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Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution

**Final Report to the
Commission on Social Determinants of Health**

Globalisation Knowledge Network

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Table of Acronyms

ADF	The African Development Fund
AfDF	The African Development Fund
AIDS	Acquired Immunodeficiency Syndrome
ATTAC	Association for the Taxation of Financial Transaction for the Aid of Citizens/ Association pour la taxation des transactions pour l'aide aux citoyens
BMI	body mass index
CEOs	Chief Executive Officers
CGD	Center for Global Development
CIPIH	Commission on Intellectual Property Rights, Innovation and Public Health
CPIA	Country Policy and Institutional Assessment
CSDH	Commission on Social Determinants of Health
CSOs	civil society organisations
CTDL	Currency Transaction Development Levy
CVD	Cardiovascular Disease
DAC	Development Assistance Committee
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis, and Tetanus vaccine
DRC	Democratic Republic of Congo
ECLAC	United Nations Economic Commission on Latin America and the Caribbean
ECOSOC	United Nations Economic and Social Council
EEA	European Economic Area
EFTA	European Free Trade Association
EPZ	Export Processing Zones
EQUINET	Regional Network on Equity in Health in Southern Africa
ESCAP	UN Economic and Social Commission for Asia and the Pacific
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FCTC	Framework Convention on Tobacco Control
FDI	Foreign Direct Investment
FTAs	free trade agreements
G10	Group of 10
G7	Group of 7
G8	Group of 8
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GAVI Alliance	(formerly known as) the Global Alliance for Vaccines and Immunisation)
GBS	General Budget Support
GDP	Gross Domestic Product
GDP/capita	Gross Domestic Product per capita
GFATM	The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GKN	Globalisation Knowledge Network
GNI	Gross National Income
GNP	Gross National Product
GPGHs	Global public goods for health
GPGs	Global public goods
GPPPs	Global Public-Private Partnerships
HHR	Health Human Resources
HIPCs	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus

HIV/AIDS	Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)
HRBA	Human rights-based approach
HSR	Health Sector Reform
ICT	Information and Communications Technologies
IDA	The International Development Association
IDPF	International Drug Purchase Facility
IEO	Internal Evaluation Office
IFF	International Finance Facility
IFIs	International Financial Institutions
IFPRI	The International Food Policy Research Institute
ILO	International Labour Organisation
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPRs	Intellectual Property Rights
IT	Information Technologies
IUATLD	International Union Against Tuberculosis and Lung Disease
IWRM	Integrated Water Resources Management, Integrated Water Resource Management
LDCs	Least Developed Countries
LEB	Life Expectancy at Birth
MAI	Multilateral Agreement on Investment
MDGs	Millennium Development Goals
MDRI	Multilateral Debt Relief Initiative
M-EGS	Maharashtra Employment Guarantee Scheme
MENA	Middle East and North Africa
NAMA	Non-Agricultural Market Access
NPV debt	Net Present Value of Debt
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OPEC	Organization of the Petroleum Exporting Countries
PHM	People's Health Movement
POEA	Philippine Overseas Employment Administration
PPP-adjusted GDP/capita	Purchasing Power Parity-adjusted Gross Domestic Product per capita
PPPs	public-private-partnerships
PRGF	Poverty Reduction and Growth Facility (the renamed Enhanced Structural Adjustment Facility)
PROMED	
PRSPs	Poverty Reduction Strategy Papers
PT	Workers Party (Partido dos Trabalhadores - Brazil)
R&D	Research and Development
RBM	Results-Based Management
SADC	Southern African Development Community
SDH	Social Determinants of Health
SES	Socio-economic status
SSA	Sub-Saharan Africa
STAKES	National Research and Development Centre for Welfare and Health (Finland)
SWAPs	Sector-Wide Approaches
TAC	Treatment Action Campaign
TB	Tuberculosis
TBT	Technical Barriers to Trade
TFCs	Transnational food companies
TNCs	Transnational Corporations
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
U5MR	Under-5 Mortality Rate

UD	Urine Diversion
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCTAD	United Nations Conference on Trade and Development
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Alternatives (Population Fund)
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USA	United States of America
USOs	Universal Service Obligations
USSR	Union of Soviet Socialist Republics
WDI	World Development Indicators
WHO	World Health Organisation
WIPO	World Intellectual Property Organization
WTO	World Trade Organisation

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Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution

Executive Summary

Globalisation, in a broad sense, holds considerable potential for improving human health, while presenting many challenges. At base, the key challenge for the Commission is to understand how globalisation affects people's access to social determinants of health (SDH) and, given an explicit concern with equity, how that access is distributed. The approach taken by the Globalisation Knowledge Network (GKN) to assist with this task emphasized the economic aspects of globalisation since the 1970s on the basis that the policies driving global market integration are the most important with respect to SDH.

There is some evidence of positive global responses to this challenge. Efforts have been made to cut across existing national, international and institutional boundaries to address issues of transnational reach, whether articulated as goals (e.g. the Millennium Development Goals), broadly stated themes (e.g. poverty alleviation, social exclusion, gender empowerment) or control of such health-damaging products as tobacco (e.g. the Framework Convention on Tobacco Control). Even disease-specific global initiatives are increasing their response to the challenge of contemporary globalisation. Efforts to tackle the HIV/AIDS pandemic, as one example, have broadened from an initial biomedical focus to issues concerning human rights, poverty and gender. Yet much more needs to be done to manage the multiple ways in which globalisation affects SDH.

Globalisation affects health and SDH through changes in social stratification, differential exposure or vulnerability, health system characteristics and differential consequences. These changes arise through globalisation's effects on power, resources, labour markets, policy space, trade, financial flows (including aid and debt servicing/cancellation), health systems (including health human resources and health services), water and sanitation, food security and access to essential medicines. While not exhaustive, this list covers the principle pathways linking globalisation to health that were examined by the GKN.

Main Findings

1. The economic benefits of recent globalisation have been largely asymmetrical, creating winners, losers and growing inequalities between the two. Globalisation's enlarged and deepened markets reward more efficiently countries that already have productive assets (financial, land, physical, institutional and human capital) than they do countries that lack them (typically low- and some middle-income nations). Globalisation's rules favour the already rich (both countries and people within them) because they have greater resources and power to influence the design of those rules.
2. Global market integration has reduced income inequalities between the world's individuals primarily through poverty reduction in China and, to a lesser extent, India. Income inequalities between countries, and between individuals within countries, however, have risen sharply. Evidence of poverty reduction supports the dominant economic theory which advances that increased global market integration through trade and financial liberalisation automatically improves growth or reduces poverty. But some of this evidence remains contested, and there is no empirical consensus on liberalisation's relationship to growth or poverty reduction. Further, historic and recent winners from globalisation have not necessarily followed the economic path associated with neoliberal or market-based policies. Much of China's growth-related poverty reduction (which accounts for most of the world's growth-related poverty reduction) occurred before its integration into the global market. Economic growth, in itself, will not improve equity in population health, at least in any acceptable time.
3. The past 25 years of intensified global market integration have seen a slowdown or reversal in health improvements, and growing health inequalities. A regression analysis commissioned by the GKN found that, compared to a continuation of trends over the 1960 – 1980 period, globalisation policy-driven changes reduced potential gains in life expectancy at birth (LEB) by 1.23 years, due primarily to increases in income inequalities. Sub-Saharan African and Latin American countries, the former USSR and countries in economic transition suffered the greatest LEB losses. Worldwide life expectancy at birth (LEB) nonetheless improved by 1.45 years since 1980, but this was due to progress in health technology. Also, while much of the reversal in LEB in sub-Saharan Africa is a result of HIV/AIDS, the high prevalence in many sub-Saharan

- African countries is partly attributable to globalisation policies associated with debt crises, capital flight and structural adjustment programmes. In the former USSR, much of the reversal in LEB is due to the collapse of public institutions and safety nets.
4. Globalisation is leading to the gradual emergence of a genuinely global labour market wherein inequalities between skilled and unskilled workers are increasing, both within and across national borders. Global economic integration and the expansion of the global labour force are also combining to generate increased pressures for labour market 'flexibility,' with negative effects on economic security for many workers.
 5. Men and women experience globalisation's effects on labour markets differently. In general, globalisation has been accompanied by the reproduction of gender hierarchies, as women tend to occupy lower paid, less desirable jobs while continuing to bear a disproportionate share of responsibility for unpaid work in the household. While increased women's employment, notably in export-processing zones, has contributed to gender empowerment, exploitative conditions, unsafe conditions and lack of labour rights in many such zones compromise any potential health gains. A further manifestation of gender hierarchies is the emergence of a global political economy of care work, overwhelmingly done by women. One of the most important barriers to women's ability to participate as full economic actors in the global economy is their domestic responsibilities and, for a large subgroup, their childcare responsibilities. These responsibilities, in turn, and the lower pay accorded women workers throughout the world, reflect deeply entrenched patterns of gender discrimination. Policy priority should be given to providing all women with access to child care, free or at minimal cost, through the appropriate combination of labour standards and direct public expenditure by national governments and development assistance providers.
 6. Among the key objectives of economic policy should be the creation of an economic environment which generates livelihoods for all people, providing stable incomes at a level consistent with their physical, mental and social well-being; and social protection for those unable to attain or sustain such a livelihood. This will mean bringing employment back in as a central concern of economic and development policy. Adoption and effective implementation of the International Labour Organization's four

- core labour standards (which address free association, collective bargaining, elimination of economic discrimination by gender, and the elimination of forced labour) must be a priority of all national governments and multilateral institutions. Some evidence suggests that this process is facilitated, rather than hindered, by economic openness, although caution is in order about the extent of effective implementation.
7. Global market integration is shrinking national policy space. For purposes of the GKN, policy space is defined by the extent to which national decision-making for health and SDH can be made without subordination to priorities such as economic growth, maintaining payments to external creditors or complying with trade agreement disciplines, to the extent this creates health-negative effects. The fact that policy space is available to governments does not necessarily mean that it will be used. Some restrictions on national policy space can be health-positive, as is the case of the international framework for human rights and global labour conventions.
 8. Trade agreements are one aspect of globalisation that limits the range of policy instruments available to governments; indeed, that is their intent. National policy space for health and SDH has to put particular emphasis on the rule-setting part of trade negotiations in sectors, such as intellectual property rights, health and health-related services, domestic regulation, government procurement, tariff reduction and domestic economic subsidies. Health concerns need to gain more ground as part of trade negotiations. Governments should explicitly ensure that national health and SDH priorities are not negatively affected by trade and economic policy choices. This requires building up their capacity for analyzing trade policy impacts and ensuring that health ministries are better able to articulate their views during agenda setting for trade negotiations. The rapid growth in bilateral and regional free trade agreements (many of which are 'WTO-plus') is worrying in regard to the policy capacities of many developing countries. WHO should ensure that it has sufficient capacity and expertise, including legal expertise, to provide Member States with technical guidance and support on how they can maintain policy space for health in existing or new trade treaties.
 9. The ease and speed with which large-scale investors can shift funds around the world in response to the prospect of economic instability or higher taxation also reduces

policy space. Even governments with strong commitments to egalitarian domestic policy directions may have to temper these commitments in order to maintain their credibility with international financial markets. The ease of capital flight further offers the rich a powerful source of influence on domestic policy. A key area for action by the international community therefore involves changes in mechanisms of global governance over what might be called the international architecture of economic power.

10. Trade and financial market liberalisation, even if potentially bringing growth-related health benefits, poses specific risks. The weight of evidence in the existing literature finds that trade liberalisation and openness increase economic insecurity, although there is not consensus on this point. There is greater research consensus that financial liberalisation and the movement of capital is a more important determinant of economic instability than trade openness. Careful sequencing of liberalisation commitments together with expanded social protection policies (notably but not exclusively health insurance) can buffer some of liberalisation's health-negative consequences. Such policies should be universal and progressively tax-funded whenever possible (to maximize risk-pooling equity and efficiency) and not tied to employment, since many of the world's poorer workers are in the informal economy or lack access to employment-based social insurance schemes.
11. Declines in public revenues from tariff reductions hurt many low-income countries, indicating a need to develop alternative and equitable forms of public revenue collection in advance of further tariff cuts. High-income countries with such systems should assist low-income countries in developing the institutional capacities for progressive forms of revenue collection. High- and middle-income countries with already diversified systems of taxation (hence less reliance on tariffs) should not demand further tariff reductions in bilateral, regional and world trade agreement negotiations with low-income countries still reliant on such tariffs for public revenue, at least until these countries are able to develop alternative methods of revenue collection and the institutional capacity to sustain them. Developing these methods further requires multilateral efforts to reduce the revenue constraints imposed by tax competition that arises from increased trade and financial market liberalisation.

12. Increased global trade in food products is associated with a nutrition transition in low- and middle-income countries that is creating obesogenic food environments and increasing the prevalence of chronic disease. The evidence linking nutrition transition processes to trade is not conclusive, but highly suggestive. The growth of transnational supermarkets has also led to changes in food availability, accessibility, price and, through marketing, desirability, shifting demand for home-produced foods or foods purchased in traditional markets to increased dependence on store-bought foods, especially processed foods. The dietary impacts of this shift, however, have not yet been subject to rigorous investigation.
13. Global financial flows affect SDH, notably through portfolio investments, foreign direct investments, capital flight and remittances. However, the poorest countries of the world, notably in sub-Saharan Africa (SSA), receive only small portions of these global financial flows. As a result, they rely heavily on official development assistance (ODA) to finance their health and SDH investments; and, with other indebted countries with large impoverished populations, require more extensive forms of debt cancellation.
14. There is now a strong body of evidence supporting aid effectiveness. Aid may lift as many as 30 million people out of absolute poverty each year. This evidence of aid effectiveness has been accompanied by a shift from off-budget programme or project-based aid to on-budget support. This allows recipient countries greater flexibility in responding to their self-selected development priorities, rather than those of donors. General budget support, however, is still fairly rare; recipient countries continue to be chosen more on the basis of donor countries' geopolitical, trade and security interests than on humanitarian concern or actual need, or according to the degree they demonstrate "good performance" as defined by the donors. Much aid remains inefficiently tied to the purchase of goods or services provided by the donor.
15. Aid coordination and alignment could best be improved through globally pooled funds that are multilaterally managed and transparently governed, with eligibility and allocation determined according to agreed needs and developmental objectives, and with multi-year stability of donor inputs and recipient receipts. This is an ideal worth promoting, albeit one with low immediate political feasibility given entrenched bilateral aid institutions. At a minimum are requirements for increased and sustained levels of

untied aid, with increasing amounts disbursed through direct budget support. Finance ministers in recipient countries may be justifiably concerned with large health sector infusions that have guarantees of three years or less. Given increased arguments that the Millennium Development Goals (MDGs) should be used as a guide to aid flows and debt cancellation, the MDGs should be revised to incorporate equity measures and to ensure that greater attention is given to SDH.

16. Foreign debt represents a significant cross-border financial flow affecting health and livelihoods in both low- and middle-income countries. The debt crises that have been a feature of the international financial and political landscape over the last 25+ years are themselves a reflection of the world's increasing interconnectedness. Further, foreign debt and associated policy reforms have been used by developed nations to lever more globalisation, in the form of trade and financial liberalisation. Some of the hardest-hit countries, known as the Heavily Indebted Poor Countries (HIPCs), have seen a massive increase in debt over the past four decades, whilst their per capita incomes have stagnated. The 1996 HIPC Initiative of debt forgiveness has led to only modest decreases in debt servicing costs in most eligible countries, and the list of eligible countries excludes many in which the bulk of the world's poor live.
17. The Multilateral Debt Relief Initiative (MDRI) of 2005 now allows 100 percent cancellation of the debts owed by HIPC nations to four multilateral institutions (the IMF, the Inter-American Development Bank, the African Development Fund and the International Development Association (IDA), the concessional lending arm of the World Bank. While debt relief may be delivering modest resources which benefit the social determinants of health, principally through increased education spending, it is nowhere near the levels required. Changes in how debt sustainability is calculated are also required, either estimating the amount of public revenue required to meet the MDGs (assuming corrections in the goals' targets for equity and SDH) before determining affordable debt-servicing, or working backwards from a feasible net revenue approach based on public investments required to support an average life expectancy at birth of 70 years. A multilateral consensus against collecting odious debts should be promoted.

18. Poverty Reduction Strategy Papers (PRSPs) required for debt relief and, encompassing a larger group of countries, aid disbursements, demonstrate some improvements in health and SDH policies but are limited by explicit or implicit macroeconomic conditionalities. They have also caused delays in debt cancellation flows. The PRSP process could be made more helpful in terms of supporting SDH by incorporating employment targets with a gender dimension, an emphasis on incomes that at the very least will lift households out of absolute poverty, and compliance with core international labour standards.
19. The PRSP process also instantiates a more general problem: the extent to which access to external financing, including debt relief and also private sector investment, is contingent on meeting performance criteria specified by the IMF. The debate about the extent to which IMF programmes constrain countries' ability to utilise increases in development assistance for meeting basic needs (e.g. by way of wage bill ceilings) shows the need for policy attention to maintaining and expanding national policy space, and also to how health equity and SDH considerations figure in today's institutions of global governance.
20. The Commission on Social Determinants of Health (CSDH) has embraced the international human rights framework as the appropriate conceptual and legal structure within which to advance towards health equity through action on SDH. Yet globalisation is weakening the entitlements of many people to the progressive realisation of their right to health. This is particularly so with respect to access to health care, food security and water/sanitation.
21. Key international institutions have contributed to health care resource scarcities, in particular as they affect the poorest and most vulnerable, by promoting a market-oriented concept of health sector reform that strongly favours private provision and financing. From the mid-1980s until quite recently, the World Bank in particular actively promoted a paradigm of health sector reform that viewed private provision of health care and the purchase of health care or health insurance on the open market as the normative baseline. Such a focus on a narrow conception of technical and economic efficiency has also privileged narrowly-defined cost effective medical interventions. This focus, combined with new sources of funding through Global Public-

Private Partnerships directed at vertical, disease specific interventions, has mostly resulted in increased inequity of health care access and increasingly fragmented and ineffective health systems. On the principle of 'first, do no harm', no further reforms based on neoliberal health sector reform should be implemented, at least until and unless evidence of their appropriateness, effectiveness and affordability in low- and middle-income countries has been established. On the other hand, there is evidence that publicly funded and universal systems which integrate strong primary health care with public health interventions are associated with better health outcomes and fewer inequities.

22. Globalisation contributes in various ways to the migration of health professionals. This migration is asymmetrical – from poor countries to rich ones – with the poorest countries unable to attract replacement workers. The result is diminished health care access and services. The absence of an adequate density of health workers, in turn, correlates with increased mortality (i.e. IMR, U5MR and maternal). A notable trend within developing countries is the internal migration of health personnel from public to private health care systems and from rural or under-served areas to urban communities. This trend is partly a result of the pull from rich countries, with positions in urban communities seen as a necessary stepping stone to recruitment abroad; and of increased trade in private health services leading to a boom in so-called 'medical tourism.' Policy measures to mitigate the loss of health professionals include programmes to promote return migration (minimal impact/high cost), restricted emigration (minimal impact) or immigration (moderate impact but unpopular), bi- or multilateral agreements (somewhat successful but limited in scope), improved domestic HHR planning and self-sufficiency (widely endorsed but not followed and against the grain of growing global labour market integration), restitution/compensation (potentially most equitable but not popular with countries accepting HHR émigrés).
23. A key concern with international trade treaties is that trade commitments may lock-in policy choices that are detrimental to health outcomes. This is particularly the case for trade (including investment) in health services, given the sector's susceptibility to market failure. While governments may still want to experiment with commercialisation in some components of their health systems, making these policy experiments part of

binding trade treaties will strongly limit their ability to undo these reforms if they wish to do so in the future. Unless, and until, governments have experience regulating private investment and provision in health services in ways that enhance health equity, and that these are consistent with their obligations related to the right to health, they should avoid making any commitments in binding trade treaties. At a multilateral level, cancelling existing trade treaty commitments and removing health services from the scope of trade treaties remains an option, albeit one with low political feasibility given the interests of private health insurance and other service companies in the EU, USA and some middle-income countries.

24. The key challenges for water/sanitation are ensuring sustainability in supply and affordability in access. Globalisation has diffused new approaches to the former, emphasising innovative technologies easily adapted to poor and rural settings (e.g. closed loop sanitation systems and waterless urine diversion toilet systems) and greater attention to management scale at the water-catchment level. With respect to the latter, globalisation has also seen increased involvement of water transnational corporations in the management or supply of water in many low- and middle-income countries. This has often led to inequities in access, public dissent, the withdrawal of private investment and, so recently the results cannot yet be assessed, experimentation with 'public-public' partnerships involving public agencies cooperating in worker- and community-controlled water systems, as in Bolivia and Venezuela. For those already on a grid supply, water pricing should be reformed with much greater cross-subsidisation, a guaranteed free 'lifeline' supply and tariff-structuring that provides incentives to conserve.
25. Trade reforms in agriculture can affect health equity through its impact on food security. For low-income countries whose economies are still heavily dependent on agriculture, raising agricultural productivity and creating non-agricultural employment should precede trade reforms such as the reduction of tariffs on crops grown by low-income households. Trade liberalisation can also, but not always, negatively affect nutritional food security at the household level. Where improvements have occurred, most were attributed to female-controlled incomes within the household. Global market instabilities in food supply and price also require mitigating national policies,

notably in low-income countries, ranging from targeted input subsidies and supports to improved rural infrastructure, to compensatory measures for low-income groups.

26. Expanding Intellectual Property Rights (IPRs), notably TRIPS and 'TRIPS-plus' agreements, jeopardise equitable access to patented medicines. While IPRs do stimulate new research and development (R&D) by pharmaceutical companies, such R&D goes primarily to treatments for problems in high-income countries that can afford to pay for them. Consumers in developing countries thus contribute to the R&D budgets of pharmaceutical companies but are unlikely to benefit from future innovations to the same extent, if at all, as consumers in developed countries. Policy flexibilities for compulsory licensing were clarified in the Doha Ministerial Declaration on TRIPS and Public Health. Subsequent agreements were reached to permit parallel importing of generic drugs but with excessively burdensome conditions. Even so, TRIPS-plus agreements are removing even these flexibilities. To minimise health inequities due to stronger and expanding IPR regimes, developing country governments should actively participate in the Intergovernmental Working Group on IPRs established by the World Health Assembly, ensure that their national legislation allows full use of the flexibilities provided for by TRIPS, explore the use of compulsory licenses of patented essential medicines whenever the price can be significantly reduced through competition (local production or importation) and avoid concessions in bilateral or free trade agreements that increase the level of IPRs protection. WHO, as a matter of priority, should evaluate mechanisms other than the patent system, such as contests, public-interest research funding and advance purchase agreements, to encourage the development of drugs for diseases that disproportionately affect developing countries.
27. Under the current system, SDH are not well served by global governance mechanisms, either within the field of health or more generally. This is reinforced by the fact that few multilateral institutions with mandates affecting SDH abide by criteria for good governance. While more detailed studies of global governance for SDH are required, preliminary findings point to a need to: strengthen governance through core (regular budget) funding of WHO and other UN agencies with SDH mandates; establish the UN's Economic and Social Council ECOSOC, with WHO, as lead institutions for coordination of multilateral actions on SDH; democratise international institutions by

increasing the representation of developing countries, increasing and equalising accountability to members, and increasing transparency; increase openness to civil society organisations; create a permanent and sufficiently resourced position of UN Special Rapporteur on the Right to Health. A comprehensive review of the overall and out-dated system of global governance should be initiated urgently with a view to establishing a system conducive to health equity in the context of the conditions, needs and generally accepted principles of governance in the 21st century.

28. A global governance policy agenda that responds to globalisation's present asymmetries can usefully be structured around the "three R's" of redistribution, regulation and rights (in the words of a team from the Finnish social policy research unit STAKES), and will require coordinated action on an international scale by national governments and multilateral institutions. The most productive areas for policy innovation include: international or global taxation (e.g. of air travel and financial transactions); regulating the use of offshore financial centres to avoid existing national tax regimes; and assessing trade policy commitments in light of their implications for the right to health. More generally, the international human rights framework presents opportunities for limiting commodification and the spread of the global marketplace in ways that undermine health equity.

Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution

1. Introduction: Globalisation's challenges to health equity

Globalisation is a term with multiple, sometimes contested meanings (Held et al., 1999). Lee (2002), amongst others, considers globalisation a process of change in spatial (the way societies organise themselves), temporal (speeding up and slowing down of time) and cognitive (how we think) dimensions, which is having consequences across a wide range of social spheres (e.g. economic, political, technological). These complex and wide reaching changes across the world are having varying impacts on different populations, creating both winners and losers. The rapidly accelerating flows of traded goods, services and capital, enabled by new technologies and market liberalisation policies, is creating new sources of wealth for many. At the same time, patterns of production and exchange, along with labour market reorganisation, are leaving many vulnerable to employment insecurity, insufficient health and safety protections, and environmental degradation. Similarly, the global economy has opened up borders to an unprecedented degree for skilled labour and the relatively wealthy. For the world's poor, however, migration remains highly restricted or can be accompanied by exploitative labour conditions, discrimination and physical dangers (Taran & Geronimi, 2002).

A global consciousness may be emerging, by way of exchanges of information via broadcast media and the Internet. At the same time, drastic disparities remain in access to the so-called information superhighway (see section 1.5). The only responsible way of describing and explaining these disparities involves the gap between rich and poor people, in rich and poor countries. More generally many dimensions and manifestations of globalisation that are not obviously economic in nature nevertheless, on closer examination, are best explained or understood with reference to economic factors. For example, the globalisation of culture is inseparable from, and in many instances driven by, the emergence of a network of transnational mass media 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, which contributes to the "global production of diet" (Chopra & Darnton-Hill, 2004) and resulting rapid increases in overweight and obesity.

1.1 Focus on the global marketplace

For purposes of this report, the Globalisation Knowledge Network adopted a definition of globalisation as "a process of greater integration within the world economy through 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, p. 1) – in other words, the emergence of a *global marketplace*. This represents an advance with respect to numerous descriptive accounts of globalisation that neither identify connections among superficially unrelated elements nor assign causal priority to a particular set of influences (e.g. Appadurai, 1990; Pappas et al., 2003).¹ Conversely, Woodward and colleagues argue that "[e]conomic globalisation has been the driving force behind the overall process of globalisation over the last two decades" (Woodward et al., 2001, p. 876).² This latter perspective is better supported by the evidence although, as we point out in section 1.6, economics is not the entire story of globalisation and its effects on health, and the perspective on globalisation we have adopted does not assume away various dimensions of globalisation that are not self-evidently economic.

Economic globalisation during the period on which we focus (the 1970s to the present) must be understood against the historical background of two world wars and the Great Depression. The ensuing devastation spurred the creation of new international organisations to promote reconstruction and development, in an effort to avoid the economic shocks that partly underpinned both wars. The post-war period was characterised by rapid de-colonisation in developing countries and expansion of social protection policies in developed

¹ Appadurai's (1990, p. 296) identification of "five dimensions of global cultural flow which can be termed: (a) ethnoscaples; (b) mediascaples; (c) technoscaples; (d) finanscaples; and (e) ideoscaples" is widely cited in support of the view that globalisation is at least as much a cultural as an economic phenomenon. However, in recent work on contests over urban space in India (Appadurai, 2000) he has moved considerably closer to our emphasis on economic drivers and processes.

² For a more extended discussion of how the global marketplace is central to understanding the relations between globalisation and the social determinants of health, with reference to recent methodological milestones, see Labonte & Schrecker, 2007a.

ones, followed starting in the 1970s by a period of global recession and debt crises that partly resulted from oil price shocks and high-interest rate policies pursued principally by the United States, the United Kingdom and Germany. Amongst the characteristics of this period were and are:

- Technological change leading to rapidly decreasing costs for transportation, communication and information processing – a development that combined with institutional changes like trade liberalisation to facilitate the global reorganisation of productive activity.
- An increase in the value of Foreign Direct Investment (FDI) relative to trade, reflecting the growing interchangeability of direct investment and trade in the production and provision of an expanding range of goods and services.
- Relatedly, an increase in the importance of ‘offshored’ or ‘outsourced’ production, often undertaken by independent contractors rather than subsidiaries or affiliates of a parent firm.
- A drastic increase in (often short-term) flows of hypermobile portfolio investment (‘hot money’), which in combination with the preceding trends in trade and investment:
- Generated increased competition for investment, and a shift of power to decision-makers in international financial markets (transnational corporations, institutional investors, credit rating agencies and more recently hedge funds and private equity firms).³

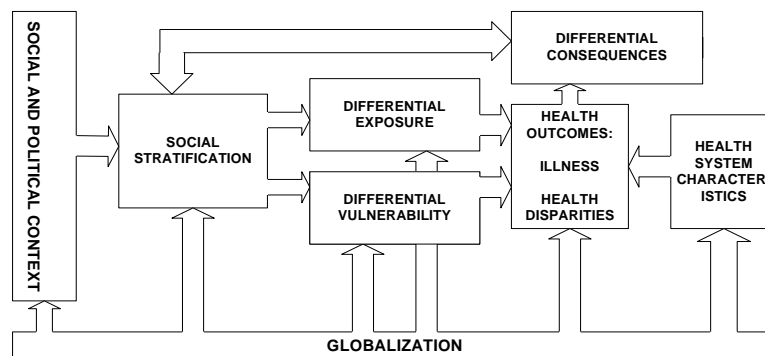
Many of these economic trends were and are either driven or facilitated by policies: for example, trade agreements entered into by national governments; deregulation of domestic financial markets; and conditions attached to loans from the International Financial Institutions (IFIs). We expand on the nature of these policies in Sections 2 and 3 below. But the changes described also reflect “the independent choices of economic agents in the field of consumption, health innovation, health and reproductive behaviour, migration, and so on, i.e. choices that depend on innumerable individual decisions of investors, researchers, firms, consumers, voters, health providers, households and communities and that are only partially influenced by public policies” (Cornia et al., 2007, p. 3). Governments may be able to influence or shape these choices, but they do not completely determine them.

³ This discussion is adapted from Baldwin & Martin, 1999.

1.2 Globalisation and social determinants of health: Mapping the linkages

Diderichsen, Evans and Whitehead (2001, p. 14) propose a framework that identifies “four main mechanisms – social stratification, differential exposure, differential susceptibility, and differential consequences – that play a role in generating health inequities.” Globalisation can affect health outcomes through each of these mechanisms. Their model contributed numerous insights to the organising framework adopted by the Commission on Social Determinants of Health (Solar & Irwin, 2007), and has been further modified for purposes of the GKN (Figure 1; see Appendix 1 for a more complex rendering of this model and the key research questions that guided the work of the GKN). Crucially in terms of the study of globalisation, for Diderichsen et al. the social context “encompasses those central engines in society that generate and distribute power, wealth, and risks” – engines that increasingly operate on a global scale (p. 16).

Figure 1: Globalization and social determinants of health



Source: Modified from Diderichsen, Evans & Whitehead, 2001

A stylised illustration, necessarily oversimplified but supported by evidence cited later in this Report, serves to illustrate the model's relevance. Import liberalisation may reduce the incomes of workers in sectors serving the domestic market, or shift them into the informal economy, thereby affecting social stratification, differential exposure (e.g. as workers are exposed to new hazards) and differential vulnerability (e.g. as income loss means adequate nutrition or essential health care become harder to afford, or in the extreme cases in which women are driven to reliance on “survival sex” (Wojcicki & Malala, 2001; Wojcicki, 2002).

Increased vulnerability may also magnify the negative consequences of ill health by reducing the resources available to households to pay for health care or absorb earnings losses, increasing the chance of falling into “poverty traps” (hence the feedback loop to social stratification). Import liberalisation may also reduce tariff revenues (and therefore funds available for public expenditures on income support or health care) in advance of any offsetting increases from income and consumption taxes. In countries with high levels of external debt, the need to conserve funds for repaying external creditors, perhaps by initiating or increasing user fees for health and education, may create a further constraint; at the same time, scarcity of resources for health systems increases the attractiveness of ‘vertical,’ disease-specific external funding mechanisms. (The rationale for including health systems as a separate element of the diagram now becomes apparent.) Conversely, if import liberalisation is matched by improved access to export markets, new employment opportunities may be created for specific groups, such as women working in export processing zones, who are thereby empowered to escape patriarchal social structures (social stratification) and reduce their economic vulnerability

As Commission Chair Sir Michael Marmot has pointed out: “The further upstream we go in our search for causes,” and globalisation 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, p. 308). Much of the evidence reviewed by the GKN does not directly link globalisation to health outcomes. Rather, it describes pathways linking globalisation with social stratification, differential exposure or vulnerability, differential consequences or health systems: elements that are already established as “causes of the causes” of health inequalities (Rose, 1985; Marmot, 2005). If globalisation creates inequalities in these more distal causes, then at the very least defensible grounds exist to assume that increased health inequalities are a result.⁴

An illustrative application of this approach is provided by De Vogli & Birbeck (2005), who identified five multi-step pathways that lead from globalisation to increased vulnerability to HIV infection among women and children: currency devaluations, privatisation, financial and trade liberalisation, 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

⁴ An expanded version of this argument is provided by Labonte & Schrecker, 2007a.

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 vulnerability to risky consensual sex, commercial sex and sexual abuse by reducing access to education. The authors examined each of these pathways through a review of available studies examining the linkages, concluding that adjustment policies may inadvertently produce conditions facilitating the exposure of women and children to HIV/AIDS. Their conclusions are supported by the conclusions reached by the Commission for Africa (2005), which considered some of the domestic austerity programmes arising from structural adjustment (see section 3.1.3) as important causal factors in the rapid rise of AIDS in Africa, and by field research that convincingly links economic restructuring with the insecurities that render certain populations, especially certain populations of women, more vulnerable to HIV infection (Schoepf, 1998; Schoepf et al., 2000; Mill & Anarfi, 2002; Schoepf, 2002; Schoepf, 2004). The variation in HIV prevalence across African countries indicates that other factors are important, as well. These include variations in how rapidly nations accepted the existence of the pandemic, the causative role of HIV and the need for scaled up programs of prevention and treatment; differences in male circumcision rates (Beyrer, 2007); and cultural differences in the patterning of sexual relationships, specifically considering the role of multiple concurrent partnerships on HIV prevalence (Halperin & Epstein, 2004). National policies and social norms still matter; our point here is simply that globalisation also matters, and is increasingly a conditioning and constraining influence on both.

