

13 Rights, Redistribution, and Regulation

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INTRODUCTION

The authors of Chapter 5 noted Birdsall's description of globalization as "disequalizing" and her identification of three distinct, although interrelated, kinds of "asymmetries" that characterize its operations. These characteristics must be addressed, at multiple institutional levels, in any serious effort to reduce the toll of millions of readily preventable deaths every year by way of social determinants of health (SDH). In today's world economic order, unprecedented affluence for a minority (Figure 13.1)¹ coexists with continued massive deprivation for literally billions of people, with dramatic effects on health. Consider, as just one example, the fact that the lifetime risk of death from complications of pregnancy and childbirth for Canadian women is one in 11,000. For women in Niger, one of the world's poorest countries, it is one in seven (Say, Inoue, Mills, & Suzuki, 2007). Policy prescriptions that presume the ability of countries outside the industrialized world to grow their way out of poverty and into better health (and reductions in health inequity) for their populations have been tried and found wanting over the past two or three decades.

During that period, neoliberal social and economic policies were actively promoted on pragmatic grounds, as the only ones that "worked." The superficial credibility of that claim relied on systematic amnesia about the recent history that created the context in which social and economic policies were applied, and about how that recent history embodied the asymmetries identified by Birdsall. In extreme cases, those asymmetries included U.S. support for military coups against egalitarian governments, notably that of Salvador Allende in Chile (see Chapter 3, this volume). More often, the promotion of neoliberal policies took the form of conditionalities attached to loans from the international financial institutions (IFIs), and—as noted in Chapter 5, this volume—of the "implicit conditionalities" that technological change and financial deregulation enabled the owners of mobile financial assets to impose on national governments.

As a number of authors have noted, globalization could offer tremendous benefits in terms of reducing health inequity worldwide. However,

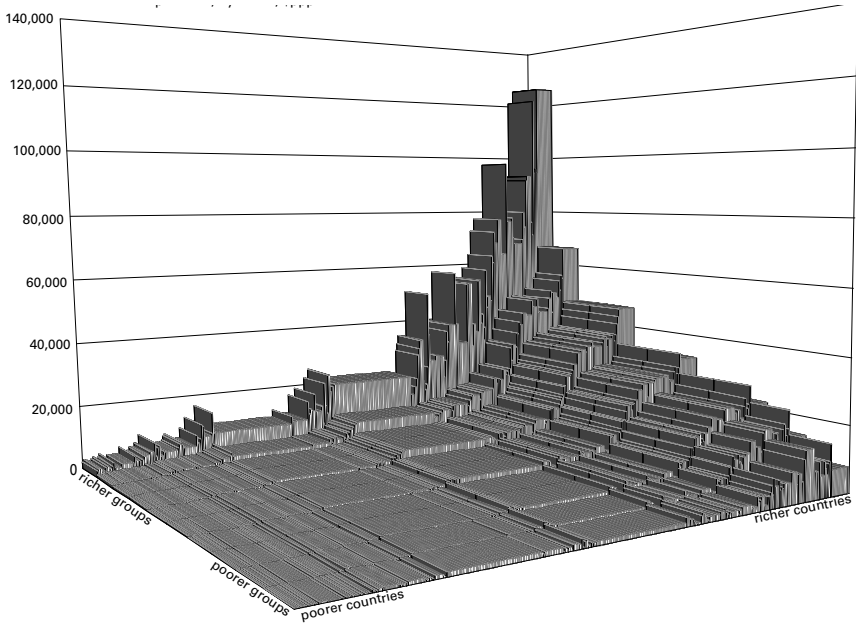


Figure 13.1 Gross annual national income per head by deciles (US\$ at purchasing power parity).

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this would require changes that go far beyond those that are normally described in terms of “managing” globalization, or (less frequently) in terms of ameliorating its negative effects (see, for instance, the discussion of social protection policies in Chapter 6, this volume). Here, we build on the discussion in Chapter 12 but also go beyond it.

