

## **Interrogating globalization, health and development: Towards a comprehensive framework for research, policy and political action**

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### **Abstract**

Health researchers recognize the need to better understand the ways in which contemporary globalization can lead to improved health for all, especially for the poor. This requires expanding the global health research agenda beyond a disease-specific focus to one that also examines the social, environmental and economic contexts that partly determine the incidence and persistence of many diseases, and to understand how these contexts shape health opportunities and behaviours at different levels. Organizing extant findings for policy purposes and to generate new studies capable of embodying such complexity is rendered more feasible if guided by reasonably comprehensive frameworks identifying the differing levels and pathways by which globalization phenomena can influence health. This article presents such a framework, illustrating it with evidence of health effects of globalization presently known though often disputed. Its value lies in its ability to shape future research allowing detailed and rigorous study of certain of the relationships it maps to be located within a broader research-informed policy context.

### **Introduction**

Although globalization is not new, interest in its potential health impacts is relatively recent. Understanding how globalization affects health is not easy; the concept itself is multifaceted, and the breadth and depth of the pathways by which it influences health almost defies study of causal relations. Any explanation for how globalization affects health (for better or for worse) becomes an evidence-based argument, in which evidence necessarily derives from multiple studies examining differing aspects of globalization (what this article calls ‘processes’ or ‘drivers’) for their impact on theoretical or empirically established causal chains. The evidence is built up link by link; the problematic becomes one of organizing the evidence into a coherent story.

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In this article we provide an analytical framework for developing such a story, and proffer its usefulness as a heuristic for organizing both past and future research and policy studies. We begin by defining ‘globalization’, and what the rudiments of a critical approach to its health study imply. We then differentiate ‘global health’ from its older kin of ‘international health’, and critique briefly the dominant neo-liberal discourse on globalization and health. This leads us to an elaboration of our analytical framework and a presentation of some of the extant findings of globalization’s impacts on important pathways to health. We conclude with an instance of how the framework is being used, an example of how it might be applied, and a commentary on how researchers can approach globalization/health study from a more ‘critical’ perspective.

### **Defining globalization**

Globalization, at its simplest, describes a constellation of processes by which nations, businesses and people are becoming more connected and interdependent via increased economic integration and communication exchange, cultural diffusion (especially of Western culture) and travel. By emphasizing processes we draw attention to the means by which this interdependence and connectivity is occurring and how these processes are embedded within current political and economic differentials within and between countries. We differ from others in this respect (e.g. Lee, 2002) who consider globalization more broadly as a function of technology, culture and economics leading to a compression of time (everything is faster), space (geographic boundaries begin to blur) and cognition (awareness of the world as a whole). This is undoubtedly true but, as others have argued, ‘economic globalization has been the driving force behind the overall process of globalization over the last two decades’ (Woodward, Drager, Beaglehole, & Lipson, 2001, p. 876). As such, and from a health vantage, the globalization processes that require intense scrutiny are those pertaining to the economy.

Even considered in this narrower cast, globalization is not a new phenomenon; the history of humankind—or at least of Western civilizations—has been one of continuous pushing against borders, exploring, trading, expanding, conquering and assimilating, generally driven by an economic pursuit of resources or wealth (Diamond, 1997). Nor is this the first time in more recent history that capital, and capitalists, have had greater interest in foreign markets than in those in their home jurisdictions. The period of rapidly increased integration of global markets that began in the 1980s continues a longer historical trajectory. The percentage of global economic output accounted for by international trade has only recently returned to the levels characteristic of the late nineteenth and early twentieth century (Cameron & Stein, 2000). But contemporary globalization also differs from previous eras in significant ways, including the speed and scale of capital flows, the existence of enforceable trade and investment liberalization agreements and the size of transnational corporations, many of which are economically larger than most of the world’s countries. These new global phenomena carry (some) health benefits and (many) health risks that demand critical appraisal, an undertaking that is still in its infancy (Drager & Beaglehole, 2001). We use ‘critical’ here in the sense described in an earlier article in this series (Labonte, Polanyi, Muhajarine, McIntosh, & Williams, 2005), with three key tenets: (1) health is seen as embedded in social relations of power and historically inscribed contexts; (2) research questions to ‘unpack’ the policy- and program-relevant aspects of health determinants are shaped by the interests of those who face the greatest burden of disease; and (3), where applicable, research methods aim to be empowering and health-enhancing in their own right.

### **The first critical step: From international to global health**

Until recently, researchers, development agencies and non-governmental organizations (NGOs) mobilized around 'international health' issues: the greater burden of disease faced by poor groups in poor countries. More critical elements, the 'new internationalists', pointed to the role of powerful First World nations and corporations in undermining the efforts of many postcolonial Third World countries to create Western-style democracies and social policies to improve the health, education and economic well-being of their least well-off. International health remained essentially an extension of national health, the 'global' component being the rich world's modest efforts, whether official or funnelled through NGOs, to aid in the development of countries lagging behind, or a critique of their role in creating the lag in the first place.

Four world events changed the landscapes of these international relations irrevocably. The first was the 1970s recession in the industrialized world, compounded by the 'oil crisis' and domestic monetary policies that dramatically increased interest rates. These events led many developing countries to default on international loans, and reshaped the International Monetary Fund (IMF) and World Bank into 'watchdog[s] for developing countries, to keep them on a policy track that would help them repay most of their debts and to open their markets for international investors' (Junne, 2001, p. 206). The policy track of 'structural adjustment', which we discuss later, embodied the neo-liberal economic orthodoxy and conservative politics of the wealthier countries that dominate decisions in both institutions. The second event, the fall of the Berlin Wall, established the United States as the world's only superpower and created a normative vacuum for alternative models of development that could no longer experiment with 'third way' blends of state centralism and market capitalism. The birth of the World Trade Organization (WTO) in 1995, with its first set of agreements tilted steeply in favour of transnational corporations based in wealthier nations, followed only a few years later. Third, the 1992 United Nations Conference on Environment and Development (United Nations, 1992) fostered a 'global environmental consciousness' with special emphasis on the developing world's need both for economic growth and for environmental protection. The fourth event, harder to date, has been the diffusion of convergent information and communications technologies (ICTs) that transformed the nature of global capitalism. The instantaneous global information systems enabled by technology, of course, also increase the speed and scale with which civil society can analyze and mobilize responses to its economic abuses.

In this new landscape, a shift is needed in how global health is conceptualized. An international concern with poorer countries' greater burden of disease needs to give way to a more critical recognition that both the determinants and the consequences of their excess disease are inextricably linked to processes of globalization. Labonte and Spiegel (2002, 2003) use the concept of *Inherently Global Health Issues* (IGHIs) to describe health-determining phenomena that transcend national borders and political jurisdictions (Table I), and urge greater research and policy attention to the linkages between these issues, and to their economic and political 'drivers' or what we call globalization processes.<sup>1</sup>

The first (international) conceptualization predominates in global health discourse, from the new global fund 'partnerships' (e.g. the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunization) to the US Administration's 2002 commitment to increase bilateral AIDS funding to developing countries. It is exemplified by the recent list of 'top 10 biotechnologies'

Table I. Inherently global health issues.

Environmental global degradation	1. Greenhouse gas emissions (climate change) 2. Biodiversity loss 3. Water shortage 4. Decline in fisheries 5. Deforestation
Social/economic	6. Increasing poverty 7. Financial instability (capital markets) 8. Digital divide 9. Taxation (tax havens, transfer pricing)
Cross-cutting	10. Food (In)security 11. Trade in health-damaging products (tobacco, arms, toxic waste) 12. Governance 13. War and conflict

*Source:* Labonte and Spiegel (2003). This table omits two other inherently global health issues: Tourism and human migration (voluntary or forced). We thank one of our reviewers for this insight.

to improve health in developing countries (Daar et al., 2002) that range from better diagnostic devices and recombinant vaccines against HIV/AIDS to simpler vaccine devices replacing needle injections. The pursuit of such technologies also lies at the heart of the Gates Foundation ‘Grand Challenges in Global Health’ initiative, which promises to help fund new breakthroughs in treating ‘neglected diseases’ in poor countries. These approaches confine their analyses of disease aetiology and intervention to individual or, at best, community levels. Little or no attention is paid to inadequate public health systems (and how they came to be so) or to the shifting social and economic conditions that underpin many of the developing world’s persisting pandemics. The African HIV/AIDS pandemic, for example, has roots in global macroeconomic changes as much as in the failures of African states and donor nations to confront the problem. ‘The top epidemiological predictor for HIV infection around the world’, Basu (2003) notes, ‘is not “risk behaviour” but rather a low income level’. The pathways linking poverty (low income) to HIV infection are multiple but, in sum, ‘the background for increasing HIV transmission is a background of neo-liberalism—a context where the movement of capital is privileged above the ability of persons to secure their own livelihoods’ (Basu, 2003).<sup>2</sup>

### Questioning globalization’s dominant discourse

Debates over globalization tend to be polarized. Proponents claim, in ‘history-ending’ fashion, that it represents the logical triumph of liberal capitalism, a humanizing victory that should be propelled more quickly through rapid liberalization and global market integration. Opponents counter, in ‘anti-globalization’ rhetoric, that it represents less a humanizing victory than one of corporate and elite group interests based largely in a few high-income countries. More nuanced perspectives argue that globalization is neither good nor bad. Its momentum may be unstoppable, but its shape is not ineluctably determined (the notion that ‘there is no alternative’ is a specious simplification) and its human impacts are readily malleable to human-made policies and regulations.

