Chapter 17

Technologies of neoliberal governmentality

The discursive influence of global economic policies on public health

Heather M. Zoller

In 1997 the World Health Organization (WHO) predicted that, "The interrelationship between global trade and industrialization, environmental sustainability and public health will become major public policy issues" (WHO, 1997, p. 4). Indeed, some argue that the locus of power in health policy making has shifted as the World Bank (WB) now outspends the WHO in health-related funding (Barris & McLeod, 2000). This chapter examines the significant influence of global economic and trade agreements on public health. The development and growth of neoliberal policies through organizations such as the World Bank, International Monetary Fund (IMF), World Trade Organization (WTO), and North American Free Trade Area (NAFTA) materially affect key structural predictors of health including income levels, education, access to basic resources, safety measures, and environmental quality (Millen & Holtz, 2000). At the same time, the neoliberal ideologies that undergird these policies actually impede health promoters' ability to address these problems by discursively privileging the private market and undermining the language of public investment and protection we associate with public health promotion. Thus, although economic policies may seem far from the purview of health communication, these policies represent vital communication issues for the field to address.

As Conrad and Jodlowski describe in this volume, policy negotiation, construction, and implementation are communicative processes that involve struggles over meaning among actors with different levels of access and power (see also Conrad & McIntush, 2003). Although the field of health communication works internationally and has given some attention to health policy, little research has considered the influence of global trade policy discourse on the social context of health and illness. Examining economic discourse may at first seem removed from the work of health communication, thus one goal of this chapter is to illustrate its centrality to understanding health in both its symbolic and material/biological dimensions. The chapter begins by describing how a critical, multisectoral approach to public health demonstrates the linkage by prioritizing the political, economic, and social roots of health inequality across social domains. I then present the concept of

governmentality (Foucault, 1991; Rose & Miller, 1992) as an analytic framework. The chapter demonstrates the utility of this critical framework by interrogating three significant neoliberal policy mechanisms as governmental technology. These technologies include Structural Adjustment Policies (SAPs), Harmonization mechanisms, and Investor-to-State Lawsuits (ISLs). The analysis illustrates how these policies, in privileging commercial interests, make it difficult to promote good health by raising standards of proof for health protection, disqualifying health as a counter-discourse, and discouraging democratic decision-making. The chapter ends with discussion of the ways that health communication scholars can address the problems of neoliberalism in our research, and support health activism that seeks to resist and transform economic policies in ways that serve rather than undermine public health.

Global trade and development discourse: economic governmentality and public health

First, I define some key terms related to globalization and public health. "Globalization" is a polysemic term that may be used to refer to growing interplay between multiple cultures, homogenization of cultures due to the growth of international media, and the growth of particular trade and economic relationships. This chapter is limited in its scope to the latter meaning, focused on the set of economic arrangements usually associated with the development of the post-World War II Bretton Woods economic institutions, including the WB, IMF, the General Agreement on Tariffs and Trade (GATT) that gave way to the WTO, and a host of multilateral trade agreements, including NAFTA and proposed Free Trade Area of the Americas (FTAA).

The WTO is a mechanism to manage the world trade system that allows member countries to make commitments to trade liberalization and hold one another accountable through dispute settlement. The WB facilitates multilateral development loans primarily to developing countries, originally for certain development projects (e.g. building a dam), and now for more broad-based structural support. The IMF is charged with coordinating global economic policy (monetary policy, inflation) for economic stability, and it imposes structural economic requirements on countries receiving development loans (Falk, 1999).

The WB and the IMF were originally designed to prevent economic crises (Gershman & Irwin, 2000), and it has been argued that members felt the goal of opening trade would be achieved through government support for social welfare. However, Western financial leaders adopted policies known as the "Washington Consensus," "free trade" and "neoliberalism" (Falk, 1999; Gershman & Irwin, 2000) in the face of the "debt crisis" of the 1970s and 1980s, as Western investors feared that heavily indebted "third world" countries would default on international loans due to global stagflation. Rose and Miller

(1992) describe neoliberalism as "A re-organization of political rationalities" (p. 199) that aims to decouple government, business, and welfare issues, while proliferating strategies for creating markets. In this system, development is equated with "economic growth, privatization, and minimal state interference" (Carpenter, 2000, p. 344). This market-based economic agenda directly influences health by affecting key predictors of health status. It also influences the ability to protect and promote health discursively by privileging market ethics over the normative foundation that supports public health efforts.

The discourse of public health

Trade policy is often discussed as a health issue in narrow terms, such as intellectual property and AIDS mediciation. Yet economic decisions guide the public investments and social protections that are at the heart of public health, which involves population-based efforts to prevent disease and promote health (Garrett, 2000; Petersen & Lupton, 1996) such as sanitation, epidemiology, vaccination, public safety regulations, health promotion campaigns, and medical care access. Unfortunately, dominant discourses of public health (and health communication) have helped to shield linkages between health and economic policy. Theories of health and disease causation act as discourses in the Foucaultian (1980) sense, as constructed sets of meaning that create and are created by power relations. Discourse as knowledge production mediates between the symbolic and material, as Fairclough (1995) notes: "Discourse contributes to the creation and constant recreation of the relations, subjects ... and objects which populate the social world" (p. 73). Public health is guided by different theories about disease causation, and these discourses act politically to guide interventions.

"Germ Theories" of public health focus on micro-organisms (germs, viruses) and represent a prevailing rationale of health; they are popular efforts that seem to embody scientific progress. This discourse focuses public attention at the individual body first, lifestyle choices second, environmental issues third, and only lastly sociopolitical issues (Tesh, 1994). Another dominant approach to public health is the lifestyle theory of causation, which promotes the idea that good health can be achieved through better individual choice-making. This discourse operates similarly to maintain the political status quo by directing attention toward the individual and away from social and political contexts.

An alternative is the environmental theory of disease, which attempts to place more emphasis on ecological contexts of health. Yet Tesh (1994) argues that prevailing institutions tend to define the environment in discrete terms to include lifestyle choices over more comprehensive definitions that would attend to such issues as resource depletion or industrial practices. Similarly, the multicausal web approach to health promotion (exemplified by the U.S. *Healthy People* initiative) examines health as a multifactorial issue, but fails to prioritize structural and political issues, making discrete changes an easier

choice for decision makers (e.g. asthma treatment over pollution reduction) (Zoller, 2005b).