FIRST, DO NO HARM

A starting point must be recognition that many neoliberal policies of the past thirty years have failed to produce the results claimed by their proponents. Hence the generic policy recommendation: *First, do no harm*. Specifically, abandon policy measures that demonstrably increase health inequity, such as those limiting the scope for public provision for basic health-related needs, or resulting in their commodification.

Chapter 8 (this volume) described the way in which the World Bank has promoted the reorganization of health services on commercial lines, emphasizing private insurance and cost recovery, thereby increasing both the direct and indirect costs of illness. Since a recent report on chronic

poverty noted with particular reference to rural locations that “ill health and the costs of healthcare are overwhelmingly the single most important reason why households enter into poverty” (Addison et al., 2008, p. 14), the implications for health equity are especially disturbing. In addition to general critiques of the effects on incomes, income security, and social protection of structural adjustment conditionalities attached to Bank and International Monetary Fund (IMF) lending (see the discussion in Chapter 1, this volume), recent evidence suggests that wage expenditure ceilings insisted upon by the IMF have restricted the ability of governments—especially in sub-Saharan Africa—to spend on health care and education, thus potentially working against the benefits of debt cancellation and development assistance (see the discussion in Chapter 7, this volume, and, for more extensive analysis, Center for Global Development, 2007; Independent Evaluation Office, 2007; Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008). It is not entirely fair to criticize the IMF for this stance, given its mandate; it is fair—and in our view essential—to insist on policy coherence around a set of values that emphasizes meeting human needs, and includes global redistribution in support of efforts to meet those needs. We return to this theme in later sections of the chapter.

Because the importance of water and sanitation as determinants of health was underscored in a recent WHO report (World Health Organization/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, 2008), it is useful briefly to consider these as an additional illustration of how globalization has influenced access and affordability. IMF loan policies systematically promoted privatization of water utilities, the operation of publicly owned utilities on commercial principles of full cost recovery, or both (Grusky, 2001). “In general,” according to Grusky, “it [was] African countries, and the smallest, poorest and most debt-ridden countries that [were] being subjected to IMF conditions on water privatisation and full cost recovery.” However, abundant evidence exists that privatization has failed to provide higher quality, more affordable and accessible services, and in many cases has increased the cost of access (Loftus & McDonald, 2001; Jaglin, 2002; McDonald, 2002; Budds & McGranahan, 2003; International Consortium of Investigative Journalists, 2003; Freedom from Debt Coalition, 2005; Cashmore, Gleick, Newcomb, Morrison, & Harrington, 2006; Public Services International Research Unit, 2006). An alternative strategy, which is preferable from an equity perspective, starts from the premise that water provision should be “decommodified” because access for certain purposes is a basic health-related human need and arguably, therefore, a human right as recognized by the United Nations Committee on Economic, Social and Cultural Rights (Committee on Economic, Social and Cultural Rights, 2003).² Strategies of decommodification demand not only the formal recognition of rights but also their use as a basis for mobilizing of resources, domestically and (at least in low-income countries) from development assistance, sufficient to support provision independently of

ability to pay. We expand upon this point about the nature of human rights in the section of the chapter that follows.

RIGHTS AGAINST THE GLOBAL MARKETPLACE

Ten years after the United Nations' 1995 Copenhagen social policy summit, a team from the Finnish National Research and Development Centre for Welfare and Health (STAKES) argued the need to organize economic and social policies organized around the "three Rs" of:

1. systematic resource **redistribution** between countries and within regions and countries to enable poorer countries to meet human needs,
2. effective supranational **regulation** to ensure that there is a social purpose in the global economy, and
3. enforceable social **rights** that enable citizens and residents to seek legal redress (Deacon, Ilva, Koivusalo, Ollila, & Stubbs, 2005).