Contrasting discourses similarly accompany discussion of the health impacts of globalization. The diffusion of new knowledge and technology through trade and investment, it is argued, can aid in disease surveillance, treatment and prevention (Lee, 2001). Information communication technologies (ICTs) can enable more rapid scientific discovery, create virtual communities of support, increase knowledge about human rights and strengthen diasporic communities. Globalization has had positive effects on gender rights and empowerment (Sen, 1999; Chinkin, 2000; Harcourt, 2000), largely through increasing employment opportunities. The dominant health pro-globalization discourse, however, rests principally on the rationale put forward by pro-liberalization economists and trade ministers. Liberalization (the removal of border barriers, such as tariffs, on the flow of goods and capital), proponents claim, increases trade. This increases economic growth, which decreases poverty; and any decline in poverty is good for people's health (Dollar & Kraay, 2000; Dollar, 2001). Growth also provides revenue for investments in healthcare, education, women's empowerment programs and so on. Improved health, particularly amongst the world's poorer countries, also increases economic growth (Savedoff & Schultz, 2000; WHO, 2001) and so the pro-globalization, pro-health circle virtuously closes upon itself.

This virtuous circle, however, has some vicious undertows. These include the more rapid spread of infectious diseases, some of which are becoming resistant to treatment, and the increased adoption of unhealthy 'Western' lifestyles by larger numbers of people (Lee, 2001), 'globalizing' new pandemics of tobacco-related diseases, obesity and diabetes. Diffusion of new health technologies to developing countries usually benefits the wealthy, often at the expense of already under-funded and fraying public healthcare systems for the poor. And there are important gender relational and power implications. Trade openness might increase women's share of paid employment, an important element of gender empowerment (UNDP, 1999). Such work, however, is frequently in Export Processing Zones that often pay below market wages, have poor health and safety standards and suppress union organizing (Durano, 2002; ICFTU, 2003). Public support for the care of young children has been declining in many trade-opened countries, portending future health inequalities. In an emerging global 'hierarchy of care', women from developing nations employed as domestic workers in wealthy countries send much valued foreign currency back home to their families. Some of this is used to employ poorer rural women in their home countries to look after the children they have left behind. These rural women, in turn, leave their eldest daughter (often still quite young and ill-educated) to work full-time caring for the family they left behind in the village (Hochschild, 2000).

More fundamentally, trade and financial liberalization does not inevitably lead to increased trade or economic growth (Rodrik, 1999; Rodriguez & Rodrik, 2000). When it does, such growth does not inevitably reduce health-damaging poverty, and almost always leads to health-damaging inequality (UNDP, 2000; Cornia, 2001; Weisbrot, Baker, Kraev, & Chen, 2001).<sup>3</sup> Much depends upon pre-existing social, economic and environmental conditions within countries; and upon specific national programs and policies that enhance the capacities of citizens, such as health, education and social welfare programs (UNDP, 1999, 2000). Yet such programs and policies are often cut back radically as part of structural adjustment, whether undertaken at the behest of international financial institutions or independently by governments seeking to attract investors with low taxes and an expanding pool of low cost labour.

### **Of devils and the details: A framework for critically assessing globalization's impacts on health**

Sufficient evidence now exists to support a profound scepticism about the dominant 'story' that links globalization, growth, development and health. Two recent reviews comparing economic, health and social development indicators in the 'pre-globalization' era (roughly 1960–80) with those following structural adjustment and trade liberalization indicate that the net beneficiary was the group of wealthy countries (Weisbrot et al., 2001; Milanovic, 2003), what Milanovic calls the WENAO (Western Europe, North America and Oceania). In language notably blunt for a (now former) World Bank economist, Milanovic argues, 'maintaining that globalization as we know it is the way to go and that, if [its] . . . policies have not borne fruit so far, they will surely do so in the future, is to replace empiricism with ideology' (2003, p. 679). How, then, can one harness research to a more critical interrogation of globalization's health impacts? The impacts of globalization on health cannot be inferred from one or two independent variables, such as trade liberalization or levels of inward foreign direct investment (FDI); there are simply too many historical and contingent confounders. The range of health outcome measures (the dependent variables) is vast and the reliability of the historic data in many countries is poor. An especially important point is that national-level comparisons provide little useful information about how health gains or risks are distributed sub-nationally or by different population groups. Locally oriented research, especially when it gives much needed voice to marginalized groups, can partly address this problem.

The task of identifying health impacts that are a direct consequence of globalization processes is complicated by the interactions of such processes with domestic political and economic opportunity structures. For example, the anticipation of conditionalities attached to lending by the IMF or World Bank can lead countries to adopt domestic social and economic policies in the absence of overt intervention by lenders. Cheru quotes a finance minister from one of the heavily indebted poor countries: 'We do not want to second-guess the Fund [IMF]. We prefer to pre-empt them by giving them what they want before they start lecturing us about this and that. By so doing, we send a clear message that we know what we are doing, i.e. we believe in structural adjustment' (2001, p. 12).<sup>4</sup> Methodologically, there are lag-time problems: are present health gains the result of a national economy's recent embrace of globalization (liberalization), or of previous periods of domestically oriented economic policy? There are also lead-time problems: How may today's embrace of globalization lead to health-related environmental damage from rapid urbanization, increased resource depletion, or industrial pollution?

Our own approach to this complexity was to undertake a reasonably comprehensive review of analytical frameworks to create a 'map' of the linkages between globalization and health (Labonte & Torgerson, 2003), using as a reference point the work of David Woodward and colleagues at the WHO (Woodward et al., 2001). We defined 'frameworks' as graphic, visual representations of concepts, contexts and pathways that link globalization to health, whether these pathways are defined in terms of arithmetical relationships or qualitative descriptions of causal relations. Most frameworks identified in our literature review were partial, reflecting the disciplinary or sectoral interests of their creators, e.g. physical environment, social environment, economic growth, healthcare services. We found that many frameworks failed to define, much less operationalize, their key constructs. Few frameworks incorporated people as social actors able to influence public policies, social norms or macroeconomic contexts. Interestingly, those that did, identifying community organizations or civil society groups as mediators between globalization and its impacts, were developed

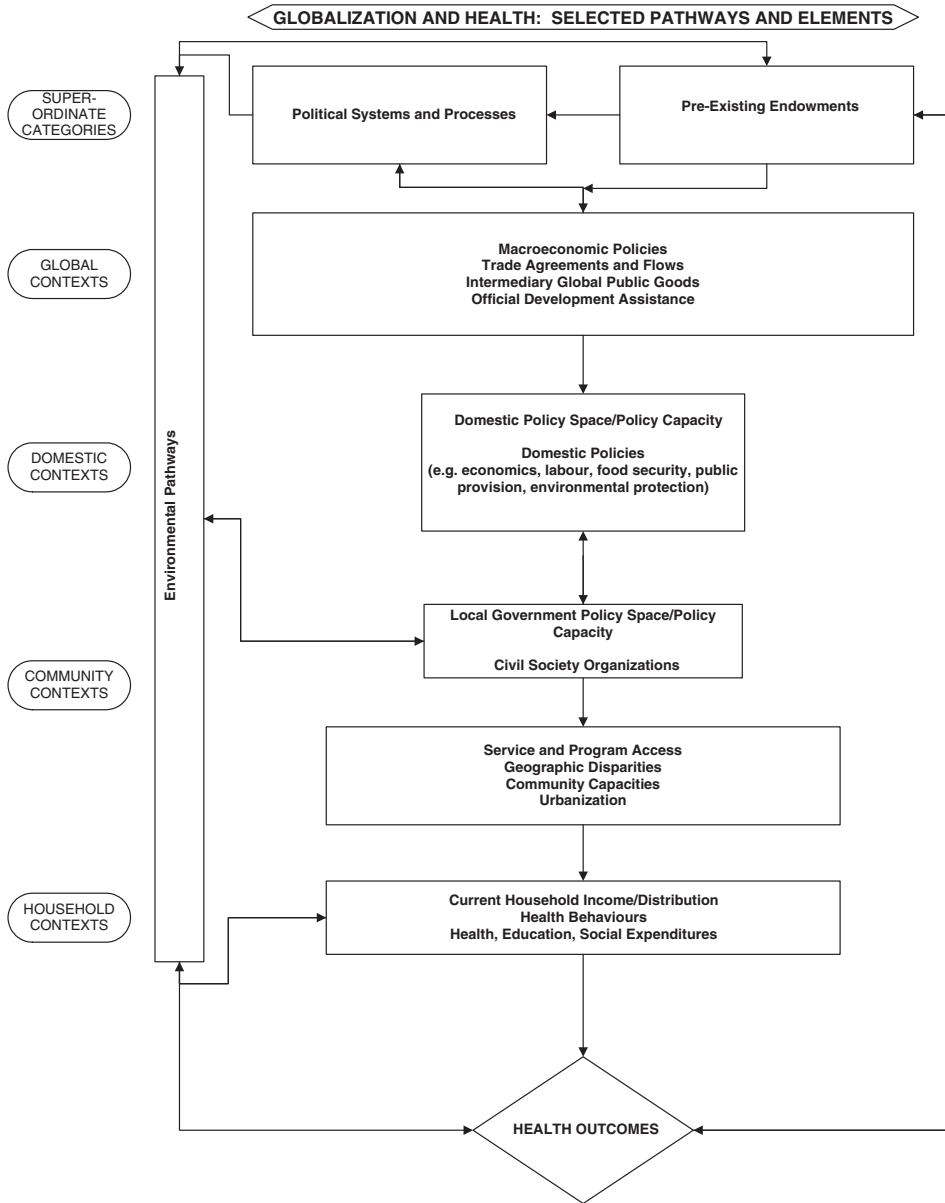


Figure 1. Globalization and health: Basic framework.

by non-governmental organizations. The frequent absence of social actors relates to another common omission: Analysis of social power relations, by class, gender or ethno-racial background (notable exceptions are Rico, 1998; Woodward et al., 2001). Such analysis, we argue, is basic to a critical approach to understanding health determinants.