Thus, only the critical approach to public health prioritizes interventions in sociopolitical power (including poverty, access to decision making, and capitalist production processes). Originators of radical approaches to public health include Virchow, Engels, and Allende (Tesh, 1994; Waitzkin, 1983). As early as 1840, Chadwick's publication of the *Inquiry into the Sanitary Conditions of the Labouring Population of Great Britain* connected poverty and environmental pollution with health and disease, and framed efforts to redress these problems as the common good. Engels documented the relationships among class structure (housing, work conditions), and infectious disease, nutrition, and alcoholism, and pointed for the need for fundamental change in class inequality (Waitzkin, 1983). This work influenced Virchow, one of the founders of social medicine, who focused on reforming resource availability as a key to good health (Waitzkin, 1983). Allende worked in the 1930s and 1940s to address the role of underdevelopment and imperialism in public health problems. Although the three point to different solutions (from revolution to reform), each prioritizes intervention in political, economic, and social inequities as the work of health promotion. Waitzkin also notes that each is "multisectoral," demonstrating that health policy must transcend the health sector alone to address political changes such as wages, housing, planning, occupational safety, and social safety nets. Critical scholars should also note that social disparities including gender, sexuality, ethnicity and nationality must be considered in understanding health inequality.

The discourse of the "new public health" makes reference to economic and political change using the language of empowerment, cooperation, and community participation (Petersen & Lupton, 1996); for instance, WHO's 1978 Alma Ata declaration of "Health for All by the Year 2000" links health to social and economic justice, political autonomy, and resistance to Western, biomedical definitions of health (Carpenter, 2000). Yet programs such as the WHO's "Healthy Communities" initiative continue to emphasize individual responsibility, localize what are often national and international problems, ignore power imbalances at the local level, and justify state rollbacks in health protection investments (Petersen & Lupton, 1996). Moreover, many argue that the rising power of market-based policies from the IMF and WB has encouraged the WHO to largely abandon any comprehensive approach to social change and adopt a reformist stance in order to survive, focusing on discrete campaigns such as vaccinations or health education (Banerji, 1999). Thus, there is an absence of critical, multisectoral public health discourse that prioritizes social change in the roots of inequality.

Public health and health communication

Scholars of health communication play an increasing role in promoting public health, both in the United States and globally. As they do so, researchers tend to operate within dominant discourses of public health focused on lifestyle theories and medical compliance, producing models and persuasive initiatives to alter individual behavior, with little attention to the social and political circumstances of target audiences (Dutta-Bergman, 2005). As a result, many projects take existing political and economic contexts as a given, such as research into vaccine information in the Philippines (McDivitt et al. 1997), Bolivian contraceptive promotion (Valente & Saba, 2001), radio programming in Nepal (Storey et al., 1999), nutrition communication in Sub-Saharan Africa (Pratt et al., 1997), and organizational factors in HIV/AIDS campaigns in Africa (Kiwanuka-Tondo & Snyder, 2002; Witte, 1998).

Yet health scholars are beginning to articulate linkages between communication theory and health-policy changes. Research examines policy construction as both a communicative process (Murphy, 2001; Sharf, 1999) and a power-laden activity (Conrad & McIntush, 2003; Dejong & Wallack, 1999; Zoller, 2003). A growing number of projects acknowledge the role of policy in influencing the cultural, political, and economic foundations of health in countries outside the United States, and their impact on risk communication and disease prevention (Airhihenbuwa et al., 2000; Melkote et al., 2000). For example, Chay-Nemeth (1998) links the growth of the sex industry, a risk for the spread of HIV/AIDS in Thailand, in part to unequal wealth distribution, poverty, and low educational levels of women. Such studies largely have focused on the decisions of individual governments. This chapter expands this research by critically examining international policies that transcend the specific domain of health. In the next section, I provide a framework for analyzing global trade as a governmental discourse to understand its communicative implications for health promotion.

Neoliberal governmentality

Neoliberalism, understood as a set of international trade, economic, and development arrangements, can be analyzed as a governmental effort. Drawing from Foucault (1991), *governmentality* is not necessarily linked with state authority, although the state may participate. Rather, Foucault describes governmentality as an ensemble of "institutions, procedures, analyses and reflections, the calculations and tactics" (p. 102) that facilitates the exercise of a form of power concerned with managing populations and addressing issues of political economy. Governmentality is constituted by and implemented through discourse.

Lupton (1995) provides an excellent discussion of governmentality in terms of the productive and coercive efforts of public health groups to establish

"voluntary" social norms regarding the body and care for the self. Rather than examine public health as a governmental discourse, this chapter examines the governmental practices of neoliberal market economics as they shape public health efforts.

Rose and Miller's (Rose, 1996; Rose & Miller, 1992) discussion of governmentality can be read to provide a framework for analyzing governmental discourse. First, the authors argue that governmentality is primarily a problematizing activity: "it poses the obligations of rulers in terms of the problems they seek to address" (1992, p. 181). Programs of government develop around these defined problems, rendering them apparently governable through diagnosis, prescription, and intervention. Thus it is necessary to understand the problems a governmental system construes and the process through which they form intervention.

Second, Rose and Miller (1992) argue that the problematics of government can be analyzed "in terms of their political rationalities, the changing discursive fields within which the exercise of power is conceptualized" (p. 175), or "principles to which government should be directed" (p. 179). This involves explaining not just systems of thought but also "systems of action" (p. 177). Analysis should discern how tasks are divided among different social authorities (family, politics, spiritual, etc.).

Third, political rationalities also must be understood in terms of governmental technologies, "the complex of mundane programmes, techniques, apparatuses, documents, and procedures through which authorities seek to embody and give effect to governmental ambitions" (Rose & Miller, 1992, p. 175). Thus we can examine the systems created for executing goals. That these systems are understood as "technologies" is important. Peterson (1990) defines technological discourse as "language used to structure human action according to rules of closed systems" (p. 78). She notes that technological discourse can become problematic when experience that cannot be managed or utilized within a particular system is rejected or ignored. Technological discourse emphasizes efficiency, substituting procedure for creative invention. Thus, analyzing technological discourse can reveal "orthodoxies": the organizational sense making or public consciousness embedded in it (Vickery, 1990).

When looking at neoliberalism generally, we see that the problems to which neoliberalism addresses itself are state interference and economic inefficiency. Neoliberal institutions forward solutions to these problems based on the rationalities of privatization, deregulation, and trade liberalization, particularly among developing countries in the global south (Falk, 1999). In this system, what were previously thought to be issues of political governance are "to be transformed into commodified forms and regulated according to market principles" (Rose & Miller, 1992, p. 198). For example, services such as health care, water, and utilities should be privatized and delivered through the market. This chapter focuses on three specific trade mechanisms as neoliberal technologies to understand their material and symbolic influence on

public health and its promotion. These mechanisms include structural adjustment, harmonization, and investor lawsuits. These three were chosen because they significantly influence the material/biological elements of health, but also because they have, somewhat quietly, altered the landscape for public health actors.

