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Globalization and social determinants of health: Analytic and strategic review paper

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I.1 Introduction

In 2001, the Commission on Macroeconomics and Health turned much conventional wisdom on its head by demonstrating that health is not only a benefit of development, but is also indispensable to development (1). Illness leads to “medical poverty traps” (2), creating a vicious circle of poor nutrition, forgone education, and still more illness – all of which undermine the economic growth that is necessary, although not sufficient, for widespread improvements in the social determinants of health (SDH). Most of the Commission’s recommendations, which could by its own estimates save millions of lives each year by the end of the current decade, have not been translated into policy. Further, the Commission did not inquire into how the economic and geopolitical dynamics of a changing international environment (‘globalization’) support and undermine health, or how these dynamics can be channeled to improve population health. This task represents that contribution that the Globalization Knowledge Network (KN) will make to the work of the Commission on Social Determinants of Health.

This paper was originally commissioned in Spring, 2005 as a step in selecting the Hubs for the Commission’s various KNs; an earlier draft was delivered in August, 2005 for purposes of discussion at a meeting of candidate KN Hubs, and of the Commission, in India in September, 2005. It was written to a specified maximum length of 25 pages, excluding references. Because of delays in establishing the operations of the Globalization KN (and indeed of all the KNs), the paper was at that point a product of the work of the identified authors, respectively the co-chair and coordinator of the Globalization KN Hub. Subsequently, limited revisions were undertaken in response to comments received at the Indian meeting and from a limited number of KN members. However, it is not intended in any way as a policy statement, although dissemination with appropriate attributions, acknowledgements and disclaimers would (in our view) be highly desirable and the Globalization KN Hub is actively pursuing opportunities.

The outline of the paper is as follows. The remainder of Section I puts forward a definition of globalization and describes key strategic and methodological issues, emphasizing that globalization is unlike the topics of most other KNs, and demands a distinctive perspective and approach. Section II describes a number of key ‘clusters’ of pathways leading from globalization to changes in SDH. In our view the most important

¹ Efforts have been made to respond to thoughtful editorial suggestions provided by Mickey Chopra, David Sanders and Claudio Schuftan, but they are not responsible for the content of the paper. Some of the revisions incorporated into this document draw on T. Schrecker, R. Labonte and D. Sanders, “Breaking faith with Africa: The G8 and population health post-Gleneagles” and R. Labonte, T. Schrecker and D. Sanders, “Coherence or collision course? Trade policy, health equity, and social determinants of health” (both under review). The research assistance of Caitlin Burley, Corinne Packer and Joëlle Walker is gratefully acknowledged.

pathways have been generically identified, but the list is not exhaustive and is subject to refinement in the course of the Globalization KN's work. Section III provides a similarly generic inventory of potential "interventions," although in the context of globalization an intervention must be understood much more broadly than in a clinical or community public health setting. Reflecting a desire to complement the work of other KNs concerned with micro- and meso-level policies, special attention is paid to the potential for innovations in global governance.² Finally, Section IV provides a list of the specific research synthesis papers that will comprise a key element of the KN's activities, as these were refined at the Network's first meeting in February, 2006. However, the final version of this list is still under development.

I.2 Defining globalization: The global marketplace and global governance

Globalization is a term with multiple, contested meanings. Generically, it describes the ways in which nations, businesses and people are becoming more connected and interdependent across national borders through increased economic integration, communication, cultural diffusion and travel. Lee (5) considers globalization as a product of the interaction of technology, culture and economics leading to a compression of time (everything is faster), space (geographic boundaries begin to blur) and cognition (awareness of the world as a whole). This is an important and useful theoretical contribution. Further, it can be argued that in terms of the overall trajectory of humankind's future, one of the most important influences is the unprecedented 'globalization' of human impacts on the natural environment (6) – a phenomenon with important implications for human health (7) some of which are discussed in section II.5, below. For purposes of the globalization KN hub, our focus will be on globalization 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" (8, p. 1) – in other words, to the emergence of a global marketplace. This focus on processes of economic integration and on the global marketplace does not mean a focus solely on economic phenomena as conventionally defined. Notably, we do not wish to exclude various social and cultural dimensions of globalization, such as the increased speed with which information about new treatments, technologies and strategies for health promotion can be diffused and the opportunities for enhanced political participation and social inclusion that are offered by new, potentially widely accessible forms of electronic communication, such as the web-based workspace to be hosted by the Pan-American Health Organization (PAHO) for the Commission. Neither will we exclude consideration of the differential impacts of globalization on SDH as these are transmitted by resource scarcities or changes in the biophysical environment. Our initial work, however, will proceed from the assumption that "economic globalization has been the driving force behind the overall process of globalization over the last two decades" (9). This chosen focus reflects the facts (a) that the economic aspects of contemporary globalization are also the most important in terms of potential policy interventions to improve equity in health outcomes, and (b) that many of the social, cultural and biophysical dimensions and manifestations of globalization that are most significant in terms of health equity are best understood with reference to the nature of the global marketplace.

² For discussions of such proposed innovations, not necessarily related to health, see e.g. (3;4)

For example: even synthesizing available published information on the factors that affect a particular health outcome in human populations requires infrastructure that must be paid for, as any researcher in a developing country without the e-journal access that her Canadian colleagues take for granted can attest. Health research requires investment in educating researchers, paying their salaries, and providing laboratories, basic institutional facilities, and support for the research students whose work is integral to most research projects of any size. As an increasing proportion of health research is financed privately, based on expectations of commercial returns, research on diseases of the poor tends to lose out in the global marketplace (see Section II.5). Globalization of culture is inseparable from, and arguably driven by, the emergence of a network of transnational corporations that dominate not only distribution but also content provision through the allied sports, cultural and consumer product industries (10-12). Global promotion of brands such as Coca-Cola and McDonald's is a cultural phenomenon but also an economic one, and a contributor to the "global production of diet" (13) and resulting rapid increases in obesity and its health consequences in much of the developing world. And global demand for natural resources by consumers half a world away can have transformative effects on local or regional ecosystems, economies, societies and political processes.

The definition of globalization adopted here also does not exclude the global transmission of ideas, including (for instance) the diffusion of certain human rights norms and political 'democratization.'³ However, the most conspicuous example of the global transmission of ideas with a demonstrable impact on SDH involves the promotion by key Western governments and multilateral institutions in which they play a dominant role of an "intellectual blueprint ... based on a belief about the virtues of markets and private ownership" (18, p. viii). Polanyi's (19) historical research on development of markets at the national level demonstrated that markets are not 'natural,' but depend on the creation and maintenance of a complicated infrastructure of laws and institutions. Polanyi's insight is even more salient at the international level: "It is a dangerous delusion to think of the global economy as some sort of 'natural' system with a logic of its own: It is, and always has been, the outcome of a complex interplay of economic and political relations" (20, p. 3-4). Contemporary (roughly, post-1973)⁴ globalization has been promoted, facilitated and (sometimes) enforced by political choices about such matters as trade liberalization, financial (de)regulation, provision of support for domestically headquartered corporations (22), and the conditions under which

³ This observation in turn raises the question of how democratization should be defined. Some political scientists argue for a minimalist definition of democracy, which requires only the selection of leaders by periodic elections under realistic expectations that losers will turn over power (14). On the other hand, numerous critiques describe a new category of "low-intensity democracy" (15-17) characterized by limited civic engagement largely attributable to the existence of constraints on the policy agenda imposed by holders of resources that are extraneous to, and independent of, the electoral process. The usual constraints involve anticipation of military coups and massive disinvestment or capital flight.

⁴ The date is chosen with reference to the start of the first oil supply crisis, the resulting impacts on industrialized economies, and the recycling of 'petrodollars' that contributed to the early stages of the developing world's debt crises (see Section II.2). Identifying a precise starting point is less important than recognition that some time in the early 1970s the world economic and geopolitical environment changed decisively, so that (for instance) by 1975 the Trilateral Commission was warning of a "Crisis of Democracy" in the industrialized world (21).

development assistance is to be provided. These choices have been made by national governments both individually and through multilateral institutions like the World Bank, the International Monetary Fund (IMF) and more recently the World Trade Organization (18;23-25). These institutions are created in the first instance by agreement among national governments, but the distribution of power within those institutions is highly unequal.⁵ Underscoring the interplay of politics, economics and ideas, these institutions and networks of academic and professional elites have also played an important role in the outward diffusion of ideas about policy design.⁶ The implementation of such ideas, in turn, requires “legitimation by resource-bearing constituencies [such as] foreign investors, multilateral institutions, and US government officials” (28, p. 20; see also 30) – an observation made with respect to Mexico, but almost certainly applicable to other countries as well.

The global marketplace is not the entire story of globalization as it affects SDH. The G8 (originally G6) group of countries originated as an effort to coordinate macroeconomic policy in the industrialized world, but have now expanded their role into many other areas with effects on health systems and SDH. Support is now building for expanding the ‘club’ of nations into a larger group of 20 (the G20/L20), an initiative that would bring many smaller industrialized and middle-income countries to the table, including rising powers such as India and China, while arguably further deepening the gap between these and the world’s poorer and weaker countries. Supranational political institutions such as the World Bank, IMF and WTO have been central to promoting and structuring the global marketplace. Others (e.g. WHO and the International Labour Organization) have expanded or redefined their functions in response to its emergence. The recent ILO Commission on the Social Dimensions of Globalization (31) is one among many initiatives that have argued for innovations in global governance to respond to the stresses created by the global marketplace. The international body of human rights law, starting with the 1948 Universal Declaration of Human Rights, includes various provisions related to SDH.⁷ Most notably, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) proclaims “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” and obligates States Parties to ensure “provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure to all medical service and medical attention in the event of

⁵ For example, the G8 nations (the G7 group of industrialized economies plus Russia) “account for 48% of the global economy and 49% of global trade, hold four of the United Nations’ five permanent Security Council seats, and boast majority shareholder control over the International Monetary Fund (IMF) and the World Bank” (26, p. 5). They also account for roughly 75 percent of the annual value of development assistance expenditure, and their deep pockets are among the resources that provide them with formidable advantages in trade negotiations and dispute resolution proceedings, both within and outside the framework provided by the WTO (27).

