

## PART A | Health and globalization

The processes of economic globalization are shaping people's health across the world – and not for the better. This first section of the *Global Health Watch* paints a negative picture of the impacts. The number of people in poverty has been increasing in some parts of the world, as has inequality between richer and poorer both within and between countries. The liberalization of international trade and investment has created unrestrained market forces that have enabled a few people to gain significant wealth but that have deepened immiseration and insecurity for the majority.

The current form of economic globalization did not come about by accident or 'naturally'. It has been influenced by and still relies upon a wide range of decisions and policies of national governments and international organizations that have acted largely in private interests rather than public ones. Part A therefore highlights how reforms of the global financial and trading systems are urgently needed to improve people's well-being – and even to keep economies going in future. For some countries, the existing set of international trade rules and practices has sucked them ever deeper into a poverty trap so that they have to export more and more raw materials at lower and lower prices, and thus gain little in the way of sustainable development. Despite the rhetoric of globalization, entrance to several markets in high-income countries is still largely restricted for many developing countries – the governments of the developed world may preach trade liberalization, but they tend to impose it on poorer countries while being very reluctant to lower their own trade barriers to outside competition.

The institutions of global governance – particularly the World Trade Organization – and their member countries need to recognize these imbalances of power and reform accordingly to create a genuine level playing field in international trade. Part A also shows that increasing transfers of resources from richer to poorer nations are a vital component of a globalization that works for the health of all.



## A1 | Health for all in the 'borderless world'?

'The current path of globalization must change. Too few share in its benefits. Too many have no voice in its design and no influence in its course' – World Commission on the Social Dimensions of Globalization, 2004

In rural China, high school student Zheng Qingming kills himself by jumping in front of a train. Friends say it was because he could not afford the last US\$ 80 of school fees, which meant he could not take the college admission test. The overall annual tuition is more than the average village family in his region earns in a year. Health care, like education, has become scarce and expensive since China embraced the market economy, and his grandfather had already spent the family savings on treating a lung disease.

In Zambia, Chileshe waits painfully to die from AIDS. The global funds and antiretroviral programmes are too little and too late for her. She was infected by her now dead husband, who once worked in a textile plant along with thousands of others but lost his job when Zambia opened its borders to cheap, second-hand clothing. He moved to the city as a street vendor, selling cast-offs or donations from wealthier countries. He would get drunk and pay for sex – often with women whose own husbands were somewhere else working, or dead, and desperately needed money for their children. Desperation, she thought, is what makes this disease move so swiftly; she recalls that a woman from the former Zaire passing through her village once said that the true meaning of SIDA, the French acronym for AIDS, was 'Salaire Insuffisant Depuis des Années' – too little money for too many years (Schoepf 1998).

In northern Mexico, a young girl named Antonia is suffering from severe asthma. She is falling far behind in school. Her parents do not have enough money to pay for specialists or medicines, and wonder whether her problems are connected to the industrial haze and foul-smelling water that come from the nearby factory. They cannot afford to move. All their savings were used up when corn prices plunged after the market opened to exports from the US, and it is not clear how they would make a living. How could so much corn grow so cheaply, her father Miguel used to wonder.

In a Canadian suburb two people die when a delivery van swerves into oncoming traffic and slams into their car. The van driver, Tom, survives. He either fell asleep at the wheel or suffered a mild heart attack. No one knows,

and he cannot remember. It was his 15th day of work without a rest. When the assembly plant where he once worked relocated to Mexico, driving the van became one of his three part-time jobs, at just over minimum wage and with no benefits. He alternated afternoon shifts at two fast food outlets, did early night shifts at a gas station and drove the van late nights as often as the company needed him. With the recession over, they had needed him a lot lately.

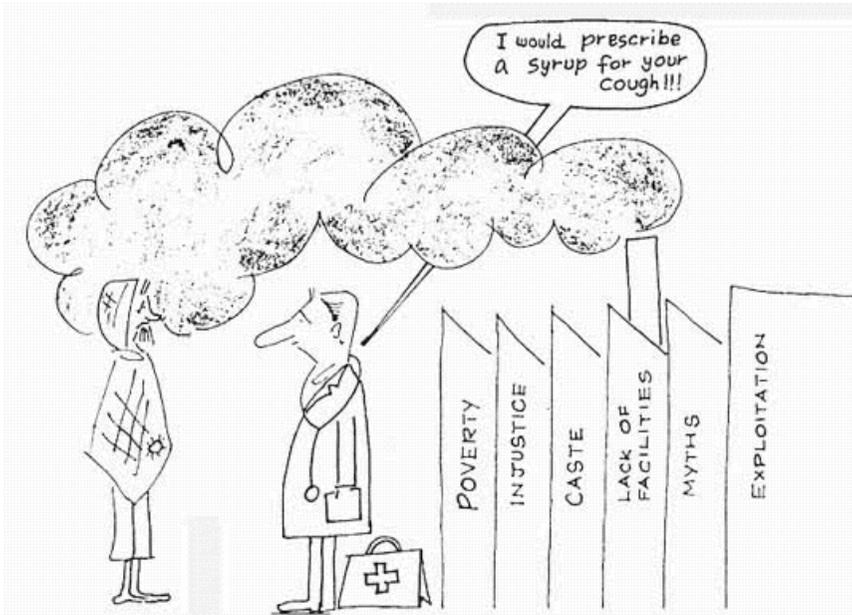
## Introduction

These vignettes show how recent, rapid changes in our global economy can imperil the health of millions. The first describes a real event (Kahn & Yardley 2004). The other three are composites, like those used in the *World Development Report 1995* (World Bank 1995), but in this case based on evidence that the remarkable accumulation of wealth associated with transnational economic integration ('globalization') has deepened the division between the rich and the rest.

Winners from globalization, in high- and low-income countries alike, comprise a global elite that sociologist Zygmunt Bauman (1998) calls 'tourists'. They have the money and status to 'move through the world' motivated only by their dreams and desires. 'Vagabonds', on the other hand, are those less privileged hundreds of millions: North Africans crossing the Mediterranean, Chinese hiding in Canadian-bound cargo ships, and more than a million Mexicans each year who try unsuccessfully to enter the US illegally. National borders are increasingly closed to them. Not all of globalization's losers become vagabonds, but their numbers may continue to rise as losers outnumber winners, because of how winners have set the global rules. The rules and institutions of globalization are 'unfair to poor countries, both in the ways they were drawn up and in their impact' (World Commission on the Social Dimensions of Globalization (WCSDG) 2004).

The causal pathways that link globalization with the illness or injury of particular individuals are often non-linear, involving multiple intervening variables and feedback loops. Individual circumstances and opportunities are still shaped by the policy decisions of national and local governments. For example, HIV prevalence rates during the 1990s fell in Uganda, but rose in South Africa: Uganda's early, active governmental response, including willingness to support and work with civil society organizations, contrasted with South African political leaders' reluctance to place HIV prevention and treatment high on the national agenda.

National policies still matter. But globalization may limit the ability of national and subnational governments to make policy choices that would



**1 Medicine cannot deal with the many factors that cause ill-health.**

lead to improvements in health, such as redistributing wealth, either directly or through public provision and financing of goods and services, and regulating the operation of markets and for-profit enterprises. The more steps in the pathway from globalization to the health of any particular individual, group or community, the more difficult it becomes to describe the web of causation. In order to address these difficulties we first describe globalization and extract a few health lessons from its history.

**Globalization past and present**

Globalization is best described as ‘a process of greater integration within the world economy through movements of goods and services, capital, technology and (to a lesser extent) labour, which lead increasingly to economic decisions being influenced by global conditions’ (Jenkins 2004). The focus of this chapter is on trade liberalization (increasing the cross-border flow of goods) and deregulation of national and international financial markets (facilitating rapid transnational movements of capital).

Historically, the transnational movement of people has been a crucial element of globalization, and to some extent remains so. Over 175 million people lived outside their country of birth in 2000. Remittances of foreign-born workers to their low- or middle-income countries of origin – some US\$ 80 billion

in 2002, more than double the amount in 1990 – have become an important source of foreign currency for many countries (Kapur and McHale 2003). Nevertheless, large-scale migration remains ‘the missing flow in today’s globalization’ (Dollar 2002), mainly because of policy changes in one dominant nation, the US, ‘which has switched from a protectionist welcoming immigrants to a free trader restricting their entrance’ (Williamson 2002).