Their policy brief was explicit in arguing that national governments must do more in terms of implementing the three Rs, and more must be demanded of them in countries rich and poor alike. At the same time, national and sub-national governments' options are limited by globalization and the actions of various supranational institutions and processes. Only some of those constraints are embodied in formal institutional arrangements like trade agreements; others arise from the operations of global financial markets, and from a policy environment in which competition for foreign direct investment and outsourced production "mercilessly weeds out those centers with below-par macroeconomic environments, services, and labor-market flexibility" (World Bank, 1999, p. 50). Achieving "a vision of the world where people matter and social justice is paramount," in the words of Commission Chair Sir Michael Marmot (2005, p. 1099), therefore *requires coordinated action on an international scale by national governments and multilateral institutions*.

An important background paper prepared for the Commission on Social Determinants of Health concluded that "The international human rights framework is the appropriate conceptual structure within which to advance towards health equity through action on SDH" (Solar & Irwin, 2007, p. 8). Key texts in international law include the 1948 Universal Declaration of Human Rights (UDHR), which states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and his [*sic*] family" (Article 25); the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), which specifies the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12); and General Comment 14 by the UN Committee on Economic, Social and Cultural Rights (2000), which sets out states' specific legal obligations "to *respect, protect and fulfill*" the rights cited under

Article 12.³ Conventional wisdom is that these obligations apply only to the actions of national governments with respect to people living within their borders. Even if one chooses to disregard the 1966 Covenant, which has not been ratified by the United States, it is essential to consider the argument made by Pogge (2002, 2005) that cross-border obligations follow from Article 28 of the UDHR, which specifies that “Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.”

In 2002, the United Nations Commission on Human Rights appointed a special rapporteur on the Article 12 right under ICESCR for a three-year period (an appointment renewed in 2005, and then again with a new rapporteur in 2008). Over the first six years of the term, Special Rapporteur Paul Hunt addressed issues including health worker migration, poverty-reduction strategies, trade agreements, health systems, mental health care, neglected diseases, access to medicines, maternal mortality, and indigenous populations through the prism of the right to health (Labonté et al., 2007, pp. 79–80). Notably, following a 2004 mission to the World Trade Organization he observed 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, p. 24), and recommended “that urgent attention be given to the development of a methodology for right to health impact assessments in the context of trade” (Hunt, 2004, p. 74). Subsequently, he provided examples of how the Article 12 obligations had been implemented within individual national jurisdictions (Hunt, 2007). These observations indicate the importance of devising mechanisms to ensure that trade policy outcomes are consistent with human rights norms, including—but not limited to—the right to health. The challenge is perhaps best viewed as part of the larger imperative of ensuring that the commercial objectives of trade agreements do not undermine achievement of social objectives such as poverty elimination (McGill, 2004), and as a response to the need, identified by the UN Special Rapporteurs on globalization and human rights, “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, p. 25).

The human rights framework represents an important foundation for legally enforceable obligations. For the moment, these remain contingent on implementation by national and subnational governments. National governments are obviously capable of entering into agreements that establish supranational mechanisms of implementation and enforcement, as illustrated by the European Union’s Convention for the Protection of Human Rights and Fundamental Freedoms, but this example (which has not been studied further for purposes of this chapter) reflects a distinctive institution that has taken decades to build. Meanwhile, even if countries have not incorporated recognition of a human right in their national legislation, their ratification of the ICESCR may be sufficient for courts to require action by national

governments. This has happened at least twice (in Argentina and in Ecuador) with respect to the right to health (Singh, Govender, & Mills, 2007). The human rights framework also, and perhaps more importantly, offers a normative challenge to the priorities of the global marketplace. If what human rights scholar Audrey Chapman, one of the drafters of General Comment 14, describes as the “intrinsic value and worth of all human beings” (Chapman, 1993, p. 21) is to have much meaning, then it cannot be contingent on accidents of birth that mean some people are born in Zambia, where life expectancy at birth is now thirty-eight years, and others in Canada, where life expectancy at birth is eighty years and all but the country’s poorest residents can anticipate far better health from the moment of their birth. And when priorities are set for allocating resources among competing options for improving social determinants of health, it must be kept in mind that human rights of any kind lose meaning when their realization must be vindicated with reference to an external criterion such as the right holder’s future income earning potential (human capital), or the contribution that improving her health might make to a regional or national economy.

