QUESTIONS:

1. Why do you think most people in China know very little about AIDS?
2. How does the unawareness of the epidemic increase its effects?
3. How could increasing awareness influence positive outcomes?
4. If India is a major supplier of generic drugs to the developing world, then why are so few people in India receiving AIDS treatment?
5. What do you see as the next action steps in China and India?

AIDS: The New Apartheid. Gevisser, Mark.

The Nation May 14, 2001 v272 i19 p5

"Phanzi, Pfizer, Phanzi!" "Get out, Pfizer, go!" At rallies they sing the old liberation songs, replacing the names of apartheid leaders with those of multinational pharmaceutical companies. On the streets they chant demands, no longer for the vote or a living wage or freedom, but for fluconazole and cotrimoxazole and nevirapine. Their leaders and organizers might well be human rights lawyers and healthcare professionals, but most of the foot soldiers of the Treatment Action Campaign (TAC)--which has spearheaded the campaign for affordable medicine for HIV-related illnesses in South Africa--are ordinary South African men and women, HIV-positive but too poor to afford the drugs needed to keep them alive.

For most of us, globalization remains an abstract and troubling concept, but for the TAC's activists the pharmaceutical industry's cynical abuse of international trade agreements to keep its profit margins high has meant that globalization is literally killing them. What makes their activism so compelling is that their battle for access to treatment has brought them up against the consequences of the global economy--and that they appear to be triumphant.

In mid-April, after a three-year fight, thirty-nine multinational pharmaceutical companies agreed to settle a suit against the South African government to prevent it from purchasing brand-name drugs from third parties at the cheapest rates possible. This, Big Pharma had claimed, was in violation of international trade and property agreements the South African government had signed. The withdrawal was brokered directly by UN Secretary General Kofi Annan, who had been asked by the five biggest companies to help them find a way out of what had become a public relations nightmare. Annan called South African President Thabo Mbeki, whose officials drafted a last-minute settlement that committed the country to negotiate with the multinationals before implementing its policy. The victory, however, was the TAC's: Not only had it proved that the suit was unwinnable, it had brilliantly mobilized a broad spectrum of support at home and abroad against the drug companies, which were shamed into the settlement--in effect, an honorable withdrawal.

The icon of this victory, broadcast all over the world, was the image of a large African man in the courtroom popping a bottle of champagne in a circle of jubilant celebrants. This man was Zwelinzima Vavi, the general secretary of Cosatu, South Africa's largest labor federation and the backbone of the "Revolutionary Alliance" that brought the African National Congress to power--and that keeps it there. Surrounding him was a fascinating mix of working-class activists, high-powered lobbyists from international organizations like Medecins Sans Frontieres and Oxfam, and ecstatic government officials reliving, for one brief moment, the euphoria of activism.

The TAC has managed to put together the first seriously effective social movement since South Africa's transition to democracy in 1994. The keynote speaker at its first national conference, in March, was Cosatu president Willie Madisha. "There is no urgency from government," he told an audience of 500 delegates from more than 169 organizations, including major religious and healthcare groups. "Sometimes it drags its feet, at other times its HIV/AIDS work is incoherent. Broader social mobilization is essential to engage government constructively."

In 1994 most antiapartheid activists either went into government and became enmeshed in the workings of the new state or set off for the private sector to exercise their newfound freedom and follow their own interests. The result was that the broad-based social movements that brought apartheid to its knees in the 1980s ossified into bureaucracy or withered into nonexistence. The TAC offers a cogent example of the consequences: In the early 1990s, AIDS activists played a major role in the drafting of an exceptional National AIDS Plan, which was adopted by the African National Congress. But instead of mobilizing mass support to achieve the demands of the plan, AIDS activists found themselves inside the system and thus bound by the inevitable constraints of government, relying too heavily on what the TAC calls "the politics of access." Outsiders became insiders, and without the oxygen of a mass movement to keep it alive, the plan was suffocated by red tape.

But just a week before the victory against Big Pharma, TAC's chairman and chief strategist (himself a product of the antiapartheid movement), Zackie Achmat, publicly accused two senior government officials--both medical doctors and former healthcare activists themselves--of having the blood of children on their hands because they were retarding the implementation of antiretroviral programs for pregnant mothers with HIV. "We face a greater tragedy than the acts of omission of the drug companies," he said, "and that is the failure of government officials to act with courage, humility and urgency."

The accusation may have been unduly harsh--Achmat himself could be accused of understanding neither the constraints of bureaucracy nor the choices that the ill-resourced government must make--but he has a significant mass-based constituency behind him when he makes it. The TAC's brilliance was in recognizing that it had an issue that would appeal to the broad left wing of South African society not only because of the government's manifest ineptitude in the face of a horrifying pandemic (4.7 million infected out of a population of 40 million) but because the battle for treatment was a perfect vehicle for taking on the heartlessness of global capital and the perceived wrongheadedness of the ANC government's neoliberal macroeconomic policy. South Africa has been the good boy of the World Bank, the IMF and the WTO, Achmat says, and we're sicker and poorer than we've ever been.
The reason Cosatu and the left like the treatment access issue so much is that it allows them to say this; it puts flesh on their critique of the government's quest for a balanced budget in line with the World Bank's specifications, a quest that means less funding for programs like the provision of lifesaving medication. Globalization, finally, has a face. TAC activists appeared at court wearing ghostly, leering masks of Big Pharma's mandarins. Globalization is itself on trial: The masked activists were in handcuffs.

Just last year, Mbeki accused the TAC of actually being in the employ of Big Pharma because of its strident criticism of the government's AIDS policy. Now, despite the brief and effective courtroom alliance between activists and government, the same battle lines are drawn again, sharper than ever. Minister of Health Dr. Manto Tshabalala-Msimang held a press conference after the courtroom celebration at which she made it clear that providing AIDS drugs was not a government priority; the TAC shot back that it would do whatever was needed--including confronting government head on--to bring "real drugs to real people."

It remains to be seen whether the victory against Big Pharma is anything more than symbolic, whether it will have any effect at all in bringing affordable drugs to the ailing masses of South Africa. Its significance, rather, is in its creation of a mass-based, independent, critically minded social movement that takes the best of South Africa's tradition of struggle and engages it, in a sophisticated and tangible way, in a battle against the negative consequences of the global economy and the manipulation of institutions like the WTO by multinational corporations. The TAC's battle could provide the same brand of moral leadership in the global struggle that the antiapartheid movement did in decades past.

Mark Gevisser, The Nation's Southern Africa correspondent, is completing a biography of Thabo Mbeki.

Document Number: A73748576

QUESTIONS:

1. What was the significance of TAC’s victory over multinational pharmaceutical companies?

2. How did South African’s transition to democracy in 1994 effect AIDS activism?

3. What does the author mean by the statement, “Globalization, finally, has a face?”

4. Why is the battle to bring “real drugs to real people” still raging in South Africa?

Americans on AIDS in Africa: Help and Discipline Needed
Epidemic Blamed On Africans for Unsafe Practices

By Richard Morin and Claudia Deane Washington Post Staff Writers
Saturday, July 6, 2002; Page A03

Most Americans favor modest and targeted increases in spending on the global AIDS crisis but many believe any additional money likely will do little to slow the spread of AIDS in Africa and elsewhere in the developing world, according to a survey by The Washington Post, the Henry J. Kaiser Family Foundation and Harvard University.

Nearly three in four -- 74 percent – members of the public support a proposal by President Bush to spend an additional $500 million mostly in Africa over the next three years to help combat the transmission of the AIDS virus from mothers to their unborn children.

But this compassion is tempered by caution. Other poll findings and interviews with survey participants suggest that few Americans believe that inadequate funding is the major problem. Instead, the public blames the deepening AIDS emergency in the region on factors it feels are largely immune to a quick financial fix: The stubborn reluctance of many Africans to abandon unsafe sex practices, crippling poverty and governments that are either too corrupt, too incompetent or too overwhelmed to deal effectively with the disease.

"I think it's a matter of people there understanding they need to stop the actions they're doing," said Elizabeth Stokesberry, 26, of Barre, Mass., a homemaker who is expecting her first child at the end of this month. "I don't think the United States should be the world's parent."

But Stokesberry also believes the United States has a "duty to help countries that don't have the resources" -- and then to keep a watchful eye on how its assistance is used.

AIDS experts from around the world will gather in Barcelona for the 14th International AIDS Conference on Sunday. The Barcelona meeting comes as the AIDS crisis continues to worsen in Africa and elsewhere in the developing world. Seventy percent of all individuals infected with the AIDS virus live in sub-Saharan Africa, home to about 11 percent of the world's population. In some African nations, nearly a third of the population is infected.

United Nations Secretary General Kofi Annan recently proposed collecting as much as $10 billion a year from wealthier nations for a global fund aimed at fighting AIDS, as well as malaria and tuberculosis. The presumed U.S. share of the fund would be in excess of $2 billion, about double U.S. spending on AIDS abroad.

Few Americans are ready to endorse such a large increase, the Post/Kaiser/Harvard survey suggests. Not even a third -- 31 percent of those polled -- believes the United States is spending "too little" to deal with AIDS in developing countries. Half of those interviewed said this country was spending the "right amount" (34 percent) or "too much" (16 percent) and the remainder were unsure.

And twice as many respondents opposed increasing U.S. support to $2 billion as favored it. But a clear majority -- 59 percent -- acknowledged that they needed to know more before making up their minds, suggesting that many Americans have not yet ruled out a more generous U.S. assistance package. And Americans are far less likely to oppose U.S. assistance to fight global AIDS than they are to object to foreign aid in general.

Bush's proposal to spend $500 million internationally came on the heels of a well-publicized trip by Treasury Secretary Paul H. O'Neill and rock singer Bono to Africa to study the AIDS crisis. Assistance to Africa for AIDS relief was a major focus of the recent Group of Eight meetings in Canada.

The Post/Kaiser/Harvard survey found that Americans clearly recognize the magnitude of the global AIDS crisis. Two-thirds agreed that AIDS had reached epidemic proportions throughout the world. Eight in 10 correctly believe that Africa has been hardest hit by the disease. Two-thirds say they expect that "the worst is yet to come" in Africa, a fear universally shared by the world's AIDS experts.

"I think the worst of the problem [in Africa] is still out there," said Gary James, 42, who works with the mentally handicapped and is a deacon at his church in Columbia, S.C. "I think it's worse than people really perceive."

James believes the AIDS crisis in Africa will eventually harm the United States. "Eventually it will spread. . . . It has already impacted the United States. To just sit back and cover it up, I think it's kind of wrong."

James is not alone. Eight in 10 believe that AIDS in other countries threatens the quality of life in the United States, and 43 percent rate it as a "very serious" threat, though it ranks well behind terrorism and nuclear proliferation. Nearly half of those surveyed said it was "very likely" that the global AIDS crisis could loose a flood of refugees into the United States. And one in five thought the epidemic abroad probably would weaken the U.S. economy.

At the same time, many question the wisdom of spending more money to combat AIDS in Africa and other developing countries. Nearly half -- 47 percent -- said they doubted that additional assistance will lead to meaningful progress while 40 percent said it would.

Behind those numbers are fundamental disagreements between blacks, Latinos and whites over the merits of spending more on global AIDS. Barely a third of all whites -- 34 percent -- said more money would significantly help, a view expressed by 62 percent of all blacks and 60 percent of Latinos. More blacks (47 percent) than whites (30 percent) or Latinos (37 percent) ranked AIDS as the most urgent health problem facing the world today. Blacks and Latinos also were more likely to say that prevention programs would make "a lot" of difference in combating AIDS in developing countries.

The survey suggests that many Americans doubt that more money will help because they don't believe that money -- or the lack of it -- is a major reason the disease has spread so far, so fast across sub-Saharan Africa.

Eight in 10 say a major reason that AIDS has been so hard to control in Africa is the unwillingness of people to change their unsafe sexual practices." Three in four blame African governments that "are not doing enough themselves to fight AIDS." Two in three -- 65 percent -- said poverty was a big reason.

But only one in four -- 25 percent -- said the lack of financial support from the United States and other developed countries was a big reason it has been difficult to control the spread of AIDS in Africa.

"We send them money and the government takes it and the money doesn't reach the people that need it," said Bill Stalfa, 65, a retired firefighter who lives in Forked River, N.J. "And they've got to curb themselves. They're the leading population with AIDS. Stop having sex if they're going to get AIDS. Then ask us for help. We got enough problems in this country right now. Forget about Africa."

Many Americans question whether AIDS is the biggest health problem facing Africans. When asked what the priorities of the United States should be to deal with health-related problems in Africa, the public ranked the lack of access to clean water and widespread hunger ahead of AIDS, a priority list that precisely echoes the views of Treasury Secretary O'Neill after his Africa trip.

Ronald Mann, 44, of Sanderson, Fla., a sales representative for a steel manufacturer, said he does not think the United States has a responsibility as the richest and most powerful country to spend more to fight global AIDS, an argument that Annan and other world leaders have made. "Until people are willing to help themselves, and that includes their government and their leadership, we can't lead them with American dollars," Mann said.

According to the survey, 51 percent of the public shares his belief that the United States has no more obligation than other wealthier countries to fund AIDS programs in Africa or elsewhere in the developing world. Slightly more than four in 10 -- 44 percent -- believe this country does have a special role.

"I think we do have that responsibility," said Nancy Graham, 69, a dog breeder and retired nurse who lives in Damariscotta, Maine. "It is an advantage in terms of world opinion, and I would hopethat we care about that . . . I would hope that it would hold us up as standard-bearers that we care about our fellow man."

Is she worried that the money might be squandered? "Maybe it will go down the drain," she allowed. "But you can hope."

QUESTIONS:

1. Some people believe the US shouldn't be "the world's parent," but what might happen if it doesn't act that way?
2. Should the US spend more money on AIDS prevention in other countries, or should those countries be responsible for it?

Kaiser Daily HIV/AIDS Report

Friday, November 15, 2002

Across The Nation

Southern States' Health Officials Urge More Legislative Action to Fight AIDS in Region

Southern U.S. health officials yesterday in Charlotte, N.C., at the three-day Southern States Summit on HIV/AIDS and sexually transmitted diseases urged state and federal lawmakers to "speak louder" and to "take bolder action" to fight HIV/AIDS in the 16-state region, which is home to nearly 40% of U.S. residents with AIDS, the *Charlotte Observer* reports. The region stretches from Delaware to Texas.

The officials, who have released a "Southern States Manifesto" outlining the steps needed to improve HIV/AIDS programs, added that the South has a bigger HIV/AIDS problem than elsewhere in the United States because of its racial and economic demographics and "a cultural conservatism that interferes with attempts to arrest the disease," the *Observer* reports.

Steven Cline, chief of the North Carolina Department of Health and Human Services' communicable diseases program, added that "part of the puzzle" in the Southern United States was that "[i]t's not popular to ... single out Southerners as not being able to talk about problems well or not being as accepting of different lifestyles and different sexual orientations."

Former U.S. Surgeon General David Satcher, who delivered yesterday's keynote address, added that the Southern states need to make "a lot more changes" in HIV/AIDS education, prevention and treatment, as indicated in the manifesto. Officials mentioned the need for increased funding for HIV/AIDS programs, better sex education programs and condom distribution but also highlighted the South's need for improved access to health care and antiretroviral drugs for HIV-positive residents (Stobbe, *Charlotte Observer*, 11/15).

Moving South

NPR's "Morning Edition" today reported on the conference and on HIV/AIDS in the South. Many HIV-positive residents of Southern states "came from somewhere else," often returning home from other U.S. urban areas "to be sick, to be with their families, and in some case, to in fact die." Because of "wide eligibility criteria" and "different levels of service" for Medicaid and AIDS Drug Assistance Programs in each state, some HIV-positive people who receive assistance accessing HIV/AIDS medications and treatment in one area lose access to treatment when they move to the South.

According to some AIDS directors in Southern states, "fear of stigma coupled with a history of discrimination" and a "chronic lack of resources" complicates efforts to fight the disease in the region (Wilson, "Morning Edition," NPR, 11/15). The full segment will be available in RealPlayer Audio online after noon ET.

http://kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=14612&dr_cat=1

Economic Concepts in Health Care

Health care has always been an economic activity. People invest time and other resources in it, and they trade for it with one another. In this way, health care is open to economic analysis. This means understanding the demand for it, its supply, its price, and the relationship between all three. Economic analysis does not merely determine what the supply, demand, and price for health care in private or public markets are. It also tries to understand why those are what they are. How does suppliers' behavior affect the demand for health care? How does a particular insurance framework affect the supply and demand?

The economics of health care, in fact, has grown into a specialty within professional economics. Although almost all goods are in some sense "economic goods," economists have noticed some differences between most health-care and ordinary market commodities. In health care, the supplier seems to create a final demand more than with most goods, since both the shape of health services and their price are directly influenced by health-care providers. Other forms of "market failure" also occur in health care. An example of this is when people do not receive health-care services because their high risk to insurance companies drives prices for even the most basic coverage to levels that no one can afford.

Cost-Effectiveness, Cost-Benefit, and Risk-Benefit Analysis

Efficiency involves the basic economic idea of "opportunity cost." This is the value from alternatives that we might have chosen using the same resources. When the value of any alternative is less than the value of the current service, the current one is efficient. When the value of some alternative is greater, the current service is inefficient. If we focus on whether we can get more benefit for our health-care dollars, or whether we can get the same health care more cheaply, we are performing cost-effectiveness analysis (CEA). But if we compare an investment in health care with all the other things we might have done with the same time, effort, and money, we are performing cost-benefit analysis (CBA). CEA asks whether the money spent on a particular program or treatment could produce healthier or longer lives if it were spent on other forms of care. CBA asks an even more difficult question: whether the money we spend on a particular portion of health care is "matched" by the benefit. In other words, could the money produce greater value, not just healthier or longer lives, if it were spent on other things?

Cost-effectiveness analysis

CEA is the less difficult activity: We compare different health-care services and find either final differences in expense to achieve the same health benefit or differences in some health benefit. But in CBA, we must compare the value of the longer life and better health achieved by health care with the value of the other possible improvements in human life that would be gained by making other investments with the same resources.