This brings us to:

1.3 The importance of being clear about policy goals

In keeping with the orientation of the Commission, the GKN has adopted a clear normative commitment to health equity as a core value (Solar & Irwin, 2007). We have therefore not been primarily concerned with adding up aggregate gains and losses from globalisation as they affect SDH, apart from the discussion in Sections 1.4 and 2.1. Deterioration in access to SDH for relatively disadvantaged members of a society cannot be balanced by gains elsewhere if the effect is to increase health inequity. Priority has to be given, in the first instance, to avoiding any effects that increase health inequity; thus, our concern is with how

globalisation may be generating such effects. Beyond this, priority must be given to improving the health status of the worst-off in a particular society – “levelling up” (Dahlgren & Whitehead, 2006; Whitehead & Dahlgren, 2006) – and we have therefore also focused on how globalisation facilitates or impedes that process.

This is not an easy task for countries to undertake unilaterally – a theme to which we return frequently in this Report. As one example: increased global trade accompanied by the growth of export processing zones has created new employment opportunities for millions of women in low-income countries worldwide (Razavi et al., eds., 2004). Evidence of occupational hazards, long working hours, low wages, and lack of sick leave/benefits that preclude caring for children at home leaves little doubt that such conditions are far from ideal in terms of their implications for social determinants of health (SDH). But the alternatives for many of the affected women (rural farm work or precarious informal work or commercial sex work), often performed in cultural contexts where women’s autonomy in terms of finances and daily choice are circumscribed by patriarchal customs, makes a very bad job in a factory geared to the global export market a small but decided improvement (Barrientos et al., 2004, p. 2; see also Kabeer, 2004a; Kabeer, 2004b; Chen et al., 2006a). At the same time, these improvements tend to be disproportionately vulnerable both to economic crises and to systemic, globalisation-related pressures for “labour market ‘flexibility’ and fiscal restraint” (Razavi & Pearson, 2004, p. 25), i.e. lower wages and benefits.

Few would disagree that these present conditions demand a broadly stated policy goal of ensuring decent work for all. The conundrum for individual nations is how to achieve it. For poorer countries integrating into the global economy, how can conditions in such factories be improved – and in ways that also improve working conditions in the larger and often informal domestic economy – without undermining the comparative advantage offered by their low wages or regulatory standards? Given a global surplus of inexpensive labour and increasingly integrated global production networks or value chains (a point discussed later in this paper), this is not a question that any one country can address unilaterally. It requires an inherently global policy response – involving workers and producers in low-income countries, corporations and consumers in high-income countries, and their respective governments – framed within a clear commitment to reducing disparities in access to SDH

both within and among countries (Labonte & Schrecker, 2007c; see also Section 4 of this Report).

1.4 Globalisation's contested gains: It all depends

Economic globalisation – specifically, the expansion of the global marketplace – is often defended on the basis that it has had a positive impact on several important SDH. We take as a given that poverty – either absolute or relative – is a fundamentally important SDH. Perhaps the single most important basis on which it is claimed that globalisation is good for health (Feachem, 2001) derives from research that purports to show a positive relation between liberalisation, economic growth and poverty reduction (Dollar, 2001; Dollar & Kraay, 2002; Dollar, 2002). These oft-cited World Bank studies concluded that during the 1980s and 1990s, “globalizers” grew faster than “non-globalizers,” potentially expanding the resources at their disposal to address SDH. (Whether they did so is another matter.) This conclusion has been criticised on several counts. Countries held up as model high-performing globalisers (China, India, Malaysia, Thailand and Viet Nam) actually started out as more closed economies than those whose economies stalled or declined during this period, mostly in Africa and Latin America (Dollar, 2002). The problem is one of definition. Globalisers are defined as countries that saw their trade/GDP ratio increase since 1977; non-globalisers are those that saw their ratio drop. Thus India and China are considered globalisers, 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-globalisers started out more highly integrated into the world economy (several having lower tariffs at the start than globalisers had at the end); and traded globally as much, if not more, than the globaliser group (Birdsall, 2006).⁵ The key contention is whether developing countries would be better off (growth-wise) if they liberalised their trade policies, other things being equal; there is little disagreement that they would be better off if high-income countries liberalised market access (Cline, 2004, p. 227).

⁵ Comparing “globalizing” and “non-globalizing” countries also overlooks the effects of globalisation as a whole, through international markets, on “non-globalizing” countries. For example, if country X expands its export coffee production, this is seen as globalising, and it may well grow faster as a result; but world coffee prices could fall due to oversupply, adversely affecting other exporting countries, including the “non-globalizers”.

A systematic review of major econometric studies of trade openness and growth since the early 1990s, some using observations dating back to 1950, concluded that “overall, it would seem that the weight of the empirical evidence is on the side of those who judge that more open trade policies lead to better growth performance” (Cline, 2004, p. 248). This appears to buttress the argument that liberalisation is necessary – if not necessarily sufficient – for growth. However, this conclusion is not as robust as it seems.

Firstly, considerable disagreement remains over the relevance of variables used to measure trade openness or otherwise entered into the cross-country regressions; and much of the empirical evidence raises serious methodological issues which cast doubt on this conclusion’s validity (Rodriguez & Rodrik, 2000). A more recent review and commentary on these econometric studies further points out that countries benefiting in terms of liberalisation-related growth had already intensified their agricultural production, providing an economic surplus that was invested in education and technology upgrading, which in turn allowed for diversification away from dependency on exports of primary commodities (Thorbecke & Nissanke, 2006). In simpler terms: While trade liberalisation on average is associated with better growth, it “is neither automatically guaranteed nor universally observable” (Thorbecke & Nissanke, 2006, p. 1342).

Secondly, it is now commonly accepted that China (along with other successful late industrialisers) did not follow the standard package of market-oriented macroeconomic reforms, but exercised a trial-and-error flexibility in the timing and depth of liberalisation and domestic market reforms. This unorthodox approach to economic reform, while promoting growth, nonetheless failed to prevent a huge rise in rural/urban inequality (Cornia et al., 2007). Third, it has been argued that the current form of globalisation, by shrinking national policy space through explicit trade treaty and implicit financial market conditionalities, may prevent low- and middle-income countries from adopting many of the policies used successfully by both developed and ‘emerging market’ economies at an equivalent stage of their development (see Section 3.1.3).

Even if a straightforward connection could be shown between trade liberalisation and growth, such a connection cannot be established between growth and poverty reduction. The decline between 1981 and 2003 in the number of people in the world living on \$1/day

or less may have been substantial: 414 million.⁶ However, more than three-quarters of this reduction occurred before 1987, as the rate of decline has slowed from 3.8 percent annually in 1981-87 to 0.4 percent annually in 1996-2003 (Chen & Ravallion, 2004, Table 3, p. 152; World Bank, 2007b, Table 2.3., p. 60). Nor has the depth of poverty been greatly reduced, since the number of people living on \$2/day or less rose by 285 million over the same period (Chen & Ravallion, 2004, p. 183). The rising tide did not lift people very far. It also failed to keep pace with population growth in most parts of the world. Excluding China, where the accuracy of poverty data has been questioned (Reddy & Minoiu, 2005), the number of global poor actually rose by 30 million at the \$1/day level and by 567 million at the \$2/day level. In sub-Saharan Africa (SSA), 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). Importantly, 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, p. 184; Ravallion, 2005). A recent paper incorporating multiple methodologies (country regression analyses, a macro time-series analysis for China and two micro-economic studies) concludes: "It is hard to maintain the view that expanding external trade is, in general, a powerful force for poverty reduction in developing countries" (Ravallion, 2006, p. 188).

Further, simple arithmetic reveals growth to be an ineffective way of reducing poverty. Recent calculations for Latin America (Paes de Barros et al., 2002; Jubany & Meltzer, 2004; de Ferranti et al., 2004) conclude that even a little redistribution of income through progressive taxation and targeted social programmes would go farther in terms of poverty reduction than many years of solid economic growth, because of the extremely unequal distribution of income and wealth in most countries in the region. On a global scale,

⁶ Various concerns exist about the reliability of data on incomes and household assets and the appropriateness of the World Bank's definitions of poverty with reference to poverty lines or thresholds of \$1/day and \$2/day (Reddy & Pogge, 2005), especially in rapidly expanding large metropolitan areas (Satterthwaite, 2003). As one example: a recent study of 11 Asian countries showed that surveys on which the World Bank estimates are based understate the extent of poverty as measured by the \$1/day poverty line because they are based on surveys of the value of household consumption that include out-of-pocket health care costs. Ironically, large numbers of households thus appear to have escaped poverty because of catastrophic medical expenses (van Doorslaer et al., 2006).

calculations by the New Economics Foundation show that: "Between 1990 and 2001, for every \$100 worth of growth in the world's income per person, just \$0.60 contributed to reducing poverty below the \$1-a-day line, 73 percent less even than in the lost decade for development, the 1980s" (Woodward & Simms, 2006, p. 19).

The empirical uncertainties associated with the argument that liberalisation improves growth which reduces poverty and thus improves health provide ample support for Deaton's (2006) warning that "economic growth, by itself, will not be enough to improve population health, at least in any acceptable time." The issue of acceptable time raises the ethical question of how long is too long. Diffusion of the benefits of economic growth in ways that lead to widespread improvements in population health 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 globalisation has resulted in deterioration in SDH for substantial segments of national populations, this is not just an academic point.

1.5 What is left out

Because of limits on time, space and resources, a number of dimensions of globalisation are omitted from this Report.

Firstly, growing demand for natural resources, the associated expansion of resource extraction and harvesting to new areas of the world and the global reorganisation of industrial production are all important dimensions of the global marketplace. Environmental exposures in jurisdictions where regulation is minimal are often an important source of illness, and demands for resources often contribute to conflicts that are inimical to health equity (Labonte & Schrecker, 2007b). Further, climate change may prove to be one of the most crucial influences on various SDH. Nevertheless, these issues are not discussed here although environmental and resource questions are being addressed in a separate study for the Commission.

Secondly, although we have identified numerous asymmetries of resources and power in the global marketplace (in Sections 2 and 3, below), this Report does not include a detailed discussion of the historical and contemporary "causes of the causes" of these asymmetries.

Some of these have been more extensively discussed in two background papers for the Globalisation Knowledge Network (Lee et al., 2007; Bond, 2007).

Thirdly, we have not addressed the implications of the information and communications technology (ICT) revolution, instantiated by the spread not only of Internet access but also of cellular telephony. Numerous possibilities thereby arise for health-positive knowledge sharing and the establishment of communities of practice that would otherwise have taken far longer and been less predictable (Box 1). As an illustration, the contribution of technological advances to improving access to water and sanitation is addressed in section 3.4.5.

Box 1. Knowledge sharing activities that have had a positive impact on health

- Understanding the role of micronutrient deficiencies, leading to the implementation of vitamin A supplementation and bio-fortification
- Understanding the health risks of aflatoxins in groundnuts and providing cheap kits to test for it, which will reduce risks to the health of poor farmers and potentially restore Africa's lost share of the world market;
- Demonstrating the possibility of micro-dosing to restore fertility to Sahelian soil
- Transferring improved varieties of coarse grains and of low cost water management techniques from India to Africa.
- Giving illiterate farmers access to alternative market prices for their produce through phone services;
- Sharing success stories in preventive health such as those published by the Center for Global Development,
- Diffusing successful micro credit experiences

Contributed by Caroline Pestieau, former Vice-President (Programmes), International Development Research Centre (Canada).

These issues deserve further investigation, yet scepticism may also be in order about equations of information with power. Access to information is, in the first instance,

distributed in a highly unequal manner as between rich and poor countries. Six out of every ten people in high-income countries are connected (United Nations Development Program, 2006, p. 327), as compared with scarcely 1 in every 100 persons in sub-Saharan Africa (World Bank, 2006, p. 6). This global equity gap in connectivity is directly attributable to costs that are *170 times higher* in low- than in high-income countries (World Bank, 2005a, p.312) when stated as a percentage of Gross National Income (GNI) per capita. Indeed, bandwidth limitations at times compromised the operations of the GKN, despite its role in a high-profile activity sponsored by a UN system agency. Further, knowing about what is happening to you as a consequence of globalisation is quite different from being able to do anything about it – or, in the absence of necessary resources, to take advantage of the new opportunities provided by ICT. Thus, in the context of globalisation and SDH, advances in ICT may be necessary for improving health equity, but are unlikely to be sufficient.

2. Globalisation's role in increasing health inequalities: An overview

The first two considerations in examining globalisation as it affects SDH are:

1. Social stratification, differential exposure, differential vulnerability, and differential consequences on a variety of scales (globally, regionally, country-specific and regionally within countries); and
2. The extent to which these trends can be explained by globalisation-specific phenomena, policies and practices.

Several recently published studies and a new analysis undertaken for the GKN (Cornia et al., 2007) address the first issue; the new analysis provides some insights into the second. For purposes of assessing the impact of globalisation on health status, this analysis identified five different pathways to morbidity and subsequent mortality:

1. Material deprivation (mortality shifts due to nutritional, infectious and sexually transmitted diseases in low income societies, among poor households, or in countries in economic transition).
2. Acute psychosocial stress (unexpected changes and rising uncertainty explaining mortality changes in coronary heart disease, cardiovascular disease and violent deaths, including suicides, found in countries such as the former Soviet Union (see Appendix 3) that are undergoing rapid change and social upheavals).
3. Unhealthy lifestyles (such as smoking, excessive drinking, drug use, poor diet, lack of exercise and so on, explaining shifts in mortality due to chronic disease, notably but not exclusively in higher-income countries).
4. High levels of social stratification and lack of social cohesion (associated with chronic stress and lack of access to health and other services by poorer groups within more steeply hierarchical societies).
5. Positive and negative "shocks" (including disasters, famines, economic sanctions, wars and epidemics as well as technological progress, although this last variable is not a "shock" in the everyday sense).

Trend analyses on a wide range of health outcomes were carried out by Cornia & Menchini (2006). The intent of their study was to examine health convergence within and across

countries over recent decades. Globally, the study found that progress in under-5 mortality rate (U5MR) reduction worldwide was slower in the 1990s than in the 1980s, as well as in many countries. Global convergence in life expectancy at birth (LEB) occurred until 1992, at which point divergence began due mainly to the AIDS pandemic in SSA and a rapid decline in life expectancy in the transition economies. There are important cluster differences: LEB continues to converge and plateau in high-income countries⁷, and is rapidly converging toward high-income country levels in middle-income countries. In many countries⁸ (most, but not all, low-income) LEB in 2001 was lower than in 1960, 1980 and 1990. Divergence in key health indicators also occurred between the 1980s and 1990s within many countries. This divergence (or health inequality) was associated with rising income inequalities and explained, in part, by LEB improvements in the middle- and high-income groups with little or no gain in the low-income group, although this pattern is not consistent.

A study of 24 developing countries using Demographic and Health Survey (DHS) data found that, between the 1970s and 1980s, despite an increase in the mean within each country, the U5MR ratio between bottom and top income quintiles worsened in 11 cases, stayed the same in 10 and improved in only 3 small countries. There was no relationship, however, between worsening income distribution (measured by the directly observable 'assets index') and worsening U5MR inequalities (Minujin & Delamonica, 2003). The authors conclude that more detailed country case-studies are needed to determine how public policy differences improve the U5MR relative gaps.

Using 100-LEB as the outcome variable⁹ and aggregating country trends by income-group and regions, Cornia and Menchini (2006) found that, from 1960 – 2000, there was "steady and generalised decline in the rate of progress in 100-LEB ... robust to the removal of SSA

⁷ LEB and to a lesser extent mortality in the 5-14 age group converged markedly in the (then) fifteen European Union countries between 1970 and 1995, attributed to the EU Cohesion Fund that contributed 3-4 percent of the GDP of previously lagging southern European countries; that is, the convergence was policy-driven.

⁸ Including those in SSA, transition economies and the Bahamas, the Dominican Republic, Fiji, Haiti, Honduras, Iraq and North Korea,

⁹ By setting a hypothetical life maximum of 100 years, and then subtracting LEB, the study is able to compare trends in high LEB and low LEB countries/regions in a scale invariant fashion. As they note, "a two-year rise in LEB in a country with an LEB of 80 years generates a 10 percent improvement, that is identical to that generated by a rise of 6 years in a country with a LEB of 40 years" (p. 7). Their findings are the same when calculated using a hypothetical life maximum of 90 years.

and Eastern Europe” and “evident also in China and the East Asian countries” (p. 9). The slowdown was more modest in high-income countries and, overall, “was most pronounced in the 1990s” (p. 9). Global and regional inequalities in health also began to increase in the 1980s and persisted into the 1990s in between-country comparisons, even after removing SSA, implying that increasing inequalities in health status cannot be explained by AIDS only. The authors posit that “a broader set of factors is likely to have been at play” (p. 11). The authors identify these as including declines in revenue collection and public health spending associated with globalisation-driven tax reforms, tax competition and informalisation of the economy¹⁰; rise in local conflicts (which are often fuelled by global trade in scarce mineral or oil resources); changes in the structure and stability of households; and “last but not least ... the slow or negative growth and soaring income inequality observed over the last twenty years in many developing and transition countries that adopted botched liberalisation and globalisation policies such as loose bank deregulation, premature external liberalisation and regressive tax reforms” (p. 22). One example: a panel study of 68 developing countries found that worsening U5MR was significantly correlated with economic instabilities that are often linked to globalisation, such as financial crises, fluctuations in global commodity prices, unemployment following import liberalisation (Guillaumont et al., 2006). Global and regional inequalities in IMR have been rising since the 1980s, with the exceptions of transition economies and SSA where there was downwards convergence due to increases in countries with previous low rates of IMR.

Box 2. Globalisation, AIDS and health inequality

The AIDS pandemic has occurred concurrently with intensified global market integration. Dorling et al. (2006) examined the impact of AIDS on life expectancy at birth (LEB), aggregating findings at the level of continents (regions). It found a slowdown in improvements in LEB for all regions beginning in the early 1980s, with a decline in Africa beginning in 1985. The global slowdown is not entirely surprising,

¹⁰ The authors note that Latin America and the Middle East/North Africa regions managed to maintain fairly high levels of public health spending during the 1980s, despite rising income inequalities; and also recorded a less pronounced slowdown in 100-LEB during this period. However, both regions experienced substantial slowdowns in IMR and U5MR in the 1990s, “a period characterized by slow and volatile growth, mounting economic income inequality and stagnant or declining coverage of key public health programmes in favour of children” (p. 15).

since much of the improvement in LEB can occur in high infant mortality conditions with relatively low-cost public health interventions; further reductions in infant and under-5 mortality rates are more difficult and slower to achieve. Of more concern are findings that global health inequality declined steadily between 1950 and 1990, but has since reversed. This reversal, according to this study, is due almost entirely to the AIDS pandemic. The study further found that trends in global health parallel those in global wealth (measured as PPP-adjusted GDP/capita) with a slight time lag suggesting that rising wealth inequalities might partly underpin subsequent health inequalities. The authors conclude that “global inequality in wealth will have compounded the effects of AIDS on Africa” (p. 664).

While the level of data aggregation in their study makes it difficult to assess this inference, we earlier cited substantive evidence of how globalisation-related policies, notably those associated with structural adjustment programmes, increased HIV vulnerability in many SSA countries (e.g. De Vogli & Birbeck, 2005). The explanatory approach adopted by De Vogli & Birbeck is congruent with the findings of extensive multidisciplinary reviews of research on HIV/AIDS, tuberculosis and malaria (Bates et al., 2004a; Bates et al., 2004b), which emphasised less-developed countries and 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 reduce access to care are important determinants of vulnerability; and that “[c]omplex 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, p. 268). These studies not only caution against too great a reliance on narrowly targeted, disease-specific interventions (a topic addressed later in this Report and by the Health Systems Knowledge Network), but also suggest that the divergence in LEB has other causes (notably co-morbidities) besides AIDS.

The globalisation linkage hypothesized by Cornia and colleagues was tested in a commissioned paper undertaken for the GKN, which posits two categories of globalisation-related health determinants. The first category is “endogenous” in that the variables are only partially influenced by public policies. Endogenous variables include changes in consumption patterns, diffusion of health technology, health-related behaviours and migration. The

second category is “exogenous” or policy-driven, exemplified by the suite of neoliberal economic policies (see Box 3) that came to dominate social and economic policy discourse starting in the 1980s.

Box 3. Neoliberalism (briefly) defined

David Harvey defines neoliberalism as “in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (Harvey, 2005, p. 2). He and others identify as key promoters of the process of “neoliberalisation” the governments of Thatcher and Reagan (elected in 1979 and 1980) and, crucially in the developing world context, the post-1973 dictatorship of Pinochet in Chile.

Key elements of neoliberalism include deregulation of trade, investment and labour markets (the last often by way of direct legislative and judicial attacks on labour standards and collective bargaining) as well as privatisation. Privatisation involves not only selling off state assets (often on terms that made possible the accumulation of immense fortunes by the politically well connected, as in Mexico and the former Soviet Union), but also repudiation of norms of solidarity and collective responsibility that characterized an earlier era of social protection policy, in favour of a radically individualized approach to the risks that individuals and households face in the global marketplace (Fudge & Cossman, 2002; Hacker, 2004). The World Bank's *Social Protection Sector Strategy* (Holzmann & Jörgensen, 2001) is one of the purest expressions of this individualized ethos in the official literature.

This having been said, it is not clear how much is “neo” about neoliberalism. In many respects, it represents a return to the “non-redistributive laissez faire liberalism of the seventeenth and eighteenth centuries, which held that the main function of government was to make the world safe and predictable for the participants in a market economy” (Jaggar, 2002, p. 425). Even governments that are strongly committed to the neoliberal agenda of ‘free trade and free markets’ may be selective about implementing it when the stakes (e.g. maintaining support from domestic

producer interests that can affect a government's political survival) are sufficiently high.

The study provided prototypical case studies examining each of the five pathways identified earlier: material deprivation, acute psychosocial stress, unhealthy lifestyles, stratification and lack of social cohesion, and positive and negative shocks. This led to identification of a number of variables associated with each of the pathways that had been identified by other studies as correlated or causally associated with globalisation policies. Regression analyses on these variables for 136 countries were carried out using a Globalisation-Health Nexus database constructed for this purpose for the period 1960 - 2005. Key findings from these analyses are:

1. Most of the global gain in LEB (4.5 years) can be attributed to technological progress in medicine, with the caution that this was estimated using 'time dummies' that could be capturing other residual effects.
2. Income inequality strongly and significantly affected LEB and IMR, though was less robust for U5MR for which fewer data points were available.
3. Large increases in the Gini coefficient from one 5 year-period to the next reduced LEB by 1.6 years in the 1960s and 1.2 years over the 1980-2005 period, similar to values observed in the former USSR during the 1990s and supporting findings from other studies on the stress effects of large and sudden worsening inequalities, and their health impacts via increases in cardiovascular disease (CVD) and violent mortality.
4. Female illiteracy strongly and significantly affected health status; a reduction of 10 percent in the number of illiterate women would raise average LEB by just over one year, and reduce IMR and U5MR by 8.7 and 13.7/1,000 respectively.
5. Availability of health services (log physicians per 1,000 people/log GDP/c as an indicator of country effort) and preventive public health programmes (measured using DPT immunisation rate) were both highly significant in reducing IMR and U5MR.
6. Excess alcohol consumption (the only measure of unhealthy lifestyles used in the regression) negatively affected LEB, as well as IMR and U5MR.

7. AIDS was the only “random shock”¹¹ that had a significant impact on health status; wars and disasters, posited as possible shocks, were non-significant in the regression.

To test these findings econometrically, a new regression was undertaken in which results for the period 1980 – 2005 were compared to a counterfactual presuming continuation until 2005 of trends observed in the 1960 – 1980 period. Worldwide, globalisation-related policy-driven changes reduced LEB by 1.23 years relative to the counterfactual. However, this outcome was generated by several effects with opposing signs. The most significant explanatory variable was the rise in income inequality, which accounted for a world LEB reduction of 2.52 years when compared to the counterfactual. Smaller losses were explained by a slower rise in the number of physicians/1,000 population relative to GDP/capita (an indicator of the availability of health services). Conversely, improvements in health behaviours (in the OECD countries) and a rise in migrant stock/population (a measure of population flows) generated small but telling improvements in worldwide LEB relative to the counterfactual.

These findings do not mean that LEB globally actually *declined* between 1980 and 2005. In fact, it increased by 1.45 years. However this increase was explained not by globalisation, which *ceteris paribus* would have led to a decline in life expectancy, but rather by progress in health technologies that more than offset the globalisation-related losses. LEB also improved in most regions of the world, except for:

- The transition economies (-1.42 LEB) and the USSR (-3.57 LEB), where the LEB loss was explained by the collapse of their previous state-run health systems and lack of access to improvements afforded by health technology
- Latin America (-0.32 LEB), where health technology gains were insufficient to offset globalisation policy-related losses and
- SSA (-7.90 LEB), where HIV-AIDS losses overwhelmed substantial gains in health technology. (See Appendix 2 for the Table providing the full regression results.)

¹¹ Although a “random shock” for purposes of the modelling exercise, it should not be presumed that AIDS is in fact unrelated to globalisation and its influence on social stratification, differential exposure and differential vulnerability, as noted in Section 1.2.

The “biggest losers of the policy-driven changes...are sub-Saharan Africa and the two regions in transition [transition economies and former USSR] ... among the winners one can count the OECD and ... MENA ... while there is no appreciable change in East Asia excluding China” (Cornia et al., 2007, pp. 63-64).

The authors of this study treat progress in health technologies as an endogenous variable, that is, unaffected by globalisation-related policies. In the regression model it is approximated by DPT immunisation coverage and a period dummy. This is arguably a questionable assumption, since the diffusion of some health technologies was arguably facilitated by globalisation-related policies. That is, health technology gains may be partly exogenous. Nonetheless, as the study points out, health benefits of new technologies “will mainly accrue to high income countries and people, with the risk of enlarging mortality differential between countries, at least over the short term, and that the ability to control such differential depends crucially on the cost of transferring health technologies” (Cornia et al., 2007, p.17). Such costs could be affected *inter alia* by the new global regime of intellectual property rights. More general limitations in all such regression analyses render the findings suggestive rather than definitive.¹² However, “the negative association found between liberalisation-globalisation policies, poor economic performance and unsatisfactory health trends – for whatever reason – [s]eems to be quite robust” (Cornia et al., 2007, p. 71).

The results of this study further indicate the need for caution in assuming that global market integration will inevitably or equitably lead to health improvements. Rather, the study implies that national governments need to give much greater consideration to the health equity impacts of all macroeconomic or liberalisation policies they consider adopting or accepting. Health ministries, in particular, must engage with finance and trade ministries to ensure that such policies reduce health inequity. This requires careful *a priori* assessments

¹² In particular, apart from health technologies progress and HIV-AIDS, the authors attribute all the (positive or negative) differences in observed and simulated (counterfactual) LEB to neoliberal globalisation policies. They recognize that other factors could also account for the findings. They test this in a final regression analysis for two regions (Eastern European transition economies and Latin America) using a composite ‘overall reform index’ that measures the intensity of these policies, and three key determinants of LEB: GDP/capita, income inequality and income volatility, concluding that “in the two regions considered...the policy reforms of the last twenty years have affected negatively [these] three key social determinants of health” (Cornia et al., 2007, p. 69).

of potential health equity effects. A stronger obligation is implied on the part of wealthier and more powerful countries. They must ensure that the positions they take with respect *inter alia* to trade policy, debt cancellation and the conditions attached to development assistance will improve health equity in the countries with which they have foreign policy relationships. All these issues are discussed in greater detail in the sections of the Report that follow.

3. Globalisation and health (in)equity: Key pathways and policy implications

3.1 Globalisation magnifies asymmetries in power and resources

Economically, the past decades of global market integration have generated winners and losers because of what Nancy Birdsall of the US-based Centre for Global Development describes as globalisation's inherent asymmetries. Birdsall concludes that "a fundamental challenge posed by the increasing reach of global markets ('globalisation') is that global markets are inherently disequalizing, making rising inequality within developing countries more rather than less likely" (Birdsall, 2006, p. 18). She identifies three related reasons for this pattern:

1. The global marketplace rewards countries and individuals that already have abundant productive assets (financial, land, physical, institutional and human capital); for countries that lack them (the low- and some in the middle-income group) "success in global markets might be a future outcome of success with growth and development itself, but does not seem to be a key input" (Birdsall, 2006, p.23).
2. Market failures, such as financial crises, create negative externalities that disproportionately burden low- and middle-income countries with the least resources to deal with them. The costs (e.g. increased poverty, mandatory austerity measures, new debts incurred to regain currency stability) dampen growth; as does the increase in national income inequality that has been found to follow such crises.
3. Globalisation's rules favour the already rich (both countries and people within them) because they have more resources and greater ability to influence the design of the rules. Disparities of resources and bargaining power in trade negotiations, within and outside the framework of the WTO, are an important case in point (see e.g. Jawara & Kwa, 2003; Stiglitz & Charlton, 2005).

The result has been an increase in income inequality in all regions since 1980, apart from some high-income OECD countries where social transfers and public programmes have prevented the increase. Wide variation exists among OECD countries, and recent studies of inequalities, welfare regimes and health outcomes shed light on the relationship with globalisation. A statistical comparison of 17 OECD countries using data going back 50 years found that political parties with egalitarian ideologies tend to implement redistributive

welfare state and labour market policies and that such policies appear to have a positive effect on infant mortality and life expectancy at birth (Navarro et al., 2006). However a study of 11 affluent OECD countries found that most failed fully to compensate for the effects of growing inequality in market incomes during (roughly) the post-1980 period of contemporary globalisation; at best, all they did was to blunt the impact through increased transfers (Kenworthy & Pontusson, 2005). Outside the high-income countries, numerous examples exist of globalisation's tendencies to magnify inequalities both within and among countries; some of the reasons, although not all, are explored in greater detail in the discussion that follows.

Box 4. Visualising global inequality

---- **Insert Figure 2 here** ----

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 intra-country 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).

3.1.1 Initial endowments and primary commodity traps

There is virtual consensus amongst development economists that a country's ability to compete effectively in a more open global market depends upon its initial stock of productive assets, or what are sometimes called factor endowments. An unhealthy and uneducated populace is less able to work productively. A lack of domestic savings (wealth) requires costly borrowing on international markets. Weak regulatory institutions for domestic markets (e.g., property rights, labour rights, contracts enforcement or access to capital especially by poorer segments of the population) can diminish entrepreneurship. A land-locked country with minimal natural resources or industrial capacity, a large rural population engaged primarily in sustenance agriculture, and an unsustainable foreign debt load would be patently unable to compete with virtually any country faring better on any of these pre-existing endowments. Historical evidence suggests the importance in low-income countries of increasing both the labour intensity and the productivity of domestic agricultural production as a precursor to industrial development and growth, partly though not entirely through export of agricultural surpluses (Lipton, 2004; Diao et al., 2006).

At the same time, another near-axiom of development economics is what has been called the primary commodity trap, which Birdsall amongst others cites as explanation for weak economic growth over the past 20 years in many developing countries reliant on a small basket of primary commodities for their export earnings. Several factors have come into play: volatile global prices; slack demand due to the global economic slowdown of the 1980s and 1990s; and an oversupply partly attendant on more low-income countries, following World Bank advice, exporting more of the same commodity in competition with other low-income countries as they open themselves to the global economy. These factors have combined to drive down world prices, especially relative to the cost of imports many low-income countries require to produce their commodities. Reliance on primary commodities in the world's poorest region (SSA) declined as a percentage of merchandise exports from 88 (1984) to 73 (2004), but remains high and problematic in terms of effects on the volatility of economic growth (World Bank, 2007c, Section 6.1). Recently, high oil prices and increased demand for many minerals from India and (especially) China have driven prices for the relevant commodities higher, but it is too early to say whether this represents a long-term trend or what the implications might be for developing economies.

3.1.2 Global labour markets

“For most of the world’s people, economic opportunities are primarily determined, or at least mediated, by the labor market – in formal and informal work The functioning of the labor market has a profound effect on equity – across workers, in patterns of access to work, and between workers and employers” (World Bank, 2005b, pp. 185-186). Because of their close relation to income, labour market outcomes can either reduce or increase the socioeconomic gradient in health status that is observable in countries rich and poor alike (Marmot, 2006).

To return to the typology outlined in Section 2.1, the pathways can involve both material deprivation and acute psychosocial stress. A further influence involves the connection between labour markets and the consequences of illness. This connection is evident in countries as diverse as the United States, where insurance coverage for much of the privately insured population is tied to a particular job and more than 40 million people lack insurance, and Viet Nam, where limited compulsory insurance coverage for a minority of workers in the formal economy coexists with a very high proportion of private, out-of-pocket health expenditure and out-of-pocket health care costs push large numbers of people into poverty every year (Sepehri et al., 2003; United Nations Country Team Viet Nam, 2003; van Doorslaer et al., 2006). At the same time, the labour market opportunities presented by globalisation offer possibilities for improving SDH through, e.g., poverty reduction and the improvements in nutrition and housing that accompany higher incomes. Although generalisations about the balance of negative and positive effects must be treated with caution given context- (country-) specific differences, it is useful to describe these effects by way of a series of stylised facts.

Firstly, “More than one billion people struggle to survive on less than \$1 a day. Of these, roughly half – 550 million – are working. By definition, these working poor cannot work their way out of extreme poverty. They simply do not earn enough to feed themselves and their families, much less to deal with the economic risks and uncertainty they face. Yet employment is not high on the international agenda for poverty reduction ...” (Chen et al., 2006a, p. 2131, citations omitted but checked).¹³ Thus, employment issues must be central

¹³ Despite the language of the first MDG, the targets specified for measuring progress toward it do not specify “eradicating” extreme poverty or hunger, but merely reducing their prevalence.

to any analysis of globalisation's effects on SDH, and must be explicitly addressed in development and health policy alike.

