

# 1 Introduction

## Globalization's Challenges to People's Health

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### INTRODUCTION: HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH

This book describes some of the findings of a research network that examined the relation between contemporary globalization and social determinants of health (SDH), with particular attention to health equity. By social determinants of health, we mean simply those conditions of life and work that make it relatively easy for some people to lead long and healthy lives, and all but impossible for others to do the same. Especially in the global frame of reference, taking SDH seriously means starting from a recognition “that many of the most devastating problems that plague the daily lives of billions of people are problems that emerge from a single, fundamental source: the consequences of poverty and inequality” (Paluzzi & Farmer, 2005, p. 12). We define health equity as “the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage” (Braveman & Gruskin, 2003, p. 256).

Global commitments to health equity, whether or not stated with reference to that specific phrase, are not new. In 1978, a landmark United Nations conference in Alma-Ata proposed the goal of health for all by the year 2000 (World Health Organization, 1978). Yet in 2007, despite progress toward that goal, millions of people die or are disabled each year from causes that are easily preventable or treatable (World Health Organization, 2004) at a cost that would be regarded as trivial in the high-income countries. For example, more than ten million children under the age of five die each year, 97 percent of them in low- and middle-income countries and from causes of death that are rare or now unheard-of in the industrialized world (Figure 1.1). Undernutrition—an unequivocally economic phenomenon, resulting from inadequate access to the resources for producing food, the income for purchasing it, or simply access to the right food nutrients—is an underlying cause of roughly half these deaths (Bryce, Boschi-Pinto, Shibuya, & Black, 2005), and lack of access to safe water and sanitation contributes to 1.5 million (Black, Morris, & Bryce, 2003). An expanding

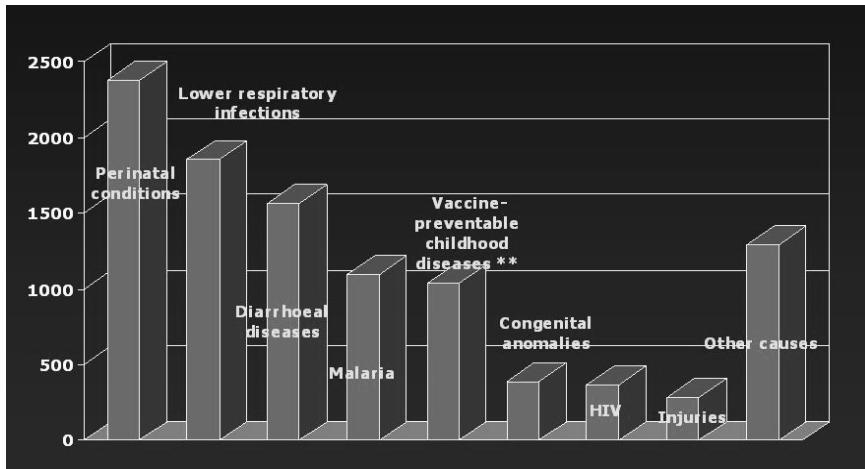


Figure 1.1 Child deaths and diseases of the poor, 2002.

Source: Data from Stein, Inoue, & Fat, 2004.

Notes: \*97 percent of which occur in developing countries; \*\* Measles, pertussis, tetanus.

body of literature describes a similarly unequal distribution of many non-communicable diseases and injuries, with incidence and vulnerability often directly related to poverty, economic insecurity, or economic marginalization (Uauy, Albala, & Kain, 2001; Chopra, Galbraith, & Darnton-Hill, 2002; Peden, McGee, & Sharma, 2002; Nantulya, Sleet, Reich, Rosenberg, Peden, and Waxweiler, 2003; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2003; Monteiro, Moura, Conde, & Popkin, 2004; Monteiro, Conde, & Popkin, 2004; Ezzati et al., 2005).

In 2001, the World Health Organization (WHO) Commission on Macroeconomics and Health turned much conventional wisdom on its head by demonstrating that health is not only a benefit of development but also is indispensable to development (Commission on Macroeconomics and Health, 2001). Illness often leads to “medical poverty traps” (Whitehead, Dahlgren, & Evans, 2001), creating a vicious circle of poor nutrition, forgone education, and still more illness—all of which undermine the economic growth that is necessary, although not sufficient, for widespread improvements in health status. Like the Alma-Ata commitment to health for all, most of the commission’s recommendations, which it estimated could have saved millions of lives each year by the end of the current decade, have not been translated into policy. However, the Commission on Macroeconomics and Health did not inquire into how the economic and geopolitical dynamics of a changing international environment (“globalization”) support and undermine health, or how these dynamics can be channeled to improve population health.

# Knowledge Network Themes



*Figure 1.2* The Knowledge Networks of the WHO Commission on Social Determinants of Health.

Source: Commission on Social Determinants of Health.

In 2005, WHO established the Commission on Social Determinants of Health (CSDH), on the premise that action on SDH is the fairest and most effective way to improve and to reduce inequities in health. To inform its work, the commission established nine Knowledge Networks (KNs), charged with critically reviewing research evidence on their respective topics (Figure 1.2). Globalization was the focus of one of the KNs, and most of the chapters in this book are based on research synthesis activities undertaken during the work of the Globalization KN, as background to its final report (Labonté et al., 2007).

## GLOBALIZATION AND THE GLOBAL MARKETPLACE

For purposes of its work, the Globalization KN defined globalization as “a process of greater integration within the world economy through movements of goods and services, capital, technology, and (to a lesser extent)

labor, which lead increasingly to economic decisions being influenced by global conditions” (Jenkins, 2004, p. 1)—in other words, with reference to the emergence of a *global marketplace*. This definition does not assume away such phenomena as the increased speed with which information about new treatments, technologies, and strategies for health promotion can be diffused, or the opportunities for enhanced political participation and social inclusion that are offered by new, *potentially* widely accessible forms of electronic communication. However, in contrast to simply descriptive accounts of globalization that do not attempt to identify connections among superficially unrelated elements or to assign causal priority to a specific set of mechanisms (e.g., Appadurai, 1990; Pappas, Hyder, & Akhter, 2003), we adopt the view of Woodward and colleagues that “[e]conomic globalization has been the driving force behind the overall process of globalization over the last two decades” (Woodward, Drager, Beaglehole, & Lipson, 2001, p. 876). This view is supported by evidence that many dimensions and manifestations of globalization that are not at first glance economic in nature are nevertheless best explained with reference to their connections to the global marketplace and to the interests of particular powerful actors in that marketplace. For example, the globalization of culture is inseparable from, and in many instances driven by, the emergence of a network of transnational mass media corporations that dominate not only distribution but also content provision through allied sports, cultural, and consumer product industries (McChesney, 2000; Miller, 2002; McChesney & Schiller, 2003). Relatedly, global promotion of brands such as Coca-Cola and McDonald’s is a cultural phenomenon but also an economic one (driven by the opportunity to expand profits and markets), even as it contributes to the “global production of diet” (Chopra & Darnton-Hill, 2004) and resultant rapid increases in obesity and its health consequences in much of the developing world, a theme explored in Chapter 10.