⁶ See e.g. the work of Babb (28) on academic economists in Mexico and Lee and Goodman (29) on the World Bank’s role in promoting health sector ‘reform’.

⁷ These include Article 25 of the Universal Declaration of Human Rights, Article 24(1) of the Convention on the Rights of the Child (1989/90), Article 5(e)(iv) of the Convention on the Elimination of All Forms of Racial Discrimination (1965/1969) and Articles 11(f) and 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (1979/1981).

sickness.” In 2000 the Committee on Economic, Social and Cultural Rights (CESCR) issued General Comment 14 (2000) on Article 12, which both clarified the scope of the right and identified state obligations under it.⁸ The endorsement by the UN General Assembly of the Millennium Development Goals (MDGs) in 2000 arguably represents a ‘first’ in terms of commitments by the international community to a specific development agenda,⁹ and the consensus document that emerged from the 2002 International Conference on Financing for Development (41) has been cited as providing “for the first time, an agreed comprehensive and balanced international agenda that should be used to guide and evaluate reform efforts” with specific reference to the international financial system (42). Yet another illustration of the importance of the global governance agenda is increasing attention within parts of the UN system to the fact that the global marketplace under-supplies a variety of global (more accurately, regional or multinational) public goods (43-45). The Framework Convention on Tobacco Control (FCTC) represents an innovative step toward supranational regulation of a very specific health-destructive aspect of the global marketplace.

Governments are not the only relevant actors in global governance. Transnational corporations have long been features of the economic landscape, and their increasing importance as organizers of production across national borders is a distinctive feature of contemporary globalization as they organize an increasing proportion of the world’s economic activity, not only through affiliates and subsidiaries (46) but also through ‘outsourcing’ to networks of independent contractors (47-49). The existence of truly global mass media and the convergence of content provision and distribution expands opportunities for global marketing and branding. At the same time, civil society organizations (CSOs) in a variety of areas have taken advantage of opportunities for rapid transnational information sharing opened up by advances in computing and telecommunications.¹⁰ Perhaps the best illustration of the political influence of CSO concerns as they relate to health is the initiative to interpret the Agreement on Trade-Related aspects of Intellectual Property (TRIPs) in a way that allows health concerns to ‘trump’ harmonized patent protection under some

⁸ (32); for explication see (33-39)

⁹ Notwithstanding critiques of their limitations (in terms of equity stratifiers), lack of ambition – especially respecting poverty reduction (40) and improvement in the lives of slum dwellers – and the difficulty of measuring progress.

¹⁰ Pogge observes that: “Broadly, [civil society] refers to social relationships and organizations outside either state (government) functions, or market-based relations that define people simply as ‘consumers’ rather than more collectively, for example as citizens, neighbours or colleagues. In a narrower context, civil society includes organized groups concerned with public interests” (40, p. 737). Similarly Somers (50, p. 23) notes that “the civil society concept ... promises a fresh political vocabulary liberated from the stifling constraints of cold war Manichean dichotomies [between market and state], and it resonates to the desiderata of conceptualizing more generally the necessary conditions for democratic and participatory social organization.” From a research perspective, the need exists to distinguish among public-interest, business-interest and self-interested (often profession-based) CSOs, although boundaries frequently blur. With respect to globalization and health equity, three specific analytical issues deserve attention: the rapid growth of quasi-private NGOs bidding on service delivery contracts in developing or transition-economy countries (51); and the impacts of more traditional international CSOs on the development of public health, education and other service sectors; and the migration of human resources from public to NGO-provided service sectors, within developing countries.

circumstances (52-55).¹¹ Women's health movements have become "transnationalized," partly within (and shaping the agenda of) the institutional framework provided by the UN system (57). Another illustration, the policy impact of which cannot yet be determined, is the launch in July 2005 of the first *Global Health Watch* report on health equity and development worldwide (58) – a report prepared by a network of more than 80 collaborators, interacting primarily by way of the Internet. The Globalization KN will pay special attention to opportunities for improving SDH by way of innovations in global governance that address what has been described as the "asymmetrical" character of contemporary globalization (59;60).

Against this background, the KN may also need to consider claims that the transnational (economic and other) integration of the past three decades can be expected to continue. On this line of argument, a variety of factors may lead to a reversal of integration (as they did following the earlier, 1870-1914 period of integration). These might include increased competition among national economies over scarce resources such as fossil fuels (61); a resurgence of protectionism in the industrialized world, hinted at by some recent US trade policy decisions; major depressions in the industrialized world resulting from domestic policy choices (62); and various combinations of economic and geopolitical overextension on the part of the major powers (63). These possibilities are admittedly speculative, but it is also premature to consider contemporary globalization as a pattern irrevocably established over the time frames characterized by the *Annales* school of historians as "*la longue durée*."

1.3 Globalization and the Social Determinants of Health (SDH): Recent Conceptual and Methodological Milestones

A UNICEF study of "Adjustment with a Human Face" (64) represented an early and important attempt to identify causal pathways linking what we would now call globalization with the SDH. The study involved 10 countries¹² that had adopted policies of domestic economic "adjustment" in response to economic crises that led them to rely on loans from the IMF. It found that in many cases, although not all, the policies adopted had resulted in deterioration in key indicators of child health (e.g. infant mortality, child survival, malnutrition, educational status) and in access to determinants of health (e.g. availability and use of food and social services), with reductions in government expenditure on basic services emerging as a key intervening variable. The study situated these national cases within an analytical framework that linked changes in government policies (e.g. expenditures on education, food subsidies, health, water, sewage, housing and child care services) with selected economic determinants of health at the household level (e.g. food prices, household income, mothers' time) and selected indicators of child welfare (65). Based on that analysis, it identified a generic package of policies that would minimize the negative effects of economic adjustment on what

¹¹ Concerns remain among CSOs about the practical effect of this interpretation because of informal pressures from the pharmaceutical industry and industrialized country governments and 'TRIPs-plus' provisions in bilateral trade agreements, and a few academic observers are sceptical about the extent to which intellectual property protection has created barriers to access to essential medicines (56).

¹² Botswana, Brazil, Chile, Ghana, Jamaica, Peru, Philippines, South Korea, Sri Lanka, Zimbabwe

would today be called health equity (66). The package emphasized protecting the basic incomes, living standards, health and nutrition of the poor or otherwise vulnerable (66) – priorities that have been stressed in subsequent policy analyses. Only the final chapter of the UNICEF study (67) addressed elements of the international policy environment that might facilitate implementation of “adjustment with a human face” in some countries while obstructing it in others, and it did not directly address the comparative merits of “compensating for adjustment” (68) in health policies and programs and rethinking the adjustment process itself in light of considerations of health equity.

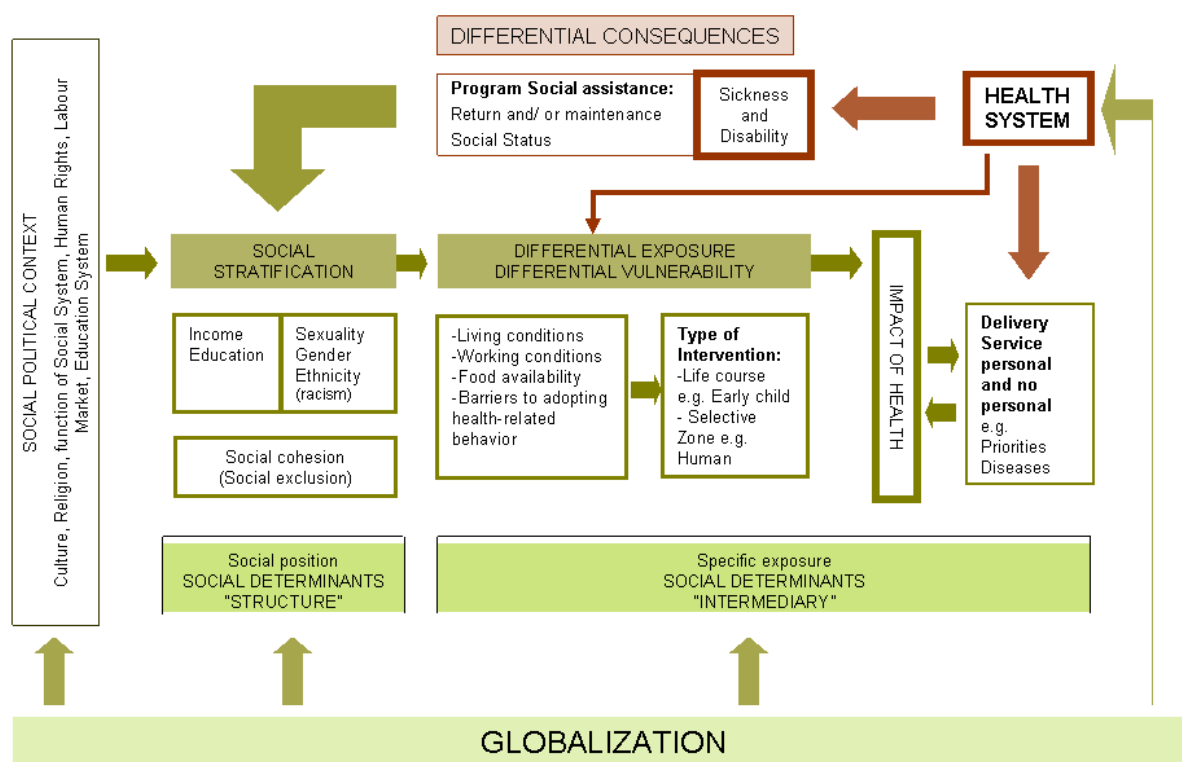
Woodward and WHO colleagues (69) devised a model that focused on “five key linkages from globalization to health,” three direct and two indirect. Direct effects included impacts on health systems, health policies, and exposure to certain kinds of hazards such as infectious disease and tobacco marketing; indirect effects were those “operating through the national economy on the health sector (e.g. effects of trade liberalization and financial flows on the availability of resources for public expenditure on health, and on the cost of inputs); and on population risks (particularly the effects on nutrition and living conditions resulting from impacts on household income).” This model has the advantage of focusing on the range of policy choices (by both governmental and private actors) that operate at the supranational level to affect health; its value is arguably limited by a focus on health systems rather than on SDH. A subsequently WHO-supported systematic review examined numerous models of the relations between globalization and health, generating a diagrammatic synthesis hierarchically organized around various scales ranging from the supranational to the household (70;71). A key strength of this synthesis is its explicit attention to globalization’s influences on the “policy space” available to national and subnational governments. The term is used by McGill (72) and Kozul-Wright and Rayment (20), and the concept is implicit in the work of Tanzi, Avi-Yonah, Williamson (73-75) and others on taxation (see section III.1, below). Conversely, a limitation of this synthesis may be its lack of focus on the detailed mechanisms of action by which various causal pathways lead to changes in individual and population health status.¹³