Cost-benefit analysis

CBA is difficult because the advantages gained from those other uses of resources so often cannot be compared to benefits in health and in living a longer life. But improvements within health care often cannot be measured either. How do we really compare the value of hip

replacement, which will not make a person live longer, with that of kidney dialysis or organ transplants, which will?

Risk-benefit analysis

This is another kind of analysis: We compare the probabilities of harm presented by a certain course of action with its likely benefits. If another procedure is likely to produce almost the same benefits with less risk, then that is obviously better. But it is not always clear when one risk is "less" than another. One risk may be of paralysis for life and the other may be of ongoing pain. Moreover, one procedure may have lower risk but also promise fewer health benefits. Again we are left with a final trade-off that cannot be measured. Unlike CEA, the positive effects in risk-benefit analysis are not all measured on the same level. And unlike CBA, the benefits are not put in the same terms as the costs or risks. The analysis helps us only to see what risks we take on in the pursuit of what benefits.

Other standards

Unlike CBA, CEA does not try to answer the question of how much money to spend for a given health benefit. But it does attempt to make comparisons within health care. All that it needs to be able to do this is to determine a common unit of health benefit. One idea developed for this purpose goes by various names: a "well-year," a "quality-adjusted life year" (QALY, pronounced to rhyme with "holly"), or "health-state utility." In any case, the basic idea is a common unit that combines longevity with quality of life considerations--such as a year of healthy life. We can then compare not only actions that extend life with each other, but also actions that improve the quality of life with those that prolong it. A hip replacement, which improves the quality of life, can be compared with kidney dialysis, which prolongs it. In public-health terms, we could also track the health of a population, calculating increases (or decreases) in years of healthy life.

The major moral argument for using both quality of life and lengthening life as standards for getting the most benefit that a plan or an entire health-care system produces is that it is people themselves who rank the quality of their lives. It is also people who agree to the priorities that QALYs or well-years bring. Critics believe, however, that increasing years of healthy life in our lifesaving policies fails to respect the person with an admittedly lower quality of life.

The Monetary Value of Life

How much is your life worth? In contrast to CEA, CBA asks us to equate an amount of money with the benefits of the program or procedure that is being assessed--including life itself. Putting a price on life is an ordinary event of modern times. Now that many effective but often costly means of preserving life are available, we often pass up potential lifesaving measures for other choices. And money eases those trade-offs.

Discounted future earnings

Economists have developed two main models for translating data into an economic value of life. These models are discounted future earnings (DFE) and willingness to pay (WTP). DFE looks at the future earnings that are lost when a person dies. Economists feel it would be self-defeating to refuse to save a life for $200,000 if the value of the person's earnings was more than that. While such DFE calculations are still used in some health-care CBAs, the idea of discounted future

earnings has been largely surpassed in the work of economists by WTP. With WTP, the value of life is measured by people's willingness to use resources for increasing their chances of survival.

Willingness to pay

In economics, WTP is thought of as being the better model. It captures the range of life's individual, elusive values that DFE ignores. People often spend money on something they like independent of the return they will get from it. This is the case with WTP. But WTP has raised many objections nonetheless. For one thing, just as with DFE, there are wide variations in willingness to pay, largely based on people's wealth and income. Should we see those variations as affecting what is spent on saving a life?

The move that economists make in WTP to get from an initial trade-off between money and risk to the value of a real, unique life is puzzling. John Broome (1982) claimed that only a money value made directly in the face of death can correctly reflect the actual economic value of a life. But as Ezra J. Mishan (1985) noted, we do not know of anyone "who would honestly agree to accept any sum of money to enter a gamble in which, if at the first toss of a coin it came down heads, he would be summarily executed." Some economists conclude from this that CBA can set no reasonable limit on what to spend to save a life because no amount of money adequately represents the real value of life.

The money value placed on life brings up the idea of insurance. In medical economies, most people either subscribe to private insurance plans or are covered by public health-care spending. Once insured, subscribers and patients, as well as health-care providers, find themselves with a strong incentive to overuse health care and a tendency to underestimate opportunity costs. Why should we not address the problem of controlling the use of health care at the point in the decision process--insuring--where the cost-expansion trouble starts?

The Difficulties That Economic Concepts Pose for Clinical Practice

Suppose that economic efficiency analysis--such as CEA or CBA--lays the groundwork for recommendations about the kind and amount of health care to use. How does such an efficiency system relate to the ethical duties of those people who provide health care? The traditional code of doctors is one of loyalty to their individual patients. In turn, that means doing whatever helps a patient most, within the limits of what the patient willingly accepts. If health care is to be rationed to control the money and other resources it uses, will the basic ethical code between doctor and patient have to change? If it will, is the achievement of efficiency worth its moral cost? This potential clash between traditional ethical obligations and the economic and social demands of the "new medicine" in an age of scarce resources will be the focus of ethical controversies in medicine for years to come.

One can divide the potential views surrounding the controversy into two camps: those who think that the economic-efficiency demands of society cannot be reconciled with the ethical obligations of doctors, and those who think that they can be. The first group will go after economic efficiency regardless of the moral cost. The second group will oppose rationing of health-care services in the name of a moral commitment to helping individual patients. The views of this second group will come in distinctly different varieties: (1) the view that the controversy was more apparent than real all along, since providers of health care have always

shaped the lengths to which they would go to help individual patients; (2) the position that distant third parties make all the rationing decisions and that the doctors then ration to patients within determined guidelines; and (3) the view that a provider's loyalty to a patient, though not controlled by efficiency, is that of a member of a just society, a condition that then allows the doctor to participate in the rationing of health-care resources with a clean conscience when it is based on ideas of fairness and justice.

Externalities and Public Goods

Externalities and public goods play an important role in discussions of public policy. Externalities are burdens, costs, or benefits that are added onto other people, not to the people who are performing some action. Externalities pose a problem for achieving efficiency in market exchanges.

Public goods raise questions of public regulation and taxation. To an economist, a "public good" is one whose benefits extend even to those who do not buy it. If you clean up your yard, I benefit from a somewhat better appearance on the block regardless of whether I clean up my own yard or help you clean up yours. The benefit is thus public. It is difficult if not impossible to exclude from the benefits of such activities someone who chooses not to contribute. The obvious solution to this unfairness on my part is for the community to tax me my fair share.

The use of both public goods and externalities is on the rise in certain health-care issues. One is the taxing of health-complicating products such as tobacco and alcohol. Smoking and too much drinking increase certain costs to others. These costs include health-care expenses for smoking- and drinking-related diseases; lost work time; unhappiness; and pain in dealing with other people's destruction of their lives. Even direct loss of life (from secondhand smoke and drunk driving) is often passed on to other people. These external factors provide part of the force behind the movement to raise taxes on tobacco and alcohol. As societies look for ways to deal with rising health-care costs, a fair source of revenue (income) would be from special taxes on activities that increase the health-insurance premiums and taxes of others through voluntary behavior.

In the case of smoking, the picture is very complicated. Informal cost analysis tells us that smokers cost nonsmokers a great deal of money. But that conclusion ignores two hidden "savings" of smoking that extend to others. Because smokers die earlier, and usually at the end of their earning years or shortly after retirement, they save others the pension payouts and unrelated health-care expenses they would have incurred had they lived longer. One leading study found that the average 1989-level U.S. cigarette tax of $.37 per pack was enough to cover all the costs that smokers impose on other people. Of course, this is not the last word on the external costs of smoking. But it illustrates the hidden costs and savings that economic analysis reveals.

Many economic challenges to health care will continue to surround us. Questions such as how to determine what is efficient in the investment of resources in health care, how to arrange efficient use of care, and how the achievement of efficiency compares with other health-care values will become the economic focus of the whole health-care system.

Related Literature

James Wright's "The Minneapolis Poem" (1968) records the experiences of the nameless poor who live on the streets and do not have the money to get enough to eat, let alone afford any kind of health care. Poor old men die of hunger and exposure in the cold winter nights. A companion poem, "In Terror of Hospital Bills" (1968), is told in the voice of a homeless Sioux Indian, hungry and desperate on the winter streets. He cannot afford hospital bills.

"The cost-benefit analysis approach to whether we live or die is generally unappealing."
--John Sullivan, editor, *National Review* (1989)
"Whatever the costs are, we can't measure health and lives in economic terms."
--Thomas Luken, U.S. Congressman, 1990.

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QUESTIONS:

1. How is health care an economic activity?
2. Should cost-effectiveness, cost-benefit, risk-benefit, and other standards be used to determine how much we spend on health care? What concerns do you have?
3. How does the use of discounted future earnings and willingness to pay to place a price on life impact insurance and medical decisions?
4. What is the impact of an efficiency system on the ethical duties of health care providers?

International Comparisons of Health Care

International comparisons are often difficult to make, because cultures and values differ. What is important in one society may be unimportant in another. A political or human right in one nation may not exist in a neighboring state. The question of quality in health care, for example, may be difficult to measure from one culture to another. Thus, a comparison as subjective as health care should be done with great caution.

A COMPARISON OF SIMILAR COUNTRIES

The 30 member nations of the Organisation for Economic Co-operation and Development (OECD) are generally considered the wealthier, more developed nations in the world. The OECD includes the Western European nations, Canada, the United States, Japan, Australia, New Zealand, Mexico, the Czech Republic, South Korea, Poland, Hungary, and the Slovak Republic (the Slovak Republic joined the OECD in 2000).

Percentage of Gross Domestic Product Spent on Health Care

Although health has always been a concern for Americans, the growth in the health care industry since the mid-1970s has made it a major factor in the American economy. For many years, the United States has spent a larger proportion of its gross domestic product (GDP) on health care than have other nations with similar economic development. From 1975 through 1990, total health care expenditures as a percentage of the U.S. GDP rose from 8 to 12.7 percent. From 1990 to 1996, the ratio rose to 14.2 percent, the highest rate in the OECD. Other nations that spent large percentages of GDP on health care in 1995 and 1996 included Germany (10.5 percent), Switzerland (9.8 percent), France (9.6 percent), and Canada (9.2 percent). Ireland (4.9 percent), Mexico (4.5 percent), and Poland (4.4 percent) spent the least in the OECD. (See Table: Spending on health care: 1990 and 1996.)

The exponential growth in health care spending in the United States during the 1990s was not an international trend, although a number of other countries also experienced rapid increases in the percentage of GDP spent on health care from 1990 to 1995-96. These included the Czech Republic (from 5.5 to 7.9 percent), Germany (from 8.2 to 10.5 percent), Greece (from 4.2 to 5.9 percent) Japan (from 6 to 7.2 percent), South Korea (from 3.9 to 5.3 percent), and Portugal (from 6.5 to 8.2 percent). These countries, however, were spending a relatively small percentage of their GDP on health care in 1990. Six countries--Denmark, Finland, Iceland, Ireland, Italy, and Sweden--spent less of their GDP on health care in 1996 than they did in 1990. The majority of other countries experienced small increases. (See Table: Spending on health care: 1990 and 1996.)

Per Capita Spending on Health Care

In 1996 the United States also enjoyed the highest per capita spending for health care services, spending an average of $3,708 per citizen (that number had risen to $4,094 by 1998). No other country came close to spending that amount per capita in 1995 and 1996: Switzerland spent $2,412 per citizen; Germany, $2,222; Luxembourg, $2,206; and Canada, $2,002. In 1995 South Korea spent the least of any OECD nation on health care: 5.3 percent of its GDP and $666 per capita. (See Table: Spending on health care: 1990 and 1996.)

Proportional Spending on Health Care

In 1995, in a ranking of the proportion of health care resources spent on hospitals, the United States, at 43 percent, placed in the middle of the Group of 7 (G7) nations, a group of countries (which originally consisted of Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States, and later included Russia, thereby becoming the G8) whose representatives meet to discuss economic concerns. Canada and France used the largest chunk of their health care dollars on hospitals (46 and 44 percent, respectively), while Japan spent the least (29 percent).

Of all the G7 nations, the United States spent the third-highest proportion on physicians (20 percent), after Japan and Italy. (Japan consistently spent the highest percentage on physicians: 35 percent in 1994.) France spent the least: only 12 percent of its overall health care spending went to its physicians.

Only 8 percent of U.S. health care resources was spent on drugs. This number was considerably lower than any other industrialized country. Japan had the highest distribution of drug spending in 1994, at 20 percent. Germany and Canada also used relatively small proportions of their overall spending on drugs, at 13 percent each. (See Table: Distribution of health care spending: 1990 and 1995.)

Hospitalization Statistics

Of all the G7 countries, Japan had the highest number of inpatient hospital beds in 1990 and 1994 (16 and 16.2 beds per 1,000 population respectively). This is probably because Japan does not distinguish between acute and long-term care beds. Germany had the next-highest number of beds, at 9.7 per 1,000 population in 1995. The United States had the lowest, 4.1 in 1995, and the United Kingdom and Canada followed with 4.7 and 5.1 beds, respectively, per 1,000 population. (See Table: Inpatient hospital data: A comparison of G7 member nations: 1990 and 1995.)

Japan also had the longest average hospital stay, by far, of all the G7 nations: 45.5 days in 1995, down from 50.5 days in 1990. This compares with 14.2 days in Germany and 12.2 days in Canada. The United States permitted its patients to stay in the hospital for the fewest average days of any country: 8 days in 1995. (See Table: Inpatient hospital data: A comparison of G7 member nations: 1990 and 1995.) These figures included stays in community hospitals, federal hospitals, and psychiatric hospitals.

France had the highest hospitalization rate of any of the G7 nations. More than one in five of its citizens--22.7 percent--were admitted to a hospital in 1995. Germany and the United Kingdom also had relatively high hospitalization rates: 20.7 and 20.8 percent, respectively. Japan had the lowest rate, at 8.9 percent. Approximately 13.7 percent of the U.S. population was hospitalized in 1995.

OVERVIEWS OF SELECTED HEALTH CARE SYSTEMS

In 1992 a group of academics examined the operation of health systems in the United States and several other developed countries. The authors studied the methods of financing and providing health care in the United States, Germany, Canada, the United Kingdom, France, and Japan, and issued a detailed report on the differences between the systems (George Schieber, Jean-Pierre Poullier, and Leslie Greenwald, "U.S. Health Expenditure Performance: An International Comparison and Data Update," *Health Care Financing Review*, Summer 1992). Although some aspects of those systems have changed since 1992, the essential models remain the same. Summaries from this article follow, with updates since the article was written.

United States

The U.S. health care financing system is based on the consumer sovereignty, or private insurance, model. There are more than 1,000 private insurance companies in the United States. Employer-based health insurance is tax-subsidized: health insurance premiums are a tax-deductible business expense but are not taxed as employee compensation. Individually purchased policies are partially tax-subsidized for self-employed Americans. Benefits, premiums, and provider reimbursement methods differ among private insurance plans, and among public programs as well.

Physicians who provide both office visits and inpatient care are generally reimbursed on a fee-for-service basis, and payment rates vary among insurers. Hospitals are paid on the basis of charges, costs, negotiated rates, or diagnosis-related groups, depending on the patient's insurer. There are no overall global budgets or expenditure limits. Nevertheless, managed care (oversight by some group or authority to verify the medical necessity of treatments and to control the cost of health care) has played an increasing role. Health maintenance organizations and health insurance companies now exert greater control over the practices of individual doctors, in an effort to control costs. A growing number of doctors are finding their decisions and fees open to question by insurers, and health insurance companies may deny coverage for a procedure selected by the physician. Many doctors are joining group practices or organizations, or are being forced to lower their fees so they can treat patients covered by large insurers.

In 1996 there were 6,201 hospitals in the United States: 290 federal hospitals and 5,911 nonfederal hospitals. About 59 percent of nonfederal community hospitals were nonprofit; 15 percent were proprietary (privately owned); and 26 percent were operated by state and local governments. Increasingly, hospitals are being absorbed into for-profit operations.

Germany

The German health care system is based on the social insurance model. Statutory sickness funds and private insurance cover the entire population. Approximately 1,200 sickness funds cover about 88 percent of the population. Employees and employers finance these sickness funds through payroll contributions. Almost all employers, including small businesses and low-wage industries, must participate.

In the mid-1990s, contributions to sickness funds averaged about 13 percent of a worker's salary. About 9 percent of sickness fund members purchased complementary private insurance. Another 7 percent of the population chose not to participate in the public system and were fully covered by private insurance. Seventy-three percent of all health

expenditures were public, and about 11 percent were direct, out-of-pocket payments. Under the sickness funds, losing or changing jobs does not affect health insurance protection.
Ambulatory (outpatient) and inpatient care are completely separate in the German health care system. German hospitals generally do not have outpatient departments. Ambulatory care physicians are paid on the basis of fee schedules negotiated between the organizations of sickness funds and organizations of physicians. A separate fee schedule for private patients uses a similar scale. Hospitals were previously paid on the basis of negotiated per diem (or length of stay) payments, but the 1993 Health Care Reform law instituted a sliding scale based on specific fees for specific procedures.
Public (federal, state, and local) hospitals account for about 51 percent of hospital beds; private voluntary hospitals, often run by religious organizations, account for 35 percent of beds; and private for-profit hospitals, generally owned by physicians, account for 14 percent. Ambulatory care physicians are generally self-employed professionals, while most hospital-based physicians are salaried employees of the hospital.
On January 1, 1993, Germany's new Health Care Reform law went into effect. Among its many provisions, the new law tied increases in physician, dental, and hospital expenditures to the income growth rate of members of the sickness funds. This limited the licensing of new ambulatory care physicians (based on the number of physicians already in an area) and set a cap for overall pharmaceutical outlays. It also changed the hospital compensation system from per diem payments to specific fees for individual procedures and conditions. The government was also trying to limit what it considered excessive health benefits, such as cutting back on how often a patient might visit a health spa to recuperate.