Secondly, a generation ago, researchers examining changing patterns of employment in the industrialised world described a "new international division of labour," exemplified by the relocation of labour-intensive production in the textile and garment industries to sites in the developing world selected on the basis of low wages and minimal protections for workers, often located in Export Processing Zones (EPZs) that offered incentives to investors in export production (Fröbel et al., 1980).¹⁴ More recently, labour markets in industrialised and developing countries alike have been transformed by the global integration of production (Dicken, 2003), which now involves not only foreign direct investment by transnational corporations (TNCs), but also contractual relationships with external suppliers and service providers ('outsourcing'), with the latter expanding rapidly in importance. The resulting, increasingly fine-grained process of "slic[ing] up the value chain" (Krugman, 1995, p.332) locates each step of production where it contributes most to overall returns while reducing risks (Sturgeon, 2001). Another way of thinking about this process is that trade in goods is being replaced by trade in tasks, and not only for labour-intensive elements of routine production (Grossman & Rossi-Hansberg, 2006a; Grossman & Rossi-Hansberg, 2006b).

Thirdly, globalisation is leading to the gradual emergence of a genuinely global labour market (World Bank, 1995), within which there are both winners and losers (Rama, 2003). The industrialised countries have seen a precipitous drop in the demand for, and the labour incomes of, 'unskilled' workers (Nickell & Bell, 1995).¹⁵ Globalisation tends to increase inequalities between 'skilled' and 'unskilled' workers, both within national economies and across national borders. This point is emphasised in the World Bank's 2007 *Global Economic*

¹⁴ According to the International Labour Organization, EPZs continue to be important sites of production, with more than 63 million workers employed in more than 2700 EPZs worldwide; of these, approximately 40 million workers are in China (International Labour Organization, 2004). The degree of protection workers in such zones enjoy with respect to wages and working conditions varies considerably.

¹⁵ The distinction between skilled and unskilled workers is problematic, although widely used in the literature, for at least two reasons: (a) in conventional usage it does not appear to have any clear relation to the complexity of the tasks involved (an exception, which refers specifically to the ease of difficulty of outsourcing a particular task, is Grossman & Rossi-Hansberg, 2006a), and (b) it focuses attention on characteristics of the individual rather than on the social environment and on factors affecting stratification such as law and public policy related to unionization.

Prospects report, which predicts the expansion of a global middle class, yet at the same time anticipates that labour market effects of globalisation will lead to increased economic inequality in countries accounting for 86 percent of the developing world's population over the period until 2030, with the "unskilled poor" being left farther behind (World Bank, 2007b, pp. 67-100). This is almost certainly a substantial understatement of the true increase in economic inequality that can be anticipated, since the World Bank scenario does not consider the potential impact on economic distribution, either directly or by way of influence on policies that affect it, of shifts in the distribution of income from labour to capital.¹⁶

The integration of India, China and the transition economies into the global economy will roughly double the size of the global labour force. Some commentators argue that this will exert long-term worldwide downward pressure on wages, indeed is already doing so (Woodall, 2006; see also Freeman, 2006). Collier further warns that the implications for development possibilities in countries outside Asia are substantial, because countries that have yet to begin the process of industrialisation have no labour cost advantage relative to their Asian competitors – in contrast to the situation of those Asian competitors when they began to compete in markets for manufactured exports based on "a wage advantage over the existing competition (in OECD countries) of around forty-to-one." (Collier, 2006, p. 1437) An alternative perspective is that wage inflation in economies like China's "will create space for low-income countries to move into the lowest-skill activities vacated by producers in the large emerging countries" (World Bank, 2007b, p. 102).

Fourthly, global economic integration and the expansion of the global labour force are almost certainly combining to generate increased pressures for labour market 'flexibility,' with negative effects on economic security. Generically, Cox (1999) argues that globalisation leads to a division among integrated, precarious and excluded forms of employment – a typology that is valuable because it focuses on the character of the employment relationship, rather than its geographical situation within production networks that are often

¹⁶ This is an important omission: between 1980 and 2006 wages as a share of national income in the G10 countries as a percentage of GDP fell from almost 63% to just under 59%, while corporate profits in the G7 countries rose from 13 percent to roughly 15.5 percent (Woodall, 2006, pp. 6-7). Outside the industrialized world, in Mexico the proportion of GDP going to wages fell from 40 percent in 1976 to 18.9 percent in 2000, during a period of rapid integration into the global economy and two major economic crises (Palma, 2006, pp. 15-16).

in continuous flux, as in the case of the global software industry (Mir et al., 2000) Within the industrialised world, Cox's typology is validated by research on US corporate downsizing in the 1990s, and the associated rise in temporary or contractual employment relationships (Gringeri, 1994; Hammonds et al., 1994; Uchitelle et al., 1996; DiTomaso, 2001). Elsewhere, the typology is validated by 1997 survey data from eight Latin American countries¹⁷ showing that "the occupational structure has become the foundation for an unyielding and stable polarisation 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, pp. 61-91). Although connections with globalisation will vary among countries and regions, interpretation of these data by links "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, pp. 93-102).

Fifthly, men and women experience globalisation's effects on labour markets differently. In general, globalisation has been accompanied by the reproduction of existing gender hierarchies (Mills, 2003), as women tend to occupy lower paid, less desirable jobs while continuing to bear a disproportionate share of responsibility for unpaid work in the household. A further manifestation of gender hierarchies is the emergence of a global political economy of care work, overwhelmingly done by women. "The same processes that increase cross-border supply through the disembodied export of labor in EPZs (export processing zones) or outsourcing of IT (information technology) service work also promote the embodied supply of care work through transnational migration" (Summerfield et al., 2006, p. 281; see also United Nations Development Programme, 1999, pp. 77-96; Ehrenreich & Hochschild, eds., 2002; Misra et al., 2006; Pyle, 2006b), often at considerable emotional and health cost to migrants themselves and their families (Pyle, 2006a). Sassen identifies the global political economy of care as just one of several "survival circuits" into which women are driven, and in which they are often exploited, as a consequence of globalisation's effects on national economies and the capacities of national governments (Sassen, 2000; Sassen, 2002).

¹⁷ Brazil, Chile, Colombia, Costa Rica, El Salvador, Mexico, Panama and Venezuela.

A review of gender dimensions of the globalisation of production carried out for the World Commission on the Social Dimension of Globalization concluded that: "The single most important factor which acts as a barrier to women's ability to participate as full economic actors in the global economy is their domestic responsibilities, and for a large subgroup, their childcare responsibilities. The childcare constraint appears to operate across contexts which are otherwise very different" (Barrientos et al., 2004, p. 13). This finding is borne out by other studies, notably Heymann's report of cross-national research involving surveys of 55,000 households and more than 1,000 in-depth interviews in eight countries (Heymann, 2006). At the same time, it is important to identify elimination of this constraint as a necessary, but not a sufficient condition for the equal participation of women in national economies and the global marketplace. More generally, the role of women in labour markets cannot be separated from broader issues of gender inequality and discrimination, or from the asymmetrical distribution of power, resources and opportunities that characterises contemporary globalisation.

Sixthly, discussion of globalisation and labour markets often concentrates on people employed in the formal economy. However, in many low- and middle-income countries they are in a minority (Garcia, 2004; Chen et al., 2006a). In India, for example, 92 percent of workers are engaged in informal employment, either self-employed or in waged employment but without contracts or social protection (Chen et al., 2006a), and for the developing world as a whole "fully 50 to 80 percent of non-agricultural employment is informal" (Chen et al., 2005a, p. 8). Although generalisations about the link between globalisation and informalisation of work should be made with caution, abundant descriptive evidence suggests that at least four elements of globalisation can shift workers from the formal into the informal economy: (a) rapid import liberalisation, leading to job losses in formerly protected sectors; (b) the organisation of production in global commodity chains with intense price competition among suppliers, creating pressure (for example) to maximise flexibility by employing women who work from their homes as self-employed individuals or contractors; (c) austerity programmes that are adopted in response to lender conditionalities, especially those of the International Monetary Fund (IMF); and (d) currency crises. In most regions of the world, gender hierarchies in labour markets extend to the informal sector, with women more likely to engage in this type of employment while at the same time, as almost everywhere, bearing a disproportionate share of the burden of unpaid care work. Thus, it is crucial (for instance) to reject the categorisation of women outside the

money economy as economically inactive, and to question the view that participation in the formal economy even on more egalitarian terms than are now available will lead to women's "equality or empowerment" (Pearson, 2004, p. 119).

Finally, the effects of currency crises demand special policy attention from an economic and health equity perspective. It is important to recognise not only short-term consequences for economic inequality – such crises can quickly push literally millions of people into poverty – but also the longer term employment impact. Multiple country case studies show that economic growth after a crisis is not accompanied by comparable growth in employment (van der Hoeven & Lübker, 2005); these case studies do not take into account crisis effects on wage levels and economic (in)security, and therefore almost certainly understate the full negative impact of such crises as transmitted through labour markets.

Policy implications

Among the key objectives of economic policy should be the creation of an economic environment which generates livelihoods for all people, providing stable incomes at a level consistent with their physical, mental and social well-being; and social protection for those unable to attain or sustain such a livelihood. This will mean 'bringing employment back in' as a central concern of economic and development policy, which in recent years has often been more concerned with macroeconomic variables such as GDP growth and low inflation, neglecting equity implications and the fact that there are often multiple viable approaches to sound macroeconomic policy, with radically different human consequences (World Bank, 2005b, pp. 188-189). Thus, governments such as South Africa's have opted for policies that have resulted in "dismal development and excellent macroeconomic outcomes" (Streak, 2004, p.271) with the former including negative employment growth and an official unemployment rate around 30 percent. The issue of employment suggests that it is important for national governments and multilateral institutions alike to incorporate health equity and human development considerations into their assessments of economic policy. For example, in a discussion of labour market policy the World Bank (2005b) argues that Indian states that amended their labour legislation "in the direction of reinforcing security rights of workers and other pro-labor measures had lower output and productivity growth in formal manufacturing than those that did not change it or that made labor regulations more

flexible" (p. 187). Whether or not the finding is correct, the indicators selected are not the appropriate ones for purpose of health equity.

One approach to labour market policy treats the primary objective as correcting for market failures; this approach is exemplified by recent World Bank inventories (World Bank, 2005b, pp. 186-193; World Bank, 2007b, pp. 125-133) of measures that national and sub-national governments can take to make labour markets function more equitably. Although these inventories represent a useful starting point, they sometimes state objectives too narrowly and imply that interventions that do not correct for market failures normally involve rent-seeking or corruption (World Bank, 2005b, p. 187). While recognising the constraints within which national labour market policies must operate in a global economy, in our view it is more productive to view labour market policies as just one part of a much larger set of social protection policies explicitly organised around reducing inequalities in access to SDH. This is, in fact, the approach implicitly adopted by the World Bank in its 2006 World Development Report, where (for instance) early childhood development programmes, public expenditure on health care to improve equity in access to treatment, and public works programmes to provide employment incomes are identified as important policies to improve human capacities (World Bank, 2005b, pp. 132-155). This approach should guide national governments, development assistance providers and other key institutions of the international community. Social protection policies themselves must be guided by consideration of health equity objectives that may be quite distinct from the market-driven allocations of resources taken as a baseline in the World Bank's own Social Protection Sector Strategy (Holzmann & Jörgensen, 2001).

Adoption and effective implementation of the International Labour Organisation's four core labour standards (which address free association, collective bargaining, elimination of economic discrimination by gender, and the elimination of forced labour) must be a priority of all national governments and multilateral institutions – especially given evidence of the continued pervasiveness of slavery and other forms of forced labour (Bales, 2000; O'Brien, 2007; Van den Anker, 2007; Belser, 2007; Ndiaye, 2007; Pangsapa, 2007). As noted below (Section 3.2), some evidence suggests that the process of improving labour standards is facilitated, rather than hindered, by economic openness, although caution is in order about the extent of effective implementation. At the same time, efforts to internationalise the enforcement of labour standards by way of such mechanisms as 'social clauses' in trade

agreements may have undesirable and unintended consequences, for reasons suggested in the case study of Bangladesh's export-oriented garment industry in Appendix 3.

Many instruments of labour market policy are likely to be of limited relevance to the very large proportion of workers in the developing world who are employed in the informal economy. Initiatives like India's Self-Employed Women's Association (SEWA; see Appendix 3) have demonstrated their effectiveness in improving the situation of the majority of active labour force participants in the developing world who are outside the formal economy (Jhabvala & Kanbur, 2002; Chen et al., eds., 2004; Chen et al., 2005b; Vaux & Lund, 2006), and must therefore be encouraged with (for example) appropriate legislative changes (by national governments) and, where appropriate, financial support from donors and lenders. At the same time, such organisations cannot be expected to replace or avoid the need for involvement by national governments (in the first instance) and the international community.

Finally, in view of the evidence on how (lack of) access to child care facilitates or impedes women's abilities to take advantage of the labour market opportunities presented by globalisation, quite apart from its importance on other counts, priority must be given to providing all women with access to child care, free or at minimal cost, through the appropriate combination of labour standards and direct public expenditure by national governments and development assistance providers (Heymann, 2006). Research provides an indispensable starting point and resource guide, and policy here should be motivated by the twin (and inseparable) goals of improving children's welfare and improving that of the women who care for them. Economic opportunity is only part of the equation, and this is a win-win opportunity for national governments and the international community if ever there was one.

3.1.3 Global market integration and national policy space

For our purposes, the concept of policy space is broadly applicable to situations in which characteristics of the international (economic, political, legal) environment create constraints on the ability of national (or sub-national) governments to adopt policies that promote health equity. Policy space is defined by *the extent to which national decisions for health and on SDH can be made on the basis of health policy concerns and priorities* as distinct

from other priorities such as economic growth, maintaining payments to external creditors or complying with trade agreement disciplines. Restrictions on national policy space can also be health-positive, as with the international framework for human rights and global labour conventions, to the extent that these actively bind governments or can serve as resources for domestic and international advocacy. The fact that policy space is available to governments does not necessarily mean that it will be used; governments may not take advantage of the policy space available to them to promote health, tackle social determinants of health or equity in access to health care, for a variety of reasons.

Trade agreements limit the range of policy instruments available to governments; indeed, that is their intent. The most familiar health-related example involves the harmonisation of intellectual property protection for pharmaceuticals under the Agreement on Trade-Related Aspects of Intellectual Property (TRIPs). Similar concerns arise with respect to other sectors important to SDH, such as provision of water and food. Each set of these concerns is addressed separately later in the Report. Trade in health services is a concern because of the emergence of social and health services as areas of global commercial activity (Mattoo & Rathindran, 2006); impacts of the General Agreement on Trade in Services have been identified in relation to overall health policy (Fidler et al., 2005; Blouin et al., eds., 2006), domestic regulation stipulations (Luff, 2003) and public services (Krajewski, 2003; Adlung, 2006). To protect national policy space for health and SDH, more emphasis must be placed on the rule-setting part of trade negotiations covering measures in several sectors, such as those concerning domestic regulation, government procurement and subsidies. This requires concerted effort, as trade negotiations tend to be driven by commercial considerations (Koivusalo, 2003). Indeed, the TRIPs agreement is an example of the power and capacities of commercial actors to secure their rights through international legal agreements (Matthews, 2002; Sell, 2003). The availability of policy space provided for by multilateral trade agreements, such as TRIPs, may also be lost due to more extensive bilateral agreements or pressures with respect to particular interpretation and understanding of what trade agreements actually imply (Correa, 2002; May, 2004).

Effects on SDH can also arise from the context of economic development policy as a whole. A frequently stated concern is that World Trade Organization (WTO) disciplines that are either already in place or under negotiation will restrict the ability of developing country governments to favour domestic producers and industries with the potential for rapid

growth. Such policies were routinely used by today's high-income countries during the process of industrialising, and successful late industrialisers have adopted dirigiste policies at least some of which would not be allowed under the current WTO regime (Akyüz, 2005; Rodrik, 2005). Looking to the future, Chang warns that remaining policy flexibilities could be eliminated by the outcome of WTO negotiations on non-agricultural market access (NAMA), "re-introducing precisely the trade rules employed by the imperial powers to stifle the development of poor countries" (Chang, 2005, p. 62). However, demonstrating the mercantilism of the industrialised world's trade policy stance is not the same as showing that it actually constrains developing country economic policies. Straightforward examples of situations in which governments have been prevented by current WTO disciplines from implementing objectives related to economic development or redistributive social policy to which they were genuinely committed are harder to find, and the extent to which such measures are now in fact impermissible is not clear (Amsden, 2000; Di Caprio & Amsden, 2004; Rodrik, 2004; Akyüz, 2007).

Even if more policy flexibility under WTO agreements as now written is available than pessimistic assessments conclude, reasons exist for concern. Trade negotiations are ongoing, and flexibilities that exist today may be precluded tomorrow (Akyüz, 2005). Differences in market size affect not only initial bargaining positions but also the ability of countries to make effective use of dispute resolution even when the outcome is favourable (Stiglitz & Charlton, 2004, p. 504).¹⁸ Further, the WTO is only part of the international trade policy regime; bilateral and regional agreements are increasing in number and importance (World Bank, 2004, pp. 27-56; Choudry, 2005). In these negotiating relationships, disparities in bargaining power and resources may be even more glaring than at the WTO, so '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).

Conditionalities attached to loans from the World Bank and the International Monetary Fund (IMF) became a central feature of the economic policy landscape in many developing

¹⁸ Trade compensation won by a high-income country against a low-income nation could be devastating for the latter, ensuring compliance with the ruling. Conversely, such compensation won by a low-income country against a high-income nation would scarcely be noticed, minimizing the likelihood of compliance, and might even be damaging to the low-income country's economy.

countries over the past 25 years. These conditions were aimed at providing governments with an incentive to restructure domestic economies (“structural adjustment”) in order to reduce inflation, improve macroeconomic fundamentals and protect the ability to repay external creditors (Kahler, 1992; Woods, 2006a). Like trade agreements, their intent was to restrict the policy space available to national governments – sometimes with the agreement of the government in question, sometimes in the face of intense governmental and popular resistance. Although it is often difficult to separate the effects of structural adjustment from other variables, research emphasises that it often preceded increased disparities in health outcomes and in SDH (see e.g. Cornia et al., eds., 1987; Cheru, 1999; Breman & Shelton, 2001; Bhattacharya et al., 2002). The historical literature on lender conditionalities, structural adjustment and impacts on SDH cannot be reviewed here in detail.¹⁹ Although structural adjustment has been superseded by the supposedly more participatory Poverty Reduction Strategy Paper (PRSPs) process, concerns remain about the extent and direction of lender influence, within this process itself and, more generally, because private investors in international financial markets view IMF approval of a country’s macroeconomic policies as an almost indispensable seal of approval (Sachs, 1998; Woods, 2006b, pp. 375-376). Furthermore, as one Canadian study on efforts to rebuild health systems in Tanzania put it: “The era of structural adjustment may be over, but the effects of earlier damage continue to cast a long shadow” (de Savigny et al., 2004, p. 10).

Above and beyond the effects of explicit conditionality, the increased ease and speed with which money can move around the world facilitates what Griffith-Jones & Stallings (1995) have called “implicit conditionality.” The “open production environment” created by the global reorganization of production “mercilessly weeds out those centers with below-par macroeconomic environments, services, and labor-market flexibility,” according to the World Bank (1999, p. 50). Recurrent financial crises that have seen national currencies lose half their value or more (see Section 3.3) are the extreme consequence of the hypermobility of

¹⁹ A longer discussion of structural adjustment and its implications for SDH is provided by Labonte & Schrecker, 2007b. The counterargument is that, to the extent that macroeconomic constraints on policy space that formed the standard adjustment package improved economic growth, they enhanced policy space by increasing the revenues potentially available to fund public expenditure. As will be seen later, however, tariff reductions that were part of adjustment failed in most low- and middle-income countries to generate a sufficient level of growth to compensate for lost government revenues and, more recently, constraints on the wage bill component of public expenditures have in at least some instances limited governments’ ability to spend on basic needs like health care and education.

portfolio investment. Anticipation of such a crisis means that even governments with strong commitments to egalitarian domestic policy directions may have to temper these commitments in order to maintain their credibility with international financial markets, as in the Brazilian case briefly summarized in Appendix 3. However, analysis should not focus only on investors outside a country's borders. Capital flight (see the further discussion in section 3.3) magnifies inequalities by offering the rich a powerful source of influence on domestic policy, and also an escape route that is not available to the rest of the population in the event of financial crises (World Bank, 2005b, pp. 199-201).

Policy implications

Lack of governmental attention to the implications of policies outside the health sector for health outcomes and SDH may be a function of limited capacity and understanding. Neither of these is independent of globalisation. In the first instance, capacity relates to a country's ability to mobilise financial and human resources, which can be compromised in a number of ways. Governments should explicitly address national priorities with respect to health and social determinants of health as these may be affected by trade and economic policy choices. They should build up their capacity for analyzing policy impacts of this kind, and should in particular ensure that health ministries are able to articulate their views effectively. This is why, elsewhere in the Report, we cite the importance of ensuring that health officials are actively engaged in the preparation of trade negotiation positions as they relate to health (Blouin, 2007). Mechanisms such as health equity or right to health impact assessments can be utilised to move health and SDH issues higher on national government and multilateral political agendas.

WHO support is of particular importance when health concerns and trade concerns are in conflict at the national level. WHO should ensure that it has sufficient capacity and expertise, including legal expertise, to provide Member States with technical guidance and support with respect to maintaining policy space for health. This would require (for example) a broader focus on what takes place in WTO negotiations. WHO presence and capacities to follow negotiations that take place in WTO and the World Intellectual Property Organization (WIPO) remain limited. Specific attention needs to be given to addressing trade-related negotiations on domestic regulation, subsidies and government procurement, as well as those affecting globally organised production and financial markets. This may

include or require collaboration with other UN agencies, such as the International Labour Organization (ILO), UNESCO, FAO, UNCTAD and the United Nations Department of Economic and Social Affairs (UNDESA), to create a cross-sectoral and more extensive evidence base for understanding issues related to governance, globalisation and social determinants of health (see Section 4).

Constraints on policy space also arise from the globalisation of ideas and assumptions about what should/should not be done through public policies. In the recent past this has included intensive promotion of market-oriented prescriptions “developed within the walls of the North American academia and shaped by international financial institutions,” meaning that “[f]or the first time in history capitalism is being adopted as an application of a doctrine, rather than evolving as a historical process of trial and error” (Przeworski et al., 1995, p. viii). Alternatively, as in the case of capital flight by domestic asset-holders, the choices involved may constrain public policy on the basis of property rights rather than democratic accountability. A key area for action by the international community therefore involves changes in mechanisms of global governance, and in what might be called the international architecture of economic power (Labonte & Schrecker, 2007c). We return to this topic in Section 4.

3.2. The global marketplace: Trade liberalisation

As noted above, the policy environment within which trade policy commitments are made is characterised by major asymmetries in bargaining power – a point that is important to keep in mind when considering opportunities to reform the international trade regime. At the country level, direct evidence of impacts on social determinants of health is mixed. The Introduction reviewed arguments that trade liberalisation increases growth, which in turn reduces poverty and improves health, concluding that there is no automatic relationship between increased trade or growth and poverty reduction or better health.

On the health-positive side, there is some evidence that trade openness (measured by the sum of exports and imports divided by GDP) and a higher stock of foreign direct investment are correlated in cross-country regression analyses with a lower incidence of child labour (Neumayer & De Soysa, 2005b). The same trade openness measure also correlates with a lower incidence of reported violations of core labour standards such as free association,

collective bargaining, and the elimination of economic discrimination (by gender) and forced labour (Neumayer & De Soysa, 2005b; Neumayer & De Soysa, 2006). The study's design, however, does not allow determination of whether a lower incidence of child labour precedes or follows trade openness, or whether it is affected by an emphasis on exports rather than imports or vice versa – i.e., the direction of causation is unclear. Regarding labour rights, the authors themselves caution that their findings are suggestive only: "It is entirely possible, of course, perhaps even likely, that globalisation boosts the bargaining power of capital at the expense of labor, which would put downward pressure on outcome-related labour standards such as wages, working times and other employment conditions" (Neumayer & De Soysa, 2005a, p. 29).

In addition to underscoring the overall importance of increased attention to the relations between trade and health, as noted above in discussion of national policy space, the GKN focused its analysis of trade liberalisation and its policy recommendations on a limited number of issues.

3.2.1 Economic insecurity

Economic insecurity is closely linked to many chronic stress-related diseases: its impact on health outcomes can be direct (Sen, 1997; Marmot & Bobak, 2000; Wilkinson & Marmot, 2003). Epidemiological research has shown that acute stress leads to physiological and psychological arousal, which provokes sudden changes in heart rate, blood pressures and viscosity, a reduction in the ability to maintain emotional balance and a pervasive sense of uncertainty, powerlessness and loss of social role (Cornia et al., 2007). One example of the negative impact of trade liberalisation on economic insecurity and health is the sharp rise in the suicide rate among cotton farmers in the Warangal District in Andhra Pradesh, India (Sudhakumari, 2002). In 1991, the Indian government changed agricultural policy to encourage farmers to produce commodities for exports such as cotton. However, due to the high volatility of world market prices in cotton, the absence of any domestic insurance programmes, decline in state support for rural activities and problems with the local credit markets, many cotton farmers become heavily indebted and increasingly desperate.

The most dramatic case of rising stress-related mortality linked to unmitigated macro and micro instability is that observed in the difficult transition to a market economy in the former

Soviet Union and the southern Eastern European states. The health impact of these developments entailed for the 1990s an excess mortality of over 10 million people, due primarily to the psychosocial stress endured by a large part of the population trying to adjust to loss of employment, unstable employment in unregulated labour markets, family breakdown and distress migration (Cornia & Paniccà, 2000). The decline in life expectancy for males in Russia since the early 1990s is another startling case of the impact of economic insecurity on the level of psychosocial stress, especially reflected in increase in alcohol consumption, alcohol-related illness and violent mortality (suicide, homicide) (Cornia & Paniccà, 2000; United Nations Development Programme, 2005).

Globalisation generally, and trade liberalisation specifically, create winners and losers in domestic economies. As noted in the preceding discussion of labour markets, workers and producers in the sectors that were protected from foreign competition may see their revenues decrease or their employment disappear when tariffs or regulatory barriers are removed. The negative impacts are not limited to one-time adjustments to trade reforms. An ILO study of manufacturing employment in 77 countries, for example, found that a higher level of international trade in a national economy is associated with greater movement of workers between sectors. Such intersectoral movement makes it more difficult and costly for displaced workers to find new employment, as moving into a different sector usually requires a different set of skills (Torres, 2001). The literature generally supports the view that trade liberalisation and openness increase economic insecurity (e.g., Rodrik, 1997; Garrett, 1998; Rodrik, 1998; Burgoon, 2001; Hayes et al., 2002; Boix, 2002; Gunter & van der Hoeven, 2004), although consensus is lacking on this point (see Bourguignon & Goh, 2003 for a review of studies challenging this linkage).

Greater agreement exists that financial liberalisation and capital movements are more important determinants of economic instability than trade openness (Cornia, 2001; Scheve & Slaughter, 2004; van der Hoeven & Lübker, 2005). Trade liberalisation, however, is usually accompanied by increased openness to foreign capital and liberalisation of financial markets and services²⁰. The combined effect of trade and financial liberalisation has been more

²⁰ Some disaggregation of the effects of different forms of liberalisation on income inequalities exists in the literature. For example, an analysis of the impact of overall liberalisation in 18 Latin American countries over 1980-98. Behrman et al. (2000) found that the reform had a significant short and medium term disequalizing effect, though such effect declined over time. Trade liberalisation did not affect significantly inequality, and specific

volatile markets and increased frequency of external shocks (such as financial crises, currency devaluations and rapid changes in labour markets and employment) which translate into increased economic insecurity of individuals.

Policy implications

Stronger social protection policies are needed to mitigate the negative impacts of trade liberalisation-related economic insecurity. The literature usually warns against adopting special measures to deal with risks associated with trade liberalisation, recommending instead improvements to general social protection. Indeed, it can be difficult to identify which individuals or households which have been affected by instability linked to trade openness, in contrast to other sources of instability such as economic restructuring due to technological change.

It is important to distinguish social protection recommendations for low- and for middle-income countries. Low-income countries generally have limited financial resources available to fund social protection, and limited capacity to raise such funds given that a large part of their economy is informal and/or based on subsistence agriculture. The resources available may be further reduced by trade liberalisation (see Section 3.2). Given these limited resources social protection should focus on interventions that contribute to long-term poverty reduction and that have multiplier effects (Smith & Subbarao, 2003), such as health insurance schemes that protect against unexpected medical expenses. Medical expenses constitute one of the main threats to household livelihood in low-income countries (Norton et al., 2001; Wagstaff et al., 2001) and are a major source of impoverishment (so-called 'medical poverty'). However, social health insurance (i.e., insurance tied to employment) generally covers no more than 5 percent of the workforce in low-income countries, given their low level of formal employment.²¹ In these conditions, the focus of the national government should be on creating an enabling environment for the development of community-based health insurance schemes (Van Ginneken, 2003) or national health

country outcomes depended on country conditions. The strongest disequalizing effect was due to international financial liberalisation, followed by domestic financial liberalisation and tax reform (adapted from Cornia et al., 2007, p. 67).

²¹ Even in high-income countries like the United States, health insurance linked to employment creates both health inequities for workers when labour markets create less secure forms of employment, and higher costs for employers.

insurance schemes funded by progressive taxation. The latter are preferable, both because communities may lack sufficient savings for effective risk-pooling (for more detailed discussions on this point, see the Final Report of the Health Systems Knowledge Network) and because, if there are large inequalities in average income or wealth between communities, relying on community-based insurance may fail when measured against the WHO criteria for fairness in cross-subsidisation from rich to poor, and from healthy to sick (World Health Organization, 2000).

Middle-income countries have a wider range of instruments available to them to reduce economic insecurity. A key policy issue becomes whether social protection should be targeted to particular groups or tend towards universality of coverage. Targeted programmes may be attractive in terms of reducing the fiscal implications of social protection (Ravallion, 2003; Coady et al., 2004; Prichett, 2005). Many middle-income countries, however, are now striving for universal coverage, realising that there is a need “for broad-based social security systems that have the support of the majority of the population” (Van Ginneken, 2003). While some analysts argue for a combination of social insurance (tied to employment) and tax-funded benefits, evaluative and policy studies offer powerful arguments in favour of tax-funded universal systems. Targeted coverage is exclusionary and reinforces existing social stratification and stigmatisation. Macroeconomic shocks are a rude reminder that in times of systemic crisis there is little that separates middle from lower-middle classes, and even from those below the official income poverty line. This reinforces the claim that universality of coverage is inherently desirable, insofar as it forms the foundation of a wider economic solidarity that is indispensable in precarious times. Finally, targeted programmes often involve greater administrative costs and are prone to ‘leakage’ on many levels.

The financial and economic crisis that hit Asia in 1997 generated responses in the form of social protection programmes from which a number of lessons can be drawn (Gough, 2001; United Nations Economic and Social Commission for Asia and the Pacific, 2001a; Whiteford, ed., 2002; Blouin et al., 2007). Firstly, social protection programmes should be designed in a flexible manner, allowing them to be easily scaled-up in response to large economy-wide shocks; the case of an employment guarantee scheme in India provides an example of such flexibility (see Appendix 3). Secondly, it is important that critical programmes be identified *a priori* with commitments for their protection from budget cuts during a crisis. This forces

recognition of policy/ programme priorities, institutionalises the link between social and economic domains and sends a clear message to donors with respect to which sectors require greatest assistance when a crisis hits (Blomquist et al., 2002). The list of safeguarded programmes should be guided by an overall strategy to prevent human development reversal, with a focus on preventing the long-term health impacts of insecurity.

3.2.2 Declines in public revenues

The second area for intervention concerns the impact of trade liberalisation on government revenues. Trade reforms often take the form of reduction or elimination of tariffs on imports. Despite years of tariff reductions, tariff revenues are still an important source of public revenues in many developing countries.²² Public expenditures on health, water, social services and others public initiatives linked to SDH thus can be directly affected by trade reforms – important since reduction in government expenditures on basic services was found to be the key intervening variable linking structural adjustment policies of the 1980s to deterioration in indicators of child health and access to determinants of health (Cornia et al., eds., 1987).

A number of recent studies have concluded that trade reforms in low-income countries have reduced tariffs revenues since the 1970s. Many of these countries have not been able to replace these losses with other sources of public revenues or taxation. For a majority of low-income countries there has been a net decline in overall public revenues. Middle-income countries have fared slightly better, but in general trade liberalisation has translated into a reduced capacity of national governments to support public expenditures in health, education and other sectors. High-income countries, with already well established taxation systems and existing public infrastructures, have been able to move away from tariffs revenues with minimal loss in fiscal capacity.

²² It is important to highlight the stark difference between developed and developing countries when it comes to tariffs as a source of government revenue. World Bank data indicate that the contribution of tariff revenues to total government revenues ranges greatly, from virtually nothing in the European Union to over 76 percent in Guinea (Baunsgaard & Keen, 2005). Less extreme examples (more representative of developing countries) are those of Cameroon and India, where tariff revenues represent some 28 and 18 percent of government revenues respectively, whereas in OECD countries, tariff revenues represent on average 1 percent or less of total government revenue. Ten countries collect more than half their revenues from tariffs and a further 43 collect more than a quarter (see Table 1 in Laird et al., 2006).