An immediate step toward solidifying the human rights foundations for action to improve SDH would be to establish the post of the UN Special Rapporteur on the Article 12 right as a permanent position within the UN system, supported by a secretariat with the necessary research and advocacy capabilities; this secretariat might have a permanent location or might “float” geographically to follow the rapporteur. Research and advocacy have their limitations, since producing yet another series of critical reports (however authoritative the source) to add to the existing pile is likely to have only limited value. In particular, such reports cannot in themselves directly address the “asymmetry between enforceable economic (market-based) rules and unenforceable social and environmental obligations,” which has been described as “arguably the biggest governance challenge of the new millennium” (Labonté, Schrecker, Sanders, & Meeus, 2004, p. 3). Caution is in order about formal linkages between trade policy and human rights, because of the risk (noted in Chapter 4, this volume, with respect to labor standards) that such linkages could be used in a self-interested way as disguises for protectionist policies that injure those they are supposedly intended to protect. However, again as noted in that chapter, this is almost certainly a problem that could be overcome through thoughtful institutional design. In general, institutional innovation to establish effective linkages between human rights standards (including labor standards) and trade is one of the critical challenges for advocacy and multilateral action.

REDISTRIBUTING RESOURCES

As noted at several points in the book, a need exists both to redistribute more resources across national borders and to make existing mechanisms

of redistribution work more effectively in support of health equity. Despite fashionable skepticism about the effectiveness of development assistance, in our view the burden of proof has now shifted decisively to those who argue against substantial long-term increases in development assistance—recognizing, at the same time, that this is a necessary rather than a sufficient condition for ameliorating global inequities that threaten health. Chapter 7 (this volume) refers to Sachs’s calculations of the gap between the amount needed to provide basic health care in low-income countries and the amount that their governments can realistically expect to raise from domestic revenue sources: Chapter 5 (this volume) points out that in many cases, import liberalization promoted by the industrialized world has substantially *reduced* the tariff revenues available to these same countries.

Here, we provide only two illustrations of the magnitudes involved. First, Ooms et al. (2008) use Sachs’s \$40/capita cost figure to estimate the amount that would be needed to transform the Global Fund to fight AIDS, Tuberculosis and Malaria into a Global Health Fund that supported comprehensive health system strengthening. Assuming that all countries that received grants from the expanded Fund were to commit 15 percent of their general government budgets to health—which may be an optimistic assumption—such a fund would need to disburse approximately US\$28 billion per year. This is a dramatic increase relative to the estimated US\$12–14 billion value of all development assistance for health, of which support for the Fund of course represents only a part. However, it is also equivalent to the cost, circa 2007, of the US war in Iraq for roughly one month (Leonhardt, 2007). Second, the long-standing United Nations target of committing 0.7 percent of the rich countries’ gross national income (GNI) to development assistance has consistently been met only by a few northern European countries. The G7 countries have never come close. Figure 13.2 shows how much it would have cost the population of each G7 country to have met the target in 2007, stated not as an aggregate figure but rather in terms of the cost to each man, woman, and child in those countries, measured using a ubiquitous gastrocommodity: the Big Mac. The amounts needed, although not large, do not appear to be beyond the realm of possibility when stated in this way, and the result would have been to mobilize an additional US\$140 billion per year for development assistance: in other words, more than doubling the G7’s spending.

Chapter 7 (this volume) also notes that existing mechanisms for debt cancellation have a number of limitations. These must be addressed in order to eliminate the current process in which “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, p. 35). In

