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Globalization and Health

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Abstract

Globalization describes how nations, peoples, and economies are becoming increasingly interconnected and interdependent. Globalization has contributed to health improvements through diffusion of new health knowledge, low-cost health technologies, and human rights. Economic globalization based upon a neoliberal model of liberalized trade and investment and minimal government regulation, however, has brought many health risks. This article outlines the health risks of neoliberal globalization from structural adjustment of the 1980s, through economic financialization of the 1990s and the 2000s, to the financial crisis and global recession of 2008 and subsequent 'austerity agenda' of state retrenchment. It concludes with a discussion of high-level public policies that would ensure that globalization works for 'health for all'.

Introduction

Globalization is a relatively new term, first appearing in the 1970s and quickly supplanting earlier concepts sharing roughly similar terrain (internationalization, postcolonialism, new international economic order). Broadly defined, globalization describes how nations, businesses, and people worldwide are becoming more connected and interdependent through increased economic integration and communication exchange, cultural diffusion, and travel. Lee (2002) further considers globalization to be effecting change in spatial, temporal, and cognitive dimensions: social activities increasingly transcend borders and occur more rapidly, as do peoples' understanding of global events and their place in the world. By such an account, globalization is not a new phenomenon; rather, apart from small and geographically isolated settlements, this push, prod, and sharing against 'borders' has characterized much of the history of human societies. At base, it is driven by economic and political expansion, whether by trade or conquest.

Some historians date the 'modern' era of (Western) globalization with European colonial expansion and the Westphalia formation of nation states in the late seventeenth century. Mercantilism dominated globalization's policies and practices over the next two centuries, as governments supported their local merchant class in competition for an expanding global trade facilitated by technological advances in maritime navigation. A series of late nineteenth-century economic recessions, rising social inequalities, staggering inflation, and nationalist protectionism became the fertile ground from which the Great War emerged, which devastation and lessons failed to find a sufficiently firm political foothold to avoid a recurrence in the Second World War. This foothold became more secure in the 30 years following the Second World War, which saw a new pattern in globalization emerge with the creation of stronger multilateral governance bodies. The United Nations (UN) replaced the League of Nations. The International Monetary Fund (IMF) was created to maintain macroeconomic stability and avoid the recessionary crises underpinning both world wars. The World Bank (WB) was founded to finance reconstruction of war-torn Europe (and later, developing country economies and social infrastructure). The General Agreement on Tariffs and Trade provided a negotiating platform intended to interconnect national economies (at that time, of the high-income developed countries only) in mutually beneficial ways, with the expectation that this would also provide economic disincentives to future war.

Contemporary Globalization

A new 'contemporary' globalization began to emerge in the 1970s. More economic recessions, two oil price shocks, profligate international bank lending, an end to fixed currency exchange rates, and a 'stagflation' leading to sharp interest rate spikes in the world's (then) major economies combined to create a developing world debt crisis. This crisis provided an opportunity for neoliberal economic theories first advanced by Friedrich Hayek in the 1920s to become policy practice, in the form of structural adjustment programs imposed largely on the heavily foreign indebted countries of Africa and Latin America, which needed financial assistance from the IMF and WB to avoid government default and bankruptcy. The key elements of these programs, later codified as the Washington Consensus, are well known and included such requirements as:

- privatization of state assets to generate revenue,
- deregulation of economic markets to promote private sector growth,
- lower corporate and individual taxes to attract foreign direct investment,
- reduced government spending and increased cost recovery (user pay for public services), and
- increased trade and financial liberalization.

These policy prescriptions were intended to increase economic growth and the ability of governments both to service their foreign debt obligations and to reduce their debt burden. Evidence of their effectiveness in doing so is mixed, with other regions of the world not adopting these policies (notably Southeast (SE) Asian countries) performing much better over this period (Chang, 2005). The policies also resulted in a number of health-negative impacts, first documented with respect to children's health in the landmark United Nations International Children Emergency Fund publication, *Adjustment with a Human Face* (Cornia et al., 1987). Subsequent studies similarly found singularly negative health impacts of

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structural adjustment programs, attributed to user fees that created barriers to health and education services, labor market adjustments from trade liberalization that led to unemployment or insecure informal work, and tax reductions and the loss of tariffs revenues that reduced government health and social protection spending (Breman and Shelton, 2001). But even as evidence and argument over the economic and health impacts of structural adjustment continued, the neoliberal policy context shaping contemporary globalization became firmly embedded.