The most recent major investigation on the impact of trade reforms on revenues (Baunsgaard & Keen, 2005) confirmed that for poorer countries, the reduction of tariffs has meant a reduction of tariffs revenues and of tax revenues more generally. Using panel data from 111 countries over 25 years, this study investigated whether countries had recovered from other sources the public revenues they have lost from trade liberalisation. Whereas middle-income countries have been able to recover 40 to 60 percent of the lost tariff revenue, low-income countries, which are the most dependent on tariffs revenues, have at best been able to raise about 30 percent of lost revenues. Analysing this dataset, Glenday (2006) noted that between 1975 and 2000, 28 low-income countries “experienced trade tax yield decline, but only 6 were able to fully replace these losses and a further 10 partially replaced the trade tax losses with non-trade taxes,” leaving 12 with a net loss from this revenue stream. These studies confirm earlier findings, using different data sources, that trade liberalisation reduces net tax revenues in developing countries (Khattry & Rao, 2002).

Aizenman & Jinjarak (2006) studied the impact of globalisation on the tax base of 60 countries at varying stages of development; choice of countries was dictated by data availability over the period 1980-1999 (Appendix B.2). This study found that trade liberalisation imposed new fiscal challenges on developing countries, forcing them to scale down traditional “easy to collect” revenue sources. High- and many middle-income countries were able to shift (or had already shifted) the tax base to the “hard to collect” taxes (Aizenman & Jinjarak, 2006, Figure 2). Low-income countries were less able to adapt, frequently experiencing a drop in the net tax revenue/GDP ratio.

In theory, national governments should be able to shift their tax bases from tariffs to domestic taxes such as sale or income taxes. But in reality developing countries, especially low-income countries, have not been able to do so. The reasons include the informal nature of their economies, with large subsistence sectors making income taxation difficult (Khattry & Rao, 2002; Glenday, 2006) and lack of institutional capacity for effective revenue collection when taxation is more administratively complex than collecting tariffs at the border. Various other globalisation-related policies add to this difficulty, e.g. constraints on corporate taxation to attract Foreign Direct Investment (FDI), on taxation on savings to prevent capital flight, and on high-income earners to prevent human capital mobility (see Box 5). With declining public revenues (whether absolute or relative to GDP) developing

countries experience a decline in their state capacity to affect the material conditions affecting health via income transfer, or more equitable and sustained access to water, sanitation, health services, education and public health programmes.

Box 5. Tax competition and “fiscal termites”

Globalisation has limited the ability of governments to collect taxes by increasing the opportunity of corporations and wealthy individuals to minimise their tax liabilities by shifting assets, transactions and even themselves from high- to low-tax jurisdictions. The former Chief of the IMF's Fiscal Affairs Department has identified a number of “fiscal termites” he says will gnaw at the fiscal capacity of governments in rich and poor countries alike, and in some cases are already doing so (Tanzi, 2001; Tanzi, 2002; Tanzi, 2004; Tanzi, 2005). These include:

- Expansion of offshore financial centres and tax havens (Ramos, 2007), combined with the ease with which funds can be transferred electronically to such locations;
- Growth in the number and complexity of new financial instruments and institutions, such as derivatives or hedge funds, which are incompletely regulated and complicate identification of the owners of financial assets.
- The hypermobility of financial capital and of high-income individuals with highly marketable skills, as “high tax rates on financial capital on highly mobile individuals provide strong incentives to taxpayers to move the capital to foreign jurisdictions that tax it lightly or to take up residence in low tax countries” (Tanzi, 2002, p. 125).

A termite not identified by Tanzi but one of increasing concern arises from the growing importance of intra-firm trade among components of transnational corporations: according to one estimate, one-third of total world trade in the late 1990s. This creates multiple opportunities for corporations to reduce their tax liabilities through transfer pricing (Zdanowicz et al., 1999; de Boyrie et al., 2004; Ramos, 2007, pp. 9-10). One recent estimate is that such mispricing accounted for financial outflows of over \$31 billion from Africa to the United States between 1996 and 2005 (Pak, 2006).

Policy implications

Four policy inferences can be drawn from this discussion.

Firstly developing countries, particularly low-income countries with a relatively high reliance on tariffs for public revenue, should develop viable alternative methods of revenue generation that are conducive to an equitable distribution of wealth (i.e. which do not increase inequities in SDH) prior to further tariffs reductions.²³

Secondly, high-income countries with such systems should assist low-income countries in developing the institutional capacities for progressive forms of revenue collection.

Thirdly, high- and middle-income countries with already diversified systems of taxation (and hence less reliance on tariffs) should not demand further tariff reductions in bilateral, regional and world trade agreement negotiations with low-income countries still reliant on tariffs for public revenue. Only after alternative methods of revenue collection, and the institutional capacity to sustain them, are well developed, should such countries be asked to engage in formulae for gradual aggregate tariff reductions.

Finally, multilateral efforts to reduce the tax competition constraints associated with increased trade and financial market liberalisation are also required.

3.2.3 Trade in health services

Trade agreements, notably the General Agreement on Trade in Services (GATS), allow countries to make binding trade commitments in health services. GATS proponents claim that whether liberalisation in health services produces a net public health gain or loss depends on the domestic regulatory structures put in place to manage its impacts (Adlung & Carzaniga, 2002). This may be true. But as the 2000 World Health Report cautioned, "few countries have developed adequate strategies to regulate the private financing and provision of health services," noting that "the harm caused by market abuses is difficult to remedy

²³ We remind readers that evidence on the contribution trade liberalization makes to growth and poverty reduction remains equivocal, which underscores the importance of this first inference.

after the fact" (World Health Organization, 2000, p. 125). Health services meet basic human needs in a way that many other services do not; and commitments in trade agreements may lock in policy choices that are detrimental to health equity. "Making a commitment under [a trade agreement] is very different from undertaking liberalization unilaterally within one country's own policy framework. ... Unlike a country's own unilateral decisions, which can be reversed if found to be damaging, the trade commitment is binding and effectively irreversible," because it invites the application of economically damaging trade sanctions. "This requires there to be a far higher threshold of certainty before countries decide to make any commitments – particularly in crucial services sectors such as health" (Smith et al., 2006, pp. 12-13).

Specifically, the concern is that trade policy commitments will lock in commercialisation of health services: foreign investors or service providers will be able to invoke trade dispute resolution processes if denied access to a country's domestic market, and denying similar opportunities to domestic actors will become politically infeasible. The available evidence indicates that commercialisation in health services or insurance creates inequities in access (Barrientos & Lloyd-Sherlock, 2000; Bennett & Gilson, 2001; Cruz-Saco, 2002; Barrientos & Peter Lloyd-Sherlock, 2003; Hutton, 2004) and in health outcomes (Koivusalo & Mackintosh, 2005), whether commercialisation is led by domestic or foreign actors. Measures to increase private investment and provision in health services are often justified on the basis that they 'free up' public resources for more effective and targeted provision to the poor. However, there is little to no evidence indicating that developing countries can achieve such reallocation, and the Thai experience offers important cautions in this regard (see Appendix 3). Governments may still want to experiment with commercialisation in some components of their health systems, but making these policy experiments part of binding trade treaties will strongly limit their ability to undo these reforms if they wish to do so in the future. Up to now, the level of commitment under GATS in health services is low (Adlung & Carzaniga, 2006). Nevertheless, as trade negotiations on health services at the regional and bilateral levels are ongoing, a cautious approach remains crucial.

Policy implications

Until governments have demonstrated their ability effectively to regulate private investment and provision in health services in ways that enhance health equity, they should avoid

making any health services commitments in binding trade treaties. It is not clear that any government, anywhere in the world, has met this test. Changes to the trade policy process at the national level should ensure that health officials are actively engaged in the preparation of trade negotiation positions as they relate to health (Blouin, 2007). A more fundamental response would involve cancelling existing commitments on health services and removing health services from the scope of subsequent GATS negotiations (Woodward, 2005). Given abundant evidence of increased inequity associated with the commercialisation of health care and arguments that health is a special kind of service, this latter proposal clearly requires further discussion despite the formidable political obstacles.

3.2.4 Food security

As globalisation proceeded between 1980 and 2000, the proportion of undernourished children and adults in the world declined. The proportional rate of decline²⁴, however, was slow and has reversed since 2000, resulting in a net decline in developing countries of only 3 million since 1990 (United Nations Food and Agriculture Organization, 2006a). The numbers of undernourished people rose in sub-Saharan Africa. While under-nutrition declined substantially in the early 1990s, it slowed in the mid- to late 1990s. These trends partly relate to trade liberalisation, and raise concerns with respect to long-term food security.

Little evidence directly addresses the link between trade liberalisation and food security. One exception is a recent United Nations Food and Agriculture Organization (FAO) comparative study of trade liberalisation and food security in fifteen small and large developing countries. The case studies combined qualitative and quantitative data (e.g. price analysis, supply response in key commodities, food expenditures per household) to assess the impact of economic (notably trade) reforms on both aggregate and household food security. Their key finding was that "trade reform can be damaging to food security in the short to medium term *if it is introduced without a policy package designed to offset the negative effects of liberalization*" (United Nations Food and Agriculture Organization, 2006b, p. 75, emphasis added). Domestic producers are often in a weak position to compete with foreign competition; a well-targeted subsidy for agricultural inputs is one measure to manage the

²⁴ A declining proportion implies that nutritional improvement has kept pace with population growth; an increase in numbers even where proportion has declined reflects a failure to keep pace.

initial negative impacts of trade liberalisation. Trade reforms generally benefit farmers producing exports crops, but had negative impacts on farmers producing import-competing food stuffs, especially those that are highly subsidized by exporting countries.

For low-income countries whose economies are still heavily dependent on agriculture, the study stressed the importance of the sequencing of reforms. Raising agricultural productivity and creating non-agricultural employment should precede trade reforms such as the reduction of tariffs on crops grown by low-income households (United Nations Food and Agriculture Organization, 2006b, p. 76).

Another issue is whether liberalized international markets are sufficiently stable in terms of price to ensure food security. Many poor developing countries import only relatively small volumes of food in world market terms, but those imports are critical for meeting their population's food security needs. Their capacity to pay even 10 percent more for that food is severely constrained by their lack of foreign currency. As one example of this: In 1995-96, developing countries faced an average 40 percent increase in their food import bills, due to poor harvests, demand in China, and the dramatic drop in food aid levels as US surpluses were absorbed in commercial markets.

Trade liberalisation can also affect food security at the household level. Studies by the International Food Policy Research Institute (IFPRI) in the 1980s examined the nutritional impact of a series of cash cropping schemes in ten developing countries. The findings suggested that cash cropping generally results in higher incomes and spending on food, but has a relatively small impact on energy intake, and, in most cases, little or no impact on childhood malnutrition (von Braun & Kennedy, 1986; von Braun, 1994; von Braun, 1995). Two of the schemes – potato production in Rwanda and a technological change to maize production in Zambia – lowered malnutrition among children aged five or under in participating households through higher incomes. But more than half the selected projects had no or even negative impacts on nutrition. Where improvements did occur, most were attributed to the control of income within the household. Female-controlled incomes were related to higher levels of caloric intakes among children, as women are more likely than men to allocate resources towards food.

Policy implications

In theory, access to a global market should stabilise supply and therefore price and it has the potential to do just that. But the world market is not stable enough to obviate the need for national and regional food stocks to complement the market, if food security is the government's objective. The FAO's study of trade and food security identified several key mitigating policies that could reduce negative impacts.

Specifically, greater attention needs to be paid to the sequencing of reforms in markets for inputs and outputs. Appropriate incentives on the side of outputs should be assured before (or at the same time as) input prices are raised, even at the cost of maintaining some well-targeted input subsidies during a transitional adjustment period. Improving rural infrastructure is an important concomitant for successful policy reform in most countries, but it is particularly needed in low-income areas, along with support for productive investments by small farmers. Without such investments it is difficult for such farmers to respond to price incentives. Policies to encourage the development of rural non-farm employment are also important for the rural poor. These can include the development of microfinance, simplification of regulatory regimes, infrastructure improvement, and special incentives for rural industrialisation in poor areas.

Because policies of the kind mentioned above can take time to bear fruit, transitional compensatory measures, targeted on lower-income groups, may be needed. The absence of measures to protect the poor, and the problems of targeting the most vulnerable groups, were noted in several of the case studies.

For countries with a large proportion of low income and resource poor people living in rural areas and who depend on agriculture, reforms aimed at raising productivity and at non-agricultural employment creation are essential for enhancing food security in the medium to long term. However, since such reforms may take some time to yield results, it seems preferable that these reforms be set in motion before (or at least at the same time as) implementing measures such as removing subsidies on agricultural inputs, and reducing tariffs on key crops grown by low-income households (United Nations Food and Agriculture Organization, 2006b).

Finally, many low-income countries remain net food-importers. In the absence of international commitments to assist these nations financially, their food security and subsequent equity in health outcomes could be seriously compromised by sharp increases in global food prices, even if these increases benefit producers in low-income countries that are net food exporters.

3.3 The global marketplace: Aid and investment

Globalisation has drastically increased the ease and speed with which money can move around the world. It is useful to begin a discussion of the effects on SDH by distinguishing among various kinds of financial flows:

- Portfolio investment, primarily foreign purchase of shares (normally without the intention of acquiring a controlling interest in the enterprise), bonds or other securities by an individual, corporate or institutional investor
- foreign direct investment or FDI that involves a continuing ownership interest, either through acquisition of shares or 'green field' investment in new production facilities
- bank and trade-related lending (foreign commercial bank lending and other private credit)
- loans from the international financial institutions (IFIs: the World Bank, International Monetary Fund, and various regional development banks), only the concessional portion of which is recorded as
- official development assistance (ODA) from national aid agencies, the IFIs, and such multilateral purpose-specific agencies as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM)
- flows from UN agencies²⁵
- payments to foreign creditors (of particular significance for many low- and middle-income countries)
- capital flight, some of which takes the form of 'outward' portfolio investment; and
- remittances.

²⁵ While important, such flows (>US\$3.5 billion in 2006) are relatively small, derive principally from 4 UN agencies: UNDP, UNFPA, UNICEF, and the World Food Programme (World Bank, 2007c) and were not considered further by the GKN.

Each of these flows affects SDH differently, and the discussion that follows is necessarily abbreviated.

Portfolio investment is perhaps the most significant, partly because it dwarfs all other forms of capital flow. Whereas the value of global foreign direct investment (FDI) flows was US\$1.2 trillion for all of 2006, the *daily* value of foreign currency transactions is now estimated at US\$1.9 trillion (Bank for International Settlements, 2005). These speculative capital flows are subject to panics, manias and crashes (Bhagwati, 2000). Speculators might emerge unscathed from these crashes, while sudden large-scale disinvestment results in financial crises with devastating effects on SDH through depreciation of national currencies and purchasing power (US General Accounting Office, 1996; Bello et al., 1998; Gruben & Kiser, 1999; Singh, 1999; Goldfajn & Baig, 2000; World Bank, 2000, chapter 2; Carranza, 2005). Subsequent austerity measures reduce public revenues or expenditures on health and social programme transfers (Leightner, 2002; Kim et al., 2003; Azis, 2004; Kaminsky, 2005; Crotty & Lee, 2005; Pirie, 2006). As an illustration of the interaction of these effects, financial crises in Indonesia, Thailand and Malaysia during the late 1990s led to reduced food intake, health care utilisation and education expenditure (Hopkins, 2006). Furthermore, a comparison of financial crises in 10 countries by (van der Hoeven & Lübker, 2005) found that employment recovers much more slowly than GDP in the aftermath of financial crises, exacerbating their effects on social stratification and the vulnerabilities associated with economic inequality and insecurity. Predictably given existing national and household-level distributions of power and access to resources, the impact of financial crises is often felt first, and worst, by women (Floro & Dymiski, 2000; Parrado & Zenteno, 2001).

Foreign direct investment (FDI), in contrast, can improve SDH by increasing employment opportunities, contributing to economic growth, transferring new technology and providing a source of public revenue through taxation that can be used to improve equity in access to SDH. Despite being the largest source of external financing for developing countries, most FDI actually flows between high-income countries (World Bank, 2005a, Table 6.7). Of FDI flowing to developing countries, 90 percent goes to middle-income countries (World Bank, 2007c); China alone received 35 percent of all such FDI in 2004 (World Bank, 2005a). FDI to SSA remains very low and concentrated in extractive industries (oil and minerals), control over which has been the source of considerable domestic conflict and environmental externalities damaging the livelihoods of people involved in the agriculture or fishing sectors.

Overall FDI flows have also been declining in recent years (World Bank, 2007c) and only began to recover in the past two years. The positive contributions of FDI to SDH in low- and middle-income countries can be weakened or negated by competition to attract such investment through tax holidays and the establishment of EPZs: the direct and indirect costs of such incentives may be high relative to the human benefits (Kozul-Wright & Rowthorn, 1998). Although FDI may be essential to growth, it is not clear that it necessarily generates the widely shared benefits that are of primary concern from a health equity perspective. In addition to concerns about wages and working conditions in EPZs, even when FDI is not restricted to resource industry enclaves it is likely to be concentrated in relatively capital-intensive sectors of the economy with high labour productivity that create little employment (Jenkins, 2006a; Jenkins, 2006b).

Capital flight is "the movement of capital from a resource-scarce developing country to avoid social control. 'Social control' means the actual or potential, as well as formal and informal, control on capital that includes, among others, taxation, regulation of the use of foreign exchange, the capacity to direct resources into productive activities, thus engendering growth, enhancing competitiveness, and consequently, realizing economic development" (Beja, 2006, p. 265). The resource flows are substantial. For example, Ndikumana & Boyce, (2003) estimated the value of capital flight from sub-Saharan Africa between 1970 and 1996 at US\$186.8 billion (in 1996 dollars), noting that during the period "roughly 80 cents on every dollar that flowed into the region from foreign loans flowed back out as capital flight *in the same year*" (p. 122; emphasis added). Using a similar methodology, Beja (2006) estimates the accumulated value of capital flight from Indonesia, Malaysia, the Philippines and Thailand over the period 1970-2000 at US\$1 trillion, not only during periods of financial crisis, as expected, but also during periods of economic growth and stability. Capital flight has worsened debt crises in many developing countries (Naylor, 1987). When governments borrow on external markets in order to finance their operations while private investors are shifting assets abroad, the effect is to reduce domestic savings and foreign exchange available for development; to increase inequalities in income and wealth, as governments must cut back services or tax the population as a whole to finance debt service charges; and to create downward pressure on exchange rates that further reduces the purchasing power of those who do not have the option of diversifying into foreign assets (Rodriguez, 1987).

Remittances are private capital flows from émigrés to their country of origin. Estimates indicate that remittance flows have more than tripled since 1990, with US\$161 billion going to developing countries in 2004 (World Bank, 2007c). Thus, their annual value now substantially exceeds the value of ODA, and remittances are now major sources of national income for a number of small and medium-sized low- and middle-income countries. Summarising a comprehensive review of the empirical evidence on remittances, the World Bank found that “remittances typically boost income levels, especially for the poor, and may encourage investment in physical and human capital and help to buffer the impact of negative shocks” (World Bank, 2007c, Section 6). Remittances are a stable source of foreign exchange, can contribute to improvements in SDH for individual recipient households in developing countries, and are not subject to the distortion in response to donor agencies’ economic and geopolitical priorities (for example ‘leakage’ through tied aid; see Section 3.3.1) that continues to afflict ODA. Conversely, because they are private flows remittances increase the welfare of recipient households, but support policy interventions that enhance health equity across the whole population only to the extent that they expand the domestic tax base. As well, there has been a marked increase in the educational levels of émigrés moving from developing to developed countries, a “flight of human capital” that the World Bank warns “may increase the concentration of poverty and reduce the beneficial effects of globalisation” (World Bank, 2007c, Section 6).

3.3.1 Official development assistance (ODA)

In absolute terms, ODA increased between 1950 and 1990 (Fuhrer, 1996). However, only a few countries have consistently met the UN Pearson Commission’s target of 0.7 percent of GNI (see Figure 3).²⁶ More immediately, it is uncertain whether G8 and EU commitments to double annual ODA flows to Africa, made at the Gleneagles summit in 2005, will be fulfilled. Since 1990, ODA as a major source of international finance has been displaced by growth in FDI, although the contribution of FDI in some regions has been minimal. In 1997, for example, ODA to Latin America amounted to US\$13 per capita, as compared with US\$62 per capita in FDI, and ODA inflows to Latin America are consistently dwarfed by the outflow of foreign debt service payments (see Section 3.3.2). In sub-Saharan Africa, at the same

²⁶ Some have questioned the ongoing relevance of this target given changed global economic conditions, i.e. growth and poverty reduction in China, India and parts of Asia. Since poverty reduction has not kept pace with population growth, however, we see little reason to reconsider the target as it relates to ODA flows.

period, the balance was reversed, at US\$27 per capita ODA compared with US\$3 per capita FDI (Kohli, 2004). Aid dedicated to health has also seen significant increase in the period following the Second World War, both in absolute terms and, more recently, as a proportion of the total aid. Between 1990 and 2004, annual development assistance for health rose from US\$2 billion to US\$11-12 billion (Michaud, 2003; Schieber et al., 2006b).

---- **Insert Figure 3 about here** ----

The UN Millennium Project and the Commission for Africa each concluded that an approximate doubling of current development assistance spending will be necessary, although not sufficient, for the countries they studied to meet the MDGs and targets (UN Millennium Project, 2005; Commission for Africa, 2005). In a direct rejection of received wisdom that weak governance or “absorptive capacity” constraints seriously limit the potential benefits from large 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, p. 146). While numerous concerns remain about the effectiveness of aid, and opportunities for improvement are many, in the view of the GKN these reports decisively shift the burden of proof to those who argue against substantial, long-term new development assistance commitments.

The savage arithmetic underlying this position is most clearly evident with respect to health systems (see also Section 3.4.1), and Sachs’s description is worth quoting at length:

“Let’s recognize the iron laws of extreme poverty involved here. A typical tropical sub-Saharan African country has an annual income of perhaps \$350 per person per year, of which much income is earned in kind (as food production for home use), rather than as money income. The government might be able to mobilize 15 percent of the \$350 in taxes from the domestic economy. That produces a little over \$50 per person per year in total government revenues (and in many countries, much less). This tiny sum must be divided among all government functions: executive, legislative, and judicial offices; police; defense; education; and so on. The health sector is lucky to claim \$10 per person per year out of this, but even rudimentary

health care requires roughly four times that amount. (In rich countries, public spending on health is \$2,500 per person or more.) Foreign aid is therefore not a luxury for African health. It is a life-and-death necessity" (Sachs, 2007).²⁷

Indeed, Sachs's position becomes stronger when one considers the limitations of 'rudimentary' health interventions that might represent a dramatic improvement relative to the *status quo*, but do not comprise a more comprehensive health system. As one reviewer of a previous draft of this Report put it: "[I]n the absence of such higher aid flows, finding the financial resources to pursue many of the policies advocated in the report will be very difficult for the poorest countries ... There is only so much genuinely unproductive expenditure to prune before one starts cutting into the bone."

Outside the health sector, the apparent inability of aid flows to some parts of the world to provide the 'big push' to economic take-off led to a powerful backlash that broadly viewed aid as either ineffective or counter-productive: distorting market function, creating inflationary pressure, increasing size of government and bureaucratic inefficiency, encouraging rent-seeking, weakening governance relationships between State and population, and financing consumption rather than investment (Friedman, 1958; Bauer, 1981; Mosley & Jolly, 1987; Boon, 1996; Svensson, 2000; Schneider, 2005; Quartey, 2005; Easterly, 2006; Rajan & Subramanian, 2006). In the late 1990s and early 2000s new empirical analysis, partly made possible by higher quality data, began to show a more positive relation between ODA and growth (Hansen & Tarp, 2000; Burnside & Dollar, 2000; Hermes & Lensink, 2001; Morrissey, 2002; McGillivray, 2003; McGillivray et al., 2005). Meta-analyses reported consistently positive associations across dozens of individual empirical studies (Clemens et al., 2004; McGillivray et al., 2005).²⁸

Thus a strong body of evidence now supports aid effectiveness in increasing economic growth, often acknowledging the benefits of a sound policy environment, but in several cases arguing aid effectiveness regardless of those conditions (Cassen, 1986; Gounder, 2001; Morrissey, 2002; Harms & Lutz, 2003; Dalgaard et al., 2004; Snowdon, 2005; Addison et al., 2005b). Dollar & Collier (1999) estimate that aid lifts around 30 million people per

²⁸ McGillivray identifies 35 empirical studies that affirm a positive relation between ODA and growth; Clemens et al. (2004) identify another 11 studies (seven positive).

annum out of absolute poverty, as defined by the World Bank. This probably underestimates the value of aid given the counterfactual of what a recipient country would have looked like in the absence of aid (McGillivray et al., 2005). This evidence of aid effectiveness has been accompanied by a shift from off-budget programme- or project-based aid to on-budget support: that is, to aid run through government allocation and accounting systems rather than through parallel and/or independently operated systems (e.g. those of contracted national or non-national implementing agencies).²⁹ This allows recipient countries greater flexibility in responding to their self-selected development priorities, rather than those of donors. However, several concerns remain.

Firstly, and most fundamentally, the choice of criteria for assessing aid's effectiveness is a moral issue. Should aid be assessed primarily in terms of its contribution to economic growth, or primarily in terms of its contribution to meeting basic needs – the priority that is at least implicit in Sachs's position – even when meeting these needs would be categorized from a microeconomic perspective as consumption rather than investment? Even if we disregard the role of donor self-interest, this choice has critical implications for the allocation of aid not only between countries but also within them.

Secondly, the Paris Declaration on Aid Effectiveness (2005) raised two key issues for aid: *coordination* (the degree to which donors coordinate aid to increase coherence of approaches and reduce often high transaction costs); and *alignment* (the degree to which all incoming aid supports or distorts nationally-determined policy priorities). Several new administrative approaches (e.g., Sector-Wide Approaches, or SWAPs, and government budget support) partly overcome these problems, but the proliferation of new aid agencies, strategies and vertical interventions continues.

Thirdly, selection of recipient countries continues to reflect donor countries' geopolitical, trade and security interests rather than actual need. Over 60 percent of the total increase in ODA between 2001 and 2004, for example, went to Afghanistan, the Democratic Republic of

²⁹ Full general budget support (GBS) funding, not earmarked for a particular sector or set of activities within a government budget, remains relatively rare (approximately 5 percent of total current ODA) (Daniels, 2001; Morrissey, 2002; de Renzio, 2005). This may reflect a lag between policy change by donors and actual disbursements. Notably, GBS makes up a little over a quarter of ODA allocated in 2004-05 by the Strategic Partnership for Africa (Schneider, 2005). The US reportedly remains outside this trend.

Congo (DRC), and Iraq, in spite of the fact that the three countries account for less than 3 percent of the developing world's poor, as defined using the standard if contentious US\$1/day poverty measure (World Bank & International Monetary Fund, 2006). Much of the ODA increase in 2005 can be accounted for by one-shot debt relief to Iraq and Nigeria (United Nations, 2006), whose geopolitical and resource importance to donor nations is transparent.

Fourthly, concern persists that aid providers attempt to shape the policy choices of recipient countries by rewarding with aid those who apparently are following the 'right' development path, even when (as noted earlier) the appropriateness both of development strategies and of priorities for aid allocation is highly and legitimately contested terrain.³⁰ Most of the increase in ODA after 1999 went to good performers, as measured mainly by the World Bank's Country Policy and Institutional Assessment (CPIA) rating system, and to post-conflict states (IMF Independent Evaluation Office, 2006; McGillivray, 2006). This raises the question, what is happening to non-fragile states or 'poor performers', and with what consequences for SDH?

Fifthly, release of aid funds is increasingly tied to 'Results-Based Management' (RBM) or payments for progress (Barder & Birdsall, 2006), with new tranches disbursed only after evidence of positive results from earlier flows. This demand underestimates the complexity of conditions in which aid is applied, and of the service delivery and developmental processes it is geared to promoting (Eyben, 2005). It also reduces the predictability of aid flows, creating enormous planning problems for recipient countries and, ironically, reducing aid effectiveness (Quartey, 2005; Lensink & White, 2000). RBM risks skewing recipient priorities towards interventions with immediate (and easily detectable or attributable) outcomes, for example, rates of fully-immunised children stipulated by the GAVI Alliance (formerly known as the Global Alliance for Vaccines and Immunisation) (Jamison & Radelet, 2005). These are worthwhile achievements, but RBM is not necessarily appropriate with respect to SDH, where more complex policy and programme interventions that address underlying social conditions may take longer to show results but deliver far more value overall (Southern African Regional Network for Equity in Health, 2003)

³⁰ Similarly, promises of increased bilateral aid are often used to gain agreement with trade treaties of arguably greater benefit to donor than to recipient countries.

Sixthly, much aid remains tied to the purchase of goods or services provided by the donor. Tied aid recoups to donors a considerable part of the aid disbursed. Tying aid reflects commercial self-interest among donors (Svensson, 2000), and has negligible positive or actively negative impact on aid effectiveness (Kohli, 2004; Mazzotta, 2005). It is estimated that tying reduced the value of ODA by US\$5-7 billion in 2003 (Development Co-operation Directorate, 2004), and that tied aid is in the region of 25 percent less effective than untied (United Nations Development Programme, 2003). Belatedly, several donor countries claim they are beginning to untie most, or even all, of their aid.

Finally, there have been calls to use the Millennium Development Goals (MDGs) as the basis for coordination and alignment in aid disbursements. Three MDGs -- 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. The MDGs are ambitious when measured against recent progress toward meeting basic human needs, yet at the same time modest when considered against the scale of those needs. The poverty reduction target only specifies reducing by half, in the year 2015, the proportion of the world's people living on less than \$1/day (Pogge, 2004). 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).

At the same time, the MDGs and associated targets are imperfect in that they refer to health and SDH outcomes as measured across national populations. This means that movement towards the health MDGs carries no *necessary* benefit for some of the most vulnerable groups in recipient countries, except where they are affected by progress in other goals such as those for poverty and nutrition (Gwatkin, 2005; Spinaci et al., 2006); extreme vulnerability, social exclusion and health inequity could remain entrenched even if the goals were met. Considerable doubt also surrounds the MDGs' lack of focus on the underlying socio-economic, cultural, political and environmental conditions that contribute to health disparities (Leipzig et al., 2003; Ahmed & Cleve, 2004; Therkildsen, 2005; Addison et al., 2005a). Further, using the MDGs as a basis for setting development assistance risks diverting attention from the "big ticket, less glamorous items for which public investment is

desperately needed – infrastructure, institution-building, improving governance, capacity-building” (Howard, 1991).

Thus, the MDGs are a useful set of commitments and aspirations against which to measure the performance of donor countries. However, they do not adequately reflect the Commission on Social Determinants of Health’s (CSDH) key concerns with equity (with the possible exception of poverty reduction), and provide inadequate guidance for (re)designing the development assistance architecture and setting priorities for the major increases in funding that are now widely recognised as essential. Basing algorithms for aid delivery and aid-funded programmes on the MDGs will not necessarily generate the best results in terms of reducing health inequities.

3.3.2 External debt and debt reduction

Foreign debt service payments represent a significant cross-border financial flow affecting health and livelihoods in both low- and middle-income countries. As the UN Millennium project noted:

“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 every region of the world except sub-Saharan Africa, annual debt service payments far exceed development assistance receipts (see Figure 4). In SSA, development assistance accounts for a larger share of many countries’ budgets than in other regions, so the negative impact of *any* outflow of funds for debt servicing is especially serious.

---- **Insert Figure 4 about here** ----

The debt crises that have been a feature of the international financial and political landscape over the last 25+ years are themselves a reflection of the world’s increasing

interconnectedness. Further, foreign debt and associated policy reforms have been used by developed nations to lever more and faster globalisation, in the form of trade and financial liberalisation (Labonte & Schrecker, 2007b). Debt crises originated largely with structural changes in the industrialised economies. The oil-reliance of those economies led to a major economic slowdown and increase in inflation after the members of the Organization of Petroleum Exporting Countries (OPEC) tripled the price of oil in 1973 (Mosley et al., 1995). Meanwhile, 'petrodollars' created by the rise in oil prices were deposited in Western banks, which then lent the money on to developing countries at low interest rates. A second oil price shock in 1979 was followed by dramatic increases in interest rates in the industrialised economies, as conservative governments came to power in the United States, West Germany and the United Kingdom on a monetarist platform of tackling inflation. Global recession then followed.

For developing countries this was a triple blow: rising prices of oil, worsening loan repayments and less demand from the developed economies for their exports meant that many nations were struggling to repay their debts. The hardest-hit countries were located mostly in sub-Saharan Africa. Their debt burden was principally generated not by commercial loans but through a glut of official loans, provided by the World Bank, IMF and the export credit departments of the bilateral donors, the size of which had already sparked warnings of a debt crisis in the 1970s. These countries have seen a massive increase in debt over the past four decades, whilst their per capita incomes have stagnated. Thirty-five such countries in sub-Saharan Africa received US\$294 billion in loans and paid back US\$268 billion between 1970 and 2002, they were still left with a debt stock of US\$210 billion *circa* 2003 (United Nations Conference on Trade and Development, 2004).

Debt cancellation on a small scale for some of the hardest hit countries was initiated in 1988, but only in 1996 did creditors propose a broader scheme under which debt to the multilateral financial institutions could be cancelled; this was known as the Heavily Indebted Poor Countries (HIPC) initiative, expanded in 1999 as the enhanced HIPC Initiative (e-HIPC). In 2005, the value of debt relief available under the initiative was further expanded as the Multilateral Debt Relief Initiative (MDRI). MDRI provides for 100 percent cancellation of debts owed by HIPCs to four multilateral institutions – the IMF, the Inter-American Development Bank, the African Development Fund (AfDF) and the International Development Association (IDA), the concessional lending arm of the World Bank – with the

proviso that the latter two institutions receive compensatory funding from donors. Debtor countries will see future contributions from the IDA and AfDF reduced by the annual amount of debt service relief they gain from these institutions, although they can potentially win this (and more) back if they achieve good policy performance (United Nations Conference on Trade and Development, 2004; International Development Association & International Monetary Fund, 2006). However, MDRI does *not* extend eligibility to a longer list of countries than those originally eligible for debt cancellation under the HIPC initiative, and there are questions about whether this latest initiative is providing additional resources for HIPCs.

