The purpose of this article is to explain how globalization has evolved, in order to provide a context for assessing the health care restructuring that is occurring worldwide. The authors begin by defining globalization and introducing a framework for considering pathways that can affect social organization and health. They then draw attention to current trends, such as the GATS (General Agreement on Trade in Services), that promise to open health services provision to increased pressures of globalization.

**Keywords**: globalization; deregulation; privatization; health determinants.

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Research over the past 50 years has prompted a more systematic consideration of how living and working conditions affect health. Locally experienced non-medical health determinants, however, are driven by forces that operate on a global scale—a phenomenon increasingly identified as “globalization.” The SARS outbreaks of 2003, for example, vividly demonstrated how the international movement of people can accelerate the transmission of infectious diseases, rapidly creating new exposures for healthcare workers. While this incident highlighted how scientific knowledge can be rapidly produced and shared in response to newly emerging risks, it also called into question whether the capacity of public health and health care systems to meet such challenges is being compromised by global pressures promoting privatization and deregulation.

**WHAT IS GLOBALIZATION?**

According to many social scientists, globalization involves profound worldwide shifts in economic, geographic, cultural, and social relations, marked by features such as:

- Emergence of a single global market for money and credit
- Intensification of worldwide social relations such that local happenings are shaped by events occurring many miles away, and vice versa
- Growth of strategic global cities where the infrastructure (physical and in terms of services) of the new global economy is located
- Establishment of enforceable regional and global trade and investment liberalization rules that constrain domestic economic, environmental, and social policy flexibility
- Decreasing effectiveness of state policy instruments and decline of state sovereignty
- Development of global bureaucracies and emergence of new political entities
- Compression of time and space as a result of technologic developments
- Rapid worldwide transmission of cultural images and lifestyle norms

An overriding characteristic of the transition experienced over the past 40 years has been an exponential increase in global linkages within economic, technologic, and cultural domains, alongside similar expansions of trade, finance, production, and a dense web of international treaties and institutions. Globalization, to some analysts, is considered a “process of closer interaction of human activities across a range of spheres including economic, political, social and cultural . . . [and] occurring along three dimensions: spatial, temporal and cognitive.” While such descriptive
definition provides a rich context for appreciating the scope of what is at stake, it fails to target the key “drivers” of contemporary globalization, namely the changes in global capitalist organization and associated macroeconomic policies that are a source of rising global inequalities.5

Global economic linkages are quite unevenly distributed, occurring with greatest frequency among and within multinational corporations based in the United States, Western Europe, and parts of East Asia. Most of Africa and large parts of Southern Asia and Latin America are only selectively included, restricted to being sources of primary resource materials or, in certain cases, skilled professionals.14 Almost half of global trade is no longer goods transported between nations, but “intra-firm” trade in which production chains are reorganized across national borders to maximize profitability.15 This is accomplished, in part, by taking advantage of low labor costs (reinforced by inadequate labor protection and health and safety policies)16 and transfer pricing (arranging intra-firm trade of partially completed commodities to locate corporate profits in low-tax countries).17 This reorganization is accompanied by the global dominance of a neo-liberal macro-economic framework, especially imposed upon poor countries in the 1980s and 1990s through the structural adjustment conditionalities of International Monetary Fund (IMF) and World Bank loans,18 and subsequently “globalized” under enforceable regimes of trade and investment liberalization agreements (e.g., those of the World Trade Organization). As a result, benefits are very unevenly distributed globally.

While the formation of an interconnected world economy is not a new phenomenon, as it dates back over 500 years, the intense nature of this interconnectedness has progressed to a systematically different qualitative stage. And it is the dominating economic aspects of contemporary globalization that, we contend, are the key drivers, ultimately conveying the greatest consequences for health—albeit with controversy as to what these are.