Globalization is not new. The history of humankind has been one of pushing against borders, exploring, expanding, trading, conquering and assimilating (Diamond 1997). By the 16th century the geographic and resource endowments of Europe, combined with new sailing and navigation technologies, ushered in the first truly global era of colonization and trade. Globalization came to a temporary halt in the early 20th century, with two world wars and the Great Depression. The ensuing devastation spurred the creation of new international organizations to promote reconstruction and development, in an effort to avoid the economic shocks that partly underpinned both wars. The UN would provide political oversight to global peace and development. The IMF would maintain global economic stability by helping countries with balance of payments problems. The World Bank would provide concessional (low interest) loans or grants for postwar reconstruction and, later, for global development. The General Agreement on Tariffs and Trade (GATT) would be a venue for negotiating the removal of protectionist barriers to international trade.

Globalization was back on track, even if its new rules and institutions represented the interests of the world’s dominant, victorious nations, and even if international trade as a percentage of global economic output did not reach levels characteristic of the late 19th and early 20th centuries until the 1990s (Cameron and Stein 2000). The collapse of the USSR and the fall of the Berlin Wall, marking the end of an ideological counterweight to capitalism, arguably accelerated the pace of global market integration and certainly enhanced its legitimacy.

International trade in goods is only one dimension of globalization. Several other trends reveal how and why today’s globalization differs from earlier eras.

*The scale of international private financial flows resulting from capital market liberalization.* Aided by technologies that allow round-the-clock global trade and new forms of finance capital such as hedge funds and derivatives, currency transactions worth US\$ 1.5–2 trillion occur daily. Much of this is speculative portfolio money chasing short-term changes in currency valuations, rather than foreign direct investment that may go into new productive capacity. The scale

of these transactions dwarfs the total foreign exchange reserves of all governments, reducing their ability to intervene in foreign exchange markets to stabilize their currencies, manage their economies and maintain fiscal autonomy (UNDP 1999). Each country experiencing a 'currency crisis' has seen increased poverty and inequality and decreased health and social spending, with women and children bearing the burden disproportionately (Gyebi et al. 2002).

*The establishment of binding rules, primarily through the World Trade Organization.* WTO (the successor to GATT) and other regional or bilateral trade agreements such as the North American Free Trade Agreement (NAFTA) have established enforceable supranational obligations on states, and have expanded to include services, investment and government purchases.

Countries have also entered into multilateral covenants and treaties on human rights and environmental protection. Notably, the 1948 Universal Declaration on Human Rights purportedly protects individuals and groups against state repression or discrimination, while obliging states to take 'progressive measures, national and international, to secure... universal and effective recognition and observance' of a package of rights including 'a standard of living adequate for the health and well-being of [oneself] and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control' (Article 25). The 1966 International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights expanded these goals. Even though the latter are treaties and therefore binding on signatory countries that have ratified them (in the case of Economic, Social and Cultural Rights, conspicuously not including the US), they are unlike trade agreements in that no economic interests drive their enforcement through the limited mechanisms that are available.

*Reorganization of production across national borders.* This third trend is one of the most significant characteristics of the contemporary global political economy. Multinational enterprises (MNEs), several of which are economically larger than many nations or whole regions, are central to it (Anderson and Cavanagh 2000). At least a third of global trade is intra-firm trade between affiliated companies (WCSDG 2004), in which an MNE subsidiary in one country sells parts or products to a subsidiary in another country (Reinicke 1998). MNEs can now locate labour-intensive operations in low-wage countries (often in exclusive export processing zones); carry out research and development in countries with high levels of publicly funded education and investment in research; and declare most of their profits in low-tax countries. The result

is global tax competition and lower corporate tax revenues in all countries (Wade 2003).

These changes did not ‘just happen’, but required policy decisions by governments around the world from which the most affected citizens were often excluded. The breadth and depth of that exclusion generated a global social movement during the 1990s that was, if not actively hostile to globalization, at least profoundly sceptical about the claims of its cheerleaders. Protests during meetings of the WTO, the G8 countries, the World Bank and IMF and the World Economic Forum aroused considerable media attention. The quality of the campaigns’ research and advocacy have compelled grudging acceptance of their legitimacy.

Health concerns have been slower to enter the globalization debate than environmental, social or economic issues (Deaton 2004), although the relation between health and globalization is far from new. Disease and pestilence have long followed trade routes from one part of the world to another. The economic costs associated with the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) alerted many high-income countries to the value of global infection control. But the increased spread of communicable diseases or unhealthy consumption by trade vector is only a small part of the globalization/health relationship. Of far more importance is how globalization affects such health determinants as poverty and inequality, and here we confront the dominant story of globalization’s health benefits.

### **Globalization – a success story?**

China, India and a handful of east Asian countries are often used to support a view of globalization which argues that sustained economic growth leads to higher standards of living and better health for all. China is increasingly cited as a model because it has experienced phenomenal economic growth since introducing selective internal economic reforms and beginning aggressive pursuit of export markets and foreign direct investment. Understanding the source of that growth and the reason China may rival the US as the world’s largest economy within 20 years (Ramo 2004) is as easy as looking at the labels on merchandise at Wal-Mart, the giant US chain of department stores.

The story starts from the premise that increased trade and foreign investment improve economic growth, which increases wealth and reduces poverty, leading to improved health; greater wealth can sustain investment in public provision of such services as health care, education and water/sanitation; and improved education and population health accelerate economic growth, so the circle is completed. But much is left out of the story.



**2 'I became sick because of my poverty.' 'Well, I became poor because of my sickness.' The two-way relationship between poverty and ill-health affects billions.**

Consider, first, the impact of globalization on poverty, one of the most powerful predictors of poor health. It is claimed that globalization has reduced the number of people living in abject poverty (defined by the World Bank as living on less than a dollar a day) by 200 million since 1980 (Dollar 2002). This still leaves 1.2 billion people living on less than a dollar a day, and 2.8 billion, almost half the world's population, on less than two dollars a day (Chen and Ravallion 2004). Critics point to flaws in how the Bank measures poverty (Wade 2002), and raise questions about the validity of the purchasing power parity estimates used to measure cost of living differentials between countries (Reddy and Pogge 2003); use of questionable historical data (Wade 2004); the irrelevance of the dollar a day threshold to the realities of life in the developing world's fast-growing cities (Satterthwaite 2003); and lack of reliable data from China and India where almost all the poverty reduction has taken place (Wade 2002). All these factors mean that official figures on the extent of world poverty are likely to be under-estimates (Reddy and Pogge 2003). In India, for example, new research is finding that poverty and rural hunger probably increased during the 1990s (Patnaik 2004).

Even if recent growth in China and India has reduced the number of their

people living in extreme poverty, poverty increased in many regions including Sub-Saharan Africa, eastern Europe, central Asia and, until the early 1990s, Latin America. On the one or two dollars a day measure, the number living in poverty in Sub-Saharan Africa roughly doubled between 1981 and 2001 (Chen and Ravallion 2004). Modest economic growth in Latin America in 1990–7 cut poverty rates by 5%, but the Asian-precipitated recession in the late 1990s caused them to rise again, with almost 44% of the Latin American population living below official poverty lines in 2002 (UN-Habitat 2003a).

Why? Enthusiasts of globalization argue that countries that open themselves to the global economy grow, while those that retain outdated forms of protectionism languish (Dollar 2001). But reality is more complicated, in at least two respects.

First, those countries held up as model high-performing globalizers (China, India, Malaysia, Thailand and Vietnam) actually started out as more closed economies than the countries whose economies stalled or declined, mostly in Africa and Latin America (Dollar 2002). The sleight-of-hand lies in definition. David Dollar's globalizers are countries that saw their trade/GDP ratio increase since 1977; his non-globalizers are simply those that saw their ratio drop. But his non-globalizers were already twice as integrated into the world economy in 1977, a degree of integration his supposed globalizers did not reach until the late 1990s. There is, in fact, a long and contentious debate among development economists over the impacts of liberalization on growth and poverty reduction, much of it directly challenging Dollar's conclusions on theoretical, methodological and empirical grounds (e.g. Rodrik 2001, Rodriguez and Rodrik 2000). The problem for the non-performers was not their retreat from globalization, but their high dependence on natural resources and primary commodities (Milanovic 2003).

Second, the performing globalizers, notably China and India, experienced much of their poverty-reducing growth *before* they began to reduce their import tariffs and open themselves to foreign investment (Wade 2002). Like Japan, South Korea and Taiwan before them, China and India grew behind walls of import protection for their domestic producers, strict controls over banking and investment, and (at least in the case of China) direct and indirect subsidies for exporters. They liberalized trade only as they became richer. This was precisely how European and North American countries grew their wealth a century earlier (Chang 2002). New trade rules that deny low- and middle-income countries the opportunity to do the same today are kicking away the ladder.