The discursive influence of neoliberal governmentality on health: three exemplars

For each of these mechanisms, I describe the problems the policy defines and addresses, the guiding political rationality, and technologies of implementation. In doing so, I trace the discursive implications of these policies for global public health promotion.

Structural Adjustment Package (SAP) loans: neoliberalism and public investment

Development loan policies are key governmental mechanisms that greatly influence the ability to promote health. Loans to "developing" nations require the approval of the IMF, which imposes a set of requirements on borrower nations. These "structural adjustment policies" reflect neoliberal rationality by demanding austerity measures (drastically reducing social expenditures) and privatization (selling state-owned facilities to for-profit groups) (Stiglitz, 2002). From a public health perspective, this orthodoxy prioritizes investment concerns, thereby failing to account for its material effects on health in individual countries, and disqualifying health as a substantive counter-discourse.

IMF and WB discourse constructs the central problem around which they orient their actions in terms of the need for borrower countries to repay debts, which is thought to be impeded by inflation and closed markets (Stiglitz, 2002). The corresponding solutions have been to require that borrowing nations dramatically decrease spending to balance the budget and avoid inflation (austerity), privatize governmental services such as education, health care, and water systems to open markets for business, and deregulate markets to improve efficiency. Advocates believe open markets will push countries to develop a comparative advantage (Neumayer, 2001).

The political rationality of SAP programs transfers authority in social decision making from the nation-state and indigenous actors to global economic elites. For example, in developing nations, health care is often defined as public goods distributed by need, after SAPs, financial institutions redefine health care as a private commodity to be distributed by ability to pay. Policies direct governments to attempt cost-recovery through health measures.

Evidence suggests that these technologies, the programs and procedures used to implement SAPs, have become ends in themselves. For example,

the interest paid to multilateral banks has exceeded the amount of money borrowed by many developing nations (Schoepf et al., 2000).[1] Although lowering interest rates was an original rationale for these policies, Stiglitz (2002) argues that eventually, "To the fund, a liberalized financial system was an end in itself" (p. 35). Thus, the technological discourse of the WB/IMF shows itself as a closed system as described by T. Peterson (1990) in at least two ways. First, economic advisors ignored contextual evidence that these policies did not lower interest rates.[2] They ignored data that showed that developing countries undergoing SAPs have experienced increased poverty and political instability, continuing to focus on a country's ability to repay debt in the short term to the detriment of building infrastructure that would create long-term social improvements (Gershman & Irwin, 2000). Second, alternate approaches were dismissed as "ideological," such as policies that would account for historic imperialism and income inequalities in producing poverty rates for countries such as Africa (Schoepf et al., 2000). In light of publicized failures and public pressure, the WB and IMF instituted "poverty reduction strategy paper" (PRSP) requirements in the late 1990s that emphasize poverty reduction, however, the economic calculus remains largely the same[3] (Craig & Porter, 2003).

The direct health influence of SAP discourse has been severe. Since the inception of neoliberal policies, the incidence of poverty has risen dramatically to an estimated 1.5 billion people (Carpenter, 2000). Although trade advocates argue that liberalization will result in a transfer of capital between developed and developing countries, between 1965 and 1995, GDP per capita fell by half in sub-Saharan Africa and by 30 percent in Latin America (Rowson, 2000). "Free trade" has resulted in negative income growth for the poorest 40 percent of the population. Mounting evidence documents the ensuing public health crises. As government spending declines, safety nets for the increasing number of poor have disappeared. In Nicaragua after structural adjustment, three out of four people live below the poverty line, and debt repayments exceed the entire social-sector budget (Gershman & Irwin, 2000). SAPs in Bolivia led to poverty as $400 million in taxes from the state-owned petroleum industry shrank to $80 million in taxes after privatization (Brubaker, 2001).

There are now more homeless and higher rates of disease and malnutrition throughout Africa. A longitudinal study by UNICEF in Brazzaville Congo, before and after SAPs, demonstrated that as adjustment policies took effect, there was a doubling in low-birth weight babies for children of the poor, and an increase in acute malnutrition and growth stunting (Schoepf et al., 2000). Privatization and subsidy cessation policies play a significant role in increasing hunger. In 1999, when Mexico eliminated some agricultural price controls and subsidies, the price of tortillas increased 350 percent, while wages increased only 10 percent that year (Brubaker, 2001). Privatization threatens global access to clean water, a major public health issue when more than a third of

people living in developing countries lack access to clean water and sewers (Sidel, 2000). Following IMF requirements to privatize public holdings, the Bolivian government sold its publicly built and funded water system to Bechtel Corporation, which raised rates to what was for most people one third of their salary (Brubaker, 2001).

These direct health effects are particularly pernicious for health promoters because as disease rises, the re-definition of health care as a commodity under SAPs reduces access to health care. Thus the policies create discursive barriers to addressing the very problems they create. Studies in Zaire, Zimbabwe, and Nigeria show attendance rates for health-care services plummet when fees are charged (Millen et al., 2000). The WB itself found that in fifty-three countries under structural adjustment, health expenditures fell from 2.3 to 1.1 percent of their budget (Carpenter, 2000).

In 1988, O'Brien, chief economist of the WB, stated about structural adjustment policies in sub-Saharan Africa: "We did not think that the human costs of these adjustment programs could be so great, and economic gains so slow in coming" (cited in Bienefeld, 2000, p. 53). SAP policies suggest that global trade and economic institutions are forms of governing the global south on behalf of economically advanced countries. They represent the uneven application of neoliberal theories that disproportionately affect already poor countries. Developed countries such the United States and the European Union retain trade tariffs, monetary support for industry (such as steel, agriculture, and aviation), and public investment in education and health (Navarro, 1999) while continuing to require privatization and austerity measures in developing countries. The privileging of *privatization* and liberal markets is an inherent barrier to those who promote *public* health with its basic need for public expenditure and infrastructures.

Harmonization: neoliberal governance and the discourse of regulation

We have seen that "trade negotiations" extend beyond traditional concepts of trade such as tariffs to the domestic policies of individual states. Advocates refer to achieving standardization as "harmonization" whether bilaterally (e.g., European Union–United States), or multilaterally (e.g., the WTO). Harmonization agreements, whereby nation states and industries attempt to make uniform regulatory requirements for everything from car headlights to chemicals, now influence public health, environmental, and safety regulations. These policies fail to account for health effects, and impede health promotion by raising the discursive burden to create or maintain regulation as a means of protecting public health and safety.