GLOBALIZATION AND HEALTH

Proponents of globalization have emphasized the potential that exists for improving health as a consequence of increased trade and wealth creation leading to decreased poverty and increased revenues for investing in key health determinants such as health services, education, and gender-equality programs.19,20 Critics, however, have expressed concern over lack of consistent empirical evidence of the trade/growth/wealth association,21,22 and have specifically questioned whether the policies that promote economic growth in low-income countries23 actually produce results of this, while nonetheless generating increases in disparities, loss of public revenues, and accompanying threats to health in relation to increasing economic globalization.24,25 As our knowledge of non-medical health determinants expands and deepens to more systematically assess the health impacts of workplaces as well as other dimensions of people’s lives, it is a short leap to consider how these sets of determinants are themselves increasingly being subjected to “upstream” pressures of economic globalization.26 As is the case with many powerful forces, impacts can be both positive and negative. In strictly economic terms, the past 20 years of increased global market integration has disproportionately benefited the world’s wealthiest nations, reversing the trend of the previous two decades (1960–1980), when economic growth in poor countries outpaced that in rich ones.27,28 This fact underpins the complaint by many poor countries and international nongovernmental organizations that the rules of contemporary globalization are being crafted to protect and enhance the wealth of already-rich nations at the expense of the rest of the world.

Determining the health consequences of these competing claims for globalization’s beneficence or hazard requires a more nuanced description of the pathways linking globalization’s processes to health outcomes. Analyzing these linkages can better identify the policy questions that should be considered—and allow us to better take stock of trends that can overwhelm more local factors over which we might otherwise exert some control.

While economic factors provide a basic framework for understanding the expansion of globalization, its influence can be traced through different dimensions. Appadurai10 outlined five “scapes” to provide a rudimentary framework for such analyses. These are:

- ethnoscapes (the flow of people—tourists, refugees, immigrants, guest workers, etc.);
- technoscapes (the export of technology);
- finanscapes (global capital transfer);
- mediascapes (mass media images); and
- ideoscapes (images invested with political–ideological meaning).

This framework, depicted in relation to our emerging understanding of how social, economic, and environmental conditions affect health outcomes over the lifespans of individuals within larger community and national contexts, is provided in Figure 1. It provides a context for tracing influences that can affect and constrain the options available to individuals and social groupings: laying the terrain for either homogeneity and domination by forces dictated by the power centers of globalization, or a heterogeneity and resistance, if not the development of new values through these interactions.

The development of new technologies, for example, can alter the strategic importance of labor within health-service–provision systems. The export of new health technologies, for example, can improve disease diagnosis and treatment. But the high costs of new
technologies, sustained by extended patent protection under the Agreement on Trade-Related Intellectual Property Rights (TRIPS), and coexisting with the collapse of public health and rise in private health systems in many poor and middle-income countries consequent to structural adjustment programs, mean that the beneficiaries are likely to be elites who can afford to purchase access. Battles over the resolution of such controversies, such as at the 2003 Cancun WTO Meeting, create the basis for reaching new forms of consensus to resolve the inherent tensions within the “scapes.” Similarly, global mainstream media images increasingly promote American (and to a lesser extent, European) consumption lifestyles, if not always American or European products. This is partly blamed for the global rises in rates of obesity, diabetes, heart disease, and cancer, which are linked to increased poor-world consumption of unhealthy processed foods and tobacco products, a consumption further exacerbated by poor-country tariff reductions on processed food imports usually originating from rich-country producers. Furthermore, as the economic and ideologic influences within countries favor privatized and deregulated service provision, the landscape for local work environments changes drastically.

SIX UNIQUE FEATURES OF CONTEMPORARY ECONOMIC GLOBALIZATION

Contemporary globalization did not emerge fully formed, but has resulted from an interplay of historical forces. Appreciation of this evolution provides a context for understanding not only its essence today, but how it may continue to change.