Canada

The Canadian system has been characterized as a provincial government health insurance model, in which each of the 10 provinces runs its own health system under general federal rules and with a fixed federal contribution. Entitlement to benefits is linked to residency, and the system is financed through general taxation. Private insurance is prohibited from covering the same benefits covered by the public system. More than 60 percent of Canadians, however, are covered by complementary private policies. Seventy-three percent of all health expenditures are public, and consumers pay an estimated 20 percent of health care expenditures out of pocket.
In Canada, all citizens have equal access to medical care, regardless of their ability to pay. Canadian health insurance covers all medically necessary services, including hospital care and physician services. Some provinces also cover preventive services, routine dental care for children, and outpatient drugs for the elderly and the poor. No restrictions are placed on a patient's choice of physicians. For some time, the government reimbursed patients in full for hospital treatment and doctors' services. Now, however, individuals incur additional out-of-pocket expenses for services such as adult dental care, cosmetic surgery, and private or semiprivate hospital rooms. Many Canadians purchase additional health insurance to cover these charges.
Hospitals are funded on the basis of global budgets, and physicians in both inpatient and outpatient settings are paid on a negotiated, fee-for-service basis. (A global budget is one that authorizes a lump sum of money to a large department or area. Then all the groups in that department or area must negotiate to see how much of the total money each group receives.) The systems vary somewhat from province to province, and certain provinces, such as Quebec, have also established global budgets for physician services. The federal government's share of spending has progressively declined, from a historic high of 50 percent to 38 percent in 1990, 30 percent in 1993, and less than 20 percent in 1997. The delivery system is composed largely of nonprofit community hospitals and self-employed physicians. About 95 percent of Canadian hospital beds are public; private hospitals do not participate in the public insurance program.

Financial Problems

In the 1990s public revenues did not increase fast enough in Canada to cover rising health care costs. The Canadian government attributed many of the financial problems to lower revenue from taxes, higher prices for medical technology, relatively lengthy hospital stays, and too many doctors paid on a fee-for-service basis. In 1993, for the first time since Canada instituted universal health insurance 27 years earlier, Canadians had to pay for common services such as strep throat tests.
As a result of cutbacks and inadequate equipment, waiting times for nonemergency surgery, such as hip replacement, and high-technology diagnostic tools, such as computerized axial tomography (CAT scans), could amount to months, or even years. Although Canadians generally still support their present system, there has been growing dissatisfaction with the rising costs and long waiting periods among both patients and doctors.

The Safety Valve to the South

Some Canadians have begun to cross the border to avoid the lines in their hospitals. Canadian doctors sometimes refer their more seriously ill patients who need immediate attention to American hospitals in such cities as nearby

Buffalo, New York; Cleveland, Ohio; and Detroit, Michigan. In fact, many American hospitals have begun to market medical services, most notably cardiac care and addiction treatment, to the Canadian public. Overall, however, there has been very little border-jumping. Canadians accounted for less than 1 percent of total admissions in each of the nine border hospitals surveyed by the American Medical Association.

Cutting Costs

The general consensus is that no one wants to disassemble what has become Canada's most popular social program, but most agree that change is inevitable. The Ontario Health Insurance Plan insures 10 million people, or almost 40 percent of all Canadians. They have managed to cut costs in several ways:

- Reducing fees to commercial laboratories and allowing them to bill patients directly for tests performed.
- Stopping payment for certain services connected with employment. For example, someone who needs a physical examination to qualify for a job must pay for it.
- Ending coverage of electrolysis (removal of unwanted hair) and reviewing coverage of such items as psychoanalysis, vasectomies, newborn circumcision, in vitro fertilization, and chiropractic, podiatric, and osteopathic services.
- Increasing the amount that patients must pay for prescriptions covered under the Ontario Drug Benefit Plan, which is used mainly by persons over age 65.

Similarly, in an effort to cut hospital costs, British Columbia was moving to shift some services away from hospitals to outpatient clinics, public health programs, and home care. Canadian officials hoped that cutbacks in covered services and caps on doctors' fees and hospital budgets could keep the popular health care system afloat.

United Kingdom

The United Kingdom employs the National Health Service, or Beveridge, model to finance and deliver health care. The entire population is covered under a system that is financed mainly from general taxation. There is minimal cost sharing. About 15 percent of the population also purchases private insurance as a supplement to the public system. Eighty-four percent of all health spending is from public funds, and about 4 percent of all spending represents direct, out-of-pocket payments.

Services are organized and managed by regional and local public authorities. General practitioners serve as primary care physicians and are reimbursed on the basis of a combination of capitation payments (payments for each person served), fees, and other allowances. Hospitals receive overall budget allotments from district health authorities, and hospital-based physicians are salaried. Private insurance reimburses both physicians and hospitals on a fee-for-service basis.

Self-employed general practitioners are considered independent contractors, and salaried hospital-based physicians are public employees. Of the United Kingdom's hospital beds, 90 percent are public and generally owned by the National Health Service. As of 1991, it became possible for large physician practices to become "budget holders," and receive a larger capitation payment. Similarly, individual hospitals may become "self-governing trust hospitals," whereby they may compete for patients and sell their services. While emergency health service is immediate, persons needing elective surgery, such as hip replacement, may end up on a waiting list for years.

France

The French health care system is based on the social insurance, or Bismarck, model. Virtually the entire population is covered by a legislated, compulsory health insurance plan that is financed through the social security system. Three major programs, and several smaller ones, are quasi-autonomous, nongovernmental bodies. The system is financed through employee and employer payroll tax contributions. More than 80 percent of the population supplements their public benefits by purchasing insurance from private, nonprofit *mutuels*, and about 2 percent of the population has private commercial insurance.

The public share of total health spending is 74 percent, and about 17 percent of expenditures represent direct, out-of-pocket payments. Physicians practicing in municipal health centers and public hospitals are salaried, but physicians in private hospitals and in ambulatory care settings are typically paid on a negotiated, fee-for-service basis. Public hospitals are granted lump-sum budgets, and private hospitals are paid on the basis of negotiated per diem payment rates. About 65 percent of hospital beds are public, while the remaining 35 percent are private (and equally divided between profit and nonprofit).

In April 1996, the French government announced major reforms aimed at containing rising costs in the national health care system. The new system would monitor each patient's total health costs and penalize doctors if they overran their budgets for specific types of care and prescriptions. In addition, French citizens would be required to

consult general practitioners before going to specialists. Doctors--specialists, in particular--denounced the reforms and warned that they could lead to rationing and low-quality health care.

Japan

Japan's health care financing is also based on the social insurance model and, in particular, on the German health care system. Three general schemes cover the entire population: Employee Health Insurance, Community Health Insurance, and Health and Medical Services for the Aged. About 62 percent of the population receives coverage through about 1,800 employer-sponsored plans. Small businesses, the self-employed, and farmers are covered through Community Health Insurance, which is administered by a conglomeration of local governmental and private bodies. The elderly are covered by a separate plan that largely pools funds from the other plans. The emphasis is on the government, not business, bearing the major financial burden for the nation's health care.

The system is financed through employer and employee income-related premiums. There are different levels of public subsidization of the three different schemes. Limited private insurance exists for supplemental coverage. Public expenditures account for 72 percent of total health spending, while out-of-pocket expenses account for about 12 percent.

Physicians and hospitals are paid on the basis of national, negotiated fee schedules. Physicians practicing in public hospitals are salaried, while those practicing in physician-owned clinics and private hospitals are reimbursed on a fee-for-service basis. The amount paid for each medical procedure is rigidly controlled. Physicians prescribe and dispense pharmaceuticals. Perhaps because of this, the Japanese take about 50 percent more drugs than Americans do.

A close doctor-patient relationship is unusual in Japan; the typical doctor tries to see as many patients as possible in a day in order to earn a living. A patient going to a clinic for treatment may have to wait many hours in a very crowded facility. As a result, health care is rarely a joint doctor-patient effort. Instead, doctors tend to dictate treatment without fully informing patients of their conditions or of the drugs and therapy that have been prescribed.

About 80 percent of Japan's hospitals are privately operated (and often physician-owned) and the remaining 20 percent are public. For-profit hospitals are prohibited. Hospital stays are typically far longer than in the United States, or any other G7 country, allowing hospitals and doctors to overcome the limitations of the fee schedules.

Despite the limitations of Japan's health care system, Japanese men and women had the longest life expectancy in the world in 1995: 82.8 years for women and 76.4 years for men. The Japanese infant mortality rate in 1995, at 4.3 per 1,000 live births, was the lowest in the world. (See Table: Infant mortality and life expectancy, OECD countries: 1990 and 1995.) These two statistics are usually considered reliable indicators of a successful medical system. It must be noted, though, that Japan does not have a large impoverished class, as does the United States, and its diet is among the healthiest in the world.

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QUESTIONS:

1. Do you believe that doctors in our country view their ethical obligations to be more important than monetary concerns?
2. Why do you believe that money plays such an important role in health care?

Professor Jeffrey Sachs: More investment in agriculture could save millions from starvation and death

ROME, 12 June 2002 -- "The world has the means and the know-how to end hunger and poverty but it has lacked the ability to move from words to action," according to Professor Jeffrey Sachs, addressing the World Food Summit: five years later.

"There is absolutely no excuse for a further lack of progress in the fight against hunger and poverty," said Mr Sachs, who was recently named Director of the Earth Institute at Columbia University in New York City and serves as a special adviser to the UN Secretary-General on the Millennium Development Goals.

For its just-launched Anti-Hunger Programme, FAO has calculated that US$24 billion is needed annually in public investment in agriculture and rural development in poor countries to reduce by half the number of hungry people - currently 800 million -- no later than 2015. To finance this, Mr Sachs said, "we in the rich countries need to put aside 5 cents out of every 100 dollars. This investment could serve to save millions of people from starvation and death.

"We went to the first World Food Summit in 1996 and decided to cut hunger by half by 2015. It is shocking to note that the official development assistance for agriculture in the 1990s fell sharply. This is a mistake," Mr Sachs added.

"If the rich countries provide important investment to agriculture and rural areas in poor countries, the poor will live, they will grow out of poverty and have a better future," he said. "So far, the rich countries have not really made the commitment to resolve the world hunger problem."

Mr Sachs said that FAO's Anti-Hunger Programme "is realistic, it shows that we can act and it lists what is needed to fight hunger. We need to increase productivity in subsistence agriculture, help farmers to use technology and improve infrastructure in rural areas. We need nutrition programmes, school meals and emergency aid for the people affected by disasters. We need better seeds that are resistant to drought and salinity, and we will need advanced biotechnology."

Mr Sachs warned that it costs money to increase productivity in agriculture, health and education and to reach the UN Millennium development goals. "Without added assistance from the rich countries, we will not make any progress. We also require leadership from poor and rich countries, from industry, non-governmental organizations and scientists."

The FAO Anti-Hunger Programme calls for a twin-track approach to fighting hunger, combining agricultural and rural development with targeted programmes to enhance access to food by the neediest people. Countries that have followed this approach are seeing the benefits, FAO said.

FAO estimated the economic benefits of reducing the number of hungry people to be at least US$120 billion per year.

The costs of the FAO programme would be equally shared by the international donor community and developing countries. This would result in a 20 percent increase in developing countries'

budgets for agriculture and rural development and a doubling of ODA and non-concessional lending.

http://www.fao.org/english/newsroom/news/2002/6385-en.html

QUESTIONS:

1. Do you believe the world can end hunger and poverty in your lifetime if we move from "words to action?" Why or why not?
2. What are your thoughts about the author's statement, "there is absolutely no excuse for a future lack of progress in the fight against hunger and poverty."
3. What other data should we gather before moving forward with additional investments in agriculture and rural development in poor countries?

"Globalization and Inequality: Are They Linked and How?".

Lundberg, M. and B. Milanovic. 2000.

World Bank: Washington, DC.Globalization and inequality have recently received a great deal of attention (Martin Wolf, "The big lie of global inequality", *Financial Times*, February 8, 2000). We feel that the discussion has been clouded by the lack of terminological and conceptual clarity, and often rather cavalier depiction of the links between the two. Some proponents of globalization claim that the process brings free and universal benefits. Conversely, some opponents equate globalization with social and environmental destruction. We would like to shed some empirical and substantive light on this highly contentious subject.

There are at least three distinct concepts of inequality which are linked with globalization. First is inequality *within* nations. This is the inequality people have in mind when they argue, for example, that globalization may be responsible for widening income disparities in the UK or the US. Second, there is *inter-national* inequality, which refers to differences between countries' average per capita incomes (or GDPs). This is the inequality one has in mind when he speaks of how globalization affects different countries' growth rates; whether they converge (which still does not mean that their GDP levels converge!) or not. The third concept of inequality is *world* inequality, which combines the two previous concepts. World inequality refers to income inequality between all individuals in the world, irrespective of where they live. The effects of globalization on world inequality are both the most difficult to gauge and possibly the most interesting. Widening within-country inequality might be more than compensated by faster growth of average income in poor countries, so that world inequality might go down while within-country inequality increases everywhere. Or the reverse may be the case.

In addition to the conceptual problems, there is a substantive issue. Whether inequality goes up or down while globalization proceeds is no proof of causality. One has to come up with a plausible explanation of the channels through which globalization or openness affects inequality, and test the theory empirically.

The evidence recently cited in this newspaper purports to show that inequality in the world has decreased during the last two decades. Andrea Boltho and Gianni Toniolo in the December 1999 issue of *Oxford Review of Economic Policy* calculate that the world Gini coefficient fell from 54 in 1980 to 50 in 1998. (The Gini ranges between 0 for complete equality and 100 if all income is received by a single person.) Boltho and Toniolo's Gini is calculated by looking at cross-country differences in average per capita GDP (weighted by population size). It is a measure of inter-national, not world, inequality. But even as a measure of inter-national inequality the Boltho-Toniolo estimate is low. Three recent studies—by Schultz in the June 1998 issue of *Journal of Population Economics*, Firebaugh in the May 1999 issue of *American Journal of Sociology*, and most recently Milanovic in a World Bank working paper* estimates that inter-national inequality is some 10 to 20 percent higher than the Gini reported by Boltho and Toniolo. Milanovic, moreover, shows that the inter-national Gini *increased* between 1988 and 1993 from 55 to 58. Most likely, the Boltho and Toniolo results can be explained by their relatively small sample of 49 countries. The other studies include at least 80 and some more than 100 countries.

The more serious problem is the difference between inter-national and world inequality. The former assumes (e.g.) that all Chinese and all Americans have the mean income of their respective nations. Once we allow for within-country inequality, that is, for income differences among the Chinese, among the Americans, etc., as well as inequality between them, the Gini must go up. Including intra-national inequality, Milanovic finds that the *world* Gini coefficient increased from 63 in 1988 to 66 in 1993. If purchasing power differences are not taken into account, that is, if we simply look at differences in dollar incomes, the Gini increased from 78 to 80.

Turning to the link between globalization and inequality, most economists would agree that while globalization is inevitable and most likely key to continued growth, the process of shifting resources to meet new opportunities is costly and takes time. Following the adjustment period, greater openness probably leads to greater manufacturing employment, at least in developed countries. But, even for developed countries, there is some evidence, as argued by Dani Rodrik of Harvard University, that globalization is responsible for a part of the increased wage gap between low- and high-skilled workers.

How does openness affect the poor? In a recent World Bank paper, Lundberg and Squire** find that greater openness to trade is correlated negatively with income growth among the poorest 40 percent of the population, but strongly and positively with income growth among remaining groups, in a sample of 38 countries between 1965 and 1992. The costs of adjusting to greater openness are borne *exclusively* by the poor, regardless of how long the adjustment takes.

The poor are far more vulnerable to shifts in relative international prices, and this vulnerability is magnified by the country's openness to trade. Even those who have never heard of the WTO, such as poor farmers, are affected by changes in the prices of their inputs and products. Considering that the prices of non-oil commodities have uniformly declined since the beginning of the 20th century, this bodes ill for poverty and for aggregate distribution. It also suggests that much more needs to be done to restructure liberalization, so that a larger share of the population benefits from the process.

The debate on the effects of globalization desperately needs greater conceptual clarity and more rigorous empirical testing. We have tried to make clear two points. First, world income inequality is much greater than the inter-national inequality reported by Boltho and Toniolo; and the recent trend has been toward increasing inequality. Second, the benefits of increased global integration are not necessarily evenly distributed. It may be possible to convince the anti-globalization forces of the benefits of increased integration, but this will require discussions based more on the evidence and less on ideology.

* Milanovic, B. 1999. "True world income distribution, 1988 and 1993: First calculation based on household surveys alone", World Bank Policy Research Working Paper No. 2244, November 1999.

** Lundberg, M. and L. Squire. 1999. "The simultaneous evolution of growth and inequality", December 1999.

QUESTIONS:

1. In your own opinion, do you believe that globalization "brings free and universal benefits" or causes "social and environmental destruction?"

2. Which problem do you believe is more severe and needs the most attention: inequality within nations, inter-national inequality, or world inequality?

3. Identify ways that globalization affects the poorest nations of our world.

A New Compact for Development in the Battle Against World Poverty

By George W. Bush
President of the United States

The president, renewing the U.S. commitment to fight against poverty, calls for a new compact for development defined by greater accountability for rich and poor nations alike. The following are excerpts of remarks made March 22, 2002, at the United Nations Financing and Development Conference in Monterrey, Mexico.

We meet at a moment of new hope and age-old struggle in the battle against world poverty. I'm here today to reaffirm the commitment of the United States to bring hope and opportunity to the world's poorest people, and to call for a new compact for development defined by greater accountability for rich and poor nations alike.

Many here today have devoted their lives to the fight against global poverty, and you know the stakes. We fight against poverty because hope is an answer to terror. We fight against poverty because opportunity is a fundamental right to human dignity. We fight against poverty because faith requires it and conscience demands it. And we fight against poverty with a growing conviction that major progress is within our reach.

Yet this progress will require change. For decades, the success of development aid was measured only in the resources spent, not the results achieved. Yet pouring money into a failed status quo does little to help the poor, and can actually delay the progress of reform. We must accept a higher, more difficult, more promising call. Developed nations have a duty not only to share our wealth, but also to encourage sources that produce wealth: economic freedom, political liberty, the rule of law, and human rights.

The lesson of our time is clear: When nations close their markets and opportunity is hoarded by a privileged few, no amount -- no amount -- of development aid is ever enough. When nations respect their people, open their markets, invest in better health and education for their people, then every dollar of aid, every dollar of trade revenue and domestic capital is used more effectively.