While the many analytical frameworks we encountered generated *partial* answers to *some* questions about globalization and health, the absence of more comprehensive frameworks makes it difficult to identify the full range of both positive and negative effects. We present below our own composite and more comprehensive framework, which incorporates

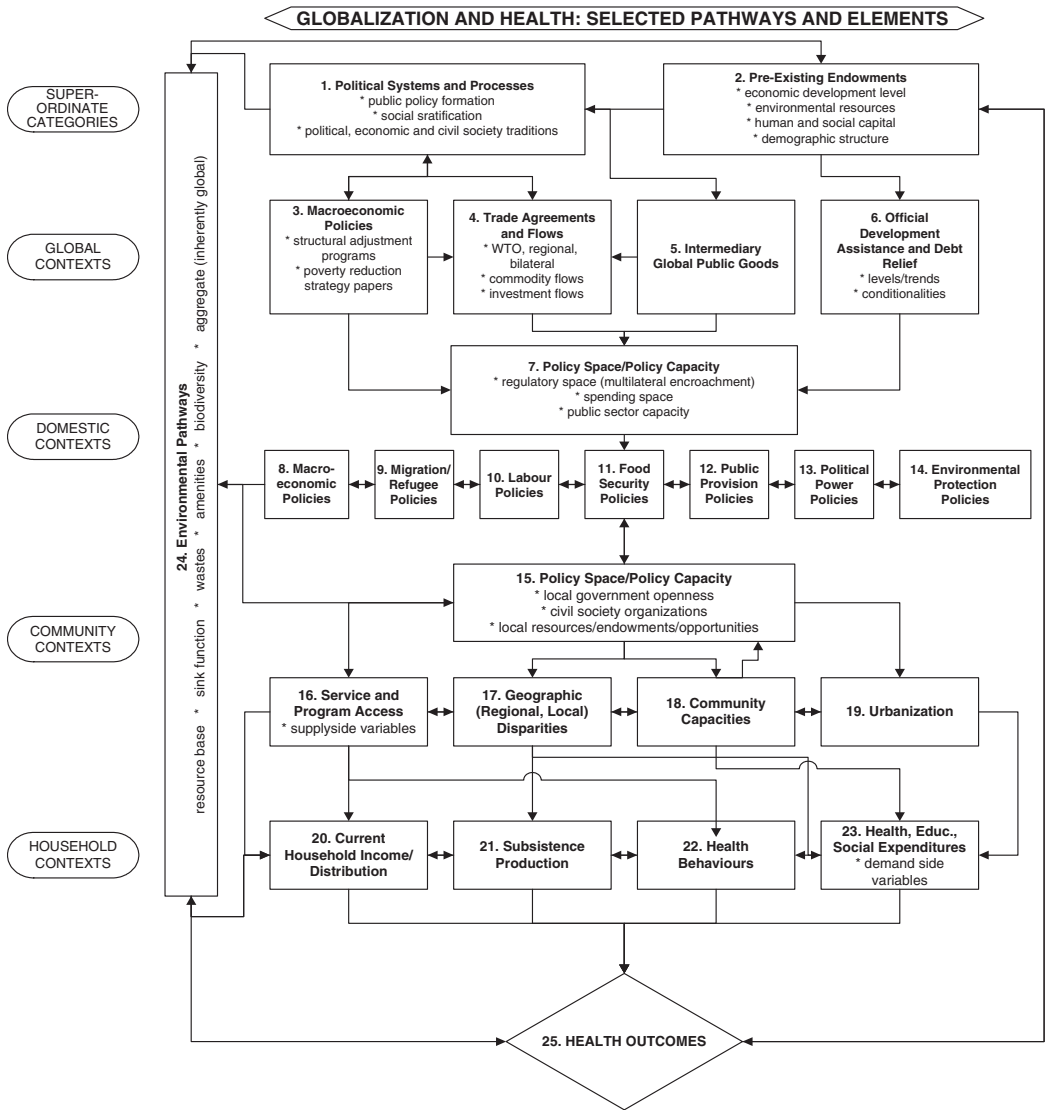


Figure 2. Globalization and health: More complex framework. *Note:* Health systems, and other public infrastructures essential to better health outcomes, are subsumed under the categories of ‘Public Provision Policies’ and ‘Services and Program Access’.

elements that we found from our review to be theoretically and/or empirically ‘rich’ (substantiated).<sup>5</sup> It is organized as a simple hierarchy. What follows is a brief discussion of the framework’s different levels, and their implications for assessing globalization’s impacts on health.

**Health outcomes**

Our concern is with greater equity (fairness) in health within and between nations. But reliance on health measures such as mortality, morbidity or disability rates as

Table II. The first seven millennium development goals.

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Goal 1	: Eradicate extreme poverty and hunger
Target 1	: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day
Target 2	: Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Goal 2	: Achieve universal primary education
Target 3	: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education
Goal 3	: Promote gender equality and empower women
Target 4	: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015
Goal 4	: Reduce child mortality
Target 5	: Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate
Goal 5	: Improve maternal health
Target 6	: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Goal 6	: Combat HIV/AIDS, malaria and other diseases
Target 7	: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS
Target 8	: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases
Goal 7	: Ensure environmental sustainability
Target 9	: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources
Target 10	: Halve, by 2015, the proportion of people without sustainable access to safe drinking water
Target 11	: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

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*Source:* Devarajan, Miller and Swanson (2002, pp. 34–35).

indicators in studies of the health impacts of globalization is insufficient for the lead- and lag-time reasons already mentioned. The HIV/AIDS pandemic, national or regional conflicts and environmental catastrophes, while associated with globalization processes, nonetheless are ‘wildcards’ that render suspect any direct cross-national comparative analyses using measures of globalization and of health outcomes alone. The value of analytical frameworks linking globalization to health is that the effects of such wildcards, and the sundry ways in which globalization phenomena influence health by affecting known social and environmental determinants of health, can be assessed by individual studies detailing partial relationships that are then collected and assembled against a framework of the whole. Gaps in the pathways can be identified for future research, while reasoned and fairly comprehensive conclusions about globalization’s complex impacts on health, via its more direct impacts on multiple pathways, can be tentatively reached. At the same time, it is helpful to have a delimited set of health outcomes for cross-national comparisons, supported by detailed longitudinal case studies. An obvious shortlist, particularly for developing countries, is provided by the health targets associated with the first seven of the Millennium Development Goals (Table II), which are the focus of the United Nations Development Programme’s 2003 Human Development Report (UNDP, 2003) and a recently released five-year review of progress (UN Millennium Project, 2005). Some caution is still in order because the MDGs are stated in aggregate terms. Improvements in health status and in the determinants of health sufficient to meet the MDG targets when measured at the national level only may not reflect improvements in the situation of the poorest or least healthy (Gwatkin, 2002). A country could conceivably reach the MDG targets by increasing health inequalities between high- and low-income groups within its borders. Careful monitoring of the incidence of such improvements using national-level equity stratifiers is needed.

### Superordinate categories

Governments' decisions to contribute to, negotiate or abide by globalization's key economic drivers, and their capacities to mitigate any health-damaging or otherwise undesired social and environmental impacts, are conditioned by their national histories—a point that has been made with special force in the case of Africa (Mkadawire & Soludo, 1999, pp. 1–20). We identify two categories of elements (many are still too broadly stated to be considered variables) that reflect this: Pre-existing endowments and political systems and processes.

#### *Pre-existing endowments*

Crude measures of pre-existing economic endowments include *per capita* income or wealth, currency reserves and other monetary measures. Natural resources also constitute a pre-existing endowment. Countries facing deficits in water, arable land, fibre (forests), energy and other natural resources will experience the impacts of globalization more harshly than those with a surfeit of natural capital. Human capital (traditional knowledge, new knowledge, education attainment, individual and collective skills or abilities) and social capital (social networks predicated on trust and reciprocity) are other pre-existing endowments. A country's demographic profile can also be considered another important facet of its pre-existing endowments, particularly with regard to its impact on environmental resources use/depletion (Leach & Mearns, 1991).