We date the emergence of the contemporary global marketplace from approximately 1973: the year in which various events described in Chapter 3 signaled a fundamental change in the nature of the global economic and political order. Choosing a year is less important than recognizing (a) that some time in the early 1970s the world economic and geopolitical environment changed decisively, and (b) that the changes did not “just happen” but rather were a consequence of strategic behavior by economic and political elites (Marchak, 1991; Kozul-Wright & Rayment, 2004). In the mid-1990s, a consortium of social scientists convened to assess the prospects for “sustainable democracy” noted that key Western governments have promoted an “intellectual blueprint . . . based on a belief about the virtues of markets and private ownership” with the consequence that: “For the first time in history, capitalism is being adopted as an application of a doctrine, rather than evolving as a historical process of trial and error” (Przeworski et al., 1995, p. viii). The blueprint has been promoted and implemented by national governments, in particular those of the G7,<sup>1</sup>

individually and through multilateral institutions like the World Bank, the International Monetary Fund (IMF), and more recently the World Trade Organization (WTO) (Marchak, 1991; Przeworski et al., 1995; Gershman & Irwin, 2000; Kapur & Webb, 2000). The conditionalities associated with structural adjustment lending by the first two of these organizations, discussed later in this introductory chapter, were a primary channel of influence, establishing the primacy of market-based principles throughout much of the world. Both within and outside the Bank and the fund, networks of academic and professional elites have played an important role in the diffusion of market-oriented ideas about policy design, as shown, for example, by the work of Babb (2002) on academic economists in Mexico, Lee & Goodman (2002) on the World Bank's role in promoting health sector "reform," examined in Chapter 8, and of Brooks (2004, pp. 54–65) and Mesa-Lago & Müller (2002, pp. 709–12) on the Bank's role in promoting privatization of public pension systems, especially in Latin America.

Challenges to the perspectives that emanate from the command centers of the world economy have been many, and in some instances have been facilitated by the technological infrastructure of globalization that, while essential to the needs of its corporate users (Schiller, 1999), have proved amenable to use for quite different purposes. Perhaps the best-known illustration of the political influence of civil society organizations (CSOs) as it relates to health and globalization is their role in challenging the primacy of economic interests as defended by multilateral institutions. In the 1990s, for example, CSO activity contributed to the French government's withdrawal from negotiations on a Multilateral Agreement on Investment, and its subsequent abandonment by the Organization for Economic Cooperation and Development (Birchfield & Freyberg, 2004). In the early 2000s, CSO activism resulted in an interpretation of the Agreement on Trade-Related Aspects of Intellectual Property (TRIPs) that allows health concerns, under some circumstances, to "trump" the harmonized patent protection that was actively promoted by pharmaceutical firms during the negotiations that led to the establishment of the WTO ('t Hoen, 2002; Sell, 2003, 2004; Brysk, 2004). However, concerns remain about the practical effect of this interpretation because of informal pressures from the pharmaceutical industry and industrialized country governments and "TRIPs-plus" provisions in bilateral trade agreements, as discussed in Chapters 5 and 11. Thus, although we insist on the primacy of the economic dimensions of globalization, and on the economic elements of SDH, our view is not narrowly deterministic, and allows for the possibility of effective challenges to the interests that dominate today's global economic and political order.

The outline of the remainder of the chapter is as follows. Immediately following, we summarize some key conceptual and methodological issues in the study of globalization and health. We then address a basic controversy in this field: the extent to which globalization, as defined primarily with reference to trade liberalization, is beneficial to population health

because of its contribution to economic growth, poverty reduction, and the availability of resources for public provision of services such as education and health care. Following this discussion, the implications of which are picked up in some subsequent chapters, we address a process that is simultaneously a manifestation of the increasing interconnectedness of national economies and a key “driver” of national commitment to globalization: the debt crises that affected many developing countries, often for reasons outside their control, starting in the 1970s.

We then describe two dimensions of globalization’s consequences that are critical areas for future understanding of population health: implications for the form and fabric of the world’s cities, and for the natural environment and the life-sustaining ecosystem services that it provides. The brevity of these discussions does not reflect their lesser importance; the lack of attention to them in the course of the operations of the Globalization Knowledge Network (GKN) was simply a manifestation of the prioritization that must be undertaken when time and resources are limited. We conclude with an outline of the book’s remaining chapters.

## **MODELING GLOBALIZATION AND SOCIAL DETERMINANTS OF HEALTH: CONCEPTUAL AND METHODOLOGICAL ISSUES**

We begin from the premise that processes comprising globalization affect access to SDH by way of multiple pathways that interact in various ways. Because of our focus on health equity (or reducing health inequities) and given that the effects of globalization on SDH are almost never uniformly distributed across populations, our concern throughout this book is on how globalization affects disparities in access to SDH. This “equity lens” approach also explains our emphasis on what might be described as negative effects of globalization: we presume (based on a large body of international evidence) that disparities in access to SDH lead to deterioration in the health status of those adversely affected, and that when the result is to increase health disparities that deterioration is unacceptable even if offset by positive impacts (e.g., improved health for the well-off) elsewhere in the economy or the society. Stated another way, we regard as *prima facie* undesirable changes in access to SDH that are likely to steepen the socio-economic gradients in health that are observable in all countries, rich and poor alike (Marmot, 2006).

In a conceptual framework developed specifically for explaining social disparities in health, Diderichsen and colleagues (Diderichsen, Evans, & Whitehead, 2001, p. 14) identify “four main mechanisms—social stratification, differential exposure, differential susceptibility, and differential consequences—that play a role in generating health inequities.” Globalization can affect health outcomes by way of each of these mechanisms, and

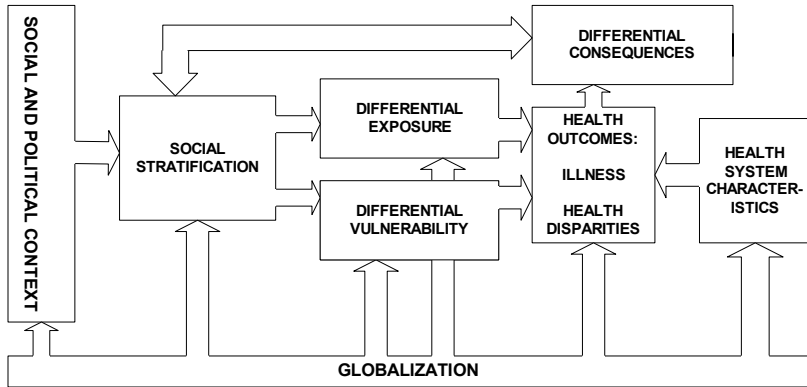


Figure 1.3 Globalization and health: A framework for analysis.

Source: Developed by the authors based on Diderichsen et al. (2001).

the authors' reference to the influence on stratification of "those central engines in society that generate and distribute power, wealth and risks" (Diderichsen et al., 2001, p. 16) is especially apposite in this context. A variant of this model was adopted for purposes of the KN; Figure 1.3 presents this variant in simplified form.