So two key elements of the mainstream story – that liberalization reduces poverty and promotes growth – are shaky at best, and wrong as global gener-

alizations. What, then, of the third, that globalization has no health-damaging effect on income inequalities? Health researchers dispute whether, or how, income inequalities that do not involve absolute poverty affect population health. Poverty, which is higher in countries with high levels of income inequality, may be the bigger problem whether poverty is defined in absolute or relative terms. But greater inequality of income or wealth makes it harder for economic growth to lift people out of poverty. Moreover, income inequalities continue to be associated with declines in social cohesion, public support for redistributive social policies (Deaton 2001, Gough 2001), and political engagement (Solt 2004), as well as with higher rates of infant mortality, homicide, suicide and generalized conflict (Deaton 2001).

This returns us to the story of the Chinese student who killed himself and its relationship to these trends. The key link is China's domestic market reforms, which while credited with rapid growth have also drastically increased economic inequalities. China's Gini coefficient (a standard measure of income inequality) was a low 29 in 1981 but reached 41 in 1995, similar to the US (Chen and Wang 2001). The rural-urban divide is increasing, regional disparities are widening and access to opportunities is becoming less equal: during the 1990s, only the incomes of the richest quintile of the population grew faster than the national average – again remarkably similar to the US (Chen and Wang 2001). Similar trends exist in India, Vietnam, Brazil and other countries experiencing rapid liberalization, rapid growth or both (although such inequalities often existed earlier, as legacies of colonialism). And in all these countries inequalities may be rising even in 'rich' regions, as they are in many industrialized countries (Cornia et al. 2004).

Many population health indicators, such as mortality of infants and children under five, actually improved over the past decade in countries where inequalities increased (China, Vietnam and India); however, immunization rates for one-year-olds saw significant worsening in all three countries (Social Watch 2004). But aggregate data hide important changes in intranational, interregional and other inter-group inequalities. Thus urban-rural and gender-related health inequalities in China increased (Akin et al. 2004, Liu et al. 2001), partly because market reforms not only increased economic inequality but also led to the collapse of employment- and community-based health insurance.

The government share of health expenditures fell by over half between 1980 and 1998, almost trebling the portion paid by families (Liu et al. 2003). This led to the growth of private delivery systems for those who could afford them, and increased cost-recovery schemes for services that were still under some form of public health insurance. The result was two-fold. There was a surge in the

number of people who fell into poverty by exhausting their income and savings to pay for medical treatment – Qingming’s grandfather was just one of 27 million rural Chinese in 1998 to whom this happened (Liu et al. 2003). There was also a dramatic slowdown in China’s population health improvements (Deaton 2004), particularly infant mortality and life expectancy (Akin et al. 2004).

Similar trends are found in India, where rural poverty has deepened in many states. Women in the poorer states have shorter life expectancies and lower literacy rates (Abbasi 1999). Government expenditure on health care accounted for just 18% of health care spending, with the rest financed by users – making it one of the world’s most privatized health care systems (WHO 2004). Predictably, the quality of public health services is low and deteriorating: the infant mortality rate for the poorest fifth of the population is 2.5 times higher than the richest fifth, and poorer children are almost four times as likely to die in childhood (International Institute for Population Sciences & ORC Macro 2004).

What if Qingming had completed his education and found employment in one of the many export processing zones (EPZs) to which 10–20 million rural

*Box A1 Women and export processing zones*

Had Qingming found work in an export processing zone (EPZ), his sex would have placed him in the minority. EPZ employers favour young, often single women, particularly in textile, garment manufacturing and electronics assembly: their fingers are thought to be more nimble than men’s, and they receive only 50–80% of the wages paid to men (ICFTU 2003). Eighty per cent of China’s EPZ employees are women (Durano 2002); the global average is 70–90% (Athreya 2003). EPZ employment for women is credited with increasing gender empowerment by providing them with income. This may sometimes be true, but women’s earnings are often channelled back to the control of male family members, and many women’s domestic responsibilities remain unchanged, creating a double burden of work (Durano 2002). To reduce costs, EPZs frequently employ women on part-time, casual or subcontracting arrangements that involve working at home. This gives women flexibility between their domestic and paid duties, but denies them the social protections that might come with regular forms of employment (Durano 2002).

Because they are located in countries with a large supply of cheap labour, EPZs rarely improve wage conditions for either women or men

Chinese migrate each year (AFL-CIO 2004)? EPZs have proliferated throughout the developing world in the past 20 years, with the free trade, foreign investment and export-driven ethos of the modern economy transforming them into 'vehicles of globalization' (ILO 1998). Between 40 million and 50 million workers were employed in some 5000 EPZs in 2004, 75% of them in China alone (Howard 2004; ILO 2004a). This migration to urban areas creates new health crises: public resources are rarely sufficient to provide essential housing, water, sanitation or energy. Indeed, the elements of globalization described here (the market reforms of liberalization, privatization and deregulation) are largely blamed for the worldwide growth of slums and the lack of public resources to cope with them (UN-Habitat 2003b). This UN report also finds that the rising wealth of globalization's winners creates inflationary pressure on most goods and services, particularly on land and housing, which only worsens conditions for the losers.

Qingming would also have been exposed to the hazardous working conditions associated with most EPZs. Some countries extend national labour laws

(ICFTU 2003). Workers are plentiful so there is little incentive for enterprises to train and retain their staff. Technology transfer, one of the key means by which low- and middle-income countries can improve their domestic economic efficiency and performance, is rare. Liberalization of financial markets means that little of the foreign currency that enters the EPZs stays in the host country. To attract foreign investment in EPZs, countries often offer extensive tax holidays (ILO 1998). By definition, these zones do not levy tariffs on imported materials, further limiting the tax benefits a country might receive for redistribution as health, education and other development investments. In many instances few locally produced goods are used in the EPZs. In 30 years of *maquiladoras* (as EPZs are called in Mexico), only 2% of the raw goods processed came from within the country (ILO 1998). Apart from the jobs created, and now departing to China, the EPZs have had virtually no impact on Mexico's overall economic development. They may help countries develop their internal economies, but only if there are strong 'backward and forward linkages' – requirements that companies in EPZs purchase raw materials from, and transfer new technologies to, the host country through partnerships with local firms outside the special zones (Wade 2002)

and protections to them, but exceptions, violations and union-free policies are commonplace (ILO 1998). Hours are frequently long, the work is generally repetitive and arduous, and even minimal social safety nets are lacking. This leads to pervasive stress and fatigue (ILO 1998). Practices such as locking in workers have led to numerous deaths and injuries (ICFTU 2003). Hours of work and wages in China's EPZs are effectively unregulated; many people work 12–18-hour days, seven days a week, for months at a time. 'Death by overworking' – *guolaosi* – has become a common term in China. Workplace accidents reportedly killed 140,000 workers in 2003, or one in every 250 workers (AFL-CIO 2004).

China led the world in the amount of foreign investment it received in 2002, second only to the US in 2003 (*China Daily* 2004). It is more profitable to produce many kinds of goods in the world's largest supplier of cheap, non-unionized labour than almost anywhere else. Employment in Mexico's EPZs dropped from 1.3 million in 2000 to 1 million in 2002 as production shifted to China (AFL-CIO 2004).

Greater equality, employment security and safe working conditions – all essential to sustained population health – will perhaps in time return to China and to other rapidly liberalizing countries. But how long are those whose health is negatively affected by globalization expected to wait?

### **AIDS and poverty**

As noted earlier, causal pathways that link globalization with the illness of individuals are not linear or straightforward. However, it is plausible to link Chileshe's HIV infection to the triumph of free markets in Zambia, actively promoted by international agencies dominated by high-income countries. In 1992, as part of a structural adjustment programme attached to loans from the IMF, Zambia opened its borders to imports including cheap, second-hand clothing. Its domestic, state-run clothing manufacturers, inefficient in both technology and management by wealthier nation standards, produced more expensive and lower quality goods. They could not compete, especially when the importers had the advantage of no production costs and no import duties. Within eight years, 132 of 140 clothing and textile mills closed and 30,000 jobs disappeared, which the World Bank acknowledged as 'unintended and regrettable consequences' of the adjustment process (Jeter 2002). Many of the second-hand clothes that flooded Zambia and other African countries ironically began as donations to charities in Europe, the US and Canada. Surpluses not needed for their own poor were sold to wholesalers who exported them in bulk to Africa, earning up to 300% or more on their costs (Jeter 2002).

The scale of this exchange is significant. Sales to sub-Saharan Africa from the US are worth about US\$ 60 million annually (Jeter 2002); in 2001, Canadian exports of *salaula* ('rummaging through the pile', as used clothing is called in Zambia) were worth US\$ 25 million (Industry Canada 2002).