Diderichsen, Evans & Whitehead (77, p. 14) note “four main mechanisms – social stratification, differential exposure, differential susceptibility, and differential consequences – that play a role in generating health inequities.” Globalization can affect health outcomes by way of each of these mechanisms, as reflected in the analytical framework developed by the CSDH Secretariat; in fact, Diderichsen et al. draw specific attention to its influence on stratification by way of “those central engines in society that generate and distribute power, wealth and risks” (77, p. 16).. We have modified the analytical framework diagram slightly (Figure 1) to indicate in grossly schematic terms the pathways that link globalization with SDH, as well as directly with the operation of health systems. A further modification, important in view of the mandate of the CSDH, would involve incorporation of the role of domestic politics, which do not now appear in the model. Historian Simon Szreter, whose work on the origins of public health measures and their impact on health status in nineteenth-century England

¹³ A recent paper by Huynen, Martens and Hilderink (76) offers another conceptual model of the globalization-health relationship, although it largely re-organizes the schemata presented by the previous two with a special emphasis on the global movement of people (tourism, voluntary and forced migration).

is widely cited, emphasizes the importance of political coalitions (a “cross-class reform movement”) in translating the benefits of rapid economic growth into broadly shared improvements in SDH, such as access to clean water, sanitation, and limited hours of work (78; see also 79). This observation is of special importance given the comparable challenges now facing a number of developing countries experiencing rapid economic growth, in a context where the necessary health-related infrastructure is either not available or else has been dismantled as part of growth-oriented economic ‘reforms’ (80-82). What initiatives will be necessary to facilitate the formation of domestic political coalitions in support of improving SDH?

Figure 1. Causal pathways to health outcomes



Source: WHO Equity Team diagram, modified by Globalization KN

I.4 The nature of the evidence base

The evidence for assessing globalization’s effects on SDH and identifying opportunities for intervention is quite different from, and much more heterogeneous than, the evidence base that is available with respect to clinical and (most) public health interventions. As described in greater detail in section II of the paper, globalization comprises multiple, interacting policy dynamics or processes the effects of which may be difficult if not impossible to separate. For instance, trade liberalization may reduce the incomes of some workers or shift them into the informal economy, while reducing tariff revenues (and therefore funds available for public expenditures on health or education)

in advance of any offsetting revenue gains from income and consumption taxes. Simultaneously, the need to conserve funds for repaying external creditors may create a further expenditure constraint. The causal pathways linking globalization with changes in SDH are not always linear, do not operate in isolation from one another, and may involve multiple stages and feedback loops.¹⁴ It is necessary to rely on evidence generated by multiple disciplines, research designs and methodologies (transdisciplinarity) and consisting of both qualitative and quantitative findings. Research that situates data from local-scale survey research in the context of structural adjustment in Zimbabwe (84) and that identifies globalization-related influences on health in South Africa (85), demonstrates the need to integrate work using different units of analysis or scales (e.g. the household, the region, the national economy) in order to describe relevant causal relations in sufficient detail, and in order to reflect intra-national issues of distribution (e.g. by region, class and gender) that are crucial for health equity but not apparent from national level data -- and, indeed, arguably obscured when progress toward such goals as the MDGs is assessed only using national aggregate data (see (86-88)).

Policy-relevant linkages between globalization and SDH are therefore best described, and the strength of evidence evaluated, by way of narrative syntheses – referred to in comparative historical sociology as process tracing – “in which hundreds of observations are marshalled to support deductive claims regarding linkages in a causal chain” (89, p. 49). These narrative syntheses should incorporate several elements, including: (a) description of the national and international policy context; (b) country- or region-specific studies that describe changes in determinants of health, such as the level and composition of household income, labour market changes, access to education and health services (to provide simple examples); (c) evidence from clinical and epidemiological studies that relates to demonstrated or probable changes in health outcomes arising from those impacts¹⁵; (d) ethnographic research, field observations, and other first-hand accounts of experience ‘on the ground’.¹⁶ In all this, it is necessary to recognize that rarely, if ever, can conclusions be stated with the degree of confidence in findings that is possible in a laboratory situation or even in many epidemiological study designs, where almost all variables can be controlled. “The further upstream we go in our search for causes,” and globalization is the quintessential upstream variable,

¹⁴ Similarities exist with the task of analyzing causal links between environmental change and human health, which “are complex because often they are indirect, displaced in space and time, and dependent on a number of modifying forces,” in the words of WHO’s synthesis of the health implications of the findings of the Millennium Ecosystem Assessment project (83, p. 2).

¹⁵ For purposes of the work of the Commission, much of this evidence will be supplied in the first instance by other Knowledge Networks.

¹⁶ Field observations can be valuable *inter alia* in providing information about differential impacts (e.g. by region, gender, kind of employment) that are not revealed by standard indicators, and about such matters as the problems created by the imposition of user charges and cost recovery in water and sanitation systems (90). Within the ethnographic literature, Schoepf (91-94) demonstrates the value of qualitative evidence about the relations between micro-level outcomes and such macro-level factors as falling commodity prices, domestic austerity policies that involved cuts in public sector employment and in subsidized access to health care, and migration driven by economic desperation. For illustrations of the potential contributions of other kinds of ‘on the ground’ research, see e.g. the World Bank’s Voices of the Poor study (95;96) and the report of the Structural Adjustment Participatory Review International Network (97).

“the less applicable is the randomized controlled trial,” and the greater the need to rely on “observational evidence and judgment in formulating policies to reduce inequalities in health” (98). The choice of a standard of proof with respect to the evidence for such causal relations is critical, and must be made with explicit reference to the underlying, potentially competing values. A critical point here is that excessively high standards of proof supply, as always, a credible and convenient rationale for doing nothing: the “tobacco industry standard of proof” (99). As in the context of national public health and regulatory policy, algorithms for assessing the evidence must reflect explicit consideration of the consequences of being wrong in various kinds of ways: schematically, Type I and II errors.

De Vogli and Birbeck (100) identify multi-step pathways that lead from globalization to increased vulnerability to HIV infection and its consequences among women and children in sub-Saharan Africa by way of five manifestations of, or responses to, globalization at the national level: currency devaluations, privatization, financial and trade liberalization, implementation of user charges for health services and implementation of user charges for education. The first two pathways operate by way of reducing women’s access to basic needs, either because of rising prices or reduced opportunities for waged employment. The third operates by way of increasing migration to urban areas, which simultaneously may reduce women’s access to basic needs and increase their exposure to risky consensual sex. The fourth pathway (health user fees) reduces both women’s and youth’s access to HIV-related services, and the fifth (education user fees) increases risk of exposure to risky consensual sex, commercial sex and sexual abuse by reducing access to education. This explanatory approach complements recent synthetic reviews of research on determinants of vulnerability not only to HIV/AIDS but also to tuberculosis and malaria (101;102) which concluded that vulnerability to all three diseases is closely linked; that poverty, gender inequality, development policy and health sector ‘reforms’ that involve user fees and reduced access to care are important determinants of vulnerability; and that “[c]omplicated interactions between these factors, many of which lie outside the health sector, make unravelling of their individual roles and therefore appropriate targeting of interventions difficult” (102, p. 268).

For purposes of identifying policy entry points, the vulnerabilities identified in these exercises must be traced retrospectively to policy choices, constraints and incentives in the domestic and international environment. In doing so, it must be kept in mind that the scale at which an intervention needs to be implemented is not necessarily the scale at which the problem arises. For instance, state/provincial or national level changes in tax policy to increase revenues and redistributive effects,¹⁷ or national changes in trade policy that require the agreement of trading partners or supranational institutions, may be the most effective means of correcting economic deprivation at the household level that is associated with particular elements of globalization. Such larger scale, ‘upstream’ interventions are not intrinsically preferable, but neither can they responsibly be dismissed as “romantic but impracticable” (106). They may be the only category of intervention that is effective in changing SDH, as distinct from compensating for their effects. Alternatively, ‘upstream’ interventions may decisively affect success or failure of curative and preventive interventions, because of

¹⁷ As recommended by a number of recent comparative studies of social policy in Latin America (103-105).

their impacts on the context within which they must be implemented or scaled up. For example, limits on governments' public expenditures on health, whether adopted at the insistence of foreign lenders (107) or in response to the demands of domestic elites whose bargaining position is strengthened by globalization's facilitation of the rapid shifting of financial assets, can doom the best designed and most demonstrably effective clinical or public health interventions to failure by starving them of necessary resources or creating situations in which essential health personnel migrate toward better paid and less insecure jobs in other jurisdictions.

A choice must also be made about the time frame of concern. Since over the long run wealthier societies are healthier, it could be argued that the optimal approach to improving SDH is the one that will maximize economic growth in the countries or regions of concern. Implicit in this position is the presumption that whatever short-term deterioration in SDH may arise is justified by long-term gains.¹⁸ But how long is too long? Szreter points out that diffusion of the benefits of economic growth in ways that improve health, because of the need to form supporting political coalitions, is neither automatic nor rapid: it took more than 50 years in the industrial cities of nineteenth-century England, for example (78;109;110). Given the frequency with which globalization has resulted in deterioration in SDH for substantial segments of national populations (see Section II), despite impressive economic growth as measured by national indicators, this is not just an academic point. Both the spirit of concern for health equity and more general ethical considerations support the scale-independent argument that: "At the very least ... those who stand to benefit from the process [of globalization] should be expected to agree to provide systematic and substantial assistance to the victims, presumably via government channels, and supported liberally by the wealthier communities. If that is not acceptable politically, there is surely little that can be said convincingly in support of a contention that the suffering of the victims will be justified by the promised future benefits to their descendants" (111). Section III of the paper outlines, indicatively rather than comprehensively, a range of approaches to this task.