Globalization's Positive Health

Even as this neoliberal model of global market integration strengthened its grip on countries' economic policies, civil society movements, the foreign aid arms of governments, and several UN agencies were emphasizing the social dimensions of global health development. Key innovations at this time included the 'child health revolution' of the 1980s, with its emphasis on low-cost health interventions: GOBI (Growth monitoring, Oral rehydration, Breastfeeding, Immunization), later followed by the triple FFF (Family planning, Female education, and Food supplementation). Some have argued that much of the improvement in global health during the last half of the twentieth century arose not from economic growth in developing countries, but from health technologies and knowledge transfers between wealthier (developed) and poorer (developing) countries (Deaton, 2003): one indication of globalization's health beneficence.

Ratification by most of the world's countries of international human rights conventions is seen as another health-positive facet of contemporary globalization. Several of these conventions make specific reference to the right to health, and most others deal with rights associated with access to social determinants of health. Though sometimes critiqued for a perceived Western bias (emphasizing individual rather than collective rights) and for their lack of enforcement (apart from 'naming and shaming' states that fail to fulfill their obligations under these treaties), international human rights have become a set of global tools used in the struggle for better health throughout much of the world (Chapman, 2002). A global diffusion of concerns for gender equity has also been attributed to globalization, from increased funding to improve conditions for maternal/child health, to new employment opportunities in export-oriented industries allowing women to earn income outside patriarchal social structures. That the poor working conditions in these outsourced factories have become a focus of international and civil society activism attests to another distinguishing quality of contemporary globalization: the breadth and reach of digital communication technologies. These technologies enable not only the more exploitative elements of open markets but also the platforms for oppositional civil society mobilizations.

The past 15 years have also seen global attention to health rise considerably. Health concerns directly informed three of the UN Millennium Development Goals, have been central in bilateral and multilateral development aid policies, and have led to the creation of over 100 global public–private partnerships for health. International financing for health followed suit, increasing substantially over this period, partly on the accumulating evidence that health should be considered an investment in economic growth, rather than a cost (World Bank, 1993; CMH, 2001).

Globalization's Negative Health

The emphasis on health as an investment relates to one of the more contentious positive health claims made for globalization: that of the contribution of liberalized markets to economic growth. This argument holds that trade and investment liberalization improves growth, which generates wealth that reduces poverty. Poverty reduction, in turn, improves health (poverty being the single greatest risk condition for disease), creating more productive and skilled workers, which spur the economy to even greater growth and more trickle-down health. It is by interrogating the links in this 'virtuous circle,' however, that globalization's health risks begin to emerge.

Most econometric studies do find that trade liberalization is associated with better growth, but this positive relationship is neither automatic nor always observed (Thorbecke and Nissanke, 2006). There also remains doubt about the direction of causality in these studies: does openness lead to growth, or does growth give rise to openness? Many development economists are critical of the assumption that liberalization is inevitably a 'global public good' for the economic growth it is presumed to engender. Some argue that trade liberalization rules are 'kicking away the ladder' of development policies successfully used by high-income countries in the past, and by middle-income SE Asian economies in the two decades prior to the birth of the World Trade Organization (WTO) in 1995 (Chang, 2005). Others point to evidence that trade and investment liberalization disproportionately benefits larger, wealthier nations with greater factor endowments and the political strength to set the terms of liberalization rules in their favor (Birdsall, 2006). One study of four different scenarios of a completed 'Doha Development Round' of WTO negotiations (so named as it was intended to give more attention to the economic interests of developing countries) showed net income gains for wealthy countries but net income losses for the world's poorest countries (Polaski, 2006). While the number of people living in extreme poverty (US \$1.25 day^{-1}) has decreased since liberalized trade began its acceleration in the 1980s, the 'rising tide' of global economic growth has not lifted people very far with poverty at the US \$2.50 day^{-1} level increasing by almost the same number (Chen and Ravallion, 2008). Expanding external trade has not been a powerful force for poverty reduction in developing countries.

There are three other ways in which trade liberalization and global market integration poses specific health risks: spread of disease, loss of government policy space and capacity, and increased labor market insecurity.