To better understand today’s “winners” and “losers,” it is helpful to highlight how current global market integration differs from that in previous eras. Much of the era from 1850 to 1913 saw Britain and other industrialized European countries move from mercantilism, itself established through expansionist domination of overseas colonies, to policies of free trade. During this period, the value of capital and goods traded between the nations of Northern Europe was proportionately larger in relation to total Gross Domestic Product (GDP) than the amounts transferred today between developed nations. However, there are six major contrasts in the economics and geography of globalization between then and now that render contemporary globalization a qualitatively unique phenomenon.

First, contemporary globalization has been accompanied by the rise of new international organizations with...
wide cross-national jurisdiction and powers to set out rules on a supra-national basis, such as through the General Agreement on Tariffs and Trade (GATT), which was established in 1946 specifically to reduce tariffs on the trade in goods.\textsuperscript{35–38} By 1987, tariffs on American, European Union, and Japanese industrial goods had been reduced, respectively, to averages of 4.3\%, 4.7\%, and 2.9\%\textsuperscript{36} from levels that averaged 40\% at the end of the Second World War.\textsuperscript{37} Presently the focus of trade regulation has shifted to the removal of non-tariff trade barriers, meaning those domestic government policies and regulations that may—ever unintentionally—inhibit the cross-border flow of goods, services, and capital. These shifts include removing “technical barriers to trade” (e.g., health and safety regulations that are not “least trade restrictive”), requiring scientific risk assessment of domestic food and drug regulations (even when they do not discriminate against imported products) and disallowing performance requirements on foreign investment (e.g., requiring certain levels of domestic hiring or use of locally produced components or products). The World Trade Organization (WTO), the direct successor of GATT, was established on January 1995 specifically to further this process, but coexists with a growing collection of regional trade agreements.\textsuperscript{1}

Second, late 19th-century globalization was centered in Northern Europe. Today, the world economy revolves around three supra-regional economies located in Western Europe, East Asia,\textsuperscript{8} and North America. Trade within and between this “triad” accounts for 70\% of total world trade flows and approximately 75\% of the world trade in manufactured goods.\textsuperscript{38} According to Emmott, the investment and growth patterns of trade within and between the triad are controlled by multinational corporations (MNCs), which have, with some exceptions, produced regional rather than truly global patterns of trade. For example, foreign direct investment by MNCs has a distinctly regional flavor so that European firms principally invest in Europe, American firms by and large invest in Canada, Mexico, and South America, and Japanese firms invest in South Korea, China, and Southeast Asia.

A third difference between the past and current periods of globalization is in the absolute amounts and speed with which capital flows between nations. In 1973 the daily trade in money amounted to USD 20 billion, but by 1987 it had increased to 590 billion.\textsuperscript{40} The present volume of capital traded daily is approximately USD 1.5 trillion, a sum far exceeding the capacity for any one state, or bloc of states acting together, to regulate, to alone control, the market. Most of this exchange is speculative; it creates no useful economic production. Enormous profits can be made by (literally) betting on slight shifts in currency valuations. Rapid inflows of speculative finance, made possible by digital technology and capital market liberalization, eventually lead to rapid outflows, creating currency crises with often devastating economic, social, and health consequences for people in affected countries, particularly the poor. In each affected country, the result has been increased poverty and inequality, and decreased health and social spending.\textsuperscript{41}

A fourth unique difference is the role of foreign direct investment (FDI) and trade in services. While these both currently represent significantly smaller values and volumes than the trade in goods, their rapid rate of growth, their dependence on “high technology,” and their growing importance in the context of international trade agreements mean that those nations and corporations best positioned to capitalize on them will be the new “winners.”\textsuperscript{**} We return to this point in our next section.