II. How the global marketplace affects SDH

This section of the paper identifies key 'clusters' of pathways leading from globalization to changes (usually, deterioration) in SDH. The clusters are defined largely for convenience of presentation; as noted above, it is difficult, and often impossible, to separate the effects of individual elements of globalization from their context. As in other areas of policy studies, meaningful synthesis of research findings must recognize that more than one thing is usually happening at the same time.

II.1 Trade liberalization, incomes, and the new international division of labour

Perhaps the most familiar element of contemporary globalization is trade liberalization. The concerns identified above are among those that should be kept in mind when considering the often-cited research carried out under the auspices of the World Bank

¹⁸ An argument that is made explicitly by Adeyi et al (108) with respect to the transition economies of the former Soviet bloc.

(112-114), which concluded that during the 1980s and 1990s, “globalizers” grew faster than “non-globalizers,” and therefore (presumably) increased their ability to improve SDH. This conclusion has been criticized on several counts. Those countries held up as model high-performing “globalizers” (China, India, Malaysia, Thailand and Vietnam) actually started out as more closed economies than the countries whose economies stalled or declined, mostly in Africa and Latin America (114). The problem is one of definition. This study’s “globalizers” are countries that saw their trade/GDP ratio increase since 1977; the “non-globalizers” are simply those that saw their ratio drop. Thus India and China are considered “globalizers,” even though their trade/GDP ratios at the end of the study period were lower than the average of all countries studied. Conversely, the “non-globalizers” started out more highly integrated into the world economy. Thus, it can be argued that the economic problems of the non-globalizers are partly an artifact of study design, and partly attributable to factors outside the control of national economic policy-makers – specifically, a decline in commodity prices that damaged both the export performance and the ability to import of those countries heavily reliant on commodity exports, but already highly integrated into the global economy on some measures (115-117). Further, excluding India and China from the sample actually changes the conclusion: the “globalizers” grew more slowly than the “non-globalizers” over the period 1980-2000 (117).

Similar methodological limitations, with the addition of concerns about the reliability of data on incomes and household assets and the appropriateness of definitions of poverty (118;119), have been pointed out with respect to the parallel argument that globalization has been accompanied by worldwide reductions in poverty (120).¹⁹ Even if one takes as given the (World Bank) measures of poverty used in such work, it is not at all clear that globalization leads to poverty reduction or that observed reductions are substantial. For example, between 1981 and 2001, the number of poor at the \$1/day level fell by 392 million, but at the \$2/day level rose by 285 million, indicating only a marginal improvement in income gains (120, p. 183). Excluding China, the accuracy of whose poverty data has been questioned (121), the number of global poor actually rose by 30 million at the \$1/day level and 567 million at the \$2/day level. It is also important to note that half of China’s estimated poverty decline occurred from 1981 – 1984, before that country’s global economic integration, and attributed to land reform that “gave farmers considerably greater control over their land and output choices” (120, p. 184; 122).²⁰

From the perspective of health equity, such debates about trade and growth performance are scholastic. Even the most ardent enthusiasts of trade liberalization concede that there will be losers: for example, those whose livelihoods in Zambian

¹⁹ We accept as a given, without critical review, the preponderance of evidence identifying both the importance of, and multiple pathways by which, poverty (both absolute and relative) acts as a social determinant of health.

²⁰ Similar methodological debates surround trends in income inequalities, which vary depending on whether one measures trends within countries, between countries or between individuals globally -- cf. for example (116). There is also a lack of scientific consensus on whether, or why (how), such inequalities matter in terms of inequities in health outcomes, although it is generally accepted that poverty reduction from economic growth is less under conditions of higher income inequality. The importance given to poverty and income inequality in policy debates concerning both globalization and health will necessitate a close review of evidence related to both by the globalization KN.

manufacturing, Ghanaian poultry production, or (in some cases) Mexican corn farming were destroyed by low-cost imports (123-125). From a theoretical perspective, “the immediate impact of rapid trade liberalization could ... be unemployment, deindustrialization and growing external deficits even though there may be a significant increase in export growth,” with the survival of existing industries depending on such measures as “downsizing and labour shedding” (126, p. 6). A substantial and expanding body of context-specific quantitative research that addresses labour market effects within national economies and on specific firms, regions and populations provides a more nuanced and distribution-sensitive picture than is available from cross-national comparisons of national-level data. The findings of this research reflect the reorganization of production across national borders into global “commodity chains” or “value chains” (127-131), a development that is sometimes described in terms of a new international division of labour (132;133). “Globalization entails uneven development for firms and workers both within and across regions and nations, and viewing the process through the lens of the commodity chains framework contributes to our understanding of who wins and who loses, and why” (134, p. 165).

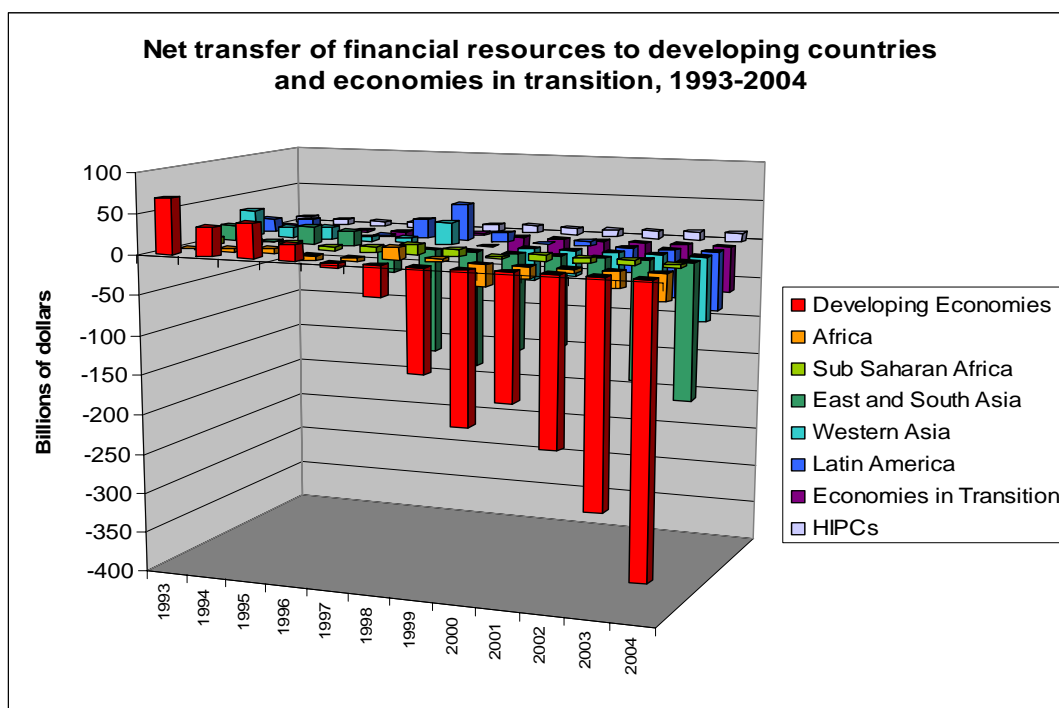
For example, studies of horticulture and textile and garment production in Kenya, South Africa, Bangladesh and Vietnam provided “no universal conclusion regarding the impact of globalization on poverty” (135, p. 18). Much was found to depend on the niches that individual workers, firms and national economic policy were able to carve out in the global commodity or value chains that increasingly characterize the production process (135;136).²¹ Substantial opportunities for employment and income gains were associated with integration into global value chains, but conversely: “Global value chain pressures are ... associated with increasing casualization of labour and excessive hours of work” (136, p. 25).²² A separate study applying value chain analysis to the South African furniture industry warned of a future of “immiserizing growth” under almost any plausible set of future conditions (137). The case of Mexico’s *maquiladoras* is often cited to illustrate how aggressive pursuit of integration into global value chains can result in growing economic and social inequalities among workers (138); falling wages and deteriorating working conditions for many or most workers (139;140), especially women (141-143); loss of jobs to jurisdictions, notably China, which can offer even lower labour costs (144); and increased workplace hazards and industrial pollution (145-147). To the extent that generalizations can be drawn from a limited number of case studies, economic policies that emphasize integration into global value chains are likely to be accompanied by increased economic polarization within the wage labour force and substantial, usually gender-differentiated, deterioration in SDH for some portion of the population engaged in formal employment. Further, it has been argued that moving up a particular value chain using similar strategies is a path to growth that can be followed only by a limited number of firms, regions or countries (137).

²¹ These articles summarize research carried out in the early stages of the World Institute for Development Economics Research (WIDER) program on The Impact of Globalization on the World’s Poor. This research program is still under way, and will serve as a valuable source of primary research and research syntheses as our work progresses.

²² Labour market effects alone are not a reliable indicator of globalization’s effects on SDH; although they are crucial to understanding the sources of poverty and economic insecurity, and often the gender-differentiated effects of globalization, evidence on these points must be combined with (for instance) evidence on changes in housing costs and in access to health services.

The Mexican example is also valuable as an illustration of the interplay among multiple elements and consequences of globalization that affect SDH. Mexico embraced economic integration well before trade liberalization was entrenched as a “conditioning framework” (148) through NAFTA; it did so partly as a response to the first of a series of financial crises (a temporary default on foreign debt in 1982) the origins of which were themselves global, or at least multinational. Drastic currency depreciation that occurred because of those crises, and in spite of the policies adopted in response, exacerbated both overall declines in purchasing power and economic polarization within Mexican society (148-151). This is just one example of how trade liberalization, the new international division of labour and other elements of globalization are bound up with international financial integration and specifically a succession of ‘debt crises’.