A stylized example shows the model's relevance. Import liberalization may reduce the incomes of some workers in sectors serving the domestic market, or shift workers into the informal economy, thereby affecting social stratification, differential exposure (e.g., as workers are exposed to new hazards), and differential vulnerability (e.g., as income loss means adequate nutrition or essential health care becomes harder to afford, or in the extreme cases in which women are driven to reliance on "survival sex" [Wojcicki & Malala, 2001; Wojcicki, 2002]). Increased vulnerability may also magnify the negative consequences of ill health by reducing the resources available to households to pay for health care or absorb earnings losses, increasing the chance of falling into "poverty traps" (hence the feedback loop to social stratification). Import liberalization may also reduce tariff revenues (and therefore funds available for government to use for public expenditures on income support or health care) in advance of any offsetting increases from income and consumption taxes. In countries with high levels of external debt, the need to conserve funds for repaying external creditors, perhaps by initiating or increasing user fees for health and education, may create a further constraint on social spending. (The rationale for including health systems as a separate element of the diagram now becomes apparent). Conversely, if import liberalization is matched by improved access to export markets, new employment opportunities may be created for specific groups, such as women working in export processing

zones, who are thereby empowered to escape patriarchal social structures (social stratification) and reduce their economic vulnerability.

Despite the sense of simplicity created by diagrammatic representations, no single such representation can adequately capture the complexities of globalization and its influences. Globalization comprises multiple, interacting policy dynamics or processes the effects of which may be difficult if not impossible to separate. Pathways from globalization to changes in SDH are not always linear, do not operate in isolation from one another, and may involve multiple stages and feedback loops. Similarities exist with the task of analyzing causal links between environmental change and human health, which “are complex because often they are indirect, displaced in space and time, and dependent on a number of modifying forces,” in the words of WHO’s synthesis of the health implications of the findings of the Millennium Ecosystem Assessment project (Corvalan et al., 2005, p. 2).

It is therefore necessary to rely on evidence generated by multiple disciplines, research designs, and methodologies—the approach now widely described as transdisciplinary (Somerville & Rapport, 2000)—which comprises both qualitative and quantitative findings. Issues of scale are also relevant: for example, research that situates data from local-scale survey research in the context of structural adjustment in Zimbabwe (Potts & Mutambirwa, 1998; Bassett, Bijlmakers, & Sanders, 2000) and that identifies globalization-related influences on health in South Africa (Gilbert & Gilbert, 2004) demonstrates the need to integrate work using different units of analysis (e.g., the household, the region, the national economy) in order to describe relevant mechanisms of action in sufficient detail, and to reflect intranational disparities (e.g., by region, class, and gender) that are not apparent from national level data (Lozano et al., 2001; Gwatkin, 2002; Henninger & Snel, 2002).

The evidence base for assessing globalization’s effects on SDH and identifying opportunities for intervention is therefore different from, and more heterogeneous than, the body of research that is available with respect to clinical and (many) public health interventions. Notably, qualitative research provides information about differential impacts (e.g., by region, gender, kind of employment) that are not revealed by standard indicators, and about such matters as the access problems for the poor created by the imposition of user charges and cost recovery in water and sanitation systems (Lundy, 1996). Within the ethnographic literature, Schoepf (1998, 2002, 2004; Schoepf, Schoepf, & Millen, 2000) demonstrates the value of qualitative evidence in explicating in considerable depth and detail the relations between microlevel outcomes and such macrolevel factors as falling commodity prices, domestic austerity policies that involved cuts in public sector employment and in subsidized access to health care, and migration driven by economic desperation.<sup>2</sup>

Policy-relevant linkages between globalization and SDH are therefore best described, and the strength of evidence evaluated, by way of syntheses

that incorporate several elements, including (but not limited to): (a) description of the national and international policy context and its history; (b) country- or region-specific studies that describe changes in determinants of health, such as the level and composition of household income, labor-market changes, access to education and health services; (c) evidence from clinical and epidemiological studies that relates to demonstrated or probable changes in health outcomes arising from those impacts; (d) ethnographic research, field observations, and other firsthand accounts of experience “on the ground.” This choice of elements is not random; it recognizes the need for study at the various levels identified in Figure 1.1, and the need not only to connect contextual factors with changes in SDH and their distribution but also to demonstrate where feasible a relation between changes in SDH and changes in health outcomes.

At the same time, the complexity of the evidence base and the relevant causal chains means that rarely will it be possible to state conclusions with the degree of conclusiveness that may be possible in a laboratory situation or even in many epidemiological study designs, where almost all variables can be controlled. In the words of social epidemiologist Michael Marmot, who chaired the CSDH: “The further upstream we go in our search for causes,” and globalization is the quintessential upstream variable, the greater the need to rely on “observational evidence and judgment in formulating policies to reduce inequalities in health” (Marmot, 2000, p. 308). The choice and defense of a standard of proof—how much evidence is enough—is also important. As in the context of national public health and regulatory policy (Page, 1978; Schrecker, 2001), the decision must be made with explicit reference to the underlying, potentially competing values. Excessive concern with avoiding false positive findings (Type I errors, or the incorrect rejection of the null hypothesis) can supply, as in other contexts, a credible and convenient rationale for doing nothing. This is the “tobacco industry standard of proof” (Crocker, 1984, pp. 66–67)—so demanding that there is always room to claim that evidence is less than conclusive. In the environmental policy context, Page (1978) has convincingly demonstrated the negative health outcomes that may result when standards of proof are set without explicit reference to the possible consequences of being wrong in different kinds of ways. On this point, it cannot be emphasized too strongly that the choice of a standard of proof is inescapably value-driven, and is not always a choice with respect to which scientific researchers have any special competence.

A choice must also be made about the time frame of concern. In the long run, wealthier societies are healthier, albeit with wide variations in both the health status at a given level of income per capita (World Bank, 1993; Deaton, 2004) and in the distribution of that status within societies. It can be argued that the optimal, or at least most realistic, approach to improving SDH is the one that will maximize economic growth in the countries or regions of concern. However, the empirical uncertainties associated with this position, some of which are described in the next section of the chapter, have

led Angus Deaton, one of the leading researchers on the relations between economic growth and health, to warn flatly that “economic growth, by itself, will not be enough to improve population health, at least in any acceptable time” (Deaton, 2006). The issue of acceptable time further raises the ethical question of how long is too long. As suggested by Deaton, diffusion of the benefits of economic growth in ways that lead to widespread improvements in population health is neither automatic nor rapid: it took more than fifty years for such diffusion in the industrial cities of nineteenth-century England, for example (Szreter, 1997, 2003; Szreter & Mooney, 1998). Given the frequency with which globalization has resulted in deterioration in SDH for substantial segments of national populations, despite impressive economic growth as measured by national indicators, this is not just an academic point.