Fifth, the 1970s recession in the rich world, compounded by the “oil crisis” and monetary policies that dramatically increased interest rates, led many poor countries to default on international loans, and reshaped the IMF and the World Bank into “watchdog[s] for developing countries, to keep them on a policy track that would help them repay most of their debts and to open their markets for international investors.”\textsuperscript{42} The structural-adjustment policy track embodied the neo-liberal economic orthodoxy of the wealthier countries that dominate decisions in both institutions: reduced subsidies for basic items of consumption, the reduction or elimination of tariffs and controls on capital flows, privatization of state-owned productive assets, currency devaluations to increase the competitiveness of exports, and domestic austerity measures such as reduced government spending on education and health and the introduction of cost recovery through user fees.\textsuperscript{43} These policies have since been associated with many negative health and social outcomes,\textsuperscript{44} as well as increased inequalities and eroded domestic labor market institutions.\textsuperscript{45} Moreover, they literally condemned the majority of poor nations to a “structural” future of heavy indebtedness to rich ones.\textsuperscript{46,47}

\textsuperscript{**}The United States is particularly well placed, in this regard, as its economy is the most service-oriented in the triad and has the largest surplus in the trade in services.

\textsuperscript{1}The WTO may cease to be the most important set of trade agreements in the global macroeconomic structure, indicating the overriding concern that free trade “principles” will be most strongly endorsed when they are coincident with those holding political power, and may be nuanced when interests are at odds with these principles. When developing countries succeeded in the 2903 WTO Ministerial talks in Cancín, Mexico, to block the trade interests of rich countries that had dominated to that time, the United States and the European Union announced their intentions to pursue bilateral and regional trade agreements where they could more easily impose their agendas on economically weaker nations dependent on them for aid.

\textsuperscript{2}In the two decades following the Second World War, the East Asian economy was dominated by a rebuilding Japan. However, by the early 1980s, explosive growth began in the so-called “tiger” economies, including Singapore, Taiwan, Hong-Kong, and Korea, which rapidly enhanced the economic power of the region.
A sixth and final major difference between globalization now and in the pre–World War I era is that there is no counterpart to the mass migrations from labor-rich/land-poor Europe to labor-poor/land-rich colonies such as Australia, Mexico, and Canada, and ex-colonies, such as the United States, which saw over 60 million (mainly poor and unskilled) people immigrate in the latter half of the 19th century. Since World War II, most immigrants to developed nations have come from undeveloped countries. However, since the 1970s, immigration policies in developed nations have increasingly favored skilled workers or entrepreneurs with capital as permanent immigrants.

In summary, economic globalization is managed within a new international trading regime led by the WTO and, increasingly, regional trade agreements. True economic globalization is most advanced and visible in the hyper-mobility of capital within global financial markets while trade in goods and services—which is largely driven by multinational corporations—is increasingly concentrated within and between the supra-regional economies. Unrestricted movement of capital, and immigration policies that hamper the movement of unskilled workers, empower capital relative to labor. (See Ostry and Spiegel for a more detailed discussion of how these globalization trends have affected labor markets.) As economic globalization has extended its influence, its proponents have sought new frontiers for expansion. The provision of services, including health services, has been explicitly put on this agenda in the past decade.

HEALTH SYSTEMS AND THE GATS

While earlier forms of economic globalization concentrated on export of capital and trade in goods, interconnectedness in all the scapes described in Figure 1 has set the scene for a growing emphasis on opening services to global rules. The General Agreement on Trade in Services (GATS) provides the central framework for pursuing this.

While the greatest predictors of population health are income and education levels, and gender equity, access to health services remains an important influence directly and through interactions with other determinants. For poor groups within countries, for example, untreated illness is a major barrier to both income generation and education, while medical spending is a major reason that many families in poor countries fall into poverty. The GATS agreement is also a case example of how trade agreements embody at least three of the “scapes” identified by Appadurai: the movement of people, the export of technologies, and global capital transfers. GATS is a WTO “framework agreement” with complex “top down” (mandatory) and “bottom up” (optional) provisions, allowing countries to specify which services they will liberalize, under what conditions, and in which of four different “modes”:

1. Cross-border delivery of trade (such as shipment of laboratory samples or provision of telehealth services)
2. Consumption of health services abroad (so-called “health tourism,” where people from one country are treated by health services in another)
3. Commercial presence (where foreign private investors provide private hospitals, clinics, treatment centers, or insurance, or have management contracts for such facilities, whether they are public or private)
4. Movement of national persons (the temporary movement of health professionals from one country to another)

There is considerable pressure from commercial services groups, particularly in the United States and the European Union, to use GATS to open up government services for commercial and foreign provision. European negotiators are urging greater service liberalization because they see China as a lucrative market, especially as that country dismantles its previous state welfare infrastructure. Private U.S. health care providers regard GATS as the main vehicle for gaining market access in countries where public funding and provision currently predominate; indeed, the key concern is that GATS will ineluctably lead to increased privatization of such essential public services as health care, education, and water/sanitation. GATS is not the cause of public service privatization, which is increasing worldwide for a number reasons that are associated with globalization but which are beyond the scope of this article to detail. GATS, however, “locks in” present levels of privatization and the agreement’s requirement for “progressive liberalization”—countries can only liberalize more, not less—means that pressures to continue to open service markets, including public services such as health care, to foreign investors or

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10Indeed, concern over GATS extends to liberalization commitments in education and water/sanitation services, both of which are considered fundamental underlying health determinants. Health care, water/sanitation, education, food, and housing are all considered facets of the “right to health.” Governments that have ratified human rights conventions (and most have) are obliged to ensure that all citizens have reasonable access to these goods and services, unencumbered by cost. Poorer countries are allowed to phase in such access, based on available resources. This “progressive realization” of the right to health is undermined by the “progressive liberalization” requirement of the GATS agreement (Labonte, in press), i.e., GATS may violate international human rights agreements.

11Indeed, publicly funded (cross-subsidized) health systems can contribute to reducing two important underlying health risks: poverty and income inequality. A study of the Canadian province of Manitoba found that the non-cash health benefits of its publicly funded health care system, when monetized, shrunk the post-tax and transfer ratio between the top and bottom income deciles by an additional 20%.
providers will only increase. Globally, roughly 30% of all economic activity lies in government (publicly) provided services. Since most of these services are essential, meaning there is a guaranteed market for them, at least among those able to privately pay, it is easy to understand why private foreign investors are keen to open up this market to profit-making ventures.

Health services liberalization, proponents claim, can lead to new private resources to support the public system, introduce new techniques to health professionals in developing countries, provide such professionals with advanced training and credentials, and introduce new and more efficient management techniques. The export of health professionals from poor to rich countries is argued to be an important source of foreign currency to the exporting nation, through the remittances sent home to family members. But there are powerful counterarguments to each of these points. Private resources disproportionately benefit the wealthy and increase the regressive privatization of health systems. Private investments in health services concentrate in services for the affluent that can afford to pay for them, undermining support for universal, cross-subsidized public provision of health services. Liberalization in the movement of health professionals can worsen the already critical “brain drain” from under-serviced poor countries to wealthier nations; the “temporary movement” of such persons can easily become permanent. Finally, there is nothing preventing countries from trading in health services in any of these modes without making any commitments under the GATS agreement. The only effect of such commitments is to make it extremely difficult for countries to change their minds in the future.

To date, 54 WTO members have made commitments to liberalize some health services under GATS (see Table 1). The number of health-liberalized countries grows to 78 if one includes private health insurance. The GATS agreement has a built-in requirement for “progressive liberalization,” meaning that countries can only liberalize more, not less. Once a service sector has been committed under GATS, there is no cost-free way of reversing it. Canada, for example, committed to private health insurance under GATS in 1994. Should Canada wish to extend its public system into areas that are privately insured, and so reverse the current trend away from privatization, this commitment could trigger trade penalties.

The GATS agreement offers an exception for “a [government] service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers.” This 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, and the history of WTO dispute panels to date has been to favor liberalization over health, the only exception being a ruling against Canada’s challenge to the E.U. ban on asbestos products. Uncertainty is only increased by the absence of enforceable standards to protect public services from adverse effects of trade and market forces.