We must tie greater aid to political and legal and economic reforms. And by insisting on reform, we do the work of compassion. The United States will lead by example. I have proposed a 50-percent increase in our core development assistance over the next three budget years. Eventually, this will mean a $5,000-million annual increase over current levels.

These new funds will go into a new Millennium Challenge Account, devoted to projects in nations that govern justly, invest in their people, and encourage economic freedom. We will promote development from the bottom up, helping citizens find the tools and training and technologies to seize the opportunities of the global economy.

I've asked Secretary of State Powell and Secretary of Treasury O'Neill to reach out to the world community to develop clear and concrete objective criteria for the Millennium Challenge Account. We'll apply these criteria fairly and rigorously.

And to jump-start this initiative, I'll work with the United States Congress to make resources available over the 12 months for qualifying countries. Many developing nations are already working hard on the road -- and they're on the road of reform and bringing benefits to their people. The new Compact for Development will reward these nations and encourage others to follow their example.

The goal of our development aid will be for nations to grow and prosper beyond the need for any aid. When nations adopt reforms, each dollar of aid attracts two dollars of private investments. When aid is linked to good policy, four times as many people are lifted out of poverty compared to old aid practices.

All of us here must focus on real benefits to the poor, instead of debating arbitrary levels of inputs from the rich. We should invest in better health and build on our efforts to fight HIV/AIDS and other diseases, which threaten to undermine whole societies. We should give more of our aid in the form of grants, rather than loans that can never be repaid.

The work of development is much broader than development aid. The vast majority of financing for development comes not from aid, but from trade and domestic capital and foreign investment. Developing countries receive approximately $50,000 million every year in aid. That is compared to foreign investment of almost $200,000 million in annual earnings from exports of $2.4 million million. So, to be serious about fighting poverty, we must be serious about expanding trade.

Trade helped nations as diverse as South Korea and Chile and China to replace despair with opportunity for millions of their citizens. Trade brings new technology, new ideas, and new habits, and trade brings expectations of freedom. And greater access to the markets of wealthy countries has a direct and immediate impact on the economies of developing nations.

As one example, in a single year, the African Growth and Opportunity Act has increased African exports to the United States by more than 1,000 percent, generated nearly $1,000 million in investment, and created thousands of jobs.

Yet we have much more to do. Developing nations need greater access to markets of wealthy nations. And we must bring down the high trade barriers between developing nations themselves. The global trade negotiations launched in Doha confront these challenges.

The success of these negotiations will bring greater prosperity to rich and middle-income and poor nations alike. By one estimate, a new global trade pact could lift 300 million lives out of poverty. When trade advances, there's no question but the fact that poverty retreats.

The task of development is urgent and difficult, yet the way is clear. As we plan and act, we must remember the true source of economic progress is the creativity of human beings. Nations' most vital natural resources are found in the minds and skills and enterprise of their citizens. The

greatness of a society is achieved by unleashing the greatness of its people. The poor of the world need resources to meet their needs, and like all people, they deserve institutions that encourage their dreams.

All people deserve governments instituted by their own consent; legal systems that spread opportunity, instead of protecting the narrow interests of a few; and the economic systems that respect their ambition and reward efforts of the people. Liberty and law and opportunity are the conditions for development, and they are the common hopes of mankind.

The spirit of enterprise is not limited by geography or religion or history. Men and women were made for freedom, and prosperity comes as freedom triumphs. That is why the United States of America is leading the fight for freedom from terror.

We thank our friends and neighbors throughout the world for helping in this great cause. History has called us to a titanic struggle, whose stakes could not be higher because we're fighting for freedom itself. We're pursuing great and worthy goals to make the world safer, and as we do, to make it better. We will challenge the poverty and hopelessness and lack of education and failed governments that too often allow conditions that terrorists can seize and try to turn to their advantage.

Our new approach for development places responsibility on developing nations and on all nations. We must build the institutions of freedom, not subsidize the failures of the past. We must do more than just feel good about what we are doing; we must do good. By taking the side of liberty and good government, we will liberate millions from poverty's prison. We'll help defeat despair and resentment. We'll draw whole nations into an expanding circle of opportunity and enterprise. We'll gain true partners in development and add a hopeful new chapter to the history of our times.

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http://usinfo.state.gov/journals/itgic/0402/ijge/gj01.htm

QUESTIONS:

1. How do we help citizens of nations with corrupt governments that hoard resources? Is it possible to get aid to the citizens who need it?
2. Do you support giving monetary aid to impoverished countries or technology that can be used for economic development? Which method do you believe is the most effective to help citizens in poverty?
3. Do you agree with President Bush that the expansion of trade markets will help impoverished nations or do you believe this will primarily benefit the wealthier nations that control trade markets?

Bank Declaration of Human Rights

Bretton Woods Project

July 24, 2002

The World Bank intends to incorporate human rights strategies into poverty reduction plans. However, problems related to inconsistency and accountability seem difficult to solve. The World Bank President has asked his staff to prepare a human rights strategy. The Bank has previously avoided talking directly about a role for itself in supporting human rights, despite pressure to do so emanating from the United Nations bodies and NGOs.

The Bank aims to prepare a strategy which "without overstepping our mandate or compromising our advantage of political neutrality in the eyes of our members, fully realizes our mission's tie to the advancement of human rights", according to its general counsel Ko-Yung Tung. Ko-Yung was a member of the board of Human Rights Watch before he joined the Bank.

The Bank held a workshop in May to discuss the issues. A memo circulated to Bank staff by Ko-Yung after this said: "we should not be afraid to state that the Bank plays a critical role in the realization of human rights". He continued: "human rights to me fundamentally means respecting the dignity of each individual. Poverty being an abject indignity, our mission of fighting poverty directly involves the advancement of human rights. Human rights is also tied closely to our efforts in promoting the rule of law through our legal and judicial reform activities. We are not, however, a 'world government' or 'world policeman'--we do not legislate human rights, nor do we enforce them. We are a development bank, and as such we assist our member states and their citizens to realize their rights by helping them address crucial issues of health, environment, education, and other basic needs".

In a 1998 publication on human rights, the Bank accepted in general terms that property rights, participation rights, special measures for excluded persons and groups and independent judicial systems are fundamental to poverty reduction, the Bank's primary goal. However it did not state that the Bank has a legal obligation to respect human rights. In May, Alberto Saldamando, General Counsel for the International Indian Treaty Council, told the Permanent Forum on Indigenous Issues: "The World Bank and the IMF have a duty, a legal obligation, to observe human rights in everything they do".

Many critics of the Bank will be glad that the Bank does not intend to become the world's interpreter and arbiter of human rights. But concerns have already been raised about the extent to which the Bank will be ready to be held accountable for its performance against the full set of relevant rights. Korinna Horta, who works with US campaign group Environmental Defense, commented in a recent article for the Harvard Human Rights Journal: "The institution makes a disingenuous distinction by separating political and civil rights from economic and social rights". The Bank is known to be looking at the right to education and food in the context of the PRSPs, but will it cover freedom of association and similar issues?

Horta argues that the Bank's talk of fighting corruption, reforming governance and empowering citizens is inconsistent with its continued technocratic and depoliticized approach to development financing. Horta points out that "large amounts of money continue to flow to

governments that systematically abuse human rights and have shown little commitment to alleviating poverty or protecting the natural resources".

In the past the World Bank has been much-criticised for its loans to Suharto's Indonesia, Mobutu's Zaire or the Philippines under Marcos. But more recently it has turned a blind eye to the responsibilities of countries neighbouring the Democratic Republic of Congo (DRC). Horta describes the findings of a recent report for the UN Security Council which found that the illegal exploitation of gold, diamonds, copper and cobalt is being carried out and exported via Rwanda and Uganda, with massive financial gains for officers in the Rwandan and Ugandan armies. The World Bank must have been aware of this situation (if only because Uganda started exporting large quantities of diamonds and other minerals which it does not produce). Horta argues "had the World Bank publicized the looting of the DRC by Uganda and Rwanda and threatened to cut off funding for both governments instead of rewarding them, it could have made a contribution to establishing peace, a critical pre-condition to its mission of alleviating poverty."

Campaigners also point to the fact that the Bank has recently diluted its operational policies on indigenous peoples and on resettlement. In discussions on these policies as well as its forest policy, it has consistently refused to mention international law. Bank reviews state that around three million people have been displaced from their lands as a result of World Bank projects. Very few of those affected have been properly compensated. The UN Committee on Economic, Social and Cultural Rights has underscored the human rights obligations of these two institutions and notes that "the international agencies should scrupulously avoid involvement in projects which, for example, involve the use of forced labour or large-scale evictions or displacement of persons".

The World Bank's recent support for the Chad/Cameroon oil pipeline reveals its inconsistent approach. The area of the proposed oilfield in Southern Chad has seen many human rights breaches. An organization working to represent the local population (Entente des Populations de la Zone Pétrolière) did not receive legal recognition from the government and was disbanded. Yet the Bank overruled requests from Chadian civil society groups for a moratorium on Bank support for the project until such issues were resolved. In a specific instance of human rights abuse, however, Bank President James Wolfensohn personally intervened with the president of Chad to help secure the release of Ngarlejy Yorongar, a presidential candidate who campaigned against the pipeline.

It will certainly be good for the World Bank to clarify what it sees as its role in pursuing human rights. Bank staff are carefully considering the options available to them following Wolfensohn's edict to produce something to discuss for the annual meetings this September. It is clearly sensible for the Bank to clarify its understanding of rights issues. But how far will the Bank go in a situation where a number of governments sitting on its board as well as its own legal and other staff will urge extreme caution? Will the Bank accept:

· its responsibility to respect international human rights law in full?

· that it should share financial, legal and moral responsibility for projects or programmes which have direct negative social impacts?

· claims for compensation from people negatively affected by projects or programmes where the Bank can be proved to share responsibility for this outcome?

· the judgement of relevant UN bodies on human rights?

· that it should avoid large-scale evictions resulting from its actions?

· demands from unions that World Bank contracts should incorporate clauses protecting workers' rights?

· that the rights of workers and service users need better protection during Bank-backed privatisation of services or other public service reforms?

The Bretton Woods Project plans to work with others to track the Bank's progress towards a new human rights agenda.

http://globalpolicy.org/socecon/bwi-wto/wbank/2002/0724hr.htm

QUESTIONS:

1. In what ways are human rights and poverty linked?
2. If the World Bank will not be the arbiter of human rights, then what organization or government should take on this responsibility?
3. Who is responsible for interpreting what human rights are and what constitutes a violation of human rights?
4. Who has the authority to enforce punishment for human rights violations?

Globalisation: A Challenge for Peace Solidarity or Exclusion?
Susan George
Insitituto Internazionale Jacques Maritain
Milano, 29-31October 1998

> *The value, or worth of a man... his price... is so much as would be given for the use of his power, a thing dependent on the need and judgment of another... And as in other things, so in men, not the seller but the buyer determines the price."*
> Thomas Hobbes, Leviathan [1651], Chapter X

All of us use the word 'Globalization'; it figures in the titles of countless seminars and conferences like this one, it has been repeated so often that we tend to accept it uncritically. Allow me to suggest that by doing so, we all become victims of a particularly successful ideological hijacking of language.

The word "globalization" conveys the sense that all people from all regions of the globe are somehow caught up in a single movement, an all-embracing phenomenon and are all marching together towards some future Promised Land.

I will argue that precisely the opposite is the case, that the term "globalization" is in fact a word which masks rather than reveals present reality and is convenient shorthand for de facto exclusion. It has nothing to do with the creation of a single, somehow integrated world or a process from which all earth's inhabitants will somehow benefit. Rather than encompassing everyone in a collective march towards a better life, globalization allows the world market economy to "take the best and leave the rest".

To use Hobbes' words, cited above, globalization allows "the buyer to determine the price of a man" on a massive scale, unprecedented in human history. When the buyer can choose his men anywhere, that price may well be zero. Whole regions are being left out of the globalization process, including most of Africa. Individuals may be jettisoned at any time. Politics in the twenty-first century will no longer be mostly about who shall rule whom, nor even about who shall receive what share of the pie. Politics, if neo-liberal globalization is allowed to succeed, will rather be about the deadly serious issue of survival-who has a right to live and who does not.

Although it is impossible fully to justify my position in the twenty minutes allowed, I should like to defend briefly three major assertions concerning the neo-liberal globalization model:

1. Globalization inevitably transfers wealth from the poor to the rich and increases inequalities both within and between nations;
2. Globalization shifts sovereignty from more-or-less democratic States to non-elected, non-transparent, non-accountable entities which consider democracy irrelevant and obstacle to economic efficiency. **(1)**
3. Globalization generates far more losers than winners yet those most responsible for its spread have absolutely no plans for the losers.

The first statement-that globalization implies the transfer of wealth from poor to rich is easy enough to prove. At the level of world wealth distribution, I assume all the participants in this Conference are familiar with the UNDP's Human Development Index and the "champagne-glass graph" which shows that the top 20% of humanity now captures 86% of all wealth [compared to 70% thirty years ago], while the bottom 20% has seen its already meager portion of this wealth reduced to just 1.3%.

The North-South differential was about 2 to 1 in the 18th century, 30 to 1 in 1965 and is now 80 to 1 and rising. Many of you will also have heard the comparison between the billionaires and the billions-not a scientific comparison, but striking. The combined assets of the world's 440-some dollar billionaires is equivalent to the net worth, as measured by GDP share, of roughly half the world's people.

If we look at wealth disparities within nations as opposed to global disparities between North and South, we discover the same tendencies. Twenty years of neo-liberal policies-structural adjustment programmes in the South and East and Reaganite or Thatcherite policies in the North-have resulted in huge transfers of wealth from the bottom of society to the top and in a "hollowing out" of the middle classes. Here are a few citations from the UNCTAD 1997 Trade and Development Report to make this point: **(2)**

In the 1990s, income inequality has increased sharply from relatively low levels in the former socialist countries of Eastern Europe and also in China".

[This is also true in Latin America and in many OECD countries, particularly the US, Britain, Australia and New Zealand].

A recurrent pattern of distributional change in the 1980s was an increase in the income shares of the rich which was almost invariably associated with a fall in the income shares of the middle class. For many countries, this was a reversal of trends before 1980...

A[n] important feature of these patterns is the degree of synchronization in the timing of distributional changes in countries with very different economic structures and cultures. Synchronized shifts can be taken as an indicator that income inequality trends are increasingly being influenced by forces common to all the countries, i.e. forces which are global in character...This phenomenon [of rising inequality despite, in some cases, growth] appears to be related to a sudden shift in policies giving much greater role to market forces."

These trends towards greater inequality are neither accidents nor acts of God. They are built-in effects of liberalization, privatization, forced integration into world markets through structural adjustment and much greater reliance on market forces which reward capital to the detriment of labour. Dozens of empirical studies document the stagnation of wages and the growth of disparities between rich and poor so there is no need to labour this point.

The second assertion I want to argue-that globalization is accompanied by a grave and growing democratic deficit-is becoming more obvious daily. We are constantly being told of the need for "deregulation". Like "globalization", "deregulation" is another trap word. No system can function

without rules-the real question is who makes the rules and for whose benefit. At present, only States are being made to "deregulate", to liberalize and in particular to make labour markets less "rigid" so that workers will have to compete even more fiercely with each other while being deprived of social protection.

Although States are being downgraded, new rules are constantly being put in place at the international level. Once enacted, almost invariably without citizens' knowledge or debate, they are enforced by non-elected, opaque institutions like the International Monetary Fund, the World Trade Organization and other international or regional bureaucracies [e.g. NAFTA].

Globalization has been led by corporations and banks so it is not surprising that the new rules benefit their interests and ensure even greater freedom for market forces. The Multilateral Agreement on Investment [MAI] is a particularly pernicious example of the attempt to transfer sovereignty from elected governments to transnational corporations and financial speculators. Thanks to international citizen involvement and protest, this treaty has almost certainly been defeated at the OECD but will just as certainly reappear in another form, probably at the World Trade Organization.

Under the new rules, there is no protection for ordinary people, even skilled people. Anyone can be ejected from the system at any time. Global, transnational corporations are constantly downsizing their staffs; the top 100 corporations accounting for over 15% of World Product employ only 12 million people and they sacked a further 4% of their personnel between 1993-1995. Nor are there any rules to prevent the establishment of transnational oligopolies and monopolies: in the past three years, three-quarters of all foreign direct investment has been devoted to mergers and acquisitions which invariably result in job losses, not to new, job-creating investment.

If human betterment were the object of globalization, its instigators would have to admit it has been a colossal failure. Market forces and unelected international bureaucracies have been allowed to dictate the rules, with consequences that are spread all around us. Following the Mexican crisis and devaluation of 1994-95, half the Mexican population has dropped below the poverty line. A year or two ago, the Asian tigers were singled out as paragons. Today, literal starvation has returned to Indonesia. A sharp increase in suicides has taken hold in Korea where workers no longer see any hope for themselves and their families: locally, their deaths are called IMF suicides. In Russia, life-expectancy rates for men have plummeted by 7 years in less than a decade, an unheard of occurrence in the 20th century.

Uncontrolled financial speculation in so-called "emerging markets" has led to disaster for the majority of the population in the affected countries, yet the IMF is still seeking to change its statutes for the first time since it was founded so that it can oblige member countries to liberalize completely their capital accounts.

Citizens and their governments are, however, sometimes useful to the prime movers of globalization. For example, when the US hedge-fund Long Term Capital Management was on the edge of collapse after borrowing at least a hundred times its initial capital base, the Federal

Reserve Bank of New York leaned heavily on US banks to bail out this fund, made up of multi-millionaires, as the Fed was afraid that its failure could destabilize the entire global economy.

Citizens are also unwittingly forced to contribute their taxes to IMF bailouts-most of which do not go to the people who are suffering but to the very speculators who caused the crises in the first place-this is particularly flagrant in the case of Russia. Citizens are further obliged to save reckless private firms that are considered "too big to fail" [Savings and Loans in the US, Credit Lyonnais in France, large firms or banks in Japan]. One could say this is a certain kind of solidarity, but I doubt it is the kind the organizers of this Conference have in mind.

