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Globalization and social determinants of health: A diagnostic overview and agenda for innovation

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I. Introduction and methodological background

I.1 Introduction: Health equity and the social determinants of health

In 1978, a United Nations conference proposed the goal of health for all by the year 2000 (World Health Organization, 1978). In 2006, despite progress toward that goal, millions of people die or are disabled each year from causes that are preventable or treatable (World Health Organization, 2004). Recent reviews (Bates, Fenton, Gruber, Lalloo, Medina Lara, Squire et al., 2004a; Bates, Fenton, Gruber, Lalloo, Medina Lara, Squire et al., 2004b) of research on HIV/AIDS, tuberculosis and malaria, communicable diseases that together account for almost six million deaths per year, identify poverty, gender, inequality, development policy and health sector 'reforms' that involve user fees and reduced access to care as contributors. More than four million children die each year from diseases that could easily be prevented with appropriate interventions: diarrhoeal disease, lower respiratory infections and vaccine-preventable diseases. These causes of death are highly infrequent in the industrialized world, and undernutrition is an underlying cause of roughly half these deaths (World Health Organization, 2003; Bryce, Boschi-Pinto, Shibuya & Black, 2005). An expanding body of literature describes a similarly unequal distribution of many non-communicable diseases and injuries, again with poverty or economic marginalization as a major contributor (Uauy, Albala & Kain, 2001; Chopra, Galbraith & Darnton-Hill, 2002; Peden, McGee & Sharma, 2002; Nantulya, Reich, Rosenberg, Peden & Waxweiler, eds., 2003; Krug, Dahlberg, Mercy, Zwi & Lozano, eds., 2003; Monteiro, Conde & Popkin, 2004; Monteiro, Moura, Conde & Popkin, 2004; Ezzati, Vander Hoorn, Lawes, Leach, James, Lopez et al., 2005).

In 2001, the World Health Organization (WHO) Commission on Macroeconomics and Health turned much conventional wisdom on its head by demonstrating that health is not only a benefit of development, but also is indispensable to development (Commission on Macroeconomics and Health, 2001). Illness all too often leads to "medical poverty traps" (Whitehead, Dahlgren & Evans, 2001), creating a vicious circle of poor nutrition, forgone education, and still more illness – all of which undermine the economic growth that is necessary, although not sufficient, for widespread improvements in health status. Like the earlier commitment to health for all, most of the Commission's recommendations, which it estimated could have saved millions of lives each year by the end of the current decade, have not been translated into policy. Further, the Commission did not inquire into how the economic and geopolitical dynamics of a changing international environment ('globalization') support and undermine health, or how these dynamics can be channelled to improve population health.

In 2005, WHO established the Commission on Social Determinants of Health (CSDH), on the premise that action on social determinants of health (SDH) – that is, the social conditions in which people live and work – is the fairest and most effective way to improve health for all people and reduce inequalities. Good medical care is vital, but unless the root social causes that undermine people's health are addressed, the opportunity for well being

will not be achieved.¹ Central to the Commission's remit is the promotion of health equity, defined in the literature as "the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage" (Braveman & Gruskin, 2003:256). This paper describes research strategies to address the relation between globalization and social determinants of health through an equity lens, and invites dialogue and debate about preliminary findings. A much earlier version was prepared in Spring, 2005, as part of the process of selecting the Knowledge Networks that comprise a major element of the CSDH's work. After the authors' institution was selected as the "Hub" for the Globalization Knowledge Network,² an initial draft was discussed at a meeting of the Commission in September, 2005 and at the first meeting of the Knowledge Network in February, 2006. Extensive revisions were later undertaken, partly in response to comments received at the September and February meetings and from Knowledge Network members. However, the paper is not a policy statement on the part of the Knowledge Network and does not represent a position of the Commission on Social Determinants of Health or the WHO. All views expressed are exclusively those of the authors.

This first part of the paper identifies and defends a definition of globalization and describes key strategic and methodological issues, emphasizing how and why the special characteristics of globalization as a focus of research on health equity and SDH demand a distinctive perspective and approach. The second part describes a number of key 'clusters' of pathways leading from globalization to equity-relevant changes in SDH. Building on this identification of pathways, the third part provides a generic inventory of potential interventions, based in part on an ongoing program of research on how policies pursued by the G7/G8 countries affect population health outside their borders (Labonte, Schrecker, Sanders & Meeus, 2004; Labonte & Schrecker, 2004; Labonte & Schrecker, 2005; Labonte, Schrecker & Sen Gupta, 2005; Labonte, Schrecker & McCoy, 2005; Labonte & Schrecker, 2006; Schrecker & Labonte, in press). It concludes with a few observations about the need for fundamental change in the values that guide industrialized countries' policies toward the much larger, and much poorer, majority of the world's population living outside their borders.

1.2 Globalization and the global marketplace

Globalization is a term with multiple, contested meanings. Here we adopt a definition of globalization as "a process of greater integration within the world economy through

¹ Adapted from the Commission's web site, http://www.who.int/social_determinants/en/ (accessed May 4, 2006).

² The authors are, respectively, coordinator and co-chair of the Hub. The network starts from the premise that globalization's dynamics affect health outcomes in a variety of sociopolitical contexts by way of the pathways described in section 1.3. The uneven distribution of globalization's gains and losses and the impact on health disparities within and between countries will be analyzed as a basis for developing national and global policies to mitigate the harmful effects of, as well as maximize the benefits of globalization on health. For further information on the Knowledge Networks, see: http://www.who.int/social_determinants/knowledge_networks/en.

movements of goods and services, capital, technology and (to a lesser extent) labour, which lead increasingly to economic decisions being influenced by global conditions" (Jenkins, 2004:1) – in other words, to the emergence of a *global marketplace*. This definition does not exclude various social and cultural dimensions of globalization, such as the increased speed with which information about new treatments, technologies and strategies for health promotion can be diffused, and the opportunities for enhanced political participation and social inclusion that are offered by new, *potentially* widely accessible forms of electronic communication. Nevertheless, "[e]conomic globalization has been the driving force behind the overall process of globalization over the last two decades" (Woodward, Drager, Beaglehole & Lipson, 2001:876). Many of the social, cultural and biophysical dimensions and manifestations of globalization that are most significant in terms of their effects on SDH are best understood with reference to their connections to the global marketplace. Globalization of culture, for example, is inseparable from and arguably driven by the emergence of a network of transnational corporations that dominate not only distribution but also content provision through the allied sports, cultural and consumer product industries (McChesney, 2000; Miller, 2002; McChesney & Schiller, 2003). Global promotion of brands such as Coca-Cola and McDonald's is a cultural phenomenon but also an economic one, and a contributor to the "global production of diet" (Chopra & Darnton-Hill, 2004) and resulting rapid increases in obesity and its health consequences in much of the developing world

Ideas matter, and the definition of globalization adopted here does not exclude the global transmission of ideas, including (for instance) diffusion of human rights norms and political democratization.³ Polanyi's (1944) historical research on development of markets at the national level demonstrated that markets are not 'natural,' but depend on the creation and maintenance of a complicated infrastructure of laws and institutions. This insight is even more salient at the international level: "It is a dangerous delusion to think of the global economy as some sort of 'natural' system with a logic of its own: It is, and always has been, the outcome of a complex interplay of economic and political relations" (Kozul-Wright & Rayment, 2004:3-4). Contemporary (roughly, post-1973)⁴ globalization has been promoted, facilitated and (sometimes) enforced by political choices about such matters as trade

³ This observation in turn raises the question of how democratization should be defined. Some political scientists argue for a minimalist definition of democracy, which requires only the selection of leaders by periodic elections under realistic expectations that losers will turn over power (Przeworski, 1997). On the other hand, numerous critiques describe a new category of "low-intensity democracy" (Stahler-Sholk, 1994; Ellner, 2001; Teichman, 2003) characterized by limited civic engagement largely attributable to the existence of constraints on the policy agenda imposed by holders of resources (such as financial capital) that are extraneous to, and independent of, the electoral process.

⁴ The date is chosen with reference to the start of the first oil supply crisis, the resulting impacts on industrialized economies, and the investment of 'petrodollars' in high-risk loans to developing countries that contributed to the early stages of the developing world's debt crises. Identifying a precise starting point is less important than recognizing that some time in the early 1970s the world economic and geopolitical environment changed decisively, so that (for instance) by 1975 the Trilateral Commission was warning of a "Crisis of Democracy" in the industrialized world (Crozier, Huntington & Watanuki, 1975).

liberalization, financial (de)regulation; provision of support for domestically headquartered corporations (Ruigrok & van Tulder, 1995); and the conditions under which development assistance is provided. Notably, key Western governments and the multilateral institutions in which they play a dominant role⁵ have promoted an “intellectual blueprint ... based on a belief about the virtues of markets and private ownership” (Przeworski, Bardhan, Bresser Pereira, Bruszt, Choi, Comisso et al., 1995: viii). These choices have been implemented by national governments both individually and through multilateral institutions like the World Bank, the International Monetary Fund (IMF) and more recently the World Trade Organization (Marchak, 1991; Przeworski et al., 1995; Gershman & Irwin, 2000; Kapur & Webb, 2000). Within these institutions, the distribution of power is highly unequal. Networks of academic and professional elites, often with institutional connections to governments and international financial institutions (IFIs) like the World Bank and IMF, have played an important role in the outward diffusion of ideas about policy design.⁶ However, implementation of such ideas is not automatic: it requires “legitimation by resource-bearing constituencies [such as] foreign investors, multilateral institutions, and US government officials” (Babb, 2002:20; see also Teichman, 2004) – an observation that was made with respect to Mexico, but which is certainly applicable to other countries as well.

This point underscores the fact that governments are not the only relevant actors in global governance, even while it demonstrates the importance of asset ownership as a political resource. Transnational corporations (TNCs) have long been features of the economic landscape (Millen & Holtz, 2000; Millen, Lyon & Irwin, 2000), and their importance grows as they organize an increasing proportion of the world's economic activity across national borders, not only through affiliates and subsidiaries (Dicken, 2003) but also through ‘outsourcing’ to networks of independent contractors (Donaghu & Barff, 1990; Milberg, 2004; Rothenberg-Aalami, 2004). Conversely, civil society organizations (CSOs) active in various policy fields have taken advantage of opportunities for rapid transnational information sharing opened up by advances in computing and telecommunications. Perhaps the best illustration of the political influence of CSOs as they relate to health is the initiative to interpret the Agreement on Trade-Related aspects of Intellectual Property (TRIPs) in a way that allows health concerns to ‘trump’ harmonized patent protection under some circumstances (’t Hoen, 2002; Sell, 2003; Brysk, 2004; Sell, 2004).⁷ Women’s health movements, as another example, have become “transnationalized,” partly within, and shaping the agenda of, the institutional framework provided by the UN system (Petchesky,

⁵ The G8 nations (the G7 group of industrialized economies plus Russia) “account for 48% of the global economy and 49% of global trade, hold four of the United Nations’ five permanent Security Council seats, and boast majority shareholder control over the International Monetary Fund (IMF) and the World Bank” (Corlazzoli & Smith, eds., 2005)

⁶ See e.g. the work of Babb (2002) on academic economists in Mexico and Lee & Goodman (2002) on the World Bank’s role in promoting health sector ‘reform’.

⁷ Concerns remain among CSOs about the practical effect of this interpretation because of informal pressures from the pharmaceutical industry and industrialized country governments and ‘TRIPs-plus’ provisions in bilateral trade agreements, and a few academic observers are sceptical about the extent to which intellectual property protection has created barriers to access to essential medicines (Attaran, 2004).

2003). CSOs have also been important actors in the admittedly uneven and incomplete international diffusion of human rights norms in the decades following the 1948 Universal Declaration of Human Rights – norms to which we return in the third part of the paper as a potential challenge to the current organization of the global marketplace. Thus, despite much of what is said here, we do not view globalization as magnifying only the value of those political resources related to earning capacity and asset values; the world is more complicated and less predictable than that.

I.3 Globalization and social determinants of health: Recent conceptual and methodological milestones

A 1987 UNICEF publication on “Adjustment with a Human Face” (Cornia, Jolly & Stewart, eds., 1987) reported early and important research on how what we would now call globalization was affecting SDH. The study involved 10 countries⁸ that had adopted policies of domestic economic adjustment in response to economic crises that led them to rely on loans from the IMF. It found that in many cases the policies adopted had resulted in deterioration in key indicators of child health (e.g. infant mortality, child survival, malnutrition, educational status) and in access to determinants of health (e.g. availability and use of food and social services), with reductions in government expenditure on basic services emerging as a key intervening variable. The study situated these national cases within an analytical framework that linked changes in government policies (e.g. expenditures on education, food subsidies, health, water, sewage, housing and child care services) with selected economic determinants of health at the household level (e.g. food prices, household income, mothers’ time) and selected indicators of child welfare (Cornia, 1987). Based on that analysis, the study identified a generic package of policies that would minimize the negative effects of economic adjustment by protecting the basic incomes, living standards, health and nutrition of the poor or otherwise vulnerable (Cornia, Jolly & Stewart, 1987) – priorities that have been stressed in subsequent policy analyses. Only the final chapter of the UNICEF study (Helleiner & Stewart, 1987) addressed elements of the international policy environment that might facilitate implementation of “adjustment with a human face” in some countries while obstructing it in others, and it did not directly address the comparative merits of “compensating for adjustment” (Mosley & Jolly, 1987) in health policies and programs and rethinking the adjustment process itself.

Woodward and colleagues (2001) devised an explanatory model that focused on “five key linkages from globalization to health,” three direct and two indirect. Direct effects included impacts on health systems, health policies, and exposure to certain kinds of hazards such as infectious disease and tobacco marketing; indirect effects were those “operating through the national economy on the health sector (e.g. effects of trade liberalization and financial flows on the availability of resources for public expenditure on health, and on the cost of inputs); and on population risks (particularly the effects on nutrition and living conditions resulting from impacts on household income).” This model

⁸ Botswana, Brazil, Chile, Ghana, Jamaica, Peru, Philippines, South Korea, Sri Lanka, Zimbabwe.