Spread of Disease

Infectious diseases such as the plague, smallpox, and cholera have long followed trade and military routes; it was a freighter's dumping of infected bilge waters that caused the Latin American cholera pandemic of the 1990s, and the deployment of UN Nepalese peace keepers that introduced cholera into Haiti in 2010. Trade has also been responsible for the movements of

insect or animal species destructive to natural resources essential for health (food, water, and biomass). Modern transportation allows such pathogens and pests to spread faster and farther, with the severe acute respiratory syndrome outbreak in the early 2000s shaking public health systems out of their recent complacency. New International Health Regulations monitored by the World Health Organization (WHO) followed quickly, as did ongoing 'pandemic preparedness' within and between countries and the 'securitization' of health within global governance structures (the WHO and the UN), wherein pandemic disease is viewed as a risk to national and international security (OUNHCHR, 2000). The global trade in fake medicines alongside the misuse of antibiotics in many countries, especially those that lack well-regulated public health systems, is heightening concern over the spread of multiple or extremely drug-resistant infections.

While increased research and policy attention is being paid to the globalization of infectious diseases, chronic noncommunicable diseases (NCDs) such as cancer, cardiovascular disease, and diabetes have been steadily growing in prevalence and now account for the largest proportion of the global burden of disease, outpacing infectious diseases in all developing countries except for those in sub-Saharan Africa. The rise in NCDs, particularly problematic in many low- and middle-income countries still coping with infectious epidemics, is partly attributable to international trade and investment policies that are globalizing 'Western' lifestyles, including increased consumption of unhealthy products. The nutrition transition in many of these countries toward a low-nutrient, high-energy diet is occurring much faster and at earlier stages of development than it did in high-income countries (Popkin, 2009). Increased trade in tobacco and alcohol products, in turn, is associated with higher levels of consumption and health-related problems (Labonté et al., 2011), at the same time that trade and investment treaties are being used by transnational companies (or governments on their behalf) to challenge public health restrictions on advertising, points of sale, taxation, and other measures now widely accepted as essential tools in health promotion.

Loss of Government Policy Space and Capacity

Another aspect of trade and investment liberalization with indirect health outcome is the loss of governments' 'policy space' and 'policy capacity.' 'Policy space' describes "the freedom, scope, and mechanisms that governments have to choose, design and implement public policies to fulfill their aims" (Koivusalo et al., 2009: p. 105). Policy capacity refers to the fiscal ability of states to enact those policies or regulations, which depends upon their ability to capture sufficient revenue through taxation for this purpose. The increasing 'behind-the-border' reach of an ever larger number of multilateral, regional, and bilateral trade and investment treaties is shrinking policy space by prohibiting a range of domestic regulatory options that could be used to promote more equitable population health outcomes. Although governments retain substantial policy flexibilities within existing trade treaties, these flexibilities continue to be eroded through ongoing negotiations, notably the shift to bilateral and regional treaty negotiations, which are often 'WTO+,' limiting policy space to a much greater extent than current WTO rules. Of particular concern is the proliferation of investor state dispute settlement provisions in bilateral and regional treaties, which allow corporations to sue governments for regulations that result in expropriation of their investments, with expropriation often defined in very broad terms. Anticipating the cost of such disputes can lead governments to choose not to exercise the health flexibilities that might still exist within these treaties: a 'regulatory chill.'

Policy capacity, in turn, can be affected by liberalization's requirements for progressive reductions in tariffs. Many low- and middle-income countries rely much more upon tariffs for their tax revenue than do high-income nations. These tariff rates have come under intense trade negotiation pressures from high-income countries to be 'locked in' and rapidly reduced. In theory, governments should be able to shift their tax base from tariffs to sales or income taxes, assuming their economies grow with increased liberalization. In reality, most low- and middle-income countries subject to tariff reductions under structural adjustment loans from the IMF and WB were unable to do so (Baunsgaard and Keen, 2010), partly the result of inadequate institutions to implement alternate tax regimes. For a majority of these countries, there was a net decline in overall public revenues – a loss in policy capacity – with implications for spending in health, education, or public regulations that can affect primary and secondary prevention of disease.