### TRADE LIBERALIZATION, GROWTH, AND POVERTY REDUCTION

We accept as given the proposition that poverty (both absolute and relative) is inimical to health equity and undermines access to SDH. Thus, to the extent that trade liberalization (or globalization more generally) could be shown to be positively associated with growth, a presumption would exist in favor of growth-inducing policies *if* growth reliably reduced poverty without other offsetting negative consequences. The argument that globalization is beneficial in terms of population health (Feachem, 2001) often starts from an equation of globalization with trade liberalization: the lowering of tariffs and other barriers to imports that has been a defining characteristic of the post–World War II economic order. As a consequence of such liberalization, the value of world trade doubled from 24 percent of world gross domestic product (GDP) in 1960 to 48 per cent in 2003 (World Bank, 2007).

Widely cited comparative studies of national economies carried out under the auspices of the World Bank (Dollar, 2001, 2002; Dollar & Kraay, 2002, 2004) concluded that during the 1980s and 1990s, the economies of “globalizers” (trade liberalizers) grew faster than “non-globalizers.” However, countries held up as model high-performing globalizers (China, India, Malaysia, Thailand, and Viet Nam) actually started out as more closed economies than those nonglobalizers whose economies stalled or declined, mostly in Africa and Latin America (Dollar, 2002). The reason for this seeming anomaly, and the basis for several critiques of the studies, is one of definition. Globalizers in these studies are defined as countries that saw their trade/GDP ratio increase since 1977; nonglobalizers are simply those that saw their ratio drop. Thus, India and China are considered globalizers, even though their trade/GDP ratios at the end of the study period were lower than the average of all countries studied.

Conversely, the nonglobalizers started out more highly integrated into the world economy. The positive globalization to growth relationship becomes an artifact of the studies' design.

Furthermore, the economic problems of the nonglobalizers are at least partly attributable to global factors outside the control of national economic-policy makers: specifically, a decline in most commodity prices (only recently reversed for some) that damaged both export performance and import ability of countries that were heavily reliant on commodity exports, but already highly integrated into the global economy on some measures (Birdsall & Hamoudi, 2002; Milanovic, 2003; Dowrick & Golley, 2004). The decline in commodity prices was partly an effect of other policies that drove countries into intensified export competition with one another in order to pay their debts to external creditors. Further, excluding India and China from the sample—each of which is arguably a special case, albeit for different reasons—actually changes the conclusion: globalizers grew more slowly than nonglobalizers over the period 1980–2000 (Dowrick & Golley, 2004). Added concerns exist about the reliability of data on incomes and household assets and the appropriateness of the World Bank's definitions of poverty with reference to poverty lines or thresholds of United States (US) \$1/day and \$2/day (Reddy & Pogge, 2005; Woodward & Abdallah, 2008), especially in large metropolitan areas (Satterthwaite, 2003). As just one illustration, Van Doorslaer and colleagues have recently shown, for eleven Asian countries, that the World Bank understates the extent of poverty as measured by the \$1/day poverty line because the surveys on which the estimates are based ask questions about the value of household consumption that include out-of-pocket health care costs. Ironically, then, large numbers of households appear to have escaped poverty because of catastrophic medical expenses (van Doorslaer et al., 2006).

Even if for the sake of argument one accepts the World Bank measures of poverty, it is not at all clear that globalization has reliably led to substantial poverty reduction. Between 1981 and 2004, a period during which the value of the world's economic output quadrupled, the number of people in the world living on \$1/day or less fell by five hundred million. Although superficially impressive, this net reduction is due entirely to poverty reduction in China, with gains elsewhere in the world being offset by increases in the number of poor people elsewhere, mainly in sub-Saharan Africa. There was almost no change in the number of people worldwide living on \$2/day or less: 2.45 billion in 1981, 2.55 billion in 2004. In this case, reductions in China were more than offset by increases in the number of poor people in South Asia (principally India) and sub-Saharan Africa (Chen & Ravallion, 2007). Even globalization's enthusiasts concede that there may be substantial numbers of losers within national economies. This underscores the importance of Chapter 4's focus on labor markets (on which trade policy is just one influence among many) and the global reorganization of production as pathways leading from globalization to changes in

access to SDH and in health outcomes; and Chapter 6's discussion of social protection approaches that, with varying degrees of success, buffered some of the Asian financial crises of the late 1990s brought on by liberalization of their capital markets. Thus, the only responsible conclusion is that "the net effects of globalization on the poor can only be judged on the basis of 'context-specific' empirical studies" (Nissanke & Thorbecke, 2006, p. 1340). In other words: Does globalization reduce poverty? It all depends (and some of the factors on which it depends are topics of this book).

A more fundamental critique of growth as a route to poverty reduction, which stands on its own apart from issues of trade policy, arises from calculations by the New Economics Foundation showing that growth is a very ineffective way of reducing poverty. "Of every \$100 of growth in income per person in the world as a whole between 1981 and 2001, just \$1.30 contributed to reducing poverty as measured by the \$1-a-day line, and a further \$2.80 to reducing poverty between \$1-a-day and \$2-a-day lines"; furthermore, the effectiveness of growth in reducing poverty declined in the 1990s relative to the 1980s (Woodward & Simms, 2006, p. 16). This is not just an academic point: recent studies of social policy in Latin America concluded that even a little redistribution of income through progressive taxation and targeted social programs would go farther in terms of poverty reduction than many years of solid economic growth, because of the extremely unequal distribution of income and wealth in most countries in the region (Paes de Barros et al., 2002; de Ferranti, Perry, Ferreira, & Walton, 2004; Jubany & Meltzer, 2004). If global health equity is considered a desirable social goal, then the case for redistribution both within and across national borders is almost incontrovertible—a theme to which we return in the concluding chapter.

## **DEBT CRISES, STRUCTURAL ADJUSTMENT, AND MARKETIZATION UNDER PRESSURE**

A long history of debt crises constrains the ability of many developing countries to meet basic needs in the areas of public health, education, water, sanitation, and nutrition. Recently, debt service payments have contributed to a larger pattern of financial transfers from the South to the North, most importantly to the United States, that contradicts colloquial wisdom about the direction of global financial flows (United Nations Department of Economic and Social Affairs, 2006). The etiology of debt crises varies from country to country and over time (Naylor, 1987; George, 1988; Strange, 1998; Hanlon, 2000) and is discussed in more detail in Chapters 3 and 7, but a stylized list of major causes includes: (a) the oil price shocks of 1973 and 1979–80, which had an especially severe impact on low-income, oil-importing countries; (b) aggressive lending by banks seeking to invest deposits from oil-exporting countries; (c) a rapid increase in real interest

rates during the early 1980s generated by the monetary policies of the US Federal Reserve, meaning that debtor countries often had to roll over existing debt at much higher interest rates; (d) falling world prices, that is, deteriorating terms of trade, for the primary commodities that are the key exports of many developing economies; and (e) capital flight, consisting both of outright theft and of the rational, mostly legal shifting of assets abroad by economic elites worried about tax increases and future devaluations. A further precondition is so basic that it is sometimes overlooked. Banks, national governments, and multilateral institutions such as the World Bank have been willing, almost without exception, to accord leaders of developing countries what philosopher Thomas Pogge has called the “borrowing privilege”: the right to incur debts on behalf of those they rule without having to defend the legitimacy of their rule. The borrowing privilege is accorded even to leaders who have taken power by force or deceit, maintain it by extreme repression, and are not accountable to citizens in any meaningful way (Pogge, 2002).