**CONCLUSIONS**

The current round of economic globalization across developed nations differs from the globalization that occurred during the latter part of the 19th century and early 20th century. In particular, the earlier period of globalization was characterized by marked mobility of labor (especially low-skilled labor) between developed nations, a feature absent in the current round of globalization. Immigration policies that work in conjunction with increasing rates of FDI and decreasing restrictions on capital mobility allow entrepreneurs in developed nations to move capital and technology anywhere in the world in order to utilize unskilled labor. This both reduces the need to import unskilled workers and puts unskilled workers, already living in developed nations, in a wage race “to the bottom” with cheaper unskilled labor in developing countries.

Despite the generally poor wages and working conditions in many of the “export processing zones,” for example, workers are often unable to organize for improved conditions (sometimes by law) and are vulnerable to permanent plant closures when cheaper sources of labor become available, as is presently happening with a relocation of manufacturing from Mexico to China. One can speculate that, if and as Chinese labor conditions improve, and if and as African countries are sufficiently supported to curb the HIV/AIDS pandemic and rebuild a public health and education system capable of improving the base of human capital, manufacturing might find yet another pool of even cheaper labor.

It is harder to predict how these global trends might affect health care workers, in rich or poor nations. The impact of the GATS agreement is still only speculative. Generally, one can expect a further stratification of wages and working conditions favoring highly skilled

**TABLE 1 Commitments to Liberalize Health Services**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Total WTO Members</th>
<th>WTO Developing Country Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental services</td>
<td>54</td>
<td>36</td>
</tr>
<tr>
<td>Hospital services</td>
<td>44</td>
<td>29</td>
</tr>
<tr>
<td>Nursing and midwifery services</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>&quot;Other&quot; health services</td>
<td>17</td>
<td>15</td>
</tr>
</tbody>
</table>

Source: Adlung and Carzaniga.

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professionals in private systems (vs those remaining in eroding public systems), and a widening gap between skilled health professionals (regardless of sector) and those responsible for facilities maintenance, cleaning, or food preparation, services that are increasingly outsourced to private firms that pay lower wages and offer less employment security.16

These labor patterns are simply a subset of economic globalization’s broader patterns. The “ethno-scapes,” or movements of people, are skewed so that those with wealth, or needed by the wealthy, can move to locales of opportunity; while those with neither must barter between lives of enclosed poverty (urban slums, refugee camps) or risky and illegal border crossings (in airless shipping containers or on less-than-seaworthy ships, for example). “Technoscapes,” or global exchanges of technology, tantalize with new work and wealth opportunities (even as they displace the work and wealth of the last century’s oil-based technologic revolution); yet the majority of the world’s population remains “unwired” and, when it is, the wires belong to distant companies and investors who grow more unequally powerful as their global oligopoly expands. The “finanscapes” of global speculation threaten not only countries with currencies vulnerable to a “run” (and few countries can claim not to be); they weaken the very global economic system that birthed this possibility.36 “Mediascapes,” though providing critics of contemporary globalization’s inequitable contours with new tools and organizing capacities, are increasingly homogeneous and monopolized mouthpieces of those “winning” under the current rules. This makes it more difficult to counter the dominant “idescape,” the TINA (“There Is No Alternative”) of economic globalization’s seemingly unstoppable “free market” trajectory.

Many of the articles in this special issue resonate with the daunting challenge of minimizing what is wrong with contemporary globalization (in terms of health, ethics, equity, survival) while maximizing its very potential for gains in all of these areas. But a similar challenge confronted many of those in our different disciplines who, a century ago, struggled to harness research, argument, and civil society movements to create legislation and social rights obligations that helped to make workplaces healthier, pay rates more equitable, and essential human services accessible for most within national boundaries. There is no reason similar energies today, applied globally, cannot, with most within national boundaries. There is no reason equitable, and essential human services accessible for

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