The key problem for global capital, according to proponents, is that the burden to meet different regulatory requirements is cumbersome and deters

trade (Green Cowles, 2001). Additionally, proponents note that domestic regulation may disguise protectionism for national industries (Cameron, 1999). Critical analysis suggests that harmonization discourse privileges the problem of market efficiency for goods producers over public health.

Examples of harmonization technologies include two discursive mechanisms, the Technical Barriers to Trade (TBT) and Sanitary and Phytosanitary (SPS) agreements of the WTO, which stipulate that members should "base their technical regulations, standards, and conformity assessment procedures on international standards, guides, and recommendations" (Motaal, 1999, p. 226). More specifically, these rules "require that technical regulations and health and safety laws are not more trade restrictive than necessary to achieve their legitimate objectives, and do not create unnecessary barriers to trade" (Martin, 2001, p. 114). WTO rules require that public health goals be achieved in the "least trade restrictive" manner possible.

This guiding political rationality transfers a good deal of public health authority to global trade institutions such as the WTO, NAFTA, where public health advocates play no formal role, and where business leaders have access to trade officials that public advocates do not (Greider, 2001; Zoller, 2004). This is particularly problematic because, from a communication perspective, establishing that laws are not "more trade restrictive than necessary" is a discursive process that involves definitional conflicts among competing interest groups. The use of scientific measures of risk adds to this conflict rather than ameliorates it, given that the negotiation of risk itself is ideological, involving value-laden choices that benefit some over others (Sass, 1999).

TBT and SPS agreements are technologies that protect investor rights, but discursively restrict public health protections. Although the clause requiring regulation to be implemented in the least trade restrictive way appears reasonable from an economic perspective, it also acts as a mechanism for industry to challenge domestic public health standards. Critics refer to harmonization as the "race to the bottom." In practice, we see Japan and the European Union claim that U.S. nutrition labeling requirements are too trade restrictive, and argue for voluntary labeling (Goldman & Wagner, 2000). Canada submitted a challenge to a French asbestos ban, arguing that "protective clothing and other measures that limit exposure would be less burdensome on trade than a ban" (Goldman & Wagner, 2000, p. 265). Milmo (2002) reported that the European Chemical Industry Council was openly optimistic that the EPA will assure that harmonization procedures match the United States' more lenient chemical testing program rather than the stricter policies of Europe.[4] As these examples suggest, industry uses harmonization mechanisms to promote lenient regulatory standards.

Harmonization technology makes public health protection more difficult as business interests attempt to establish standards of certainty over the precautionary approach to risk. Environmental and health advocates argue

that WTO rulings should rely upon the Precautionary Principle (PP), which holds that in the face of incomplete or uncertain evidence of harm, decision makers will protect the public from potential harms rather than await total certainty. However, harmonization advocates frame the PP as an unfair trade barrier that keeps foreign products out of domestic markets (Martin, 2001). By calling for evidence of "statistical human assessments and certainties of harm" in order to establish regulation (Labonte et al. 1999, p. 27), industry leaders shift the burden of proof from producers proving a product or service safe to advocates establishing a certainty of harm to warrant regulation.

For example, the pharmaceutical "Expert Group" of the TABD, a business advisory group to the WTO states, "It is essential that regulatory decisions be made on the basis of sound scientific and medical risk assessment, with clear, reasoned, and unambiguous methodology. The so-called Precautionary Principle is neither necessary nor appropriate, especially with respect to the pharmaceutical sector" (p. 42). The United States and Canada used SPS measures before the WTO to protest the European Commission's import ban on beef from hormone treated cows, arguing that scientific certainty did not exist regarding the harms of hormone-treated animals on humans. The decision resulted in authorization to impose trade sanctions of 191.4 million dollars against the European Union.[5]

The concept of "sound scientific risk assessments" obscures the very uncertainty in establishing causation that the PP was designed to deal with. Appeals for resolute scientific findings are problematic because such data are rarely available in biological contexts, given multifactorial causation and an inability to use controls (Sass, 1999). Standards of certainty would have prevented passage of much existing regulation intended to prevent potential harms. For example, the U.S. Food Quality Protection Act of 1996 added protections for children against pesticides, based on the *lack* of epidemiological research that demonstrates safe levels of pesticide exposure for children (Goldman & Wagner, 2000).

Additionally, SPS and TBT mechanisms may alter the definition of the "status quo." If the burden of proof rests with those who want to change the unaltered environment, producers must provide evidence that what they produce is safe, whereas if it rests with those who want to alter existing production processes, public health and environmental groups must prove a substance harmful before it can be regulated (Cameron, 1999).

In sum, harmonization agreements that construct a burden to prove a substance harmful before it can be regulated discursively create a significant barrier to promoting health protections. Trade negotiators can use private, market-based mechanisms to undermine important public health protections. These technologies exclude open public processes, reducing the influence of public health advocates.

Investor-to-State Lawsuits: neoliberalism and the discourse of investment protection

Investor-to-State Lawsuits (ISLs) are global trade mechanisms in treaties such as the WTO and NAFTA that protect global corporate economic investments. However, these governance technologies also assert and expand the notion of a corporation's right to profits (Greider, 2001) by allowing corporate legal claims against governments for lost profits and potential profits due to domestic laws. By discursively defining regulation as expropriation, these obscure policies shift the locus of public health and environmental lawmaking from democratic localities to investor courts.

ISL mechanisms define and address the problem of protecting foreign investment from seizure or unfair competition. The solutions forwarded include those such as NAFTA Article 1110, which states that "governments must compensate foreign investors for measures that 'expropriate' their property or are 'tantamount to a direct or indirect expropriation" (Public Citizen, 2002, p. 2). Also known as Chapter 11 lawsuits, NAFTA cases transfer governing authority to a private three-judge arbitration tribunal. Unless both sides agree otherwise, tribunal decisions are secret and never made available to the public (Greider, 2001).

In addressing these problems, the discourse of ISL treaties expands corporate rights through key re-definitions of property rights and regulation through the everyday terminology of "taking" and "tantamount."[6] The concept involves defining public regulation as "a government 'taking' of private property that requires compensation to the owners" (Greider, 2001, p. 22). This idea finds expression in the term "tantamount to expropriation." As a result of this re-definition, lawsuits are now filed against foreign governments for loss of *potential* profits due to regulation. Such suits involve large damage claims that could be very difficult to pay, particularly for impoverished countries.