For conventional economists, this is a textbook example of how and why trade liberalization works: consumers get better and cheaper goods, and inefficient producers are driven out of business. However Chileshe and her husband paid a heavy price, one that cascaded throughout other sectors of Zambia's limited manufacturing base, with some 40% of manufacturing jobs disappearing during the 1990s (Jeter 2002). Large numbers of previously employed Zambian workers came to rely on the informal, ill-paid and untaxed underground

*Box A2 What is structural adjustment?*

The World Bank initiated structural adjustment loans in 1980 to help developing countries respond to the impact of the 1979–1980 recession on their ability to service external debt. The Mexican debt crisis of 1982, the first of many around the world, saw the IMF and World Bank change into 'watchdogs 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). The mechanism of this transformation was the provision of new loans to help with debt rescheduling, provided countries agreed to a package of macroeconomic policies that included the following:

- reduced subsidies for basic items of consumption;
- trade and investment liberalization;
- reductions in state expenditures, particularly on social programmes such as health, education, water/sanitation and housing;
- rapid privatization of state-owned enterprises.

It is sometimes argued that structural adjustment failed because countries failed to implement it fully, and their economies were so crisis-ridden when adjustment was imposed that deterioration might have been worse without it. Many economists and historians disagree. Many previously buoyant African countries began to slide into stagnation after adopting structural adjustment (UN-Habitat 2003b). Over half the countries undertaking structural adjustment underperformed relative to expectations (IMF 2004).

economy. The privatization of state enterprises eliminated a further source of revenues that might have been used to support social programmes such as education and health care.

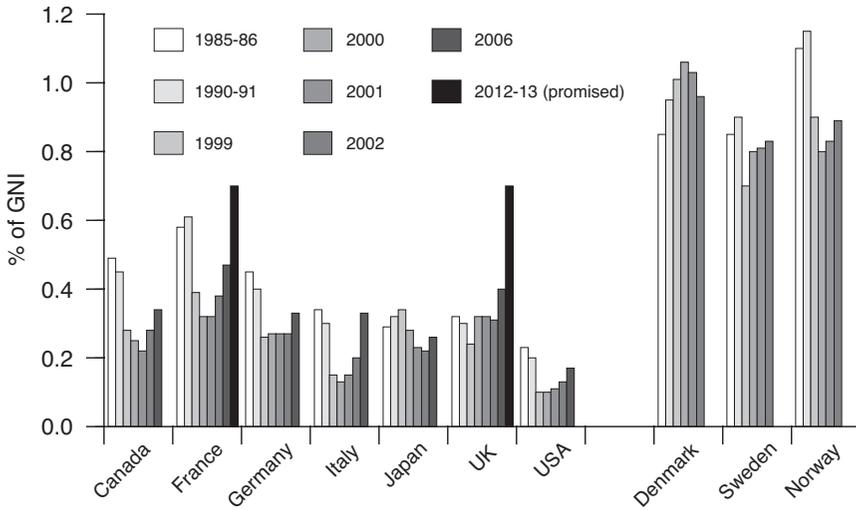
Other causes for the public revenue decline included a continuous slide in world prices for copper, Zambia's main export; Japan's 1990s recession (it was Zambia's main importer of copper); high debt service costs; declining development assistance; and capital flight (WTO 1996, Lindsey 2002). Faced with public revenue declines and a donor preoccupation with 'cost recovery', Zambia began to impose user charges for schools and health services in the 1990s. Not surprisingly, this was followed by a rapid rise in school dropout and illiteracy rates, projected to double by 2015 (UN-Habitat 2003b), and costs became the main reason people failed to seek health care or did not follow up medical treatment (Atkinson et al. 1999).

The Zambian government is now seeking to undo many of these policies, to reimpose tariffs on *salaula*, and to reorient its development inwards. 'In a sense,' two officials recently wrote, 'Zambia is now a victim of its own honest policies. Trade in goods and services is now one of the mainstays of the economy, to the detriment of more productive activities and thereby employment opportunities' (Mtonga and Chikoti 2002). Or, as one of the Zambians interviewed by Jeter (2002) commented, 'The young people really love the [*salaula*] clothes they see ... but is this the way to develop your economy?'

Globalization played an important part in Chileshe's HIV infection. The web of connection between globalization and the HIV pandemic in Africa has many strands. Two of these include the debt crisis and the donors' response, particularly by the wealthy G7 countries (Canada, Germany, Italy, Japan, the UK and the USA).

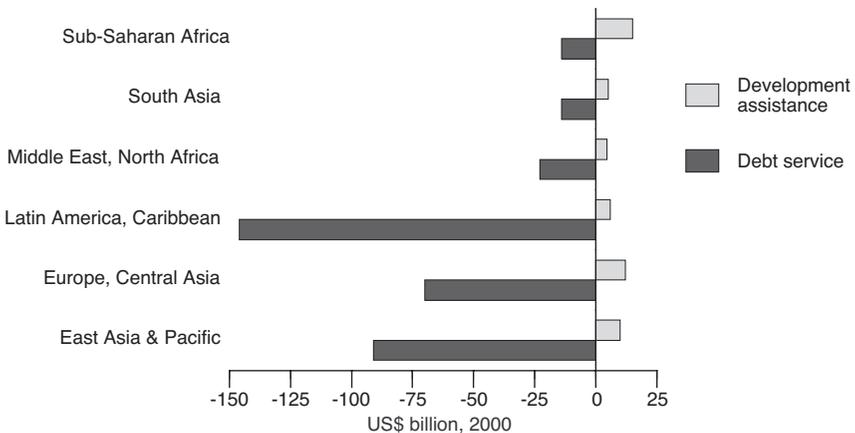
### **Debt and aid**

The long-standing debt crisis is a major factor in the inability of low-income countries to sustain or benefit from economic growth (UNCTAD 1999), or to invest in health-sustaining infrastructures. Worldwide, the amount of money returned to high-income countries dwarfs the amount received in development assistance: donor countries receive back many times over in debt repayments what they give in aid. Journalist Ken Wiwa, son of Ken Saro-Wiwa, the activist hanged for opposing Shell Oil's destruction of Nigerian homelands, noted: 'You'd need the mathematical dexterity of a forensic accountant to explain why Nigeria borrowed \$5 billion, paid back \$16 billion, and still owes \$32 billion' (Wiwa 2004). The specific causes of debt crises vary from country to country and over time but the major contributors are as follows:



**Figure A1 Trends in G7 development assistance, with selected comparison countries (Source: OECD 2004a, Chirac 2003, MacAskill 2004)**

- The oil price shocks of 1973 and 1979–1980. All countries were affected, but low-income countries in particular had to borrow to pay the costs of suddenly expensive imported oil.
- Profligate lending by banks stuffed with new petrodollars, with few checks on the viability of the loans, or whether the money would simply disappear into the offshore bank accounts of corrupt political leaders.
- The rapid increase in inflation-adjusted interest rates during the early 1980s, resulting from US monetarist policies. Poor, indebted countries



**Figure A2 How debt servicing dwarfs debt assistance (Source: Pettifor and Greenhill 2002)**

*Box A3 Debt, corruption and the cost of doing business*

Transfers of resources to developing countries, as debt relief or direct grants, are increasingly accompanied by requirements that recipient countries demonstrate 'good governance', notably by reducing corruption. Superficially the logic of such requirements is unassailable. Transparency International, perhaps the most influential actor in civil society with regard to anti-corruption efforts (Serafini 2004), estimates that ten of the most notoriously corrupt leaders of the past 20 years, led by Indonesia's Suharto, the Philippines' Marcos and Zaire's Mobutu, embezzled US\$ 29–58 billion from some of the poorest countries in the world (Hodess 2004).

The irony of such conditions, however, lies in the routine involvement of Western businesses in a range of corrupt practices. Western businesses in 1999 are said to have paid over US\$ 80 billion in bribes to officials in low- and middle-income countries to gain market access (often for weapons purchases) and regulatory relaxation (often in the mining, logging and oil sectors). Such bribes inflate the costs of projects, and may increase the debts of low- and middle-income countries by creating an incentive for leaders to borrow for financially unsustainable but personally lucrative projects (Hawley 2000).

Multilateral initiatives to control corruption include an OECD Convention on Combating Bribery (which came into force in 1999) and the 2003 UN Convention Against Corruption. It potentially represents a major advance not only because of its provisions requiring domestic criminalization of various forms of corruption, but also because it specifically addresses the crucial issue of recovery of illegally obtained assets. However, although 113 countries had signed the convention by 2004, it had been ratified by only 13 and 30 ratifications are needed before it comes into force, even with respect to those countries that have ratified it.