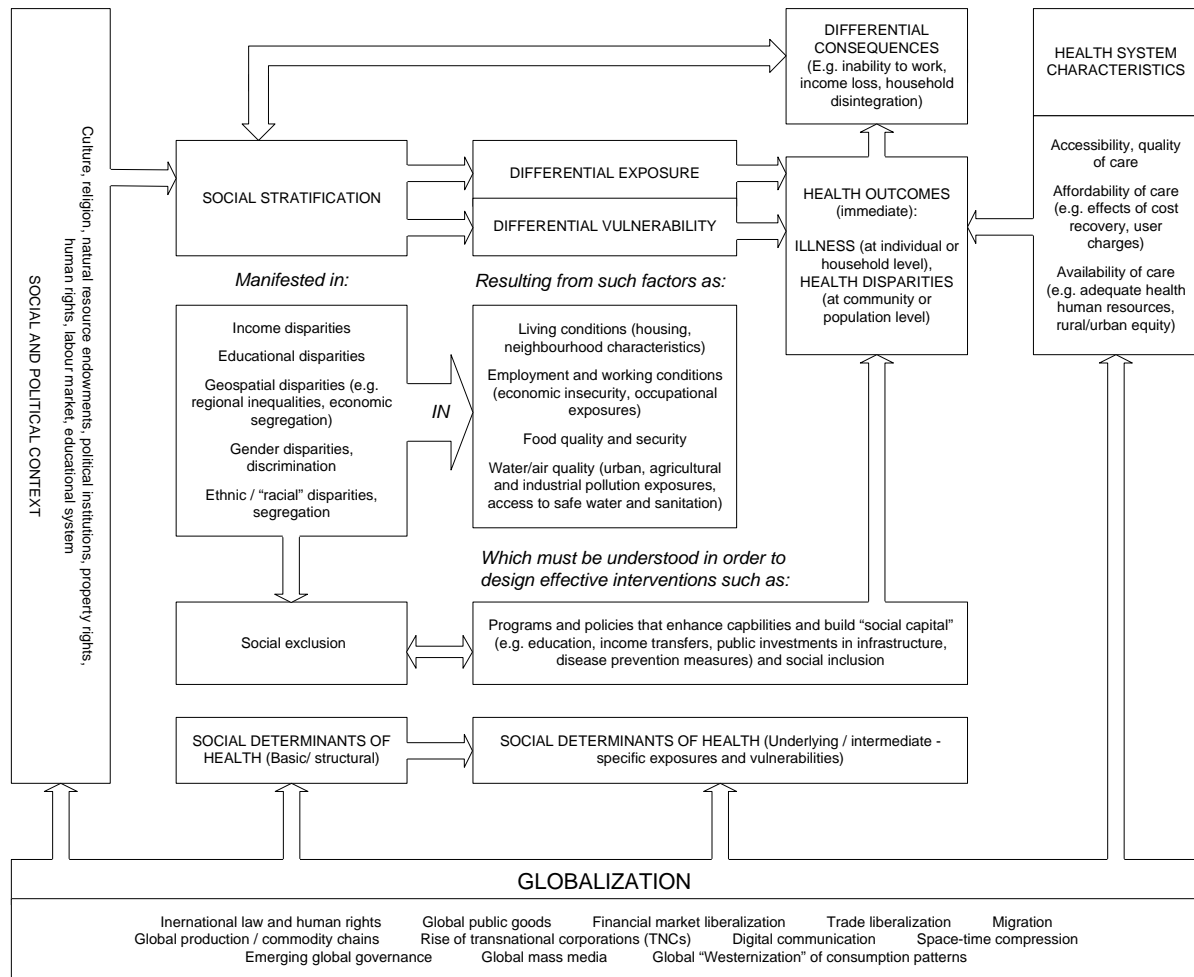
has the advantage of focusing on the range of policy choices (by both governmental and private actors) that operate at the supranational level to affect health; its value is arguably limited by a focus on health systems rather than on SDH. A subsequently WHO-supported systematic review examined numerous models of the relations between globalization and health, generating a diagrammatic synthesis hierarchically organized around various scales ranging from the supranational to the household (Labonte & Torgerson, 2005). A key strength of this synthesis is its explicit attention to globalization's influences on the 'policy space' available to national and subnational governments. Conversely, its limitation is a lack of focus on the detailed mechanisms of action by which various causal pathways or channels of influence lead to changes in individual and population health status.

Diderichsen, Evans & Whitehead (2001:14) group these pathways into "four main mechanisms – social stratification, differential exposure, differential susceptibility, and differential consequences – that play a role in generating health inequities." Globalization can affect health outcomes by way of each of these mechanisms, and the authors draw specific attention to its influence on stratification by way of "those central engines in society that generate and distribute power, wealth and risks" (Diderichsen et al., 2001:16). A variant of this model was adopted as an organizing framework in a concept paper for the Commission on Social Determinants of Health (Solar & Irwin, 2005); it has been further modified for purposes of the Globalization Knowledge Network (Figure 1). Both the figure and the analytical framework it describes require further refinement in order to recognize more explicitly the links between globalization and domestic politics. Historian Simon Szreter's research on public health measures and their impact on health status in nineteenth-century England emphasizes the importance of political coalitions (a "cross-class reform movement") in translating the benefits of rapid economic growth into broadly shared improvements in SDH, such as access to clean water, sanitation, and limited hours of work (Szreter, 1997; see also Szreter, 2003b). This observation is of special importance given the comparable challenges now facing a number of developing countries experiencing rapid economic growth, in a context where the necessary health-related infrastructure is either not available or else has been dismantled as part of growth-oriented economic reforms (Szreter, 1999; Segall, Tipping, Lucas, Dung, Tam, Vinh et al. 2002; United Nations Country Team Viet Nam, 2003). How will globalization affect the formation of domestic political coalitions in support of policy initiatives to improve SDH?

I. 4 The nature of the evidence

As described in Part II of this paper, globalization comprises multiple, interacting policy dynamics or processes the effects of which may be difficult if not impossible to separate. For instance, trade liberalization may reduce the incomes of some workers or shift them into the informal economy, while reducing tariff revenues (and therefore funds available for public expenditures on health or education) in advance of any offsetting revenue gains from

Figure 1. Globalization and the social determinants of health



Source:

Developed by the authors based on Diderichsen et al. (2001) as refined by Solar & Irwin (2005) for the WHO Commission on Social Determinants of Health

income and consumption taxes. Simultaneously, the need to conserve funds for repaying external creditors may create a further expenditure constraint. The causal pathways linking globalization with changes in SDH are not always linear, do not operate in isolation from one another, and may involve multiple stages and feedback loops.⁹ It is necessary to rely on evidence generated by multiple disciplines, research designs and methodologies – the approach now widely described as transdisciplinary (Somerville & Rapport, eds., 2000) – and

⁹ Similarities exist with the task of analyzing causal links between environmental change and human health, which “are complex because often they are indirect, displaced in space and time, and dependent on a number of modifying forces,” in the words of WHO’s synthesis of the health implications of the findings of the Millennium Ecosystem Assessment project (Corvalan, Hales, McMichael, Butler & et al., 2005: 2).

comprising both qualitative and quantitative findings. Issues of scale are also relevant: for example, research that situates data from local-scale survey research in the context of structural adjustment in Zimbabwe (Potts & Mutambirwa, 1998; Bassett, Bijlmakers & Sanders, 2000) and that identifies globalization-related influences on health in South Africa (Gilbert & Gilbert, 2004) demonstrates the need to integrate work using different units of analysis (e.g. the household, the region, the national economy) in order to describe relevant causal relations in sufficient detail, and to reflect intra-national disparities (e.g. by region, class and gender) that are not apparent from national level data (Lozano, Zurita, Franco, Ramirez, Hernandez & Torres, 2001; Gwatkin, 2002; Henninger & Snel, 2002).

All this means that the evidence base for assessing globalization's effects on SDH and identifying opportunities for intervention is quite different from, and much more heterogeneous than, the body of research that is available with respect to clinical and (most) public health interventions. Policy-relevant linkages between globalization and SDH are therefore best described, and the strength of evidence evaluated, by way of syntheses that incorporate several elements, including: (a) description of the national and international policy context; (b) country- or region-specific studies that describe changes in determinants of health, such as the level and composition of household income, labour market changes, access to education and health services (to provide simple examples); (c) evidence from clinical and epidemiological studies that relates to demonstrated or probable changes in health outcomes arising from those impacts; (d) ethnographic research, field observations, and other first-hand accounts of experience 'on the ground'.¹⁰

Rarely, if ever, will it be possible to state conclusions with the degree of conclusiveness that may be possible in a laboratory situation or even in many epidemiological study designs, where almost all variables can be controlled. In the words of social epidemiologist Michael Marmot, who now chairs the CSDH: "The further upstream we go in our search for causes," and globalization is the quintessential upstream variable, the greater the need to rely on "observational evidence and judgment in formulating policies to reduce inequalities in health" (Marmot, 2000:308). The choice and defence of a standard of proof is also important. As in the context of national public health and regulatory policy (Page, 1978; Schrecker, 2001), the decision must be made with explicit reference to the

¹⁰ Field observations can be valuable *inter alia* in providing information about differential impacts (e.g. by region, gender, kind of employment) that are not revealed by standard indicators, and about such matters as the problems created by the imposition of user charges and cost recovery in water and sanitation systems (Lundy, 1996). Within the ethnographic literature, Schoepf (1998; Schoepf, Schoepf & Millen, 2000; Schoepf, 2002; Schoepf, 2004) demonstrates the value of qualitative evidence about the relations between micro-level outcomes and such macro-level factors as falling commodity prices, domestic austerity policies that involved cuts in public sector employment and in subsidized access to health care, and migration driven by economic desperation. For illustrations of the potential contributions of other kinds of 'on the ground' research, see e.g. the World Bank's Voices of the Poor study (Narayan, Patel, Schafft, Rademacher & Koch-Schulte, 1999; Narayan, Chambers, Shah & Petesch, 2000); the report of the Structural Adjustment Participatory Review International Network (Bhattacharya, Moyo, Terán, Morales, Lóránt, Graham et al. 2002); and a summary of studies of sources of livelihood in KwaZulu-Natal, South Africa by Lund (2004).

underlying, potentially competing values. Excessive aversion to false positive findings (Type I errors) can supply, as in other contexts, a credible and convenient rationale for doing nothing. This is the “tobacco industry standard of proof” (Crocker, 1984:66-67) – so demanding that there is always room to claim that evidence about the relevant causal relations is less than conclusive.

In a study that illustrates the application of these insights about explanation and causation, De Vogli and Birbeck (2005) identify five multi-step pathways that lead from globalization to increased vulnerability to HIV infection and its consequences among women and children in sub-Saharan Africa by way of: currency devaluations, privatization, financial and trade liberalization, implementation of user charges for health services and implementation of user charges for education. The first two pathways operate by way of reducing women’s access to basic needs, either because of rising prices or reduced opportunities for waged employment. The third operates by way of increasing migration to urban areas, which simultaneously may reduce women’s access to basic needs and increase their exposure to risky consensual sex. The fourth pathway (health user fees) reduces both women’s and youth’s access to HIV-related services, and the fifth (education user fees) increases risk of exposure to risky consensual sex, commercial sex and sexual abuse by reducing access to education. The explanatory approach they adopt complements recent synthetic reviews of research on determinants of vulnerability not only to HIV/AIDS but also to tuberculosis and malaria (Bates et al., 2004a; Bates et al., 2004b) which concluded that vulnerability to all three diseases is closely linked; that poverty, gender inequality, development policy and health sector ‘reforms’ that involve user fees and reduced access to care are important determinants of vulnerability; and that “[c]omplicated interactions between these factors, many of which lie outside the health sector, make unravelling of their individual roles and therefore appropriate targeting of interventions difficult” (Bates et al., 2004a:268).

A choice must also be made about the time frame of concern. Since in the long run wealthier societies are healthier, it could be argued that the optimal approach to improving SDH is the one that will maximize economic growth in the countries or regions of concern, even at the cost of substantial short-term deteriorations in health status or increases in health disparities. This argument has been stated explicitly by a team of economists with respect to the transition economies of the former Soviet bloc (Adeyi, Chellaraj, Goldstein, Preker & Ringold, 1997). However, a number of empirical uncertainties are associated with this position, as well as a problematic ethical presumption that whatever short-term deterioration in SDH may arise is justified by long-term gains. And how long is too long? Diffusion of the benefits of economic growth in ways that improve health, because of the need to form supporting political coalitions, is neither automatic nor rapid: it took more than 50 years in the industrial cities of nineteenth-century England, for example (Szreter, 1997; Szreter & Mooney, 1998; Szreter, 2003a). Given the frequency with which globalization has resulted in deterioration in SDH for substantial segments of national populations, despite impressive economic growth as measured by national indicators, this is not just an academic point. We return to it in section III.8.

II. The role of the global marketplace

II.1 Introduction

Globalization is a key context for the study of SDH. This second part of our paper identifies and describes 'clusters' of pathways leading from globalization to changes in SDH that are relevant to health equity: the relation among trade liberalization, incomes, and the new international division of labour; debt crises, structural adjustment and the marketization of developing world economic societies; the globalization of flows of capital and information, described by Castells (1996) in terms of the "space of flows"; influences on SDH that operate by way of the physical environment and pressures for natural resource extraction; and the effect on health systems of integration into the global marketplace. The most important pathways have been generically identified, but the list is not exhaustive. Although illustrative examples have been provided, neither have we systematically assessed the strength of evidence associated with each pathway – a kind of assessment that is necessarily specific to particular regions of the world, countries, and even regions or populations within countries.

II.2 Trade liberalization and the new international division of labour

Perhaps the most familiar element of contemporary globalization is trade liberalization. Researchers who claim that globalization is good for the poor (Feachem, 2001) often cite comparative research on national economies carried out under the auspices of the World Bank (Dollar & Kraay, 2000; Dollar, 2001; Dollar, 2002), which concluded that during the 1980s and 1990s, "globalizers" grew faster than "non-globalizers," expanding the resources at their disposal to address SDH. This conclusion has been criticized on several counts. Countries held up as model high-performing globalizers (China, India, Malaysia, Thailand and Viet Nam) actually started out as more closed economies than those whose economies stalled or declined, mostly in Africa and Latin America (Dollar, 2002). The problem is one of definition. Globalizers are defined as countries that saw their trade/GDP ratio increase since 1977; non-globalizers are simply those that saw their ratio drop. Thus India and China are considered globalizers, even though their trade/GDP ratios at the end of the study period were lower than the average of all countries studied. Conversely, the non-globalizers started out more highly integrated into the world economy and the positive globalization to growth relationship becomes a questionable artefact of the studies' design. Others argue that the economic problems of the non-globalizers are partly attributable to global factors outside the control of national economic policy-makers – specifically, a decline in commodity prices that damaged both the export performance and the ability to import of those countries heavily reliant on commodity exports, but already highly integrated into the global economy on some measures (Birdsall & Hamoudi, 2002; Milanovic, 2003; Dowrick & Golley, 2004). Further, excluding India and China – each of which is arguably a special case, albeit

for different reasons – from the sample actually changes the conclusion: globalizers grew more slowly than non-globalizers over the period 1980-2000 (Dowrick & Golley, 2004).

We accept as given, without further review, the preponderance of evidence identifying both the importance of, and multiple pathways by which, poverty (both absolute and relative) acts as a social determinant of health. This point is important because, to the extent that globalization is associated with growth, it would appear to be a good thing for SDH *if* growth reliably reduces poverty. However, similar methodological limitations have been pointed out with respect to this claim (Chen & Ravallion, 2004), with added concerns about the reliability of data on incomes and household assets and the appropriateness of the World Bank's definitions of poverty (Satterthwaite, 2003; Reddy & Pogge, 2005). Even if one takes as given the World Bank measures of poverty, it is not at all clear that globalization leads to poverty reduction or that observed reductions are substantial. For example, between 1981 and 2001, the number of people in the world living on \$1/day or less fell by 392 million, but the number of people living on \$2/day or less rose by 285 million, indicating only that the economically desperate are getting slightly less desperate (Chen & Ravallion, 2004:183).¹¹

Excluding China, where the accuracy of poverty data has been questioned (Reddy & Minoiu, 2005), World Bank data show that the number of global poor actually rose by 30 million at the \$1/day level and 567 million at the \$2/day level; in sub-Saharan Africa, the number of people living on \$1/day or less doubled between 1981 and 2001 (from 164 million to 313 million), and the number living on \$2/day or less almost doubled (from 288 million to 516 million). Moreover, half of China's estimated poverty decline occurred from 1981 – 1984, before that country's domestic social policy changes and embrace of the global marketplace, and has been attributed to land reform that "gave farmers considerably greater control over their land and output choices" (Chen & Ravallion, 2004:184; Ravallion, 2005). Similar debates surround data on trends in income inequalities, which vary depending on whether one measures trends within countries, between countries or between individuals globally (see e.g. Milanovic, 2003). In any event, calculations by the New Economics Foundation show that, on a global scale growth is a very ineffective way of reducing poverty: "[O]f every \$100 of growth in income per person in the world as a whole between 1981 and 2001, just \$1.30 contributed to reducing poverty as measured by the \$1-a-day line, and a further \$2.80 to reducing poverty between \$1-a-day and \$2-a-day lines"; furthermore, the effectiveness of growth in reducing poverty declined in the 1990s relative to the 1980s (Woodward & Simms, 2006:16). These points should be kept in mind as background to the current development policy rhetoric of "pro-poor growth."