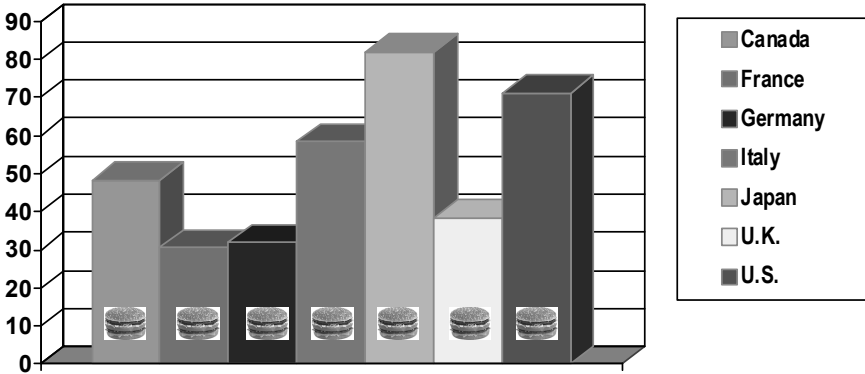


Figure 13.2 Additional cost to the G7 nations in 2007 of spending 0.7 percent of their gross national income on development assistance, in Big Macs per capita.

Source: OECD Development Assistance Committee, 2008; Big Mac prices from Anon., 2007.

this case, one illustration indicates the magnitudes involved: the proposal briefly described in Chapter 7 of this volume to structure debt cancellation around ensuring that debtor countries have available the resources needed to raise the living standard of their poorest residents to an “ethical poverty line” of \$3/person/day implies that a total of 136 countries would require either complete or partial debt cancellation with a net present value of between \$424 and \$589 billion. This represents a fivefold increase relative to the amounts of debt cancellation available under the combined enhanced HIPC and MDRI initiatives, spread over a much larger number of countries (Mandel, 2006) and probably over a number of years. It is possible, of course, that the tremendous opportunity offered by such cancellation would be squandered by debtor governments. Multilateral measures need to be developed both to minimize the chances of such an outcome and to prioritize the cancellation of odious debts. Although the point is not fully explored here, the close connection between foreign debt burdens and domestic capital flight (Rodriguez, 1987; Helleiner, 2001) and the constraint that capital flight can create on domestic social and macroeconomic policy suggest a need to rethink today’s widespread opposition to capital controls, and indeed consider measures to facilitate their effective use in certain equity-related contexts.

Then there is trade. Development policy protagonists who disagree about much else agree on the need for high-income countries to open up their markets, although both the magnitude and the distribution of the economic benefits that result is a matter of continued debate. At this writing (July 2008), talks aimed at ending the impasse that has characterized the so-called development round of WTO negotiations, begun in 2001, have just collapsed. This means that at least in the near future, bilateral and

regional trade agreements that reflect asymmetries in bargaining power and resources even more glaring than those present within the WTO framework will continue to proliferate. (The existence of “TRIPS-plus” provisions in a number of such agreements, as noted in Chapter 11 (this volume), is just one cause for concern among many about the health consequences of such an outcome.) An interesting proposal by development economist Paul Collier would see the OECD countries periodically offer nonreciprocated access to certain sectors of their markets, essentially as a way of revitalizing the negotiating process by offering low- and middle-income countries something of clear value to them in advance of bargaining over further trade liberalization—in other words, adding an explicitly redistributive component to the WTO process (Collier, 2006). Arithmetically, a logical starting point involves market access concessions that would in short order generate taxable revenues sufficient to compensate for past losses resulting from tariff reductions. As with many of the institutional innovations described in this chapter, the fundamental question here is one of political will: are national governments in general, and those of high-income countries most particularly, willing to exercise leadership in support of policies that are specifically focused on redistributing resources to reduce inequities in health by way of the SDH?

REGULATING FOR HEALTH EQUITY: IMPROVING GLOBAL GOVERNANCE

Many of the policies driving the past three decades of globalization have placed economic growth ahead of health improvements or human development, regarding the latter as positive externalities and the former as their essential prerequisite. The past decade, however, has seen an accumulation of evidence suggesting a more complex relation between growth and health. It is characteristic of that relation that improvements in population health and education (“human capital”) often precede growth (Commission on Macroeconomics and Health, 2001); growth does not automatically improve health (Deaton, 2006) and has proved remarkably ineffective in reducing poverty (Woodward & Simms, 2006); and under some circumstances health can be improved dramatically at quite low levels of GDP/capita by universal and relatively generous social protection and provision (Halstead, Walsh, & Warren, 1985). This implies that both national government policies and the policies of supranational institutions that establish the context for those policies, especially in low- and middle-income countries, should be organized more effectively around improving health equity and not only or primarily on increasing economic growth.