Turmoil in Labor Markets

At the same time that many countries saw their policy space and capacity erode under structural adjustment, a global reorganization of production was unfolding through the creation of 'export processing zones' (EPZs) in low- and middle-income countries. Industrial manufacturing previously centered in high-income countries began to outsource production to EPZs, which are tax-free and provide a low-paid and often minimally regulated workforce (Martinez, 2004). Most of the world's trade no longer occurs between nations, but between multiple subsidiaries of transnational companies. Much of the value added (and the profit) is captured by the firm at the top of the chain, often in offshore financial centers ('tax havens'), and often by way of relentless pressure on competing suppliers to bear most of the risk associated with investments in plant and equipment and to contain labor and other production costs. Corporations' ability to relocate production to lower cost jurisdictions limits the ability of workers to negotiate better wages and working conditions, and to expand social provision through the political process that was at the core of the postwar compromise between workers and capital in the high-income world. The result: 'most workers are being squeezed' (Woodall, 2006). This is occurring in all countries of the world. Even those in low- and middle-income countries who have seen their incomes rise as a result of the growth in global production chains live in conditions variously described as 'vulnerable' or 'precarious,' where their employment is often informal, temporary, part-time, or generally lacking in adequate remuneration, security, or benefits (Standing, 2011). Social protection programs can compensate, at least in part, for job and labor income losses that result from trade liberalization. However, given the extent of global market liberalization in capital, goods, and services, most of the world's governments find themselves converging on a policy model in which they strive to make their own geographic location as competitive as

possible in international markets. Both labor market 'flexibilization,' with its stress-related health risks, and limits on the taxes that could finance improved health and social protection policies constitute important elements of competition state policies (Schrecker and Labonté, 2011).

Globalization's New Health Challenges: Financial Crises and Austerity

In parallel with the globalization of the 'real economy' of production and consumption since the 1980s, a new form of capital accumulation arose in the rapid growth of a 'financialized' economy. Aided by new digital technologies, investors and financial institutions discovered that it was easier and faster to make money from money than lending it to the 'real economy' of production and consumption. The scale of this financialization is almost hard to imagine, with the value of outstanding derivatives in 2011 exceeding $700 trillion, or more than 10 times the total value of the world's gross domestic product. In late 2011, and despite the 2008 Global Financial Crisis (GFC), this daily arbitrage amounted to almost $5 trillion (Bech, 2012).

The Great Financial Crisis

The proximate cause of the GFC was the collapse of the US housing market, leading to publicly financed trillion-dollar bailouts and countercyclical spending. Public deficits were created to cover the risks taken by private financiers, with one estimate of the total amount of public financing that went into the bank rescues among the G20 countries placing it at $11.7 trillion (Ortiz and Cummins, 2012), several hundred billion of which was direct subsidies. Some of this amount has since been repaid or recovered through sale of government shares in quasinationalized failed banks, although not without large public losses. Less evident but more systemic is the interest rate spreads on what governments and their central banks provide to banks and what they then borrow back to cover this lending, leading to a massive transfer of public wealth to the very institutions and individuals responsible for the GFC (Altvater and Mankopf, 2012).

The depth of global production chains meant that the GFC's credit crunch and subsequent Great Recession rippled rapidly across supply chains in low- and middle-income countries. While there is some worry that this will lead to a rise in extreme poverty (the greatest risk condition for disease) and increased child mortality, the most striking concern is a sharp rise in global unemployment, much of it concentrated among young adults, and creating a surplus (unemployed) labor pool of over 200 million (ILO, 2013). The GFC also accelerated a longer standing trend in rising wealth and income inequalities within and between most nations of the world, notwithstanding some notable exceptions in South America. Although still subject to empirical contestation, such inequalities have been argued to pose a number of health and social risks (Wilkinson and Pickett, 2009). While the GFC has negatively affected the pensions and savings of many of the world's middle and working classes, the 24 million whom investment banks refer to as 'high- and ultrahigh-net-worth individuals' saw their balance sheets decline for a year or two, before increasing by over 20% (Baxter, 2011), a remarkable feat the pre-1929 oligarchs never accomplished. Billionaire wealth rose 20% alone in 2012 over 2011, in what Forbes described as 'a very good year for billionaires' (Forbes, 2013).