More detailed attention is not devoted here to these debates about trade and growth performance because, for purposes of designing policies and interventions to improve health equity and reduce disparities in SDH, they are scholastic. Trade policy may be just one element of a package of economic policy measures that increase the economic vulnerability of large numbers of people, making its effects difficult to isolate, and even the most ardent enthusiasts of trade liberalization concede that there will be direct economic losers: for example, those whose livelihoods in Zambian manufacturing, Ghanaian poultry production,

¹¹ All currency values in this paper are stated in US\$.

or (in some cases) Mexican corn farming were destroyed by low-cost imports (Jeter, 2002; Henriques & Patel, 2004; Atarah, 2005) and, more generally, those whose work is defined as 'unskilled' (e.g. World Bank, 1995).¹² "[T]he immediate impact of rapid trade liberalization could ... be unemployment, deindustrialization and growing external deficits even though there may be a significant increase in export growth," with the survival of existing industries depending on such measures as "downsizing and labour shedding" (Akyüz, 2005b:6). These observations suggest that labour markets are an important pathway leading from globalization to SDH – an observation familiar from early research on a new international division of labour (Fröbel, Heinrichs & Kreye, 1980) – and also that context-specific quantitative empirical research on labour market effects within national economies and on specific firms, regions and populations provide a more nuanced and distribution-sensitive picture than is available from comparisons of national-level data.

Much research on globalization and labour markets emphasizes the fragmentation and reorganization of production across national borders into global "commodity chains" or "value chains" (Gereffi & Korzeniewicz, eds., 1994; Gereffi, 1995; Gereffi, 1999; Gereffi & Memedovic, 2003; Carr, ed., 2004; Collins, 2005), for which trade liberalization has been a necessary although not a sufficient condition. For example, studies of horticulture and textile and garment value chains in Kenya, South Africa, Bangladesh and Viet Nam provided "no universal conclusion regarding the impact of globalization on poverty" (Jenkins, 2005:18). Much depended on the niches that individual workers, firms and national economic policy were able to carve out in those value chains (Nadvi, 2004; Jenkins, 2005). Substantial opportunities for employment and income gains were associated with integration into global value chains, but conversely: "Global value chain pressures are ... associated with increasing casualization of labour and excessive hours of work" (Nadvi, 2004:25). A separate study applying value chain analysis to the South African furniture industry warned of a future of "immiserizing growth" under almost any plausible set of future conditions (Kaplinsky, Morris & Readman, 2002).

The case of Mexico's *maquiladora* export-oriented manufacturing plants and zones is often cited to illustrate how aggressive pursuit of integration into global value chains can result in growing economic and social inequalities among workers (Hualde, 2004); falling wages and deteriorating working conditions for many or most workers (Cypher, 2001; Cypher, 2004); loss of jobs to jurisdictions, notably China, which can offer even lower labour costs (Anon., 2003); and increased workplace hazards and industrial pollution exposure to which is in turn affected by labour market position (Kopinak & Barajas, 2002; Kopinak, 2002; Frey, 2003). In general some workers, and some sectors of national economies, will be able to gain substantially from economic integration if firms can move up the value chain by engaging in intermediate or final (often more knowledge- and capital-intensive) stages of the production process, where value added is higher. This requires that firms and workers have access to the necessary financial resources, skills ('human capital'), and technology.

¹² It should be emphasized that changes in labour markets that affect SDH are not only, and sometimes not even primarily, directly attributable to trade liberalization; as in other areas of study, it is difficult if not impossible to separate effects of trade liberalization from other elements of globalization that are occurring simultaneously.

This may or may not be the case, and even when it is economic dislocations from the reorganization of production may be substantial because formerly valuable skills and equipment cannot always quickly, frictionlessly or affordably be replaced by those most relevant to the new global marketplace and some workers, firms and regions will almost inevitably be left behind (Akyüz, 2005b).

Cox has argued without reference to specific country data that globalization is dividing labour forces into a hierarchical structure of “integrated, precarious, and excluded” workers (Cox, 1999). According to the United Nations Economic Commission on Latin America and the Caribbean (ECLAC), 1997 survey data from eight Latin American countries¹³ confirm that “the occupational structure has become the foundation for an unyielding and stable polarization of income,” with lower income personal service, agricultural, commercial and industrial workers making up 74 percent of the working population; an intermediate stratum of technicians and administrative employees 14 percent, and higher-income professionals, employers and managers just 9 percent (United Nations Economic Commission for Latin America and the Caribbean, 2000: 61-91). Although connecting this outcome with globalization necessarily involves country-specific investigation, both in Latin America and in other regions, ECLAC does explicitly link “the need to participate competitively in the world economy” to labour market deregulation, increased flexibility, and the growth of economic insecurity (United Nations Economic Commission for Latin America and the Caribbean, 2000: 93-102).

Labour market effects of globalization are also gender-specific. Although poor working conditions for women are cited as a characteristic of *maquiladora* employment (Alarcón-González & McKinley, 1999; Fussell, 2000; Martínez, 2004), some observers of the effects on women of globalization note that: “The reality is that, for many women, working in exports is better than the alternatives of working (or being unemployed) in the domestic economy” (Barrientos, Kabeer & Hossain, 2004:2; see also Kabeer, 2004a; Kabeer, 2004b; Chen, Vanek, Lund & Heintz, 2006). A United Nations Research Institute for Social Development (UNRISD) study of export-oriented employment and social policy in six countries where economic policies have facilitated the expansion of export employment, often in export processing zones (EPZs),¹⁴ found that such employment was associated with some economic gains for women, in terms both of labour incomes and of work-related entitlement to benefits (Razavi, Pearson & Danloy, eds., 2004). However, these gains tend to be disproportionately vulnerable both to economic crises and to systemic, globalization-related pressures for “labour market ‘flexibility’ and fiscal restraint” (Razavi & Pearson, 2004:25). Health consequences of the work itself are another issue: one study of women in Bangladesh found that they “do not necessarily expect to work in garment factories for a prolonged period. Indeed, given the toll taken on their health by long working hours, it would not be possible to undertake such work for an extended period of time” (Kabeer & Mahmud, 2004:151). Thus, globalization’s benefits for women may remain precarious: ‘better than the alternative’ is hardly a ringing endorsement, and does not provide a basis

¹³ Brazil, Chile, Colombia, Costa Rica, El Salvador, Mexico, Panama and Venezuela.

¹⁴ South Korea, China, Mexico, Mauritius, South Africa, and India.

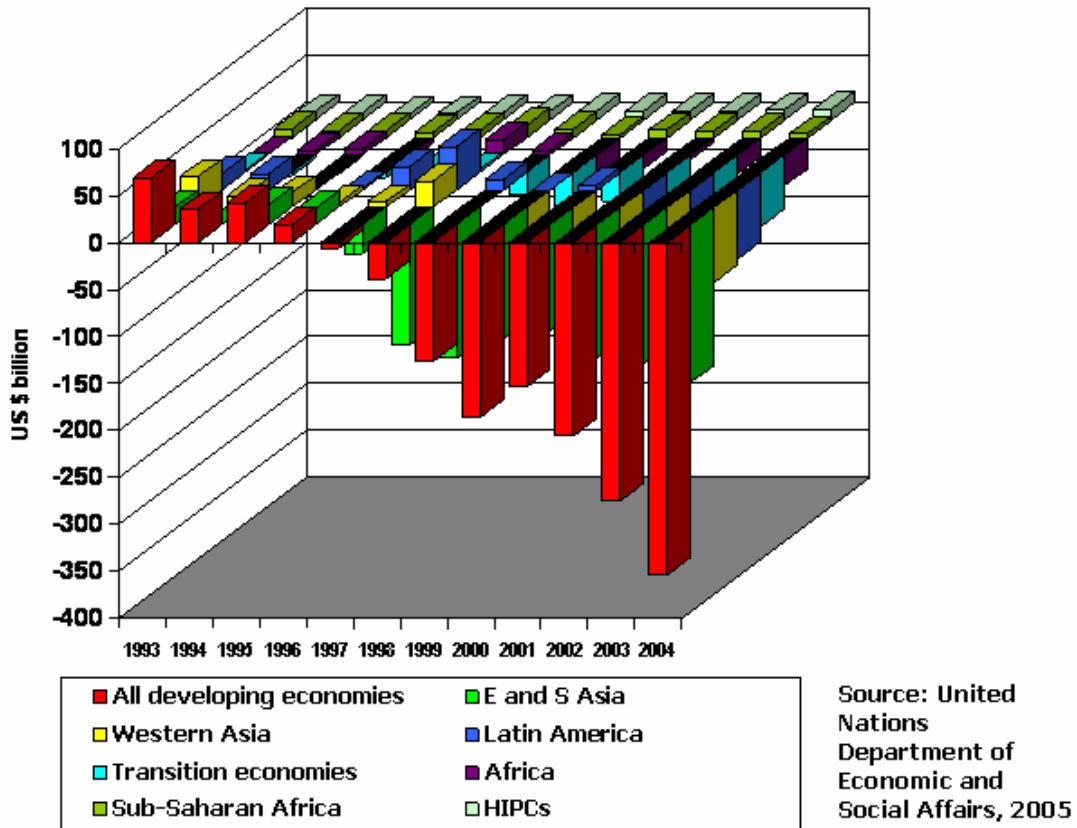
for critically understanding, or resisting, power structures that define the options available for access to employment and livelihood in developing countries.

The UNRISD study is one illustration among many of the need to consider the interplay among multiple elements and consequences of globalization. The South Korean case study, for example, emphasizes the relations among labour markets, social policy, trade agreement commitments, and responses demanded by the International Monetary Fund to the financial crises of 1997-98 (Cho, Zammit, Chung & Kang, 2004). Mexico actively embraced economic integration well before trade liberalization was entrenched through the North American Free Trade Agreement (NAFTA). It did so partly as a response to the first of a series of financial crises (a temporary default on foreign debt in 1982) the origins of which were themselves global, or at least multinational, but the global diffusion of free-market ideology likewise played a role (Babb, 2002; Fourcade-Gourinchas & Babb, 2002). Drastic currency depreciation that occurred because of Mexico's financial crises, and in spite of the policies adopted in response, magnified the direct effects of labour markets on declines in purchasing power and economic polarization within Mexican society (Grinspun & Cameron, 1993; DePalma, 1995; Myerson, 1995; Dussel Peters, 2000). This is just one example of how trade liberalization, the new international division of labour and other elements of globalization are bound up with international financial integration and specifically a succession of 'debt crises'.

11.3 Debt crises, structural adjustment and marketization

A long history of debt crises constrains the ability of many developing countries to invest in public health, education, water, sanitation and nutrition -- part of a larger pattern of financial transfers from the South to the North that contradicts colloquial wisdom about the direction of global financial flows (Figure 2). The Figure shows that, far from being generous with investments and development assistance, the industrialized world has in fact been extracting savings from the developing world with growing effectiveness since the end of the last century. This partly because, as Stiglitz has pointed, the current international financial architecture means that countries routinely hold reserves in low-interest US treasury bills while their businesses and governments borrow from US banks at sharply higher interest rates (Stiglitz, 2003: 66). The picture provided is admittedly incomplete in at least one respect, probably two. First, it has been claimed that the underlying data on financial flows do not include the value of capital flight from developing countries (Greenhill & Watt, 2005). Second, the Figure does not reflect the value of remittances from emigrants to their home countries, which now exceeds the gross annual value of development assistance (Ratha, 2003). However, these two values have opposite signs, and quite possibly cancel one another out on a worldwide basis -- although not necessarily, it must be emphasized, for individual countries or regions.,

Figure 2. Net global financial flows, 1993-2004



The etiology of debt crises varies from country to country and over time (Naylor, 1987; George, 1988; Strange, 1998; Hanlon, 2000), but a stylized list of major causes includes: (a) the oil price shocks of 1973 and 1979-80, which had an especially severe impact on low-income, oil-importing countries; (b) aggressive lending by banks seeking to invest deposits from oil-exporting countries (c) a rapid increase in real interest rates during the early 1980s generated by the monetary policies of the US Federal Reserve, meaning that debtor countries often had to roll over existing debt at much higher interest rates; (d) falling world prices, i.e. deteriorating terms of trade, for the primary commodities that are the key exports of many developing economies; and (e) capital flight, consisting both of outright theft and of the rational, mostly legal shifting of assets abroad by economic elites worried about tax increases and future devaluations.¹⁵ A precondition for the occurrence of debt

¹⁵ Economic historian Thomas Naylor (1987) has commented that: "There would be no 'debt crisis' without large-scale capital flight" (p. 370). More recently, Ndikumana & Boyce estimated that: "During 1970-96, roughly 80 cents on every dollar that flowed into [sub-Saharan Africa] from foreign loans flowed back out as capital flight *in the same year*" (Ndikumana & Boyce, 2003:122, emphasis added). They also calculate that the

crises was and is the willingness of banks, national governments and multilateral institutions such as the World Bank to accord leaders of developing countries what Pogge has called the “borrowing privilege.” This refers to lenders’ practice of allowing leaders to incur debts on behalf of those they rule without inquiring into the legitimacy of their rule, even when leaders have taken power by force or deceit; maintain it by extreme repression; and are not accountable to citizens in any meaningful way (Pogge, 2002).

The term “structural adjustment” entered the international development lexicon in 1980, when the World Bank initiated structural adjustment loans, normally in conjunction with stabilization loans from the IMF, to assist recipient countries to reorganize their economies in order to increase their ability to repay external creditors. The urgency of such lending grew after 1982, when Mexico’s announcement that it was prepared to default on billions of dollars in loans, primarily made by major US banks, raised concern about the stability of financial systems in the industrialized world. Conditionalities attached to such loans, and the associated rescheduling of loan payments to the World Bank and IMF, emphasized reduction of subsidies for basic items of consumption such as food; rapid removal of barriers to imports and foreign direct investment; reductions in state expenditures, particularly on social programmes such as health, education, water/ sanitation and housing; and rapid privatization of state-owned enterprises, on the presumption that private service provision was inherently more efficient, and that proceeds from privatization could be used to ensure debt repayment (Milward, 2000; Babb, 2005). In other words, the IFIs systematically promoted multiple, more or less coordinated domestic policies of integrating national economies into the global marketplace. In keeping with widespread usage (see e.g. Babb, 2005), structural adjustment here refers to the entire set of domestic policies adopted to reorganize national economies in response to the priorities of the IFIs.