The impacts of debt crises cannot be understood without considering structural adjustment. The term entered the international development lexicon in 1980, when the World Bank initiated structural adjustment loans, normally in conjunction with stabilization loans from the IMF, to assist recipient countries to reorganize their economies in order to increase their ability to repay external creditors. The urgency of such lending grew after 1982, when Mexico’s announcement that it was prepared to default on billions of dollars in loans, primarily made by major US banks, raised concern about the stability of financial systems in the industrialized world. Conditionalities attached to such loans, and the associated rescheduling of loan payments to the World Bank and IMF, emphasized reduction of subsidies for basic items of consumption such as food; rapid removal of barriers to imports and foreign direct investment (FDI); reductions in state expenditures, particularly on social programs such as health, education, water/sanitation, and housing; and rapid privatization of state-owned enterprises, on the presumption that private service provision was inherently more efficient, and that proceeds from privatization could be used to ensure debt repayment (Milward, 2000; Babb, 2005). In other words, the international financial institutions systematically promoted multiple, more or less coordinated domestic policies of integrating national economies into the global marketplace.

Research on health-related impacts of structural adjustment, however, has had to confront at least three design problems. First, implementation of conditions attached to World Bank and IMF loans was often incomplete (Killick, 2004)—leaving open at least the theoretical possibility that if the reforms in question had been undertaken even more aggressively, outcomes might have been more favorable. However, the recent history of market-oriented development policy in the two regions of the developing world where it has been pursued most aggressively, Latin America and Africa (Eyoh & Sandbrook, 2003; Kaufman, 2003), calls this claim into question. So too

does the pattern of magnification of inequality through labor-market outcomes that has resulted from domestic marketization and export orientation (Razavi, Pearson, & Danloy, 2004; van der Hoeven & Saget, 2004). Second, it can be difficult to separate effects of structural adjustment from those of the globalization-related economic crises that preceded and led to engagement with the World Bank and IMF. Third, and relatedly, every assessment of public policy effects relies implicitly or explicitly on a counterfactual: an alternative state of the world against which the state of the world post-introduction of the policy in question is compared (as is the case with the econometric study presented in Chapter 2). If structural adjustment is compared with the continuation of business as usual, which would in many cases have involved (continued) hyperinflation and the isolation of countries from international financial markets, then structural adjustment may appear as the least destructive option. On the other hand, if the comparison is with an alternative set of policy options that would have given priority to meeting basic needs, then conclusions about the necessity and desirability of structural adjustment are likely to be less sanguine. For countries highly exposed to the international economy, this counterfactual requires further assumptions about an alternative international order at least partly driven by solidarity or conceptions of obligations that cross national borders—a point to which we return in the book's final two chapters (13 and 14).

It is also difficult to separate impacts on SDH of domestic policies that were adopted in specific response to lender conditionalities from those adopted in response to the broader diffusion of market-oriented policy ideas. However, the policy changes undertaken as part of structural adjustment programs, which can be generically described as marketization or (re)commodification (Elson & Cagatay, 2000; Bond, 2005), are congruent with the market-oriented policy shifts that are a key element of globalization more generally (Babb, 2002, 2005), succinctly codified by Williamson as the “Washington consensus” on development policy (Williamson, 1990). This “consensus” identified the suite of policies pursued throughout the 1990s to integrate developing countries into the global economy by, *inter alia*, financial and trade liberalization, domestic deregulation, privatization, fiscal discipline and reduced public expenditure, tax reforms emphasizing consumption rather than income, competitive exchange rates, openness to FDI, and strengthened property rights. It may be interesting to know how much of a country's social and economic policy orientation in years can be attributed to responses to the World Bank and IMF, and how much to national decision makers' interpretation of the available options within an international economic context over which they may have minimal influence. However, even if it were answerable, this question would not alter the fact that if we want to know how globalization affects SDH by way of marketizing domestic social and economic policy and commodifying basic needs, then research on structural adjustment is valuable independent of specific historical connections between lender conditionalities and policy responses. Indeed, it constitutes

one of the single most important bodies of evidence available on the effects of globalization—a fact reflected in the discussions of the impacts of structural adjustment on policy space in Chapter 5, on health systems in Chapter 7, and on health worker migration in Chapter 9.

## CITIES RESTRUCTURED BY THE GLOBAL MARKETPLACE

Long-distance effects of quite a different kind are evident in changing patterns of urban form and settlement, and assume special importance given the estimate that the world's urban population will have grown by more than two billion people between 2005 and 2030. While not a theme explored by the KN (there was a separate knowledge network devoted to the rapid growth in urban settlements; see Kjellstrom et al., 2007), it has a direct relationship to globalization and potentially profound health-equity effects. Almost all of this population growth will occur in countries with limited resources to provide urban and peri-urban infrastructure that is taken for granted in most of the industrialized world (UN Millennium Project Task Force on Improving the Lives of Slum Dwellers, 2005). A consistent pattern in the transformation of cities and metropolitan areas by transnational economic integration, in countries rich and poor alike, is that gaps between economic winners and losers grow, based on their position within the global economy and the basis of their connection (or lack of connection) to it. Statistics on income disparities capture only part of the picture. Castells's description of the urban impacts of globalization in terms of a "space of flows" (Castells, 1996) is valuable because it reminds us that "connectedness" to the networks of investment and information that characterize the globalized economy may have nothing to do with proximity as viewed on a road map. Castells observes that urban districts whose residents are not part of the "process that connects advanced services, producer centers, and markets in a global network" can become "irrelevant or even dysfunctional: for example, Mexico City's colonias populares (originally squatter settlements) that account for about two thirds of the metropolitan population, without playing any distinctive role in the functioning of Mexico City as an international business centre" (Castells, 1996, pp. 380–81). Thus, large metropolitan areas will contain substantial "local populations that are either functionally unnecessary or socially disruptive" (Castells, 1996, p. 404).

Spatial divisions that reflect or reinforce the pattern of gains and losses from globalization arise in a variety of ways. In parts of the industrialized world, they have been initiated by large-scale job and income losses and economic polarization associated with deindustrialization (Adams, 1997; Reardon, 1997; Storper, 1997; Warf & Holly, 1997). Even in the immensely wealthy United States, some cities with economies built on manufacturing lost half to three-quarters of their manufacturing jobs in the second

half of the twentieth century (Abu-Lughod, 1999; Hodos, 2002; Savitch, 2003), with devastating effects on economic opportunities and the social fabric (Kasarda, 1989; Coulton, 2003). Urban “revitalization” may include not only policies that favor more desirable (read: higher-income) residents, but also reconfiguration of urban space in pursuit of profitable commercial development and tourism revenues, similarly leading to displacement of residents and sometimes the literal enclosure of public spaces (see, e.g., Leaf, 1996; Makdisi, 1997; Vasconcellos, 1997; Bunnell & Nah, 2004; Fernandes, 2004; Lakshmi, 2005). Residential segregation deepens through gentrification, suburbanization, and the creation of fortified enclaves with separate private systems of service provision, while those less able to pay are shifted to less desirable locations and rely on inferior services.<sup>3</sup> Policy choices with special significance for the boundaries of inclusion/exclusion involve transportation, specifically the balance between public transit and car-centered development (see, e.g., Leaf, 1996; Alcantara de Vasconcellos, 2005; Pucher, Korattyswaropam, Mittal, & Ittyerah, 2005). In this and other cases, access to essential resources is often determined by individual households’ ability to pay or by group/neighborhood attractiveness as a market. Poverty may be criminalized (Wacquant, 2001, 2002). These processes are documented in an indispensable UN Habitat synthesis on *Cities in a Globalizing World* (United Nations Centre for Human Settlements, 2001), hence the lack of more extensive references here.