The Austerity Agenda

After a brief period of stimulus spending by many of the world's high-income countries and those low- and middle-income countries that could afford it, most governments quickly signed on to 'the austerity agenda': a protracted period of state retrenchment argued as necessary to reduce government debt (much of it incurred to rescue failed banks) and to stimulate economic growth. The key tenets of austerity differ little from earlier structural adjustment (Ortiz and Cummins, 2013). Unlike structural adjustment, the austerity agenda began in those high-income countries that were the epicenter of the GFC before becoming a more globalized set of policy prescriptions with fiscal contractions most severe in the developing world. Although there was little consensus among economists on the wisdom of pursuing austerity, the majority of IMF post-GFC loans pushed for elimination of food and fuel subsidies; wage bill cuts including salaries of education, health, and other public sector workers; rationalizing (reducing) safety net expenditures; and pension reform to delay eligibility. Several countries have been advised to reform their public health systems and increase labor market flexibilization, while many governments are attempting to generate revenue by broadening their consumption taxes to items disproportionately consumed by poor households (Ortiz and Cummins, 2013).

The austerity agenda is expected to have mixed health impacts on populations in high-income countries, on the one hand potentially reducing discretionary expenditures on tobacco or excess alcohol consumption, but on the other hand increasing poverty rates for those in less secure employment settings; homelessness, particularly in the United States; and increased reliance on low-cost, highly processed obesogenic foods. Unemployment- and poverty/insecurity-related stress levels are also predicted to rise; and suicide rates since the crisis have increased by 12–15% in the worst affected European countries, at the same time that health and social protection financing has been dramatically cut back and user charges imposed on many services (Stuckler and Basu, 2013). The health implications of austerity in low- and middle-income countries will likely follow that which accompanied earlier, regional financial crises: increased social stratification and inequalities; reduced food intake, health care utilization, and education expenditure; and increased morbidity and mortality, experienced first and worst by women, rural populations, and the poor.

A Deepening Neoliberalism

It is important to understand these recent globalization health risks as an extension of a 40-year uncontrolled experiment in neoliberal economic theory. From neoliberalism 1.0 (structural adjustment) to 2.0 (financialized economy) to 3.0 (austerity agenda), the rationale first proposed by Hayek – that the economy is too complex for government regulation

and best left to an open, unfettered market with minimal state interference – has deepened and proved resilient even in the face of its failures. The present fiscal contraction of austerity is due, in no small measure, to decades of advice to developing countries by the international financial institutions (the IMF and WB) to keep taxes low to attract foreign investment, and tax cuts, notably among the high-income Anglo-American liberal economies and defended in the name of debt reduction and international competitiveness, that saw substantial declines the 1980s in marginal tax rates (paid by highest income earners) and corporate taxes, and increases in regressive consumption taxes. There would be no fiscal crisis and no need for austerity in most of the world's countries if progressive taxation had been retained. Even in those countries facing structural deficits, such as Greece, or reliant on aid transfers, such as many sub-Saharan African countries, liberalization of capital markets and global banking integration (including branches in all the world's tax havens) continue to allow companies and wealthy elites to avoid taxation almost altogether. The African continent has lost more wealth over the past 40 years in illicit capital flight, partly due to criminality and corruption but most of it involving commercial tax evasion, than it has received in foreign aid (African Development Bank, 2013).

The two international institutions most implicated in the diffusion of neoliberal economics, the WB and the IMF, have begun to accept the empirical evidence of its shortcomings, calling for greater government caution in implementing austerity measures, partly in recognition of the 'fiscal multiplier' effect of government spending. In times of recession, public spending yields far more economic return to the 'real economy' of production and consumption (through purchasing and employment) than do tax cuts intended to spur private sector investments. Conservative estimates of this fiscal multiplier find that every dollar in public spending generates between 1.6 and 1.7 dollars in economic growth (Stanford, 2013), with recent estimates of European public spending by sector showing much greater multiplier impacts for public investments in health, education, and environmental protection (Reeves et al., 2013). The WB and IMF are also now cautioning against 'extreme austerity' and calling for higher taxation rates, especially for 'ultrahigh-net-worth individuals.' In 2012, the world's 1426 billionaires between them had as much wealth (USD 5.4 trillion) (Forbes, 2013) as the entire continent of Africa (USD 2.3 trillion) and India (USD 3.2 trillion) (Shorrocks et al., 2012). Given Africa's and India's 2011 combined population of 2.2 billion, this represents an inequality ratio of roughly 1 500 000:1.