Research on the health-related impacts of structural adjustment has encountered at least three design problems. First, implementation of conditions attached to loans from the World Bank and IMF was often incomplete (Killick, 2004) – leaving open at least the theoretical possibility that if the reforms in question had been undertaken even more aggressively, outcomes might have been more favourable.¹⁶ Second, it can be difficult to separate effects of structural adjustment from those of the economic crises that preceded the process. Third, and relatedly, conclusions and policy recommendations depend heavily on the choice of a counterfactual (Huber & Solt, 2004). If the counterfactual is the continuation of business as usual, which would in many cases have involved (continued)

accumulated value of flight capital from 25 African countries between 1970 and 1996, plus imputed interest earnings, was considerably *higher* than the entire value of the combined external debt of those 25 countries in 1996 (Boyce & Ndikumana, 2001). In other words, taking into account privately held as well as public assets, those African countries should be regarded as net creditors rather than debtors vis-à-vis the rest of the world.

¹⁶ The recent history of market-oriented development policy in the two regions of the developing world where it has been pursued most aggressively, Latin America and Africa (Eyoh & Sandbrook, 2003; Kaufman, 2003), further calls the claim of ‘least worst option’ into question. So too does the general pattern of labour market outcomes that have resulted from domestic marketization and export orientation (van der Hoeven & Saget, 2004; Razavi, Pearson & Danloy, eds., 2004).

hyperinflation and the isolation of countries from international financial markets, then structural adjustment may appear as the 'least worst option'. On the other hand, if the counterfactual selected "is a different sort of change from neoliberal change, let us call it for convenience's sake a social democratic model" (Huber & Solt, 2004:150), one's conclusions about the necessity and desirability of structural adjustment are likely to be less sanguine.¹⁷ In the international context, the "social democratic" counterfactual arguably includes assumptions about an international order that is to an extent driven by solidarity or conceptions of obligations that cross national borders, rather than solely by considerations of economic and geopolitical self-interest on the part of powerful nations and powerful groups within them.

A review of studies of the health effects of structural adjustment carried out for the Commission on Macroeconomics and Health (Bremner & Shelton, 2001) found a preponderance of findings of negative effects among 76 studies identified, especially with respect to studies of impacts in Africa. This review understated the case against structural adjustment because of incomplete sampling of the literature: the authors' review of the country cases from the "adjustment with a human face" study was cursory, and they did not consider ethnographic studies (e.g. Schoepf, 1998; Schoepf et al., 2000; Farmer, 2003) and country-level participatory assessments (e.g. Bhattacharya et al., 2002) that shed considerable light on the human consequences of adjustment policies. In addition a larger literature, in much of which the "social democratic" counterfactual is implicit, describes negative effects of structural adjustment on SDH, but does not extrapolate from the conclusions to generate predictions or hypotheses on health outcomes.¹⁸ A stylized summary is that structural adjustment operated on SDH both directly and indirectly. To illustrate, cuts in food subsidies and in government wages and employment had direct negative effects on access to nutrition and on household income. Import liberalization measures may also have had negative impacts on social structure mediated by labour markets, as livelihoods were lost to low-cost imports. The major documented effects on social structure, which are often difficult to trace to specific elements of structural adjustment programs (say, to import liberalization as opposed to cuts in state employment)

¹⁷ See also Stallings (2003). Another illustration of the importance of the choice of counterfactual comes from a recent study that applied standard econometric modeling to the question: What would economic growth have been in sub-Saharan Africa over the past 20 years had its countries not been forced to liberalize their economies by the IFIs and conditions attached to aid (Kraev, 2005; Melamed, 2005)? Based on results from a sample of 22 African countries, the study implies costs of roughly \$272 billion – about the same amount the continent received in aid during this time. According to Christian Aid, the organization that commissioned the study: "Effectively, this aid did no more than compensate African countries for the losses they sustained by meeting the conditions that were attached to the aid they received" (Melamed, 2005:2). Because of the dramatic growth in poverty in this region, noted in section II.2, such findings – like those of Boyce and Ndikumana on the value of capital flight from sub-Saharan Africa, deserve special attention.

¹⁸ For illustrative examples see Simon, van Spengen, Dixon & Nörman, eds., 1995; Cheru, 1999; Adedeji, 1999; Laurell, 2000; Sparr, ed., 2000; Mohan, Brown, Milward & Zack-Williams, eds., 2000; Bhattacharya et al., 2002; Babb, 2005.

have to do with poverty, income inequality and changing gender relations: for example, the disproportionate impact both on women's incomes and on their household activities (see e.g. Alarcón-González & McKinley, 1999; Sparr, ed., 2000). Poverty and economic insecurity, in turn, have multiple effects on exposure and vulnerability, mediated e.g. by housing, working conditions, and access to nutrition and education. Structural adjustment also had important equity-related effects on health systems, by way of expenditure reductions and implementation of cost recovery measures; these are discussed in section II.6.

In addition, it is difficult to separate impacts on SDH of domestic policies that were adopted in specific response to lender conditionalities from those adopted in response to the broader diffusion of market-oriented policy ideas, such as the real or perceived need to implement macroeconomic policies that will attract foreign investment and keep domestic elites from shifting their assets abroad. However this difficulty arguably increases rather than limits the value of the body of structural adjustment research: the form and direction of changes undertaken as part of structural adjustment programs are in most respects congruent with the market-oriented policy shifts that comprise a key element of globalization more generally (Babb, 2002; Babb, 2005). In other words, it might be useful to know how much of a country's social and economic policy orientation in year x can be attributed to responses to the IFIs and how much to national decision-makers' interpretation of the available options within an international economic context over which they often had minimal influence. However, even if it is answerable this question does not alter the fact that if we want to know how globalization affects SDH by way of 'marketizing' domestic social and economic policy, then research on structural adjustment is valuable independent of specific historical connections between IFI conditionalities and policy responses. Indeed, given the breadth and depth of structural adjustment conditionalities, it may be the single most important body of evidence available.

That body of evidence is also valuable prospectively. Poverty reduction has replaced structural adjustment in the official vocabulary of the World Bank and the IMF, but very similar macroeconomic policy directions can be observed in the Poverty Reduction Strategy Papers (PRSPs) that must be approved by the World Bank and IMF before countries can receive debt relief under the Heavily Indebted Poor Countries (HIPC) initiative and its successor program, the Multilateral Debt Relief Initiative (MDRI), both of which are discussed in section III.3. Increasingly, PRSPs are also a condition for receiving bilateral development assistance or concessional loans from the World Bank (Cheru, 2001; Gottschalk, 2004). The potential health benefits of PRSPs include the explicit identification of poverty reduction as an objective of government policy, requirements for civil society participation and other administrative conditions. One recent illustration of a specific benefit is the requirement in the case of Zambia that District Health Management Boards actually receive at least 80 percent of their specified annual budgets (International Monetary Fund & World Bank, 2005:¶120), which apparently had not been the case in the past. On the other hand the macroeconomic policy content of PRSPs, in particular, may be unduly influenced by lender preferences, because of country experience with previous World Bank and IMF conditionalities (Labonte et al., 2004:26-31). A further complication exists because the IMF

has apparently insisted that some countries adopt domestic public expenditure ceilings sufficiently restrictive that they limit spending on health and education, even when the necessary funds have been committed by external donors (Ooms & Schrecker, 2005; Ambrose, 2006). These issues are expanded upon in section III.4.

II.4 The “space of flows” and SDH

Castells (1996) describes contemporary globalization, and in particular contemporary cities, in terms of their situation within a “space of flows” that take little account of national borders and are similarly indifferent to the spatial relationships that were central to earlier forms of economic activity. Flows with direct impacts on health involve people and consumption patterns. The declining cost of international travel means that people (and communicable diseases) move across borders with increasing ease – a phenomenon now familiar from the example of SARS (Pang & Guindon, 2004) and of special concern with respect to influenza transmission (Grais, Ellis & Glass, 2003).¹⁹ The ‘communicability’ of smoking and the associated burden of disease across national borders, by way of trade liberalization and aggressive global tobacco marketing, is also well documented (Taylor, Chaloupka, Guindon & Corbett, 2001; Bettcher, Soll, Subramanian, Grabman, Guindon, Joossens et al., 2001; Bialous & Shatenstein, 2002; Collin, 2002). Less familiar are the contributions of trade liberalization and increased foreign direct investment in food processing and retailing to nutritional transitions in the developing world and the associated rapid increases in obesity (Chopra, 2002; Hawkes, 2005; McMichael, 2005; Hawkes, 2006). This issue is of special importance because of the seemingly paradoxical observation that in many fast-growing regional and national economies obesity, and corollaries such as cardiovascular diseases and diabetes, are more prevalent among the poor than among the rich (Uauy et al., 2001; Monteiro et al., 2004; Ezzati et al., 2005).

High velocity financial flows and the related competition for space and location-sensitive resources have important indirect impacts on health, by way of social determinants. These phenomena instantiate Giddens’ (1990:64) identification of globalization with “an intensification of world-wide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa.” Increased volumes of foreign direct investment (FDI) in actual production facilities have been accompanied by vastly more rapid growth in portfolio investment: investment in financial assets such as shares, bonds, and an expanding range of financial instruments generically described as derivatives. The daily value of foreign currency transactions is now estimated at \$1.5-\$2 trillion. Financial liberalization may be an even more important influence on SDH than trade liberalization, as it exposes national economies to the uncertainties created by extremely large and volatile short-term capital flows (Cornia,

¹⁹ Zygmunt Bauman (1998) makes an important distinction between “tourists” and “vagabonds” in this global flow of people. Tourists have the money and status to “move through the world” motivated only by their dreams and desires. “Vagabonds,” on the other hand, are those less privileged hundreds of millions whose migrations to escape war, famine or poverty, or to pursue opportunity and a better life are not welcome. National borders are increasingly closed to them, except perhaps as temporary or illegal workers.

2001). Crucially, large-scale disinvestment in response to apprehensions about the viability of a particular national economy or currency requires no formal coordination, still less any kind of conspiracy; it can be driven by reliance on similar sources of information, such as credit rating agencies, and incentives for comparable levels of risk aversion.

The resulting effects on the 'real economy' and on SDH have been devastating, undermining the livelihoods of hundreds of millions of people as currencies are devalued, purchasing power evaporates, and restoring the country's creditworthiness in the eyes of investors takes priority over meeting basic needs domestically. This happened in Mexico in 1994-95, as Mexican investors shifted their assets out of Mexican government debt securities and forced further devaluation of the peso (US General Accounting Office, 1996); in south Asia in 1997-98, even among the so-called Tiger economies that were counted among globalization's success stories, after flight from the region's currencies began with speculation against the Thai baht (Bello, Cunningham & Kheng Poh, 1998; Singh, 1999; World Bank, 2000: 47-71) and most recently in Argentina in 2001-02 (Carranza, 2005). The Mexican crisis of 1994-95 reduced the value of the peso by almost half; direct effects on purchasing power were compounded by the wage reductions, workforce economies and public sector austerity measures needed to restore investor confidence (Grinspun & Cameron, 1993; Dussel Peters, 2000; Cypher, 2001). In an especially dramatic example of long-distance effects, investor concern about the stability of all developing country currencies in the wake of crises in Korea (late 1997) and Russia (early 1998) led to a selloff of Brazilian assets that forced a currency devaluation. This happened even though connections between Brazil's economy, and the economic lives of most Brazilians, with events in Korea or Russia were minimal (Gruben & Kiser, 1999; Goldfajn & Baig, 2000).

Using a schematic framework that is analogous to the work of De Vogli and Birbeck on globalization and HIV discussed earlier in this paper, Hopkins (2006) demonstrates that reductions in household income as a result of financial crises in Indonesia, Thailand and Malaysia during the late 1990s led to reduced food intake, health care utilization and education expenditure. Indicative of the potential health effects is a Korean national survey that found substantial increases in morbidity, and decreases in health service utilization, following the 1997 currency crisis (Kim, Chung, Song, Kang, Yi & Nam, 2003). Simultaneously, declining tax revenues led to lower public expenditure on health and education. The combined effect was to increase mortality and reduce longevity – a disturbing reprise of the findings of UNICEF's original "adjustment with a human face" study (Cornia et al., eds., 1987), although the depth and duration of these crises and their impacts on SDH vary considerably, and factors affecting the effectiveness of national policy responses represent an important area for future research.

Long-distance effects of quite a different kind are evident in changing patterns of urban form and settlement. As cities or metropolitan areas are 'globalized,' which is a process quite distinct from that of becoming a so-called world city,²⁰ gaps between

²⁰ For example, North American experience shows that cities may experience major employment losses associated with the process of deindustrialization, accompanied by few of the benefits associated with becoming a major node in global financial and management networks of the kind exemplified by New York, London and Tokyo (Storper, 1997; Reardon,

economic winners and losers grow. This happens not only because of urban job losses associated with deindustrialization, but also because access to essential resources is determined by households' ability to pay, or by group/neighbourhood attractiveness as a market. Residential segregation deepens through gentrification, suburbanization, and the creation of fortified enclaves with separate private systems of service provision, while those less able to pay are shifted to less desirable locations and rely on inferior services. Key policy choices about urban services that define the boundaries of inclusion/exclusion involve transportation, specifically the balance between public transit and car-centred development (see e.g. Leaf, 1996; Alcantara de Vasconcellos, 2005; Pucher, Korattyswaropam, Mittal & Ittyerah, 2005) and accessibility and affordability of the broadband connections that are an increasingly indispensable gateway to the information society. Urban 'revitalization' may include not only policies that favour more desirable (read: higher-income) residents, but also reconfiguration of urban space in pursuit of profitable commercial development and tourism revenues, similarly leading to displacement of residents and sometimes the literal enclosure of public spaces (see e.g. Leaf, 1996; Makdissi, 1997; Vasconcellos, 1997; Bunnell & Nah, 2004; Fernandes, 2004; Lakshmi, 2005). Poverty may be criminalized (Wacquant, 2001; Wacquant, 2002). These processes are documented in an indispensable UN Habitat synthesis on *Cities in a Globalizing World* (United Nations Centre for Human Settlements, 2001), hence the lack of more extensive references here. Bidding contests for urban spaces that epitomize that interaction of global power relations and local opportunities are paralleled by contests over locationally valuable non-urban resources, notably those associated with the expanding business of tourism. These contests can exclude current, low-value or low-productivity users of a resource either by degradation, e.g. by using surface or ground water as a sink for the disposal of toxic wastes (Stonich, 1998), or by enclosure, e.g. by pricing the use of specific locations and resources out of reach of all but the wealthy (Griffith, 2000; Richter, 2001; Leatherman & Goodman, 2005). The common analytical denominator in these conflicts is that in the global marketplace, some resources simply command too high a price to be used for the basic needs of people with limited purchasing power.

II.5 Environment, resources, and SDH

The unprecedented scale of recent human impacts on the natural environment (Turner, Clark, Kates, Richards, Matthews & Meyer, eds., 1993), exemplified by the case of global climate change, is in itself an important health-related dimension of globalization. On a smaller scale, exposures to environmental hazards that arise from the operation of the global marketplace comprise an important and complex set of influences on SDH. Economic competition for scarce and valuable resources and ecosystem services is one mechanism mediating those exposures. At least two mechanisms can be identified: (a)

1997; Adams, 1997; Warf & Holly, 1997). Even within such world cities, distribution of gains and losses is massively unequal, driven by such factors as dramatic increases in residential real estate values, wage polarization, a shift to less secure forms of employment and a general trend towards welfare minimalism.

urbanization and intra-urban disparities in exposure to such hazards as vehicle traffic and air and water pollution, and (b) global migration of hazardous industries, production processes and waste. Some authors argue that “agroindustrialization” as production is reorganized into global, input-intensive commodity chains, constitutes yet another mechanism (Barrett, Barbier & Reardon, 2001). To some extent these pathways overlap or interact with other elements of globalization, as when agroindustrialization and associated environmental damage are driven by the imperative of increasing revenues from exports destined for foreign consumers. For example, Stonich and Bailey (2000:23-24) argue that pressure to increase export earnings leads governments to promote “export-oriented aquacultural development regardless of the social and environmental consequences,” creating situations in which “the increasing use of low-value fish species in the production of fishmeal for aquacultural feeds in effect puts the poor in competition with shrimp,” and with the rich consumers who can afford to buy them (see also Stonich & Vandergeest, 2001).