The third statement I want to argue is that globalization as now conceived creates far more losers than winners and no one has any plans for the losers.

It creates innumerable losers because:

- It places in direct competition people who will never meet, so that as Hobbes said, "Every man is enemy to every man";
- Such competition creates the well-known "race to the bottom" concerning labour and environmental standards as countries compete for foreign direct investment;
- It allows capital total freedom to cross borders, whereas labour is rooted and cannot migrate freely;
- It allows transnational capital almost entirely to escape taxation; **(3)**
- By not taxing capital, it makes social protection much more difficult to pay for. Governments then tax local salaries, wages and consumption more heavily to make up for the loss;
- It strips well-endowed regions of their natural capital, and moves on when those resources are exhausted, leaving ecological devastation in its wake;
- It systematically externalizes environmental and social costs;

Economic globalization is no accident. Naturally technology made it possible, but it was deliberately designed by neo-liberal economists and governments, international financial institutions, corporate and banking leaders-in other words, the sort of people who meet every February in Davos at the World Economic Forum. They claimed everyone would benefit from globalization and this claim has been revealed as a lie. Neo-liberal globalization is a vast, planetary experiment but it is not the natural or desirable condition of mankind.

Above all, it cannot include everyone. As already mentioned, transnational corporations employ very few people compared to their sales. **(4)** They also contribute to the destruction of local employment. Open borders in agriculture will bankrupt more and more local farmers. Local communities are losing their autonomy: they can no longer protect their resources or their inhabitants. National elites in the South are given opportunities for enrichment and on the whole cooperate with this system.

Such a system, operating in the interests of a tiny minority, should not be expected to concern itself with the plight of the majority. However, the social misery and upheaval already surfacing as a direct result of globalization will eventually strike the minority as well. The fatal flaw of the

perpetrators of globalization is their inability to protect durably the very system that sustains their power and profits.

This brief talk is diagnostic and descriptive rather than prescriptive, but I should still like to conclude with a few words concerning remedies. This does not mean that they have any chance of application without broad political mobilization of the type that has won an initial victory by defeating the MAI at the OECD.

The first task is to force decision-makers to recognize that the current model will necessarily produce and exacerbate poverty, exclusion and social conflict. The point is to demolish the reigning ideology which claims that neo-liberal globalization is inevitable and will eventually shower its benefits on all, in some far-off future time. This is doctrine, not political reality and it is best to leave matters of religious faith to religion.

Second, since globalization is withdrawing economic and therefore social power from citizens, communities and nation-States while simultaneously decreasing their capacity to protect themselves from the onslaughts of the market, one must seek to re-empower communities and States while working to institute democratic rules at the international level. A new Bretton Woods Conference is urgently required in this regard and future attempts to institute the MAI in any context should be fought.

Finally, at a more fundamental level, a re-examination of the meaning of legitimacy should take place. Fully exploring this notion would require another talk: here I can only note that the major actors in the present world system exert enormous influence on the basis of self-conferred legitimacy. Corporate directors and bankers, fund managers, IMF economists, WTO trade lawyers and arbiters, the "Davos People"-all are unelected, all exert enormous power over other peoples' lives, all are unaccountable.

Through their self-conferred legitimacy, they seek to exclude all other voices. "Exclusion", a major subject of this Conference, does not only concern exclusion from material benefits but also from the decision-making process and the right to control vital aspects of one's own life and humanity. Restoring the right to a voice is another challenge to establishing genuine solidarity.

http://www.tni.org/detail_page.phtml?act_id=1489&username=guest@tni.org&password=9999&publish=Y

QUESTIONS:

1. What examples have you learned about the author’s view of globalization as a “take the best and leave the rest” movement? To refute it?
2. How can policymakers encourage the redistribution of wealth?
3. If international organizations like the WTO are detrimental because they are not elected bodies, as the author suggests, then with what form of governing body should they be replaced?

What is Sustainable Development?

What is sustainable development? The United Nations Development Program provides a useful explanation:

> To address the growing challenge of human security, a new development paradigm is needed that puts people at the center of development, regards economic growth as a means and not an end, protects the life opportunities of future generations as well as the present generations and respects the natural systems on which all life depends…
>
> A major restructuring of the world's income distribution, production and consumption patterns may therefore be a necessary precondition for any viable strategy fir sustainable human development.
>
> In the final analysis, sustainable human development is pro-people, pro-jobs and pro-nature. It gives the highest priority to poverty reduction, productive employment, social integration and environmental regeneration…And sustainable human development empowers people – enabling them to design and participate in the processes and events that shape their lives.

This is an excerpt from the book:

> Sklar, Holly. Chaos and Community?: Seeking Solutions, Not Scapegoats For Bas Economics. Boston: South End Press, 1995.

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Sustainable Development Gains University Cachet

By JON E. HILSENRATH
Staff Reporter of THE WALL STREET JOURNAL

NEW YORK -- Environmentalists and left-leaning economists have been trying to get people interested in sustainable development for nearly two decades. Now they're getting a new breath of life from Columbia University.

Columbia, which is throwing huge resources at the subject, is betting that sustainable development will be the next hot-button issue in academia. This month, Columbia disclosed that it is housing its new star economist, Jeffrey Sachs, in an $8 million townhouse near Central Park West in Manhattan, a neighborhood that is also home to celebrities such as Jerry Seinfeld and Madonna. The townhouse will double as a place where Mr. Sachs can entertain world dignitaries to push his wide-ranging views about the environment, infectious disease and Third-World poverty.

The townhouse is just a small piece of Mr. Sachs's growing empire at Columbia, which lured him away from Harvard University in April to head its Earth Institute. A previously obscure institution known mostly to geologists and atmospheric scientists, the Earth Institute -- with an overall annual budget of $80 million -- will be the university's attempt to put its own stamp on a range of issues important to the developing world.

"I'm trying to make sustainable development work," says Mr. Sachs, who made a name for himself in the 1980s and 1990s pushing "shock therapy" economic reforms in countries experiencing hyperinflation.

But many economists scratch their heads when asked to define sustainable development. "I have no idea what it means, except that it is politically correct," says Michael Kremer, a Harvard University economist who researches health and education in poor countries.

The notion of sustainable development first gained traction during the 1980s and was mostly related to a concern by advocacy groups that rich countries were depleting the world's resources and ruining its atmosphere. Economic growth, the argument went, was not sustainable unless government policies were more environmentally friendly. To right-leaning economists, it sounded like the discredited notion proposed by Thomas Malthus two centuries ago that the world population might grow too fast to feed itself.

"It is not a very useful concept," says William Easterly, a former World Bank economist who will soon join the faculty of New York University.

What is clear is that reaching out to the world's poor is becoming a priority again in universities and policy circles. The subject has been elevated in part by the realization that terrorism can brew in poor places such as Afghanistan and by the devastation of AIDS and poverty still plaguing large parts of Africa, Latin America and Asia.

In Washington, Treasury Secretary Paul O'Neill put the plight of poor countries on the Bush administration's agenda when he toured Africa earlier this year with the rock star Bono. From corporate America, Bill Gates earlier this month pledged $100 million to address AIDS in India. Meanwhile, the latest round of trade negotiations between rich and poor countries is supposed to be a "development round," focused on opening trading opportunities for the world's poorer countries.

Mr. Sachs says old ideas about sustainable development are outdated. "I don't believe that growth in rich countries imperils the poor," he says. Instead, he and Columbia want to give their own eclectic definition to the idea.

A conversation with Mr. Sachs ranges from the level of nitrogen in African soil to the role that magnesium silicate might play in addressing global warming to the peculiar perils posed by the anopheles gambiae strain of mosquitoes. It neatly sums up sustainable development for him and the Earth Institute.

In Mr. Sachs's mind, addressing the problems of the world's poor means getting your hands dirty with the science behind those problems, such as how soil can be altered to improve African agricultural productivity.

"Development economics has cornered itself by looking at too limited a range of issues," says Mr. Sachs. "If you want to understand the problems in Africa, you really need to understand malaria; you need to understand African-soil fertility and El Nino."

This is where the Earth Institute comes in. It is a collection of large and disparate research centers, from the Lamont-Doherty Earth Observatory, which studies earthquakes and volcanoes, to the Goddard Institute for Space Studies, which studies climate change. Mr. Sachs wants to use these institutions to marry the science behind poor-country problems with economic solutions. The approach isn't entirely unique. The Massachusetts Institute of Technology's Center for Global Change Science, for instance, brings economists together with scientists. But the scale at Columbia will be much larger.

Mr. Sachs is going at sustainable development with missionary zeal. He's starting a new doctorate program in sustainable development. He's bringing in new faculty, such as Pedro Sanchez, a tropical-soil expert. He's planning a large fund-raising campaign to expand the institute's resources. And he'll use his perch at Columbia to launch advisory work with the United Nations and individual countries.

But making any kind of economic development work is tough business, says Mr. Easterly, whose book "The Elusive Quest for Growth" lays out the many pitfalls of development economics.

"The list of failed panaceas," Mr. Easterly says, "includes foreign aid, foreign investment, education, family planning, big infrastructure projects, conditional aid, debt forgiveness, and so on." The real problem for many countries, he says, is that they don't have the political institutions needed to make development work -- like even-handed courts or clean government. Good science is important, but it won't change that.

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Updated November 25, 2005

Johannesburg Summit: Jeffrey Sachs: 'Accountability of Promises Made by Donor Governments at Rio is the Key to Success'

» By PREETI DAWRA

JOHANNESBURG--Jeffrey Sachs, considered to be one of the world's foremost economists -- having advised people who undertook dramatic reforms in Bolivia, Poland, and Russia -- ltook on critics Thursday who contend that the UN is holding yet another talk-shop at the World Summit on Sustainable Development (WSSD). These critics contend that the UN is setting new goals when the previous ones set at Rio have not been met. Sachs pointed out that the failure in meeting the targets is largely the fault of donor countries that have backtracked on the commitments made at Rio. Sachs was especially critical of his own country, the United States, in making the lowest possible commitments towards meeting these goals.

"I think it is very ironic for those that have the means to make a dent in the desperate poverty conditions of the world's poor," Sachs said in an exclusive interview with The Earth Times, "to say that UN is making lofty declarations, that it is holding a talk fest. I would like to remind them, that they are the ones that signed up to these commitments [referring to the Rio commitments and Millennium Development Goals]. It is their moral and political obligation to meet them. Instead of blaming the UN they should explain to the world why they have broken their promises."

The World Summit on Sustainable Development is taking place against the backdrop of 10 years of substantial failures to implement the agreed agenda of the Rio summit: Agenda 21. Sachs estimates that if the developed world were to commit to putting aside just one penny out of every $10, it would create a fund of $25 billion--an amount that the WHO study predicts would save 8 million lives per year.

Sachs, who is currently a special adviser to the UN Secretary General Kofi Annan, is arguably one of the most eloquent voices today in promoting development. Long affiliated with Harvard, first as a student and since the early '80s as a professor, in early 2002, Sachs was recently named director of the Columbia University Earth Institute. He is also the most vocal advocate of the UN's Millennium Development Goals (MDG's) that aim to reduce absolute global poverty by half by 2015. Some 189 Heads of State signed on to the MDG's at the Millennium Summit in September 2000.

"The MDG's are the recycling of old goals set at Rio that have not been met," said Sachs. "They have now been recalibrated for a new deadline. Their success will depend on the commitments made by rich countries to finance them by providing 0.7 percent of their GDP."

Achieving the MDG would require doubling the Official Development Assistance (ODA) to $50 billion. At the UN's Financing for Development conference in Monterrey, Mexico, early this year, ODA took a marginally positive turn. The ODA forthcoming from donor countries -- that had been declining for decades -- began to increase. But the amounts that were committed -- would result in increasing ODA by $12 billion beyond the current figure of $40 billion in the next few years-- one fourth of what was deemed as minimal necessity to meet the MDG's. UNDP, which is the scorekeeper and campaign manager of the MDG's has confirmed that dozens of countries are seriously off track to meet these goals.

Sachs pointed out that dismal progress on sustainable development in the last decade -- is not due to due to developing countries not being able to deliver on good governance but specifically because of the backtracking on commitments made by donor governments. Sachs contends that the donor countries have cut funding even in countries that have delivered on good governance, especially in Africa.

There are countries in Africa, such as Ghana, Tanzania, Malawi, Mozambique, that Sachs points out have multiparty democratic governments that are urgently trying to face the needs of their people but are still unable to access the level of assistance that they need.

Sachs elaborated that he personally reviewed the proposal of funding that the Government of Malawi prepared to address their AIDS problem. While the donor countries admitted it was a very good proposal, they felt too much was being asked of them financially. An exasperated Sachs said, "In effect they were saying, we will not come up with the dollar a day which will help thousands of your people alive."

"If the debate is about good governance, then everyone has to deliver on them including the rich," said Sachs. "We here cannot sit here and lecture governments about good governance and not apply that rule to us. United States and EU need to be held accountable."

But the big question here is whether it is realistic to expect more. Sachs thinks it is. The developed world is an economy that generates $25 trillion in annual GNP. The US is presently spending 0.1 percent of 1 percent in ODA, one-seventh of what has widely been considered to be an international norm.

When asked if the low commitments from US could be attributed to the state of its present economy, a notably amused Sachs responded: "The US is a $10 trillion economy. When the US was rich and booming, it was giving little money, now when the US is in recession it is giving little money." "When the stock market had raised more than $10 trillion, it was giving little money. Now when the stock market has plunged, it is giving little money," noted Sachs. When there was a $4 trillion cumulative projected budget surplus, US was giving little money, now that the budget surplus has been vanquished it is giving little money."

Commenting on the absence of US leadership here at the Summit, Sachs said that he felt very uncomfortable about his country's commitment. "When almost the entire world is in Johannesburg discussing the urgency of sustainable development," Sachs noted, "Washington is discussing a potential new war on Iraq. This is a great risk for the US foreign policy and a significant risk for the world, which is discussing a common agenda without the US."

So what are Sachs expectations of this conference and who should be held accountable if the world, yet again, fails its poor? "It is my personal view that if there are no new financial commitments that come forward," said Sachs, "it will be fair to ask if the rich countries are serious about sustainable development. It will be very unfair to ask what is the UN doing holding these meetings."

http://www.earthtimes.org/aug/johannesburgsummitjeffreysachsaug29_02.htm

QUESTIONS:

1. How have the donor countries failed to keep their promises to the world’s poor?

2. To whom does the author attribute what he describes as “a dismal progress on sustainable development in the last decade?” Is this justified?

3. Given the poor condition of its present economy, do you think it is realistic to expect more money from the US?

4. Who should be held accountable for the world’s poor?

http://www.sustdev.org/Features/mitchgold.shtml

Sustainability Discussion and the WSSD Conference Johannesburg 2002: (an educators point of view)

Some of the most important aspects of the Sustainability movement largely remain hidden behind all the activity that led up to the World Summit.

The Kyoto agreement is moving forward, but how different is this from the Montreal Protocols of 1987? Are we making progress? Look at the sunset tonight for your answer.

Earlier this summer when the G8 met in Kanaskis the plight of the G&77 was sideswiped by the formation of a new Africa Initiative – NEPAD. The agreement in Kanaskis to fund NEPAD may be a starting point for Africa and in this light is a positive happening, but it does not move the Millennium Report of the Secretary General forward at the necessary pace.

There are two other large issues that Johannesburg is going to pay little attention to, and that is a shame.

Firstly, the very business model that is being put forth by many of the world corporations. This model is generally referred to as the Triple Bottom Line (TBL), and is being championed by companies like Sun Oil, and Alcan Aluminum and an organization known as SustainAbility Inc. This triple bottom line philosophy leaves something to be desired when you bring a holistic analysis to the process. The International Association of Educators for World Peace (IAEWP) through its One Percent Solution (TOPS) program promotes a different model from the three pillar approach of contemporary thinking bureaucrats. The three pillars of the Triple Bottom Line are identified as Environment, Social Justice and Economics.

What is unfortunate about this model is that at first glance it feels viable, as it sounds inclusive. Its effect however is the exact opposite and the pillars are set as being in balance and not related to each other.

Holistic thinkers have adopted a more effective model. It suggests that the environment is not one of the pillars, but rather it is the mantel which all of the pillars hold up. It relies on the definition of environment that includes, and does not exclude. If you look at the Triple Bottom Line model and move Environment to the top as a mantel, then you have two pillars holding up the environment. Holistic modeling suggests that we add at least two more pillars, and leaves the field open for others to be added. The two additional pillars are, health (of planet, and of humans) and energy (in all its forms). These four pillars form a new basis for thinking on environmental issues. Johannesburg, unfortunately, did little to bring forth this educational modeling.

Beyond the modeling, is the core problem - financing. In 1992 at Rio, failure was defined by the inability of the World Bank to support Agenda 21. Canadians can point to Morris Miller who reported this decision of the World Bank to the World Futures Society in 1993 Washington Conference. This writer was shocked to learn that it was a Canadian who spoke on behalf of the World Bank and identified the inability of the World Bank to endorse Agenda 21 because of the US and its ownership position in the World Bank.

Here we are ten years later, and the World Bank has not shifted its position very drastically, nor is it looking favorably on the suggestion of George Soros to use the provision of Special Drawing Rights (SDR) to fund global development.

While this writer does not understand fully the implications of the SDR provisions, it is not too great a leap of faith to try. The SDR idea will establish an immediate funding base of approximately $30 billion. This discussion needs to take place. I do not mean to distract the reader but we are more supportive of the TOPS model to refinance civil society. This program has an opportunity to do so and can be found at http://hpa.ccjclearline.com/hpf_1percent.asp. It should be noted that several components of the TOPS model support Mr. Soros SDR proposal and in fact empower it.

This program does not require governments and bureaucracy to move forward. TOPS functions through the collective will of individuals that desire to see change, and institutions both old and new that see a role for themselves in the process. The UN Global Compact is a focal point for getting the discussion moving and the TOPS program is bringing value added to the initiative of the Secretary General. We have asked the UN Global Compact to bring forth the discussion of the TOPS program and look forward to developing the relationship with the UN Global Compact as an important initiative for all Civil Society to support.