Although this surge in private wealth has led to new philanthropies, some of them focused on global health issues, these are driven by individuals and their own ideas about how their wealth should be distributed, rather than through tax-funded, publicly representative, and accountable processes. A 2013 US review of econometric studies found that raising marginal tax rates from their present historic low of 35% to their previous high of 68% would have no statistically significant impact on factors driving economic growth, but would reduce poverty, inequality, and stimulate growth through public spending (Fieldhouse, 2013). Similar findings exist for imposition of global taxation measures, such as a financial transaction tax that, by one study's estimate and if applied at a very low rate (.05%, or 5 cents on every 100 dollars) on every currency transaction, would generate over US $8 trillion in annual revenues (McCulloch and Pacillo, 2011). Globalized capital calls for global systems of taxation, toward which some of the world's governments are now slowly turning their attention.

Simply stated, we do not have a problem of excess public debt. We have a problem of inadequate private taxation. We do not have a crisis of scarcity. We have a crisis of extreme inequality. These conditions and the health risks they pose are not 'natural,' but the result of policy choices for which there are alternatives.

Global Governance for Health

There is nothing inherently unhealthy in globalization as first defined: the growing interdependence of peoples across the world, through increased economic integration, cultural diffusion, and travel. It is the particular economic form of this interdependence – the 'neo'liberalization of capital from the checks and balances that once existed when capital was confined within national borders – that is problematic, not only for public health. It has been argued for some time that the crisis facing contemporary globalization is that national governments and powerful elites have created binding and enforceable rules for a 'free' global economy without a global governance system capable of regulating that economy for a social purpose. That may be slowly changing.

Putting More Health in Trade

There is some evidence that WTO panels are increasingly accepting the importance and legitimacy of public health arguments in trade disputes, albeit only if there is no obvious trade discrimination involved. A 2010 case involving a tobacco dispute between Indonesia and the United States is illustrative. To comply with domestic legislation to prevent adolescent smoking, the United States banned imports of flavored cigarettes. Indonesia argued that the domestic legislation, by exempting 'menthol' from the list of flavors, discriminated against its clove cigarettes in favor of US-manufactured menthol cigarettes, which are the favored choice of American teens. This constituted a violation of WTO rules on national treatment (there should be no discrimination against 'like' imported goods). Indonesia further argued that there were 'less-trade-restrictive' ways (another WTO requirement) to meet the public health goal of reducing adolescent smoking than a ban on clove cigarette imports. The WTO dispute panel ruled with Indonesia on the first argument (nondiscrimination) but with the United States on the second (agreeing that a ban was a necessary public health policy). Provided there is no obvious discrimination, public health regulations appear to have growing latitude within (at least some) WTO (McGrady, 2012). There is also greater public health attention being given to proposed trade and investment treaties, with efforts to ensure that before such treaties are finalized, public health concerns are given due consideration, and that 'policy space' for future public health regulation is assured, e.g., regarding trade or investment in food, alcohol, or other health-damaging commodities. The potential for a healthier governance of

trade and investment treaties, however, remains constrained by the secrecy in which the treaties are negotiated, the privileging of business interests over public interests in informing government positions during negotiations, and the still-dominant assumption that liberalization is an inherently positive development for all countries involved. As argued, this is not a universally held or observed assumption.

Building Up the Social Protection Floor

In a different vein, the International Labor Organization is actively promoting a 'Social Protection Floor Initiative' to encourage countries to systematically build up their social protection systems. The argument for such an initiative is simple and compelling – social protection equitably redistributes wealth, opportunity, and health – and it is rooted in globally shared principles of social justice and human rights. It is supported by a large number of UN agencies, development banks, and government development agencies. There are glimmers of its implementation in different parts of the world: extended health coverage (now embraced by the WHO and the WB in the call for 'universal health coverage'), social cash transfers, and public sector and rural employment guarantee schemes. The Initiative highlights the important role that a strong and strongly tax-supported social protection system can play in times of economic crises. Its implementation, however, rests on countries' willingness to increase rather than decrease progressive taxation (a race to the top, rather than to the bottom), and, in the case of many sub-Saharan African countries, an increase in the very low level of royalties or 'rents' charged to transnational extractive industries, and imposed during neoliberalism 1.0 as structural adjustment conditionalities (OSISA, 2009). Finally, while the Social Protection Initiative offers countries good technical advice, it does not and cannot address the political will needed to implement such schemes.