#### *Political systems and processes*

Political institutions and processes similarly shape the range of possible policy responses. In a case study of post-apartheid South Africa, McIntyre and Gilson (2001) argue that the influence of global contexts on domestic (national) policy space and capacity has been mediated by acceptance of discrimination (on the basis of race, ethnicity or gender), definition of public need and attitudes towards privatization, determination of public policy (degree of civil society participation), level of unionization and accountability of public administration. Some of these influences (notably the second, third and fourth) have been found in other cross-national studies (Global Social Policy Forum, 2001; Gough, 2001), particularly those contrasting the social and labour market impacts of global market integration between different forms of rich world capitalism (i.e. the Nordic social democratic, European corporatist and Anglo-American liberal models; see Esping-Anderson, 1990).<sup>6</sup>

Related to these points is the discounting of the political nature of globalization. 'Making globalization work for the poor'—the language of the Communiqué issued at the conclusion of the 2001 G8 Summit (¶3)—becomes an exercise in adjudicating fine details of particular trade agreements or domestic 'regulatory frameworks' that might help to mitigate the 'no alternative' juggernaut of increased global economic integration. Lost in the technical discussions is the extent to which global capitalism, however technically buffered, is substantially shifting power away from public governing structures and towards private economic organizations, the power of which is defined by national and supra-national structures of property rights. Conflict and political instability are other aspects of political systems and processes that can effectively determine the acceptance of, or compliance with, macroeconomic policies and trade regimes. The extent of prior social status systems within countries, whether stratified by gender, class,

caste, ethnic or wealth-based criteria, is also posited as an important prior condition influencing how macroeconomic policies are selected, implemented and ultimately shape health outcomes (Diderichsen, Evans, & Whitehead, 2001). Countries with unequal power distribution are more likely to support global macroeconomic policies that retain elite group privileges than are those with a broad middle-class, gender equity and strong civil society groups and labour unions. We emphasize that our use of the term 'pre-existing' refers only to how a country's current endowments affect its ability to respond to future challenges. In fact, most 'pre-existing' endowments are reflections of past historical processes; the current endowments of many developing countries are directly traceable to their colonial past.

### **Global policy and economic contexts**

A focus of much of our work to date concerns the health impacts of four key elements of the global context, each of which is primarily under control of the rich, industrialized countries and the holders of transnationally enforceable property rights: domestic macroeconomic policies, trade agreements (global, regional or bilateral), official development assistance and debt relief (for elaboration see Labonte, Schrecker, Sanders, & Reeus, 2004). To this list can be added the movement of peoples (over 175 million people lived outside their country of birth in 2000) and the flow of remittances to developing countries, some US\$80 billion in 2002, more than double the amount in 1990, and an important source of foreign currency for many poorer countries) (Kapur & McHale, 2003).<sup>7</sup>

#### *Macroeconomic policies*

The most commonly examined macroeconomic policies are those embodied in the conditionalities imposed by the IMF and World Bank on indebted countries in return for loans, grants or partial debt relief, collectively known as structural adjustment programs, or SAPs (Mohan, Brown, Milward, & Zack-Williams, 2000). Funds were made available only if the debtor country agreed to a relatively standard package of macroeconomic policies including reduced subsidies for basic items of consumption, the reduction or elimination of tariffs and controls on capital flows, privatization of state-owned productive assets, currency devaluations to increase the competitiveness of exports, and domestic austerity measures such as reduced government spending on education and health and the introduction of cost recovery through user fees (Milward, 2000). SAPs are associated with the erosion of labour market institutions (full employment policies, decreased minimum wage and reduction in public sector employment), shifts in taxation policies (less progressive) and reduced public spending (e.g. on education, health, environmental protection) (Cornia & Court, 2001).

While SAPs have disappeared in name, many of their macroeconomic elements are still found in the conditionalities associated with the Heavily-Indebted Poor Countries (HIPC) initiative launched in 1996 to provide partial debt relief for some of the world's most desperate countries.<sup>8</sup> A key element of eligibility for HIPC is the preparation of a national Poverty Reduction Strategy Paper (PRSP) as the basis for domestic social and economic policy. Key PRSP elements include commitments to poverty reduction, broad public participation and local government ownership. However, the lenders who assess PRSPs operate on the presumption that poverty reduction is best achieved through neo-liberal prescriptions for privatization, deregulation and rapid integration into the global economy, PRSPs sometimes requiring more rapid liberalization than that mandated

under World Trade Organization agreements, all of which is likely to exacerbate existing inequalities (UNDP, 2001; SAPRIN, 2002; Brock & McGee, 2004). The World Health Organization (2001) identifies several serious health-related shortcomings in existing PRSPs: negative effects of cost recovery for healthcare services and the failure of fee-exemption programs for the poor; lack of clear government commitments to increase resources for health and education; and failure to consider health as an outcome, rather than simply a means, of development.

### *Trade agreements, flows and institutions*

Trade liberalization is a sub-set of macroeconomic policy. The aim of contemporary trade agreements is to facilitate the reorganization of production or commodity chains across national borders in order to maximize profitability. Considerable disagreement surrounds the question of whether trade liberalization per se will improve or worsen health and health-determining social contexts (Kirkpatrick & Lee, 1999; Cornia, 2001; Cornia & Court, 2001; Dollar, 2001; Labonte, 2001). Trade liberalization by definition reduces tariffs. This can shrink the amount of revenue governments have to spend on health, education and environmental protection. Tariff reduction has been particularly hard on developing countries, which used to get much of their revenue from tariffs. Few countries experiencing sharp post-liberalization declines in tariffs have been able to generate other forms of compensatory taxation (Hilary, 2001). This severely reduces their 'spending capacity'—the amount available for key health-promoting investments such as public healthcare, education, water/sanitation and gender empowerment programs, or to enforce occupational, environmental or labour rights and standards.<sup>9</sup>

Trade policy may have perverse effects on health in two further ways. First, development policy observers who disagree on many other points agree that meaningful improvements in market access for the products of the world's poorest countries would result in dramatic increases in income and, therefore, in opportunities to improve health. A recent Oxfam report on making trade work for the poor, for example, notes that: 'If developing countries increased their share of world exports by just five per cent, this would generate \$350bn—seven times as much as they receive in aid' (Watkins, 2002, p. 8). Despite the free-trade rhetoric of the industrialized countries, and their demands that developing world markets be opened up to imports, they protect their own domestic markets in various ways, ranging from high tariffs on products of special importance to developing countries to trade-distorting subsidies to agricultural producers (Figure 3). Indeed, the industrialized world can be seen as giving with one hand (in the form of limited debt relief and development assistance) and taking away much more aggressively (in the form of trade protection and agricultural subsidies) with the other. The collapse of the WTO trade talks in Cancun in September 2003 can be read as a simultaneous success and failure in this regard. The success is the increased strength of organized developing countries; the failure lies in the apparent commitment of wealthier countries, particularly the US, to focus now on bilateral and regional trade agreements where its economic might can overwhelm a more diluted developing world opposition.<sup>10</sup>

Second, an additional and increasingly scrutinized aspect of trade agreements involves the loss of domestic 'regulatory space' (Rao, 1999; Labonte, 2001) (Table III). This loss can have positive health consequences, if it prevents governments from providing subsidies to domestic companies that lead to resource depletion or environmentally destructive activities (for example, in agriculture or fisheries). But its impact is negative 'when the ability of governments to enact and implement appropriate environmental regulations is undermined

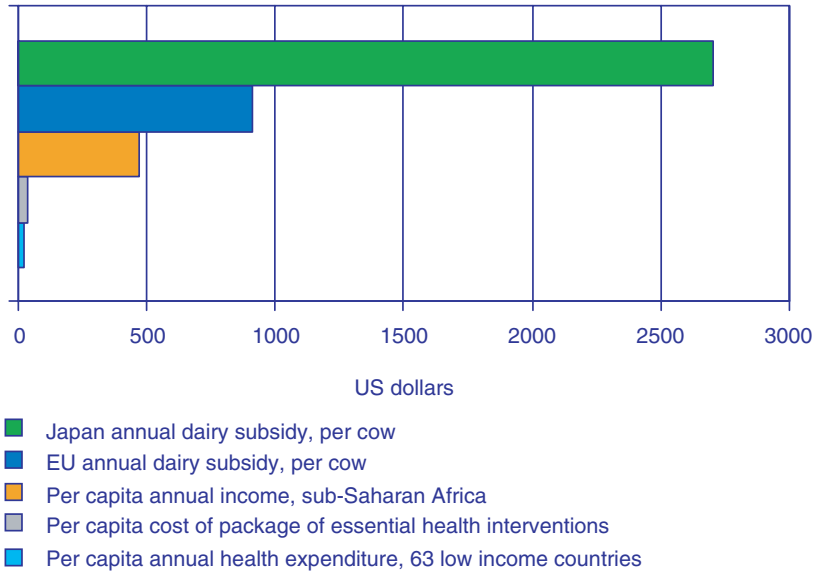


Figure 3. Rich world agricultural subsidies in perspective. *Source:* Commission on Macroeconomics and Health (2001), United Nations Development Programme (2003) and World Bank (2002).

by the provisions of trade and investment agreements' (OECD, 2001, p. 54). Most of the environmental frameworks reviewed in our study, using empirically based modelling experiments or case studies, concluded that increased global trade will create negative environmental externalities through accelerated resource depletion, trade-related energy consumption and greenhouse gas emissions (Labonte & Torgerson, 2003), the health implications of which are profound.