To get involved in your country contact the writer mgold@homeplanet.org and visit our website: www.homeplanet.org

QUESTIONS:

1. How did the events leading up to the World Summit detract from some important aspects of the Sustainability movement?

2. What were two large issues neglected at the WSSD Conference in Johannesburg?

3. Why is financing the core problem?

4. How does the TOPS program move forward without the assistance of governments and bureaucracy?

Beyond the Johannesburg Summit: The Challenge of Effective Implementation

By IAN JOHNSON

The World Summit on Sustainable Development (WSSD) represented the culmination of a cycle of major intergovernmental meetings aimed at helping translate the Millennium Declaration into action. The Summit was the first major multi-stakeholder international gathering where both the agreed texts and the spirit of change that characterized these international agreements is reflected in commitments or recommendations for action.

If Monterrey in February 2002, achieved a new level of consensus based on mutual accountability and on a modern framework for development partnership between rich and poor countries, the Johannesburg outcome will allow the international community to put into practice a new approach to global issues that is directly linked to the interests of poor people around the world.

Now, implementation. The WSSD provided space for a broad discussion on long-term sustainability, global equity and justice, and on the centrality of poverty reduction to sustainable development. At times, such UN large meetings are criticized for their lack of "instant gratification." However, their lasting importance is often felt over the long term in strategic changes, new and emerging priorities, and new modalities of implementation. Summits can also contribute to defining the "big issues" and "big ideas" for a certain period of time. The WSSD needs to be analyzed within this logic.

Long-term thinking is now defined as essential to dealing with sustainability issues (economic change, ecological threats). A new consensus emerged about the need of moving towards a new development path, one that integrates growth with environmental responsibility and social equity. The World Bank has been advocating for this vision of Responsible Growth. The Summit reaffirmed the notion that poverty reduction is much more than a development aid issue but also an issue of peaceful co-existence and planetary survival.

UN Summits such the WSSD, are part of a process of consensus building, which generates the enabling environment for action. The framework has been agreed, the Millennium Development Goals and Targets reaffirmed. Now, it is time for action, for effective implementation.

The new plan of action defined at the Summit represents a broad enough platform to allow implementation at the national, regional, and global level, involving governments, civil society, the private sector, the UN, bilateral development agencies and the Bretton Woods institutions.

There is a critical mass of substantive commitments (fisheries, water and sanitation, energy in Africa, chemicals, biodiversity, etc), and no backtracking on a number of central cross cutting agreements already incorporated in the Doha Trade Round and in the Monterrey Consensus.

The era of fragmentation is over. The Summit demonstrated that interaction between governments, international organizations, civil society, and private sector is here to stay. New

participatory modalities for implementation, with real-time monitoring and assessment, oriented towards achieving better results on the ground will need to be addressed. This is one of the key pragmatic challenges of global sustainable development governance. The message emerging from Johannesburg is clear: new "institutions"--supported by enlightened public policy, a responsible and accountable private sector, and proactive civil society organizations--are going to be needed in order to achieve the WSSD targets and the Millenium Development Goals in 2015.

The South African government, under the leadership of President Thabo Mbeki, played a key role at the WSSD in creating the environment for constructive and open dialogue among governments, civil society, private sector and international organizations. This spirit of cooperation and constructive engagement generated among all stakeholders in Johannesburg is a promising starting point. Now, it is up to us to make it happen.

(Ian Johnson is World Bank Vice President for Sustainable Development.)

QUESTIONS:

1. What difficulties do you foresee the policymakers of the WSSD encountering in the implementation of the ideas for policy discussed?
2. How can the spirit of international cooperation seen at the WSSD be applied in other realms of international policy?

Sustainable Development / Agenda 21

Eckhard Gerke

The term “sustainability” originally derives from the field of forestry. It stood for a specific principle of management which aimed at not felling more trees than were able to regrow. This principle was soon after extended and applied to all functions of forest affairs. Sustainability related to ecological as well as to recreational aspects.

The term “Sustainable Development” is more elaborated and was established in the Nineties of the last century. Reflecting the growing global importance of its impact, the English term “Sustainable Development” has gained recognition internationally. The idea behind the concept has not been perceived unanimously and goes back to the report “Our Common Future” (1987) of the World Commission on Environment and Development (“Brundtland-Commission”) and can be interpreted as the result of the debate of growth following the first Report of the Club of Rome (“The Limits of Growth, 1972). The original concept of “Sustainable Development” has been extended since the UN conference on Environment and Development in Rio de Janeiro (UNCED) in 1992 towards developmental and environmental policy but still excluding ecological aspects.

Following the Agenda 21 agreement in 1992 the UNO set up the Commission on “Sustainable Development” (CSD) to implement the ideals of Agenda 21 on international, national, regional and local level which calls for global interdisciplinary action. “Sustainable Development” describes a complex scenario in which the interrelations between economic, ecological, social and political-institutional dimensions have to be seen as an entity.

The characteristic feature of the basic concept of SD is the universality of the claims of life i. e. the global improvement of basic living conditions while maintaining equal opportunities for living: The aim is a development to satisfy global demands of the present generation and at the same time secure needs and living conditions for future generations. Within this concept e. g. the institutional and political factor for implementing global justice is valued equally to a Sustainable, fair distribution of resources.

The problem of distribution therefore is to be seen as a fundamental principle of SD with the associated claim of intertemporal justice (consideration of the interests of future generations and responsibility for the future), as well as with the postulation of an intragenerative justice in favour of socially deprived groupings and the fight against global poverty.

According to the Wuppertal Institute the graph shows the “Prism of Sustainable Development”. It represents the four relevent social “worlds”, i. e. the institutional, the ecological, the economic and the social dimensions as well as their focal points. The different paths indicate the processes by which the “worlds” are being interrelated.

A comprehensive understanding and reception of SD thus leads to a strategy which takes into account the reciprocal dependencies and interconnections of economic, social and ecological development in the sense of a lasting ecologically aware “Sustainable Development”

Essential for “Sustainable Development” is also the protection of the natural basis of life and the realisation of the significance of nature, i. e. the natural resources in the ecological system. The requirement of initiating such a process is an ecologically sound development.

The concept of “Sustainable Development” does not only imply a shift in standards and terms but also a change of meaning. Instead of “growth” the term of “development” is used with the significance of growth with regard to quality being emphasized. As in the long run quantitative growth (in terms of a growth in national product) does not seem to be feasible because of the limits of nature's resources, a development in terms of raising quality of living conditions, potentials in productions and structures is considered necessary.

Development does not only relate to an general increase in income but also to an improvement in the diversity of development factors. There are close relations to the measurement of quality of life and prosperity. Current attempts of the calculation of an overall indicator are the “Human Development Index” and the World Bank's concept of prosperity.

All in all SD comprises a process of social changes leading to fresh views, new values and action. In order to contribute to a solution of the North-South conflict, problem solving has to start with the overpopulation in industrialised countries under 20% of the world population and a consumption of about 75% of the world's mineral resources and fossil fuels, thus being mainly responsible for global environmental damage.

Increasing emphasis within the sustainability debate is laid on concepts like “One World” and “Spaceship Earth” to point out the limitations involved. Fundamental changes of production and consumption structures as well as a self limitation of consumption in industrialised countries are considered essential to prevent ecological disaster.

Particularly organisations in the field of development aid and environment protection complain about the concept of SD being more or less limited to political declarations whereas environmental actions and programmes are mainly geared towards economic targets and interests.

In order to capture the widest possible scope of the sustainability debate and to structure activities in this field the DataBank was originally based on 40 keywords (from Agriculture to Youth) to cover all activities of relevant experts and institutions. Later, it turned out to be neccessary to add three more keywords to improve the online search facilities of the DataBank, including a full-text search option.

http://www.sd-eudb.net/index.htm?section-engl/articles/gerke1.htm

The World Summit on Sustainable Development: Beginning a New Chapter in Sustainable Development History

By Paula J. Dobriansky
Under Secretary of State for Global Affairs

The upcoming World Summit on Sustainable Development in Johannesburg offers an historic opportunity to re-energize the international community's pursuit of sustainable development. Doing this will require working together to ensure that all countries have robust institutions and sound policies, and forging public-private partnerships to achieve concrete results.

In a landmark foreign policy address at the Inter-American Development Bank on March 14, President Bush announced substantial increases in U.S. development assistance programs and confirmed the United States' commitment to a new vision for helping the developing world. He underscored that the "advance of development is a central commitment of American foreign policy. As a nation founded on the dignity and value of every life, America's heart breaks because of the suffering and senseless death we see in our world. We work for prosperity and opportunity because they're right. It's the right thing to do."

The World Summit on Sustainable Development (WSSD) to be held August 26 to September 4 in Johannesburg is an historic opportunity to re-energize and re-focus the international community's pursuit of sustainable development.

The 1992 Rio Conference on Environment and Development and the 10 years since have established much of the framework for our pursuit of sustainable development. Now, to fulfill the promise of the Rio decade -- to truly achieve sustainable development -- the Johannesburg Summit must usher in a new chapter in which we focus on implementation and concrete results. To do so, we must work together to ensure that all countries have the robust institutions and sound policies that are essential to building a prosperous future for their people and our planet. We must forge partnerships with other governments, with businesses, and with civil society groups that ensure successful on-the-ground implementation.

The Rio Legacy: All Development Must Be Sustainable

The Rio decade has elevated the world's understanding that development must be sustainable, that the three "pillars" of sustainable development -- environmental protection, economic development, and social development -- must go hand-in-hand. Because each pillar is integrally linked to the others, effective pursuit of sustainable development requires a balanced approach that integrates all three components.

Rio and the post-Rio era have also established a framework for addressing sustainable development. The Rio Declaration and Agenda 21 provide us with guiding principles and a roadmap for fulfilling those principles. Multilateral environmental agreements that effectively balance the three pillars of sustainable development as well as voluntary mechanisms such as the International Coral Reefs Initiative and the Arctic Council provide avenues for addressing

environmental problems. Further, the international development goals in the United Nations Millennium Declaration help to outline a path that fosters economic and social development.

Guiding Principles for the Johannesburg Decade

As we head to Johannesburg, we must now turn our attention from building the framework to implementing sustainable development on the ground.

For all countries -- developed and developing -- sustainable development must begin at home. Environmental protection, economic development, and social development all depend on a foundation of good governance in which free markets, sound institutions, and the rule of law are the norm. Sustainable development cannot be achieved in an atmosphere where corruption runs deep, private property is unprotected, markets are closed, and private contracts are unenforceable.

In his March 14 address, President Bush stressed the importance of good governance, pledging a $5,000 million increase in development assistance as part of a "new compact for global development." In return for this additional commitment, the United States seeks developing country actions on the reforms and policies that make sustainable development effective and lasting.

Sound economic policies, solid democratic institutions responsive to the needs of the people, and improved infrastructure are the basis for sustained economic growth, poverty eradication, and employment creation. Freedom, peace and security, domestic stability, respect for human rights -- including the right to development -- the rule of law, gender equality, market-oriented policies, and an overall commitment to just and democratic societies are also essential and mutually reinforcing. Operationally, five of the key elements that are critical to creating an enabling domestic architecture that makes sustainable development possible are: effective institutions; education, science, and technology for decision-making; access to information; stakeholder participation; and access to justice.

Building a solid foundation for sustainable development is a responsibility shared by developed and developing countries. In the United States, we often take these elements for granted, even while we strive to improve our efforts in this arena. Many developing countries, however, recognize the fundamental importance of these issues to sustainable development, but are just beginning to explore how to operationalize them.

Implementation through Partnerships

Another major theme we and other countries bring to the WSSD is a belief that public/private partnerships -- involving governments at all levels, as well as NGOs, businesses, and other stakeholders -- are critical to achieving sustainable development. Within the United States, concrete action on sustainable development takes place not just at the national level, but at the state and local levels as well. Furthermore, it rarely involves only the government; much more often, it happens in partnerships involving business and civil society.

The World Summit on Sustainable Development should be a launching point for these partnerships. The United States will lead by example, seeking to work in partnership with stakeholders and other governments in key sectors such as the following:

- Health
- Energy
- Water
- Education
- Oceans and Coasts
- Food Security, Sustainable Agriculture, and Rural Development
- Forests

A New Chapter

The World Summit on Sustainable Development is a tremendous opportunity to turn a new corner on sustainable development. President Bush has clearly articulated that the United States will "lead by example." We have a destination. To get there, we need to turn our attention towards implementation. By working together to strengthen the foundation of domestic good governance that is essential to the realization of sustainable development and by forging partnerships that achieve concrete results, we can make Johannesburg a success.

http://usinfo.state.gov/journals/itgic/0402/ijge/gj02.htm

APPENDICES

THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS

HIV/AIDS POLICY FACT SHEET

The Global HIV/AIDS Epidemic

July 2002

The HIV/AIDS epidemic has claimed over 20 million lives and more than 40 million people are estimated to be living with HIV/AIDS worldwide. HIV/AIDS cases have been reported in all regions of the world, but most people living with HIV/AIDS (96%) reside in developing nations, where most AIDS-related deaths occur. The nations of sub-Saharan Africa have been particularly hard-hit.[1,2] AIDS is now a leading cause of death worldwide.[3,4] HIV/AIDS is also considered a threat to the economic well-being and social and political stability of many nations.

Current Global HIV/AIDS Statistics

- During 2001, an estimated 5 million people became newly infected with HIV.[2]
- There were an estimated 3 million AIDS-related deaths in 2001.[2] Of these, 1.1 million were women and 580,000 were children under 15.[2]
- AIDS is the number one cause of death in Africa, and the fourth leading cause of death globally.[3,4]
- Worldwide, most HIV-positive individuals are unaware they are infected.[1]

Impact on Women, Children, & Young People

- Women comprise an increasing proportion of adults living with HIV/AIDS, rising from 41% in 1997 to 50% in 2001.[2,5] In sub-Saharan Africa, women represent more than half (58%) of all people living with HIV/AIDS.[2,6] Gender inequalities in social and economic status and access to medical care increase women's vulnerability to HIV/AIDS.[5]
- Teens and young adults have been particularly affected.[7] Young people ages 15-24 account for 42% of new HIV infections and represent almost a third of the global total of people living with HIV/AIDS.[7,8] Infection rates are five times higher among young women than young men in some African countries.[5,7]
- At the end of 2001, an estimated 14 million children under age 15 were alive who had lost one or both parents to AIDS[2]; 90% of these children live in sub-Saharan Africa.[9]

Impact by Region

The major route of HIV transmission worldwide is heterosexual sex, but risk factors for HIV vary around the world. In many regions of the world, men who have sex with men, injection drug users, and sex industry workers have been particularly affected.[1]

Several regions and countries have been particularly hard-hit by the HIV/AIDS pandemic (see Figure 1). Even in areas where HIV incidence has leveled, such as the U.S., there are increasing numbers of people living with HIV/AIDS and continued risk of HIV infection in many communities.[10,11] The regions most affected by HIV/AIDS include:

- **Sub-Saharan Africa.** Sub-Saharan Africa has 71% (28.5 million) of the population living with HIV/AIDS but only 11% of the world's population.[2,12] In some sub-Saharan African nations, up to a third of adults are estimated to be infected with HIV.[1,6] South Africa has the largest number of people living with HIV/AIDS in the world (5 million).[6]
- **Latin America & The Caribbean**. About 1.9 million adults and children were living with HIV/AIDS in Latin America and the Caribbean at the end of 2001, 200,000 of whom were newly infected with HIV in that year.[2,13] Twelve countries in this region have an estimated HIV prevalence of 1% or more.[13] In Haiti and the Bahamas, 6% and 3.5% of adults are estimated to be HIV-positive.[13] HIV/AIDS prevalence rates in the Caribbean are second only to those in sub-Saharan Africa.[2]
- **Eastern Europe & Central Asia**. The epidemic is growing fastest in this region.[2,14] Driven largely by injection drug use, HIV prevalence rates have risen sharply over the last several years in the newly independent states of the former Soviet Union. The estimated number of people living with HIV/AIDS in Eastern Europe/Central Asia was 1 million at the end of 2001.[2,14]
- **Asia & The Pacific**. At least two countries in the region – Cambodia and Thailand – have HIV prevalence rates above 1% among 15 to 49 year olds.[15] There are increasing concerns about the spread of the epidemic in China, India, and elsewhere.[8,15,16] In India, close to 4 million adults and children were already living with HIV/AIDS at the end of 2001.[2,15]

Figure 1: AIDS Prevalence & Incidence by Region[2,8,17]

Region	Adult Prevalence Rates	Total (%) Living with HIV/AIDS end of 2001	Newly Infected in 2001
Global Total	**1.2%**	**40 million (100%)**	**5 million**
Sub-Saharan Africa	9.0%	28.5 million (71%)	3.4 million
South & South-East Asia	0.6%	5.6 million (14%)	800,000
Latin America	0.5%	1.5 million (4%)	130,000
North America	0.6%	950,000 (2%)	45,000
East Asia & Pacific	0.1%	1 million (2%)	270,000
Eastern Europe & Central Asia	0.5%	1 million (2%)	250,000
Western Europe	0.3%	550,000 (1%)	30,000
North Africa & Middle East	0.3%	500,000 (1%)	80,000
Caribbean	2.3%	420,000 (1%)	60,000
Australia & New Zealand	0.1%	15,000 (<1%)	500

Multi-Sectoral Impact of AIDS

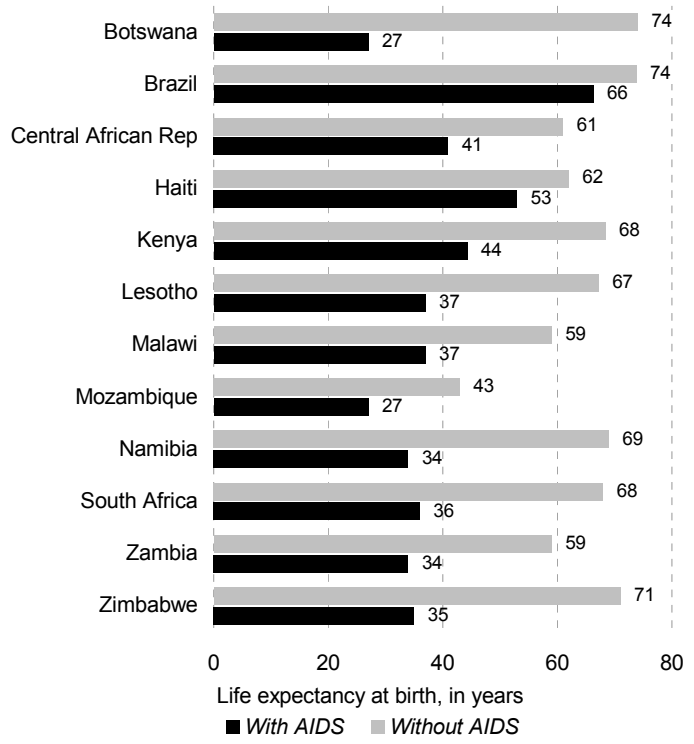
The global HIV pandemic has had a profound, multi-sectoral impact on the structure of many nations, affecting their development and economic growth, communities, households, and individuals:

- AIDS has been declared a development crisis by the World Bank.[18] In countries with prevalence rates of 20% or more, reductions of as much as 2.6% of gross domestic product (GDP) annually are possible.[19] The workforce of nations

has been affected, weakening economies and depleting skilled workers.[19] By 2020, over 25% of the labor force in some sub-Saharan African countries may be lost to AIDS.[20, 21]

- The education sector is also threatened, as AIDS claims the lives of thousands of teachers and schools are forced to close.[22] UNAIDS reports that as many as 1 million children and young people in sub-Saharan Africa lost their teachers to AIDS in 2001.[22,23]
- Increasing demand for health care services is overwhelming the public health infrastructure in many developing countries. In sub-Saharan Africa, direct medical costs of AIDS are estimated at US$30 per capita, when overall health budgets are less than $10 per person.[19]
- HIV/AIDS is significantly affecting the population structures of highly-impacted countries, including their population sizes and age distributions.[3,19,24]
- HIV/AIDS has also affected life expectancy. By 2010, life expectancies in many highly-affected countries could drop below 30 in some countries, reversing steady gains over the last century.[3,24] (See Figure 2.)