Labonte et al. (1999) reported that under NAFTA and the WTO, every challenge to a resource conservation effort had succeeded. For example, the WTO ruled that the United States must allow gas products from Brazil and Venezuela to be sold in the United States despite being below U.S. environmental standards or pay $150 million a year in damages. Rather than pay the fine, the Clean Air Act was altered to allow this gasoline, damaging public respiratory health (Labonte et al., 1999, p. 30).

The rationale of ISLs is to protect a corporate right to profit, and it delegitimizes state action in protecting the public. Once the language of "taking" is legally instituted, public health and safety measures become potentially actionable offenses. The possibility of "regulatory chill," the weakening or removal of regulation in the face of lawsuits, creates a significant barrier for public health and environmental protection.

In 1997, Canada passed a law banning the import of MMT,[7] a manganese additive. Although the substance was already banned in the United States due

to health concerns, Ethyl Corporation sued Canada for 250 million dollars in lost potential profits under NAFTA, citing the law as a Chapter 11 infraction as "measures undertaken tantamount to expropriation of its investment" (Neumayer, 2001, p. 80). Supporting the notion of regulatory chill, Public Citizen (2002, p. 4) reported that "After learning that the NAFTA tribunal was likely to rule against its position, the Canadian government revoked the ban, paid Ethyl $13 million in damages, and issued a public statement declaring there was no evidence that MMT posed health or environmental risks" (p. 4). Thus, the threat of such lawsuits encourages state self-discipline, potentially preventing health protection efforts even before rulings are made.

Methanex Corporation sued the U.S. government under NAFTA, seeking compensation for a March 1999 California-imposed phase-out and ban on MTBE (methyl tertiary butyl ether) a fuel additive (Neumayer, 2001). The U.S. Environmental Protection Agency views the product as a potential human carcinogen and groundwater contaminator. Methenex Corporation sued the US for $970 million for damage to future profits expected from its sale of methanol, an ingredient in MTBE (Greider, 2001). Neumayer argues that the company used the lawsuit to prevent other states from enacting similar legislation.

ISL lawsuits also may influence efforts to change health and safety claims by product manufacturers. For example, in 2002 Philip Morris announced their intent to sue Canada under NAFTA Chapter 11 for a proposed ban on the words "light" and "mild" from cigarette packaging. Philip Morris argued that the proposed health regulations would be "tantamount to expropriation" of its trademarks that involve those words (Public Citizen, 2002). It demanded compensation for money spent in developing brand loyalty around these terms if such rules went into effect. In this case, Canada imposed the ban and faced potential lawsuits.

This Canadian case illustrates that states maintain the ability to impose health regulations, when public attention is drawn to health threats, and resources are available. However, ISL mechanisms significantly shift the playing field for health advocates by privileging profit through a private court system versus the public mechanisms used to create health protections.

Implications: communication research and global health advocacy

Critical analysis of these three globalization policies demonstrates how these technologies of economic policy, normally thought to be outside the domain of health policy, materially and discursively impede global health promotion. Neoliberal discourse problematizes state intervention and public investment, which are key to protecting health, and forward the private market as a solution in ways that prioritize investment protections. Furthermore, the technological

discourse of trade forms a closed system that closes off the context-sensitive decision making needed to promote public health.

Global financial rules remain in flux in the face of multiple negotiations among nations. Indeed, given the breakdown of consensus about the global economy and international cooperation (Saul, 2004), now may be an opportune moment to alter the rationality guiding trade and investment institutions, and to prevent the same rationality from re-emerging in other forms (as witnessed in the privatization of Iraq (Roy, 2004), CAFTA—the Central Americas Free Trade Agreement, and the continued promotion of the FTAA). The preceding analysis provides the basis for some specific courses of action to promote public health protections, whether incrementally or more transformatively.

First, countering structural adjustment/conditionality systems involves discursively redefining and prioritizing public investment and re-valuing health as a public good. A critical discourse of public health can challenge the dominant logic of privatization. These broad changes may be facilitated by a) by moving health decisions from the economic to the political realm, b) educating the public, governments, and trade participants that improved health and economic growth have occurred where nations protect vulnerable industries and retain state investments in health and education (Navarro, 1999), and c) framing health protection as capacity building rather than an opportunity for "aid." Additionally, economic remediation must go beyond debt forgiveness to remove harmful austerity and privatization requirements if developing countries are to escape poverty and disease. The contradiction between enforcement of these rules in developed and developing countries can be used to counter the assumption that such policies result solely from a value-free economic calculus.

Second, to effectively counter harmonization procedures and reduce or remove their influence on safety standards, health advocates must work to codify the precautionary principle, place the burden of proof for safety on industry,[8] and include health professionals in trade negotiations. Such work has been achieved in the United Nations, but its relative lack of authority in relation to the financial institutions means that more work remains to be done. Additionally, health communication scholars can publicize the effects of harmonization decisions on public health and democratic processes (which involves educating the public about the importance of seemingly technical, scientific procedures).

Third, protecting health regulations and preventing regulatory chill from ISLs requires redefining "expropriation" and "taking" to exempt existing health laws that are not designed to impede foreign investment. Health communicators may achieve such goals by insisting on a participatory role in trade agreements, or through democratic advocacy, activism, and lobbying. In order to fight Chapter 11 provisions, consumer advocates recommend the inclusion of "social development and environmental protective measures" in trade

policies as a safeguard (Labonte et al., 1999, p. 25). More fundamentally, health advocates also must reject ISL mechanisms and contest the notion of a "right to profits" in order to move debate and decision-making into the public and democratic arenas, away from commercial-interest tribunals.

Health communication research and practice

The critical, multisectoral approach to public health guiding this chapter provides insight into the potential role of health communication research and practice to address neoliberal governmentality more broadly. The field needs to address some of its own practices, and it can also facilitate academic and public activism.

First, we must work to remove the field of health communication's complicity with the rationale of neoliberal governmentality. For example, health campaign efforts that emphasize behavior choices without attention to social contexts are problematic on several levels. Targeting behavioral choices such as dietary patterns, condom use, and drug abstinence, and focusing on compliance with biomedical authorities, ignores the political decision making that alters the infrastructure guiding personal agency, health knowledge, and risk decisions. It cruelly ignores the lived experience of populations around the world to emphasize only personal choice making when basics such as access to clean water are threatened by global agreements outside local control.