Figure 2. An overview of global financial flows



Source: (152)

II.2 ‘Debt crises,’ structural adjustment and marketization

A long history of ‘debt crises’ constrains the ability of many developing countries to invest in public health, education, water, sanitation and nutrition. Between 1970 and 2002, African countries borrowed \$540 billion, paid back \$550 billion and still owe \$295 billion (153, p. 19) – creating a situation in which Africa spends 2-4 times as much each year on debt servicing as on health and education, depending on the figures being used. Debt crisis as a constraint on public policy is by no means confined to Africa: worldwide, the value of annual debt service payments by developing countries consistently dwarfs the amount they receive in development assistance (154). “[D]ozens 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" (155, p. 35) – part of a larger pattern of financial transfers from the South to the North (152; see Figure 2) that is a key element of the globalization context.²³

The etiology of debt crises varies from country to country and over time (158-161), but a stylized list of major causes would include: (a) the oil price shocks of 1973 and 1979-80, which had an especially severe impact on low-income, oil-importing countries; (b) aggressive lending by banks seeking to 'recycle' oil revenues; (c) a rapid increase in real interest rates during the early 1980s generated by the monetary policies of the US Federal Reserve, meaning that debtor countries often had to roll over existing debt at much higher interest rates; (d) falling world prices (i.e., deteriorating terms of trade) for the primary commodities that are the key exports of many developing economies; (e) capital flight, consisting both of outright theft and of the rational, mostly legal shifting of assets abroad by economic elites worried about tax increases and future devaluations²⁴; and finally (f) the willingness of the international community – banks and governments alike – to accord leaders of developing countries the "borrowing privilege" of incurring debts on behalf of their citizens without inquiring into the legitimacy of their rule, even when they have taken power by force or deceit and maintained it by extreme repression (164).

The term "structural adjustment" entered the international development lexicon in 1980, when the World Bank initiated structural adjustment loans, normally in conjunction with stabilization loans from the IMF, to assist recipient countries to reorganize their economies in order to increase the chance that creditors would be repaid. The urgency of such lending grew after 1982, when Mexico's announcement that it was prepared to default on billions of dollars in loans, primarily made by major US banks, raised concern about the stability of financial systems in the industrialized world. In keeping with widespread usage,²⁵ we use the term "structural adjustment" here to refer to the entire set of domestic policies adopted to reorganize national economies in response to the priorities of the IFIs, rather than just to the World Bank program. A key point is that "conditionalities" attached to such lending, and the associated debt rescheduling, emphasized reduction of subsidies for basic items of consumption such as food; rapid removal of barriers to imports and foreign direct investment; reductions in

²³ The Figure is incomplete in at least one respect, probably two. First, it has been claimed that the underlying data on financial flows do not include the value of capital flight from developing countries (156). Second, it does not reflect the value of remittances from emigrants to their home countries – a figure somewhat higher than the gross annual value of development assistance (157). However, these two values have opposite signs, and quite possibly cancel one another out on a worldwide basis – although not necessarily, it must be emphasized, for individual countries or regions.

²⁴ Notably, Ndikumana & Boyce estimate that: "During 1970-96, roughly 80 cents on every dollar that flowed into [sub-Saharan Africa] from foreign loans flowed back out as capital flight in the same year" (162, p. 122). They also calculate that the accumulated value of flight capital from 25 African countries between 1970 and 1996, plus imputed interest earnings, is considerably *higher* than the entire value of the combined external debt of those 25 countries in 1996 (163). In other words, taking into account privately held as well as public assets, those African countries should be regarded as net creditors rather than debtors vis-à-vis the rest of the world.

²⁵ See e.g. (165)

state expenditures, particularly on social programmes such as health, education, water/sanitation and housing; and rapid privatization of state-owned enterprises, on the presumption that private service provision was inherently more efficient, and that proceeds from privatization could be used to ensure debt repayment (165;166). In other words, the policies of the IFIs systematically promoted multiple, more or less coordinated domestic policies of integrating national economies into the global marketplace.

Research on the health-related impacts of structural adjustment confronted at least three design problems. First, implementation of the conditions attached to loans from the World Bank and IMF was often incomplete (167) – leaving open the possibility that if the ‘reforms’ in question had been undertaken even more aggressively, outcomes might have been more favourable.²⁶ Second, it can be difficult to separate effects of structural adjustment from those of the economic crises that preceded the process. Third, and relatedly, conclusions and policy recommendations depend heavily on the choice of a counterfactual (171). If the counterfactual is the continuation of business as usual, which would in many cases have involved (continued) hyperinflation and the isolation of countries from international financial markets, then structural adjustment may appear as the ‘least worst option’. On the other hand, if the counterfactual selected “is a different sort of change ... let us call it for convenience’s sake a social democratic model” (171, p. 150), then one’s conclusions are likely to be less favourable.²⁷

Research findings on structural adjustment and SDH are nevertheless extremely valuable. A review of studies specific to the health consequences of structural adjustment carried out for the Commission on Macroeconomics and Health (175) found a preponderance of findings of negative effects among 76 studies identified, noting that most studies identified negative health impacts from structural adjustment in Africa. This review was weakened, however, by a selective and incomplete sampling of the literature. Notably, the authors’ review of the country cases from the “adjustment with a human face” study was extremely cursory, and they did not consider ethnographic studies (e.g. 91;93;176) and country-level participatory assessments (e.g. 97), which shed considerable light on the human consequences of adjustment policies. In addition a larger literature, in much of which the “social democratic” counterfactual is implicit, describes negative effects of structural adjustment on SDH, but does not extrapolate from the conclusions to generate predictions or hypotheses on health outcomes.²⁸ A

²⁶ The recent history of market-oriented development policy in the two regions of the developing world where it has been pursued most aggressively, Latin America and Africa, (168;169), calls this claim into question. So too does the general pattern of labour market outcomes that has resulted (170).

²⁷ See also (172). Another intriguing illustration of the importance of the choice of counterfactual comes from a recent study that applied standard econometric modeling to the question: What would economic growth have been in sub-Saharan Africa over the past 20 years had its countries not been forced to liberalize their economies by the IFIs and conditions attached to aid (173;174)? Based on results from a sample of 22 African countries, the study implies costs of roughly \$272 billion – about the same amount the continent received in aid during this time. According to Christian Aid, the organization that commissioned the study: “Effectively, this aid did no more than compensate African countries for the losses they sustained by meeting the conditions that were attached to the aid they received” (173, p. 2).

²⁸ For illustrative examples see: (97;165;165;177-182)

stylized summary is that structural adjustment operated on SDH both directly and indirectly. To illustrate, cuts in food subsidies and in government wages and employment had direct negative effects on access to nutrition and on household income. Import liberalization measures undertaken in response to conditionalities may also have had negative impacts on social structure mediated by labour markets, as livelihoods were lost to low-cost imports. The major documented effects on social structure, which are difficult to trace to specific elements of structural adjustment programs (e.g. import liberalization as opposed to cuts in state employment) have to do with poverty, income inequality and changing gender relations: for example, the disproportionate impact both on women's incomes and on their household activities (see e.g. 142;182). Poverty and economic insecurity, in turn, have multiple effects on exposure and vulnerability, mediated e.g. by housing, working conditions, and access to nutrition and education. And structural adjustment had important equity-related effects on health systems, e.g. by way of expenditure reductions and implementation of cost recovery measures (see section II.4, below) Seldom do these appear to have been offset by the gains associated either with increases in domestic productivity in sectors newly exposed to international competition or with lower prices for imports.

It is difficult to separate impacts on SDH of domestic policies that were adopted in specific response to lender conditionalities from those adopted in response to the broader diffusion of market-oriented policy ideas, such as the perceived need to implement macroeconomic policies that will attract foreign investment and keep domestic elites from shifting their assets abroad. However this difficulty arguably increases rather than limits the value of the body of structural adjustment research: the form and direction of changes undertaken as part of structural adjustment programs are in most respects identical to the market-oriented policy shifts that comprise a key element of globalization more generally (28;165). In other words, it is less important to be able to determine how much of a country's specific policy in year x can be attributed to responses to the IFIs and how much to the preferences of national decision-makers than to recognize that if we want to know how globalization affects SDH by way of the 'marketization' of domestic social and economic policy, then the body of research on structural adjustment is valuable independent of the specific historical connections between IFI conditionalities and policy responses. Indeed, it may be the single most important body of evidence available.

That body of evidence is also valuable prospectively. Poverty reduction has replaced structural adjustment in the official vocabulary of the World Bank and the IMF, but very similar macroeconomic policy directions can be observed in the Poverty Reduction Strategy Papers (PRSPs) that are required before countries can receive debt relief under the Heavily Indebted Poor Countries (HIPC) initiative and, increasingly, for bilateral development assistance or concessional loans from the World Bank (183;184). The benefits of PRSPs in theory include requirements for civil society participation, and a recent illustration of a specific benefit is the requirement in the case of Zambia that District Health Management Boards actually receive at least 80 percent of their specified annual budgets (185, ¶120), which apparently had not been the case in the past. On the other hand the macroeconomic policy content of PRSPs, in particular, may be unduly influenced by lender preferences because of country experience with previous World Bank and IMF conditionalities (186, p. 26-31). In combination with the acknowledged inadequacies of debt relief efforts to date, the expanding literature on the successes and

limitations of PRSPs²⁹ may point to a clearly defined set of interventions with potential to generate substantial improvements in SDH.

II.3 The “space of flows” and SDH

Castells (193) describes contemporary globalization, and in particular contemporary cities, with reference to a “space of flows” of both money and information. Flows of direct importance to health include those involving people and ‘lifestyles’ defined by consumption patterns. The declining cost of international travel means that people (and communicable diseases) move across borders with increasing ease – a phenomenon now familiar from the example of SARS (194) and of special concern with respect to influenza transmission (195). The ‘communicability’ of smoking and the associated burden of disease across national borders, by way of trade liberalization and aggressive global tobacco marketing, is also well documented (196-199). Less familiar are the contributions of trade liberalization and increased foreign direct investment in food processing and retailing to nutritional transitions in the developing world and rapid increases in obesity (200-204). This issue is of special importance from the perspective of health equity because of the seemingly paradoxical observation that in many fast-growing regional and national economies obesity, and corollaries such as cardiovascular diseases and diabetes, are more prevalent among the poor than among the rich (205-207).