Whatever multilateral agreements may be in place, implementation depends on legislation and enforcement at national and sometimes subnational level. Given the asymmetry of power relations in the world economy, it is especially important that industrialized countries both regulate the behaviour of firms under their legal jurisdiction, imposing sanctions that are meaningful when compared with the potential gains from engaging in corruption, and act aggressively to prevent financial institutions from handling proceeds from corruption.

had to borrow more just to keep up with suddenly very high interest payments.

- Falling world prices for the primary commodities that are the key exports (and foreign exchange earners) of many developing economies.
- Capital flight, which involved both theft by political leaders and legal choices by foreign investors and domestic economic elites to shift their assets abroad in order to avoid taxation and the prospect of currency devaluations (Ndikumana and Boyce 2003, Williamson 2004).

The health-damaging effect of debt service obligations, and the structural adjustment conditionalities attached to lending designed primarily around creditors' interests (also discussed in part E, chapters 3 and 6) were well known as early as 1987 (Cornia et al. 1987). Not until 1996, after much lobbying by international NGOs, did high-income countries respond collectively with the World Bank/IMF Heavily Indebted Poor Countries (HIPC) initiative. Almost

*Box A4 The international finance facility – sound investment or living off the future?*

The International Finance Facility (IFF) promoted by the UK is a special case of development financing. It proposes to transform the Monterrey (and subsequent) donor pledges for increased development assistance into bonds, repayable by the donor countries after 2015. The effect of issuing such bonds would be to double the amount of financing available for development within a few years. Coupled with debt cancellation it would bring international development financing closer to the estimates of the amount needed by low- and middle-income countries to meet their MDG targets.

The IFF proposal was first raised at the 2003 Evian summit as one of several possible financing instruments. Economic analyses conclude that this sudden increase in development assistance is not beyond the absorptive capacity of recipient countries (Mavrotas 2003). Almost 40 countries and numerous development agencies and NGOs support the proposal, which has been less warmly received by donor nations (Lister et al. 2004).

Chief among the many concerns is the possibility that repayments by donor countries could compromise the objective of meeting or sustaining aid levels at 0.7% of GNI after 2015. Such concerns do not negate the potential usefulness of the IFF, but they must be addressed if the proposal is to be meaningful as a contribution to improving global health equity.

half the HIPC countries' debt may remain unpaid and uncanceled at the conclusion of the initiative (Martin 2004). Despite recent promises of greater debt relief over the next 5 to 10 years, adequate debt cancellation for the world's poorest countries is still not on the global political agenda. Moreover, gains for poor countries in debt relief have come, in part, at the expense of declining amounts of other forms of development assistance (Killick 2004).

Development assistance is not a panacea. Aid has often served the political, strategic or commercial interests of donor nations, particularly in Africa (White and Killick 2001). Throughout the developing world, aid is often tied to the purchase of goods and services (in the form of technical cooperation) from donor countries, and similar criticisms are made of debt relief priorities. It has also financed large-scale, environmentally destructive projects with limited relevance to basic needs (Bosshard et al. 2003), or been stolen by corrupt officials (Vasagar 2004).

Some of these limitations are slowly being removed through commitments to untie aid and provide more aid as sector-wide budget support to government departments. At the same time, aid is increasingly accompanied by conditionalities that parallel those associated with debt relief. The 2003 US commitment to increase its annual aid spending to US\$ 15 billion by 2006, by way of its Millennium Challenge Account, makes new funds conditional on 'sound economic policies that foster enterprise and entrepreneurship, including more open markets and sustainable budget policies' (UN Secretary-General 2002) – in other words, greater market and investment opportunities for US-based firms.

At least US\$ 16.5 billion a year in new development assistance would be needed to ensure that highly-indebted poor countries could meet the basic needs of their people, even if their entire external debt were cancelled (Pettifor and Greenhill 2002). Many African countries will require aid contributions equal to 20–23% of their GDP over 2004–2015 if they are to finance achievement of the Millennium Development Goals and Targets (Sachs et al. 2004). Yet the value of aid as a percentage of most industrialized countries' GNP or GNI has been declining since the mid-1980s; only in the past two years has development assistance again begun to rise.

### **Trade and tortillas**

So far we have examined the dominant story that globalization → growth → wealth → health, and found it wanting. We have argued that the collapse of African economies and health systems is partly explained by the fact that countries opened their economies to global competition without adequate ways to

handle the consequent social and economic dislocations, and in some cases facing active hostility from international lending agencies to using existing resources and policy instruments. Antonia's story brings the issue of global trade rules as potential health threats into sharper focus.

It begins a century ago with Mexican land reforms that created subsistence and smallholding production plots. These plots were big enough to feed a family and earn some capital by selling to local markets, but did not provide (and were never intended to provide) economies of scale comparable to those of modern corporate farming practices. In the run-up to the North American Free Trade Agreement (NAFTA), the Mexican government ended its subsidies to 'small-scale producers of basic crops' including corn (Preibisch et al. 2002), the main ingredient of tortillas, Mexico's staple food. When NAFTA opened the Mexico-US border, corn from the US flooded the Mexican market. Large-scale agribusiness is massively subsidized in the US: in 2001, corn cost US\$ 3.41 a barrel to produce in the US, but sold on the world market for \$2.28 (Carlsen 2003). Currency crises and IMF conditional loans also played a role in the rapid decline of Mexico's corn prices. Following the collapse of the peso in 1995, the bail-out organized by the Clinton administration included a US\$ 1 billion export credit that obliged Mexico to purchase US corn. Predictably, Mexican imports of US corn to Mexico rose by 120% in a year (Carlsen 2003).

Mexican corn production stagnated while prices declined. Small farmers were hardest hit, becoming much poorer than they were in the early 1990s (Condesa Consulting Group 2004), despite efforts by the Mexican government to reintroduce some of the subsidies (ICTSD 2002). Some 700,000 agricultural jobs disappeared over the same period. The lack of demand for farm labour depressed wages by 2001 to less than half of what they were 20 years earlier. Rural poverty rates rose to over 70%; the minimum wage lost over 75% of its purchasing power; infant mortality rates of the poor increased; and wage inequalities became the worst in Latin America (Lichfield 2000, Schwartz 2002). Between 1984, when Mexico's 1982 debt crisis led to one of the first and most wrenching programmes of lender-driven economic adjustment, and 2000, the share of national income flowing to the poorest decile of the population fell from 1.7% to 1.5%, while the share of the richest decile increased from 33% to 39% (Schwartz 2002).

Adding insult to injury, as corn prices fell the price of commercially marketed tortillas almost tripled, because just two companies produce nearly all the corn products in Mexico. The Mexican government, apparently to ensure a cheap corn supply for these two companies, chose not to avail itself of NAFTA-

approved regulations that would have severely limited the quantity of US corn crossing the border. Nor did it collect taxes on US corn imports amounting to over US\$ 2 billion since 1994 (Henriques and Patel 2004).

Returning to Antonia, her asthma is unlikely to be treated effectively because Mexico's fragmented health care sector, despite recent improvements, still leaves half its population without access to health insurance (Barraza-Llorens et al. 2002). Her asthma may also result from exposure to air pollution from the factory or exhaust emissions from trucks taking its products north to the US. Even with the recent loss of more than 300 manufacturing plants to China (*The Economist* 2003), northern Mexico remains home to over 3000 manufacturing plants producing goods ranging from furniture and car parts to electronic components and textiles. As the cost of pollution control and health and safety standards rose in the US, and with the establishment of the NAFTA, many of the more hazardous and polluting links in the industrial production chain moved to the *maquiladoras* (Mexican export processing zones) (Frey 2003) – reflecting the market-driven rationality that underpins neoliberal economics. The environmental and occupational hazards associated with the *maquiladoras* include increased ground water and air pollution and the often illegal discharge of highly toxic chemicals. Despite a higher than average income level (Schwartz 2002), northern Mexico has higher than average infant and age-adjusted mortality and increased mortality and morbidity for infectious disease, partly due to the rapid expansion of poorly planned and serviced housing estates for the *maquila* workers.

A final danger for Antonia is the possibility that she might be tricked or kidnapped into the sex trade. Some 50,000 people annually, a third of them from Latin America, are sexually trafficked to the US by pimps and criminal gangs. Sex businesses are the largest sector of employment for women who have lost jobs as a result of globalization (Ugarte et al. 2003). The sex trade is a real element of globalization and a growing problem worldwide (Hughes 2000, Richard 2000). Antonia's story relates to a regional trade agreement, but attention should also be paid to the impacts of agreements administered by the World Trade Organization.