Individualistic communication research reinforces the rationale of individualism and personal responsibility that is a counterpart to market-based decision making. It is more difficult to argue for public investment in health protections when publics (particularly Western publics) define health as a matter of personal choices. Health communication scholars should see within its purview the job of helping to persuade the public that the individualistic approach does not adequately address the social foundations of health, including poverty, access to food, water, shelter, education, and health care, as well as health and environmental regulation. Furthermore, when health promoters ignore or treat as a given current economic arrangements, they facilitate the dominance of economic institutions in setting policies that influence health.

Thus, this analysis (along with other chapters in this book) demonstrates that challenging and constructing global policies is a communicative issue that must be considered alongside other domains of health communication research such as interpersonal interventions, health promotion campaigns, health organizations, and medical practice. Poverty rates, education levels, health investments, and protective legislation are at least in part the result of political decisions based on governance strategies that depend upon the negotiation of public meaning. The developing countries whose health status some communication researchers are working hard to improve (South Africa,

Bolivia, Nepal to mention a few) are some of those made most vulnerable by structural adjustment policies and investor protections.

With this recognition in place, health communication researchers can evaluate and promote strategies of public participation for challenging neoliberalism and develop positive alternatives. Strategies may include advocacy from health organizations and grassroots health activism (Zoller, 2005a). Examples of successful health advocacy include the Canadian Public Health Service (CPHS), which played a role in derailing the 1998 Multilateral Agreement on Investments by researching and sharing findings about the potential impact of such an agreement on public health (Pinder, 1998). This group also publicized the need for a formal role for public health in trade agreements, which became known as the "social clauses campaign" (p. 39).

It is important for us to investigate what communication strategies allow maximum policy-making input on the part of affected communities and populations. Insights from organizational studies and public relations give the field unique contributions to debates among health advocates about how to achieve change. For example, advocates disagree about whether to work within the WTO framework to create a global commitment to public health, debt forgiveness, and public participation (Carpenter, 2000), or to attempt to defeat these global trade institutions and replace them with alternate systems ("Fix it or nix it"). Debate exists about the role of transnational nongovernmental organizations (NGOs). For example, there are disagreements about whether to strengthen and reform WHO and its "Health for All" campaign (Carpenter, 2000) or to abandon it as an institution of social change (see for discussion Banerji, 1999). Communication researchers can also investigate strategies to build alternate sources of power. Rather than emphasize divisiveness by choosing a single way to proceed, research should focus on how multiple strategies might operate together to achieve public health improvements that are flexible and context-sensitive, rather than technological.

Also, health communication researchers can examine how health-related economic policies are experienced, resisted, and transformed by actual people acting locally, nationally, and transnationally. Grassroots health activism is an important area for growth in health communication scholarship (Zoller, 2005a). How are individual communities, cultures, or countries finding ways to promote health in the face of these policy conditions (see for example Dutta-Bergman, 2004)?

These questions place research and advocacy of the movement of "globalization from below" squarely within the purview of health communication research. Falk (1999) describes this movement as grassroots resistance aimed at altering social norms for social justice, sustainability, and compassion in contrast to the elite policy making of neoliberalism. Globalization from below focuses on re-asserting democracy, local control, and establishing economies that serve human interests rather than the reverse (Falk, 1999). Perhaps because health activists tend to focus on single issues or

diseases (such as AIDS activism) rather than forge a common identity, the health focus of much of this grassroots resistance may be overlooked (Zoller, 2005a). This fragmentation also may prevent activists from using arguments about public health to their full advantage. Our field can address the role of these networked activists in challenging the market-based logics and rearticulating health equity as a social good. We also can play a role in fomenting an integrated public health movement.

Critical approaches to public health emphasize the economic, social and political roots of public health, and thereby prioritize fundamental, multi-sectoral changes that may be overlooked by health efforts that work within the status quo. The obdurate outcomes of increased death and disease particularly for poor and marginalized populations provide a potentially powerful basis to bring criticisms of neoliberal techniques to public consciousness. Inequality is a problem for everyone; the rich cannot exist in a healthy state alongside the poor and sick.

Acknowledgments

The author wishes to thank Mohan J. Dutta, Shiv Ganesh and Ed Schiappa for their review of drafts of this chapter, and Gail Fairhurst and Dennis Mumby for helpful comments on the chapter.

Notes

1 "In 1996, sub-Saharan Africa received $15 billion in loans but paid out $12 billion in debt service" (Schoepf et al., 2000, p. 121). Eighty percent of the loans to Africa in the 1970s are estimated to have stayed in Western hands, yet most African countries have been using 30–70 percent of their export revenues to pay debt (Schoepf et al., 2000).

2 When confronted with problems such as unemployment, IMF economists explain it away by holding that unemployment must be voluntary or caused by government or union intervention. For example, Argentina received an "A" rating in face of double-digit unemployment because its budget appeared balanced and inflation controlled.

3 In 1999, the WB and IMF responded to outcries about the effects of SAPs on poverty and democracy. They now require a Poverty Reduction Strategy Paper (PRSP) to be written as a condition for entry into the Heavily Indebted Poor Countries Initiative II. The paper assesses a country's ability to address poverty issues. However, critics argue that PRSPs are simply an extension of SAP policies (Bradshaw & Linneker, 2003). The WB claims that because participatory assessment occurs in each country, PRSPs demonstrate the absence of a formula for poverty reduction. Yet the organization continues to state that economic growth and macroeconomic stability are the keys to poverty reduction (Ellis et al., 2003), and features of SAPs remain in the strikingly similar plans for individual countries such as Honduras, Nicaragua, and Bolivia (Bradshaw & Linneker, 2003). Thus, Craig and Porter (2003) argue that PRSPs continue to favor technical procedures and a disciplinary approach over attention to contextual human needs related to political economy.

4 For example, the *Chemical Market Reporter* (Milmo, 2002) states: "The EPA's drive for greater compatibility in the way chemicals are controlled raises hopes that the European Union (EU) can be persuaded to adopt a more conciliatory approach to chemical regulations" (p. 4).

5 The WTO dismissed carcinogenicity findings from the "benchmark" International Agency on Research of Cancer (Cameron, 1999). The Appellate Body of the WTO ruled that "the precautionary principle cannot override our finding ... namely that the EC import ban ... is not based on risk assessment" (Cameron, 1999, p. 259). According to Neumayer (2001), the WTO appellate decision shows that "in tendency the appellate body seemed to side with those who dispute that the precautionary principle is internationally and widely accepted" (p. 129).