Figure 2: Projected Impact on Life Expectancy in Selected Countries, 2010[3,24]



The Global Response

- Scarce resources and political constraints have limited many nations' ability to implement scientifically-based prevention interventions.[1] In addition, most people with HIV in the developing world do not have access to treatment, including antiretroviral therapy and other medications needed by people with HIV, due to their high prices and to limited healthcare infrastructure.[1,25,26]
- UNAIDS has estimated that $7-10 billion is needed annually to effectively respond to the global HIV/AIDS epidemic.[27,28] A subsequent analysis found that $9.2 billion will be required to be spent in 135 low- and middle-income countries by the year 2005[29]; another study found that $13.6-$15.4 billion should be spent in 83 selected low- and middle-income countries by the year 2007, rising to $20.6-24.9 billion by 2015.[30]
- Estimates of current spending on HIV/AIDS in developing countries range from $1.5 to $2.8 billion.[27,31]
- In FY 2002, estimated U.S. federal spending on global HIV/AIDS efforts is expected to total $1 billion or 7% of overall federal HIV/AIDS spending ($14.7 billion).[31,32] The U.S. made the first commitment ($100 million in FY 2001) by a government to the recently created Global Fund to Fight AIDS, TB, and Malaria. In FY 2002, the U.S. committed $200 million.[31,32] Additional contributions are pending Congressional approval.

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This fact sheet was developed as part of *AIDS at 20: A National HIV/AIDS Policy Initiative*, a joint initiative of The Henry J. Kaiser Family Foundation and The Ford Foundation. For additional free copies of this fact sheet (#3030-02) call the Kaiser Family Foundation's Publication Request Line at (800) 656-4533 or visit www.kff.org/AIDSat20.

AIDS in North Carolina: A comparison of North Carolina AIDS Statistics with the United States

Data taken from the Kaiser Foundation's State Health Facts Online Database
http://www.statehealthfacts/kff/org/

Cumulative Number of AIDS Cases, Reported through December 2001

North Carolina: 11,356
United States: 816,149

AIDS Cases Rate per 100,000 population, in 2001

North Carolina: 11.5
United States: 14.9

New AIDS Cases. Reported in 2001

North Carolina: 942
United States: 43,158

Estimated Number of Persons Living with AIDS at the End of 2001

North Carolina: 5,402
United States: 344,178

Notes: U.S. totals include data from the United States (50 states and the Distric of Columbia), and from the U.S. dependencies, possessions, and independent nations in free association with the United States. Five cases in the Pacific Islands are alos included in the U.S. total.

Sources: HIV/AIDS Surveillance Report: U.S. HIV and AIDS cases reported through December 2001, Vol. 13, No. 2, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention, Department of Health and Human Services, 2002. Available at http://www.cdc.gov/hiv/stats/hasr1302.htm.

THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS and other Sexually Transmitted Diseases (STDs) in the Southern Region of the United States: Epidemiological Overview

Prepared by

The Henry J. Kaiser Family Foundation

for

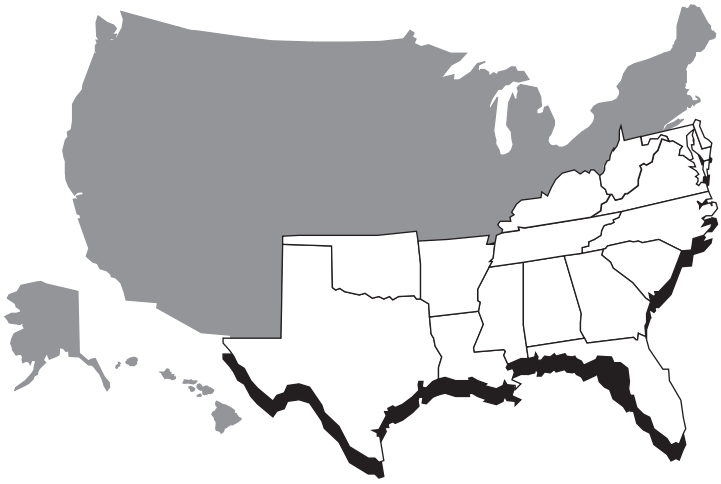
Southern States Summit on HIV/AIDS and STDs:

A Call to Action

November 13 – 15, 2002
Charlotte, North Carolina

HIV/AIDS and other Sexually Transmitted Diseases (STDs) in the Southern Region of the United States: Epidemiological Overview

HIV/AIDS and other sexually transmitted diseases (STDs) have had a disparate impact across the country, with some regions being harder hit than others. The southern region of the U.S., which includes 16 states and the District of Columbia, has been disproportionately affected by the HIV/AIDS and STD epidemics.



AIDS cases were first reported in some Southern states in the earliest years of the epidemic, and the South has the greatest number of people estimated to be living with AIDS in the nation (when compared to the Northeast, West, and Midwest).[1,2,3] In addition, the South consistently has had higher reported rates of chlamydia, gonorrhea, and primary and secondary syphilis compared to other regions of the country.[4]

Multiple factors may contribute to this disparate impact in the South, including the availability of and access to health services, poverty, and stigma. In addition, the presence of other STDs increases the likelihood of HIV transmission.

Tables I – VIII on the following pages provide select epidemiologic data on HIV/AIDS and STDs by region, state and metropolitan area/city. Key highlights include:

HIV/AIDS Data Highlights[1,2,3]

- As of the end of 2001, the South had the greatest number of people estimated to be living with AIDS (AIDS prevalence) in the U.S. While in part due to the fact that the South has the largest population size of all regions in the U.S.[5], AIDS has had a disproportionate impact in the South. While the South represents a little more than one-third of the U.S. population (36%), it accounts for 40% of people estimated to be living with AIDS and 46% of the estimated number of new AIDS cases.

- The impact in the South may be increasing. The South represents a growing share of people estimated to be living with AIDS in the nation, rising from 35% in 1993 to 40% in 2001. By comparison, AIDS prevalence as a proportion of overall prevalence in the Northeast, West, and Midwest regions of the country either decreased over this same period or remained constant.

- In addition, the South comprises an increasing share of the estimated number of new AIDS cases (AIDS incidence) diagnosed each year, rising from 40% in 1996 to 46% in 2001. Estimated AIDS incidence in the Northwest, West, and Midwest regions, as a proportion of overall incidence, either decreased over this same period or remained constant.

The Southern Region of the U.S.

Alabama
Arkansas
Delaware
District of Columbia
Florida
Georgia
Kentucky
Louisiana
Maryland
Mississippi
North Carolina
Oklahoma
South Carolina
Tennessee
Texas
Virginia
West Virginia

- While the estimated number of new AIDS cases in the U.S. remained relatively stable between 2000 and 2001

(increasing by 1%), estimated AIDS incidence in the South increased by 9%. Incidence decreased in the Northeast (-8%) and West (-4%) and increased slightly in the Midwest (2%) between 2000 and 2001.

- The South has the second highest AIDS case rate per 100,000 in the nation (18.2 in 2001). The Northeast has the highest AIDS case rate (23.5). Seven of the states with the 10 highest AIDS case rates in the nation are located in the South.

- The majority of people estimated to be living with AIDS in the South (53% at the end of 1999) are African American, but African Americans represent only 19% of the overall population in the South. Latinos represent 10% of people estimated to be living with AIDS in the South and 12% of the South's overall population.[5]

- About one-fifth (22% at the end of 1999) of people estimated to be living with AIDS in the South are women.

- In 2000, 4 of the states with the 10 highest AIDS case rates among African Americans were in the South, as were 5 of the states with the 10 highest AIDS case rates among Latinos. Data from 2001 indicate that 7of the states with the 10 highest AIDS case rates among women were in the South.

- Among the 25 metropolitan areas (with a population of 500,000 or more) with AIDS case rates in 2001 above the national average for areas of this size, 18 were in the South. In addition, 6 of the metropolitan areas with the 10 highest AIDS case rates were in the South.

STD Data Highlights[4]

- In 2000, the South had the highest case rates for chlamydia, gonorrhea, and primary and secondary syphilis in the nation. Rates of gonorrhea and primary and secondary syphilis have been higher in the South, compared to other regions, throughout the last two decades. Chlamydia rates have been higher in the South since 1997.

- Seven of the 10 states with the highest chlamydia case rates in 2000 were in the South.

- All of the 10 states with the highest gonorrhea case rates in 2000 were in the South.

- Nine of the 10 states with the highest primary and secondary syphilis case rates in 2000 were in the South.

- Four of the 10 cities (with population over 200,000) with the highest chlamydia case rates in 2000 were in the South, as were 4 of the 10 cities with the highest gonorrhea case rates. Six of the 10 cities with the highest primary and secondary syphilis case rates in 2000 were in the South.

ENDNOTES

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[1] Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, 1982 Edition.
[2] Centers for Disease Control and Prevention, *Surveillance Supplemental Report*, Vol. 7, No.1, 2001.
[3] Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, Vol. 13, No. 2, 2002.
[4] Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance* 2000, 2001.
[5] U.S. Bureau of the Census, Time Series of State Population Estimates, 2002.

Table I
Estimated Number of New AIDS Cases (AIDS Incidence) by Region, 2000-2001

REGION	Estimated AIDS Incidence (2000)	Estimated AIDS Incidence (2001)	Percent Change
	No.	No.	Percent
United States	39,491	39,910	1%
South	16,844	18,364	9%
Northeast	12,256	11,336	-8%
West	6,451	6,199	-4%
Midwest	3,940	4,011	2%

SOURCE:
Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, Vol. 13, No. 2, 2002

Table II
Estimated AIDS Prevalence, Incidence, & Population by Region, 2001

REGION	Population (2001)	Estimated Proportion Living with AIDS/ Prevalence (2001)	Estimated Number New AIDS Cases/ Incidence (2001)
	Percent	Percent	Percent
United States	100%	100%	100%
South	36%	40%	46%
Northeast	19%	30%	28%
West	23%	19%	16%
Midwest	23%	10%	10%

SOURCES:
Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, Vol. 13, No. 2, 2002;U.S. Bureau of the Census, Time Series of State Population Estimates, 2002.

Table III
Region as Proportion of Estimated AIDS Prevalence, 1993-2001

REGION	1993	1995	1997	1999	2001
			Percent		
United States	100%	100%	100%	100%	100%
South	35%	36%	38%	39%	40%
Northeast	31%	31%	31%	30%	30%
West	23%	22%	21%	20%	20%
Midwest	11%	11%	10%	10%	10%

SOURCE:
Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, Vol. 13, No. 2, 2002

Table IV
Region as Proportion of Estimated AIDS Incidence, 1996-2001

REGION	1996	1997	1998	1999	2000	2001
			Percent			
United States	100%	100%	100%	100%	100%	100%
South	40%	42%	44%	43%	43%	46%
Northeast	31%	30%	28%	30%	31%	28%
West	18%	18%	18%	17%	16%	16%
Midwest	10%	10%	10%	10%	10%	10%

SOURCE:
Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, Vol. 13, No. 2, 2002

Table V
HIV/AIDS in the United States
Select Data by Region and State/Territory

State/Territory	AIDS Case Rate[2] Per 100,000 (2001)		Number of Persons Living with AIDS/ Prevalence[3] (2001)		Number of New AIDS Cases/ Incidence[2] (2001)		African Americans as Percent Prevalence[3] (end '99)	Latinos as Percent Prevalence[3] (end '99)	Women as Percent Prevalence[3] (end '99)	Case Rate African Americans[2] (2000)	Case Rate Latinos[2] (2000)	Case Rate Women[2] (2001)
	Rate[5]	Rank[1]	No.	Rank[1]	No.	Rank[1]	Percent	Percent	Percent	Rate Per 100,000 Adults/Adolescents		
United States[4]	**14.7**	**--**	**333,881**	**--**	**41,755**	**--**	**42%**	**17%**	**20%**	**74.2**	**30.4**	**9.1**
South	**18.2**	**2**	**134,341**	**1**	**18,569**	**1**	**53%**	**10%**	**22%**	**--**	**--**	**--**
Northeast	**23.5**	**1**	**100,835**	**2**	**12,637**	**2**	**44%**	**26%**	**27%**	**--**	**--**	**--**
West	**10.3**	**3**	**64,977**	**3**	**6,634**	**3**	**17%**	**22%**	**10%**	**--**	**--**	**--**
Midwest	**6.1**	**4**	**33,728**	**4**	**3,915**	**4**	**42%**	**8%**	**16%**	**--**	**--**	**--**
SOUTH	**18.2**	**2**	**134,341**	**1**	**18,569**	**1**	**53%**	**10%**	**22%**	**--**	**--**	**--**
Alabama	9.8	23	3,427	23	438	23	62%	1%	20%	37.8	18.1	5.6
Arkansas	7.4	30	1,781	30	199	32	36%	1%	18%	26.2	13.2	3.9
Delaware	31.1	5	1,367	34	248	30	68%	5%	28%	137.9	64.6	24.1
District of Columbia	152.1	1	7,205	11	870	12	80%	4%	23%	260.1	102.6	92.0
Florida	31.3	4	38,742	3	5,138	2	47%	16%	26%	164.3	37.7	21.0
Georgia	20.8	6	11,269	8	1,745	8	67%	2%	20%	55.1	20.7	12.9
Kentucky	8.2	26	1,873	29	333	26	32%	3%	16%	34.1	34.2	3.0
Louisiana	19.3	8	5,851	14	861	13	58%	3%	19%	46.7	11.7	13.1
Maryland	34.6	3	11,288	7	1,860	5	79%	2%	29%	108.0	18.4	26.5
Mississippi	14.6	12	2,341	26	418	24	67%	1%	25%	40.1	44.2	9.5
North Carolina	11.5	18	5,402	15	942	11	68%	3%	23%	37.9	27.0	7.3
Oklahoma	7.0	31	1,685	32	243	31	19%	5%	12%	41.0	9.4	2.5
South Carolina	17.9	9	5,172	16	729	15	71%	1%	25%	68.5	39.6	13.1
Tennessee	10.5	20	5,021	17	602	16	49%	2%	17%	71.1	30.3	6.3
Texas	13.6	13	24,936	4	2,892	4	33%	21%	15%	53.6	15.3	7.4
Virginia	13.2	14	6,443	12	951	10	57%	4%	19%	51.8	19.8	7.9
West Virginia	5.5	36	538	41	100	39	20%	1%	14%	26.0	--	2.8

NOTES:

1. U.S. territories, dependencies, possessions, associated nations not included in regional or state rankings.
2. Represents or based on reported AIDS cases.
3. Prevalence data represent estimates only.
4. United States totals do not include U.S. territories, dependencies, possessions, associated nations, except for case rates for African American, Latino, and female adults/adolescents.
5. Regional AIDS case rates per 100,000 derived from aggregated U.S. Census population data and CDC reported AIDS incidence data.
Population estimates (data not shown) for U.S. territories, dependencies, possessions, associated nations derived from reported AIDS incidence and case rate data.
6. "--" indicates data not available or cell size too small to include.

SOURCES:

Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, Vol. 13, No. 2, 2002; Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Supplemental Report*, Vol. 7, No. 1;
Centers for Disease Control and Prevention, HIV/AIDS Surveillance by Race/Ethnicity L238 Slide Series; U.S. Bureau of the Census, Time Series of State Population Estimates, 2002.