Under that initiative, “the amount of debt relief ... was determined by eligibility thresholds which (according to public statements by Fund and Bank officials) were based on initial analysis... and then modified to suit political compromises amongst G7 creditors, balancing the need to include strategic G7 allies and their desire to keep costs down” (Martin, 2004, p. 17). Debt ‘sustainability’ was defined based on ratios of the net present value (NPV) of debt to exports and government revenues. The IFIs have been over-optimistic in the past about likely levels of economic growth in the HIPCs, leading them to overestimate the amount of debt that would be sustainable. There are signs that this is changing and, on average, the ratio of NPV debt to export or government revenue has declined in several HIPCs (World Bank Independent Evaluation Group, 2006). However, some bilateral and commercial creditors outside the main formal ‘Paris Club’ grouping have not felt bound by the Initiative (World Bank Independent Evaluation Group, 2006). HIPCs owe about US\$2 billion to commercial creditors, some of whom are increasingly litigious (International Development Association & International Monetary Fund, 2006). In 2007, so-called ‘vulture funds’ – private investors who buy up poor country debts at a fraction of their book value and then press claims in the courts for the full legal value of the debt – have been in the media. Politicians from across the political spectrum have condemned the actions of the vulture funds, but there is little they can do, as the transactions the vultures are making are perfectly legal.

Only the poorest developing countries falling below a particular average income level are eligible for debt relief under HIPC/MDRI. Several commentators have proposed that the scope of the initiative be widened to include more debt-distressed developing countries in which, in fact, a majority of the world’s poor people live. Dervis & Birdsall (2006) are

concerned about a group of emerging market economies with high incomes and high debts. Arslanalp & Henry (2006) echo these concerns pointing to the problems faced by Indonesia, Pakistan, Colombia, Jamaica, Malaysia and Turkey. There is a risk of moral hazard (as defined in microeconomics) in debt cancellation, in that countries that may have been most irresponsible in their borrowing are disproportionately rewarded. A concern also exists that extending debt relief beyond the HIPCs could come at the expense of other forms of donor aid. Especially in retrospect, it is difficult to operationalise a distinction between 'irresponsible' borrowing and borrowing that reflects governments' attempt to continue meeting basic needs in a context of financial crises. Further, invocation of irresponsibility in borrowing must be matched by consideration of irresponsibility in lending, *and of* industrialized countries' role in facilitating both legal and illegal capital flight. The more general underlying issue involves the practical and moral necessity of substantially increased transfers of resources from developed to developing countries.

An early assessment concluded that debt cancellation for HIPCs had made possible increases in public spending on such basic needs as health and education in several recipient countries (Gupta et al., 2002). More recent research found that poverty reducing expenditures in 28 decision point countries have gone up from 6.4 percent to 8.1 percent of GDP from 1999 to 2004, and are now four times as great as debt service payments. According to this work most of the rise is accounted for by education, and spending is the same or less on health, agriculture, and transportation (World Bank Independent Evaluation Group, 2006). It should be noted, however, that this assessment is based on data from just five countries, which are not identified in the source document. The United Nations Conference on Trade and Development (2006) found similarly positive results for the relations between government revenue and debt service and poverty reducing expenditures in 29 countries at or beyond the HIPC "decision point," at which countries began to receive debt relief on a provisional basis conditional on their "maintain[ing] macroeconomic stability under a PRGF-supported program, carry out key structural and social reforms, and implement[ing] a Poverty Reduction Strategy satisfactorily for one year."³¹ Thomas (2006), based on his analysis of the impact of debt service payments on social expenditures, predicts that the projected decline in debt service ratio of 1 percent of GDP in low-income countries is likely to lead to

³¹ World Bank web site, <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTDEBTDEPT/0,,contentMDK:20655535~menuPK:64166739~pagePK:64166689~piPK:64166646~theSitePK:469043,00.html> (accessed June 26, 2007).

an increase in social expenditures between 2004 and 2007 of about 0.35 percent of output.³² Chauvin & Kraay (2005), however, dissent. They suggest that historically there is no connection between debt relief and increases and health and education spending and that there is little evidence that HIPC has activated a sharp upward rise, although they do point to some positive examples from individual countries. Interpreting these findings is complicated by the fact that other factors (such as increased aid) may be responsible for the observed rise in social expenditures. At any rate, the benefits for expenditures that affect SDH appear, from the limited data available, not to be large, although the rise in education expenditure may be enormously beneficial for health if directed well. Debt reduction is not releasing (*and probably cannot release*) anywhere near enough the level of resources needed to meet the MDGs (Thomas, 2006) or achieve other benchmarks of minimal adequacy in meeting basic needs

Furthermore, the benefits of debt relief will only be apparent if they are truly additional to revenue already raised from development assistance. Bird & Milne (2003) and Arslanalp & Henry (2006) indicate that past debt relief has not been additional to aid: when the HIPC initiative started, aid flows as percentage of GDP decreased from 13.7 percent of GDP to between 9.9 percent and 11.1 percent; this reflected a decline in the net transfer of resources towards HIPCs. The World Bank's assessment of the additionality question (World Bank Independent Evaluation Group, 2006) is more upbeat: it notes that net annual transfers to HIPCs have increased substantially over the period of the implementation of the initiative from US\$7.3 billion in 2000 to US\$15.8 billion in 2004. US\$4 billion of this increase is attributed to debt relief, and the 11 percent annual increase of non-debt relief transfers over the same period suggests donors "have not... cut back on non-debt-relief transfers, and that debt relief was additional in the aggregate" (p. 11).

Aid to HIPCs, however, has not been additional when assessed over the whole life of the Initiative, i.e. from 1996 rather than from 1999/2000. The recent rise in ODA, once debt relief is deducted, "only meant a return to the level prevailing before the launch of the HIPC Initiative" (United Nations Conference on Trade and Development, 2006, p. 97). And whilst in the aggregate aid may have been additional, this is clearly not the case when it has been

³² He also suggests that low-income countries protect social expenditures from budgetary consolidation better than middle-income countries, where "social expenditures are cut considerably when the budget balance is needed to strengthen" (Thomas, 2006, p. 10).

used to re-finance the multilateral development institutions. Martin calculates that over US\$3.5 billion of aid has been promised to the HIPC Trust Fund or used directly to cancel multilateral debt owed by HIPCs, with further aid contributions of US\$1.5 billion to the IMF's Poverty Reduction and Growth Facility-HIPC Trust (Martin, 2004). This trend was continued in the MDRI in 2005. It is also unclear whether aid to non-HIPCs is rising at the same rate as aid to HIPCs. Killick (2004) has observed a redistribution of resources away from non-HIPCs since the launch of the Initiative and concludes that there is "a real sense in which the poor countries outside the HIPC scheme are subsidising those who live in HIPC countries" (p. 7). The net losses to some HIPCs which are likely to result from the implementation of MDRI are not justifiable either. Total resources available for both groups of countries must be raised.

3.3.3 Old conditionalities in new bottles? The Poverty Reduction Strategy Paper (PRSP) process and the expenditure ceilings debate

Since 1999, in order to qualify for debt relief under HIPC/MDRI, national governments have had to prepare Poverty Reduction Strategy Papers (PRSPs) and periodic updates and progress reports for approval by the World Bank and IMF. Increasingly, PRSPs are also a condition for a much larger number of countries to receive grants or concessional loans (i.e., loans at below-market interest) from the World Bank or funding from national development agencies (Gottschalk, 2004); thus, as of March 2007 54 countries had prepared PRSPs (World Bank, 2007a, accessed March 29, 2007).

PRSPs were purportedly intended to focus heavily indebted countries on using the funds from debt cancellation in a pro-poor manner (although criteria for defining pro-poor policies remain elusive), and to involve broad-based participation and a high level of country ownership. Gottschalk (2005) notes that much of the content of PRSPs reprises the priorities of structural adjustment: low inflation, balanced budgets and a competitive exchange rate. However, he does also note more weight being given to agricultural development, micro-credit and asset redistribution. Commentaries by civil society organisations and some UN system agencies on early PRSP experiences were similarly highly critical (Bhattacharya et al., 2002 and other sources summarized by Labonte et al., 2004, pp. 26-29). In 2004, the leader of the team that produces the United Nations Conference on Trade and Development (UNCTAD) annual Least Developed Countries report described PRSP preparation as "a compulsory process in which governments that need concessional assistance and debt relief

from the World Bank and the IMF find out, through the endorsement process, the limits of what is acceptable policy. [T]here is an inevitable tendency for Government officials to anticipate the endorsable" (Gore, 2004, p. 282). Cheru, in a 2001 UN report that examined eight interim PRSPs (Cheru, 2001) was harshly critical of the process as "a new form of structural adjustment." By 2006 he muted this criticism somewhat, based on a review of 12 African PRSPs, observing that growth strategies were not sufficiently pro-poor and that "[m]ost PRSPs do not include decisive measures to redistribute wealth and promote equality" by way of such measures as land reform, but that there was potential value in the process and in the importance PRSPs gave to domestic policy reforms related, e.g., to anti-corruption efforts and governmental capacity (Cheru, 2006, p. 359).

With respect to health financing, there has been much work on the poverty impact of user charges (Meesen et al., 2003), and increasing acknowledgement from donors and governments that health plans must move away from charging fees at the point of use. Some low-income countries such as Ghana are attempting ambitious plans to scale up social insurance programmes (Sulzbach et al., 2005). Arguably, this new consensus and stimulation of discussion about alternatives to user charges has been one of the more important outcomes of the PRSP process. Limitations in the PRSP process, however, persist. As noted in Section 3.1.2. despite the importance of employment in poverty reduction, more than 500 million people in the world are both working and poor. Nevertheless, employment has been a major omission in PRSPs. The United Nations Development Fund for Women (UNIFEM) reported in 2005 that it reviewed 41 PRSPs (a clear majority of those that had then been prepared) and found that while 23 incorporated some form of employment indicator, "only five ... set any kind of explicit target for employment," and the indicators might not be the most appropriate ones for the majority of non-agricultural workers in the informal economy (Chen et al., 2005a, p. 20).

A further complication of linking PRSPs to resource flows is that debt relief has been delayed in several countries because they have gone off track with IMF programmes. The most recent World Bank/IMF report on HIPC and MDRI (International Development Association & International Monetary Fund, 2006) argues that this is due to weak budget execution and the length of time it takes for countries to prepare PRSPs, as well as broader factors such as internal conflict and poor governance. Martin, however, puts the blame squarely on the demands of the IMF, arguing that it is "traditional conditionality rather than PRSP processes

[that] are causing almost all the delay" (Martin, 2004)³²) and noting that just four of 15 African HIPC's have been able to meet their conditions on schedule.

This linkage is a specific instance of a more general problem: the extent to which access to external financing, including debt relief, is contingent on meeting performance criteria specified by the IMF. "In practice, the financing provided by the IMF in such cases is now often quite small. The IMF's main leverage usually comes from the fact that other forms of financing ... are often linked to an IMF program being 'on track'" (Working Group on IMF Programs and Health Spending, 2007, p. 15) and, more generally, to the role of the IMF in providing reassurances to financial markets about the sustainability of macroeconomic policies (see Section 3.1.3). Critics, many with extensive field experience, have cited expenditure constraints associated with IMF performance criteria as limiting the ability of national governments to increase spending on education and health care, even when development assistance funds to do so were available (de Savigny et al., 2004; Ooms & Schrecker, 2005; Ambrose, 2006). A review of the evidence based on case studies of Ghana, Kenya, Uganda and Zambia in 2005-2006 confirmed that although the IMF does not explicitly set limits on health spending, its overall policies and targets do limit the resources available for health and health personnel and health ministries have difficulty influencing the budget setting process (Wood, 2006). In 2007, the IMF's own Internal Evaluation Office (IEO) examined the situation of 29 countries in sub-Saharan Africa (SSA) that were receiving support from the IMF's Poverty Reduction and Growth Facility (PRGF, the renamed Enhanced Structural Adjustment Facility). Its report found that overall, only 27 cents of every dollar of expected development assistance was earmarked ("programmed") for spending, with the balance allocated to reducing domestic debt and building up foreign exchange reserves. The IMF appeared to regard reducing annual inflation rates to five percent or lower as especially important. The report found flexibility on the part of the IMF in some cases, but also confirmed that IMF staff are primarily concerned with aggregate economic indicators rather than with "sectoral constraints and opportunities" in areas like health care and education (IMF Independent Evaluation Office, 2007, p.11). Indeed, the IMF has neither mandate nor, arguably, expertise to assess such constraints and opportunities. A further exploration of this issue under the auspices of the Center for Global Development (Working Group on IMF Programs and Health Spending, 2007) pointed out that very few African governments have lived up to their commitment (in the Abuja declaration of 2001) to increase public spending on health to 15 percent of general government expenditures

suggesting that domestic as well as external factors are at work (pp. 19-21). At the same time, the CGD working group noted *inter alia*: that IMF projections of aid for some countries in SSA had been quite pessimistic; that the IMF had not incorporated recent commitments of increased aid for SSA into its economic forecasts, hence arguably leading it to overstate the potential negative consequences of spending increases; and that “17 out of the 42 countries with PRGF-supported programs during 2003-2005 included some form of ceiling on the wage bill” (p. 50), thus in part confirming the earlier criticisms.³³

A more detailed exploration of expenditure ceilings is not provided here. Suffice it to say that the issue underscores (a) the need for policies that maintain and expand national policy space in relation to health (see Section 3.1.3); (b) the need for long-term, predictable increases in development assistance, addressed in Section 3.3.1; and (c) the urgency of attention to how health equity and SDH considerations feature in today’s institutions of global governance. This is the topic of Section 4.

Policy implications

The most fundamental issue for the international community has to do with the overall pattern of financial flows. This can be understood with reference to Figure 5, which shows the pattern of financial flows from developing countries to industrialised countries as a whole, with developing economies as a whole represented by the front-most set of bars on the graph. Over the 1993-2005 period, the developing countries as a whole moved from being net recipients of financial flows to being net losers, to the tune of close to half a trillion dollars per year.

---- Insert Figure 5 about here ----

The Figure is incomplete in two respects. Firstly, 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). Secondly, it does not reflect the value of remittances from emigrants to their home countries – a figure somewhat higher than the gross annual value

³³ The Working Group recommended that such ceilings “be dropped from IMF programs except in cases where a loss of budgetary controls over payrolls threatens macroeconomic stability” (p. 11).

of development assistance (Ratha, 2003). Since these two flows have opposite signs and may be of comparable scale, the story presented by the Figure stands: Far from being generous with investments and development assistance, the industrialised world has in fact been sucking savings out of the developing world with growing effectiveness since the end of the last century. Several phenomena contribute to this trend. One is the outflow of debt service payments; another is the fact that a number of middle-income countries have over the past several years accumulated substantial foreign exchange reserves. This has enabled them to reduce their vulnerability to currency crises and lender conditionalities, but at a price. As Stiglitz has pointed out, 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, p. 66).

If we accept that a necessary (although not sufficient) condition for improving health equity is that low- and middle-income countries receive more funds from external sources – an axiom accepted by virtually all analysts of all analytical persuasions – then the financial flows depicted in Figure 5 can only be described as perverse and among the greatest threats to global health equity. The need for long-term changes in the current pattern of financial flows, with special emphasis on increases in ODA and debt reduction that are clearly related to SDH, is the most fundamental recommendation that emerges from this discussion.

Against this background, coordination and alignment of aid flows can best be achieved through globally pooled funds multilaterally managed and transparently governed, with eligibility and allocation determined according to agreed needs and developmental objectives, with multi-year stability of donor inputs and recipient receipts (Burall et al., 2007). As interim steps toward this goal, sustained increases are necessary in levels of untied aid, primarily disbursed through direct budget support with appropriate mechanisms to ensure accountability with minimally onerous administrative requirements. Given the importance of the MDGs as a commitment on the part of the international community and the arguments that they should be used as a guide to aid flows and debt cancellation, the associated targets and indicators should be revised to incorporate equity measures and to ensure greater attention to the broader social determinants of health.

The international community should recognise that, given the large capital requirements of poor countries, borrowing on international markets will be inevitable in the future. As a

result, and to avoid the problems generated by the HIPC process, it needs to shift its focus from narrow indicators of economic sustainability towards an agreement on the need for 'debt responsibility' (Hurley, 2007). The concept of debt responsibility has economic, social and political aspects. On the economic and social sides first, broader measures of economic vulnerability must be used when assessing the likelihood of a country encountering debt problems – these might include the country's dependence on primary commodities, the frequency of natural disasters or the size of the HIV epidemic. But more ambitiously, several commentators have now proposed that debt should only be paid after social needs have been attended to. The Millennium Project recommended that debt sustainability should be redefined as the level of debt consistent with achieving the MDGs, which for many heavily indebted poor countries will require 100 percent debt cancellation and for middle-income countries, more debt relief than has been on offer (UN Millennium Project, 2005, pp. 207-208). Dervis & Birdsall (2006) have suggested a separate debt initiative for heavily indebted emerging market economies which they call a 'Stability and Social Investment Facility'. Such a Facility would provide debt relief and be housed either at the World Bank or IMF. It would help middle-income countries to avoid a future debt crisis and to protect social expenditures in the face of a high debt burden. Mandel (2006a) proposes a *feasible net revenue approach* to debt forgiveness, based on a per capita income of about \$3 per day (at purchasing power parity) that would be sufficient to support an average life expectancy of 70 years. Assuming no taxation on people below this "ethical poverty line," and a 25 percent tax on all people above it, Mandel calculates how much needs to be spent on providing essential services for the population in order to meet the MDGs and subtracts this from government revenue. Applying this method on a sample of 136 developing countries, Mandel finds that between 31 and 43 percent of all outstanding developing country debt – affecting 93 to 107 nations – needs to be cancelled if poverty is to be reduced and the MDGs met.

But the concept of debt responsibility goes further than this: it also stresses the need to change the *political* context of lending and borrowing. Firstly, more transparency is needed in the process of incurring debt itself: government borrowers and lenders should be subject to legislative scrutiny. Public participation in such important economic decisions would also be welcome (Hurley, 2007). Secondly, the strong creditor control over the HIPC process has re-invigorated calls for a more balanced approach to debt cancellation. It would seem prudent to heed the call of UNCTAD (United Nations Conference on Trade and Development, 2006) and debt campaigners for reforms to the international financial architecture to ensure

an orderly bankruptcy procedures and independent arbitration and mediation between the claims of creditors and debtors.

All these proposals merit further investigation. They do not, however, address the moral hazard issue. A partial response begins by inquiring into the legitimacy of foreign creditors' financial claims when they involve funds lent to governments that systematically looted the public treasury or used public funds for domestic repression in order to maintain power. Pogge (2002b) questions the collectability of these debts on ethical grounds, since the international community need not have permitted repressive or larcenous rulers to borrow against the assets and future earnings of their subjects. Other commentators wonder whether "odious debts" are collectable as a matter of international law (Kremer & Jayachandran, 2002; King et al., 2003). To illustrate the amounts involved, one recent study estimates that US\$726 billion of the current debt of 13 developing countries is odious and should be cancelled and, further, that 10 countries should actually receive refunds of US\$383 billion in past payments on such debts (Mandel, 2006b). The international community must not continue to avoid this question.

The PRSP process can be made more supportive of health equity by ensuring much broader discussion at country level about the setting of macro-economic policy and about the nature of poverty reduction strategies. Legislative bodies, other elected officials and representative and accountable civil society organisations can play a key role in this process. Countries should be encouraged to prepare PRSPs that incorporate employment targets with a gender dimension, an emphasis on incomes that at the very least will lift households out of absolute poverty, and compliance with core international labour standards.

WHO can play a role in encouraging countries to use the PRSP process to promote more intersectoral action to address SDH, and to help health ministries negotiate for higher budgets. More generally, as illustrated by the inadequacy of policy attention to the health implications of IMF programmes, WHO can and indeed must become an effective advocate for health within the existing institutions of global governance, as well as a proponent of reform of those institutions. These issues are addressed at greater length in Section 4.

3.4 The global marketplace and basic needs

The immediately preceding sections of the Report examined a number of what might be called macro-level dimensions of the operations of globalisation, having to do with the emergence of the global marketplace, its adverse consequences for health equity, and the incompleteness of efforts to address those consequences by way of such measures as development assistance and debt cancellation. In this section of the report, the focus shifts to specific SDH that can usefully be thought of as 'downstream' from these macro-level processes, although heavily influenced by them. Based on intensive discussion at the first GKN meeting, we identified health systems change (including human resources for health), diet and nutrition, and water and sanitation as priority issues, while being acutely aware that this is not an exhaustive list.

3.4.1 Globalisation and health systems change

Health care interventions that are taken for granted in the industrialised world are routinely unavailable, or available only to the wealthy, outside it. Access to care reflects the same distributions of economic (dis)advantage that characterise other social determinants of health. This point has been made eloquently in the context of developing and transition economies by Paul Farmer (2003), and is at least in part explained by the 100-fold difference in health care expenditures per capita between low-income countries and those in the industrialised world. It has been established that the lives of six million children per year could be saved through the universal provision of a set of low-cost, low-tech interventions at a direct annual cost estimated at US\$5.1 billion (Bryce et al., 2005). Further, the costs of necessary health care or the income losses associated with lack of access to it create destructive downward spirals or "medical poverty traps" (Whitehead et al., 2001) involving poor nutrition, abandoned education, and still more illness. These can be disastrous at the household level, and when sufficiently widespread can lead to substantial reductions in economic growth at the national level. Health systems are an integral component of the broader systems of social protection that are critical to reducing health inequities; and the irony that the poorer the country, the higher the proportion of its health care expenditure is likely to be accounted for by private, out of pocket spending, merits special and immediate attention.

Because another Knowledge Network is addressing health systems issues, and human resources for health are discussed elsewhere in this report, we are concerned here only with the specific interface between globalisation and national health systems. We start with the observation that key international institutions have actually contributed to health resource scarcities, in particular as they affect the poorest and most vulnerable, by promoting a market-oriented concept of health sector reform (HSR) that strongly favours private provision and financing (Petchesky, 2003; Mackintosh, 2003; Koivusalo & Mackintosh, 2004) chapter 4). From the mid-1980s until quite recently, the World Bank in particular actively promoted a paradigm of HSR that viewed private provision of health care and the purchase of health care or health insurance on the open market as the normative baseline, and any alternative policies as demanding justification – in the first instance, with reference to microeconomic criteria of correcting for market failures.

In its widely cited 1993 World Development Report on *Investing in Health*, the Bank stated: “In most circumstances ... the primary objective of public policy should be to promote competition among providers – including between the public and private sectors (when there are public providers) as well as among private providers, whether nonprofit or for-profit. Competition should increase consumer choice and satisfaction and drive down costs by increasing efficiency” (World Bank, 1993, p. 58.) The Bank also argued that anything other than a private sector solution required a special case to be made: “There must be a basis for believing that the government can achieve a better outcome than private markets can in providing and financing health services” (World Bank, 1993, p. 55). The point is not to demonise the World Bank, but it would be naive not to recognise its influence, which arises from its role as a lender; its research and knowledge transfer activities, which play an important role in shaping “epistemic communities” (Haas, 1992; Haas, 2002) in development policy and practice; and from its role as a node in an elite network that has promoted nostrums of markets and competition (Lee & Goodman, 2002). So pervasive is the influence of the World Bank and the regional development banks that HSR was once defined explicitly as “those activities undertaken cooperatively between the international development banks and a national government to alter in fundamental ways the nation’s health financing and health provision policies” (Glassman et al., 1999, p. 115). The Bank has recently changed some of its positions on health system design, but our concern here is at least in part with

historical explanation, and even under ideal circumstances the damage done by this legacy may take a long time and a great deal of policy innovation to undo.

Variations have been possible in middle income countries: in recent years, two OECD countries (Mexico and Turkey) have departed from the mainstream of HSR by expanding their social insurance cover to include many poorer citizens previously excluded (Frenk et al., 2006; Tatar & Kanavos, 2006; World Health Organization, 2007a). It remains to be seen whether these are isolated exceptions to a general pattern or indicators of a broader trend. It should also be noted that these counter-examples involve a social insurance model, rather than a model organised around universal provision of care financed through general tax revenues. The limitations of social insurance from an equity perspective have recently been emphasised in the research literature (Lloyd-Sherlock, 2006; Wagstaff, 2007). HSR further embodies a narrow conception of technical and economic efficiency that has privileged “cost effective” medical interventions.

This focus, combined with new sources of funding through disease-specific Global Public-Private Partnerships (GPPPs), has usually resulted not in improved efficiency but in increased inequity of access and increasingly fragmented and ineffective health systems (Brugha & Walt, 2001; Hardon, 2001; Raghavan, 2001; Nishtar, 2004; Carlson et al., 2004; Gottret & Schieber, 2006). GPPPs tend to go around rather than through governments and existing state machinery. This may in some instances result in an apparently efficient delivery of a vertical, specific medical intervention, but may also divert attention from the need for wider social and public health measures to address SDH, and may lead some governments to limit their own commitment to building equitable health care systems. Studies have concluded that effective and sustainable health interventions cannot be adequately driven by external multilateral agencies or donors: they need to be context-specific and involve the broadest participation of civil society organisations, giving the recipient government a key role in managing and shaping the system rather than reducing it to a subordinate or caretaker role. Failing this, governments that might otherwise be drawn into longer-term sustainable partnerships in developing an infrastructure of health care and public health policies will adapt their priorities to those of external and ultimately largely unaccountable donor agencies. Global partnership funding can also intensify human resource constraints in low-income countries and result in damaging duplication of procurement and other systems, and in many cases depend heavily on high cost (sometimes subsidised drugs and vaccines, but

without building the necessary capacity to sustain services at national level (Caines et al., 2004; Carlson, 2004; Stillman & Bennett, 2005; Ravindran & de Pinho, eds., 2006).

Policy implications

On the principle of 'first, do no harm,' no further reforms based on the main menu of neoliberal HSR should be implemented until and unless research has established their appropriateness, effectiveness and affordability in low- and middle-income countries. (For a detailed discussion of this issue, see the Final Report of the Health Systems Knowledge Network.) Conversely, available evidence indicates that publicly funded and universal systems which integrate strong primary health care with public health interventions are associated with better health outcomes and fewer inequities (Rannan-Eliya & Somanathan, 2005; Flores, 2006).

Above and beyond such concerns, the most crucial issue remains lack of resources to support even a basic minimum level of health service provision. In 2001, the WHO Commission on Macroeconomics and Health estimated the cost of a package of basic, low-cost and low-tech interventions (Jha et al., 2002; see also Spinaci & Heymann, 2001) at US\$34 per capita per year (approximately \$40 in today's dollars).³⁴ Making these interventions widely available, according to the Commission, would have saved "at least 8 million lives *each year* by the end of this decade, extending the life spans, productivity and economic wellbeing of the poor" (Commission on Macroeconomics and Health, 2001, p. 11). As noted in Section 3.3.1, simple arithmetic dictates that such countries will be reliant on external sources of finance far into the future if they are to provide that "rather minimal" level of health care (Gottret & Schieber, 2006; Sachs, 2007). Preoccupations with making developing country health systems "sustainable," in the sense that they can be financed using domestically raised revenues (Schieber et al., 2006a), are unrealistic at best (Ooms, 2006; Sachs, 2007).

In some contexts, substantial health gains are achievable with low-cost, targeted efforts (Anon, 2002; de Savigny et al., 2004). However, these efforts do not substitute for creation of more comprehensive primary health care systems financed through universal insurance.

³⁴ J. Sachs, personal communication, 2007 (cited in Working Group on IMF Programs and Health Spending, 2007).

They also do not obviate the need for acceptance by the industrialized world that *if* health equity is accepted as a policy goal, *then* ensuring the sustainability of health systems that serve the world's poor majority, like mechanisms to meet basic needs of other kinds, is a moral obligation that falls most heavily on those best able to finance it. Thus, international transfers of resources from rich to poor countries for health systems on a much larger scale than current development assistance for health are imperative – a point made earlier, and one to which we return in Section 4. Over the longer term, urgent attention should be directed to identifying alternative sources of funding that might generate sufficient new revenues to support health systems while reducing existing burdens on the poor. Examples in the existing policy discourse include a number of proposed systems for global taxation (Gottret & Schieber, 2006, pp. 127-138).

3.4.2 Globalisation and health human resources (HHR)

Globalisation contributes in various ways to the migration of health professionals. This migration is asymmetrical, from poor countries to rich ones, with the poorest countries unable to attract replacement workers. As a result, the complete HHR migration picture, often portrayed as a conveyor belt, does not entirely close full circle.

'Push' and 'pull' conditions fostered by globalisation have led to chronic problems in HHR shortages in many developing countries. A complex set of factors, including government policy, technological change, levels of private investment, individual aspirations and deteriorating economic and broader social and environmental conditions, at least partly attributable to liberalisation or other forms of global market integration, drive the global integration of labour markets and the movement of health workers. Ceilings on public expenditure associated with the need to secure IMF approval of national macroeconomic policies (see Section 3.3.3) may limit the ability of governments to pay badly needed health professionals, although the relative contribution of IMF demands and other factors must be assessed on a country-specific basis. As a result of these factors, physicians and nurses are being pushed out and governments are hard-pressed to implement effective remedies to stop the exodus (McDonald & Crush, 2002; Bundred et al., 2004; Dovlo & Martineau, 2004).

For countries unable to draw in new health workers to replace those who have left, the inevitable result is diminished health care access and services (World Health Organization,

2006b). "Higher worker density generates better health outcomes" (p. 24) and "[a]s the density of health workers increases, maternal, infant and under-five mortality all fall" (Joint Learning Initiative, 2004, pp. 24, 26). When countries purchase the temporary services of foreign health workers to fill the vacancies left open by departures, the price tag to the health system is high and brings in its own set of problems. A further trend within developing countries is internal migration of health personnel from public to private health care systems and from rural or under-served areas to urban communities. This trend is often portrayed as partly a result of the pull from rich countries, with positions in urban communities seen as a necessary stepping stone to recruitment abroad (Wibulpolprasert et al., 2004; Aluwihare, 2005; Elegado-Lorenzo, 2006; Gerein et al., 2006).

At the same time, globalisation makes it easier for rich countries to 'pull in' health workers. Barriers in rich countries are being actively lowered for professional, technical and 'skilled' immigrants (Crush, 2002). Some destination countries of health worker migrants suffer their own HHR shortages and are increasingly relying on the immigration of foreign-trained health workers to relieve them (Mullan, 2005). These countries are able to offer higher pay, better working conditions and greater opportunities, effectively pulling in foreign health workers. Case studies demonstrate how net source countries (such as Ghana and Zimbabwe) and net destination countries (such as Canada and the US) at times are simultaneously acting at loggerheads to stimulate or stem the crisis (Barer, 2002; Grumbach, 2002; Reinhardt, 2002; Mensah et al., 2005; Chikanda, 2005; Labonte et al., 2006).

In addition to these 'push' and 'pull' factors, a number of others foster HHR migration: notably the internationalisation of professional credentials and of citizenship and remittances. Professional credentials in health as in other fields are increasingly recognised across borders, especially where free trade areas have been formed, with the European Economic Area (EEA) serving as the best example. Eased migration and mobility (including, for instance, through cheaper, faster and easier travel, multilingualism, post-colonial ties and common academic curricula) have contributed to a sense of 'global citizenship' worldwide, with professional credentials serving as passports. The opportunity to accumulate savings and remit portions to family and communities back home is a significant draw for health workers to migrate. While remittances represent important private welfare gains, there is little evidence that they boost public welfare, including health care (Ouaked, 2002). Further,

long periods of often costly training mean that remittances from health professionals may flow disproportionately to relatively well off households, thus paradoxically increasing inequality in the country of origin (Schrecker & Labonte, 2004).

Table 1. Global health worker migration: Policy options

Policy option	Brief description
Return of migrant programmes	Evidence indicates that schemes to promote the return of migrants have so far proved costly and largely unsuccessful, particularly where root factors which caused the out-migration to occur in the first place have not been addressed. Any impact of reducing global health inequities through investments based on this strategy must be weighed (Chikanda, 2005).
Restricted emigration (bonding) or immigration	Restrictions have been applied in different countries on both the exit of individuals (e.g. through bonding in source countries) and their entry (by restrictions on immigration in destination countries). Overall, bonding schemes have been weak, leading to increased dissatisfaction among health personnel and merely delaying migration (Gilson & Erasmus, 2005). Restrictions on immigration of health personnel, on the other hand, have been modestly successful where policies are respected although have been criticised for singling out health workers over other migrants.
Bi- or multilateral agreements between source and destination countries to manage flow	A number of such agreements exist and have been deemed somewhat successful (Nullis-Kapp, 2005). Such agreements are recommended in environments where health systems (including health professional licensing and hiring) fall under national, and not sub-national, regulations. Bilateral and multilateral agreements also represent a stronger option than existing voluntary codes of practice regarding recruitment.
Improved domestic HHR planning	Improved self-sufficiency in HHR production was resoundingly advocated throughout the literature review. Better health human resource planning and greater commitment to improving working conditions for domestic HHR with the aim of improving retention would reduce 'pull' factors (World Health Organization, 2006b). This being said, the degree to which key source countries will embrace this option is questionable in the context of the global markets and massive HHR shortages in the US.
Restitution	Numerous creative measures – some merely ideas and others already tested – have been suggested, including facilitated two-way HHR flows (Nullis-Kapp, 2005) and increased contributions from high-income receiving countries to health and health-training systems in low-income source countries (Gaynor, 2005). This will likely require net capital transfers (wealth flows) from richer to poorer countries, in keeping with WHO's definition of fairness in national health system financing through cross-subsidisation (World Health Organization, 2000).