The situation described above affirms a pattern noted by the health synthesis of findings from the Millennium Ecosystem Assessment (MEA) project,²¹ in which: “Historically, poor people disproportionately have lost access to ecosystem services as demand from wealthier populations has grown” (Corvalan et al., 2005:28). This process may affect both social stratification, as when access to livelihoods is limited, and differential exposure and vulnerability to such risk factors as undernutrition and economic (in)security, as the structure of opportunities and access to ecosystem services changes within local economies. The approach described as political ecology or “political ecological analysis” may be especially appropriate for the study of such situations: it “consists of an integrated explanation of human-environmental interactions linked through different scales from the international/global to the local; centres on the relative power of various social actors (stakeholders) involving access to, and management of, natural resources; and links these actors within and among levels through relations of power” (Stonich, 1998:29, citations omitted). Another discussion of political ecology in the recent literature (Gray & Moseley, 2005) emphasizes considerations of scale. The difference globalization makes is that winning bidders may be half a world away, as in Stonich’s aquaculture example and in the case of markets for tropical timber, oil in Nigeria (a paradigmatic situation where abundant resource revenues have failed to improve the grinding poverty and poor health status of much of the country’s population), and coltan and other minerals in the Democratic Republic of the Congo (Sizer & Plouvier, 2000; Montague, 2002; United Nations Security Council, 2002; United Nations Security Council, 2003; Gellert, 2005; Watts, 2005; Ferguson, 2005).

In many such situations, as globalization increases aggregate demand for marketable resources and ecological services, it simultaneously fosters policies and institutions (e.g. transnational resource corporations) that facilitate control over gains and losses across entire regional economies by local elites and the dominant actors in global

²¹ See: <http://www.millenniumassessment.org> . The MEA’s conceptual framework explicitly recognized economic globalization as one of the drivers of change in ecosystems and human well-being by way of various causal pathways, and each of the four scenarios on which the MEA was based (“Global orchestration,” “Order from strength,” “TechnoGarden” and “Adapting mosaic”) incorporates alternative assumptions about the future direction of globalization.

commodity chains (see e.g. United Nations Security Council, 2002; United Nations Security Council, 2003). Analysis of investment in developing countries by transnational logging companies in response to increasing global demand for tropical timber was strongly critical of the sustainability of forest management practices, and further noted that: "Where analysis is available ... the economic benefit is minor, even in the short-term, and certainly far less than it could be if contracts were structured and negotiated differently. While large amounts of capital are involved, the revenue to national treasuries can be small because most of the profits leave the country or accrue in the hands of very few, often already wealthy and powerful local people" (Sizer & Plouvier, 2000:29, citations omitted). Transnational firms in the mineral industry, in particular, are often the beneficiaries of large-scale financial support from export credit and insurance agencies in their 'home' (industrialized) countries (Rich, Horta & Goldzimer, 2000; Moody, Gedicks, Smith, Bank Information Center, Bosshard, Membup et al., 2005) – an element of global influence that appears to have received little research attention outside a rather specialized community of CSOs.

The MEA health synthesis further noted a separate set of differential exposures and vulnerabilities: "Poor populations are more vulnerable to adverse health effects from both local and global environmental changes" (Corvalan et al., 2005:27), first of all because they are more likely to be exposed to hazards from which the rich can remove themselves. Disasters in Bhopal and New Orleans provide dramatic evidence of this point, as do the routine conditions of urban life for literally hundreds of millions of people²² worldwide (Stephens, 1996). Health effects in the urban environment arguably constitute a subset of the broader effects of poverty and economic inequality on SDH, but may demand and respond to distinctive types of intervention. It may further be useful to distinguish effects of consumption (e.g., those associated with vehicular traffic) from those associated with agricultural and industrial production and waste disposal. A useful paradigm for identifying such distinctions and researching the relevant impacts, although it was not specifically urban-oriented, is provided by a conceptual framework for assessing the environmental effects of trade liberalization in the Mediterranean region (Mediterranean Commission for Sustainable Development, 2001)

Some studies find a clear pattern of migration of hazardous industries to lower-income countries, notably to export processing zones (EPZs) (Kopinak & Barajas, 2002; Frey, 2003). Other, quantitative studies that do not focus on particular regions suggest that evidence for the emergence of industrial "pollution havens" is equivocal or absent (Wheeler, 2001; Cole & Elliott, 2005). An impressionistic assessment of such 'negative' findings is that many are compromised by (a) failure to focus on the global restructuring of production within specific industries or sectors; (b) concentration on foreign direct investment (FDI), without considering contractual arrangements such as outsourcing that are not recorded in

²² It is estimated that more than 850 million people now live in slums, with the number projected to rise to 1.4 billion in 2020 (UN Millennium Project Task Force on Improving the Lives of Slum Dwellers, 2005). Slum residence is an imperfect, but nevertheless probably useful proxy for exposure to urban environmental hazards including not only industrial pollution but also the collapse of a rain-soaked open rubbish dump that killed some of the residents of Manila's informal settlements in 2000 (Aglionby, 2000; Mydans, 2000).

FDI statistics but are extensively described in the literature on commodity or value chains; (c) inability to distinguish causal effects of lax environmental regulation on relocation of production (what the pollution haven hypothesis is all about) from those of other variables, such as low wages and flexible working conditions, that tend to operate in parallel; and (d) failure to distinguish between changes in pollution exposures attributable to industrial processes and to such factors as increased vehicular traffic.²³ Substantial evidence also exists of the emergence of a global trade in hazardous wastes, with disposal in low-income countries becoming increasingly attractive and met with policy responses that are at best only partially effective (Clapp, 2001; Puckett, Byster, Westervelt, Gutierrez, Davis, Hussain et al., 2002; Clapp, 2002; Iles, 2004).

In the background is the question of whether such environmental changes and their health impacts should be regarded as normal, in the sense that they are comparable to those undergone by the industrialized countries at comparable stages of their own economic development. Evidence of the extent to which contemporary technology allows for “technological leapfrogging” (Goldemberg, Johansson, Reddy & Williams, 2001) and “dematerialization” (Ayres & Ayres, eds., 2002), which avoid many environmentally destructive forms of industrial production and consumption, suggests that this conclusion should be rejected. Analogously with the use of the “social democratic” counterfactual in the case of structural adjustment programs, environmental and resource impacts can be considered with reference to a green counterfactual that assumes transfer of clean technologies on favourable terms, along with serious efforts by the industrialized economies to reduce their consumption of natural resources and ecological services, and to adopt policies that minimize negative environmental and resource impacts outside their borders. Thus, globalization’s negative effects on SDH that operate by way of the environment, like those that operate in other ways, must be regarded primarily as consequences of political choices and avoidable failures of governance.

II.6 Health systems in the global marketplace

Health care interventions that would be taken for granted in the industrialized world are routinely unavailable, or available only to rich minorities, outside it (Farmer, 1999; Farmer, 2003). Multilateral institutions like the World Bank have historically worsened this situation by promoting and reinforcing a market-oriented concept of health sector reform (HSR) that strongly favours private provision and financing (Mackintosh, 2003; Petchesky, 2003; Koivusalo, 2005; Lister, 2005). Reductions in public sector health spending, introduction of user fees, and other cost recovery measures aimed at making health systems financially self-sustaining were often mandated as part of structural adjustment conditionalities (Loewenson, 1993; Lundy, 1996; Schoepf et al., 2000; Kim, Shakow, Bayona, Rhatigan &

²³ Pollution exposures resulting from increased vehicle traffic may also be consequences of globalization, e.g. as it supports a growing ‘middle class’ and associated settlement patterns, but these consequences are analytically separable from the industrial migration or pollution havens hypotheses.

Rubin de Celis, 2000; Bassett et al., 2000) despite their regressive impacts.²⁴ The best that can be said for official user charges is that they may replace informal, and even more inequitable patterns of side payments demanded by care providers or suppliers of medicines (Killingsworth, Hossain, Hedrick-Wong, Thomas, Rahman & Begum, 1999; Ensor & Witter, 2001; Akashi, Yamada, Huot, Kanal & Sugimoto, 2004). Conversely, their effectiveness in generating revenue is limited, even while access to health care for the poor and otherwise vulnerable often deteriorates²⁵ because very large numbers of people in the developing world simply cannot afford necessary health care (Narayan et al., 2000; Whitehead et al., 2001). For example, national survey data in Mexico indicate that 51.8 percent of people who did not seek medical care for severe illness gave cost, or their own lack of money, as a reason (Leyva-Flores, Kageyama & Erviti-Erice, 2001). A smaller scale study of patterns of health service utilization in Lusaka, Zambia found that costs were the most commonly given reason for choosing self-medication as a first resort in case of illness, and also the most common reason for non-compliance with treatment regimes following a visit to the centralized university teaching hospital (Atkinson, Ngwengwe, Macwan'gi, Ngulube, Harpham & O'Connell, 1999). Ethnographic research and the experiences of front-line care providers (Farmer, 1999; Mill & Anarfi, 2002; Farmer, 2003) support the conclusion that the issue is often not one of unwillingness to pay, but rather of inability to pay, and understandable reluctance to sell off assets that may be critical to the household's economic survival (Russell, 1996; Narayan et al., 2000).

Marketization of health systems under the influence of external agencies may also have had the effect of emphasizing commodified interventions and 'vertical,' disease-specific programs at the expense of integrated approaches that incorporate SDH. For example the Global Fund to Fight AIDS, Tuberculosis and Malaria, represents the industrialized world's leading initiative in this field, "targets 49% of its expenditure on drugs and commodities such as antiretrovirals and new antimalarials but only 20% on human resources and training" (Sanders, Todd & Chopra, 2005: 756), even though human resource constraints are recognized with increasing frequency as the single most formidable challenge to improving the quality and comprehensiveness of health care in Africa (Chen, Evans, Anand, Boufford, Brown, Chowdhury et al. 2004; Friedman, 2004; Joint Learning Initiative, 2004). Marketization of health systems may also compromise progress in other health-related areas such as poverty reduction. Viet Nam is often cited as an example of the poverty-reduction benefits of embracing the global marketplace, yet health indicators reflect the 'double burden of disease' phenomenon (United Nations Country Team Viet Nam, 2003); opening up

²⁴ In its commendably equity-oriented 2006 *World Development Report*, the World Bank has now acknowledged the inequity of relying on user fees and private purchase of health care (World Bank, 2005b:146-149), even as it continues to promote private health insurance in developing countries in conjunction with the financial services industry (World Bank, 2005a).

²⁵ For reviews see Creese, 1991; Gilson, 1997; Creese & Kutzin, 1997; Lister, 2005; Homedes & Ugalde, 2005. Key case studies include Laurell, 1991; McPake, Hanson & Mills, 1993; Bloom, 1998; Barrientos & Lloyd-Sherlock, 2000; Kim et al., 2000; Gilson, Kalyalya, Kuchler, Lake, Oranga & Ouendo, 2001; Liu, Rao, Evans, Chen & Hsiao, 2001; Hung, Dzung, Dahlgren & Truan, 2001; Laurell, 2001; Bloom, Lu & Chen, 2002; Wadee, Gilson, Thiede, Okorafor & McIntyre, 2003; Liu, Rao & Hsiao, 2003.

of domestic markets has been accompanied by the dismantling of relatively equitable systems for social and economic provision (Bloom, 1998; Hung et al., 2001; United Nations Country Team Viet Nam, 2003); and "[o]ut-of-pocket payments for health care pushed 2.6m [million] Vietnamese into poverty in 1998" (Wagstaff & Yazbeck, 2004). Whatever the economic gains from China's domestic social and economic policy reforms, a survey of several Chinese provinces found that the percentage of women with insurance coverage for prenatal and delivery services fell from 58.3 percent in 1989 to 34.7 percent in 1997; overall access to insurance coverage, already available to just one in four Chinese in 1989, continued to decline slowly through the 1990s (Akin, Dow & Lance, 2004). The public share of health expenditures fell by over half between 1980 and 1998, almost trebling the portion paid by households (Liu et al., 2003), leading to the growth of private delivery systems for those who could afford them, and increased cost-recovery for services that were still under some form of public health insurance. The result was an increase in the number of people who fell into poverty by exhausting their income and savings to pay for medical treatment (Liu et al., 2003) and a slowdown in China's population health improvements, particularly infant mortality and life expectancy (Akin et al., 2004). It remains to be seen whether recent initiatives to reverse deterioration in access to health care for the poor, notably in rural areas, will be effective (Office of the World Health Organization Representative in China, 2005:15-19; Liu & Rao, 2006)

Four further dimensions of globalization's effects on health systems must be considered. First, despite a WTO interpretation of TRIPS that limits patent protection for essential medicines, concern remains about the effectiveness of this interpretation as reflected both in national legislation (in countries with substantial pharmaceutical industries) and trade policy practice (in countries without) (Pollock & Price, 2003a). Second, commitments made under the General Agreement on Trade in Services (GATS) and bilateral and regional agreements such as NAFTA have the potential to lock in privatization initiatives against future governments' efforts to expand public provision or insurance (Price, Pollock & Shaoul, 1999; Pollock & Price, 2003b), although disagreement exists about the seriousness of this prospect. Third, the 'brain drain' of health professionals from developing countries, in particular those in sub-Saharan Africa, to industrialized countries where they can earn far more is now recognized as one of the most serious problems confronting health systems (Huddart & Picazo, 2003; Chen et al., 2004; Friedman, 2004). Solutions remain elusive because the situation reflects a bidding contest for the services of health professionals that is analogous in many respects to the bidding contests for urban space and locationally valuable resources described in the preceding section. Fourth, allocation of health research priorities based on the availability of privately held resources is highly problematic on health equity grounds. As noted in section III.2, private for-profit firms (mainly pharmaceutical firms) now outspend governments worldwide on health research (Burke & de Francisco, eds., 2004; Global Forum for Health Research, 2004:112); the Bill and Melinda Gates Foundation had more money at its disposal than the World Health Organization (Kickbusch, 2004) even before its recent windfall from the assets of Warren Buffett; and public funding agencies in many industrialized countries link their priorities to the anticipation of commercial returns. The result is the so-called 10/90 gap: roughly 10 percent of health

research spending addresses conditions that account for 90 percent of the global burden of disease, overwhelmingly outside the industrialized world. Of 1556 new drugs (new chemical entities) marketed between 1975 and 2004, only 21 were for neglected diseases, malaria and tuberculosis (Chirac & Torreele, 2006). Thus, in setting priorities for scientific research as in other areas of the global marketplace, “money talks louder than need” (United Nations Development Programme, 1999:68-76).