Domestic regulatory space is further, if indirectly, encroached by the costs of implementing WTO agreements, which are estimated as far exceeding the total development budgets of the least developed countries (Finger & Schuler, 2001); and by the level of public sector employment, which is often severely curtailed as a consequence of austerity measures undertaken in response to pressure from lenders (Milward, 2000; Cornia & Court, 2001).

#### *Official development assistance*

Official development assistance (ODA) is rarely considered in globalization frameworks, perhaps because of the stagnation and subsequent decline of ODA spending by most industrialized countries during the 1980s and 1990s. (The recent attention given to the Millennium Development Goals, and the importance of massively increased levels of development assistance to achieve them, is beginning to focus more media and public attention on ODA.) Figure 4 shows a precipitous drop in ODA from the 'Group of 7' (G7) richest countries, over the very decade in which these countries experienced global trend-setting wealth creation. Only a few European countries ever achieved the internationally agreed target of 0.7% of GDP for official development assistance. Several donor countries have pledged recently to reach this target by 2015, including the UK and France, but excluding the US, Germany, Japan and Canada (UN Millennium Project, 2005, p. 252).

Table III. WTO agreements and health-damaging loss of domestic regulatory space.

Agreement	Health impacts from loss of domestic regulatory space
Agreement on Trade Related Intellectual Property Rights	Extends patent protection rights, limiting governments' abilities to provide essential medicines at affordable costs Higher cost of drugs with extended patent protection drains money useful for primary health care Case example: Access to antiretroviral drugs
Agreement on Sanitary and Phytosanitary Measures	Requires scientific risk assessments even when foreign goods are treated no differently than domestic goods (i.e. even when there is no discrimination between a domestic and a foreign supplier of the good) Such assessments are costly, and are imperfect in assessing the many potential health risks associated with environmental and manufactured products Case example: The successful challenge to the European Union's ban on the use of artificial hormones in raising beef
Technical Barriers to Trade Agreement	Requires that any regulatory barrier to the free flow of goods be 'least trade restrictive as possible' Many trade disputes over domestic health and safety regulations have invoked this agreement The only WTO dispute where the health exception, allowing countries to abrogate from trade agreement rules for purposes of protecting human, animal and environmental health, was in favour of France's ban on the import of Canadian asbestos products This occurred under appeal, and followed widespread negative reaction to the initial WTO ruling in favour of Canada
Agreement on Trade Related Investment Measures	Limits countries' abilities to direct investment where it would do most good for domestic economic development and employment equity, both of which are important to improving population health
Agreement on Government Procurement	Limits governments' abilities to give priority to domestic firms bidding on its contracts, or to require purchases of goods from local companies, both of which can promote employment opportunities and regional equity, which in turn have strong links to better population health This is currently an 'optional' agreement to which few developing countries have 'signed on'
Agreement on Agriculture	Continuing export and producer subsidies by the US, EU, Japan and Canada depress world prices and cost developing countries hundreds of millions of dollars in lost revenue which could be used to fund health, education and other health-promoting services Subsidized food imports from wealthy countries undermine domestic growers' livelihoods Market barriers to food products from developing countries persist and deny poorer countries trade-related earnings

Although ODA remains an essential element in many national government budgets amongst the world's least developed countries, a number of problems (aside from its insufficient value) must be considered. Targeting of countries for assistance is inconsistent, making it difficult for countries to plan sustainable infrastructures and program expenditures. Much of the aid is tied (requiring purchases from the donor country) or in the form of technical cooperation (requiring employment of donor country nationals). Reflecting an overall pattern of government expenditure in many developing countries, much aid, especially in health and education, does not go to 'basic' services benefiting

the least well off, but to technically advanced services benefiting a smaller number of the privileged (World Bank, 2000, pp. 80–85). Finally, high debt and ODA insufficiency are conjoined twins. The problem is ‘fungibility’, meaning that development dollars that are not already tied go indirectly but no less certainly into the pockets of First World bankers, investors, government marketing boards, the IMF and other creditors—many of whom could be held at least partly responsible for these debts in the first place (Stiglitz, 2003). In 1995, for all developing countries, debt service costs amounted to 3.6 times the value of ODA receipts. By 2000, the ratio had risen to over 7 : 1 (Pettifor & Greenhill, 2002).

### **Domestic public policy contexts<sup>11</sup>**

A longer and more robust history exists of mapping pathways that link national (as distinct from global) policies to health outcomes, particularly in high-income countries. There is a premise that public policies determine the ultimate allocation of opportunities and resources within a political jurisdiction. We describe these as domestic, rather than national, policies, since most countries have a complex layering of policy-making rights from national to community levels. The ones identified in our framework are those with the strongest relationship to health outcomes.

### **Community contexts**

Elements from higher-order categorizations recur within community contexts. First, there is the issue of how national resources are allocated to geographic areas, and the nature of local-level endowments capable of generating the means of livelihood and savings within communities. Second, there are aspects of local government itself (i.e. openness) and of civil society strength, both of which can enhance citizen participation in policy, program and resource decisions. But this participation, in turn, and particularly for poorer groups, is often confined by a deficit in certain ‘capacities’ identified by the international and community development practice literature (e.g. leadership, resource mobilization, assessment and analysis skills, organizational skills); hence an emphasis here on strategies that build such community capacities (Labonte & Laverack, 2001). Key vehicles for this purpose reside in various publicly provided services; and here disparities in regional or community reflect responses to a macroeconomic policy context that is determined at national and international levels. Not only might there be geographic or regional disparity; many poorer countries have significantly unequal allocations of public programming and service resources within the same geographic community. A critical juncture between globalization processes and community contexts is the impact of economic restructuring (via SAPs and free trade agreements) on accelerated urbanization, creating massive ‘slums’ in poor countries with sanitation, crowding and poverty problems rivalling the worst of the European urban slums during the early period of nineteenth-century industrialization (World Resources Institute, 1996, pp. 14–55).

### **Household contexts**

All of the analytical frameworks we reviewed that incorporated a household level describe and analyse gender roles—a perspective the importance of which was noted earlier. McCulloch, Winter and Ciera (2001) argue that the effects of poverty fall ‘disproportionately on women, children and the elderly’ (p. 69). They discuss this in terms of ‘gender

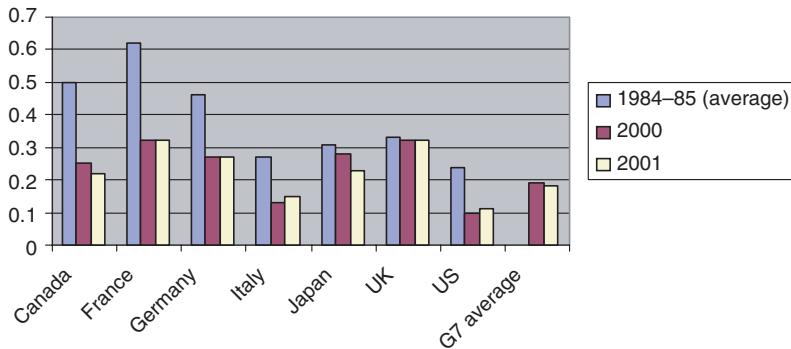


Figure 4. Total ODA as percentage of gross national income (GNI), 1984-85 (average), 2000 and 2001, G7 countries. *Note:* 1984-85 average is for bilateral aid only; data allowing for calculation of multilateral contributions for 1984-85 are not available. ODA contributions increased for some, but not all, G7 countries in 2002; data for 2003 have not been released at time of writing. *Source:* OECD (2002, Table 4); OECD (2003, Table 4). Estimates of 2000 and 2001 multilateral contributions made by authors.

power within the household', and how trade-related lowered family wage and a rise of female labour, without compensational help with household duties, may decrease women's welfare and compromise any increased household power their income-earning potential might have accrued them. Greater female control of household income, in turn, is associated with better health and educational outcomes for children.

### Conclusion: Towards an empowering methodology

The utility of any analytical framework in population health research depends on its ability to identify (or allow identification of) causal relations in ways that support and inform policy interventions, on scales ranging from the community to the transnational. Many of the links between the pathways inherent in our framework elements (e.g. trade liberalization and biodiversity, macroeconomic adjustment policies and health services) have already been studied empirically. Additional research can further explore subsets of framework linkages. The most useful information, particularly from a policy vantage, would be comparative case studies where as many as possible of the potential linkages could be assessed within one country, using secondary data, existing partial studies and new research as required; with comparisons made *ex post* between different countries displaying different superordinate and macroeconomic patterns. What is important is that such studies incorporate elements of each of the framework's different levels.

One example of where the framework has been applied is an ongoing study of health and development commitments made by the G8 countries (Canada, France, Germany, Italy, Japan, Russia, the UK and the US), in which commitments were assessed for compliance, adequacy and coherence (Labonte et al., 2004). The framework guided the selection of research studies and multilateral reports used in the assessment exercise; this article essentially extends the discussion of the framework contained in the book-length presentation of the first tranche of findings, *Fatal Indifference: The G8, Africa and Global Health* (Labonte et al., 2004).