Bidding contests for urban spaces, which epitomize the interplay of global power relations and local opportunities, are paralleled by contests over locationally valuable nonurban resources, notably those associated with the expanding business of tourism. These contests can exclude current, low-value, or low-productivity users of a resource either by degradation, for example, by using surface or groundwater as a sink for the disposal of toxic wastes (Stonich, 1998), or by enclosure, for example, by pricing the use of specific locations and resources out of reach of all but the wealthy (Griffith, 2000; Richter, 2001; Leatherman & Goodman, 2005). The common analytical denominators in these conflicts are: (a) in the global marketplace, some resources simply command too high a price to be used for the basic needs of people with limited purchasing power, and (b) domestically, the polarization of income and wealth that accompanies economic integration shifts the political allegiances of decisive political pluralities in the direction of private service provision rather than collective action.

## **GLOBALIZATION, NATURAL RESOURCES, AND ENVIRONMENTAL EXPOSURES**

The unprecedented scale of recent human impacts on the natural environment (Turner, Clark, Kates, Richards, Matthews, & Meyer, 1993), exemplified by global climate change, is in itself an important health-related

dimension of globalization. On a smaller scale, exposures to environmental hazards that arise from the operation of the global marketplace comprise an important and complex set of influences on SDH. At least two mechanisms can be identified: (a) urbanization and intraurban disparities in exposure to such hazards as vehicle traffic and air and water pollution, and (b) global migration of hazardous industries, production processes, and waste. Some authors argue that “agroindustrialization,” as production is reorganized into global, input-intensive commodity chains, constitutes yet another mechanism (Barrett, Barbier, & Reardon, 2001). To some extent these pathways overlap or interact with other elements of globalization, as when agroindustrialization and associated environmental damage are driven by the imperative of increasing revenues from exports destined for foreign consumers. For example, Stonich and Bailey (2000, pp. 23–24) argue that pressure to increase export earnings leads governments to promote “export-oriented aquacultural development regardless of the social and environmental consequences,” creating situations in which “the increasing use of low-value fish species in the production of fishmeal for aquacultural feeds in effect puts the poor in competition with shrimp,” and with the rich consumers who can afford to buy them (see also Stonich & Vandergeest, 2001).

This is one instance of a pattern noted by the health synthesis of findings from the Millennium Ecosystem Assessment (MEA) project,<sup>4</sup> which explicitly recognized economic globalization as one of the drivers of change in ecosystems and human well-being: “Historically, poor people disproportionately have lost access to ecosystem services as demand from wealthier populations has grown” (Corvalan et al., 2005, p. 28). The ecosystem services in question (such as safe drinking water or waste decomposition) may themselves be essential to health, or else may be essential sources of livelihood the loss of which leads to economic insecurity and deprivation. The difference globalization makes is that winning bidders may be half a world away, as in Stonich’s aquaculture example and in the case of markets for tropical timber, oil in Nigeria (where abundant resource revenues have failed to improve the grinding poverty and poor health status of much of the country’s population), and coltan and other minerals in the Democratic Republic of the Congo (Sizer & Plouvier, 2000; Montague, 2002; United Nations Security Council, 2002, 2003; Ferguson, 2005; Gellert, 2005; Watts, 2005).

In many cases, as globalization increases aggregate demand for marketable resources and ecological services, it simultaneously fosters policies and institutions that facilitate control over gains and losses across entire regional economies by local elites and the dominant actors in global commodity chains (see, e.g., United Nations Security Council, 2002, 2003). One analysis of investment in developing countries by transnational logging companies in response to increasing global demand for tropical timber was strongly critical of the sustainability of forest management practices, and further noted that:

Where analysis is available . . . the economic benefit is minor, even in the short-term, and certainly far less than it could be if contracts were structured and negotiated differently. While large amounts of capital are involved, the revenue to national treasuries can be small because most of the profits leave the country or accrue in the hands of very few, often already wealthy and powerful local people. (Sizer & Plouvier, 2000, p. 29, citations omitted)

Transnational mineral firms are often the beneficiaries of large-scale financial support from export credit and insurance agencies in their home countries (Rich, Horta, & Goldzimer, 2000; Moody et al., 2005)—an element of global influence that appears to have received little research attention outside a rather specialized community of CSOs. In such cases, global asymmetries of economic power are reflected in extreme inequalities in the distribution of benefits domestically.

The MEA health synthesis noted another set of differential exposures and vulnerabilities: “Poor populations are more vulnerable to adverse health effects from both local and global environmental changes” (Corvalan et al., 2005, p. 27), because they are more likely to be exposed to hazards from which the rich can remove themselves. Disasters in Bhopal and New Orleans provide dramatic evidence of this point, as do the routine conditions of urban life for hundreds of millions of people worldwide (Stephens, 1996). It is estimated that more than 850 million people now live in slums, with the number projected to rise to 1.4 billion in 2020 in the absence of effective policy interventions (UN Millennium Project Task Force on Improving the Lives of Slum Dwellers, 2005). Slum residence is an imperfect but nevertheless useful proxy for exposure to urban environmental hazards including infectious disease related to inadequate sanitation and industrial pollution, as well as other quotidian risks exemplified by the collapse of a rain-soaked open rubbish dump that killed some of the residents of Manila’s informal settlements in 2000 (Aglionby, 2000; Mydans, 2000).

Some studies find a clear pattern of migration of hazardous industries to lower-income countries, notably to export processing zones (EPZs) (Kopinak & Barajas, 2002; Frey, 2003). Other, quantitative studies that do not focus on particular regions suggest that evidence for the emergence of industrial “pollution havens” is equivocal or absent (Wheeler, 2001; Cole & Elliott, 2005). An impressionistic assessment of such “negative” findings is that many are compromised by (a) failure to focus on the global restructuring of production within specific industries or sectors; (b) concentration on foreign direct investment (FDI), without considering contractual arrangements such as outsourcing that are not recorded in FDI statistics but are extensively described in the literature on commodity or value chains; (c) inability to distinguish causal effects of lax environmental regulation on relocation of production (what the pollution-haven hypothesis is all about) from those of other variables, such as low wages and flexible working conditions, that tend to operate in parallel; and (d) failure to distinguish

between changes in pollution exposures attributable to industrial processes and to such factors as increased vehicle traffic. Substantial evidence also exists of the emergence of a global trade in hazardous wastes, with disposal in low-income countries becoming increasingly attractive and met with policy responses that are at best only partially effective (Clapp, 2001, 2002; Puckett et al., 2002; Iles, 2004).