Policy implications

Five generic policy options, illustrated in Table 1 above, have been implemented by various source and destination countries as a means to curb HHR flows or mitigate the resulting global health inequities. When framing a policy response to health worker migration, decision-makers should not overestimate how much impact they can have on the global integration of these specialized labour markets. Indeed, in this case, low-income countries experiencing outward flows of their health workers may be forced to work with the grain of market integration, since it is likely counter-productive to do otherwise (Mensah et al., 2005). Policy interventions aimed at improving domestic health systems and human resource capacities (both of which require resource transfers from high-income countries, as will be shown later) need to compensate for inequities in access to health care that are being reinforced by global labour market integration, but policies directed at stopping such integration are unlikely to succeed.

Depleted source countries can pursue two other policy measures. One, which many countries in sub-Saharan Africa are considering or planning to act upon, is training of auxiliary ('mid-level' or 'substitute') health workers (e.g. Tanzania, Zambia, South Africa, Malawi) who are less marketable globally. There is no evidence that, with an adequate training curriculum, higher skilled back-up and good supervision, the expanded deployment of such workers leads to a "second class health system," as is sometimes claimed by medical and nursing organisations in both source and receiving countries. Neither does it negate the importance of also training highly qualified practitioners as the burden of chronic disease (often requiring technically complex interventions) now rivals that of infectious illness in many SSA countries. Another important measure is giving greater priority in national budgets to health system spending; in many countries, this cannot be implemented without decisive commitments on the part of the donor/lender community. A number of source SSA countries claim HHR shortages due to out-migration, yet have large pools of unemployed nurses and physicians often coinciding with a significant number of vacancies. A combination of increased domestic priority for public sector health spending, the relaxation of IMF demands that countries limit the size of the public sector wage bill, and increased multi-year funding guarantees from donors could help resolve this unhealthy paradox³⁵.

³⁵ While health spending as a percentage of GDP and of total government spending grew moderately in many sub-Saharan African countries from the late 1990s to 2005, few

3.4.3 Globalisation of intellectual property rights

During the 1970s, developing countries sought to reverse what had been until then a slow expansion of Intellectual Property Rights (IPRs). Not only did this initiative fail, developed countries took the offensive, leading to the adoption of the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) in 1994 as part of the far-reaching changes that led to the establishment of the WTO. TRIPS represented a major victory for the pharmaceutical industry (Sell, 2003). An early study concluded that international "patent harmonization has the capacity to generate large transfers of income between countries; with the US being the major beneficiary ... These transfers significantly alter the perceived distribution of benefits from the Uruguay Round, with the US benefits substantially enhanced, while those of developing countries and Canada considerably diminished" (McCalman, 1999, p. 30). Recent data from the World Bank *World Development Indicators* database confirm this: the global value of royalty payments has increased from US\$61 billion in 1998 to US\$120 billion in 2004, with the United States being the main recipient.

The pharmaceutical industry claims that patents play a key role in ensuring financing for its research and development (R&D) activities. This claim must be questioned in two respects. Firstly, although the industry continues efforts to ensure patent protection for its products in developing countries, the latter are responsible for only about 10 percent of global sales (in value) and for 5 percent to 7 percent of global industry's profits (Pharmaceutical Research and Manufacturers of America, 2005). The extension of pharmaceutical product patents to developing countries under the TRIPS Agreement is likely to have no significant impact on the development of new medicines (Scherer, 2004). Secondly, patents are relevant only to certain types of R&D: those involving diseases that predominantly affect the rich countries. The lack of effective demand for treatments for diseases of the poor makes patent protection irrelevant for these diseases and only relatively important for such illnesses as HIV/AIDS, malaria and tuberculosis that are of some importance to high-income countries. Thus, patents may deepen existing health inequalities within and between nations; and

countries have reached the health spending level of 15% of total government budget to which they committed themselves in the 2001 Abuja Accord.

alternative mechanisms to finance and promote pharmaceutical innovation are needed, especially for diseases of the poor.³⁶

Concerns about the implications of patents for access to drugs voiced by developing countries and civil society organisations (CSOs) in many fora were ultimately reflected in the Doha Ministerial Declaration on TRIPS and Public Health (World Trade Organization, 2001). The Declaration clarified the right of countries to issue compulsory licenses, thereby affirming a degree of flexibility in access to medicines under patent protection. Until recently, however, the compulsory license system remained unused, perhaps because of concerns about hostile reaction from developed country trading partners (Outterson, 2005). A number of such licenses have recently been issued, despite claims that such licenses may reduce innovation.³⁷ In most cases, the expected price reductions are significant.

Many developing countries, however, cannot produce the active pharmaceutical ingredients needed to prepare pharmaceutical products. A TRIPS Council Decision in August 2003 allowed these countries to 'parallel import' generic versions of patented drugs through compulsory licenses issued in a different country. TRIPS rules in this Decision, however, impose burdensome constraints for the production and export of products patented in the potential supplier country (World Trade Organization, 2001; Médecins sans Frontières, 2006). As a condition for use of this Decision, potential importing countries must notify their intention to do so. So far, no country has made such notification and the Decision has never

³⁶ Several public-private-partnerships (PPPs) have been established for that purpose. The World Health Organization started a process for the discussion of alternative mechanisms to promote innovation, including a possible international treaty on the matter. The World Health Assembly passed Resolution 59.24 calling for the establishment of an Intergovernmental Working Group to draw up a global strategy and plan of action based on the recommendations of the Commission on Intellectual Property Rights (CIPRH) (Commission on Intellectual Property Rights, 2006). This would include researching a new framework to support sustainable, needs-driven, essential R&D work on diseases that disproportionately affect developing countries.

³⁷ This argument was made when Thailand announced its intent to issue a compulsory license for a heart disease drug. Available empirical evidence, however, does not support this contention. Scherer analyzed the extent to which the granting of compulsory licenses in the USA affected R&D expenditures by firms and, particularly, whether such licenses diminished or destroyed the incentives to undertake R&D by patent holders. His statistical findings relating to 70 companies showed no negative effect on R&D in companies subject to compulsory licenses but, on the contrary, a significant rise in such companies' R&D relative to companies of comparable size not subject to such licenses. (See Scherer, 2003; also Outterson, 2005, p. 230, arguing that compulsory licenses need not harm optimal innovation).

been applied. This is a worrying signal about the effectiveness and feasibility of the mechanism set up by the Doha Declaration. It was a politically and socially important initiative that seemed to reaffirm the need to give priority to public health over commercial interests inherent to the acquisition and exercise of intellectual property rights. Its implementation, however, appears to have been strongly influenced by the very commercial interests it was intended to counterbalance.

At the same time the Doha Declaration was negotiated and adopted, the USA initiated a series of negotiations of bilateral and regional free trade agreements (FTAs) with more than twenty countries. The signed FTAs incorporate TRIPS-plus requirements that are unlikely to have been reached in a multilateral framework, where developing countries have become increasingly reluctant to support a further elevation of IPR standards (World Trade Organization, 2001; World Intellectual Property Organization Secretariat, 2004). Other FTAs have been signed by or are under negotiation between developing countries and the European Union (EU) or the European Free Trade Association (EFTA). The common pattern in these FTAs is that they further elevate the level of protection in virtually all areas of IPRs, notably copyright and patents. Some FTAs, undermining the stated intent of the Doha Declaration, restrain WTO members' freedom to determine the grounds for compulsory licenses (US FTAs with Jordan, Australia and Singapore), or limit the possibility of parallel importing medicines (US FTAs with Australia, Singapore, Morocco) (Correa, 2007).

Consumers in developing countries contribute to the R&D budgets of pharmaceutical companies but are unlikely to benefit from future innovations to the same extent, if at all, as consumers in developed countries. The price increases introduced by patent protection, in turn, may be extraordinarily high and have human rights implications, particularly in restricting domestic autonomy to realise access to medicines. These are increasingly recognised as a core duty under the international human right to health (Committee on Economic, Social and Cultural Rights, 2000, ¶42a, 42d). Indeed the report of WHO's Commission on Intellectual Property Rights (CIPRH) recognises this right and the duties it imposes regarding medicines (Commission on Intellectual Property Rights, 2006, pp. 22-25). Future challenges in providing access to patented drugs may be even more difficult: all WTO member countries are now bound to confer product patent protection, and the mechanism set up by the WTO Decision is overburdened by conditions that are unlikely to encourage the supply of cheap products under patent protection in the potential exporting countries.

Policy implications

First of all, developing country governments should critically review the implementation of the WTO Decision of August 30, 2003 on an ongoing basis. All governments should ensure that their national legislation allows full use of the flexibilities provided for by TRIPS in the area of patent protection for pharmaceuticals and test data, such as exceptions to patent exclusive rights for experimentation and early approval of medicines, parallel imports, compulsory licenses and government use. Developing country governments should explore the use of compulsory licenses of patented essential medicines whenever the price can be significantly reduced through competition (local production or importation). Crucially, they should avoid concessions in bilateral or free trade agreements that increase the level of IPR protection for pharmaceuticals and, if such concessions have already been made, provide for compensatory measures to support access to drugs.

WHO, as a matter of priority, should evaluate mechanisms other than the patent system, such as contests, public-interest research funding and advance purchase agreements, to encourage the development of drugs for diseases that disproportionately affect developing countries (such mechanisms received only a few paragraphs in the CIPIH report), and assist member countries to implement such mechanisms.

3.4.4 Globalisation and nutrition transitions

As globalisation has proceeded since the 1980s, a clear nutritional trend partly related to trade liberalisation has become evident: a sharp increase in the proportion and number of adults and children who are overweight or obese (World Health Organization, 2006a), both being major risk factors for several chronic diseases. The global prevalence of these leading chronic diseases is projected to increase substantially over the next two decades, with rapid rises projected for many developing countries (Popkin & Gordon-Larsen, 2004; Prentice, 2006); cardiovascular disease is already the leading cause of mortality in developing countries (World Health Organization, 2005). The pattern found in high income countries, where obesity and related disease fall disproportionately on the groups of lower socioeconomic status (SES), is beginning to repeat itself in middle income countries. For example, after countries have crossed over a GNP threshold of about US\$2500 per capita,

women of low SES tend to have proportionally higher rates of obesity (Monteiro et al., 2004).

Table 2. Globalisation processes linked with nutrition transitions

Globalisation processes*	Nutritional implication following the conceptual framework
Growth of transnational food companies (TFCs)	Increases availability of processed foods (fast foods, snacks, soft drinks) through growth of fast food outlets, supermarkets and food advertising/promotion; driven by trade and FDI
Liberalisation of international food trade	Imports change availability of foods and/or their price
Global food advertising and promotion	Shapes food preferences by affecting desirability of different foods
Development of supermarkets	Growth of transnational supermarkets changes food availability (increases diversity of available products), accessibility , price , and way food is marketed
Cultural influences	Migration, TNCs, and tourism introduce and popularise new foods (changes food availability and desirability)
Liberalisation of foreign direct investment (FDI)	Changes type of foods available , their price and the way they are sold and marketed
Technological developments	Affects ability to transport, store and process foods, which affects their availability , accessibility and price
Liberalisation and commercialisation of domestic agricultural markets	Changes way food is produced, type of foods available , their price and the way they are sold and marketed

* Listed according to how often they are mentioned in the papers included in the literature review conducted for the Globalisation Knowledge Network.

A certain consensus emerges from the literature about globalisation's role in what is now generally described as a "nutrition transition" in most developing countries (Mendez & Popkin, 2004). Cross-country studies find that body mass index BMI increases continuously with greater urbanisation (Popkin, 1999; Ezzati et al., 2005). Countries with higher GNPs, and with more urbanised populations (as dependent and independent variables) also consume greater amounts of energy from fats, sweeteners and protein (Popkin, 1999). The most commonly identified processes linking globalisation with nutrition transitions were the rise of transnational food companies (TFCs), followed closely by the liberalisation of international food trade, and then the related factors of global food advertising and promotion and the growth of transnational supermarkets. Other factors identified were cultural influences, technological developments, the liberalisation of foreign direct

investment (FDI) and domestic agricultural liberalisation. In synthesizing these papers, it becomes clear that all these processes are inter-related and are perceived as important because they affect the availability, price, accessibility and desirability of different foods. These are set out in Table 2.

Different studies emphasise the demand and supply sides of the linkage (i.e. how consumer demand may be influencing change, versus systematic changes in the food supply). On the demand side, the evidence suggests that the role of globalisation is intertwined with that of income growth, urbanisation and changes in employment. Other evidence indicates a need to look beyond income, urbanisation and employment as the sole nexus of the globalisation-nutrition transition link. The relations among globalisation, income, urbanisation and employment are not straightforward. In some countries, people of lower SES consume more obesogenic diets, indicating that the relationship with income is not direct. Another body of literature suggests that while income provides the means, and urban living the incentive, the globalisation of the food supply chain is an important influence on food consumption patterns by altering food availability, accessibility, price and desirability (Kennedy et al., 2004).

The evidence linking these processes to trade is not conclusive, but highly suggestive. The economic value of food imports has increased with globalisation, almost doubling from (real) US\$224 billion in 1972 to US\$438 billion in 1998. Food now accounts for 11 percent of global trade, a proportion higher than that of fuel (Pinstrup-Andersen & Babinard, 2001; Chopra et al., 2002). In developing countries, food import bills as a share of GDP more than doubled between 1974 and 2004. Of more concern to the health equity problems of under/malnutrition, the amount of trade made up of processed agricultural products rose much faster than primary agricultural products (United Nations Food and Agriculture Organization, 2004). Examples include the shift in use of vegetable oils in India, where market liberalisation in the mid-1990s led to a rapid increase in imports of low-priced palm and soybean oils (Hawkes, 2006) and decreased use of traditional peanut, rapeseed and cottonseed oils. A similar process occurred in China. The most significant body of evidence on the role played by trade in the nutrition transition comes from the Pacific Islands. Four different studies found that imported foods altered the "traditional" diet, particularly by increasing fat consumption (Evans et al., 2001; Schultz, 2004; Hughes & Lawrence, 2005; Cassels, 2006).

Trade reforms can also affect diet and the nutrition transition by removing barriers to entry, through FDI and joint ventures, to TFCs such as food processors and supermarkets. TFCs have altered the food supply by increasing the availability of processed and fast foods, making them more accessible through large transnational supermarkets, and making them more desirable through the use of advertising and promotion, including global branding (Chopra, 2002; Caplan, 2002; Lang, 2002; Kennedy et al., 2004; Pingali & Khwaja, 2004; Kinabo, 2004; Sawaya et al., 2004; Fajardo, 2004; Schmidhuber & Prakash, 2004; Hawkes, 2006; Popkin, 2006). Snacks, fast foods and soft drinks manufactured by these companies still form a relatively low proportion of dietary intake in developing countries, though they are becoming more important. TFCs are probably having a more important impact on diet indirectly, since their rising power in the marketplace affects the dynamics of the food market as a whole, affecting the availability, price and desirability of food from all sources and actors.

Policy implications

TFCs in industrialised countries are currently under considerable pressure to take action against obesity and have formulated voluntary commitments to pursue this objective. In most developing countries, FDI is subject to regulation. Through its position upstream, FDI represents a single entry point to implement a range of policies affecting TFC behaviour. These include limits on advertising high-calorie, nutrient-poor foods to children, and on promoting foods associated with the nutrition transition. In addition, regulation of advertising to children is needed, and a tax on food advertising is also an option to raise funds for nutrition promotion. The WHO Code on the Marketing of Breastmilk Substitutes should be strictly enforced and monitored (World Health Organization, 1981).

From an economic perspective, taxing consumers is a more efficient way of discouraging consumption of specific foods than imposing tariffs. Excise taxes – a normal part of any tax code – could be used to reduce demand for foods unnecessary in the basic diet of all income groups. Developing country governments need to integrate these policies into a coherent strategy, taking an equity focus. They should also consider national social protection packages that require conditionalities for nutrition (e.g. visits to nutrition advice centres).

International organisations, agencies and developed country governments need to develop a coherent strategy for building capacity to address obesity and diet-related chronic diseases in developing countries, using the capacity that already exists in developed countries. WHO should take a bold leadership role in lending technical assistance to developing country governments in building policies and programs to improve nutrition.

Multilateral, regional and bilateral trade organisations must recognise the legitimacy of taking nutrition into account in trade negotiations; they should not simply assume that nutrition will improve with increasing economic growth. At the moment, food is considered only in terms of food safety. The WHO Framework Convention on Tobacco Control (FCTC; see Box 6) provides some lessons for developing a non-trade treaty that sets a pro-health standard in trade disputes: the FCTC does not specifically refer to trade, but uses language indicating that health should be the prime consideration (World Health Organisation, 2003).

Finally, researchers are beginning to address the nutritional outcomes of globalisation, but are limited by the lack of data or poorly designed studies. Work is urgently needed to link information about changes in food consumption patterns and nutritional status to globalisation policies and processes.

Box 6. Trade in tobacco products

Tobacco use remains one of the leading causes of morbidity and premature mortality in the world. Liberalisation of trade in tobacco products has become a concern for public health officials worldwide for its potential to offset declining use in developed countries by penetrating new markets in developing nations. Efforts to liberalise trade in tobacco products were led by the Office of the US Trade Representative and US Cigarette Export Association which threatened sanctions against five Asian countries (Japan, South Korea, Taiwan and Thailand), under Section 301 of the 1974 Trade Act, unless restrictions on tobacco imports were removed. It was successfully argued in 1990 by the US government, under a General Agreement on Tariffs and Trade (GATT), that Thailand's measures were discriminatory if they did not also apply to domestic producers (Campaign for Tobacco-Free Kids, 2002, Appendix 4, p. 37). Trade liberalisation has since been used by the tobacco industry to argue for the further reduction or removal of duties and tariffs, and against stronger tobacco

regulation. A range of multilateral trade agreements offer potential grounds for the liberalisation of the tobacco trade including the General Agreement on Trade in Services (GATS) in relation to advertising, Technical Barriers to Trade (TBT) in relation to labelling, and Agreement on Trade-Related Intellectual Property Rights (TRIPS) in relation to packaging and health warnings. While Article XX(b) of GATT states that member states are permitted to adopt trade restricting measures in order to protect public health, there remain uncertainties over the interpretation of this article, and the burden of proof required to demonstrate necessity. Without international case law to date, the public health community remains concerned that health protection remains secondary to trade promotion under such agreements (Callard et al., 2001a; Callard et al., 2001b).

Clear evidence exists that trade liberalisation, when applied to tobacco, leads to adverse health consequences. World Bank research found that reduced tariffs in the above cited Asian countries resulted in a 10 percent rise in smoking rates above what it would have been without trade liberalisation. Increases within certain population groups, such as teenage males (18.4 percent to 29.8 percent in one year) and teenage females (1.6 percent to 8.7 percent) in South Korea, was even starker (Taylor et al., 2001). To prevent trade policy taking precedence over health protection, health organisations and WHO have urged the exclusion of tobacco from trade treaties (BMA, 2002; Burke Fishburn, Tobacco Free Initiative, WHO Western Pacific Regional Office as quoted in Macan-Markar, 2004). Trade officials, however, may be unwilling to support such a removal, especially when they represent countries with strong tobacco exporting interests. This was evident in the (somewhat successful) efforts of the US, Germany and Japan in weakening some provisions of the Framework Convention on Tobacco Control (FCTC) (Assunta & Chapman, 2006). The FCTC notably acknowledges the link between trade and tobacco but contains no provisions to address it.

3.4.5 Globalisation, safe water and sanitation

Lack of access to safe water is closely related to poverty, economic insecurity and other forms of vulnerability (People's Health Movement et al., 2005; United Nations Development Program, 2006; United Nations Educational Social and Cultural Organization, 2006). An estimated 1.2 billion people worldwide, almost all of them in low- and middle-income

countries, lack access to improved water supplies, and “some 2.6 billion people – half of the developing world and 2 billion of whom live in rural areas – live without improved sanitation” (United Nations Educational Social and Cultural Organization, 2006, p. 221). This situation contributes to the deaths, mostly from diarrhoeal disease, of 1.5 million children per year (Black et al., 2003); other estimates place the death toll even higher (People's Health Movement et al., 2005, pp. 207-224). Women are disproportionately affected by this situation, among other reasons because of the time spent fetching water and caring for household members suffering from water-related diseases.

The connection of these trends to globalisation is not immediately obvious, but several dimensions can be identified.

Firstly, in the nineteenth and twentieth centuries urban public water and sanitation systems dramatically improved public health. These technological benefits, with a few exceptions, have failed to diffuse outside the industrialised world. This is in part because of contextual differences: even apart from financial constraints, rural settings are not amenable to the same kinds of technological solutions as urban areas. It also reflects failures of governance at the national level (for example, the lack of administrative capacity to manage complex utility infrastructure investment in parts of the developing world), as well as ineffective multilateral and bilateral financial engagement. For example, resources flowed to inefficient and technically-incompetent state agencies; privatisation was prescribed where supporting legal and regulatory frameworks were absent; and cost recovery models failed the poor. As a result much of the developing world, and especially the rural and peri-urban poor, has been left behind.

Secondly, widening access to satellite imagery and computer models coupled with new networking capabilities, and promising technological and institutional options, have spurred new ways of thinking about water provision and management choices – especially in sustainability terms (Aravinthan, 2005; United Nations Educational Social and Cultural Organization, 2006; United Nations Development Programme, 2006; Bixio et al., 2006). Institutionally, the new paradigm for water management is Integrated Water Resources Management (IWRM), which WHO has identified as making multiple contributions to health (World Health Organization, 2007b). Technological options include closed-loop and onsite systems, such as sanitation systems where waste is stored, treated and reused onsite rather

than sent to the 'end-of-the-pipe,' where it often degrades and pollutes downstream water sources. In many instances where lack of access to clean water and improved sanitation is most acute, alternative technologies can provide important advantages over the centralised model characteristic of the twentieth-century city in high-income countries. This is especially the case for the rural poor, for whom improvements and diffusion of affordable 'off the grid' technologies are long overdue. To illustrate, while boreholes and pit latrines are a long-standing tradition for rural dwellers, innovations now include soakaways (so that a water collection point is not a disease breeding ground), ventilated-improved latrines, closed loop sanitation systems that do not pollute the general water supply and waterless urine diversion (UD) toilet systems. The UD system has been well received internationally and in some areas represents a significant improvement over other onsite and closed loop sewerage options (Wilson, 2006).

Thirdly, the worldwide trend in under-investment in municipal infrastructure, maintenance and upgrades (Briscoe, 1999; Jimenéz-Beltrán, 2001; Levin et al., 2007), bolstered by growing recognition of a world water crisis (Gleick, 2002; United Nations Educational Social and Cultural Organization, 2006) have gained increased currency, and have drawn attention to the issue of water pricing. As noted by the United Nations Development Program (2006, p. 49): "Until fairly recently, water has been seen as an infinitely available resource to be diverted, drained or polluted in generating wealth. Scarcity is a policy-induced outcome flowing from this deeply flawed approach, the predictable consequence of inexhaustible demand chasing an underpriced resource." The ecological and infrastructure concerns here may be unexceptionable (as in the case of other natural resources and the ecosystem services they provide), and global models have contributed towards alleviating pressures in high income areas and countries. However, these have failed to adequately resolve distributional and affordability concerns for lower income and rural users, especially in the South where water access and health equity are set against economic growth and industrialisation.

The past two decades have witnessed the emergence of transnational networks in the water sector, which allow for the amplification of local issues. Reflecting global-national-municipal power relations, according to (Grusky, 2001): "A review of IMF loan policies in 40 random countries reveals that, during 2000, IMF loan agreements in 12 countries included conditions imposing water privatisation or full cost recovery. In general, it is African countries, and the

smallest, poorest and most debt-ridden countries that are being subjected to IMF conditions on water privatisation and full cost recovery” Thus in many countries including Bolivia, Argentina, the Philippines, Ghana, Tanzania and South Africa price increases and privatisation initiatives have been met with concerted and sustained transnationally-linked resistance based on failure to provide better affordable services and health outcomes to the poor (Loftus & McDonald, 2001; McDonald, 2002; Jaglin, 2002; Budds & McGranahan, 2003; International Consortium of Investigative Journalists, 2003; Freedom from Debt Coalition, 2005; Cashmore et al., 2006; Public Services International Research Unit, 2006). Nevertheless, both the pro-partnership and anti-privatisation lobbies have failed to initiate the paradigm shift that is required for the world’s poor to get access to safe water and effective sanitation. The quest continues for an assistance model that can bridge the gap between water’s special status, the tendency to overlook sanitation altogether, resource scarcities, critical capacity gaps and the inability of the poor to claim full citizenship rights (cf: Collingnon & Vézina, 2000; Hvistendahl, 2006; Magistad, 2006).

Theoretically, it is possible to address these equity issues through Universal Service Obligations (USOs), which are performance requirements that the state imposes on the service provider to expand service delivery to previously unserved or underserved areas, or to provide the particular service at an affordable price by way of the necessary cross-subsidies from low- to high-cost (and low- to high-volume) users. In practice, this has proved extremely difficult to achieve. The situation with respect to private provision by large corporations is similar to that addressed in Section (3.4.1) with respect to regulating private provision of health services. Since privatisation could be locked in by commitments made under the General Agreement on Trade in Services, such commitments should only be made after experience in regulating foreign and domestic private investments or involvement in water provision such that equity in access is improved and not worsened.

Policy implications

Globalisation has aided a variety of knowledge networks, innovative partnership and institutional arrangements that offer new insight into provision of water and sanitation services, especially for very low-income country sites where the state alone cannot undertake this task and capacity building emerges as critical. Many of the challenges that remain hinge on the development of technological and institutional innovation better suited

to the South. This innovation must recognize that a 'full-cost pricing' approach to extending service to the poor is indifferent to equity concerns. Needed are systematic pro-poor subsidisation measures that assure all households access to water supplies sufficient to meet all basic needs independently of ability to pay, as well as mobilisation of major new sources for capacity building around operations, maintenance, upgrades and sustainability.

A minority of poor without access to clean water and improved sanitation have a pre-existing connection to the municipal grid. Here, from an equity perspective, a central challenge for access to water and sanitation services is tariff curve design. The slope and shape of the tariff curve determines whether the overall impact is progressive; subsidies that cover a small basic amount do not ensure equitable access if the price rises sharply once this amount has been consumed (Bond, 2002). This has been the unintended effect of Free Basic Water in Johannesburg and Durban (South Africa), leaving minimally adequate use unaffordable for many households. At the same time, redesigning price structures does not easily solve the problem of mobilizing major new financial resources for water treatment and supply or questions of access for the vast number of people living in rural areas who can't get a connection in the first place. Technological options for meeting these policy challenges include increased provision of affordable on-site treatment and closed loop sanitation systems that do not pollute the general water supply. Globalisation's trend here is that a plurality of state and non-state actors (domestic and global, including the private sector) will continue to operate in the water and sanitation sector. This demands strengthened regulatory environments, particularly in low-income countries to ensure that equity in access remains a water policy priority, alongside sustainability in water resources. However, as is the case with respect to private provision of health services, little in the way of existing policy experience offers a guide for how this might be accomplished.

3.5 Politics matters – or, asymmetry is not destiny

The preceding discussion may have left the impression that globalisation's negative impacts on SDH are all but inevitable, and that the operation of the global marketplace has left no room for effective political response. The constraints associated with the global marketplace are real, but their impact can also be exaggerated.

Social historians have provided valuable descriptions of how a mixture of popular agitation and pressure by an expanding enfranchised working class resulted in a dramatic change in the role of the state, especially at a local level, with respect to providing public health infrastructure (Szreter, 1997; Szreter, 1999; Szreter, 2003a; Szreter, 2003b; Szreter, 2005). More recent examples of civil society mobilisation in response to the challenges to health equity that are presented by globalisation include:

- The use of advocacy and litigation by South Africa's Treatment Action Campaign (TAC). TAC first mobilised around HIV treatment access in 1998 and grew to have branches in all South African provinces and most major cities. TAC is credited with galvanizing opposition to the court challenge brought by multinational drug firms against the South African government's attempts to import cheaper versions of antiretrovirals, a challenge later dropped due to mobilised global outrage; and with prodding its own government to move away from HIV denialism to a belated (though still inadequate) antiretroviral roll-out. TAC consistently framed its advocacy as a matter of human rights (the right to health is part of the South African Constitution); part of a larger struggle for redistribution of wealth and resources; and part of a transnational 'anti-globalisation' movement. Unlike many social movement groups in Africa, TAC has attracted significant external funding and operates with a multi-million dollar budget and over 40 full time staff (Friedman & Mottiar, 2005).
- Widespread protests against the privatisation of water provision in Cochabamba, Bolivia in 2000, which led to the return of the municipal water utility to public management. However, assessments are mixed in terms of the effectiveness of these and subsequent protests against water, electricity and gas privatisation – the roots of which can be traced to a structural adjustment program designed in 1985 – in improving access and affordability of services to the poor. The underlying problems of undercapitalisation and insufficient funding remain (Kohl, 2002; Spronk & Webber, 2007)
- The Association for the Taxation of Financial Transaction for the Aid of Citizens (ATTAC) was founded in France in 1998 to support the Tobin tax on currency transactions (see Section 4.4) as part of a broader critique of globalisation. ATTAC, which now has branches in 40 countries, is credited by many with contributing to France's decision to withdraw from OECD talks on a proposed Multilateral Agreement on Investment (MAI), leading to the collapse of the talks, and later to French voters'

rejection of the proposed EU Constitution in a 2005 referendum (Waters, 2004; Cassen, 2005).

- The People's Health Movement is a network of health activists established in 2000, initially to revitalise the principles of the Alma-Ata Declaration on Health for All and primary health care (World Health Organization, 1978). PHM now has a presence in around 80 countries, and has become actively engaged with WHO as both critic and supporter. PHM's activities include a campaign to strengthen the right to health (discussed in Section 4, below) and facilitating the process of generating *Global Health Watch*, an alternative report on global health (People's Health Movement et al., 2005; Narayan, 2006; Lee et al., 2007).

The GKN's research program did not include assessments of these and related activities. However, they do point to both the importance of civil society mobilisation and the need to consider it as an element of the changing structure of global governance for health and SDH, discussed in the section of the Report that follows.

4. Policy directions: Rights, regulation, redistribution and reformed governance

Given the length of this Report, it is worthwhile briefly to recapitulate our findings as stated so far.

In Section 1, we identified the economic dimensions of globalisation – specifically, the emergence of a global marketplace – as those most critical from the perspective of health equity and social determinants of health (Section 1.1 of the report). We further identified numerous distinctive characteristics of contemporary or “second-wave” globalisation, and described in conceptual terms the various mechanisms through which globalisation affects the social determinants of health (SDH) and, hence, health itself (Section 1.2). We emphasised some of the evidentiary difficulties and the need to resolve these by being explicit about policy goals, organising these (as has the Commission) around the values of health equity (Sections 1.3 and 1.4).

In Section 2, we provided a more fine-grained, but still schematic, analysis based on an overview of trends in economic growth, economic inequality, and health outcomes.

In Section 3 we reviewed the evidence with respect to numerous specific effects of globalisation on SDH, and as appropriate identified policy implications for national (and sub-national governments) and the international community. We concluded *inter alia*:

- That trade liberalisation, while potentially bringing growth-related health benefits (although the research on this point is unclear and emphasises the need for country-specific assessments) also present specific risks associated with increased economic insecurity, trade in products leading to increased health risks, and loss of tariff revenues that are important for reducing disparities in access to SDH in many developing countries.
- That financial market liberalisation is demonstrably associated with a variety of negative effects on SDH, with compensatory policies at the national level impeded by the disparities in wealth and power that characterise recent globalisation.
- That globalisation is limiting the ability of many societies to meet basic needs that are relevant to health, such as access to health care, water and sanitation, and

proper nutrition. The case of nutrition underscores the point that the problem is not always traceable to scarcity of resources, but rather to the priorities of the global marketplace – specifically, in this case, transnational food processing and marketing corporations.

4.1 A general theme: Regulation, rights and redistribution

Can an overarching set of principles for policy responses to globalisation that reflect our analysis be identified? We believe that it can, and indeed is exemplified in work done ten years after the 1995 Copenhagen social summit by a team from the Finnish National Research and Development Centre for Welfare and Health STAKES. They argued the need for social policies organised around the “three R’s” of:

- systematic resource **redistribution** between countries and within regions and countries to enable poorer countries to meet human needs,
 - effective supranational **regulation** to ensure that there is a social purpose in the global economy, and
 - enforceable social **rights** that enable citizens and residents to seek legal redress”
- (Deacon et al., 2005)

The policy brief was explicit in demanding more from national governments, as we have been with respect to a number of the policy implications we have identified. At the same time, it is essential to recognize that globalisation creates an associated need for international policy initiatives.³⁸ Indeed, perhaps the single most important message the Commission can convey with respect to globalisation is that 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), *requires coordinated action on an international scale by national governments and multilateral institutions.*

In a simple, stylised illustration of this point, addressing health equity by way of poverty reduction or improving access to basic health care (an outcome observed in the first

³⁸ For an inventory of potential initiatives that was not developed with specific reference to SDH, but has considerable relevance, see World Commission on the Social Dimension of Globalization, 2004.

instance at the individual and household level) is likely to demand a variety of redistributive policy responses by state/provincial or national governments, as well as between nations. However, national and sub-national governments may be limited in their ability to act effectively because of constraints that are created, and can best be changed, by actors outside their national borders, such as multilateral institutions or institutional investors. The feasibility of these policy responses may depend on the existence, or require the creation of, new kinds of institutions for financing global redistribution. Failure to confront explicitly this issue of global scale in constructing inventories of potential interventions risks excluding from consideration, by default, some of the policy innovations that would in practice be most effective in reducing health inequities, and that are most consistent with the values underpinning the Commission's approach.

4.2 Global governance for health equity and SDH: Getting there from here

The evidence reviewed in this Report demonstrates the need for a shift in the trajectory of globalisation if global health equity is to be improved. This trajectory is not exogenous; it is determined largely by decisions made at the national and international levels, and therefore is shaped by the governance structures within which they are made. How well does the structure and practice of our current systems of global governance address the social determinants of health, and what would need to change to improve them doing so?