Moving Health Higher Up the Foreign Policy Agenda

Efforts to create that political will can be found on two fronts: governmental initiatives to raise health higher in the foreign policy positions and negotiations of states, and the international campaigning of civil society organizations. Regarding the first, there have been several recent initiatives to improve foreign policy coherence for health. The Foreign Policy and Global Health initiative launched in 2006 by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand and renewed in 2011, as one example, encourages nations to broaden the scope of national foreign policies to integrate health concerns in a sustainable way and not as a crisis driven 'one-off' (Ministers of Foreign Affairs, 2007). Resolution 63/33 'Global health and foreign policy' adopted by the UN General Assembly in November 2008 further recognizes the "close relationship between foreign policy and global health and their interdependence" and urges "member States to consider health in the formulation of foreign policy" (United Nations General Assembly, 2009). Several nations have pursued this aim through the development of coherent strategies (Labonté and Gagnon, 2010) or efforts to create platforms for a 'health-in-all-policies' approach to their foreign affairs. Despite its recent global prominence, however, health is still not typically prioritized in the foreign policy agenda of most countries, and when it is, it is driven by traditional 'high politics' of security or economic risks due to pandemics or the spread of drug-resistant diseases. The continuing funding crisis of the WHO, and its reliance on extrabudgetary (nontithed) funding from governments and private sector donors for much of its operational budget, weakens its ability to provide leadership on global health governance initiatives that may go against the short-term interests of powerful nations or corporate actors (Vaughan et al., 1996).

Supporting Civil Society Activism

Civil society activism, often aligned with organized labor movements, has been in the forefront of challenging the damaging social, environmental, and health impacts of neoliberal globalization. There have been some successes. The persistence of health activists in government and civil society moved tobacco control from indisputable evidence of smoking's harms to smoking restrictions, pricing measures, and other policies aimed at shifting cultural norms – always in conflict with tobacco transnational companies. South Africa's Treatment Action Campaign helped to break the impasse between new regimes of intellectual property rights and access to antiretroviral medicines, aligning with international groups mobilizing for a 'just' globalization and invoking international human rights treaties in their advocacy. A powerful network of 'peasant' organizations arose in Latin America in the 1990s, and has inspired similar mobilizations globally, linking together activism on agroecology, right livelihoods, food security, social protection, gender empowerment, indigenous rights, and environmental sustainability. In the same decade, a network of international civil society organizations defeated the Multilateral Agreement on Investments in 1998, an Organization for Economic Cooperation and Development (OECD) effort to further and more deeply liberalize cross-border capital flows than had been accomplished in WTO negotiations, although liberalized investment rules are increasingly being inserted into regional and bilateral trade treaties. Civil society activism demands persistence.

Conclusion: Accepting the Environmental Limits to Growth

While providing global health activists with a cautious optimism of the spirit, recent government and continued civil society activism in global health has yet to offer a sustained challenge to neoliberal globalization. Even if governments and activists succeed in curbing the predatory excesses of the financialized economy (neoliberalism 2.0), and exposing the inequitable and economically ineffective austerity agenda (neoliberalism 3.0), it will have to contend with ecological limits of returning to a pre-GFC 'real economy' of production and consumption. As the UK Commission on Sustainable Development noted in its 2009 study, "there is as yet no credible, socially just, ecologically sustainable scenario of continually growing incomes for a world of nine billion people" (Jackson, 2009). Indeed, the two sectors that are most driving climate change are energy production/consumption and transportation – the two activities central to our globalized economy.

Borrowing from an earlier study on the social dimensions of globalization, the Globalization Knowledge Network of the 2008 WHO Commission on Social Determinants of Health concluded that an equitable global health would only be secured under the 'three R's': systematic *resource* redistribution between countries and within regions and countries to enable poorer countries to meet human needs, effective supranational *regulation* to ensure that there is a social purpose in the global economy, and enforceable social *rights* that enable citizens and residents to seek legal redress (Labonté et al., 2007).

See also: Comparative Health Systems; Ecology and Health; Environmental Stress and Health; Migration and Health; Social Epidemiology; Social Exclusion, Social Deprivation and Health; Socioeconomic Status and Health; Urban Life and Health.

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