In the background is the question of whether such environmental changes and their health impacts should be regarded as normal, in the sense that they are comparable to those undergone by the industrialized countries at comparable stages of their own economic development. Evidence of the extent to which contemporary technology allows for “technological leap-frogging” (Goldemberg, Johansson, Reddy, & Williams, 2001) and “dematerialization” (Ayres & Ayres, 2002), which avoid many environmentally destructive forms of industrial production and consumption, suggests that this conclusion should be rejected. However, environmental and resource impacts can alternatively be considered with reference to a green counterfactual that assumes transfer of clean technologies on favorable terms, along with serious efforts by the industrialized economies to reduce their consumption of natural resources and ecological services, and to adopt policies that minimize negative environmental and resource impacts outside their borders. Thus, globalization’s negative effects on SDH that operate by way of the environment, like those that operate in other ways, must be regarded primarily as consequences of political choices and avoidable failures of governance.

## OVERVIEW OF THE BOOK

The GKN commissioned thirteen monograph-length research synthesis papers, each of which undertook substantial evidence reviews related to their themes. The reviews drew on studies that crossed disciplines and methodologies; incorporated research, testimony, and analyses from civil society organizations; and attended carefully to issues of geography, scale, and (particularly) gender. Each paper was subject to extensive critique and review within the network, before being externally blind-reviewed. The review process focused on three key questions: Was important evidence related to the theme missed? Was the analysis derived from the evidence based solidly on the evidence reported? Were the policy inferences (either known or implied) linked logically and coherently to the evidence? The reviews were important to the final knowledge products of the KN, since the potential evidence base for each theme explored was almost endlessly vast.

The chapters in this book are derived (with some updating) from these background papers, many of which have been Web published for readers wishing to examine each issue in greater depth. New evidence and argument surrounding globalization (generally) and how it affects health (generally or

via the themes explored in these chapters) are continually being generated. What we present in this book is the most rigorous assessment of “state-of-the-art” knowledge as of late 2007. While certain facts and trends could change rapidly, especially given the current prospect of global recession, the underlying dynamics of globalization that pose particular health risks explored in the following chapters are unlikely to alter substantially without the types of policy changes addressed throughout the book, and particularly in our final two chapters.

We begin, in Chapter 2, with a study of how globalization-related policies have affected health outcomes. Cornia, Rosignoli, and Tiberti first summarize existing evidence of change along a number of pathways by which globalization influences morbidity and mortality, notably: material deprivation; acute psychosocial stress; unhealthy lifestyles; high levels of social stratification and lack of social cohesion; and positive and negative “shocks.” Although 1980–2005 was characterized by a series of favorable political and economic “dividends” that should have led to faster improvements in health status and declines in health inequality within and across countries and regions, the period recorded a slowdown in health improvements and an increase in health inequality worldwide. The chapter explores the reasons for this phenomenon using an econometric regression model comparing global and regional trends in life expectancy at birth since 1980 attributable to globalization-related policies, against a counterfactual continuation of trends in the preglobalizing decades of 1960–80.

In Chapter 3, Bond adds depth to understanding how these globalization-related policies reflected major shifts in global political economy and geopolitics since the 1970s. These shifts brought together processes of governance and liberalization in often uncomfortable ways and with profound implications for health and SDH policies. Geopolitical realignments and neoliberal policy ascendancy are observed in a series of “moments” in which key events reflected important power shifts. The broader global context has been a series of durable economic problems: stagnation, financial volatility, and uneven development. One reaction to these persisting problems has been the turn to what the chapter describes as “extra-economic” relationships between markets and nonmarket social and ecological values; an unhealthy development when global political discourses are dominated by neoliberal and neoconservative forces.

Chapter 4 focuses on one of globalization’s main health-determining pathways: the substantial and dramatic changes that have occurred in global labor markets. Schrecker examines the relation between labor-market outcomes and poverty; the global reorganization of production and the associated emergence of a genuinely global labor market; the tendency of globalization to increase economic inequality and demands for labor-market “flexibility”; and the impact of financial crises on employment and labor income. He argues that among the key objectives of economic policy should be creation of an economic environment that generates adequate

and secure livelihoods for all, which requires “bringing employment back in” as a central concern of economic and development policy—a direct challenge to the neoliberal economic nostrums described in Chapter 3.

Chapter 5 discusses a more subtle and complex way by which globalization is affecting health and SDH: the contraction of policy space available to national governments for purposes of regulation. One of the means of doing so (trade agreements) is already well known, since the purpose of such treaties is precisely to reduce the policy flexibilities governments can use with respect to international economic transactions in order to maximize the free movement of goods, services, and capital. Koivusalo, Schrecker, and Labonté examine the many ways in which trade treaties affect policy space, extending beyond the agreements themselves to the processes by which they are negotiated. A second force reducing policy space is financial-market liberalization, which imposes an “implicit conditionality” on the range of options from which governments might select. While noting that not all international constraints on policy space are potentially health-negative (human rights treaties and multilateral environmental agreements are cited as health-positive constraints), the authors argue the importance of protecting policy flexibilities for health and SDH.

Chapter 6 focuses on one set of policies that governments can use to buffer the inherently “disequalizing” outcomes of global market liberalization: the use (and expansion) of social protection policies. Globalization generally and trade liberalization specifically create winners and losers in domestic economies as well as among countries. The negative impacts are not limited to one-time adjustments to trade reforms but more generally to the greater frequency and scope of economic restructuring in an open economy. Using the experience of East Asian country responses to the financial crisis of the late 1990s, Bhusan and Blouin assess the impact of differing national policies aimed at reducing economic vulnerability arising from trade or financial-market liberalization. The evidence underscores the importance of improving (broadening, deepening) general social safety nets prior to or alongside ongoing global market integration—a conclusion reached recently, and explicated forcefully, in the 2008–2009 *Chronic Poverty Report* by a university/CSO partnership organization known as the Chronic Poverty Research Centre (Addison et al., 2008).

Social protection policies, such as publicly financed health care, education, active labor market programs, employment insurance, and direct income transfers, have costs associated with them; many lower-income countries will be unable to self-finance effective social protection programs for some decades into the future. Chapter 7 examines two critical and enjoined issues related to improving their financing capacities: aid and debt relief. After reviewing trends in aid disbursements, Taylor and Rowson confront the heated debate regarding aid effectiveness, suggesting that new evidence shows that aid is not only essential for the health and welfare of poorer countries, but that, despite its many well-documented problems

associated in the first instance with donor country practices and conditionalities, it has been effective in promoting economic development and in improving health outcomes. Aid effectiveness, however, has been hampered by countries' continued servicing of foreign (and to lesser extent, domestic) debt. Debt relief or cancellation for a group of nations known as the Heavily Indebted Poor Countries has been compromised by a lack of speed and creditor dominance. There is also an urgent need to reframe the process of debt cancellation from one which focuses on the detail of countries' economic vulnerability to debt to one which focuses on the idea of "debt responsibility," involving greater public scrutiny of lending, the establishment of international mediation processes between debtors and creditors, and placing social needs ahead of debt repayments.