The interaction of finance and space is especially important to SDH as it relates to high velocity financial flows and to competition for space and location-sensitive resources, both of which instantiate Giddens’ (208, p. 64) identification of globalization with “an intensification of world-wide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa.” Increasing volumes of foreign direct investment (FDI) in actual production facilities have been accompanied by vastly more rapid growth in portfolio investment: investment in financial assets such as shares, bonds, and an expanding range of financial instruments generically described as derivatives. The daily value of foreign currency transactions is now estimated at \$1.5-\$2 *trillion*. Financial liberalization may be an even more important influence on SDH than trade liberalization, as it exposes national economies to the uncertainties created by extremely large and volatile short-term capital flows (209). Large-scale disinvestment in response to apprehensions about the viability of a particular national economy or currency requires no formal coordination but merely a reliance on similar sources of information and incentives for comparable levels of risk aversion.

The resulting effects on the ‘real economy’ have been devastating, undermining the livelihoods of hundreds of millions of people as currencies are devalued, purchasing power evaporates, and restoring the country’s creditworthiness in the eyes of investors takes priority over meeting basic needs domestically. This happened in Mexico in 1994-95, as Mexican investors shifted their assets out of Mexican government debt securities and forced further devaluation of the peso (210); in south Asia in 1997-98, even among the ‘Tiger’ economies that were counted as among globalization’s success stories, after flight from the region’s currencies began with speculation against the Thai baht (211-213); and most recently in Argentina in 2001-02. Indicative of the potential effects on

²⁹ In addition to the material cited in the preceding discussion, see (187-192).

health equity, a Korean national survey found substantial increases in morbidity, and decreases in health service utilization, following the 1997 currency crisis (214). The Mexican crisis of 1994-95 reduced the value of the peso by almost half; direct effects on purchasing power were compounded by the wage reductions, workforce economies and public sector austerity measures needed to restore investor confidence (139;148;149). In an especially dramatic example of long-distance effects, generic investor concern about the stability of developing country currencies in the wake of crises in Korea (late 1997) and Russia (early 1998) led to a selloff of Brazilian assets that forced a currency devaluation, even as connection between Brazil's economy (and the economic lives of most Brazilians) and events in Korea or Russia was minimal (215;216).

Long-distance effects of quite a different kind are evident in changing patterns of urban form and settlement. As cities are 'globalized,' gaps between economic winners and losers grow not only because of the loss of urban employment that is associated with 'deindustrialization' in the advanced economies, but also because access to essential resources is determined by households' ability to pay, or by group/neighbourhood attractiveness as a market. Residential segregation deepens through gentrification, suburbanization, and the creation of fortified enclaves with separate private systems of service provision, while those less able to pay are shifted to less desirable locations and rely on inferior services. Among the urban services that define the boundaries of inclusion/exclusion are transportation (public transit vs. car-centred development; see e.g. (217-219) and, crucially, access to and affordability of the broadband connections that are an indispensable gateway to the "information society" – a crucial dividing line in the international context, as well.³⁰ Urban 'revitalization' includes not only policies that favour more desirable (read: higher-income) residents, but also reconfiguring urban space in pursuit of profitable commercial development and tourism revenues, similarly leading to displacement of residents and sometimes the literal enclosure of public spaces (see e.g. 217;220-224). Poverty may be criminalized. These processes are documented in a remarkably comprehensive UN Habitat synthesis on *Cities in a Globalizing World* (225), hence the lack of specific references here. The Globalization KN will serve as a resource, as needed, for the Urban Settings KN as it explores these issues – which are not, it must be emphasized, confined to micro-level policy debates about "slums" and what to do about them. Rather, they are about how the large and growing proportion of the world's people who live in cities find their daily routines inextricably linked with global power relations and the "flows" that define globalization, and about the implications for SDH.

Bidding contests for urban spaces that epitomize that interaction of global power relations and local opportunities are paralleled by contests over locationally valuable non-urban resources, notably those associated with the expanding business of tourism. These contests can exclude current or 'low-value' users of a resource either by degradation, e.g. by using surface or ground water as a sink for the disposal of toxic wastes (226), or by enclosure, e.g. by pricing the use of specific locations and resources out of reach of all but the wealthy (227-229). The common analytical denominator of all these conflicts is that in the context of the global marketplace, some resources are

³⁰ A South African colleague and KN member informs the authors that in his middle-income country, a high speed residential Internet connection in a major city would cost ~ \$120/month at current exchange rates, as against ~\$40 for a comparable, if not superior, connection in Canada.

simply too valuable to be used to provide basic needs for those with limited purchasing power.

II.4 Environment, resources, and SDH

The sheer unprecedented scale of recent human impacts on the natural environment (6), exemplified by the case of global climate change, is in itself one important health-related dimension of globalization. More directly relevant to the work of the Commission is the fact that impacts on the natural environment arising from the operation of the global marketplace represent an important set of pathways by which those operations affect SDH. As suggested by the preceding discussion, economic competition for scarce and valuable resources and ecosystem services is one such set of pathways. At least two other sets of pathways can be identified: urbanization and intra-urban disparities in exposure to such hazards as vehicle traffic and air and water pollution; and the global migration of hazardous industries, production processes and waste. Some authors argue that "agroindustrialization" as production is reorganized into global, input-intensive commodity chains, constitutes a distinctive set of pathways or mechanisms (230). To some extent these pathways overlap or interact, as when agroindustrialization is driven by the imperative of increasing revenues from exports destined for foreign consumers. For example, Stonich (231, p. 23-24) argues that pressure to increase export earnings leads governments to promote "export-oriented aquacultural development regardless of the social and environmental consequences," creating situations in which "the increasing use of low-value fish species in the production of fishmeal for aquacultural feeds in effect puts the poor in competition with shrimp," and with the rich consumers who will buy them, "for low-quality fish products" (see also (232)).

The situation described by Stonich instantiates a pattern noted by the health synthesis of findings from the Millennium Ecosystem Assessment (MEA) project,³¹ in which: "Historically, poor people disproportionately have lost access to ecosystem services as demand from wealthier populations has grown" (83, p. 28). This process may affect both social stratification, as when access to livelihoods is limited, and differential exposure and vulnerability to such risk factors as undernutrition and economic (in)security, as the structure of opportunities and access to ecosystem services changes within local economies. The approach described as political ecology or "political ecological analysis" may be especially appropriate for the study of such situations: it "consists of an integrated explanation of human-environmental interactions linked through different scales from the international/global to the local; centres on the relative power of various social actors (stakeholders) involving access to, and management of, natural resources; and links these actors within and among levels through relations of power" (226, p. 29, citations omitted). Another discussion of political ecology in the recent literature (233) emphasizes considerations of scale. Thus, the difference globalization makes is that the winning bidders may be half a world away,

³¹ See: <http://www.millenniumassessment.org>. The MEA's conceptual framework explicitly recognized economic globalization as one of the drivers of change in ecosystems and human well-being by way of various causal pathways, and each of the four scenarios on which the MEA was based ("Global orchestration," "Order from strength," "TechnoGarden" and "Adapting mosaic") incorporates alternative assumptions about the future direction of globalization.

as in Stonich's aquaculture example and in the case of markets for tropical timber and certain mineral resources such as oil in Nigeria (an archetypal case of a country where abundant resource revenues have failed to improve the grinding poverty and poor health status of much of the country's population), and coltan and other minerals in the Democratic Republic of the Congo.

A further common characteristic of many such situations is that globalization's contribution may take the form not only of rapidly rising aggregate demand but also of policies and institutions (e.g. transnational resource corporations) that facilitate control over gains and losses (including direct health damage from environmental exposures and loss of access to economically important ecosystem services) across entire regional economies by local elites and the dominant actors in global commodity chains.³² Thus, an analysis of investment in developing countries by transnational logging companies in response to increasing global demand for tropical timber was strongly critical of the sustainability of forest management practices, and further noted that: "Where analysis is available ... the economic benefit is minor, even in the short-term, and certainly far less than it could be if contracts were structured and negotiated differently. While large amounts of capital are involved, the revenue to national treasuries can be small because most of the profits leave the country or accrue in the hands of very few, often already wealthy and powerful local people" (236, p.29, citations omitted). Transnational firms in the mineral industry, in particular, are often the beneficiaries of large-scale financial support from export credit and insurance agencies in their 'home' (industrialized) countries (237;238) – an element of global influence that appears to have received surprisingly little research attention outside a rather specialized community of civil society organizations.

The MEA health synthesis further noted a separate set of differential exposures and vulnerabilities: "Poor populations are more vulnerable to adverse health effects from both local and global environmental changes" (83, p. 27), first of all because they are more likely to be exposed to hazards from which the rich can remove themselves. Disasters in Bhopal and New Orleans (only the former directly linked to globalization) provide dramatic evidence of this point, as do the routine conditions of urban life for literally hundreds of millions of people³³ worldwide (242). Health effects in the urban environment arguably constitute a subset of the broader effects of poverty and economic inequality on SDH, but may be amenable to distinctive types of intervention. It may further be useful to distinguish effects of consumption (e.g., those associated with vehicular traffic) from those associated with agricultural and industrial production and waste disposal.

Some authors argue for a clear pattern of migration of hazardous industries to lower-income countries, notably to export processing zones, or EPZs (145;147). Other, quantitative studies that do not focus on particular regions suggest that evidence for the emergence of industrial "pollution havens" is equivocal or absent (243;244). Impressionistically, many such 'negative' findings are limited in value by (a) a failure to

³² See e.g. (234;235)

³³ The UN Millennium Project estimated that more than 850 million people now live in slums, with the number projected to rise to 1.4 billion in 2020 (239). Slum residence is an imperfect, but nevertheless probably useful proxy for exposure to urban environmental hazards including not only industrial pollution but also the collapse of a rain-soaked open rubbish dump that killed some of the residents of Manila's informal settlements in 2000 (240;241).

focus on the global restructuring of production within specific industries or sectors; (b) concentration on foreign direct investment (FDI) as a study variable, to the neglect of contractual arrangements such as outsourcing that are not recorded in FDI statistics but are extensively documented in the literature on commodity or value chains; (c) the difficulty of distinguishing the causal effects of lax environmental regulation on relocation of production (what the pollution haven hypothesis is all about) from those of other variables, such as low wages and flexible working conditions, that tend to operate in parallel; and (d) failure to distinguish between changes in pollution levels attributable to industrial processes and to such factors as increased vehicular traffic and high-emission vehicles. Stronger evidence exists of the emergence of a global trade in hazardous wastes, with disposal in low-income countries becoming increasingly attractive and met with policy responses that are at best only partially effective (245-248).