We have also proposed use of the framework in future research studies, using as an example studies of the impacts of debt cancellation on health outcomes. For any particular country, analyses could be undertaken to study the relationship between the

following variables (numbers on the left refer to particular boxes in Figure 2, for ease of cross-referencing):

4. debt service as percentage of exports of goods and services;
6. debt relief committed to case study country (amount/year);  
debt relief committed under HIPC Initiative (US\$);  
cost-recovery conditionalities attached to debt relief (this cross-refers to 3. Macroeconomic Policies, and would include *inter alia* assessment of conditions related to tariff reduction and its impact on public revenues and, thence, on indicators in categories 11, 17, 20, 21 and 23, noted below);
7. ratio of pre- to post-HIPC public expenditures on health, education, water, sanitation (in absolute terms and as a percentage of GDP);
11. changes in prices of basic foods, nationally and regionally;
12. trends in cost of essential drugs;
13. debt service as percentage of public expenditures in health, education, water, sanitation;
17. trends in public expenditures in health, education, water, sanitation by geographic regions or neighborhoods, organized by income level, gender or other social stratifiers, before and after HIPC or other forms of debt relief (i.e. regional-level changes in access to health, education, water, sanitation);
20. impact of public expenditures in health, education, water, sanitation on household income level, gender distribution or other social stratifiers;
21. impact of public expenditures in health, education, water, sanitation on health behaviors, by household income level, gender distribution or other social stratifiers;
23. impact of public expenditures in health, education, water, sanitation on private health expenditures for these services, by household income level, gender distribution or other social stratifiers (i.e. household level changes in access to health, education, water, sanitation);
25. as annual data accumulate, analyses of debt relief on health-specific indicators for the Millennium Development Goals.

These two examples bring us to the important issue of *how* globalization/health research itself might adopt some of the tenets of a *critical population health* that we identified earlier. This issue is particularly acute when the research questions concern power differentials between the world's wealthiest and poorest citizens. Normal criteria of 'community participation' is not possible in any direct sense if that community includes researchers in high-income countries and, as an example, residents of black townships in South Africa. It is complicated by national research-granting bodies that fund (in our case) *Canadian* researchers, but not necessarily their partners in developing countries. This granting policy, however, is changing, partly through the efforts of a newly established Canadian Coalition for Global Health Research and a Memorandum of Agreement between Canada's federal health ministry, health research institutes and development agencies to increase funding for such research. Several broadly stated principles for conducting global health research have been proposed (Labonte & Spiegel, 2001):

- Give priority to research on inherently global health issues that will reduce the burden of disease.
- Give priority to research on the burden of disease that includes study of inherently global health determinants.
- Within both, give priority to research that represents Southern-defined concerns or questions.

- Within such research, give priority to proposals that will increase equity in health outcomes between groups within nations.
- Within such research, give priority to proposals that have solid civil society engagement.
- Within such research, give priority to proposals that will increase equity in knowledge capacities between the North and South.

Our own efforts to act on these principles include new research work on the 'brain drain' of health professionals from southern African countries to Canada, the UK and Australia. The impetus for this research came from research/civil society networks in southern Africa, who are examining how globalization processes (from trade agreements to macroeconomic policies to aid/debt trends) affect the supply of health workers in already under-resourced nations. It has an explicit advocacy plan and time frame; indeed, it is the advocacy plan's need for the research that is driving the collaboration.

Globalization, though not an entirely new phenomenon, is a fairly new construct. Its impacts on health are potentially enormous, for better and for worse. Reaching some consensus on how globalization might maximize the former and minimize the latter depends, albeit only partly, on assembling evidence and undertaking new research that, as Starfield (2001) argues, is best based on a delimited range of frameworks. A more fundamental question, and one that for the moment remains unresolved, is that of whether responses can really be 'evidence based', or whether they will be shaped by the interests of the world's rich minority. The challenge this poses for critical population health research is the degree to which researchers are committed to the political nature of the project in which they engage.

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### Notes

1. Monbiot (2003), in an essay on creating a global democracy to countervail the abuses of unfettered global capitalism, makes the point that international or multilateral approaches based on today's institutions are inadequate. If all countries did decide to re-confine capital within their borders, internationalism might work. But poor countries want foreign capital and the elite financial and export interests in rich countries have no desire to be re-nationalized. These interests dominate most political parties, while all of our current international institutions, from the United Nations to the IMF and World Bank, routinely defer to the United States. Only new *global* responses and structures will be able to correct these international inequalities in power.
2. Even the recent report of the UN Millennium Project, which calculates the domestic and international aid resources required to meet the Millennium Development Goals (see Table 2), and which takes into account aid, trade, debt cancellation and economic growth factors, is rather anodyne with regard to the impacts of economic globalization (UN Millennium Project, 2005). It calls for increased developing country public spending on health and education through better tax measures even as it urges tax holidays to attract foreign direct investment and proposes regressive value-added taxes as the principal domestic revenue generator. It sees no conflict (real or potential) between the interests of the private (corporate) sectors, the public sector and civil society organizations, particularly in the delivery of essential health and water/sanitation services. It claims a human rights-based approach to development is powerfully linked to economic growth but is silent on the human rights abuses in China, the developing country demonstrating the greatest (albeit disputed) growth and poverty reduction

data. It costs out a comprehensive 'scaling up' of HIV/AIDS intervention programs, but is largely silent on the historic global context that abetted the pandemic. While harsh on rich world agricultural subsidies, it proposes deeper liberalization for poor countries upon which its scaled up assistance package may be conditional, essentially imposing a rich world economic model on all other countries. It assumes that, with suitable investments in environmental technologies, rapid global growth will not imperil the planet's remaining stock of natural capital. Thus, while more indicative of what we call a 'global health' approach, the project stops substantially short of being 'critical' in its analyses.

3. There are sharp debates about the impacts of globalization on poverty and economic growth. A much cited World Bank claim that globalization has reduced the number of people in extreme poverty (< \$1/day) by over 200 million since 1980, due largely to economic growth in China and India (Dollar, 2002), rests on unreliable data and has been challenged on methodological grounds (Wade, 2002). There are fewer disputes about the rise in income inequality. Whether income inequality is the root of disease inequality, however, remains contentious (Deaton, 2001). Poverty, which is higher in high income-inequality countries, may be the bigger problem. But the greater the income inequality the harder it becomes for the economic growth presumed to follow trade liberalization to actually lift people out of poverty. Moreover, income inequality is associated with declines in social cohesion, social solidarity and public support for strong states with strong redistributive income, health and education policies that have been shown to buffer liberalization's un-equalizing effects (Deaton, 2001; Global Social Policy Forum, 2001; Gough, 2001). Income inequality is also associated with higher rates of homicide, suicide and generalized conflict. Dollar (2001), in his 'health defence' of globalization, argues that liberalization does not cause inequality because there is no consistent pattern between the two. However, those market-liberalizing developing countries experiencing the greatest economic growth (China, Vietnam and India) are also the ones experiencing the sharpest increases in income inequality. The liberalizing countries where income distribution became more equal were those that failed to grow, i.e. everyone remained poor. Moreover, Dollar (2002) acknowledges that, assuming continued trade liberalization, global income inequalities will increase steeply by 2015.
4. See McIntyre, Thomas and Cleary (2004) for an important case study of post-apartheid South Africa. The newly elected ANC government voluntarily adopted neoliberal policies of liberalization and constraints on public sector spending (including health, at a time when the HIV/AIDS pandemic was rising both in prevalence and attention) in order to attract foreign direct investment and signal 'fiscal probity' to global markets. One might rightly see this choice as coerced, however subtly, by the broader globalization context; it also underscores the care that must be taken in determining the direct and indirect influences of globalization's processes on health-determining pathways.
5. Figure 1 'overviews' the framework and allows the reader to grasp its broad shape. Figure 2 unpacks its levels in more detail. We provide both versions in this article since Figure 2 is often difficult to grasp without first seeing its simpler contours. The boxes in Figure 2 are numbered, and are referred to by number in an example provided in our concluding section.
6. The loss of domestic regulatory capacity and space that this article documents as consequent to contemporary globalization has tempted some to announce the death of the nation-state as an important political actor. This is not the case. First, nations have created and agreed to the new global economic rules that subsequently diminished their own policy flexibility. Once created, these rules become a path-dependent force making it difficult, although not impossible, to alter the rules in the future. Moreover, considerable variation in domestic policies has persisted over the past two decades of global market integration. The Nordic countries continue to have high-tax, high-welfare, low-poverty capitalist regimes that also perform better, economically, than do most of the Anglo-American low-tax, low-welfare, high-poverty capitalist regimes. More at issue, and the reason why ongoing study of globalization's health impacts is important, are the effects of new global economic rules on developing countries to achieve the type of welfare capitalism still enduring in much of Northern Europe.
7. Intermediary Global Public Goods (IGPGs) comprise another element in our list of globalization processes. IGPGs refer to the agencies and regulatory structures for 'global public goods', or GPGs. The GPG concept is a new expansion of the classical economic construct of public goods. At issue for a critical population health approach is that the GPG concept is beset by definitional disputes. Some claim that free trade agreements are GPGs on the assumption that they promote economic growth, which, by definition, is a public good. Others argue that such agreements are global public 'bads' by virtue of the inequities in wealth distribution they exacerbate and the environmental pollution and resource depletion that usually accompanies rapid growth. Detailing the debates over GPGs is beyond the scope of this article; for further discussion, see Blouin, Foster and Labonte (2004); Kaul, Grunberg and Stern (1999); and Woodward and Smith (2003).
8. The 'debt overhang' is considered to be a major factor in the inability of least developed countries to sustain or benefit from economic growth (UNCTAD, 1999). It is also a major impediment to their ability to invest in health, education, water, sanitation and other essential human development infrastructures. For example, scheduled debt service in Zambia and Tanzania exceeds 40% of their governments' budgetary resources (AFRODAD, 2002). African countries are currently paying over \$15 billion annually in debt servicing charges to rich country creditors, an amount that equals the total aid they receive (OECD, 2002, p. 258). The advocacy of debt cancellation organizations, such as Jubilee Research and the 2005 'Make Poverty History' campaign, has intersected with research findings that many low-income countries will be unable to make progress on MDG targets unless their debts are written off (UN Millennium Project, 2005).