4.2.1 Improving institutions of global governance

Global governance can be defined as "the complex of formal and informal institutions, mechanisms, relationships, and processes between and among states, markets, citizens and organisations, both inter- and non-governmental, through which collective interests on the global plane are articulated, rights and obligations are established, and differences are mediated" (Weiss & Thakur, 2007). State institutions hold formal power and authority in international relations, acting through intergovernmental bodies such as the UN, the Bretton Woods Institutions and the World Trade Organization (WTO). Globalisation, however, is changing the relative number and importance of state, market and civil society actors (Krut, 1997) (Weiss, 1999). For example, civil society organisations (CSOs) have often played an important role in advancing international policies that improve equity in SDH, e.g., in tobacco control (Malinowska-Sempruch et al., 2006; FCA, 2006) and compliance with the

WHO Code of Marketing of Breast-Milk Substitutes (Richter, 2002), While some perceive contemporary developments in global governance as progress towards more pluralist and democratic forms that increasingly involve such nonstate actors, others hold concerns about the concentration and misuse of power, and the disadvantaging of certain social groups (e.g. poor, women, other groups that may lack access to participate) (Held, 1995; Falk, 1999). The nature, goals and impacts of emerging forms of global governance, including for health and SDH, remain highly contested (Kickbusch, 2003; Barnett & Duvall, eds., 2005).

A large literature on criteria for good governance exists, but was not systematically scrutinised by the GKN. Rather, our background paper on the topic (Lee et al., 2007) adopted eight criteria developed by the UN Economic and Social Commission for Asia and the Pacific: accountability, transparency, responsiveness, effective/efficient, rule of law, equitable/inclusive, participatory and consensus-oriented. (See Appendix 5 for a more detailed discussion of these criteria.) These were used to inform the case examples of global health governance studied for the background paper. Selection of examples was based on existing institutions or governing frameworks that best highlighted issues in global governance for health (Box 7). Research literature on each of these cases exists, though with wide variation in scope and rigour; little of it, however, pertained directly to the question of how their governance relates to SDH or contributes to health equity.

Box 7. Global health governance case studies

- Framework Convention on Tobacco Control
- Grand Challenges in Global Health
- World Health Organization
- Global Forum for Health Research
- The IMF and World Bank
- The World Summit on Social Development
- Millennium Development Goals
- International Health Regulations
- The Group of Eight countries
- World Trade Organization
- Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria

- Codex Alimentarius Commission
- The People's Health Movement
- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- The International Finance Facility
- UNITAID
- The global public goods approach
- The Right to Health

Some of these cases represent institutional actors, others global treaties or concepts and still others concepts more pertinent to resource mobilisation and leadership.

The emergent global governance architecture relevant to SDH is characterised by “thick” governance³⁹ in certain issue areas, notably economic relations such as trade, investment and finance, but “thinner” governance in other issue areas, notably the social sectors (Fidler, 2005). Among institutions directly concerned with SDH, the relative decline of WHO has been observed alongside the rise in prominence of the World Bank through health sector lending since the 1980s, and the proliferation of Global Public Private Partnerships (GPPPs). Beyond the health sector, the increased influence of the IMF, the World Bank and the multilateral and regional trading systems, and the dominant power of OECD and Group of Eight (G8) countries in the world economy over the last two decades can be contrasted with the corresponding decline of the UN Conference on Trade and Development (UNCTAD), and Group of 77 (and non-aligned movement).⁴⁰

Despite increased recent attention to selected global health issues, resulting in the creation of various individual initiatives, SDH have not yet been given sufficient priority in the building and running of effective global governance institutions (Koivusalo & Ollila, 1997; Buse & Walt, 2002; Ollila, 2003; Lethbridge, 2005). Considerable attention has been devoted in recent development policy discourse to global public goods (GPGs) and, to a lesser extent,

³⁹ “Thick” and “thin” governance are defined by (Held et al., 1999) with reference to the degree to which governance institutions have formed around a given issue-area.

⁴⁰ The Group of 77 was founded in 1964 as a loose coalition of low and middle-income countries designed to promote its members' collective economic interests, and create an enhanced joint negotiating capacity at the UN. There were 77 founding members, with membership since expanding to 132. The G77 is modelled on the Group of 7 (now G8) countries.

global public goods for health (GPGHs). Disagreement surrounds the specific relevance of the GPG concept to health and health equity (Box 8). Less disagreement exists about the fact that international or global public goods in general are seriously undersupplied by existing institutions for global governance, and that innovation in this area is urgently needed. Some innovation has followed in the form of a growing number of Global Public-Private Partnerships (GPPPs), such as the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization. Most GPPPs, however, are on disease-oriented activities and biomedical interventions, as opposed to changing the broader structural conditions which affect SDH, and their governance has remained firmly under the control of major donors (Buse & Walt, 2000; Litzow & Bauchner, 2006).⁴¹ Decisions continue to reflect accountability to foreign and economic policy goals and to domestic constituents which, given electoral cycles, tend to favour short-term projects with easily measurable outcomes (Shiffman, 2006). Efforts to raise additional funds, such as UNITAID (the international drug purchase facility that is funded by tax contributions on airline tickets initiated by France) and the UK proposal for an International Finance Facility (IFF), have increased awareness of the need for increased resources, but concerns remain about their governance and, in the case of the IFF, its means of resource mobilisation.⁴²

Box 8. Global (or regional?) Public Goods and health

In economic theory, a pure private good (e.g. a cake) is one from which people can be excluded until payment is made and, once consumed, cannot be consumed again. A pure public good (e.g. the services of a lighthouse, or scientific research when published in the open literature and not subject to intellectual property rights protections) has two important characteristics: (a) use by one individual does not

⁴¹ See also Hanefeld et al., 2007. There are some exceptions to this general finding, such as the Integrated Management of Childhood Illness (IMCI) approach developed by WHO and UNICEF which emphasizes actions on a range of factors that put children at serious risk.

⁴² The IFF is a proposal to float bonds based on donor countries' future aid pledges to front-load larger amounts of aid in the shorter-term for an MDG-related 'big push.' Concerns with this proposal include the likelihood that future aid would be used to repay the bonds rather than constitute new financial transfers, and the substantial interest paid on the bonds would represent a net transfer of public funds to rich investors (Moss, 2005). While an innovative proposition, from a global health equity vantage point it lacks the redistributive effects of a system of tied taxes using a broad and generally progressive tax base.

limit its use by others, and (b) once provided it is available to all. Traditionally, governments are expected to play an active role in providing public goods; left solely to the market, such goods are undersupplied – a classic instance of market failure.

The concept of global public goods (GPGs) is increasingly prominent in high-level policy discussions of development policy and financing for global health. In relation to SDH and from a health equity perspective, how useful is it? Not very many global health priorities are genuine GPGs: eradication of diseases like smallpox and polio; control of some communicable diseases like epidemic influenza and tuberculosis (because highly drug-resistant TB threatens even certain populations in the industrialized world); and control of antimicrobial resistance. Control of communicable diseases that contribute most to the global burden of disease is at best a regional public good – and within the affected regions, protection from diseases like malaria and tuberculosis is much more readily available to the rich than to the poor (Farmer, 2000; Woodward & Smith, 2003; Smith et al., 2004). More generally, Mooney and Dzator argue that GPGs do not sufficiently address issues of equity in health outcomes (Mooney & Dzator, 2003)

However, an expanding literature suggests that avoidance of financial crises represent a true GPG (Griffith-Jones, 2003) – and one with important benefits for health equity and SDH, as noted earlier. Although we have not examined the topic, it is clear that climatic stability represents a GPG that is crucial for health equity, and one that cannot be supplied except by a robust regime of international cooperation. Thus as UN agencies continue to advance work on the GPGs concept, consideration of direct and indirect health equity implications should be strongly supported.

Many key global institutions affecting SDH have inadequate systems to ensure transparency and accountability. This is especially true of the G8 (Labonte et al., 2004; Labonte & Schrecker, 2004; Schrecker et al., 2007), despite the increased attention given to health, African development and civil society engagement; the WTO (Jawara & Kwa, 2003; South Centre, 2003; Blagescu & Lloyd, 2006), particularly with respect to more exclusive 'green room' and mini-Ministerial meetings; and the World Bank and IMF (Woods & Lombardi, 2006; Chowla et al., 2007). Representation on the Executive Boards of the Fund and the Bank substantially reflects the weighted votes of the members. The result of the IMF and World Bank's economically weighted voting systems is that the developed countries that

account for 20 percent of IMF members and 15 percent of the world's population have a substantial majority of votes in both institutions. The developing countries, by contrast, are seriously under-represented relative both to their share of Fund and Bank membership and to their share of world population. Furthermore, the weighted voting system gives the US alone, and any four other G7 members acting together without the US, the ability to block policy decisions in the 18 areas requiring a qualified majority of 85% of the votes. The CEOs of the World Bank and the IMF are effectively appointed by the US and the EU, respectively, and Executive Board discussions and decision-making remain secretive. Despite efforts to engage with a broader range of stakeholders, improve public information systems, and provide fuller reporting of activities by many of these institutions, the transparency of key decision making processes remains inadequate.

There are also concerns that funding for global health has shifted from institutions accountable to a relatively broad constituency, such as WHO, to those with limited accountability (or accountable in different ways) such as the GFATM and Gates Foundation; the budget of the latter organisation exceeds that of WHO (Kickbusch & Payne, 2004). The result is great asymmetry between the capacity to affect the lives of constituencies, and accountability for such actions. Further, Deacon et al. (2003) observe fragmentation and competition among the World Bank, WTO, UN system, G8 and other groupings of countries, and national social development initiatives.

If multilateral organisations, particularly but not exclusively WHO, are to be effective policy 'knowledge banks' for actions on SDH, core funding support for their activities must be separated from the pressures of (generally high-income) donor countries whose influence has been shown to shape the work programmes of such organisations (Lee & Buse, 2006; Shiffman, 2006). This applies particularly in the case of SDH, which are intersectoral as well as intergovernmental, and thus more prone to conflicting stakeholder pressures (Blagescu & Lloyd, 2006). Of particular note and concern is the contrast between WHO's relatively static core (regular budget) funding of US\$915 million in 2006, and the growth in extrabudgetary funds over which donors exert varying degrees of control. This category of funding has grown in relative terms since the early 1990s, reaching US\$2398 million in 2006 (Lee & Buse, 2006). Another disturbing comparison is drawn by Kickbusch & Payne (2004), who note: "It is a scandal of global health governance that WHO member states ... would allow a situation to arise in which a private philanthropy, the Gates Foundation, has more money to spend on global health than the regular budget of their own organisation" (pp. 11-12).

In short, SDH are not well served by the current system of global governance, either within the field of health or more generally. There is substantial evidence of imperfections in the form of duplication of effort, overlapping mandates, gaps in effort, and undue transaction costs imposed on recipient countries (Lee et al., 1996; Buse & Walt, 1997; Walt et al., 1999; van Diesen & Walker, 1999; Martinez, 2006). Further, few multilateral institutions with mandates affecting SDH themselves abide by criteria for good governance.

Policy implications

A comprehensive review of the overall system of global governance established in the 1940s should be initiated urgently, with a view to establishing a system conducive to health equity in the context, of the conditions, needs and generally accepted principles of governance in the 21st century. Such a fundamental review would necessarily need to take place in a purpose-specific forum akin to the Bretton Woods and Dumbarton Oaks conferences, but with greater transparency and civil society participation. It would focus *inter alia* on the need to democratise international institutions by increasing the representation of developing countries, increasing and equalising accountability to members, and increasing transparency.

The impacts of globalisation and global governance on SDH should be a central concern of that process. Building the requisite worldwide support for such an initiative requires leadership on the part of WHO with respect to both its member states and key institutional and civil society partners. More specifically, critical and systematic assessment of health and non-health focused institutions is needed in terms of their impact on SDH and the implications of their governance structures, individually and collectively, in this context. WHO should assume institutional leadership in undertaking this assessment, working with an arm's length group of partner institutions, CSOs and independent researchers/scholars (Lee et al., 1996; Kickbusch, 2005; Fidler, 2005).

WHO member states should be encouraged to give higher priority to addressing SDH, notably by strengthening WHO and other UN agencies with mandates related to SDH through core (regular budget) funding. WHO should reflect that priority by allocating substantial and commensurate core funding support. This commitment should extend to an increase in the proportion of staff with social science and other disciplinary backgrounds, to

complement the expertise of professionals whose primary training and expertise is in medicine, epidemiology, and disease-based interventions (Global Health Watch, 2006).

More specific areas for increased WHO activity would include, but not be restricted to:

- broadening and strengthening its presence in international trade committees, trade negotiations and WTO Ministerial Meetings, and making explicit statements and articulation on issues which are of importance to health and SDH, and extending its expertise in these areas to WHO member nations;
- engaging more forcefully with the donor-community and other international organisations on SDH, to ensure that the links between SDH and global economic issues and poverty reduction are established, and that global vertical campaigns on targeted diseases do not compromise broader needs of health systems and health policy priorities;
- relatedly, encouraging global institutions whose policies affect SDH (notably the World Bank, IMF and WTO) to include health ministries and relevant CSOs in key decision-making or supervisory/advisory bodies, and in negotiations on issues substantially affecting SDH.
- linking SDH indicators with health equity impact assessments and health systems work to ensure that national level policy and programme action on SDH does not remain a rhetorical tool;
- offering technical assistance and guidance for countries on policies and measures that focus on addressing SDH;
- granting CSOs increased representation in its proceedings, and the management committees of major WHO programmes relevant to SDH; and
- working actively with staff and governance bodies of other UN system agencies (see Section 3.1.3) to disseminate findings and advance recommendations from the CSDH. For example, the potential value of strategic collaboration with ILO at a regional level is apparent from that organisation's decent work strategy for the Americas (International Labour Office, 2006), which is organized around SDH although it does not call them by that name, and in fact makes little direct reference to the health implications of that agenda. On a global basis, similar potential arises from efforts to move forward on recommendations from ILO's World Commission on the Social Dimension of Globalisation.

Stronger, more concerted coordination of relevant global institutions is needed if SDH are to be tackled effectively. The UN's Economic and Social Council (ECOSOC),⁴³ which coordinates all UN organisations concerned with economic and social work, should be strengthened and, together with WHO, formally tasked to oversee such work, with relevant UN organisations including WHO reporting to it. This strengthening should follow the recommendation of the World Commission on the Social Dimension of Globalization, i.e., that ECOSOC upgrade its level of representation, including an executive committee at ministerial level and inter-ministerial interaction on key global policy issues (World Commission on the Social Dimension of Globalization, 2004).

4.3 Linking institutions and principles: Human rights and health equity

"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). The Office of the United Nations' High Commissioner for Human Rights defines the human-rights based approach (HRBA) as "a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It seeks to analyse inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress" (United Nations High Commissioner for Human Rights, 2007).

Key legal texts 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 [*s/c*] family" (Article 25); the 1966 International Covenant on Economic, Social and Cultural Rights, 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 fulfil*" the

⁴³ ECOSOC has 54 members, elected by the General Assembly for three-year terms. It meets throughout the year and holds a major session in July, during which a high-level meeting of Ministers discusses major economic, social and humanitarian issues.

rights cited under Article 12.⁴⁴ Conventional wisdom is that these obligations apply only to the actions of national governments with respect to people living within their borders, but even apart from the 1966 Covenant, which has not been ratified by the United States, philosopher Thomas Pogge (2002a; 2005) argues 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 right to health for a three-year period (an appointment renewed in 2005). Since his appointment, Special Rapporteur Paul Hunt has 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 (Hunt, 2003a; Hunt, 2003b; Hunt, 2004a; Hunt, 2004b; Hunt, 2004c; Hunt, 2005a; Hunt, 2005b; Hunt, 2005c; Hunt, 2005d; Hunt, 2006a; Hunt, 2006b). 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, 2004a, ¶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, 2004a, ¶74). More recently he has provided examples of the operationalisation of Article 12 obligations within individual national jurisdictions (Hunt, 2007).

Policy implications

The HRBA represents a valuable analytical and normative framework and advocacy tool in support of SDH by WHO and other multilateral institutions. The UN Special Rapporteur on the Right to Health should be established as a permanent position within the UN system, and be provided with sufficient resources, to provide a focal point for such action. At the same time, research on access to essential medicines has shown that in order to be effective, the right to health must be embedded in national legislation, ideally in national constitutions (Hogerzeil et al., 2006). As an illustration of the potential applicability of the

⁴⁴ These obligations are explicated by Chapman, 2002 and Nygren-Krug, 2002.

HRBA to other SDH, because water is essential to health, “[t]here are compelling arguments for viewing access to water as a human right,” the commodification of which should be limited (Mehta, 2003, p. 567). This position has implications not only for national governments, which have often adopted privatisation and cost recovery measures that reduced water access for the poor, but also for suppliers of bilateral and multilateral aid as they set priorities and requirements for funding. The role of the Special Rapporteur, as important as it may be, is no substitute either for national legal commitments or for meaningful strengthening of the role of human rights law relative to other sets of global institutions.

Notably, the role of the WTO as perhaps the most effective existing institution for supra-national economic regulation raises questions about how the trade policy regime interacts with the international human rights framework, which is not linked to comparable multilateral implementation and enforcement institutions. The UN Special Rapporteurs on globalisation and human rights, whose remit did not specifically address health, have 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 liberalisation (Oloka-Onyango & Udagama, 2003, ¶25). As noted, the UN Special Rapporteur on the right to health has noted the possible impacts of trade policy. 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). It is one that the Commission and WHO could address as a matter of priority. A further challenge involves the policies of the IFIs. For example Hammonds & Ooms (2004) have made the provocative argument that some policies followed by the World Bank and IMF in the context of Poverty Reduction Strategies contribute to violations of the right to health in developing countries, and hence are in breach of the obligations of member governments under international human rights law.

4.4 Linking institutions and principles: New sources of financing

As noted in Section 3.3.1, mobilizing substantial new resource transfers from industrialized to developing countries is imperative. An obvious mechanism for doing so remains the existing, usually modestly progressive systems of income and (sometimes) wealth taxation in high-income nations. Above and beyond these national systems, several proposals for

international or global taxation to raise revenues for development assistance are now being seriously considered.

A tax on airline tickets, with revenues specifically targeted for purchase of drugs to treat HIV/AIDS, tuberculosis and malaria and to support public health systems in poor countries, has already been implemented by several countries (Ministries of the Economy, 2006; Farley, 2006). A tax on foreign currency transactions to reduce financial instability was originally proposed by economist James Tobin – hence, the proposal is often referred to as the Tobin tax.⁴⁵ This and similar tax proposals were subsequently identified as one among many potential sources of revenue for financing health systems in low- and middle-income countries, moving closer to the mainstream of development policy thought (Gottret & Schieber, 2006, p. 129). One estimate is that such a tax at a very low rate (0.02 percent) would raise US\$17-35 billion per year, with much higher estimates available in the literature (Nissanke, 2003). An alternative proposal for a Currency Transaction Development Levy (CTDL) is designed specifically to raise funds for development and, according to its authors, could be implemented unilaterally by countries or currency unions. They estimate that it could raise \$2.07 billion annually if implemented by the UK, \$170 million if implemented by Norway, and \$4.3 billion if implemented throughout the Euro zone (Hillman et al., 2006). Whatever may be the merits of any single proposal, taxing financial transactions to raise revenue for development is now widely regarded as both feasible and appropriate. As in the case of debt cancellation, if any such new revenue-raising initiatives are to be effective, they must be genuinely additional to existing development finance, rather than merely substituting for current revenue streams.

Measures to combat the use of offshore financial centres to avoid existing national tax regimes would probably provide resources for development at least comparable to those made available through new taxes. Oxfam has estimated that the use of offshore financial centres for tax avoidance costs developing countries \$50 billion per year in lost revenues (Oxfam Great Britain, 2000). The IMF has estimated the value of assets held in offshore accounts at \$8 trillion (United Nations Research Institute for Social Development, 2000, p. 34), and more recently the Tax Justice Network put the figure at \$11.5 trillion, *not* including real estate (Tax Justice Network, 2005). Using the lower figure of \$8 billion, “if these

⁴⁵ For a history of this proposal from 1978, when it was first made, through the early 1990s see Felix, 1995

deposits earned income of around 5 per cent per year and this were taxed at 40 per cent, around \$160 billion annually would be raised" (United Nations Research Institute for Social Development, 2000, p. 34) -- approximately the estimated value of additional development assistance required to reach the MDGs (UN Millennium Project, 2005). More generally, curbing illegal tax avoidance and providing for the repatriation of assets illegally shifted abroad, as would be the case in theory under the UN Convention Against Corruption, would increase the fiscal capacity of governments in rich and poor countries alike (United Nations, 2003). It would also reduce economic inequalities, since most of the opportunities in question are available only to the wealthy.

4.5 Coda

The World Commission on the Social Dimension of Globalization (2004) and the Helsinki Process on Globalisation and Democracy (2007) are two recent multilateral efforts to advocate a new form of globalisation that both recognises social obligations and incorporates new institutions for global governance.

Although cautious about the merits of a currency transaction tax, the UN High-level Panel on Financing for Development (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. A more recent initiative, focussed 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 (Ministries of the Economy, 2006; Farley, 2006) – but also research commissioned by the Norwegian foreign ministry on a CTDL (Hillman et al., 2006) and on policy options to address tax evasion and tax competition (Murphy et al., 2007). The Helsinki Process and the Leading Group on Solidarity Levies, in particular, illustrate the range of available opportunities to build important multisectoral linkages both with WHO member governments and with civil society organisations worldwide.

Global political discourse is replete with clichéd references to a 'global community.' The existence of such a community may not be treated seriously by most political scientists, except as a utopian ideal. Accepting it as an aspirational goal, and drawing upon the evidence and argument presented in this Report, we close with a compelling observation by to the 20th century French philosopher and political scientist Raymond Aron (1967): "The great obstacle to community in complex societies is obviously inequality. Beyond a certain level of inequality human communication no longer exists" (p. 42).

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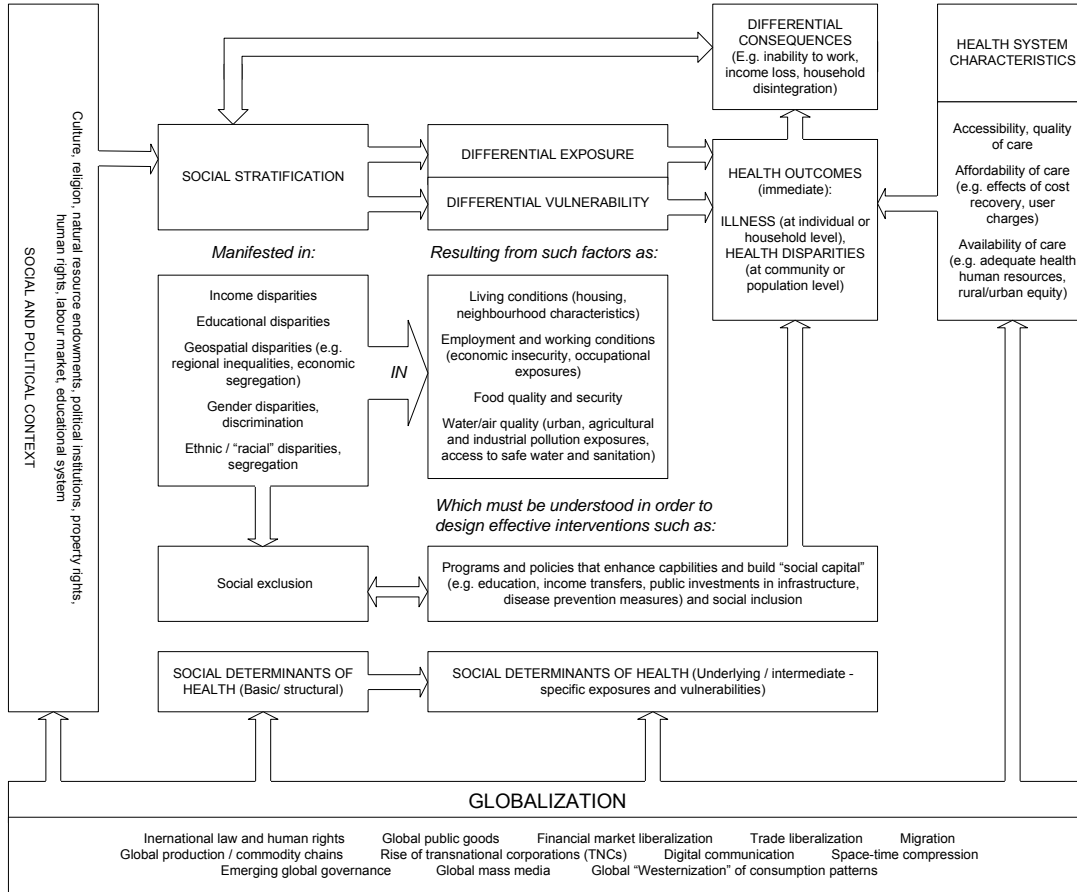
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Appendix 1: Globalisation and social determinants of health: Detailed conceptual model



Globalisation and social determinants of health: Key research questions

Based on the original analytical and strategic review paper, subsequently revised and now accepted for journal publication, and on discussions at the first Knowledge Network meeting, a series of topic areas for research synthesis was agreed upon, each with its own set of issues and questions. These topics reflected the following overarching questions:

What is the relationship between globalisation and global trends in health outcomes?

How has globalisation affected health inequities within and between countries through key health determining pathways, including poverty, income inequality/instability, unemployment/informal employment, economic insecurity and changes in people's consumption and lifestyles?

How has trade liberalisation affected the social determinants of health?

How has globalisation affected the social determinants of health through labour market restructuring?

How has globalisation affected the policy space (flexibilities) available for governments to improve health equity via actions on social determinants of health?

How well do present global governance structures take account of the health equity effects associated with the social determinants of health?

How have global financial flows (aid, debt, debt relief) and financial crises affected health equity in differing national contexts?

How has globalisation affected health systems and their ability to reduce health inequities through services, global flows of health workers and support to actions on social determinants of health?

How has globalisation affected food security, nutrition and equitable access to water and sanitation, all key determinants of health?

In addressing these questions, the GKN also examined evidence of existing policies that managed globalisation in ways supporting greater health equity; or, in the absence of such evidence, inferred where existing policies should be altered to minimise health inequities arising from contemporary globalisation.

Appendix 2: Gains (+) and losses (-) of average LEB by 2000 due to policies introduced in the 1980s and 1990s and to random shocks

Region	OECD	TRANS	USSR	E.Asia	China	LAC	MENA	India	S.Asia	SSA	WORLD
Policy driven LEB changes	0.18	-1.11	-3.26	-0.07	-0.75	-2.98	1.12	-1.03	-1.28	-5.23	-1.23
Log GDP/c		-0.43	-1.91								-0.10
Log GDP/c*Gini income	-0.08			-0.64	8.86	1.76	-0.94	2.88	1.67	0.57	2.65
Gini of income inequality	-0.80	-0.07	-0.12	-0.61	-6.13	-3.03	-2.12	-2.52	-1.33	-0.98	-2.52
Intra-period Gini >4 points	0.00	-0.58	-1.60	-0.09	0.00	-0.03	0.00	0.00	0.00	-0.13	-0.12
GDP/c Volatility	-0.25	-0.72	-0.49	-0.31	-0.69	-0.71	-0.43	-0.59	-0.30	-0.08	-0.47
Log physicians per 1000/Log GDP/c	-0.11	0.02	0.37	1.12	-1.34	0.25	0.74	-0.79	-0.36	-0.49	-0.34
Migrant stock/population	0.09	no data	no data	0.28	0.00	0.01	0.27	0.00	-0.12	0.06	0.05
DPT immunisation coverage	0.13	no data	no data	0.64	-0.41	-0.05	-0.26	-0.21	-0.66	-3.84	-0.49
Female Education	0.24	0.00	-0.16	-0.66	-0.71	-1.32	3.95	0.16	-0.21	-0.33	-0.12
Cigarette smoking/c	0.11	no data	no data	no data	no data	no data	no data	no data	no data	no data	0.02
Alcohol consumption/c	0.84	0.00	0.00	0.19	0.00	0.21	-0.01	0.00	0.00	0.00	0.16
Age dependency ratio	n. a.	0.66	0.66	n. a.	n. a.	n. a.	n. a.	n. a.	n. a.	n. a.	0.05
Shocks driven LEB changes	1.27	-0.31	-0.31	0.95	0.61	2.59	1.09	3.53	3.75	-2.66	1.25
War and humanitarian conflicts											0.00
Disasters	0.00	0.00	0.00	0.00	-0.33	-0.07	-0.07	0.05	0.03	0.01	-0.07
HIV-AIDS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-0.55	-0.31	-6.71	-0.78
Technical progress in health field	1.27	-0.31	-0.31	0.95	0.95	2.66	1.16	4.04	4.04	4.04	2.10
Total LEB changes	1.45	-1.42	-3.57	0.88	0.20	-0.32	2.29	2.46	2.44	-7.90	0.02

Source: authors' calculations (Cornia et al., 2007)

Appendix 3: Case studies

1. Health decline in the former Soviet Union

The most compelling case of rising stress-related mortality linked to unexpected and unmitigated macro and micro instability is that observed during the difficult transition to the market economy of the former Soviet Union and many southern and eastern European countries. The health impact of these developments was dramatic and, for the region as a whole, entailed for the 1990s an excess mortality of about 10 million people.

The major pathways of concern are social stratification, exposure and vulnerability: acute psychosocial stress endured by a large segment of the population when trying to adjust to employment loss, rapid labour turnover, unstable employment in unregulated labour markets, a rise in 'undeserved income inequality', and family breakdown and distress arising from migration to seek work or political asylum or to flee conflicts (Cornia & Panicià, 2000). These forms of personal instability and the inability to adjust to these new circumstances reinforced each other and interacted negatively with greater alcohol consumption and reduced access to health care. For instance, the faster than average rise in unemployment recorded between 1992 and 1994 in the northern part of Russia caused a high labour turnover, the spread of an unregulated grey economy, a surge in job-search related distress, migration and a rise in family breakdowns. All these factors interacted with each other to cause a high level of stress and a considerable fall in life expectancy. Lack of institutions and safety nets, preference for rapid liberalisation of domestic and external markets and insider-privatization, and the collapse of the state were the main causes of such rise in mortality. Slovenia, Slovakia, the Czech Republic, i.e. countries where mortality declined rather than rose in the wake of the transition, offer an interesting counterfactual to the former Soviet Union. In these countries, safety nets and regulatory institutions were sufficiently developed and the approaches to domestic and external liberalisation and to privatization were more gradual, efficient and equitable. (Adapted from Cornia et al., 2007.)

2. Export-oriented employment in Bangladesh

Poor working conditions for women are often cited as characteristic of employment in Mexico's *maquiladora* establishments (Alarcón-González & McKinley, 1999; Fussell, 2000; Martínez, 2004). However, both there (Denman, 2006) and in other countries globalisation has also led to economic gains and greater social empowerment for women by creating new

employment opportunities in export-oriented industries. Based on research in Bangladesh's garment sector (Kabeer & Mahmud, 2004a), Barrientos and colleagues conclude: "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 et al., 2004, p. 2; see also Kabeer, 2004a; Kabeer, 2004b; Chen et al., 2005a). A comparative study of export-oriented employment and social policy in six countries (South Korea, China, Mexico, Mauritius, South Africa, and India) where economic policies have supported expansion of export employment, often in EPZs, identified economic gains for women in terms both of labour incomes and of work-related entitlement to benefits (Razavi et al., eds., 2004). However, other research warns that these gains are disproportionately vulnerable both to economic crises and to systemic, globalisation-related pressures for "labour market 'flexibility' and fiscal restraint" (Razavi & Pearson, 2004, p. 25).

Health consequences of the work itself are another issue: women in Bangladesh "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, 2004b, p. 151). This finding is hardly a strong basis for supporting export-oriented development as an economic strategy, yet neither does it provide grounds for rejecting such strategies out of hand. Further, Kabeer has used the Bangladeshi case (Kabeer, 2004a) to argue eloquently that such clauses may in fact hurt precisely those workers they are purportedly designed to help, penalizing poor workers "for their poverty or for the poverty of their country" (p. 12). She argues that "the spirit of global solidarity," which she acknowledges as a motivation for proposing such clauses, "would be better served if the international labor movement were to campaign for a universal social floor that would protect the basic needs of all citizens, regardless of their labor market status" (p. 5).

3. The Self-Employed Women's Association (India)

Women account for about 1/3 (118 million) of an estimated 370 million informal workers India (Chen & Vanek, 2002). The Self-Employed Women's Association (SEWA) is the oldest and largest trade union for poor women who are self-employed and who work in the informal sector (Abbott, 1997; International Labour Office, 2001). SEWA was founded in Ahmedabad as a section of the Textile Labour Association, and later as an independent organization (Jhabvala, 1994). According to founder Ela Bhatt: "We were an organization of

chindi workers, cart pullers, rag pickers, embroiderers, midwives, forest produce gatherers; but we were not 'workers'" (Chen et al., eds., 2004, p. 4).

SEWA's ground level campaigns and policies focus on benefiting members and the communities in which they live through: inclusion; sustainable, diversified and new employment; economic and infrastructure development; policy change and fair pay for work done (Kanbur, 2001). SEWA now has more than 700,000 members in seven states in India. Members work in jobs that include paper picking, refuse collection, farming, salt production, street vending, forest product collection (gum collection), street sweeping, construction, domestic service, water-harvesting, home-based work, and craft and embroidery work (Jhabvala, 1994; Jhabvala & Kanbur, 2002). Members are also employed in support activities that enable women members to work, such as in the provision of child care and health care.

Union activities include representation and advocacy for economic and political rights, such as minimum wages. A variety of cooperatives provide opportunities for women to develop, control, and secure employment. Banking and financial services, including microcredit, are provided by the SEWA Bank which accommodates the needs, schedules and abilities of poor illiterate women (Abbott, 1997; Mehra, 1997; Mehra & Gammage, 1999; Datta, 2003). Other services include: health care cooperatives; social security (insurance) schemes; child care; health care; education, training and research (through SEWA Academy & SEWA Video); housing & shelter, and legal services. (Datta, 2003) SEWA has developed links with global markets, supported the formation of trade unions for self-employed women in South Africa, Yemen & Turkey, and drawn international attention to the economic contributions of poor women in general (International Labour Organization, 1996; Chen & Vanek, 2002; Jhabvala & Kanbur, 2002; Datta, 2003; Vaux & Lund, 2006; Chen et al., 2006b).

