Globalization and Health Promotion
The Evidence Challenge

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“We no longer inhabit, if we ever did, a world of discrete national communities. [T]he very nature of everyday living – of work and money and beliefs, as well as of trade, communications and finance . . . connects us all in multiple ways with increasing intensity” (Held, 2004).

The Ottawa Charter for Health Promotion (World Health Organization, 1986) identified in shorthand many of the strategies and tasks in an emerging field and literally wrote its practice into being. Each subsequent international health promotion conference probed a different area of the Charter’s defining raisons d’être. Each subsequent conference also involved an increasing number of health promotion workers, policy-makers and scholars from developing countries, internationalizing what had been seen as an elite field concerned primarily with changing unhealthy rich world lifestyles. There were several plausible reasons for this:

• The end of the epidemiological transition: poorer countries were adding chronic diseases associated with Western consumption patterns without diminishing their burden of infectious ills, and richer countries were experiencing costly skirmishes with new or re-emerging pandemics as microbes became 24 hours from anywhere.
• The rising importance of Asian countries within a global economy: the West could no longer give short shrift to the Rest.
• A growing consciousness of one planet, one people: From the moonwalk to Greenpeace to climate change, new technologies and new social movements were thrusting a new awareness of the slender threads of planetary survival upon all of those within media reach.
• And beneath it all, the lurking late millennial behemoth of “globalization,” a contested and already weary term that describes the accelerating global integration of trade in goods and services, and financial flows unimpeded by national borders.

Unsurprisingly, one of the foci of the 2005 Bangkok gathering was globalization itself. As the Bangkok Charter for Health Promotion expressed: “Health promotion must become an integral part of domestic and foreign policy and international relations” (World Health Organization, 2005).

Doing so raises two fundamental questions about the nature of evidence as it pertains to globalization: First, what is the evidence for globalization’s impacts on
health status, and how do we adjudicate it? Second, how do we measure the impacts of interventions aimed at a target as large as the planet and all its peoples?

It’s About the Money

Before turning to these questions, let’s consider the shibboleth itself: globalization. To some, it describes a function of technology, culture and economics leading to a compression of time (everything is faster), space (geographic boundaries begin to blur) and cognition (awareness of the world as a whole) (Lee, 2002). While undoubtedly true, these have been societal qualities for as long as there have been written records of societies. The recent and important qualitative shift lies in the intensity of these changes. Others have argued (convincingly) that “economic globalization has been the driving force behind the overall process” (Woodward et al., 2001), i.e., the source of globalization’s recent intensification, bringing with it new challenges to health and its promotion. The major forms of economic globalization include:

1. The scale of cross-border private financial flows (most of it speculative) resulting from capital market liberalization. Daily currency trades dwarf the total foreign exchange reserves of all governments reducing their ability to stabilize their currencies when speculators decide to cash in their winnings. Each country experiencing a currency crisis (from Mexico and Thailand to Russia and Brazil) has seen increased poverty and inequality, and decreased health and social spending (O’Brien, 2002; Cobham, 2002), with women and children disproportionately bearing the burden (Gyebi et al., 2002).

2. The establishment of binding trade rules, primarily through the World Trade Organization (WTO). These trade rules limit the policy flexibilities of national governments in ways that could imperil public health (Labonte & Sanger, 2006b; Labonte & Sanger, 2006a). As the “Doha Development Round” of negotiations intended to benefit disproportionately developing countries continues to sputter to an inconclusive end due to rich world mercantilism, bilateral and regional agreements multiply in which the economic might of the wealthier countries invariably eclipses the nominal democracy that inheres in the WTO.

3. The reorganization of production across national borders. At least one third (and as much as two-thirds) of global trade is intra-firm between affiliated companies of transnational corporations (TNCs) (Gyebi et al., 2002; World Commission on the Social Dimensions of Globalization, 2004). The emergence of these global production or commodity chains allows TNCs to locate labour intensive operations in low-wage countries (often in exclusive export processing zones or EPZs, known for poor wages and working conditions), carry out research and development in countries with high levels of publicly funded education and public investment in research, and declare most of their profits in low-tax countries.

4. The crisis of climate change. For over 20 years health promotion has recognized the centrality, if not primacy, of the physical environment as a prerequisite