The speed with which the US mobilized massive debt cancellation for (otherwise oil-rich) Iraq also engendered a growing awareness amongst wealthy creditor nations that it was politically unwise not to consider deeper and more widespread debt write-offs for the world's poorest countries, especially those struggling with HIV/AIDS and other disease pandemics. Despite growing support for such debt cancellations, and some unilateral action such as the UK's pledge to pay a portion of poor country debt owed to the World and African Development Banks, no multilateral commitments for debt cancellation have been made at time of writing (January 2005).

9. Cornia (2001) and Cornia and Court (2001), amongst others, argue that liberalization in capital markets has had far more negative health effects than liberalization of trade in goods, including the increased vulnerability of national economies to capital flight and currency collapse. In each country affected by such currency collapses, the result has been increased poverty and inequality, and decreased health and social spending (O'Brien, 2002).
10. A 2004 WTO agreement on a 'framework' for the gradual removal of rich country agricultural subsidies resolves little; the details of what, when and how the subsidies will be removed are still subject to ongoing WTO negotiations.
11. For reasons of space, discussion of the remainder of the framework is necessarily truncated. A longer elaboration can be found in Labonte & Torgerson (2003).

## References

- African Forum and Network on Debt and Development (AFRODAD) (2002). *The efficacy of establishing an international arbitration court for debt*, Technical Paper No. 2002/1. Available at: <http://www.afrodad.org/html/Technical%20Paper.pdf> (accessed 27 May 2003).
- Basu, S. (2003). *AIDS, Empire, and Public Health Behaviorism*. Global Policy Forum. Available at: <http://www.globalpolicy.org/soecon/develop/2003/0802public.htm> (accessed 9 December 2003).
- Blouin, C., Foster, J., & Labonte, R. (2004). Canada's foreign policy and health: Towards policy coherence. In M. Sanger & S. Sinclair (Eds), *Putting Canada first: Canadian health care reform in a globalizing world* (pp. 93–182). Ottawa: Canadian Centre for Policy Alternatives.
- Brock, K., & McGee, R. (2004). *Mapping trade policy: Understanding the challenges of civil society participation*, Working paper 225, Brighton, Sussex: Institute for Development Studies.
- Cameron, D., & Stein, J. (2000). Globalization, culture and society: The state as place among shifting places. *Canadian Public Policy*, XXVI, S15–S34.
- Cheru, F. (2001). *The Highly Indebted Poor Countries (HIPC) Initiative: A human rights assessment of the Poverty Reduction Strategy Papers (PRSP)*, Report submitted to the United Nations Economic and Social Council, E/CN.4/2001/56, New York: United Nations, 18 January. Available at: <http://www.hri.ca/forthecord2001/documentation/commission/e-cn4-2001-56.htm> (accessed 27 May 2003).
- Chinkin, C. (2000). *Gender and globalization*. *UN chronicle* 37 (no. 2). Available at: <http://www.un.org/Pubs/chronicle/2000/issue2/0200p69.htm> (accessed 21 January 2003).
- Commission on Macroeconomics and Health (CMH) (2001). *Macroeconomics and health: Investing in health for economic development*, Geneva: WHO, December. Available at: [http://www3.who.int/whosis/cmh/cmh\\_report/report.cfm?path=cmh,cmh\\_report&language=english](http://www3.who.int/whosis/cmh/cmh_report/report.cfm?path=cmh,cmh_report&language=english) (last visited 27 May 2003).
- Cornia, A. C., & Court, J. (2001). A policy briefing paper. Based on A. C. Cornia (Ed.), *Inequality, growth and poverty in an era of liberalization and globalization* (UNW/WIDER).
- Cornia, G. (2001). Globalization and health: Results and option. *Bulletin of the World Health Organization*, 79, 834–841.
- Daar, A. S., Thorsteindóttir, H., Martin, D. K., Smith, A. C., Nast, S., & Singer, P. A. (2002). Top ten biotechnologies for improving health in developing countries. *Nature Genetics*, 32, 229–232.
- Deaton, A. (2001). *Health, inequality and economic development*, CMH Working Paper Series WG1: 3, Geneva: World Health Organization, Commission on Macroeconomics and Health.
- Devarajan, S., Miller, M., & Swanson, E. (2002). *Goals for development: History, prospects and costs*. Washington, DC: World Bank. Available at: [http://econ.worldbank.org/files/13269\\_wps2819.pdf](http://econ.worldbank.org/files/13269_wps2819.pdf) (accessed 30 May 2002).
- Diamond, J. (1997). *Guns, germs and steel*. London: Random House.
- Diderichsen, F., Evans, T., & Whitehead, M. (2001). The social disparities in health. In T. Evans, F. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (Eds), *Challenging inequalities in health: From ethics to action*. Oxford: Oxford University Press.
- Dollar, D. (2001). Is globalization good for your health? *Bulletin of the World Health Organization*, 79, 827–833.
- Dollar, D. (2002). Global economic integration and global inequality. In D. Gruen, T. O'Brien & J. Lawson (Eds), *Globalisation, Living standards and inequality: Recent progress and continuing challenges, proceedings of a conference held in Sydney, 27–28 May 2002*, Canberra: Reserve Bank of Australia, pp. 9–36.
- Dollar, D., & Kraay, A. (2000). *Growth is good for the poor*. Washington: World Bank. Available at: [www.worldbank.org/research](http://www.worldbank.org/research) (accessed 22 January 2002).
- Drager, N., & Beaglehole, R. (2001). Editorial: Globalization: Changing the Public Health Landscape. *Bulletin of the World Health Organization*, 79, 803.