### **Globalization, health and the WTO**

The WTO was formed in 1995 at the conclusion of the Uruguay round of talks on the General Agreement on Tariffs and Trade (GATT). Unlike most multilateral agreements, the 29 administered by WTO provide for a dispute settlement procedure (under the auspices of WTO) backed by enforcement provisions in the form of fines or monetized trade concessions. Any of the

147 member countries can now launch a complaint against other members they think are failing to live up to their WTO commitments. Key principles underpinning all WTO agreements are *national treatment* (foreign goods, investment or services are treated the same as domestic ones); *most favoured nation* (whatever special preferences are given to one trading partner must be given to all WTO member nations); and *least trade restrictive practices* (whatever environmental or social regulations a country adopts domestically must be those that least impede trade).

Several WTO agreements have specific bearing on the pathways linking globalization and health, as summarized in Table A1.

The *Agreement on Sanitary and Phytosanitary Measures* (SPS) requires that a country's food and drug safety regulations be based on a scientific risk assessment, even if the regulations do not differentiate between domestic and imported products (Drache et al. 2002). Canada, the US and Brazil initiated a WTO dispute to force the EU to accept imports of artificial hormone-treated beef: the EU does not allow the use of these hormones on its cattle. The WTO concluded that the EU failed to conduct a proper risk assessment (Charnovitz 2000). But the EU still does not accept such imports and is paying millions of dollars a year to the complaining countries in compensating trade sanctions.

At the same time, however, the agreement can be used in ways that may discriminate against developing countries. The EU has imposed a tougher standard than any other nation on aflatoxin contamination of dried fruits and nuts, resulting in an anticipated loss of US\$ 670 million a year in agricultural export revenues for African countries (Otsuki et al. 2001). A compromise is needed between a country's sovereign right to the highest level of precautionary health protection and the financial inability of low-income countries to abide by stringent regulations.

The *Technical Barriers to Trade Agreement* (TBT) requires that all domestic regulations be 'least trade restrictive', treat 'like products' the same and be higher than international standards only if they can be justified on specific health grounds. Canada used this agreement to argue that France's ban on the use of asbestos products was discriminatory since asbestos was 'like' the glass fibre insulation France allowed. Canada lost this case – the only instance in which WTO mechanisms have favoured health over trade – because of the mass of evidence of the cancer-causing properties of asbestos (WTO 2000). (Article XX(b) of GATT permits exception to WTO rules 'necessary to protect human, animal or plant life or health.')

Such conclusive evidence is rarely available. Both TBT and SPS demonstrate 'trade creep', a process in which trade rules limit how national governments can regulate their domestic health and

TABLE A1 Key health concerns with WTO agreements

<i>Agreement</i>	<i>Health impacts from loss of domestic regulatory space</i>
Agreement on Trade Related Intellectual Property Rights	Limited access to essential medicines. Higher cost of drugs drains money useful for primary health care.
Agreement on Sanitary and Phytosanitary Measures	Requires scientific risk assessments even when foreign goods treated no differently than domestic goods (i.e. there is no discrimination). Such assessments are costly and imperfect with many health risks associated with environmental and manufactured products.
Technical Barriers to Trade Agreement	Requires that any regulatory barrier to the free flow of goods be as 'least trade restrictive as possible'. Many trade disputes over domestic health and safety regulations have invoked this agreement. To date only one dispute favoured the exception allowing countries to abrogate from rules to protect health (France's ban on the import of Canadian asbestos products).
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 important to population health.
Agreement on Government Procurement	Limits government's abilities to use its contracts or purchases for domestic economic development, regional equity, employment equity or other social goals with strong links to better population health.
Agreement on Agriculture	Continuing export and producer subsidies by the USA, EU, Japan and Canada depress world prices and cost developing countries hundreds of millions of dollars in lost revenue which could fund health-promoting services. Subsidized food imports from wealthy countries undermine domestic growers' livelihoods. Market barriers to food products from developing countries persist and deny them trade-related earnings.
General Agreement on Trade in Services	Locks in and could increase private provision of key health-promoting services, reducing equitable access by poorer families and groups.

environment affairs even if they treat products from other countries no differently than their own (Drache et al. 2002).

The *Agreement on Trade-Related Investment Measures* (TRIMS) prevents countries from attaching performance requirements (such as minimum levels of local content) to approvals of foreign investment. Such requirements have proved useful in the development of a viable domestic economy, partly by ensuring health-promoting employment and income adequacy for marginalized groups or regions. Their removal benefits investors from high-income countries much more than people in low- and middle-income nations (Greenfield 2001).

Similarly the *Agreement on Government Procurement* (AGP) requires governments to take into account only 'commercial considerations' when making purchasing decisions, precluding preferences based on environment, human or labour rights. Although this is a voluntary agreement that few low- or middle-income countries have signed, high-income countries are intent on making it mandatory and binding on all WTO members as part of their agenda for the Doha round of negotiations, begun in 2001.

The *Agreement on Agriculture* was designed to increase global trade in agricultural goods by reducing tariffs and phasing out export subsidies (financial assistance for food exports) and production subsidies (financial assistance for farmers). During a ten-year moratorium on trade challenges under this agreement that ended in 2004, many high-income countries failed to reduce their tariffs on agricultural products (World Bank/IMF 2002) and retained both tariff peaks (a higher-than-average import tax) on raw food imports and tariff escalations on finished food products (where more money can be made), taxing them at 2–3 times the rate of raw food imports (Watkins 2002). High-income countries also continued to pay huge subsidies to their domestic agricultural producers. Failure to reach an agreement on subsidy removal was the main reason for the collapse of the Cancún WTO ministerial talks in 2003. A 2004 WTO framework agreement to begin phasing out subsidies may remedy this impasse, but details are still subject to negotiation and the US says it will not begin to negotiate such reductions until after developing countries lower their agricultural tariffs (ICTSD 2004a). Incredibly, the 2004 agreement allows the US to retain a US\$ 180 billion increase in domestic farm subsidies announced in 2002, as long as it can show they do not affect current levels of agricultural production (ICTSD 2004b).

The *Agreement on Trade-Related Intellectual Property Rights* (TRIPS) is unlike other WTO agreements in that it does not 'free' trade, but protects intellectual property rights, mostly held by companies or individuals in rich countries.

Health concerns about TRIPS centre on the role of extended patent protection on access to antiretrovirals and other essential drugs. These issues are addressed in detail in Part B, chapters 2 and 3.

Finally, the *General Agreement on Trade in Services* (GATS) is a complex framework agreement introduced at the conclusion of the Uruguay round. It was conceived, and continues to be defended, primarily as a vehicle for the expansion of business opportunities for multinational service corporations (Hilary 2001), almost all based in high-income countries, which are constantly looking for new opportunities. Service businesses include health care itself, health insurance, education, and water and sanitation services (Sanger 2001).

Some commentators argue that the effects of reducing barriers to trade and investment in such services on population health depend on domestic regulatory structures (Adlung and Carzaniga 2002). However, the 2000 *World Health*

*Box A5 NAFTA, the FTAA and the right of foreign companies  
to sue governments*

The WTO is not the only free trade regime with implications for government regulatory capacity or provision of essential public services. The North American Free Trade Area (NAFTA) and the proposed Free Trade Area of the Americas (FTAA) also have potentially profound health effects. NAFTA has a particularly problematic section, Chapter 11, which permits private foreign companies to deny democratically elected governments the ability to regulate in the public health interests of their citizens.

The following illustrations of this relate to Canada. The Canadian government let its legislation for plain packaging of tobacco products die after representatives of Phillip Morris International and R.J. Reynolds Tobacco International argued that it constituted an expropriation of assets, violating NAFTA investment and intellectual property obligations. The Canadian government similarly repealed its ban of the gasoline additive MMT, a known neurotoxin, and paid US\$ 13 million in compensation after Ethyl Corporation argued, again on the strength of the NAFTA investment Chapter 11, that the ban had the effect of expropriating its assets even if there was no 'taking' in the classic understanding of expropriation. Both these NAFTA challenges achieved their goal of overturning a public health measure, although neither went to a dispute panel. More recently, a US-based water company is using NAFTA to sue the Canadian province of British Columbia for US\$ 10.5 billion due to restrictions on bulk water exports legislated by

*Report* cautioned that ‘few countries (with either high or low income) have developed adequate strategies to regulate the private financing and provision of health services’ and that ‘the harm caused by market abuses is difficult to remedy after the fact’ (WHO 2000). The same caution should be applied to education, and especially to water and sanitation – where, as described in Part D, chapter 2, privatization experiences of the last decade have generated intense political resistance because of their negative effects on the poor.