Table V
HIV/AIDS in the United States
Select Data by Region and State/Territory

State/Territory	AIDS Case Rate[2] Per 100,000 (2001)		Number of Persons Living with AIDS/ Prevalence[3] (2001)		Number of New AIDS Cases/ Incidence[2] (2001)		African Americans as Percent Prevalence[3] (end '99)	Latinos as Percent Prevalence[3] (end '99)	Women as Percent Prevalence[3] (end '99)	Case Rate African Americans[2] (2000)	Case Rate Latinos[2] (2000)	Case Rate Women[2] (2001)
	Rate[5]	Rank[1]	No.	Rank[1]	No.	Rank[1]	Percent	Percent	Percent	Rate Per 100,000 Adults/Adolescents		
United States[4]	**14.7**	**--**	**333,881**	**--**	**41,755**	**--**	**42%**	**17%**	**20%**	**74.2**	**30.4**	**9.1**
South	**18.2**	**2**	**134,341**	**1**	**18,569**	**1**	**53%**	**10%**	**22%**	**--**	**--**	**--**
Northeast	**23.5**	**1**	**100,835**	**2**	**12,637**	**2**	**44%**	**26%**	**27%**	**--**	**--**	**--**
West	**10.3**	**3**	**64,977**	**3**	**6,634**	**3**	**17%**	**22%**	**10%**	**--**	**--**	**--**
Midwest	**6.1**	**4**	**33,728**	**4**	**3,915**	**4**	**42%**	**8%**	**16%**	**--**	**--**	**--**
NORTHEAST	**23.5**	**1**	**100,835**	**2**	**12,637**	**2**	**44%**	**26%**	**27%**	**--**	**--**	**--**
Connecticut	17.1	10	6,123	13	584	17	38%	28%	29%	91.5	98.7	14.2
Maine	3.7	40	486	44	48	43	4%	4%	14%	--	--	2.0
Massachusetts	12.0	16	7,368	10	765	14	26%	24%	26%	129.4	103.8	8.1
New Hampshire	3.2	45	507	43	40	44	7%	11%	18%	--	--	2.5
New Jersey	20.7	7	15,702	5	1,756	7	55%	19%	32%	136.9	42.5	16.2
New York	39.3	2	56,792	1	7,476	1	44%	31%	27%	143.1	92.7	30.3
Pennsylvania	15.0	11	12,680	6	1,840	6	53%	14%	23%	112.9	77.6	9.3
Rhode Island	9.7	24	961	39	103	38	25%	22%	26%	103.2	35.1	6.1
Vermont	4.1	39	216	47	25	46	11%	3%	13%	--	--	2.3
WEST	**10.3**	**3**	**64,977**	**3**	**6,634**	**3**	**17%**	**22%**	**10%**	**--**	**--**	**--**
Alaska	2.8	47	239	45	18	48	9%	11%	14%	--	--	1.3
Arizona	10.2	21	3,612	22	540	20	9%	20%	11%	46.3	11.3	3.1
California	12.5	15	45,428	2	4,315	3	19%	25%	10%	60.4	19.4	4.1
Colorado	6.5	32	3,121	24	288	27	13%	16%	9%	40.2	15.9	2.1
Hawaii	10.1	22	1,070	36	124	36	6%	7%	9%	--	7.1	3.0
Idaho	1.4	49	233	46	19	47	3%	11%	14%	--	--	0.7
Montana	1.7	48	172	48	15	49	4%	2%	11%	--	--	0.8
Nevada	12.0	17	2,249	27	252	29	21%	15%	14%	70.7	21.8	5.0
New Mexico	7.8	28	1,040	37	143	35	5%	35%	8%	38.2	11.9	1.5
Oregon	7.5	29	2,218	28	259	28	6%	8%	9%	53.6	14.1	1.6
Utah	5.5	35	1,089	35	124	37	7%	12%	9%	172.5	20.2	1.4
Washington	8.9	25	4,426	21	532	21	12%	9%	10%	47.1	23.2	2.4
Wyoming	1.0	50	80	50	5	50	5%	9%	13%	--	--	0.5
MIDWEST	**6.1**	**4**	**33,728**	**4**	**3,915**	**4**	**42%**	**8%**	**16%**	**--**	**--**	**--**
Illinois	10.6	19	10,717	9	1,323	9	51%	13%	19%	74.5	26.6	5.3
Indiana	6.2	33	2,944	25	378	25	27%	4%	12%	34.7	20.4	3.1
Iowa	3.1	46	623	40	90	41	15%	5%	11%	42.8	22.9	0.8
Kansas	3.6	41	1,038	38	98	40	20%	8%	13%	29.4	15.3	1.2
Michigan	5.5	34	4,884	19	548	19	55%	4%	18%	43.5	10.7	3.2
Minnesota	3.2	44	1,737	31	157	34	24%	7%	14%	64.9	33.2	1.9
Missouri	7.9	27	4,548	20	445	22	37%	3%	12%	49.3	25.3	2.9
Nebraska	4.3	38	522	42	74	42	19%	11%	15%	38.9	29.5	1.5
North Dakota	0.5	51	46	51	3	51	9%	5%	14%	--	--	0.0
Ohio	5.1	37	4,905	18	581	18	39%	5%	15%	26.5	21.6	2.3
South Dakota	3.3	43	95	49	25	45	6%	3%	17%	--	--	1.6
Wisconsin	3.6	42	1,669	33	193	33	35%	10%	14%	42.7	20.3	1.9
TERRITORIES/OTHER	**--**	**--**	**--**	**--**	**--**	**--**	**--**	**--**	**--**	**--**	**--**	**--**
Guam	7.6	--	32	--	12	--	0%	0%	17%	--	--	1.6
Pacific Islands	0.3	--	3	--	1	--	0%	0%	50%	--	--	--
Puerto Rico	32.3	--	9,548	--	1,242	--	0%	100%	26%	--	45.4	21.1
Virgin Islands	28.6	--	248	--	35	--	52%	36%	32%	--	--	27.1

NOTES:

1. U.S. territories, dependencies, possessions, associated nations not included in regional or state rankings.
2. Represents or based on reported AIDS cases.
3. Prevalence data represent estimates only.
4. United States totals do not include U.S. territories, dependencies, possessions, associated nations, except for case rates for African American, Latino, and female adults/adolescents.
5. Regional AIDS case rates per 100,000 derived from aggregated U.S. Census population data and CDC reported AIDS incidence data.
Population estimates (data not shown) for U.S. territories, dependencies, possessions, associated nations derived from reported AIDS incidence and case rate data.
6. "--" indicates data not available or cell size too small to include.

SOURCES:

Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, Vol. 13, No. 2, 2002; Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Supplemental Report*, Vol. 7, No. 1;
Centers for Disease Control and Prevention, HIV/AIDS Surveillance by Race/Ethnicity L238 Slide Series; U.S. Bureau of the Census, Time Series of State Population Estimates, 2002.

Table VI
AIDS Case Rates Per 100,000 in Metropolitan Areas With 500,000 or More Population:
Areas with Case Rates Above Metro Area Average, 2001

Metropolitan Area	Region	Case Rate	Rank
Metro Total	**--**	**19.0**	**--**
New York, NY	NE	65.9	1
Miami, FL	S	53.8	2
Baltimore, MD	S	50.0	3
Jersey City, NJ	NE	42.1	4
Fort Lauderdale, FL	S	41.3	5
West Palm Beach, FL	S	39.4	6
Baton Rouge, LA	S	36.4	7
Newark, NJ	NE	34.8	8
San Francisco, CA	W	34.6	9
Wilmington, DE	S	33.1	10
Washington, DC[2]	S	32.8	11
Columbia, SC	S	32.7	12
Orlando, FL	S	31.2	13
Atlanta, GA	S	30.3	14
Jacksonville, FL	S	27.5	15
Philadelphia, PA	NE	26.5	16
Tampa-St Pete, FL	S	24.8	17
New Orleans, LA	S	23.4	18
Sarasota, FL	S	22.8	19
Memphis, TN	S	22.6	20
Norfolk, VA	S	21.1	21
Daytona Beach, FL	S	21.0	22
Dallas, TX	S	20.5	23
New Haven, CT	NE	20.3	24
Harrisburg, PA	NE	19.5	25

NOTES:

1. U.S. territories, dependencies, possessions, associated nations not included in rankings.
2. Washington DC represents the Metropolitan Statistical Area which includes parts of Maryland, Virginia, and West Virginia. Data for the District of Columbia only can be found in Table V.

SOURCE:

Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, Vol. 13, No. 2, 2002

Table VII
Sexually Transmitted Diseases (STDs) in the United States
Select Data[1] by Region and State/Territory, 2000

State/Territory	Chlamydia Case Rate Per 100,000 (2000)	Chlamydia Case Rate Rank[2]	Gonorrhea Case Rate Per 100,000 (2000)	Gonorrhea Case Rate Rank[2]	Primary & Secondary Syphilis Case Rate Per 100,000 (2000)	Primary & Secondary Syphilis Case Rate Rank[2]
United States	**257.5**	--	**131.6**	**--**	**2.2**	**--**
South	**296.6**	**1**	**191.8**	**1**	**3.8**	**1**
Northeast	**179.7**	**4**	**92.3**	**3**	**0.7**	**4**
West	**264.7**	**2**	**59.4**	**4**	**1.0**	**3**
Midwest	**254.5**	**3**	**142.0**	**2**	**2.0**	**2**
SOUTH	**296.6**	**1**	**191.8**	**1**	**3.8**	**1**
Alabama	350.7	7	276.0	4	2.8	15
Arkansas	243.8	26	142.7	18	4.1	10
Delaware	379.0	5	230.2	7	1.2	20
District of Columbia	617.5	1	521.4	1	7.1	2
Florida	221.0	34	150.8	16	2.7	16
Georgia	377.0	6	260.2	5	5.2	7
Kentucky	203.6	38	88.4	28	2.1	17
Louisiana	408.2	4	302.9	3	4.8	9
Maryland	281.0	15	190.2	10	5.8	6
Mississippi	458.6	2	332.9	2	4.9	8
North Carolina	287.4	14	233.0	6	6.3	3
Oklahoma	277.9	16	125.9	20	3.5	12
South Carolina	256.1	23	215.7	9	5.9	5
Tennessee	274.8	18	216.6	8	9.7	1
Texas	343.3	8	164.2	14	2.0	18
Virginia	223.4	32	148.0	17	1.8	19
West Virginia	118.7	47	35.7	42	0.2	39

NOTES:

1. Data represent reported cases.
2. U.S. territories, dependencies, possessions, associated nations not included in regional or state rankings.

SOURCE:

Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance 2000* , 2001

Table VII
Sexually Transmitted Diseases (STDs) in the United States
Select Data[1] by Region and State/Territory, 2000

State/Territory	Chlamydia Case Rate Per 100,000 (2000)	Chlamydia Case Rate Rank[2]	Gonorrhea Case Rate Per 100,000 (2000)	Gonorrhea Case Rate Rank[2]	Primary & Secondary Syphilis Case Rate Per 100,000 (2000)	Primary & Secondary Syphilis Case Rate Rank[2]
United States	**257.5**	--	**131.6**	**--**	**2.2**	**--**
South	**296.6**	**1**	**191.8**	**1**	**3.8**	**1**
Northeast	**179.7**	**4**	**92.3**	**3**	**0.7**	**4**
West	**264.7**	**2**	**59.4**	**4**	**1.0**	**3**
Midwest	**254.5**	**3**	**142.0**	**2**	**2.0**	**2**
NORTHEAST	**179.7**	**4**	**92.3**	**3**	**0.7**	**4**
Connecticut	231.7	28	88.7	27	0.5	31
Maine	117.6	48	7.2	50	0.1	46
Massachusetts	177.6	39	49.3	37	1.1	21
New Hampshire	94.1	50	9.2	48	0.2	41
New Jersey	132.8	46	88.8	26	0.9	24
New York	173.1	40	110.5	22	0.7	27
Pennsylvania	220.7	35	113.4	21	0.6	28
Rhode Island	265.6	21	66.7	32	0.4	34
Vermont	88.6	51	10.9	46	0.0	51
WEST	**264.7**	**2**	**59.4**	**4**	**1.0**	**3**
Alaska	414.7	3	58.3	36	0.0	47
Arizona	263.5	22	86.4	29	4.0	11
California	287.8	13	65.2	35	1.0	23
Colorado	295.8	12	76.7	31	0.3	36
Hawaii	299.2	10	40.7	40	0.2	40
Idaho	152.4	44	7.8	49	0.1	45
Montana	166.4	43	6.8	51	0.0	48
Nevada	222.1	33	85.8	30	0.3	37
New Mexico	299.1	11	66.2	34	0.9	26
Oregon	214.3	36	31.3	43	0.4	32
Utah	102.8	49	10.8	47	0.1	44
Washington	227.0	31	42.0	39	1.1	22
Wyoming	168.3	42	11.1	45	0.2	42
MIDWEST	**254.5**	**3**	**142.0**	**2**	**2.0**	**2**
Illinois	272.0	19	170.4	13	3.4	13
Indiana	236.6	27	109.8	23	5.9	4
Iowa	208.6	37	48.5	38	0.4	33
Kansas	228.2	29	105.3	24	0.2	38
Michigan	266.0	20	184.3	11	3.3	14
Minnesota	169.7	41	66.2	33	0.3	35
Missouri	245.9	25	162.4	15	0.5	30
Nebraska	227.5	30	92.1	25	0.1	43
North Dakota	143.5	45	11.5	44	0.0	49
Ohio	277.1	17	171.5	12	0.6	29
South Dakota	250.2	24	37.8	41	0.0	50
Wisconsin	311.7	9	133.6	19	0.9	25
TERRITORIES/OTHER	**--**	**--**	**--**	**--**	**--**	**--**
Guam	321.1	--	37.9	--	0.6	--
Pacific Islands	--	--	--	--	--	--
Puerto Rico	69.3	--	13.5	--	4.5	--
Virgin Islands	116.1	--	21.3	--	2.7	--

NOTES:

1. Data represent reported cases.
2. U.S. territories, dependencies, possessions, associated nations not included in regional or state rankings.

SOURCE:

Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance 2000* , 2001

Table VIII
STD Case Rates Per 100,000 in Cities with 200,000 or More Population:
Cities in Top 10 Rank by Case Rate, 2000

City	Chlamydia Case Rate Per 100,000 (2000)	Region	City	Gonorrhea Case Rate Per 100,000 (2000)	Region	City	Primary & Secondary Syphilis Case Rate Per 100,000 (2000)	Region
U.S. City Total	**407.2**	**--**		**234.9**	**--**		**4.6**	**--**
Richmond, VA	1175.5	S	Richmond, VA	923.6	S	Nashville, TN	37.7	S
Milwaukee, WI	995.1	MW	Rochester, NY	894.8	NE	Indianapolis, IN	37.1	MW
Philadelphia, PA	958.2	NE	Baltimore, MD	885.6	S	Baltimore, MD	34.5	S
Baltimore, MD	858.7	S	St. Louis, MO	862.1	MW	Memphis, TN	28.2	S
New Orleans, LA	828.1	S	Detroit, MI	766.7	MW	Detroit, MI	21.9	MW
St Louis, MO	811.8	MW	Norfolk, VA	659.7	S	Oklahoma City, OK	20.0	S
Detroit, MI	797.0	MW	New Orleans, LA	654.1	S	Norfolk, VA	16.4	S
Atlanta, GA	746.2	S	Kansas City, MO	595.2	MW	Atlanta, GA	15.6	S
Minneapolis, MN	724.3	MW	Philadelphia, PA	578.3	NE	Newark, NJ	9.9	NE
Kansas City, MO	692.7	MW	Milwaukee, WI	567.8	MW	Chicago, IL	9.8	MW

NOTES:

1. Data represent reported cases.

2. U.S. territories, dependencies, possessions, associated nations not included in regional or state rankings.

SOURCE:

Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance 2000* , 2001

THE ECHO FOUNDATION

AN INTRODUCTION

On March 12, 1997, as the centerpiece of the community-wide, year-long, educational Elie Wiesel Project, internationally revered humanitarian and Nobel Laureate for Peace, Elie Wiesel spoke "***Against Indifference"*** to over 23,000 students and adults. He was so inspired by this visit to Charlotte, that, as he left, he challenged the community to continue its focus on the critical issues of human dignity, justice and moral courage. He offered seed money and his wholehearted assistance in obtaining speakers and developing programs to address these issues. Thus The Echo Foundation was born, and with it its mission: ***…to sponsor and facilitate those voices that speak of human dignity, justice and moral courage in a way that leads to positive action for humankind.*** The mission is implemented by bringing speakers, exhibitions and performances to the Charlotte Region as catalysts for educational programs. For each project school-based curriculum materials that meet national and international standards are developed and made available free of charge to schoolteachers across the region.

Our goals are:

A. Educating for compassion, justice and moral decision making;
B. Teaching understanding through fostering relationships founded in respect;
C. Facilitating opportunities to act against indifference on these issues.

Our region has demonstrated a need and a desire to address issues of racial diversity, culture and the quality of human existence. The Echo Foundation brings together people from all corners of Charlotte-Mecklenburg to address these vital goals through student dialogues, teacher workshops, theatrical productions, lectures and more. The primary focus of all projects is humanity. The secondary focus is specific to the particular speaker, exhibition or performance. For example, the primary focus of The Elie Wiesel Project: *Against Indifference* was justice and world peace; the secondary focus of the Project was World War II and the Holocaust.

The Echo Foundation's recent and current projects include the production of the play, *The White Rose;* The Varian Fry Exhibition Project; The Harry Wu Project; *Living Together in the 21st Century,* with Jonathan Kozol; the Kerry Kennedy Project: *For Human Rights;* The Wole Soyinka Project: *Truth Memory and Reconciliation;* Syl Cheney-Coker Project: *Free to Write;* The Jeffrey Sachs Project: *Environment, Poverty and Healthcare on a Global Scale: What can one person do?; Considering Social Capital* with Henry Louis Gates, Jr.; Bernard Kouchner: *Compassion Without Borders*; *A Gathering of Nobel Laureates: Science for the 21st Century; ECHO RETURNS: Young Heroes of Hope*; our 10th Anniversary project, *A Decade Inspired by Elie Wiesel;* and most recently, *From Rwanda to Darfur: A Week of Hope & Reconciliation*.

The Echo Foundation is governed by an International Board of Advisors and a Charlotte Board of Trustees. Mr. Wiesel is an active Honorary Chairperson who continues to meet with Echo on a regular basis. To date, many outstanding professionals in the community have offered their services to The Foundation *pro bono.* The corporate, religious and educational communities have generously exhibited their support of Echo's mission and projects.

THE ECHO FOUNDATION

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