- Durano M. (2002). *Foreign direct investment and its impact on gender relations*, Women In Development Europe (WIDE). Available at: [http://www.eurosur.org/wide/Globalisation/IS\\_Durano.htm](http://www.eurosur.org/wide/Globalisation/IS_Durano.htm).
- Esping-Anderson, G. (1990). *The three worlds of welfare capitalism*. Princeton: Princeton University Press.
- Finger, J. M., & Schuler, P. (2001). Implementation of Uruguay round commitments: The development challenge. In B. Hoekman & W. Martin (Eds), *Developing countries and the WTO: A pro-active agenda*. Oxford: Blackwell, pp. 115–130.
- Global Social Policy Forum (2001). A North–South dialogue on the prospects for a socially progressive globalization. *Global Social Policy*, 1, 147–162.
- Gough, I. (2001). Globalization and regional welfare regimes: The East Asian case. *Global Social Policy*, 1, 163–190.
- Gwatkin, D. R. (2002). *Who would gain most from efforts to reach the millennium development goals for health? An inquiry into the possibility of progress that fails to reach the poor*, HNP Discussion Paper, Washington, DC: World Bank.
- Harcourt, W. (2000). *Communicable diseases, gender and equity in health*. Available at: <http://www.hsph.harvard.edu/Organizations/healthnet/Hupapers/gender/hartigan.html> (accessed 16 January 2003).
- Hilary, J. (2001). *The wrong model: GATS, trade liberalisation and children's right to health*. London: Save the Children.
- Hochschild, A. R. (2000). Global care chains and emotional surplus value. In W. Hutton & A. Giddens (Eds), *Global capitalism*, New York: New Press.
- ICFTU (International Confederation of Free Trade Unions) (2003). *Export processing zones – symbols of exploitation and a development dead-end*. Brussels: ICFTU.
- Junne, G. (2001). International organizations in a period of globalization: New (problems of) Legitimacy. In J. M. Coicaud & V. Heiskanen (Eds), *The Legitimacy of International Organization*, Tokyo: United Nations University Press.
- Kapur, D., & McHale, J. (2003). Migration's New payoff. *Foreign policy*, November–December, 49–57.
- Kaul, I., Grunberg, I., & Stern, M. (1999). Introduction. In I. Kaul, I. Grunberg & M. Stern (Eds), *Global public goods: International cooperation in the 21st Century*. New York: UNDP/Oxford University Press.
- Kirkpatrick, C., & Lee, N. (1999). *WTO new round: Sustainability impact assessment study, phase two report—executive summary*. Manchester: Institute for Development Policy and Management and Environmental Impact Assessment Centre, University of Manchester. Available at: <http://www.europa.eu.int/comm/trade/pdf/repwto.pdf> (accessed 22 January 2002).
- Labonte, R. (2001). *Health, globalization and sustainable development*, draft discussion paper prepared for the World Health Organization Meeting *Making Health Central to Sustainable Development*, Oslo, Norway, 29 November–1 December 2001. Available at: <http://www.spheru.ca> (accessed 30 January 2002).
- Labonte, R., & Laverack, G. (2001). Capacity building and health promotion: For whom? and for what purpose? *Critical Public Health*, 11, 111–127.
- Labonte, R., & Spiegel, J. (2001). *Setting global health priorities for funding Canadian researchers: Discussion paper prepared for the Institute on population and public health*. Canadian Institutes of Health Research. Available at: [www.spheru.ca](http://www.spheru.ca) and [www.globalhealth.liu.bc.ca](http://www.globalhealth.liu.bc.ca) (accessed 30 January 2002).
- Labonte, R., & Spiegel, J. (2003). Setting global health research priorities. *British Medical Journal*, 326, 722–23.
- Labonte, R. Schrecker, T., Sanders, D., & Reeus, M. (2004). *Fatal indifference: The G8, Africa and global health*. Cape Town, SA: University of Cape Town Press, Ottawa: IDRC Books.
- Labonte, R., Polanyi, M., Muhajarine, N., McIntosh, T., & Williams, A. (2005). Beyond the divides: Towards critical population health research. *Critical Public Health* (in press).
- Labonte, R., & Torgerson, R. (2003). *Frameworks for analyzing the links between globalization and health*. Geneva: World Health Organization.
- Leach, M., & Mearns, R. (1991). *Poverty and the environment in the developing countries: An overview study*. Final Report to the Economic & Research Council, The Global Environmental Change Programme and the Overseas Development Administration. Available at: <http://www.ids.ac.uk/eldis/cont.html> (accessed 5 March 2002).
- Lee, K. (2001). Globalization: A new agenda for health? In M. McKee, P. Garner & R. Scott (Eds), *International Co-operation in Health*, Oxford: Oxford University Press.
- Lee, K. (Ed.) (2002). *Health impacts of globalization: Towards global governance*. London: Palgrave Macmillan.
- McCulloch, N., Winter, L., & Ciera, X. (2001). *Trade liberalization and poverty: A handbook*. London: Centre for Economic Policy Research. Available at: <http://www.ids.ac.uk/ids/global/pdfs/tlpov.pdf> (accessed 14 February 2002).
- McIntyre, D., Thomas, S., & Cleary, S. (2004). Globalization and health policy in South Africa. *Perspectives on Global Development and Technology*, 3, 131–152.
- McIntyre, D., & Gilson, L. (2001). Social Africa: Addressing the Legacy of Apartheid. In T. Evans, M. Whitehead, A. Diderichsen, A. Bhuiya & M. Wirth (Eds), *Challenging inequalities in health: From ethics to action*. Oxford: Oxford University Press.
- Milanovic, B. (2003). The two faces of globalization: Against globalization as we know it. *World Development*, 31, 667–683.

- Milward, B. (2000). What is structural adjustment. In G. Mohan, E. Brown, B. Milward & A. B. Zack-Williams (Eds), *Structural adjustment: Theory, practice and impacts*. London and New York: Routledge.
- Mkadawire, T., & Soludo, C. (1999). *Our continent, our future: African perspectives on structural adjustment*. Dakar: CODESRIA, Trenton, NJ: Africa World Press; Ottawa, ON: International Development Research Centre.
- Mohan, G., Brown, E., Milward, B., & Zack-Williams, A. B. (2000). *Structural adjustment: Theory, practice and impacts*. London and New York: Routledge.
- Monbiot, G. (2003). *The age of consent*. London: Flamingo.
- O'Brien, R. (2002). Organizational politics, multilateral economic organizations and social policy. *Global Social Policy*, 2, 141–162.
- OECD (2001). *Environment outlook report*. Paris: OECD.
- OECD (2002). Development Co-operation: 2001 Report. *DAC Journal* 3(1).
- OECD (2003). Development Co-operation: 2002 Report. *DAC Journal*, 4(1).
- Pettifor, A., & Greenhill, R. (2002). *Debt relief and the millennium development goals. Human development report office. Occasional paper – background paper for HDR 2003*. United Nations Development Programme, December.
- Rao, J. M. (1999). Defining global public goods. In I. Kaul, I. Grunberg & M. Stern (Eds), *Global public goods: International cooperation in the 21st Century*. New York: UNDP/Oxford University Press.
- Rico, M. (1998). *Gender, the environment and the sustainability of development*. Santiago: United Nations.
- Rodriguez, F., & Rodrik, D. (2000). *Trade policy and economic growth: A skeptic's guide to the cross-national evidence*. Cambridge, MA: University of Maryland and Harvard University.
- Rodrik, D. (1999). *The new global economy and developing countries: Making openness work*, Cambridge, MA: Harvard University Press.
- Savedoff, W., & Schultz, T. P. (Eds) (2000). *Wealth from health: Linking social investments to earnings in Latin America*, Washington, DC: Inter-American Development Bank.
- Sen, A. (1999). *Development as freedom*. New York: Knopf.
- Sparr, P. (1994). *Mortgaging women's lives: Feminist critiques of structural adjustment*. London: Zed Books.
- Starfield, B. (2001). Improving equity in health: A research agenda. *International Journal of Health Services*, 31, 545–566.
- Stiglitz, J. (2003). *Globalization and its discontents*. New York: W.W. Norton.
- Structural Adjustment Participatory Review International Network (SAPRIN) (2002). *The policy roots of economic crisis and poverty: A multi-country participatory assessment of structural adjustment*. Washington, DC: SAPRIN, April. Available at: [http://www.saprin.org/SAPRI\\_Findings.pdf](http://www.saprin.org/SAPRI_Findings.pdf) (accessed 27 May 2003).
- UN Millennium Project (2005). *Investing in development: A practical plan to achieve the millennium development goals*. London: Earthscan.
- United Nations (1992). *Agenda 21: Report of the United Nations conference on environment and development*. New York: Division for Sustainable Development, United Nations Department of Economic and Social Affairs. Available at: <http://www.un.org/esa/sustdev/documents/agenda21/english/agenda21toc.htm> (accessed 9 December 2003).
- United Nations Development Programme (1999). *Human development report 1999*. New York: Oxford University Press.
- United Nations Development Programme (2000). *Human development report 2000: Human rights and human development*. New York: Oxford University Press.
- United Nations Development Programme (2001). UNDP Review of the Poverty Reduction Strategy Paper (PRSP). Reproduced in: IMF & World Bank, *External comments and contributions on the joint Bank/Fund staff review of the PRSP approach, Volume I: Bilateral agencies and multilateral institutions*, Washington, DC: IMF, February 2002, pp. 201–216. Available at: <http://www.imf.org/external/np/prspgen/review/2002/comm/v1.pdf> (accessed 25 January 2003).
- United Nations Development Programme (2003). *Human development report 2003: Millennium development goals: A compact among nations to end human poverty*. New York: Oxford University Press.
- Wade, R. H. (2002). Globalisation, poverty and income distribution: Does the liberal argument hold? In D. Gruen, T. O'Brien & J. Lawson (Eds), *Globalisation, living standards and inequality: recent progress and continuing challenges, Proceedings of a conference held in Sydney, 27–28 May 2002*, Canberra: Reserve Bank of Australia, pp. 37–65.
- Watkins, K. (2002). *Rigged rules and double standards: Trade, globalisation, and the fight against poverty*. Washington, DC: Oxfam International. Available at: <http://www.maketradeair.com/stylesheet.asp?file=03042002121618&cat=2&subcat=6&select=1> (last visited 12 January 2003).
- Weisbrot, M., Baker, D., Kraev, E., & Chen, J. (2001). *The scorecard on globalization 1980–2000: Twenty years of diminished progress*. Centre for Economic and Policy Research. Available at: [http://www.cepr.net/globalization/scorecard\\_on\\_globalization.htm](http://www.cepr.net/globalization/scorecard_on_globalization.htm) (accessed 29 September 2002).
- Woodward, D., & Smith, R. (2003). Global public goods and health: Concepts and issues. In R. Smith et al. (Eds), *Global public goods for health: Health economic and public health perspectives*. Oxford: Oxford University Press.
- Woodward, D., Drager, N., Beaglehole, R., & Lipson, D. (2001). Globalization and health: A framework for analysis and action. *Bulletin of the World Health Organization*, 79, 875–881.
- World Bank (2002). *World development indicators*. Washington, DC.

- World Bank (2000). *World development report 2000/2001: Attacking poverty*. New York: Oxford University Press.
- World Health Organization (2001). *Health in PRSPs: WHO submission to World Bank/IMF review of PRSPs*. Available at: <http://www.worldbank.org/poverty/strategies/review/index.htm> (accessed 25 January 2002).
- World Resources Institute (1996). *World resources 1996–97: The Urban environment*. New York: Oxford University Press.