GATS does not directly drive privatization, but functions as a trap-door that locks in existing (and future) levels of private provision of services. It may also indirectly create incentives for foreign investors and their actual or prospective host country joint-venture partners to lobby for privatization, because of the security it provides for investments in newly privatized services. The GATS exception for ‘a [government] service which is supplied neither on a com-

the government. The declared intent of Canadian federal and provincial governments to prohibit international trade in water (primarily to the US) may be in violation of NAFTA (Shrybman 1999); states bordering the Great Lakes are currently drafting legislation to permit commercial diversion of water from the basin despite Canada’s opposition, arguing that NAFTA gives them the right to do so. Of course, Canadian companies have also used Chapter 11 to challenge regulations in the US. Methanex Corporation, a Canadian-based producer of the gasoline additive MTBE, a suspect carcinogen, is suing for US\$ 970 million because California banned its use in 1999.

With respect to health care, NAFTA provides that governments can expropriate foreign-owned investments only for a public purpose and if they provide compensation. This opens the door to NAFTA claims that measures to expand public health insurance in Canada (where prescription drugs, home care and dental care are currently privately insured), or to restrict private for-profit provision of health care services, amount to expropriation and that compensation must be paid to US or Mexican investors who are adversely affected.

From a health vantage point, NAFTA’s Chapter 11 should be rescinded. Article 15 of the Chapter on Investment in the agreement on the FTAA, which would similarly allow investor-state suits, should be deleted. And no such provision should ever be adopted in the multilateral agreements administered by the WTO.

mercial basis, nor in competition with one or more service suppliers' (Article 1:3b) is often cited as evidence that concern over privatization is misplaced. This clause, however, may collapse under an eventual challenge, since most countries allow some commercial or competitive provision of virtually all public services (Pollock and Price 2003). There is further concern that Mode 4 of GATS (which applies to the 'temporary' movement of service workers between countries) could exacerbate the brain drain of health professionals.

### **Globalization comes home to roost**

Our last vignette, about Tom the Canadian van-driver, reminds us that globalization destroys lives even in high-income countries whose leaders have been among its most ardent proponents. Other things being equal, their simple aggregate wealth means that high-income countries are better able to cope with the 'shocks' of global market integration. At the same time, globalization is leading to a blurring of boundaries – evident, for example, in the spread to industrialized countries of stereotypically 'Third World' forms of work organization such as piecework assembly of automobile parts by home-based workers in the US (Gringeri 1994). Trade liberalization could result in a neo-Victorian world order in which 'the First and Third worlds will not so much disappear as mingle. There will be more people in Mexico and India who live like Americans of the upper-middle class; on the other hand, there will be more – many more – people in the US who live like the slum dwellers of Mexico City and Calcutta' (Mead 1992). Early warning signs, like Tom's precarious work situation, are unmistakable in the US and elsewhere.

Trade liberalization accelerates the loss of work and income for less qualified workers in high-income (high-wage) countries, as those jobs shift to lower-wage nations (Dollar 2002). Simultaneously, the ability of corporate managers to relocate production (or to opt for a lower-cost supplier of outsourced activities) erodes workers' bargaining power to negotiate better wages or protect existing income and working conditions. Notably, full-time work in the industrialized countries has tended to be replaced by part-time, contract and temporary employment in the interests of lower costs and labour market 'flexibility'. 'Just as Japan perfected the just-in-time inventory system,' which reduces costs by ensuring that parts arrive at the point of production literally minutes before being needed, the US 'is well on its way to perfecting the just-in-time work force, notwithstanding the grim toll it takes on labour. The harsh truth is that it is a major productivity plus' (Wysockij 1995).

These trends are most conspicuous in the US, where labour markets are the least regulated in the industrialized world. Least skilled workers are losing

ground on wages; work less regular shifts; and have poorer working conditions, fewer benefits such as pensions and health care, and less job security and job satisfaction (Fligstein and Shin 2003). Germany is facing a policy dilemma as high technology firms threaten to move to lower-wage countries with well-educated workforces, such as Hungary, leading German workers to accept longer working hours, lower pay and fewer benefits (Elliott 2004). The spread of insecure or precarious work is not confined to 'rust belt' manufacturing industries. The US, for example, has experienced a loss of over 400,000 high-tech jobs since 2001 as firms outsource work to lower-wage countries that have improved the education levels of their workforces (Srivastava and Theodore 2004).

The rising number of personal bankruptcies in the US is one of the consequences of the productivity gains from the 'just-in-time workforce', and an especially disturbing indicator of the spread of work-related insecurity and the associated stress. There were 1.5 million filings for bankruptcy in 2002 (Century Foundation 2004) and these numbers cannot tell us 'how much more of the middle class is near the fragile edge of economic failure' (Sullivan et al. 2000). In this detailed study of household bankruptcies, 68% of respondents identified job-related reasons for filing. On the other hand, incomes and entitlements are growing for those at the top of the economic pyramid (Smeeding 2002), most notably in the US but also other countries (WCSDG 2004), as illustrated by the growing gap between the pay of corporate chief executives and workers.

Meanwhile, social spending – at least since World War II the mechanism by which industrialized societies have provided safety nets against economic insecurity – has declined in high-income countries as a percentage of GDP over the 1980s and 1990s. Only four countries bucked this trend: Greece, Japan, Portugal and Turkey, and they were starting from a very low base. While the decline was slight in some countries (e.g. Switzerland, Iceland, Germany) it was dramatic in others: a drop of 28% in Ireland 1986–1998; 21% in the Netherlands 1983–1998; and 19% in Canada 1992–1999 (OECD 2004a). (Comparisons are for the year of highest social spending post-1980 to the most recent year of data.) Some of the biggest spending declines occurred in areas most important to health: health care, cash transfers to (generally low-income) families, supports to unemployed workers and programmes to increase labour market opportunities (OECD 2004b).

The decline in social spending partly results from revenue constraints created by tax competition among jurisdictions. MNE managers can relocate both production and profits to jurisdictions where tax treatment is more favourable and wealthy households can similarly relocate their assets, and sometimes

themselves. The decline can also be attributed to the much-neglected effect of globalization on the waning *political* power of organized labour – ‘the traditional counterweight to the power of business’ (WCSDG 2004) and historically the base of progressive social movements and social democratic political parties. A large industrial working class still produces products for markets in North America and western Europe. But unlike the situation during the 30 years after World War II, globalization means that very large numbers of its members no longer live in these markets. Instead they live and vote (or cannot vote) in Mexico, Malaysia, Indonesia or China.

These points must be kept in mind when considering the view that even in a globalized world, ‘the overall distribution of income in a country remains very much a consequence of the domestic political, institutional and economic choices made by those individual countries’ (Smeeding 2002). There are certainly marked differences among the G-20 countries, an informal forum of 20 of the richest industrial nations and some middle income emerging-market countries. The most unequal distributions of income are found in Mexico, the Russian Federation, the US, the UK and New Zealand, while the most equal are in Sweden, Finland, Norway, Denmark, the Netherlands and Luxembourg. Canada, Taiwan and central European countries fall somewhere in the middle. Smeeding attributes these differences to stronger wage-setting institutions in the more egalitarian countries, a result of higher rates of unionization and a cause of better minimum wage standards, stronger collective bargaining rights and more progressive forms of income redistribution and state-supported welfare.

Others organize high-income countries into three different categories: the social democratic nations (such as the Scandinavian countries), in which labour institutions and social policies remain strong; the corporatist states (such as Germany and France), in which social insurance remains relatively generous and there is a strong emphasis on supporting families to provide essential welfare; and the liberal welfare state (primarily the Anglo countries of the UK, the US, Australia and New Zealand), in which means-testing and market-based systems predominate (Coburn 2004). Not only income inequalities but also disparities in key health indicators such as infant mortality increase along the continuum from social democratic to liberal welfare states. In 1996, infant mortality rates in the *poorest* neighbourhoods in Canada, a middling country closer to the corporatist than the liberal welfare states, were lower than the average rate for all neighbourhoods in the US; but rates in Canada’s *richest* neighbourhoods were higher than the average rate for all of Sweden (Coburn 2004).



**3 Hong Kong at night: global competition has led to winners and losers in developed and developing countries.**

What do these trends have to do with Tom, and with human health more generally?

A reasonably secure job that provides an adequate income is one of the axiomatic determinants of health. Not only does decent work provide individuals and families with the income to purchase the necessities for health; it is often where people form the friendships and social networks that independently and powerfully influence their health. It is a plus, of course, if the work is relatively healthy or safe, including not only protection from accident hazards and chemical and biological pollutants, but also a work regime that does not exacerbate stress by combining high demands with low control over the pace and conditions of work (Karasek and Theorell 1990).