6 Treaty negotiators, who typically come from and return to private corporate law, have discussed alterations in the meaning of property and regulation in the U.S. Council for International Business since the mid-1980s (Greider, 2001).

7 Methylcyclopentadienyl manganese tricarbonyl.

8 The Precautionary Principle should be applied so that the burden of proof rests with those who want to alter the environment rather than those who want to alter existing production processes.

References

Airhihenbuwa, C., Makinwa, B., & Obregon, R. (2000). Towards a new communications framework for HIV/AIDS. *Journal of Health Communication*, 5(1), 101–111.

Banerji, D. (1999). A fundamental shift in the approach to international health by WHO, UNICEF, and the World Bank: Instances of "intellectual Fascism" and totalitarianism in some Asian countries. *International Journal of Health Services*, 29(2), 227–259.

Barris, E., & McLeod, K. (2000). Globalization and international trade in the twenty-first century: Opportunities for and threats to the health sector in the south. *International Journal of Health Services*, 30(1), 187–210.

Bienefeld, M. (2000). Globalization and social change: Drowning in the icy waters of commercial calculation. In J. Dragsbaek Schmidt & J. Hersh (eds), *Globalization and Social Change*. London: Routledge, pp. 46–66.

Bradshaw, S., & Linneker, B. (2003). Civil society responses to poverty reduction strategies in Nicaragua. *Progress in Development Studies*, 3(2), 147–169.

Brubaker, P.K. (2001). *Globalization at What Price? Economic Change and Daily Life*. Cleveland: The Pilgrim Press.

Cameron, J. (1999). The Precautionary Principle. In G.P. Sampson, & W.B. Chambers (eds), *Trade, Environment, and the Millennium*. New York: United Nations University Press, pp. 239–270.

Carpenter, M. (2000). Health for some: Global health and social development since Alma Ata. *Community Development Journal*, 35(4), 336–351.

Chay-Nemeth, C. (1998). Demystifying AIDS in Thailand: A dialectical analysis of the Thai sex industry. *Journal of Health Communication*, 3(3), 217–231.

Conrad, C., & McIntush, H.G. (2003). Organizational rhetoric and healthcare policymaking. In T.L. Thompson, A.M. Dorsey, K.I. Miller, & R. Parrott (eds), *Handbook of Health Communication*. Mahwah, NJ: Lawrence Erlbaum Associates, pp. 403–422.

Craig, D., & Porter, D. (2003). Poverty reduction strategy papers: A new convergence. *World Development, 31*(1), 53–70.

Dejong, W., & Wallack, L. (1999). A critical perspective on the Drug Czar's antidrug media campaign. *Journal of Health Communication, 4*(2), 155–160.

Dutta-Bergman, M. (2004). Poverty, structural barriers, and health: A Santali narrative of health communication. *Qualitative Health Research, 14*(8), 1107–1123.

Dutta-Bergman, M. (2005). Theory and practice in health communication campaigns: A critical interrogation. *Health Communication, 18*(2), 103–122.

Ellis, F., Kutengule, M., & Nyasulu, A. (2003). Livelihoods and rural poverty reduction in Malawi. *World Development, 31*(9), 1495–1511.

Fairclough, N. (1995). *Critical Discourse Analysis: The Critical Study of Language*. London: Longman.

Falk, R. (1999). *Predatory Globalization: A Critique*. Cambridge: Polity Press.

Foucault, M. (1980). *Power/knowledge: Selected Interviews and Other Writings 1972–1977* (C. Gordon, L. Marshall, J. Mepham, K. Soper, trans.). New York: Pantheon.

Foucault, M. (1991). Governmentality. In G. Burchell, & P. Miller (eds), *The Foucault Effect: Studies in Governmentality*. London: Harverster/Wheatsheaf, pp. 87–104.

Garrett, L. (2000). *Betrayal of Trust: The Collapse of Global Public Health*. New York: Hyperion.

Gershman, J., & Irwin, A. (2000). Getting a grip on the global economy. In J.Y. Kim, J.V. Millen, A. Irwin, & J. Gershman (eds), *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, Maine: Common Courage Press, pp. 11–43.

Goldman, P., & Wagner, J.M. (2000). Trading away public health: WTO obstacles to effective toxic controls. *Journal of Public Health Policy, 21*(3), 260–267.

Green Cowles, M. (2001). The transatlantic business dialogue: Transforming the new transatlantic dialogue. In M.A. Pollack, & G.C. Shaffer (eds), *Transatlantic Governance in the Global Economy*. Boulder: Rowman & Littlefield, pp. 213–264.

Greider, W. (2001). The right and US trade law: Invalidating the 20th century. *The Nation, 273*, 21–29.

Kiwanuka-Tondo, J., & Snyder, L.B. (2002). The influence of organizational characteristics and campaign design elements on communication campaign quality: Evidence from 91 Ugandan AIDS campaigns. *Journal of Health Communication, 7*(1), 59–77.

Labonte, R., International Union for Health Promotion and Education, & The Canadian Public Health Association. (1999). Brief to the World Trade Organization: World trade and population health. *Promotion & Education, VI*(4), 24–32.

Lupton, D. (1995). *The Imperative of Health: Public Health and the Regulated Body*. London: Sage.

Martin, C. (2001). The relationship between trade and environment regimes: What needs to change? In G.P. Sampson (ed.), *The Role of the World Trade Organization in Global Governance*. New York: The United Nations University Press, pp. 137–154.

McDivitt, J.A., Zimicki, S., & Hornik, R.C. (1997). Explaining the impact of a communication campaign to change vaccination knowledge and coverage in the Philippines. *Health Communication, 9*(2), 95–118.

Melkote, S., Muppidi, S., & Goswami, D. (2000). Social and economic factors in an integrated behavioral and societal approach to communications in HIV/AIDS. *Journal of Health Communication, 5*(3), 17–27.

Millen, J.V., & Holtz, T.H. (2000). Dying for growth, Part I: Transnational corporations and the health of the poor. In J.Y. Kim, J.V. Millen, A. Irwin, & J. Gershman (eds), *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, Maine: Common Courage Press, pp. 177–224.

Millen, J.V., Irwin, A., & Kim, J.Y. (2000). Introduction: What is growing? Who is dying? In J.V. Millen, A. Irwin, J.Y. Kim & J. Gershman (eds), *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, Maine: Common Courage Press, pp. 3–10.

Milmo, S. (2002). EPA and EU collaborate on chemicals regulations. *Chemical Market Reporter, 261*, 4–6.