While there has been increased nominal recognition of the importance of health globally, reflected in the Millennium Development Goals (MDGs) and increased aid for health, global governance for health remains weak or

nonexistent, whereas global governance for economic integration via trade and financial liberalization is strong. As shown in Chapter 5 (this volume), this is weakening some of the policy options national governments can pursue to improve health equity within their own borders. In addition to their more directly observable negative effects, conditionalities associated with loans and grants from the international financial institutions often reproduce this set of priorities. So too, of course, do the priorities of hypermobile capital as they are manifested in financial markets.⁴

Three responses follow from this analysis: first, a reduction in the reach of trade and financial market rules that limit national governments' flexibilities to manage their domestic economies for health and other social purposes (Chapter 5, this volume); second, a reduction in the conditionalities set by the IFIs or donor countries alongside a more profound overhaul of the entire aid and debt relief architecture (Chapter 7, this volume); and third, a strengthening of systems of global governance in order to achieve policy coherence around the explicit objective of health equity via improvements in social determinants of health (Chapter 12, this volume, and, for a more extensive treatment, see Lee et al., 2008). This third response has implications not only for the role of the World Health Organization (WHO) and the priorities of member states, but also (and just as importantly) for the overall structure of multilateral institutions and global governance.

At present, there are few multilateral institutions, apart from WHO, with a mandate to improve global health, and, as Chapter 12 (this volume) noted, none with an explicit or legal obligation to take health into consideration when formulating policies or engaging in international negotiations in their respective sectors (e.g., trade, finance, environment). Moreover, existing global governance structures that affect SDH are weak with respect to most of the conventions of good governance such as transparency, accountability, and participation (Lee et al., 2008), while in health more "public" organizations such as WHO are being overshadowed by private philanthropies and public-private partnerships. Various aspects of the contemporary international environment call for a fundamental review of present systems and institutions. These aspects include: global power dynamics that have changed substantially since the immediate postwar era; persistent poverty and health inequities throughout much of the world; and the uncoordinated manner in which global governance is emerging in the absence of an ethical foundation or a consensus on the purpose of such governance. Ideally, such a review would be in a purpose-specific forum comparable to the Bretton Woods Conference in 1944 that established the key multilateral institutions of the postwar era, but with far greater transparency and inclusiveness. As noted in a background paper for the Globalization Knowledge Network (GKN), "Building global institutional and intergovernmental support for such a large but important governance initiative requires WHO to promote this goal among its member nations, and the global institutions with which it presently actively partners" (Lee et al., 2008, p. 65).

The need for restructuring of this kind in response to globalization's asymmetries has been identified by others, for example, by the International Labour Organization's World Commission on the Social Dimension of Globalization (World Commission on the Social Dimension of Globalization, 2004) and in the Helsinki Process on Globalisation and Democracy (Helsinki Process on Globalisation and Democracy, 2007) hosted jointly by the governments of Finland and Tanzania.⁵ In June 2008, the Commonwealth Heads of Government issued an important statement on the need for reform of international institutions (Commonwealth Heads of Government Meeting on Reform of International Institutions, 2008). However, WHO has so far remained peripheral to these and other efforts, and none of them has so far been supported by consistent and decisive leadership on the part of powerful nations like the members of the G8.

CONCLUSION: THE NEED FOR A VALUES-BASED APPROACH TO SDH

As suggested by Marmot's observation quoted earlier in this chapter, the ultimate need is for institutions that embody a global health ethic. Such an ethic must explicitly acknowledge that "Global actors and institutions, whether they act bilaterally (especially direct overseas development assistance, trade agreements) or multilaterally (through, e.g., the United Nations system, World Bank or International Monetary Fund), are obligated to remedy global inequalities that exist in affluence, power, and social, economic and political opportunities" (Ruger, 2006, p. 1001). Multiple arguments can be made in support of such an ethic, but it clearly must (a) explicitly acknowledge the existence of obligations across national borders, and (b) challenge the priorities of the global marketplace by defining the scope of those obligations broadly enough to include redistribution both within and across those borders.