III. Promoting health equity in global governance

III.1 Introduction

In the first part of this paper, we identified and defended an economically oriented definition of globalization and addressed a number of important conceptual and methodological issues. In the second, we identified and described five key ‘clusters’ of pathways relevant to globalization’s influence on SDH. This discussion demonstrated that interventions to reduce health inequities by way of SDH are inextricably linked with social protection, economic management and development strategy. It follows that when the objective is to reduce health inequities by way of SDH, the scale at which an intervention must be implemented is not necessarily the scale at which the problem arises. For example, addressing the poverty of individuals and households may demand policy responses on the part of state/provincial and national governments, yet they may be limited in their ability to act effectively because of constraints that are created by, and can best be changed by, actors outside their national borders, such as multilateral institutions or institutional investors. This interconnectedness is a distinguishing characteristic of contemporary globalization, and provides the basis for Pogge’s argument that the industrialized world has an ethical obligation to reduce poverty outside its own borders (Pogge, 2001). We do not mean here to write domestic political action out of the picture; far from it. As noted in sections I.3 and I.4, Szepter’s work on industrializing England shows that the formation of effective domestic political coalitions was necessary to the translation of economic growth into improved population health status. However globalization shapes the environment within which such coalitions operate, and arguably affects their chances of success in a variety of ways.

Superficially, the times should be promising for transforming recognition of how globalization can undermine health into policies that prevent the damage and ensure that economic gains lead to widely shared improvements in SDH. In 2000, a resolution of the UN General Assembly committed the international community to achieving the Millennium Development Goals (MDGs), by the year 2015 in most cases. Three of the Goals, which involve reducing child and maternal mortality and reversing the spread of HIV/AIDS, malaria, and other communicable diseases, are explicitly health-related. Four others directly address crucial social determinants of (ill) health: extreme poverty, undernourishment, environmental hazards, and lack of access to education. Targets that have been developed with respect to each of the goals state more specific milestones, such

as reducing by half the proportion of the world's people without access to safe drinking water.²⁶

The MDGs arguably represent a 'first' in terms of commitments by the international community to a specific development agenda. The MDGs are nonetheless unambitious when viewed against the sheer volume of unmet basic human needs. Notably, Pogge (2004) has demonstrated the modesty of the poverty reduction target (reducing by half, in the year 2015, the proportion of the world's people living on less than \$1/day) when viewed against the background of expanding global affluence. Similarly, compare the MDG 7 target of improving the lives of 100 million slum dwellers per year by 2020 with the estimate that if present trends continue, 1.4 billion people worldwide will be living in slums in 2020 (UN Millennium Project Task Force on Improving the Lives of Slum Dwellers, 2005).²⁷ On the other hand, the MDGs are ambitious when viewed against the uneven pace of recent progress toward meeting the needs they address. Substantial progress has been made toward achieving the MDG targets in some regions. In others, especially sub-Saharan Africa, the situation is grim (Wagstaff, Claeson et al., 2003; Jamison, 2006:7). Recent syntheses of available evidence, notably those of the UK Commission on Africa and the UN Millennium Project, describe an emerging consensus that if the MDG targets or comparable improvements in human well being are to be achieved, then substantial long-term commitments of additional resources by the industrialized countries are necessary (UN Millennium Project, 2005; Commission for Africa, 2005; see also Wagstaff, Claeson, Hecht, Gottret & Fang, 2006:190-192). Because of the increasingly dense network of trade and investment flows that links rich and poor across national borders, achieving the MDGs or comparable goals will also require revamping the trade and foreign policies of the industrialized world to ensure compatibility with progress toward the MDGs and other objectives related to basic needs, and to address the "asymmetrical" distribution of gains, losses and power that is characteristic of globalization in its current form (Birdsall, 2006a; Birdsall, 2006b).

This asymmetry has several dimensions. In the case of trade policy, for instance, many developing countries are unable to maintain missions at the WTO in Geneva at all, much less to afford the professional expertise that is needed not only to participate effectively in multiple trade negotiations but also to pursue dispute resolution (Jawara & Kwa, 2003) – creating a strong case based on fairness for expanded assistance in capacity building. It is more difficult to get around the asymmetry created by differences in market size as it affects not only initial bargaining positions but also the ability to make use of dispute resolution even when the outcome is favourable. "The sanction for violating a WTO agreement is the imposition of duties. If Ecuador, say, were to impose a duty on goods that it imports from the United States, it would have a negligible effect on the American

²⁶ For a list of the Goals and derivative targets, see <http://www.un.org/millenniumgoals/goals.html> .

²⁷ A further problem is that, apart from MDG 3 on gender equity in education, the MDGs are stated in terms of societal averages – meaning that a country may be able to achieve MDG targets related to health, such as under-5 mortality, while failing to improve the health status of the worst-off groups (Moser, Leon & Gwatkin, 2005; Gwatkin, 2005).

producer; while if the United States were to impose a duty on goods produced by Ecuador, the economic impact is more likely to be devastating” (Stiglitz & Charlton, 2004:504).

There follows a generic overview of key policy imperatives and opportunities. It is incomplete in at least two respects. First, it focuses on policy actions at the international level, rather than on mitigative or compensatory policies that can be adopted at the national or subnational level, apart from a discussion (in section III.7) of the extent to which the international economic and political context constrains such national and subnational policy space or capacity. Second, it focuses on eliminating current barriers and constraints rather than on opportunities associated with the potential emergence of new forms and institutions of global governance. Those opportunities represent an important area for building research collaborations and communities of practice that link development policy, clinical disciplines, population health and social science fields such as international relations.

III.2 Making more resources available for equitable access to health systems

A focus on social determinants of health must not divert attention from the fact that health care and public health interventions matter, and an immediate imperative is to make more resources available to deliver them. This point has been understood for many years. The Commission on Macroeconomics and Health (Jha, Mills, Hanson, Kumaranayake, Conteh, Kurowski et al., 2002) estimated in 2001 that routinely providing a package of basic, relatively well understood low-cost and low-tech interventions, costing \$34 per capita per year and comprising “a rather minimal health system,” could save “at least 8 million lives *each year* by the end of this decade” (Commission on Macroeconomics and Health, 2001:11, 55; emphasis in original). This figure must be compared with average national health expenditure of \$24 per capita in 2001 in jurisdictions that the World Bank defines as low income countries, where 2.2 billion people live. For half of those people, annual per capita spending on health was \$14 per capita or less.²⁸ Not all of this expenditure, of course, involves services for the poor or otherwise vulnerable, and not all of it is public spending: recall the pervasiveness of “medical poverty traps” and consider that in Viet Nam, which we have mentioned earlier, *public* health care expenditure stood at less than \$4 per capita in 2001 (United Nations Country Team Viet Nam, 2003) – reflective of a general and ironic trend for private, out-of-pocket payment to comprise a high proportion of total health expenditure in many of the world’s poorest countries.

The Commission on Macroeconomics and Health and, more recently, the Commission for Africa and the UN Millennium Project all argued strongly for a several-fold increase in the value of development assistance for health, focused on improving access to basic interventions. The Commission for Africa (2005:196) was also explicit in recommending that elimination of user fees be supported by long-term donor financing commitments – often essential if the increased use of services that follows the elimination of financial barriers is not to create demands that already overstressed public health systems cannot meet. The

²⁸ Based on national health expenditure and population data from World Bank Health, Nutrition and Population (HNP) database, <http://devdata.worldbank.org/hnpstats/>, accessed May 9, 2006.

need for such commitments underscores the fact that many low-income countries will require substantial development assistance for many years, probably for decades, if their health systems are to be financed at the minimum level identified by the Commission on Macroeconomics and Health (Ooms, 2006). The urgency of providing such additional resources is clear and should not require further elaboration.

However, rich countries have so far not even lived up to the rhetoric associated with their highest profile initiative to increase support for health in the developing world. The Global Fund to Fight AIDS, Tuberculosis and Malaria was hailed at the 2001 G8 Summit as a "a quantum leap in the fight against infectious diseases," yet the Fund continues to lack a long-term financing mechanism, relying instead on periodic replenishment meetings that in effect involve passing a hat, and has estimated that it will need \$7.1 billion in 2006 and 2007 to fund new proposals and continuations of existing work (Benn & Schwartlander, 2005). The September 2005 replenishment meeting raised the total value of funds pledged for 2006-2007 to \$3.73 billion, or just over half the anticipated funding requirement for those years (Global Fund to Fight AIDS, 2005). This creates serious constraints on what activities the Fund can support even after scientific merit has been demonstrated, since the Fund "can only approve grants if the full amount required for the first two years is covered by pledges from donors in the calendar year of the approval" (Benn & Schwartlander, 2005:34). The Fund itself now estimates that future funding requirements could be as high as \$7-8 billion per year (Benn & Schwartlander, 2005:32), and a stable source of long-term financing, such as a global trust fund, is still not in place.

Provision of public goods related to health presents distinctive problems. In common usage, the phrase "public good" is often associated with the common welfare, or with such values as equity and social justice. Its definition in economic theory is more precise: a *private good* (either a service or a good in the physical sense) is one whose individual consumption is both excludable (my use of the good is not dependent on others' use) and rivalrous (my use of the good could preclude use by another). Conversely, a *public good* is one that is non-excludable (classic illustrations are the order created by traffic lights and, from the days before GPS, the safety benefits of lighthouses) and, in pure form, is non-rivalrous (my use of the traffic light or lighthouse in no way impairs your use of it). Few pure public goods exist and public policy choices, which may vary over time, often determine the balance between private and public characteristics of a good (Kaul & Mendoza, 2003; Desai, 2003).

Although health itself is not a public good, numerous public goods *for* health exist, including scientific knowledge and communicable disease control. The terminology of global public goods for health (GPGH) is now in widespread use, but a recent WHO research initiative (Smith, Beaglehole, Woodward & Drager, eds., 2003) concluded that many public goods for health are in fact regional, rather than global. Malaria control is a case in point (Woodward & Smith, 2003:23); since malaria is primarily a disease of poor regions, this fact may account for the serious underfunding of attention to malaria control on the part of the industrialized world (Narasimhan & Attaran, 2003). The key point is that whether global or regional, many public goods for health, such as communicable disease control (including vaccination) and control of antibiotic resistance, are conspicuously undersupplied in the

global marketplace, reflecting the “dramatic decay in local and global public health capacity” identified by the United Nations High Level Panel on Threats, Challenges and Change (2004). In theory scientific knowledge is a quintessential public good, yet in practice it is often ring-fenced by mechanisms such as intellectual property rights. This is arguably both cause and consequence of increased reliance on private financing of health research: in 2001, private for-profit companies spent \$51.2 billion on health research, as against \$46.6 billion in public spending (Burke & de Francisco, eds., 2004:x), but as noted in section II.6, priorities for privately financed research are far more likely to be shaped by anticipated profit than by contribution to reducing the global burden of disease. A further complication arises from the fact that potential for commercialization is an increasingly important criterion for purposes of at least some national, publicly financed granting agencies. Commercially oriented research priorities are likely entirely to ignore interventions both within and outside the health sector that address disparities in SDH, since they intrinsically not amenable to commercialization. Thus, it is imperative to develop new mechanisms for financing health research that do not rely on the anticipation of profit and avoid the resulting skewing of priorities; reform of national and international intellectual property regimes is arguably a part of such necessary reforms (Baker & Chatani, 2002; Baker, 2004; Baker, 2005), but just a part (see e.g. Webber & Kremer, 2001).

III.3 Expanding and improving development assistance

The need for more resources for health systems and to support provision of health-related public goods is just one argument among many for increasing the value of official development assistance (ODA). ODA is the most visible and conspicuous transfer of resources from rich to poor countries, although as noted in section II.3 it is far from being the single largest contributor to international financial flows. The UN Millennium Project and the UK Commission for Africa each concluded that an approximate doubling of current ODA spending is necessary, although not sufficient, if much of the developing world is to have a chance of achieving the MDGs (UN Millennium Project, 2005; Commission for Africa, 2005). The Millennium Project report was also noteworthy for recommending major changes in how ODA spending is directed in order to increase its relevance to the MDGs, thereby lending support to long-standing criticisms of aid agencies for providing assistance for specific projects rather than as general budget support and for the multiple reporting requirements they demand of recipients (UN Millennium Project, 2005:193-210). At their 2005 Summit, the G8 countries committed themselves to an additional \$25 billion in development assistance to Africa by 2010; this commitment can be read as a direct response to the report of the Commission of Africa, which was part of the British Prime Minister’s initiative to situate African development as one of the main items on the Summit’s agenda. It remains to be seen how effectively the G8 will live up to the Gleneagles aid commitments, and whether the increase will come at the expense of aid flows to other regions of the world, where national-level statistical indicators may be less bleak but poverty and other deficiencies in access to SDH are nevertheless widespread.

Some commentators were and are sceptical about the value of these commitments for a different reason. They argue that domestic governance failures, capacity limitations, and the tendency of African countries in particular toward what have been called “neopatrimonial systems of rule” (van de Walle, 2001) will render such inflows ineffective if not destructive (deRenzio, 2005; Killick, 2005). The Commission for Africa and the Millennium Project each examined the evidence and made numerous recommendations for improving the effectiveness with which aid is used to achieve the MDGs and similar objectives, which cannot be reviewed in this paper. A more important point is that each group directly challenged fashionable scepticism about the value of development assistance, crucially emphasizing *donor* policies and practices as constraints on aid effectiveness. The Millennium Project report further pointed out the irony that “the notion of taking the [Millennium Development] Goals seriously remains highly unorthodox among development practitioners” *because of a* lack of financial support from the industrialized world (UN Millennium Project, 2005:202). In a direct rejection of received wisdom that weak governance or “absorptive capacity” constraints seriously limit the potential benefits from short-term increases in development assistance, its discussion of Africa argued that the quality of governance in African countries is comparable to that in other regions with similarly low incomes, noting that “good governance requires resources for wages, training, information systems, and so forth” (UN Millennium Project, 2005:146). Important changes in delivery mechanisms and funding criteria to improve the effectiveness of aid in contributing to health equity can and should be made (e.g. Hecht & Shah, 2006). However, the Millennium Project and the Commission for Africa have decisively shifted the burden of proof to those resisting substantial new ODA commitments to show how meaningful improvements in health equity and access to SDH can be achieved in the absence of such commitments, and to the rich countries to demonstrate mechanisms for making the necessary resources available without compromising their effectiveness through ties to their own economic and strategic interests.

III.4 Expanding debt relief and taking poverty reduction (more) seriously

External debt remains perhaps the most serious constraint on aid’s effectiveness: “dozens of heavily indebted poor and middle-income countries are forced by creditor governments to spend large parts of their limited tax receipts on debt service, undermining their ability to finance investments in human capital and infrastructure. In a pointless and debilitating churning of resources, the creditors provide development assistance with one hand and then withdraw it in debt servicing with the other” (UN Millennium Project, 2005:35). In every region of the developing world except sub-Saharan Africa, inflows of development assistance are more than offset by the annual outflow of debt service payments to external creditors (Pettifor & Greenhill, 2002). Over the last ten years, the rich countries have offered gradually increasing levels of debt cancellation to a limited number of the world’s poorest countries through the Heavily Indebted Poor Countries (HIPC) initiative. Although debt cancellation for HIPCs has made possible increases in public spending on such basic needs as health and education in several recipient countries (Gupta, Clements, Guin-Siu & Leruth,

2002), many HIPC's have seen only modest decreases in their debt service obligations, and three have actually seen *increases* (United Nations Department of Economic and Social Affairs, 2005:148). In addition, the eligible countries are not those where a majority of the world's poor people live: many other countries are not statistically desperate enough to qualify, despite high levels of poverty and high external debt burden (Hanlon, 2000; Labonte & Schrecker, 2004). Both limitations arise from the fact that a "sustainable" debt load has been defined for purposes of the HIPC initiative with reference to a ratio of debt service to annual export revenues, based on what have often turned out to be optimistic projections of export earnings and commodity prices.