Motaal, D.A. (1999). The Agreement on Technical Barriers to Trade, the Committee on Trade and Environment, and eco-labelling. In G.P. Sampson, & B. Chambers (eds), *Trade, Environment, and the Millennium*. New York: United Nations University Press, pp. 223–238.

Murphy, P. (2001). Framing the nicotine debate: A cultural approach to risk. *Health Communication, 13*(2), 119–140.

Navarro, V. (1999). Health and equity in the world in the era of "globalization". *International Journal of Health Services, 29*(2), 215–226.

Neumayer, E. (2001). *Greening Trade and Investment*. London: Earthscan Publications.

Petersen, A., & Lupton, D. (1996). *The New Public Health: Health and Self in the Age of Risk*. London: Sage.

Peterson, T.R. (1990). Structuring closure through technological discourse: The Mormon Priesthood Correlation Program. In M.J. Medhurst, A. Gonzalez, & T.R. Peterson (eds), *Communication & the culture of technology*. Pullman: Washington State University Press, pp. 77–94.

Pinder, L. (1998). Health promotion meets globalisation. *Promotion & Education, V*(3&4), 37–39.

Pratt, C.B., Silva-Barbeau, I., & Pratt, C.A. (1997). Toward a symmetrical and an integrated framework of norms for nutrition communication in Sub-Saharan Africa. *Journal of Health Communication, 2*(1), 43–58.

Public Citizen. (2002). NAFTA Investor-To-State cases. *Harmonization Alert, 2*, 1–4.

Rose, N. (1996). Governing "advanced" liberal societies. In A. Barry, T. Osborne, & N. Rose (eds), *Foucault and Political Reason: Liberalism, Neo-liberalism and Rationalities of Government*. Chicago: University of Chicago Press, pp. 37–64.

Rose, N., & Miller, P. (1992). Political power beyond the state: Problematics of government. *British Journal of Sociology, 43*(2), 173–205.

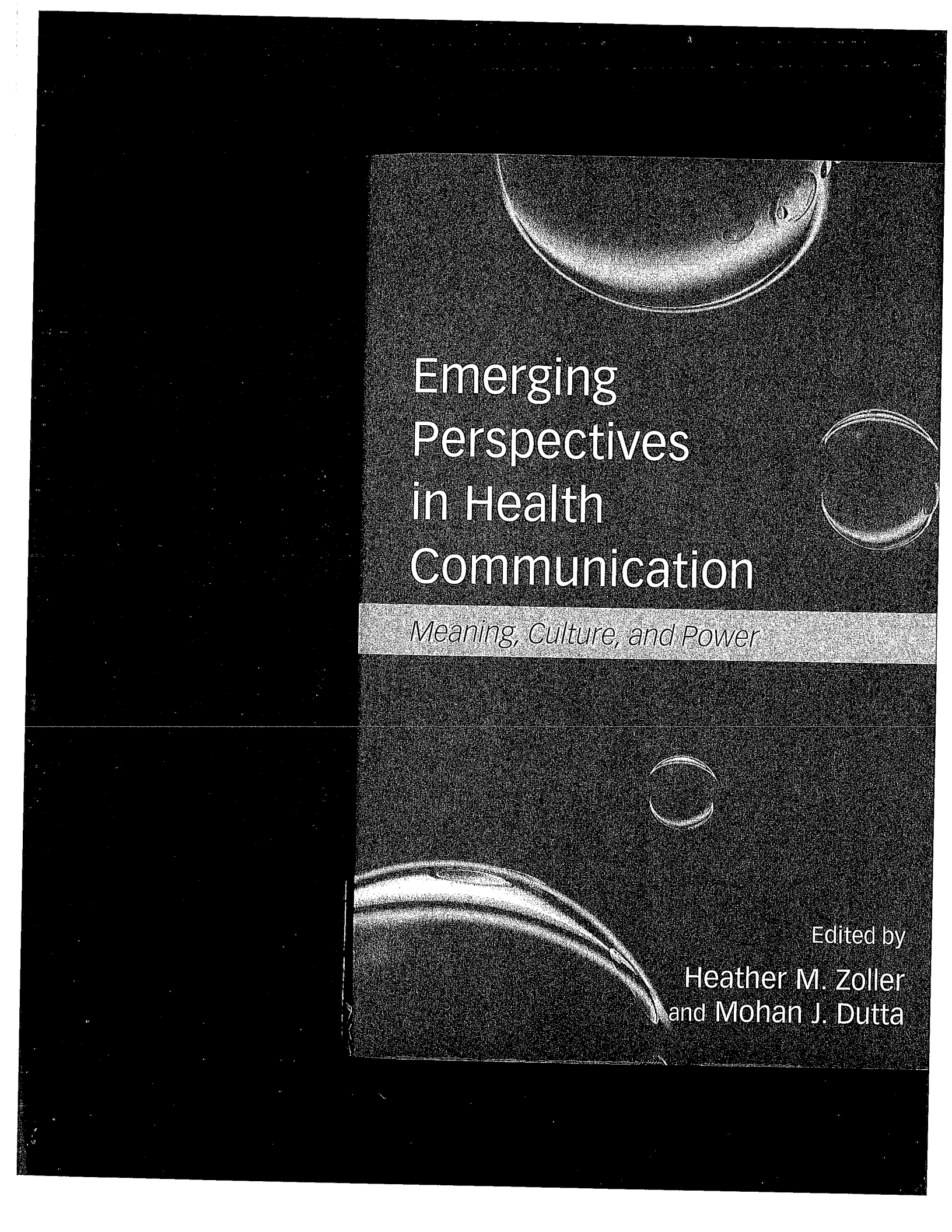
Rowson, M. (2000). Globalization and health—Some issues. *Medicine, Conflict, and Survival, 16*(2), 162–174.

Roy, A. (2004). The new American century. *The Nation, 278*, 11–14.

Sass, R. (1999). The unwritten story of women's role in the birth of occupational health and safety legislation. *International Journal of Health Services, 29*(1), 109–145.

Saul, J.R. (2004). The collapse of globalism and the rebirth of nationalism. *Harper's* (March).

Schoepf, B.G., Schoepf, C., & Millen, J.V. (2000). Theoretical therapies, remote remedies: SAPs and the political ecology of poverty and health in Africa. In J.Y. Kim, J.V. Millen, A. Irwin & J. Gershman (eds), *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, Maine: Common Courage Press, pp. 91–125.


Emerging Perspectives in Health Communication
Meaning, Culture, and Power
Edited by
Heather M. Zoller
and Mohan J. Dutta