In the background is the question of whether such environmental changes and their health impacts should be regarded as normal, in the sense that they are comparable to those undergone by the industrialized countries at comparable stages of their own economic development. The equity focus adopted by the Commission; the links between poverty and economic insecurity, environmental exposures and loss of livelihoods; and the extent to which contemporary technology allows for “technological leapfrogging” (249) and “dematerialization” (250) that avoid many environmentally destructive forms of industrial production and consumption all suggest that this conclusion should be rejected. Globalization’s effects on SDH that operate by way of the environment, like those that operate in other ways, must be regarded primarily as outcomes of political choice and avoidable failures of governance.

II.5 The global marketplace and health systems

Health care interventions that would be taken for granted in the industrialized world are just as routinely unavailable, or available only to the wealthy, outside it (176;251). Globalization may have worsened this situation, and almost certainly has inhibited progress, by promoting and reinforcing a market-oriented concept of health sector reform (HSR) that strongly favours private provision and financing (57;252;253), chapter 4). Multilateral institutions like the World Bank have been especially important in this respect (see e.g. (254;255). In keeping with the World Bank’s preference for markets and private insurance in health care (256;257), reductions in public sector health spending, introduction of user fees, and other cost recovery measures aimed at making health systems “sustainable” were often mandated as part of structural adjustment conditionalities (84;90;91;258;259).

On equity grounds, the best that can be said for official user charges is that they may replace informal, and even more inequitable patterns of side payments demanded by care providers or suppliers of medicines (260-262) ... and abundant evidence exists that their effectiveness in generating revenue is limited, even while access to health care for the poor and otherwise vulnerable often deteriorates³⁴ because very large numbers of people in the developing world simply cannot afford necessary health care (2;96). For example, national survey data in Mexico indicate that 51.8 percent of people who did not seek medical care for severe illness gave cost, or their own lack of money, as a

³⁴ For reviews see (255;263-266). Key case studies include (259;267-277).

reason (278). A smaller scale study of patterns of health service utilization in Lusaka, Zambia found that costs were the most commonly given reason for choosing self-medication as a first resort in case of illness, and also the most common reason for non-compliance with treatment regimes following a visit to the centralized university teaching hospital (279). Ethnographic research and the experiences of front-line care providers (176;251;280) support the conclusion that the issue is often not one of unwillingness to pay, but rather of inability to pay, and understandable reluctance to sell off assets that may be critical to the household's economic survival (96;281).

The marketization of health systems under the influence of external agencies may also have the effect of emphasizing commodified interventions and 'vertical,' disease-specific programs at the expense of integrated approaches that incorporate SDH. For example, although its initiatives are crucially important (and underfunded; see section III.2), "[t]he Global Fund targets 49% of its expenditure on drugs and commodities such as antiretrovirals and new antimalarials but only 20% on human resources and training," (282, p. 756), even though human resources are recognized with increasing frequency as the single most formidable challenge to improving the quality and comprehensiveness of health care in Africa (283-285). Indeed, marketization of health systems may compromise progress in other areas of SDH, such as poverty reduction. Viet Nam is often cited as an example of the poverty-reduction benefits of embracing the global marketplace, yet health indicators reflect the 'double burden of disease' phenomenon (82); opening up of domestic markets has been accompanied by the dismantling of relatively equitable systems for social and economic provision (82;269;274); and "[o]ut-of-pocket payments for health care pushed 2.6m Vietnamese into poverty in 1998" (286). Whatever the economic gains from China's domestic social and economic policy 'reforms,' a survey of several Chinese provinces found that the percentage of women with insurance coverage for prenatal and delivery services fell from 58.3 percent in 1989 to 34.7 percent in 1997; overall access to insurance coverage, already available to just one in four Chinese in 1989, continued to decline slowly through the 1990s (287). The public share of health expenditures fell by over half between 1980 and 1998, almost trebling the portion paid by families (273), leading to the growth of private delivery systems for those who could afford them, and increased cost-recovery for services that were still under some form of public health insurance. The result was an increase in the number of people who fell into poverty by exhausting their income and savings to pay for medical treatment (273) and a slowdown in China's population health improvements, particularly infant mortality and life expectancy (287). The longitudinal survey cited above found that with a rapid decline in coverage in cities, but an increase in rural areas (from 7.4% to 14.5%) as a result of a number of pilot schemes aimed at recreating some form of the insurance once provided through agricultural collectives (287).

Four further equity-related dimensions of globalization's effects on health systems must be considered. First, despite a WTO interpretation of TRIPS that limits patent protection for essential medicines, concern remains about the effectiveness of this interpretation as reflected both in national legislation (in countries with substantial pharmaceutical industries) and trade policy practice (in countries without)(288). Second, commitments made under the General Agreement on Trade in Services (GATS) and other agreement such as NAFTA have the potential to 'lock in' privatization initiatives against future governments' efforts to expand public provision or insurance (289;290), although disagreement exists about the seriousness of this prospect. Third,

the 'brain drain' of health professionals from developing countries, in particular those in sub-Saharan Africa, to industrialized countries where they can earn far more is now recognized as one of the most serious problems confronting health systems (283;284;291). Solutions, however, remain elusive because the situation reflects a bidding contest for the services of health professionals that is analogous in many respects to the bidding contests for urban space and locationally valuable resources described in the preceding section of the paper ... and to restate a point made in section III.3, without decisive policy intervention, in the case of 'brain drain' almost certainly requiring multilateral agreements, the rich will always win those contests. Fourth, leaving health research priorities to the global marketplace is highly problematic on equity grounds. The private pharmaceutical industry now accounts for 41.5 percent of all health research spending (292, p. 112), and public funding agencies in many industrialized countries are linking priorities to the anticipation of commercial returns. The result is the so-called '10/90 gap': roughly 10 percent of health research spending addresses conditions that account for 90 percent of the global burden of disease, overwhelmingly outside the industrialized world. Of 1,393 new drugs marketed between 1975 and 1999, only 16 were for tropical diseases and tuberculosis (293). As in other parts of the global marketplace, "money talks louder than need" in setting priorities for scientific research (294). Policy options for dealing with each of these health system problems have been suggested in the international literature, and will be reviewed jointly with the Health Systems KN.

III. Towards global governance for health equity: selected policy domains

The chosen focus here, on policy domains not directly or obviously related to health and (with the partial exception of section III.1) requiring initiatives on a global, or at least multilateral scale, requires brief explanation. No judgment is implied with respect to the tensions described by Irwin and Scali (295) concerning the scale and scope of changes to be advocated in support of improving health equity. However, even though many participants in the Globalization KN are clinicians, assessment of 'downstream' clinical or public health interventions is not where the specialized expertise of most participants can add value to the work of the Commission. Rather, that expertise relates to social and economic policy and their effects on SDH. In addition, the approach taken here responds to numerous recent calls for a "global social contract" and measures to address the "asymmetrical" dimensions of globalization (59;60), or measures to address the undersupply of global public goods (43-45). The inventory of policy domains and candidate interventions that follows is not exhaustive; it will be refined during the Network's operation. It should also be noted that none of the policy challenges and generic or specific interventions outlined below is a new idea: each has been identified or described in the academic research literature, in the agenda of a respected CSO concerned with SDH, or (often) both.

III.1 Income redistribution, tax competition, and SDH

As noted earlier (section 1.4), even when sustained economic growth is achieved, it cannot be assumed either that gains from growth will be widely shared. Neither should it be assumed that growth-promoting policies are the most effective way of achieving improvements in health equity by way of SDH (e.g., with respect to poverty reduction)

in the short or medium term. A recent study constructed alternative scenarios of progress by 18 Latin American and Caribbean countries – a region of the world where inequality is highest, on a variety of dimensions (296) – toward the Millennium Development Goal (MDG) of reducing extreme poverty by 50 percent between 1990 and 2015. In this region, where economic inequality is either the highest in the world or close to the highest, depending on the indicators chosen, findings were “that even very small reductions in inequality can have very large positive impacts in terms of poverty reduction. For most countries considered, a one- or two-point reduction in the Gini coefficient,” a standard measure of income inequality across an entire society, “would achieve the same reduction in the incidence of poverty as many years of positive economic growth” (104; for policy discussion see 103;297). In other words: *even a little economic redistribution can go a long way* at the national level, especially when combined with carefully designed health system and educational interventions. This is not a new observation,³⁵ but appears to require periodic revisitation and arguably deserves policy attention in other contexts, including sub-national jurisdictions, where income inequality is high. One implication, with special importance in Latin America where tax revenues as a percentage of GDP are generally low relative to those in other countries with comparable GDP levels, is that the overall level of tax revenue, the effectiveness of tax collection and the progressivity of tax systems all need improvement (105, ch. 9).

The role here for global or supranational governance is at least threefold. First, in all regions, technical assistance in improving the progressivity and revenue-raising capacity of tax systems may be a legitimate priority for development assistance.³⁶ Second, the international community can do much more to control questionably legal capital flight, which reduces the tax base for governments and arguably creates increased pressure for external borrowing.³⁷ OECD initiatives aimed at limiting the activities of offshore financial centres represent a promising, but incomplete start. So too does the United Nations Convention Against Corruption, which if ratified will bind parties to implement mechanisms to seize and repatriate illegally appropriated assets (299). Such measures will do little to address a third, globalization-related problem of perfectly legal tax competition among jurisdictions as a result of the hypermobility of financial capital and the need for foreign direct investment, at least potentially reducing fiscal capacity and leading to a shift of taxation away from capital and toward less mobile factors of production: land and the labour incomes of those without qualifications that make them internationally marketable (74;300). Evidence of the extent to which interjurisdictional competition has already reduced fiscal capacity and progressivity is inconclusive (301-303), but the former Chief of the IMF’s Public Finance Division has warned that this will clearly occur in the future (304), further identifying several “fiscal termites” including inability to tax financial capital, intrafirm trade, the proliferation of derivatives and hedge funds, and the cross-border mobility of the highly qualified (73)

³⁵ Cf. the proceedings of a conference on “Good Health at Low Cost” published in 1985 (298).