This debt sustainability criterion was adopted at the insistence of the G7, "balancing the need to include strategic G7 allies and the desire to help keep costs down" (Martin, 2004:17-18). Various refinements of this criterion are now under consideration (United Nations Department of Economic and Social Affairs, 2005:152-154), but none explicitly incorporates the alternative principle of working backward from the value of government expenditure required to meet basic needs, and only then determining how much (if any) of the public budget can be devoted to debt repayment (Pettifor & Greenhill, 2002; Greenhill & Sisti, 2003; Pearce, Greenhill & Glennie, 2005). The Millennium Project echoed many earlier critiques in recommending that: "'Debt sustainability' should be redefined as 'the level of debt consistent with achieving the Millennium Development Goals,' arriving in 2015 without a new debt overhang. For many heavily indebted poor countries this will require 100 percent debt cancellation. For many heavily indebted middle-income countries this will require more debt relief than has been on offer" (UN Millennium Project, 2005:207-208). Thus, expanding both access to debt relief and its value must be a priority from the standpoint of health equity and SDH.

At the 2005 Summit, the G8 committed themselves to increase the value of debt relief by cancelling all debts owed by HIPC's to the World Bank, IMF and the concessional (i.e., low-interest) arm of the African Development Bank once the relevant countries reach the HIPC "completion point."²⁹ This commitment, which has now been formalized as the Multilateral Debt Relief Initiative (MDRI),³⁰ was a welcome next step, as was a separate partial debt cancellation deal for Nigeria estimated to be worth \$31 billion (Elliott & Wintour, 2005). However, the reliability of the MDRI commitment is called into question by the fact that as of mid-2005, existing (i.e. pre-Summit) debt cancellation commitments under HIPC were underfunded by approximately \$12.3 billion, and were facing non-participation by

²⁹ "To reach completion point, countries must maintain macroeconomic stability under a PRGF-supported program, carry out key structural and social reforms, and implement a Poverty Reduction Strategy satisfactorily for one year. Debt relief is then provided irrevocably by the country's creditors." World Bank HIPC web site, <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTDEBTDEPT/0,,contentMDK:20655535~menuPK:64166739~pagePK:64166689~piPK:64166646~theSitePK:469043,00.html> (accessed May 13, 2006). PRGF is the Poverty Reduction and Growth Facility (formerly the Enhanced Structural Adjustment Facility) of the IMF.

³⁰ <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTDEBTDEPT/0,,contentMDK:20634753~menuPK:64166739~pagePK:64166689~piPK:64166646~theSitePK:469043,00.html> (accessed August 7, 2006)

many commercial creditors (United Nations Department of Economic and Social Affairs, 2005:146) Further, development assistance to countries that receive additional debt relief under MDRI will be reduced by some portion of the amount (IMF-World Bank Development Committee, 2005), thus repeating the shell game in which development assistance declined substantially in the late 1990s after the start of the original HIPC initiative (Killick, 2004:6-7). Indeed, Britain's Department for International Development (DFID) conceded in April, 2006 that its inflation-adjusted spending on development assistance had actually declined from 2004 to 2005 if one subtracted the value of Britain's contribution to debt relief for Nigeria and Iraq (Gow, 2006). The comparison is legitimate because these two tranches of debt relief were arguably motivated primarily by petroleum and geopolitics, not by a desire to increase recipient countries' ability to meet basic needs; external debt is hardly the most immediate constraint on that ability in either case.

As noted in Part II, in order to qualify for debt relief under HIPC, national governments have had to prepare Poverty Reduction Strategy Papers (PRSPs) for approval by the World Bank and IMF, and to update them periodically. Although the process offers great potential benefit, in practice direct parallels exist between the PRSP process of qualifying for debt relief and earlier forms of conditionality (Cheru, 2001; Bhattacharya et al., 2002); recent studies confirm the continuity of the macroeconomic principles embodied in PRSPs with the earlier era of structural adjustment (Gottschalk, 2004; Taylor, 2004; Gottschalk, 2005). For example, PRSPs may include "trade-related conditions that are more stringent, in terms of requiring more, or faster, or deeper liberalization, than WTO provisions to which the respective country has agreed" (Brock & McGee, 2004:20). Even if one rejects the position that PRSPs are being used quite cynically as a vehicle to pry open developing country markets, it appears that the sources of finance that demand and assess PRSPs continue to operate on the uncritical presumption that development is best achieved through rapid integration into the global economy, without consideration of economic distribution or health equity impact.

Further questions about the architecture of development assistance and debt relief involve effects on public health and education budgets of the expenditure ceilings on which the IMF, in particular, is reported to insist as elements of PRSPs and macroeconomic management plans, even when the necessary resources have been committed by external donors. The economic rationale involves limiting inflation and currency appreciation, with the latter viewed with special concern because it could reduce the competitiveness of a country's exports and hence its ability to repay external debts. A 2005 article based on previous research and the field experience of one of the authors identified this constraint as operating in a number of countries including Mozambique, Tanzania and Uganda (Ooms & Schrecker, 2005). In response, World Bank and IMF officials argued that Medium-Term Expenditure Frameworks (MTEFs) incorporating public sector expenditure ceilings "are not a reflection of some malign intent," but rather "state what money is available and what programmes are possible within the context of that resource envelope" (Sarbib & Heller, 2005). They provided no country-specific evidence to counter the argument that such expenditure ceilings are compromising national governments' ability to meet basic needs. Subsequent analyses (Rowden, 2005; Ambrose, 2006) have strengthened the case against

expenditure ceilings. A full assessment is difficult given the lack of transparency and the asymmetrical nature of relations between the IMF and national governments. Nevertheless, it is clear that the IMF approach does not reflect a willingness to interrogate past policy choices and present-day asymmetries in resources and bargaining power that together determine "what money is available" to a particular society or national government: say, one in sub-Saharan Africa trying to deal simultaneously with declining commodity prices, the impact of the HIV-AIDS epidemic, and the legacy of capital flight facilitated by hospitable financial centres in the developed world.

Finally, it is important to challenge the legitimacy of external creditors' financial claims when they involve repayment of funds lent to governments that systematically looted the public treasury or used public funds (including those supplied by external borrowers) for domestic repression in order to maintain power. The international community remains obstinate in its failure to confront this question. Pogge (2002) questions the collectibility of these debts on ethical grounds, since the international community need not have permitted violently repressive or larcenous rulers to borrow against the assets and future earnings of those whom they rule, which is what they did in many cases. Other commentators have similarly questioned whether "odious debts" are collectible as a matter of international law (Kremer & Jayachandran, 2002; King, Khalfan & Thomas, 2003). These neglected issues need to be explored with special urgency in cases where the imperative of repaying external creditors threatens to conflict with domestic public expenditure priorities related to health equity and SDH. In our view, and that of other commentators on debt issues (Hanlon, 2000; Pearce et al., 2005; ActionAid International, CAFOD & Oxfam International, 2005; Mandel, 2006), the latter must always take priority, and the onus is now on the industrialized countries individually and collectively to develop concrete policy responses.

III.5 Trade and development

Something close to a new conventional wisdom has grown up around the relation between trade and development. Organizations otherwise as divergent in their perspectives as Oxfam and the World Bank apparently agree on the value to developing economies, especially the world's poorest countries, of access to industrialized world markets – sometimes citing figures to the effect that annual gains from complete liberalization of trade would amount to several times the value of development assistance (World Bank, 2001; Watkins & Fowler, 2002). Because access to markets for agricultural commodities is economically critical for many developing countries, agricultural subsidies, which simultaneously lower prices within the borders of the producing country and enable producers to export at artificially low prices, are a special concern. So, too, is the continuing use of tariff escalations on high value-added or manufactured exports from poorer nations by industrialized countries, in contrast to low or no tariffs on raw commodity exports. Improved access to developed country markets for manufactured products could yield very substantial income gains for the developing world (Akyüz, 2005a; Akyüz, 2005b), although estimating the value of potential markets lost to developing country producers as a result of subsidies and trade restrictions is fraught with difficulty (Wise, 2004).

Birdsall, Rodrik & Subramanian (2005) have questioned the new conventional wisdom. They argued, unfortunately without supporting documentation, that the effects of agricultural subsidies on international prices of commodities such as cotton are far too small to affect the competitiveness of developing country producers in their own or export markets. While reserving judgment on this argument, it must be acknowledged that the relations between agricultural subsidies as defined and prospects for development are more complicated than acknowledged by many participants in the debates.³¹ Although improved market access in the developing world may increase the incomes of agricultural producers who are already part of the cash economy, it is likely to have little benefit for larger numbers of producers who are primarily oriented toward subsistence, with occasional local market sales – the problem of “two agricultures” (Howell, 2005; see also Cousins, forthcoming). The entire issue of agricultural trade and SDH requires “a more fine-grained approach, which would differentiate among crops and countries” (Stiglitz & Charlton, 2005:45). In the aftermath of the collapse of WTO negotiations in July, 2006 because of failure to make progress on agricultural subsidies, that prospect is perhaps more remote than ever.

Apart from the specifics of agricultural trade, multiple ironies surround the relation between contemporary trade policy priorities and the ability of developing countries to meet basic needs related to SDH. At a theoretical level, “the arguments advanced in favour of trade liberalization as a way of facilitating learning and productivity growth call for support and protection in the early stages of large scale, specialized enterprises, not full exposure of them to foreign competition” (Akyüz, 2005b:10). This strategy was adopted, with variations, by countries such as China, Korea and Vietnam that are now held up as exemplars of the benefits of globalization: they opened up their markets to imports selectively as their previously protected industries matured, and adopted intellectual property regimes that favoured domestic producers, just as European and North American countries had done a century earlier (Amsden, 1994; Chang, 2002; Birdsall et al., 2005). Not only current bilateral and multilateral trade agreements but also informal pressure from the industrialized world may now preclude similar development strategies by later industrializers (Di Caprio & Amsden, 2004; Chang, 2005): the reason economist Ha-Joon Chang (2002) refers to the trade policy stance adopted by the industrialized countries as “kicking away the ladder.”

Two examples suffice to show the importance of this dynamic for development – and thus, by implication, for SDH. First, as noted in section III.3, PRSPs have arguably been used as a source of leverage for import liberalization, with poverty reduction compromised as a consequence. Second, provisions for Special and Differential Treatment (SDT) have been a feature of the world trading regime since the early postwar years; they embody recognition of the distinctive needs of countries at vastly different stages of economic development. However the SDT provisions in the General Agreement on Tariffs and Trade (GATT) were seriously weakened, in terms of their value for developing economies, with the advent of the WTO. Intense lobbying by African and Asian countries led to a commitment by WTO members in 2001 to review “all Special and Differential provisions...with a view to

³¹ This discussion draws, in particular, on Wise, 2004; McMichael, 2005; Howell, 2005.

strengthening them and making them more precise, effective and operational” (World Trade Organization, 2001:¶44, emphasis added). But what should count as strengthening? The fundamental question is whether SDT provisions should be considered temporary measures to facilitate the integration of developing economies into today’s trade policy regime, or whether “the bottom-line question for the WTO should be what it can do to facilitate development, not what it is willing to allow to ease adjustment” (Garcia, 2004:300). This issue remains unresolved, and arises even more acutely with respect to the proliferation of bilateral and regional trade negotiations and agreements (World Bank, 2004:27-56). In such negotiations and relationships, disparities in bargaining power and resources may be even more glaring than at the WTO, and “WTO-plus” provisions emerging from these settings may vitiate whatever gains in terms of market access and domestic policy flexibility that developing countries are able to secure within the WTO framework (Shadlen, 2005). This is a special concern given the likelihood that bilateral and regional negotiations will become even more important following the events of July 2006.

III.6 Is health a human right? What does that mean?

The international body of human rights law, starting with the 1948 Universal Declaration of Human Rights, includes various provisions related to SDH.³² Most notably, Article 12 of the International Covenant on Economic, Social and Cultural Rights proclaims “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” and obligates States Parties to ensure “provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure to all medical service and medical attention in the event of sickness.” (The United States has not ratified this Convention.) Although state obligations are limited to the progressive realization of the human right to health in the context of their “available resources” (Article 2), all states must show measurable progress towards its full realization. Assessing the extent of such progress requires evidence of effort to reach health goals, and of empirically grounded links between social and economic policy and health status trends within and between states.

In 2000 the UN Committee on Economic, Social and Cultural Rights issued General Comment 14 on Article 12, which both clarified the scope of the right to health and identified the obligations of states parties to respect, protect and fulfil the right (Committee on Economic, Social and Cultural Rights, 2000). General Comment 14 interpreted the right to health as an inclusive right that encompasses not only timely and appropriate health care, but also key underlying health determinants, including “access to safe and potable water

³² These include Article 25 of the Universal Declaration of Human Rights, Article 24(1) of the Convention on the Rights of the Child (1989/90), Article 5(e)(iv) of the Convention on the Elimination of All Forms of Racial Discrimination (1965/1969) and Articles 11(f) and 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (1979/1981).

and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health” (¶11). It further identified “core obligations” that include ensuring access to health facilities, goods and services on a non-discriminatory basis; to ensure access to minimum essential food and freedom from hunger; to ensure access to basic shelter, housing, sanitation and potable water; to provide essential drugs as defined by the World Health Organization Access Programme on Essential Drugs; and to adopt and implement a national public health strategy (¶43). At the same time, it described the Article 12 obligations related to maternal and child health, industrial hygiene, and disease prevention and control as “obligations of comparable priority” (¶44).³³

What would public policies that acknowledge health as a human right look like, and what might they mean for SDH? The question can usefully be considered in terms of potential impacts of trade policy on access to SDH. The United Nations’ Special Rapporteurs on globalization and human rights concluded that “it is necessary to move away from approaches that are ad hoc and contingent” in ensuring that human rights are not compromised by trade liberalization (Oloka-Onyango & Udagama, 2003:¶25). A more extensive and health-specific examination of the issues has been conducted by the Special Rapporteur on the Article 12 right to health (appointed in 2002, reappointed for a second term in 2005), whose first report adopted an expansive approach that links poverty reduction and the right to health (Hunt, 2003). A more recent report, dealing specifically with the WTO, found that “the progressive realization of the right to health and the immediate obligations to which it is subject, place reasonable conditions on the trade rules and policies that may be chosen” (Hunt, 2004:¶24). Consequently, the report recommended *inter alia* “that urgent attention be given to the development of a methodology for right to health impact assessments in the context of trade” (Hunt, 2004:¶74) – a challenge that is best viewed as part of the larger imperative of balancing the inherently commercial objectives of trade agreements with other social objectives such as poverty elimination (McGill, 2004).

In both trade policy and human rights, institutions and norms of global governance have emerged. A crucial difference between the two is that no multilaterally agreed upon implementation and enforcement mechanisms exist with respect to human rights that are even roughly comparable to dispute resolution procedures under trade agreements. WHO research has found that litigation to establish access to essential medicines as an actionable human right can succeed, mainly in situations where constitutional provisions exist on the right to health and/or on the primacy of international human rights agreements with respect to domestic policies and legislation identified the importance of national legislation and policies (Hogerzeil, Samson, Casanovas & Rahmani-Ocora, 2006).