As Sachs (2003, p. 3) has noted, "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." Scarcity of resources, in any absolute sense, is not the issue. Rather, the issue is one of whether and how resources necessary to meet basic health-related needs will be mobilized rapidly and effectively and distributed equitably. Some movement on this has occurred. The UN High-Level Panel on Financing for Development in 2001 (Zedillo et al., 2001) stressed the need for new sources of development financing, and proposed the establishment of an international tax organization as a starting point for limiting tax competition and evasion. Another initiative, focused on a specific set of policy instruments, is the Leading Group on Solidarity Levies to Fund Development, established at the 2006 Paris Conference on Innovative Development Financing Mechanisms. The second plenary meeting of this group, hosted by Norway in February 2007

(Norwegian Ministry of Foreign Affairs, 2007), considered not only taxes on air travel—already implemented by a number of countries (Farley, 2006; Ministries of the Economy, 2006)—but also research commissioned by the Norwegian Foreign Ministry on a currency transaction development levy (CTDL) (Hillman, Sony, & Spratt, 2006) and on policy options to address tax evasion and tax competition (Murphy, Christensen, Kapoor, Spencer, & Pak, 2007). In 2008, a background note for the United Nations’ annual high-level meeting on financing for development noted “renewed international interest in a possible currency-transaction ‘development levy’ of 0.005 per cent” (United Nations Economic and Social Council, 2008, p. 3). If levied and based on the current estimated daily value of foreign exchange transactions of \$3.2 trillion (Chapter 5, this volume), this would generate almost \$60 billion a year in new development financing. The Helsinki Process and the Leading Group on Solidarity Levies, in particular, reflect the importance of establishing both new governance mechanisms and new sources of financing for redistributing resources; they also illustrate the range of available opportunities to build important multisectoral linkages both with WHO member governments and with civil society organizations worldwide.

Global political discourse is replete with clichéd references to an international or “global community,” even though many political scientists regard such a community only as a utopian ideal. If we take health as one of the shared values that might come to define such a community, then addressing the asymmetrical impacts of globalization on health and the underlying distributions of power and resources they reflect assumes special importance. Two well-known economists have written:

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. (Gomory & Baumol, 2004, p. 430)

That assistance, and the commitment to shared values that must drive it, will not be mobilized in the absence of decisive leadership and political action.

NOTES

1. The figure updates a multidimensional earlier description (Sutcliffe, 2005) of global economic inequality based on the most recent World Bank data. It shows the distribution of income based on global income deciles (adjusted for purchasing power) both within and among countries. In the graph, countries have been

allotted a number of rows of columns based on their populations. “So each country gets one row of columns for every 10 million population. That means that the big countries come out about right but the very small ones occupy more space in the graph than in the world”—an unavoidable compromise if the graph is not to have 60,000 rather than 6,000 columns” (B. Sutcliffe, personal communication, March 2007). The graph makes it clear that while intracountry income disparities are dramatic even in some countries that are relatively poor as ranked by income per capita, the commanding heights of the worldwide income distribution are occupied by relatively rich people in rich countries. “The top one-tenth of US citizens now receives a total income equal to that of the poorest 2,200,000,000 citizens in the world” (Sutcliffe, 2005, p. 12).

2. For explication and analysis of policy implications, see World Health Organization, 2003; Mehta & Madsen, 2004, 2005; Mehta, 2005.
3. These obligations are explicated by Chapman, 2002; Nygren-Krug, 2002.
4. “The markets” are an abstraction: their judgment of a country’s policies is simply the resource-weighted aggregation of choices made by asset owners and managers with broadly similar interests and motivations, including not only those in London, New York, and Geneva but also an increasing number of rich households in many low- and middle-income countries.
5. For illustrations of the perspectives articulated as part of the process, see Helsinki Process Secretariat, 2005.

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