These conditions are now only a faint hope for millions of workers like Tom. 'Formerly well-paid, unionized...employees have been forced to seek employment in the expanding service sector, where full-time jobs are scarce, few employees have benefits or earn living wages, hours are irregular, and many employees hold down multiple jobs in an effort to survive' (Polanyi et al. 2004). One in five Canadian workers was employed part-time in 2003, one in four of them involuntarily – that is, s/he claimed to be looking for full-time work (Statistics Canada 2004). Counting temporary, self-employed and multiple (part-time) jobholders, like Tom, the number of Canadians in 'non-standard' and more precarious employment rises to one in three.

Even as labour income is stagnant or declining for many workers, their hours, workloads and work speed are rising rapidly, not only in Canada but in almost all OECD countries. Workplace stress, work-related mental health problems and physical illness are rising in parallel, as is the number of workers experiencing difficulty in managing both work and family life (Higgins et al. 2004). In ageing societies where social provision is being cut back, as in North America, increasing numbers of working people like Tom will have to meet the demands of elder care as well. The multiple dimensions of work-related insecurity are important sources of stress: workers are unsure not only about their present employment and income and prospects for the future, but also about the shrinking safety net of unemployment and welfare transfers (ILO 2004b). Canada's contribution to labour market flexibility has been a massive 60% decline in spending on supports for unemployed workers, as a percentage of GDP, in 1991–9 (OECD 2004a). Cutbacks in the national unemployment insurance system were a major factor in the government's ability to balance its budget after years of running deficits, but they made it much harder for Tom, and others like him, to collect benefits after they lost a job and to survive on them – reducing the percentage of unemployed workers eligible for benefits to levels not seen since the original legislation of the 1940s (Rice and Prince 2000).

It is not a great leap to Tom's accident from what the data tell us about the physical and mental health risks of part-time, insecure and precarious employment. In Canada the risks are increased by the post-NAFTA integration of North American labour markets. Above and beyond the 'offshoring' of jobs, Canada has increasing difficulty in setting social and labour market policies independently of the US. Especially in central Canada where Tom's accident occurred, manufacturing industry is tightly linked to suppliers and customers in the US and the price tag of independence – measured in job losses, capital flight and forgone tax revenues – is high and almost certainly rising. Canadian trends and policy responses therefore bear watching as early warning indicators of the challenges globalization will present for high income countries.

## **Conclusion**

The fundamental health challenges inherent in our contemporary global political economy – equity and sustainability – have been central to the struggle for health for the past century. Addressing them requires some form of market-correcting system of wealth redistribution between as well as within nations. Globalization, as we know it today, is fundamentally asymmetric. 'In

its benefits and its risks, it works less well for the currently poor countries and for poor households within developing countries. Because markets at the national level are asymmetric, modern capitalist economies have social contracts, progressive tax systems, and laws and regulations to manage asymmetries and market failures. At the global level, there is no real equivalent to national governments to manage global markets, though they are bigger, deeper and if anything more asymmetric. They work better for the rich; and their risks and failures hurt the poor more' (Birdsall 2002).

The national and global are linked. Globalization's present form limits the macroeconomic, development and health policy space in rich and poor nations alike. Liberalized capital markets 'sanction deviations from orthodoxy' (WCSDG 2004), that is, anything that limits the potential for profit, and have 'added to the speed at which, and the drama with which, financial markets bring retribution on governments whose policies are not "credible"' (Glyn 1995). Between nations, liberalized trade still benefits high- more than low-income countries; and its rules-based system is frequently ignored or undermined by countries such as the US when its outcomes are not in their interests. Developing world debt is 'perhaps the most efficient form of neocolonialism' (Bullard 2004). And the wealthy world's responses to disease crises sweeping many parts of the low-income world, while belatedly improving, are woefully inadequate and eclipsed by huge expenditures on attempts to make the world safer for the rich through increased militarization and decreased civil rights (Oloka-Onyango and Udugama 2003).

The discussion of whether globalization and openness is good or bad for the poor should move on to a discussion of 'the appropriate global social contract and appropriate global arrangements for minimising the asymmetric risks and costs of global market failure' (Birdsall 2002). What should the contents of such a global social contract look like? In somewhat idealist tones, the World Commission on the Social Dimensions of Globalization urged a rights-based approach in which the eradication of poverty and the attainment of the MDGs should be seen as the first steps towards a socioeconomic 'floor' for the global economy, requiring in part a more democratic governance of globalization (WCSDG 2004). Its recommended reforms to move the global political economy in this direction resemble those that have been proffered for at least the past 20 years, as follows:

- Increases in untied development assistance to the long-standing, albeit non-binding UN target of 0.7% of rich countries' gross national income, along with efforts to mobilize additional sources of funding.

- Accelerated and deepened debt relief relative to levels available under the enhanced HIPC initiative – although the report does not specifically recommend debt cancellation for countries not eligible under enhanced HIPC.
- Trade agreements that substantially reduce unfair barriers to market access, especially for goods in which developing countries have a strong comparative advantage such as agricultural products.
- Stepped up actions to ensure core human and labour rights for workers around the world, with particular emphasis on gender inequalities.
- A multilateral framework to manage the international flow of people, such as the brain drain of education professionals from poor to rich countries and its frequent corollary of brain waste after they migrate.
- Stronger voting rights for low- and middle-income countries at the World Bank and IMF.
- Building on existing frameworks for international tax cooperation as a vital element in strengthening the integrity of national tax systems in all countries, increasing public resources for development and facilitating the fight against tax havens, money laundering and the financing of terrorism.
- Increased coherence in the global economic, financial and health/human rights system, and heads of state to promote policies in international fora that focus on well-being and quality of life.

Policy initiatives that go further than the commission's recommendations are needed in at least two areas – the relation of trade agreements to human rights obligations and the internationalization of taxation and wealth redistribution.

On the first point, the UN special rapporteurs on globalization and human rights said it was necessary to move away from ad hoc and contingent approaches in ensuring that human rights, including the right to health, are not compromised by trade liberalization (Oloka-Onyango and Udugama 2003). The initial report from the UN's special rapporteur on the right to the highest attainable standard of physical and mental health outlined an expansive interpretation which explicitly included poverty-related issues (Hunt 2003). His subsequent examination of the WTO regime led to the conclusion that 'the form, pacing and sequencing of trade liberalization [must] be conducive to the progressive realization of the right to health' and that 'progressive realization of the right to health, and the immediate obligations to which it is subject, place reasonable conditions on the trade rules and policies that may be chosen' (Hunt 2004). High priority should be given to ensuring that both the content of trade agreements and the operations of the WTO (including its

dispute settlement mechanism, which was not considered in the 2004 report) and other trade policy institutions conform to this principle.

On the second point, recognition is growing of both the desirability and the difficulty of devising some mechanism of global income transfers. Yunker (2004) uses a global econometric model (the World Economic Equalization Programme, or WEEP) to simulate the effects over a 50-year period of a 'global Marshall Plan' to raise economic growth in the developing world using major increases in development assistance financed by national treasuries. While he is candid about the huge uncertainties inherent in such simulations, he concludes that if such a programme were implemented, 'the living standards of what are the poorest countries of today would have improved sufficiently, by the end of the period, to be comparable to those of the richest countries today'. This result, inconceivable in a business-as-usual scenario, is relatively insensitive to variations in key assumptions. However, it would require annual development assistance commitments by the rich countries on the order of 2–4% of GNI or GNP – far higher than the 0.7% target, now reached by only a few countries (see part E, chapter 5).

If such national commitments are unlikely, what international revenue-raising mechanisms might be considered? Taxes on arms trade and international air travel have been proposed, although neither would raise substantial revenue (US\$ 5–20 billion annually). A carbon tax on high-income countries only (at a rate low enough not to be a drag on consumption) would generate around US\$ 125 billion annually; the rationale for not imposing it universally is that some low-income countries with small populations could pay higher amounts of their income in such a tax than people in high-income countries, rendering it regressive rather than progressive. A currency transaction tax of 0.25% (the so-called Tobin tax) would generate over US\$ 170 billion annually, according to one estimate (others suggest it may be considerably less), and is perhaps the least difficult to implement.

Other suggestions to address the problem of MNEs and wealthy individuals shifting assets and operations around the world include the issuance of one tax identification number that ensured corporate or personal confidentiality, but would allow all jurisdictions believing they had a tax claim to levy it; and national withholding taxes on all capital leaving a country, to limit the possibilities for capital flight (Clunies-Ross 2004).

These policy options, even more than others we have described, face formidable political difficulties. They challenge the orthodoxy of neoliberal economics, and would involve fundamental shifts in the global distribution of wealth and power. History suggests that such changes demand radical (and not always

non-violent) forms of political mobilization and action. Although history has not yet encountered such a demand on a global scale, it is worth recalling that the political difficulties of abolishing slavery (now achieved in many countries) and implementing maximum hours of work (now regulated in most of the industrialized world) were also once thought to be insurmountable.

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