The cases studied did not involve the provisions of trade agreements, although the intellectual property provisions of the Agreement on Trade-Related Aspects of Intellectual Property (TRIPs) remain central to debates about access to essential medicines despite a WTO interpretation that apparently offers flexibility with respect to compulsory licensing and

³³ For explication see Evans, 2002; Chapman, 2002; Nygren-Krug, 2002; Hunt, 2003; Hammonds & Ooms, 2004; Asher, 2004; Hunt, 2004.

parallel imports (Correa, 2003; Sell, 2004; Cohen & Illingworth, 2005; Musungu & Oh, 2005; Westerhaus, 2006; United Nations Committee on the Rights of the Child, 2006)

Neither do the cases studied address the (arguably) more challenging question of whether or how the right to health can be used to secure more equitable and widespread access to social determinants of health such as access to safe water, which is specifically addressed in one of the MDG targets. Water access has often been reduced for the poor or otherwise vulnerable when costs rose as a consequence of privatization or the implementation of cost recovery measures (Loftus & McDonald, 2001; McDonald, 2002; Jaglin, 2002; Budds & McGranahan, 2003; International Consortium of Investigative Journalists, 2003). Because it is essential to health, “[t]here are compelling arguments for viewing access to water as a human right,” and water as a good whose commodification and commercialization should be limited (Mehta, 2003:567). On the other hand, this position is far from universally accepted; “the struggle persists because of reluctance among powerful players to acknowledge that principles of social and economic justice must not be sacrificed for reasons related to wider political economy” (Mehta, 2003:568). In another example with potentially far-reaching policy relevance, Hammonds and Ooms (2004) have argued that many policies pursued by the World Bank, including expenditure ceilings and some aspects of loan conditionalities, lead to violations of member countries’ obligations related to the right to health. How would this claim be adjudicated, and how would conclusions be implemented? These questions underscore the importance of a lack of implementation mechanisms – an issue that is unlikely soon to be resolved. Thus, the right to health as a counterweight to the priorities of the global marketplace offers important opportunities, but also formidable conceptual and practical challenges.

III.7 The need to protect and expand “policy space”

“Policy space” has been defined as “freedom to choose the best mix of policies possible for achieving sustainable and equitable economic development given [developing countries’] unique and individual social, political, economic and environmental conditions” (South Centre, 2005). The concept is most often invoked with respect to how trade agreements constrain economic policy choices (McGill, 2004; Kozul-Wright & Rayment, 2004; Hoekman, 2005; Gallagher, ed., 2005). However, the effects of trade policy commitments on national policy space are not limited to those associated with the actual texts of trade agreements. For example, once such agreements have facilitated the reorganization of production across multiple national borders, as described in Part I of this paper, governments’ policy space is subsequently constrained by the ability of a parent or lead firm to play off subsidiaries or independent contractors in multiple national jurisdictions against one another in order to minimize costs and maximize productivity. The effect of US retail giant Wal-Mart’s procurement practices on suppliers in the developing world is sometimes cited as a case in point (Goodman & Pan, 2004), but this is arguably just an especially conspicuous example of a dynamic that is intrinsic to buyer-driven commodity chains (Donaghu & Barff, 1990; Fold, 2002; Bronfenbrenner & Luce, 2004).

Liberalization of financial markets enhances the power of the owners of financial assets relative to governments because of the (often implicit) threat of disinvestment. This process is familiar from the role of bond markets and credit rating agencies in defining the risks (to investors, not necessarily to residents of the country in question) associated with a particular government's policies, and therefore determining the interest rates bondholders will demand (Cerny, 1994; Sinclair, 1994; Cerny, 1996). Fiscal discipline is also exercised in other ways; the implications for policies related to SDH can be understood starting from the premise, defended in section II, that even when sustained economic growth is achieved, it cannot be assumed that gains from growth will be widely shared in ways that reduce poverty and other forms of vulnerability. Explicitly redistributive policies may be necessary.³⁴ As an illustration of this point, a recent study constructed alternative scenarios of progress by 18 Latin American and Caribbean countries – a region of the world where inequality is among the highest, on a variety of dimensions (Hoffman & Centeno, 2003) – toward the MDG of reducing extreme poverty by 50 percent between 1990 and 2015. The study found “that even very small reductions in inequality can have very large positive impacts in terms of poverty reduction. For most countries considered, a one- or two-point reduction in the Gini coefficient,” which is a standard measure of income inequality across an entire society, “would achieve the same reduction in the incidence of poverty as many years of positive economic growth” (Paes de Barros, Contreras, Feres & et al, 2002:13).³⁵ In other words: *even a little economic redistribution could go a long way* toward reducing inequalities in access to SDH, especially if they were combined with carefully designed publicly financed health system and educational interventions.

The nature of redistributive policies is that someone within the borders of the nation-state in question has to pay for them. The constraint on policy space that arises from the need to raise tax revenues to finance such measures, once again in the Latin American context, is succinctly described by Williamson³⁶: “[I]t would not be practical to push this very far, because too many of the Latin rich have the option of placing too many of their assets in Miami” (Williamson, 2004). The operation of this constraint is not limited to Latin America: financial deregulation and the increased mobility of financial assets have enabled the propertied worldwide to join what Sassen (1996) calls “a sort of global, cross-border economic electorate, where the right to vote is predicated on the possibility of registering capital” (p. 40); the power of this cross-border electorate is suggested by our earlier discussion of capital flight (section II.3). Evidence that interjurisdictional competition has already reduced fiscal capacity and constrained the ability of governments to increase the progressivity of taxation and improve the effectiveness of tax collection is inconclusive (Rodrik, 1997; Garrett, 1998; Wibbels & Arce, 2003). However, the former Chief of the

³⁴ This represents an application at the country level of the New Economics Foundation's insight on a global scale about the relative ineffectiveness of growth in reducing poverty, discussed in section II.2.

³⁵ For a discussion of policy implications see Korzeniewicz & Smith, 2000; Jubany & Meltzer, 2004.

³⁶ Williamson (1990) famously codified the “Washington consensus” on development policy, which throughout the 1990s focused on domestic deregulation and rapid integration of national economies into the global marketplace.

IMF's Public Finance Division has predicted that this will clearly occur in the future (Tanzi, 2004); he has identified several "fiscal termites" including inability to tax financial capital, accounting flexibilities associated with intrafirm trade across national borders, the proliferation of derivatives and hedge funds, and the cross-border mobility of high income earners (Tanzi, 2001) that will limit fiscal capacity and start chewing on the foundations of tax systems in countries rich and poor alike (see also Grunberg, 1998; Avi-Yonah, 2004). Some observers, such as the Cato Institute (Edwards & De Rugy, 2002), do not question the extent to which tax competition limits policy space, and indeed welcome the constraint as a check on 'excessive' government spending. For others, the ideal remedy would be multilateral agreement on the creation of a system for global taxation and redistribution of resources across national borders, such as the long-standing proposal for a tax on currency transactions – the "Tobin tax" – or more recent proposals for taxes on carbon emissions or air travel (Felix, 1995; Arestis & Sawyer, 1999; Jetin & De Brunhoff, 2000; Clunies-Ross, 2004; Groupe de travail, 2004).³⁷

This necessarily brief discussion suggests a rather bleak conclusion. Redistributive policies of various kinds are likely to be needed to reduce health inequities within and between countries. Globalization tends to be associated with a long-term trend toward increasing economic inequality and increasing attachment to markets as a mechanism for allocating resources and setting policy priorities. At the same time, globalization generates ability of national and sub-national governments to implement the policies that would mitigate or compensate for those impacts. Identification of 'success stories,' notably those outside the industrialized world, is therefore especially important. However, it needs to be asked whether the interventions in question are genuinely improving health equity, or are simply undoing some of the damage done by integration into the global marketplace, and how sustainable they are in view of pressures toward (for example) labour market flexibility and tax competitiveness. Because of the limited universe of case studies (how many governments in the world have actively and aggressively been concerned with reducing health inequities?) and the associated need to rely on counterfactuals (what would have happened if they had been more concerned?), much is not known about the policy space for measures to reduce health equity by way of addressing the social determinants of health. Scenario construction and analysis may be the best way of reducing this knowledge gap, and in the Canadian context it is a central methodology in a multi-year team project on globalization and health disparities in major metropolitan areas that is now getting under way.³⁸

³⁷ France has now adopted a tax on air tickets, the progressivity of which is maintained by a much higher tax on business class tickets, with the proceeds dedicated to supporting purchase of drugs to treat AIDS, tuberculosis and malaria in developing countries (Ministries of the Economy, 2006); 13 other countries have signed on to this proposal (Farley, 2006). It remains to be seen whether the existence of this levy will create a political obstacle to increasing development assistance from general revenues in the industrialized world, and such purpose-specific funds are no substitute for the larger scale global redistribution that some would argue is ethically imperative.

³⁸ The authors are respectively co-investigator and principal investigator on this study, which involves an additional 18 co-investigators from a total of 10 universities, as well as a

III.8 Conclusion: SDH and values for the global community

Economist Jeffrey Sachs, who chaired both the Commission on Macroeconomics and Health and the more recent Millennium Project, has noted that “in a world of trillions of dollars of income every year, the amount of money that you need to address the health crises is easily available in the world” (Sachs, 2003:3). Scarcity of resources, in any absolute sense, is not the issue. Rather, the issue is one of whether and how resources necessary to meet the most basic needs of the world’s majority, starting with such objectives as the MDGs (which are only a beginning), can be mobilized rapidly and effectively.

Studying the key elements of contemporary globalization almost unavoidably leads one to contrast two fundamentally distinct visions of the future, which often are only implicit in policy discussions and are presented here in stylized form.

In the first vision, individuals, households, and national economies have to ‘earn their keep’ in the global marketplace. This offers major opportunities for some, and major risks -- exemplified by long-term unemployment, economic insecurity and marginalization, and catastrophic illness -- for others. This vision does not preclude social policy interventions, but they must be justified in terms of the return on investment. Investing in health (the mantra of the Commission on Macroeconomics and Health) is defended with reference to evidence of the payoffs in improving the ability of individuals, households and societies to compete in the global marketplace. The triages that are implicitly accepted in the vocabulary of investing in health in developing countries have received too little attention from development and population health researchers.

More broadly, this first vision redefines social protection as “social risk management,” in the words of a remarkable World Bank strategy document that describes “a new conceptualization of social protection that is better aligned with current worldwide realities” (Holzmann & Jörgensen, 2001:1, 9). The initial presumption is that “[i]n an ideal world with perfectly symmetrical information and complete, well-functioning markets, all risk management arrangements can and should be market-based (except for the incapacitated) (Holzmann & Jörgensen, 2001:16). The fundamental task of social policy is redefined in radically individualistic terms, as helping households “to smooth their consumption patterns” in response to exogenous events ranging from natural disasters to financial crises (Holzmann & Jörgensen, 2001:vii-ix). Governmental intervention to help the non-incapacitated poor is justified only when “market failures” result from the fact that the poor “are more vulnerable than other population groups because they are typically more exposed to risk and have little access to appropriate risk management instruments” (Holzmann & Jörgensen, 2001: 0).

Because the norms of the market are taken as given, no attention is paid either to normative considerations of social justice or to the empirical question of how (for example) promotion of trade liberalization and financial integration has facilitated capital mobility in search of lower production costs, thereby allowing investors to *create* the “worldwide

number of collaborators and consultants from civil society organizations. Contact the authors for further information on the project’s initial conference, to be held early in 2007.

realities” that are invoked to justify a new generation of domestic social and economic policies that accelerate incorporation of people and countries into the global marketplace.

The second vision seeks to blunt the negative impact of the emerging global marketplace; it represents, in effect, the “social democratic” counterfactual referred to in section II.3. This vision, which lacks codifiers as authoritative and well financed as institutions like the World Bank, comprises such alternative futures as:

- o one in which at least minimal access to the material prerequisites for health is institutionally recognized as a human right, with some corollary claims against available resources (section III.6);
- o the call of the International Labour Office’s World Commission on the Social Dimensions of Globalization for a new form of globalization that recognizes social obligations and incorporates new institutions for global governance (World Commission on the Social Dimensions of Globalization, 2004);
- o the reference by international relations and human rights scholar Richard Falk (1996: 18) to “a regulatory framework for global market forces that is people-centred rather than capital-driven”;
- o the invocation by Michael Marmot, now the Chair of the Commission on Social Determinants of Health, of “public policy based on a vision of the world where people matter and social justice is paramount” (Marmot, 2005:1099); and
- o despite its conceptual shortcomings,³⁹ the “global social contract,” analogous to the social contract within industrialized countries that supports contemporary welfare states, proposed by Birdsall (2006b) as a way of addressing asymmetries in today’s global economy.

An incremental approach to introducing this second vision into public policy forums that matter is provided by an emerging concern for “policy coherence,” organized around the idea that policies of national governments should not complement, rather than undermining, professed or stated objectives related to development and meeting basic needs (Picciotto, 2005). More ambitiously, Cheru and Bradford (2005) present a program of coordinated actions in support of achieving the MDGs, in which the industrialized countries would adopt “a holistic view of all their actions toward developing countries that goes beyond aid to trade, investment, capital flows debt, environment, health standards, agriculture and macropolicy management” (p. 16). Adapted to the SDH frame of reference, their prescription implies integrating consideration of effects on SDH and health equity into a wide

³⁹ The idea of a global social contract ignores the long, and sometimes violent, history of political conflicts (notably, but not exclusively, between capital and labour) that preceded the implicit contract that underpins many contemporary welfare states. Those conflicts were resolved, and the implicit contracts agreed upon, in part because national boundaries delimited the relevant conflicts and negotiations. Today, given the decisive shifts of bargaining power that have accompanied the emergence of the economic “borderless world,” {Ohmae, 1991 7513 /id} in which borders are open to some and increasingly closed to others (see section II.4), it is not clear why the most powerful actors in the global political economy, or for that matter decisive electoral pluralities in the industrialized countries, would see the need for such a contract.

variety of policies and institutional routines outside the health sector of government and multilateral institutions.

Formidable obstacles to implementing the vision even in the limited trade policy frame of reference have been identified by Stiglitz & Charlton (2004), who noted that living up to the rhetorical identification of the multilateral negotiations that began in 2001 as a “development round” was likely to require “a fundamental departure from the system of mercantilism,” driven by considerations of national interest or by the economic interests of particularly powerful economic actors within nations (p. 496). The collapse of WTO negotiations in July 2006 underscored the magnitude of that departure, and the difficulty in using what is essentially a moral argument in matters of international relations. However, the alternative to the use of such argument in support of economic, social and foreign policies that are conducive to health equity and improving the social determinants of health is the position, implicit in much contemporary development policy, that growth through marketization will benefit everyone in the long term and whatever health damage occurs in the interim must be accepted as the price of progress.

Stated in this manner, the position makes consideration of issues of distributive justice unavoidable ... and while exploring the possibilities of a global ethic for health and development further is outside the scope of this paper, we would counterpose a position stated by Gomory and Baumol (2004), which applies among as well as within nations: “At the very least ... those who stand to benefit from the process [of globalization] should be expected to agree to provide systematic and substantial assistance to the victims, presumably via government channels, and supported liberally by the wealthier communities. If that is not acceptable politically, there is surely little that can be said convincingly in support of a contention that the suffering of the victims will be justified by the promised future benefits to their descendants” (p. 430).

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