4. Financial markets, implicit conditionality and social policy: The case of Brazil

Development policy scholar Peter Evans points out that "the major banks' aversion to the possibility of redistributive developmentalism" led to a 40 percent decline in the value of Brazil's currency in the run-up to elections that brought the Workers' Party (PT) to power. After the elections, "[t]he PT chose to suffer low growth, high unemployment and flat levels of social expenditure rather than risk retribution from the global financial actors who constitute 'the markets'" (Evans, 2005, p. 196; citation omitted; see Paiva, 2006 and

(Koelble & Lipuma, 2006, pp. 623-625 for similar assessments). The experiences of Mexico in 1994-95; Thailand, South Korea and Indonesia in 1997-98; and Argentina in 2001-02 show how drastic that retribution can be: "swift, brutal and destabilizing," as the IMF's managing director said in the aftermath of the Mexican crisis (Camdessus, 1995). According to Evans: "Even if [financial] crises are averted, the assessments of the most powerful global financial actors are systematically biased in a way that stifles developmental initiatives in the global South" (Evans, 2005, p. 196; citation omitted).

5. Lessons on social protection from the Indian experience

Public works programs often serve as social protection instruments in developing countries. Such programs are seen as dual purpose – on the one hand mitigating economic insecurity, while on the other alleviating poverty through employment and development of community assets. While India has a long history of public works employed in this dual purpose context, the one that stands out is the Maharashtra Employment Guarantee Scheme (M-EGS).

Certain areas of the Indian state of Maharashtra are particularly drought prone and arid. In response to an adverse famine in 1972, the Maharashtra government launched a novel public works scheme in one such area, which has received much attention primarily on account of its use of the concept of 'guaranteed employment'. Maharashtra became the first state in India to 'guarantee' work to 'every adult person (above 18 yrs), willing to do unskilled manual work on a piece-rate basis'. M-EGS has attracted attention on account of its scale (approx. 200 million person-days of work are generated annually), longevity (thirty-three years), and rights-based approach to social protection that enshrines 'employment as an entitlement' (potential workers are responsible for voluntarily registering in the scheme).

How the program works: 'something in it for everybody'

At the state level, an Employment Guarantee Fund was established which receives proceeds from primarily urban taxes (professional-employment tax, additional motor vehicle tax, sales tax, surcharge on land revenue), to which the state government contributes an equivalent amount.

It is widely believed that the reason behind M-EGS's endurance is that it offers 'something in it for everybody' – urban middle class and high-income households pay for M-EGS (approx.

60 percent of the funds come from Mumbai urban taxes) because they want to reduce overcrowding and stem rural-urban migration to Mumbai; high income groups in rural areas support the program because they benefit disproportionately from assets created. Beyond physical assets like irrigation network repairs, the rural rich benefit from not having to support off-season labour. Politicians support it because they see it as a prestigious scheme and expect political mileage from the same. Rural poor benefit both directly (weekly-wages) and indirectly (through public works such as roads in remote areas). Women in particular have benefited from the scheme as there is no gender-based wage differential, otherwise prevalent in rural India (Herring & Edwards, 1983; Dev, 1995; Echeverri-Gent, 1998).

Countercyclical effect and national coverage

The real test for public works schemes which seek to serve the dual role of poverty alleviation and self-targeted safety net occurs in times of crisis. The relevant question then becomes: how readily can such schemes be scaled-up in times of crisis? In this regard M-EGS scores well on two aspects. M-EGS, which at one time accounted for 12 percent of state expenditure, was able to expand to 64 percent in response to a drought in 1982 (Alderman & Haque, 2006), attesting to a favorable countercyclical role. While such expansion strains administration and dilutes quality, the general conclusions of several studies highlight the flexible management and targeting to low income beneficiaries during the crisis. Moreover, a comparison of the 1974–5 famine in Bangladesh with the earlier extended drought in Maharashtra also underlines the importance of *ex ante* measures (Cain & Lieberman, 1983). The authors note that the frequency of land sales in Maharashtra remained low and relatively constant over the drought period, while it soared in Bangladesh, particularly in times of crisis. Ravallion (1991, p. 166) further suggests that “from what we now know about the famine in Bangladesh during 1974, it is evident that if an effective rural public works scheme had existed, a great many people would have been saved from starvation and impoverishment.”

The experience with the Maharashtra Employment Guarantee Scheme is now widely seen as the impetus behind India's recent National Employment Guarantee Act (2004) which serves as a nation-wide 'safety net' for the country's rural poor, guaranteeing 100 days of work per year to one member of each poor family at a said piece-rate.

6. Expanding trade in health services: Lessons from the Thai experience

Thailand has not made commitments in health services under the GATS agreement, but has actively participated in global trade in health services since the early 1990s, notably the promotion of private urban hospitals and health tourism. This has been facilitated through tax incentives to investment in private hospitals, which in 2002 numbered 199. This has enabled a rapid and substantial rise in the number of foreign patients being treated, mostly from high income countries, notably Japan, the USA, Taiwan, the UK and Australia, but also increasingly from Middle Eastern oil-rich nations. In 2001, over 1 million foreign patients were estimated to have been treated in both private and public facilities (though predominantly in the former). The government policy is to continue to increase the number of foreign patients. This global trade raised many concerns:

The resources used to service one foreigner may be equivalent to those used to service four or five Thais. Thus, the workload is equivalent to three or four million Thai patients. This was equivalent to about three percent of the total workload of the system in 2001. If growth continues at the current rate, the workload for servicing foreign patients may go up to 12 percent of the total workload in five years. This means the requirement of about an additional 3,000 full-time equivalent doctors for urban private hospitals. It also raises the problem of the shift of human resources from the rural public to the urban private service sectors.

The internal brain drain from rural areas to urban health establishments is a key concern when one sees the growth of health tourism, especially in Asia. Responding to this increasing demand and internal brain drain, in mid-2004 the Thai government approved the increased production of medical doctors by 10,678 in the following 15 years. This measure may address some of the future shortage of physicians, but does not address the immediate needs, or deals with the question of how the incomes generated by health tourism can be better harnessed to benefit the local population (based on Pachanee & Wibulpolprasert, 2006).

7. Cuba and the Philippines: A tale of two HHR exporters

The situations of the Philippines and Cuba – two major and yet significantly different intentional exporters of health workers – are described here along with the impact such exports have on these countries.

Cuba

Cuba stands out as a considerable over-producer and intentional exporter of physicians. Between 1980 and 1995, Cuba saw a 14.2 percent increase in its medical graduates while graduates in the field of economics, engineering, law and agriculture decreased, in some cases substantially. In 1995, 23.5 percent of the total of its graduate population specialized in medicine (compared, for example, to 3 percent in Indonesia and 4 percent in Hong-Kong.). Paradoxically, Cuba has had very little population growth during this period – indeed the lowest rate of growth in all of Latin America. The global evidence reveals that Cuba is generating an over-supply of graduates in the field of medicine (Madrid-Aris, 2002).

The Cuban government has dealt with this surplus by sending health workers worldwide. Between 1963 and 1999, 41,400 physicians and nurses were sent to give assistance in other countries, surpassing the number sent by WHO in the same period. Many of them work throughout Latin America and sub-Saharan Africa (Madrid-Aris, 2002).

At least five Cuban bilateral agreements, where Cuban doctors are sent out, have been reported to exist; these are with South Africa, Zimbabwe, Chad, Jamaica and Venezuela. While the intentional over-production and exportation of HHR is primarily for economic reasons, for Cuba it also has a politico-ideological basis. For instance, it was reported in February 2006 that 15,300 Venezuelans were studying medicine in their country with the help of Cuban professors. Over 3,400 Venezuelan medical students are studying medicine in Cuba for free (Ridenour, 2006) at Elam, a medical school operating from a former naval base outside of Havana intended to train people from poor families; there are also students from Africa, the Middle East and Asia (Ospina, 2006). In addition, some 20,000 Cuban doctors, dentists and nurses work in newly set-up medical centres in Venezuela's poorest areas. The two countries are clearly becoming strong allies and HHR is one area contributing to their alliance since the election of Venezuelan President Hugo Chavez Frias. But Cuba's generosity is neither free nor particularly generous; Venezuela, in exchange, sends Cuba

90,000 barrels of oil a day. Nor are all Venezuelans happy with Cuba's 'humanitarianism'. Doctors and medical staff complain that their wages have not increased in half a decade, that Cuban health workers are taking their jobs, do not hold proper medical qualifications and are effectively being used as a political tool. Cuba has unveiled plans to have 150,000 new doctors trained throughout the Latin American continent in the coming 10 years. In Fidel Castro's words "Our countries send doctors. The empire sends soldiers." Cuba's strong HHR presence in South Africa, Pakistan, Zimbabwe and other countries is also arguably politically motivated.

Aside from the Venezuelan case, there is presently very little analysis of the impact or success of these agreements although some problems have been alluded to. Cuban workers, for example, often come at a high price. In Chad, where 100 Cuban health workers (mostly physicians) were temporarily hired in 2005, strong financial incentives were required to attract them and interpreters were often also required (Wyss, 2005). The economic cost of the Cuba-South Africa Agreement runs high as well; in 2001, the cost to the Eastern Cape alone amounted to ZAR 1.8 million (approximately US\$ 250,000) per month for 95 Cuban doctors (Hammet, 2003); on an individual basis, the cost is almost twice that of a monthly starting salary for a newly trained South African doctor. The high costs do not reflect high pay for Cuban doctors. Rather, doctors working abroad under these agreements are quasi-indentured servants since much of their pay is sent to the Cuban government rather than paid directly to the workers (Martin, 2003, p. 24). Thus, Cuba's massive doctors-for-hire campaign, in addition to its "sun surgery" offered to tourists within the country (Ridenour, 2006), is proving to be a major asset to the country, bringing in significant funds and hard currency.

The Philippines

The Commission on Filipinos Overseas estimates that more than 7.3 million Filipinos (approximately 8 percent of the country's population) reside abroad. The Government of the Philippines has encouraged temporary migration by its professionals in recent years and taken measures to turn its remittances into an effective tool for national development by encouraging migrants to send remittances via official channels. In 2004, the Central Bank of the Philippines reported total remittances of US\$ 8.5 billion, representing 10 percent of the country's gross domestic product (United Nations Department of Economic and Social Affairs, 2005).

Health data of two global HHR exporters

	Cuba	Philippines
Health spending as % of GDP (2003)	7.3	3.2
Public health spending as % of overall public spending (2003)	11.2	5.9
Percent of overall health spending that is private (2003)	13	56
Physicians/1,000 population (2003)	5.9	0.58
Nurses/1,000 population (2003)	7.4	1.7
Life expectancy at birth (2004)	78	68
Under-five mortality rate/1,000 (2004)	7	34
GDP/capita (2004 in constant US\$)	2798*	1088**

Source: World Health Organization, 2006b, Statistical Annexes; except * (World Bank, 2007c) and ** (United Nations Economic Commission for Latin America and the Caribbean, 2006, p. 88).

The Philippines is not only a very significant country in terms of its number of nurses employed overseas but also its pro-active approach to managing their migration (Abella, 1997). It established a specialized governmental agency known as the Philippine Overseas Employment Administration (POEA) to formulate and oversee migration policy, effectively performing the functions of an international recruiter by marketing Filipino workers to potential employers, negotiating agreements, regulating private sector recruitment agencies and inspecting employment contracts prior to departure (Bach, 2003). The POEA has been held up as an example of the beneficial effects of a managed approach to migration and recognized for its protection of migrant workers' rights (Brillantes, 1998). The managed approach of the Filipino Government health worker training and export scheme builds in safeguards and maximizes remittances but this may not necessarily accommodate other social priorities (Bach, 2006). A most obvious case in point is the fact that the Philippines itself has a shortage of nurses (primarily in rural and under-developed regions) so the policy of encouraging employment overseas conflicts with domestic priorities (OECD, 2003). As with many African countries, the Philippines combines nursing shortages with under-employment or unemployment amongst its own domestic supply (Bach, 2006).

Following the increased demand for Filipino nurses overseas, a recent trend has begun where doctors are retraining as nurses as a means of migrating; an estimated 4,000 Filipino doctors have already become nurses (Mendoza, 2005). The increased migration of Filipino nurses and doctors to overseas hospitals has resulted in severe shortages within the country; of the roughly 1,600 private hospitals in the country, only 700 were now operational due to the shortage of nurses and doctors. Over 100,000 nurses – including

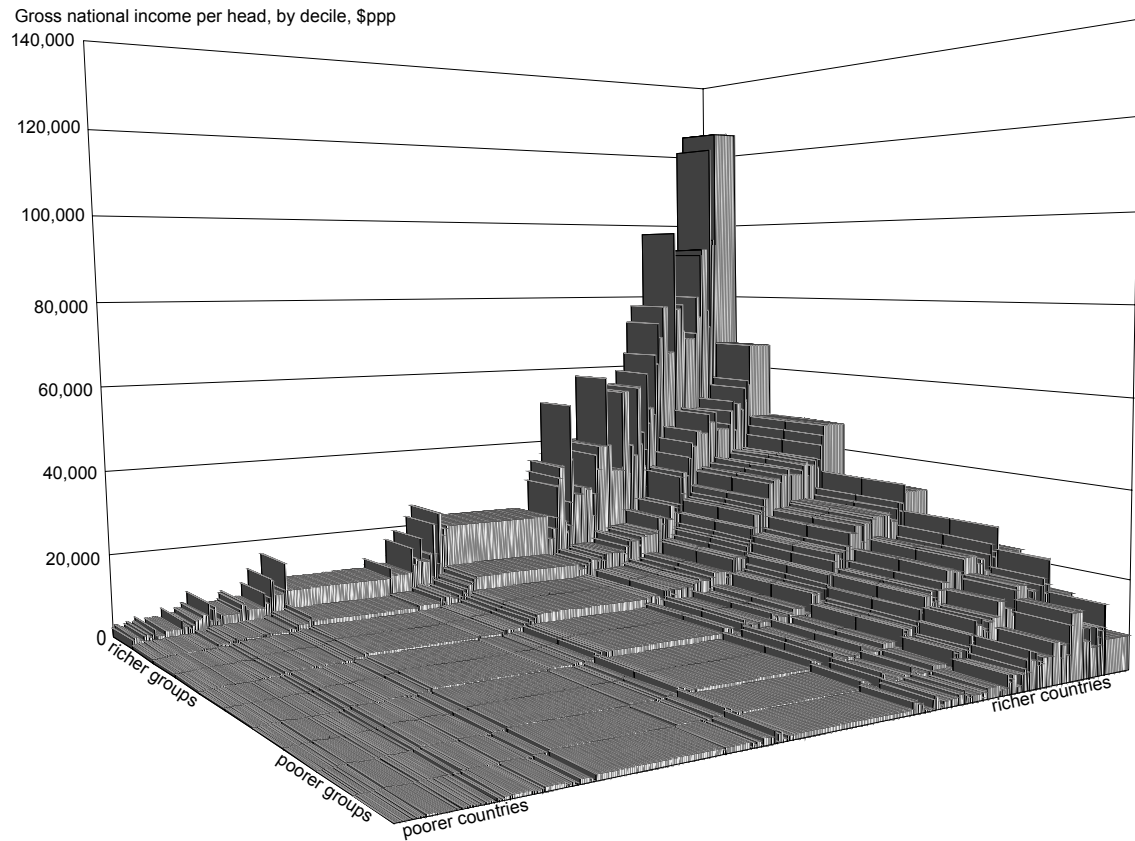
former doctors – have reportedly left the Philippines in the last decade and are now working overseas (Mendoza, 2005).

The Philippines example also demonstrates the impact of 'pull' factors. The traditional destination (pre-1990s) of Filipino nurses was the US. However, there was a relatively static period of outflow in the early to mid-1990s. This was due to the fact that the US was in a process of significant retrenchment in the nursing workforce as a result of funding constraints. New English-speaking destinations were sought; in 1998/1999, the UK reported registering only 52 Filipino nurses but three years later it reported registering 7,235. The outflow therefore changed to direction as a result of job opportunities and active recruitment (Buchan et al., 2003, pp. 49-51).

Nearly 70 percent of Filipinos working abroad are of ages 25-44. This drops sharply to 31 percent after age 45. This means that a higher share of the most productive age group (25-44) of the country's labour force is abroad which suggests loss, even for temporary periods, of those with the most experience, on-the-job training, and likely supervisory positions (Albuero & Abella, 2002).

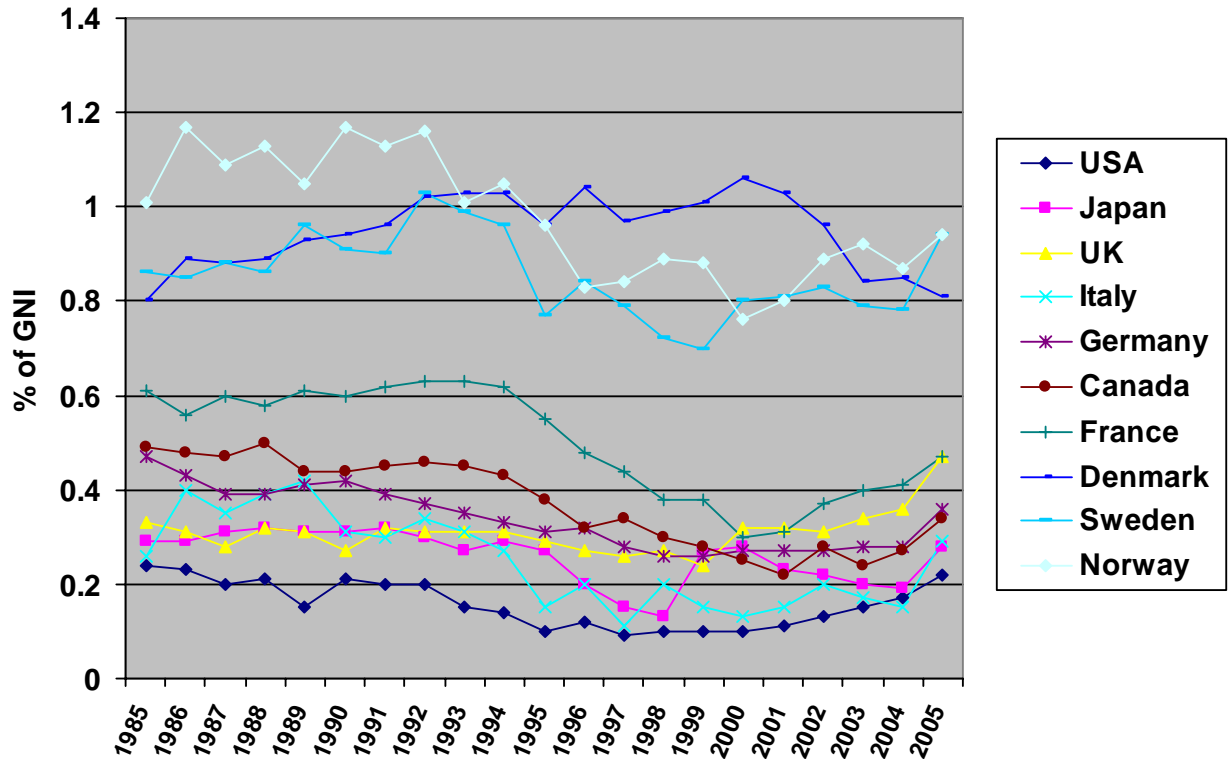
Appendix 4: Figures

Figure 2. Gross annual national income per head by deciles (US\$ at purchasing power parity)



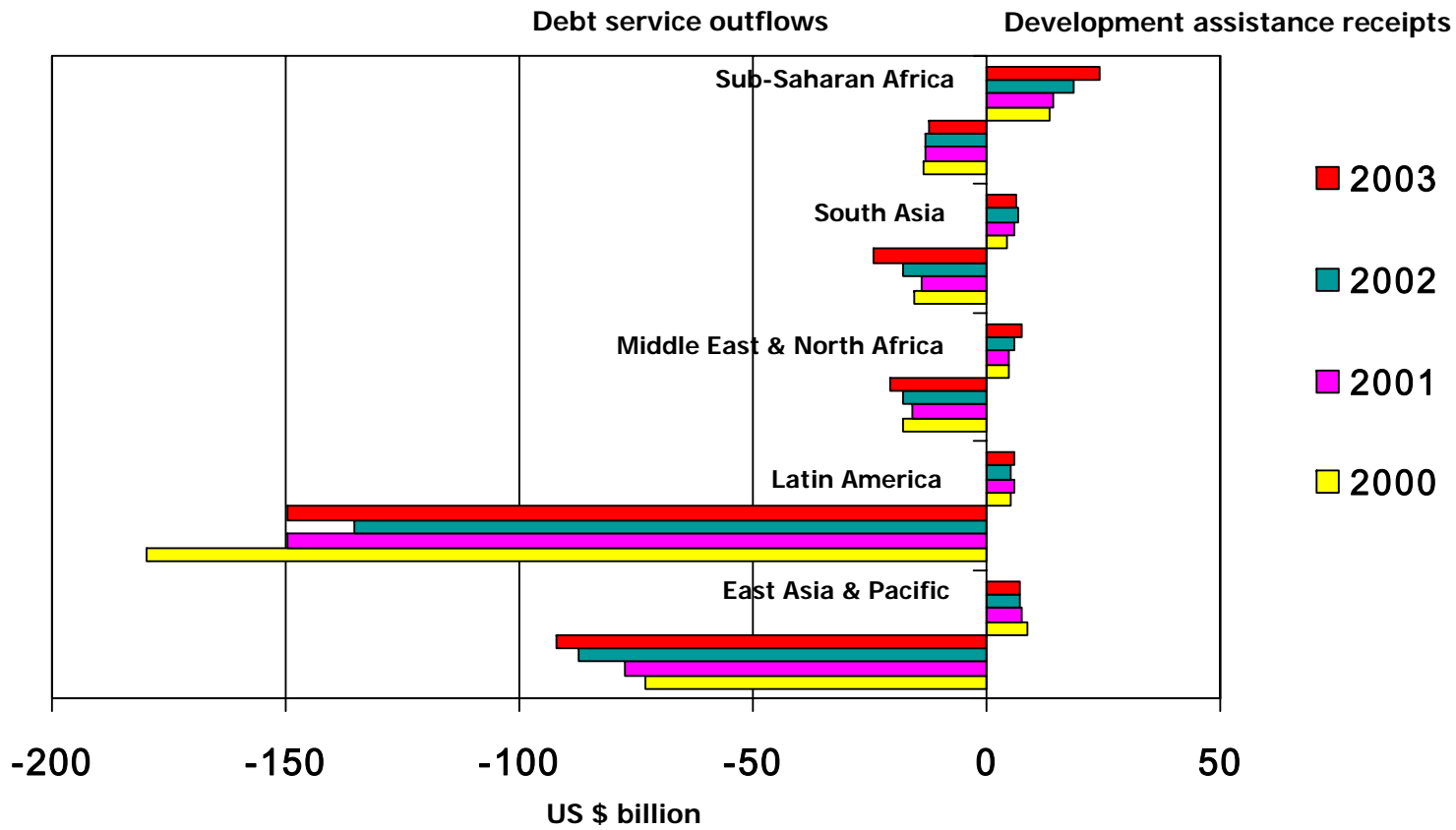
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Figure 3. Trends in development assistance, G7 and selected comparison countries



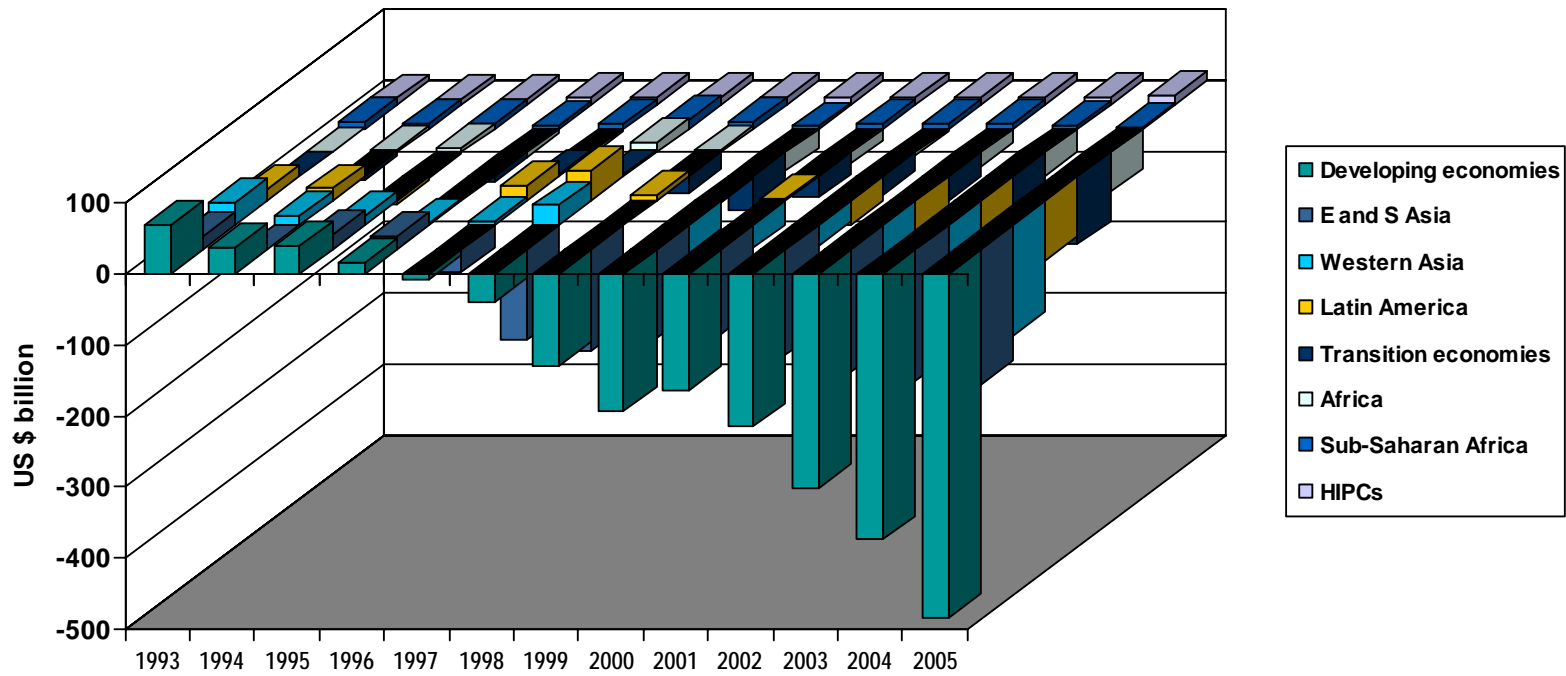
Source: OECD, Development Database on Aid from DAC Members: DAC online; <http://stats.oecd.org/wbos/default.aspx?DatasetCode=TABLE1> (accessed December 18, 2006); 2005 figures from OECD Development Assistance Committee, 2006.

Figure 4. Debt service and development assistance, by region, 2000-2003



Source: World Bank Data from Econstats, http://www.econstats.com/wb/index_glwb.htm (accessed September, 2006)

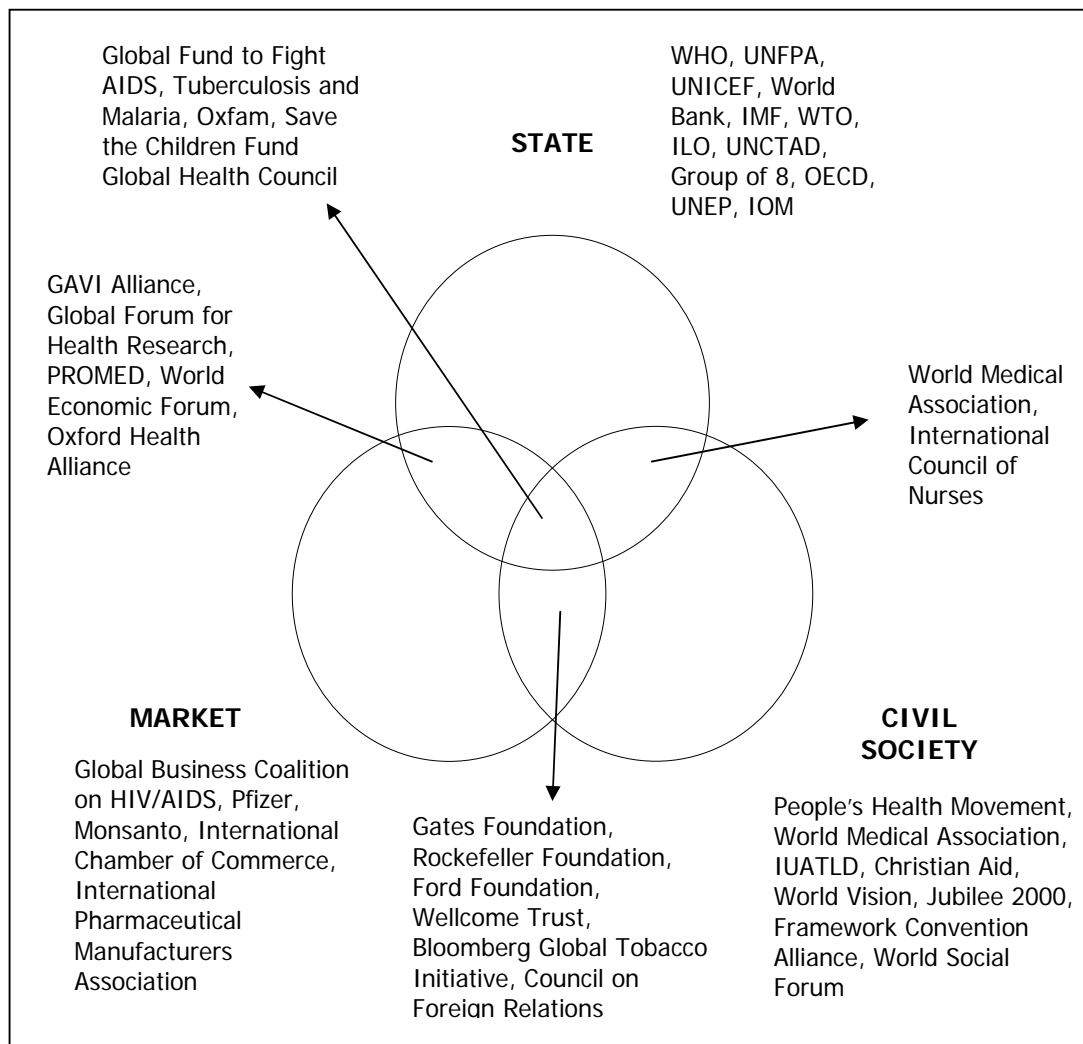
Figure 5. Net financial flows, by region and all developing and transition economies, 1993-2005



Source: United Nations Department of Economic and Social Affairs, 2006.
 2005 figures are preliminary. "Sub-Saharan Africa" excludes Nigeria, South Africa.

Appendix 5: Mapping and criteria, global governance for health equity

Selected global institutions impacting on the social determinants of health



This mapping uses the conventional sociological typology of distinguishing three broad and overlapping sectors of social organization (state, market and civil society). The typology should be considered as illustrative rather than representational, i.e. some loci of global governance for health can be regarded in more than one, or in intersections between two.

ESCAP Criteria for Assessing Good Governance



The UN Economic and Social Commission for Asia and the Pacific (ESCAP) identifies eight complementary goals as criteria for assessing good governance. The criteria are defined in the following ways:

Accountability - The requirement that officials answer to stakeholders on the disposal of their powers and duties, act on criticisms or requirements made of them and accept (some) responsibility for failure, incompetence or deceit. Accountability mechanisms can address the issues of both who holds office and the nature of decisions by those in office. Accountability requires freedom of information, stakeholders who are able to organize, and the rule of law (UNDP, 1997)

Transparency – The sharing of information and acting in an open manner. Transparency allows stakeholders to gather information that may be critical to uncovering abuses and defending their interests. Transparent systems have clear procedures for public decision-making, open channels of communication between stakeholders and officials, and access to a wide range of information (UNDP, 1997)

Responsiveness - Institutions and processes try to serve all stakeholders within a reasonable timeframe (UNESCO, 2005).

Effective and efficient - The capacity to realise organisational or individual objectives in a way that makes optimal use of available resources. Effectiveness requires competence; sensitivity and responsiveness to specific, concrete, human concerns;

and the ability to articulate these concerns, formulate goals to address them and develop and implement strategies to realise these goals (UNDP, 1997).

Rule of law - Equal protection (of human rights) and punishment under the law. The rule of law reigns over government, protecting citizens against arbitrary state action, and over society generally, governing relations among private interests. It ensures that all citizens are treated equally and are subject to the law rather than to the whims of the powerful. The rule of law is an essential precondition for accountability and predictability in both the public and private sectors (UNDP, 1997).

Equitable and inclusive - A society's well being depends on ensuring that all its members have a recognised stake and are not excluded from the mainstream of society. This requires all groups, but particularly the most vulnerable, to have opportunities to improve or maintain their well being (UNESCO, 2005).

Participatory - When group members have an adequate and equal opportunity to place questions on the agenda, and to express their preferences about the final outcome during decision-making. Participation could be either direct or through legitimate intermediate institutions or representatives. Participation needs to be informed and organized. This means freedom of association and expression on the one hand and an organized civil society on the other hand (UNDP, 1997).

Consensus oriented - Mediation of the different interests in society to reach a broad consensus in society on what is in the best interest of the whole community and how this can be achieved (UNESCO, 2005) .

Source: United Nations Economic and Social Commission for Asia and the Pacific, 2001b.

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