Chapter 8 narrows the examination of globalization's health impacts by focusing on one critical sector: health systems. Lister and Labonté argue that, since the 1980s, and particularly after the move by the World Bank into health-system financing in the 1990s, health-system reform globally has followed a "marketization" model emphasizing cost recovery (user fees), privatization, competition, technical/disease-specific interventions, and other policy approaches that undermined the earlier Alma-Ata Declaration on Primary Health Care's call for universal, comprehensive public systems. The results of the imposition of these reforms, through structural adjustment, aid, or debt-relief initiatives, has been largely health-negative, leading to recent calls for a return to broader and more integrated models of health care delivery. Even as these public interventionist policies are reemerging in global policy discourse, however, ongoing trade negotiations continue to emphasize the economic value of opening up international trade in health services. More developing than developed countries have already committed to do so, while private health providers and insurers from developed countries are most likely to benefit. Some believe that opening health services to foreign investment and providers can improve access by bringing new capital and expertise to national systems. Others worry that it will only mean better access for a very small portion of the population with higher incomes. The recent trade-related boom in "medical tourism," in which patients from high-income countries receive hospital care in low-income nations, provides a cautionary tale in this respect.

Chapter 9 highlights another facet of globalization's effect on health systems: the "crisis" in global health workforce migration. Deteriorating economic and broader social and environmental conditions at least partly attributable to liberalization or other forms of global market integration are "pushing" out health workers in many developing (and especially low-income) countries. At the same time, the main destination countries of health worker migrants suffer their own health worker shortages and increasingly rely on the immigration of foreign-trained health workers to relieve them. These countries are able to offer higher pay, better working conditions, and greater opportunities to save money, effectively pulling in

foreign health workers. Whether this flow of health workers globally constitutes a “brain drain,” as critics contend, or a “brain circulation,” as others argue, the short-term impact is a dramatic shortage of health workers in countries facing the greatest need. Packer, Labonté, and Runnels conclude by examining the feasibility and desirability of various policy options that have been proposed to manage global health workforce migration more ethically and equitably.

Chapter 10 introduces the concept of “nutrition transition,” a term referring to the globalization of poor quality energy-dense diets leading to obesity and diet-related chronic diseases. Hawkes, Chopra, and Friel explore how globalization is affecting the development of “overnutrition” in a world still plagued by undernutrition. They identify the supply-side globalization processes to the increase of poor quality diets, focusing on three particular processes: the growth of transnational food companies, international food trade, and global food advertising and promotion. The evidence finds that these processes are affecting the availability, price, accessibility, and desirability of different foods, driving uneven dietary development between different socioeconomic groups. The chapter ends by discussing the policy implications of the evidence presented.

Chapter 11 explores inequalities in health outcomes emerging from the existing intellectual property-rights regime, one of the most visible and contentious of globalization’s policies having direct health-related effects. Correa examines the impact of the internationalization of the IPR system and, in particular, the adoption of minimum standards of protection in the WTO Agreement on Trade-Related Intellectual Property Rights. The chapter highlights some of the features of innovation in the pharmaceutical field and the changes under way in the predominant business model for research and development. It notes that, in this shifting context, patents fail to encourage research and development in diseases prevailing in developing countries, while creating barriers to drug access, particularly affecting the poor. The chapter concludes by assessing how policy interventions can improve such access through strengthened flexibilities in trade treaties (e.g., for compulsory licenses) and various models for financing drug research outside of patent regimes.

Chapter 12 extends the discussion of alternatives to the current system of globalization’s various trade and investment rules to the broader terrain of global governance for health. Lee and her contributing authors document the transition taking place towards global governance related to SDH in terms of institutional actors and their relative roles, power, and authority. The chapter then assesses how emerging forms of global governance may be influencing the SDH, posing the question: How might various institutions, and the distribution and use of power and authority among them, affect the SDH? The authors answer this question, in part, by assessing the quality of emerging forms of global governance against recognized “good governance” criteria. The chapter finally identifies how global governance can play a transformational role in addressing the SDH.

Chapter 13 summarizes and distills the arguments from the previous chapters. It brings forward some of the key policy recommendations emanating from the book's chapters, and identifies a global policy agenda that responds to globalization's present asymmetries structured around the "three Rs" of redistribution, regulation, and rights. The international human rights framework is discussed for the opportunities it presents for limiting commodification and the spread of the global marketplace in ways that undermine health equity. More generally, Chapter 13 describes the new forms of coordinated action on an international scale by national governments and multilateral institutions that the "three Rs" demand, highlighting a number of productive areas for policy innovation while warning that their potential is unlikely to be realized in the absence of decisive leadership and political action.

Chapter 14 offers an invited, reflective commentary by David Sanders, one of the founders of the People's Health Movement and a long-time, African-based activist public health physician. The chapter focuses on the evidence for how power inequalities lie at the heart of both the health inequities associated with contemporary globalization, and on the historically rooted necessity of civil society struggles to challenge and alter these toxic inequalities.

## NOTES

1. The Group of 7 leading industrialized nations includes Canada, Italy, France, Japan, Germany, the United Kingdom (UK), and the United States of America (USA). Formed in 1976 to manage potentially damaging issues arising from global economic activities, the G7 became the G8 in 1997 with the addition of Russia.
2. For further illustrations of the value of qualitative research, see, e.g., the World Bank's *Voices of the Poor* study (Narayan, Patel, Schafft, Rademacher, & Koch-Schulte, 1999; Narayan, Chambers, Shah, & Petesch, 2000); the report of the Structural Adjustment Participatory Review International Network (Bhattacharya et al., 2002); and a summary of studies of sources of livelihood in KwaZulu-Natal, South Africa by Lund (2004). For description of a similar approach adopted by another of the commission's KNs, see *Employment Conditions Knowledge Network* (2007, pp. 25–29).
3. A telling example of this, and of the global reach of marketization: a commission meeting in Nairobi included a presentation where an official explained why it made sense to sell to private developers the land where the city's largest slum had grown over past decades, since the slum now abutted the growing downtown and had become valuable property. Profits from the sale, it was argued, would be used to relocate the millions of slum dwellers to the city's periphery, a location devoid of any services, shops, schools, or transportation.
4. The final report is downloadable, on a chapter-by-chapter basis, from <http://www.millenniumecosystemassessment.org>. For a description of the MEA's findings at a level of detail that will suffice even for many sophisticated users, see Alcamo et al., 2005; Butler & Oluoch-Kosura, 2005; Carpenter, Bennett, & Peterson, 2005; Cork, Peterson, Bennett, Petschel-Held, & Zurek, 2005; Nelson et al., 2005; Rodriguez et al., 2005.

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