³⁶ Impressionistically, the IFIs in particular have historically paid far more attention to promoting *lower* tax rates, reduced progressivity and a broadening of the tax base.

³⁷ Cf. the analysis by economic historian Thomas Naylor summarized in the comment that: “There would be no ‘debt crisis’ without large-scale capital flight” (160, p. 370).

that will attack the foundations of tax systems in countries rich and poor alike.³⁸ Two sets of proposed responses exist. The first, more modest, proposal is for a new “multilateral organization with different rules than the WTO, but with similarly broad membership” dedicated specifically to limiting tax competition (74). More ambitiously, proposals have been made for multilaterally agreed-upon taxes on currency transactions (the so-called “Tobin tax”) or on carbon emissions (306-309). The KN will need to consider whether technical evaluation of such proposals is within the scope of its activities, but it is essential to assess the seriousness of the tax competition problem in the context of policies to address SDH.

III.2 Development assistance

Official development assistance (ODA) is often the most visible transfer of resources between rich and poor countries (‘North’ and ‘South’). It is also among the less important terms in the overall picture of global financial flows (Figure 2), ranking below, for instance, the annual value of emigrés’ remittances to their home countries (157) and, for every region of the developing world except sub-Saharan Africa, far below the annual value of debt service payments to external creditors (154). Partly because of the end of the Cold War and associated geopolitical imperatives, overall development assistance (measured as a percentage of donor countries’ GDP) has declined substantially from its 1980s peak. This trend is especially conspicuous among the G7 countries, while a number of smaller European countries have consistently maintained higher ODA commitments over the past two decades. The picture is complicated by the ‘tying’ of aid to purchases (of goods or technical assistance) from donor countries, to the continued practice of linking aid to domestic economic priorities (156), and to the practice of counting the cost of cancelling debt to industrialized world creditors (including export finance corporations) as part of ODA expenditure.

According to many observers, although not all (310), ODA is among the policy instruments with the greatest potential for improving SDH. It is important to recognize that aid is not sent or received by “countries,” but rather by specific agencies, “individuals, groups and classes within them” (311). Even enthusiasts recognize the importance of such issues as “absorptive capacity,” meaning the ability of countries to cope with large infusions of funds and technical expertise (312) and potential diversion of funds. Two recent syntheses (by the UN Millennium Project and the UK Commission for Africa) of available evidence on development progress, and by implication on SDH, each concluded that an approximate doubling of current ODA spending is necessary (albeit not sufficient; see sections III.3 and III.4, below) if much of the developing world, especially sub-Saharan Africa, is to have a chance of achieving the MDGs (with all their imperfections) (155;313). The Millennium Project report, in particular, was also noteworthy for recommending major changes in how ODA spending was directed in order to increase its relevance to the MDGs. It thereby lent support to long-standing criticisms of aid agencies for providing assistance for specific projects rather than as general budget support and for the multiple reporting requirements they demand of

³⁸ Not all agree on the undesirability of tax competition. Thus the Cato Institute (305) concedes that globalization leads to tax competition, but enthusiastically supports this development as a check on taxation and government spending. The cited report does not address population health or SDH issues.

recipients (155, ch. 13). None of the recommended changes should present a major challenge to donor countries or multilateral agencies. The political viability of increases in development assistance, even when the amounts needed are relatively small when compared with routine consumer expenditures in the industrialized world (314), is another matter, but the credibility of such efforts would clearly benefit from the Millennium Project's recommended strategy of identifying both "fast-track" countries and "quick-win" initiatives (155, ch. 16).

Support (or the lack thereof) for health systems is a special concern, especially when viewed against a background of reduced and increasingly inequitable access to health services as a consequence of globalization (Section II.4 above). The Global Fund to Fight AIDS, Tuberculosis and Malaria, announced in 2001 with rhetoric about "a quantum leap in the fight against infectious diseases," estimates that it will need US \$7.1 billion in 2006 and 2007 to fund new proposals and continuations of existing work (315). The September 2005 replenishment meeting raised the total value of funds pledged for 2006-2007 to \$3.73 billion, or just over half the anticipated funding requirement (316) – creating serious constraints on what the Fund can support even after scientific merit has been demonstrated, since the Fund "can only approve grants if the full amount required for the first two years is covered by pledges from donors in the calendar year of the approval" (315, p. 34). Worryingly, the \$7.1 billion estimate of financial need for 2006-07 is less than the *annual* budget recommended for the Global Fund by the Commission on Macroeconomics and Health (1), and the Fund itself now estimates that future funding requirements could be as high as \$7-8 billion per year (313, p. 196; 315, p. 32). It is encouraging that both the UK Commission for Africa (313) and the UN Millennium Project (155) identified increased resources for health systems as a substantial component (in the case of the UK Commission, 36 percent) of the proposed increases in development assistance. Despite potential problems, the current state of expert opinion means that the burden of proof has now shifted decisively to those sceptical about the value of substantial new ODA commitments to show how meaningful improvements in SDH and health equity can be achieved in the absence of such commitments, and to the international community to demonstrate effective mechanisms for making the necessary resources available.

III.3 Debt relief

The seriousness of the 'debt crisis' constraint on the ability of governments to meet basic needs related to SDH was noted in section II.2. Not until 1996, after much lobbying by international CSOs, did high-income countries respond to imperative of providing debt relief in a concerted fashion with the Heavily Indebted Poor Country (HIPC) initiative, expanded in 1999 as enhanced HIPC. The Initiative has so far provided partial debt relief to 27 of the world's poorest countries, with a further 11 eligible. Although it has made possible increases in public spending on such basic needs as health and education in some recipient countries (Gupta et al. 2002), these gains have been limited by factors including a simultaneous decline in ODA and an tendency to count write-offs of arrears as development assistance (152;167, p. 145-148). Furthermore, as of mid-2005 the initiative was still underfunded by about \$12.3 billion, and facing non-participation by many commercial creditors (152, p. 146). One estimate is that half the external debt of the HIPCs will remain unpaid and uncanceled at the conclusion of the initiative, and recipient governments will have at most \$3.2 billion

more per year available for public expenditure (317). Debt relief may simply free up resources to pay other creditors: for example, between 2002 and 2005 almost two-thirds of the revenue freed by debt relief for Zambia under enhanced HIPC went to reduce debts owed to other creditors leaving only a third for investing in poverty-reducing programs including health and education (185). Many HIPCs have seen only modest decreases in their debt service obligations, and three have actually seen *increases* (152, p. 148).

Debt vs. basic needs: This is partly because a “sustainable” debt load is defined for purposes of the HIPC initiative with reference to a ratio of debt service to annual export revenues, based on what have often turned out to be optimistic projections of export earnings and commodity prices. Various refinements of this criterion are now under consideration (152, p. 152-154), but none incorporates the alternative *principle* of working backward from the value of government expenditure required to meet basic needs, and only then determining how much (if any) of the public budget can be devoted to debt repayment (154;318;319) The Millennium Project echoed many earlier critiques in recommending that: “Debt sustainability’ should be redefined as ‘the level of debt consistent with achieving the Millennium Development Goals,’ arriving in 2015 without a new debt overhang. For many heavily indebted poor countries this will require 100 percent debt cancellation. For many heavily indebted middle-income countries this will require more debt relief than has been on offer” (155, p. 207-208). One of the KN’s tasks may involve comparing the details and costs of various proposals to implement such a criterion, the calculations underlying which are now often unpublished.³⁹

Poverty Reduction Strategy Papers (PRSPs): Country governments must prepare a Poverty Reduction Strategy Paper (PRSP) and update it periodically in order to qualify for debt relief under enhanced HIPC and, increasingly, for bilateral development assistance or concessional loans from the World Bank. Placing poverty reduction at the centre of development strategy, and the emphasis on “country ownership” that is ideally part of the PRSP process, are both laudable directions. However, it appears that the lenders that assess PRSPs (in the first instance, the World Bank and IMF) continue to operate on the presumption that development is best achieved through rapid integration into the global economy – the same prescriptions that undermined SDH when they were incorporated into structural adjustment regimes. Direct parallels exist between the PRSP process of qualifying for debt relief and earlier forms of conditionality (97;184); CSOs and international organizations including the United Nations Development Programme and WHO were strongly critical of the neglect of basic needs and health equity issues, including for instance the promotion of user fees for primary health care and education, during the first few years of the PRSP era. More recent studies confirm the continuity of the macroeconomic principles embodied in PRSPs with the earlier era of structural adjustment (183;191;320) and note, for instance, that policy elements of PRSPs may include “trade-related conditions that are more stringent, in terms of requiring more, or faster, or deeper liberalization, than WTO provisions to which the respective country has agreed” (321, p. 20). Further questions involve the effects on public health and education budgets of expenditure ceilings apparently insisted on by the IMF, in particular (107). The emphasis on “country ownership” that is part of the PRSP idea is

³⁹ E.g. CSO calculations (319) on complete or partial debt cancellation for 59 (or 62) countries, based on estimated costs to achieve the MDGs.

unquestionably valuable, but major refinements may be needed in order to realize equitable outcomes if PRSPs are to be linked to eligibility for debt relief, even more so if they are to be used as a template for development policy more generally.

Odious debt: Substantial portions of several countries' external debts were incurred by governments that either systematically looted the public treasury, used public funds (including those supplied by external borrowers) for domestic repression in order to maintain power, or both. Pogge (164) questions on ethical grounds the collectibility of these debts, since the international community need not have permitted illegitimate or larcenous rulers to borrow against the assets and future earnings of their subjects. Other commentators have similarly questioned whether "odious debts" are collectible under international law (322;323). These neglected issues obviously need to be explored in cases where external debt obligations conflict with domestic public expenditure priorities related to SDH.

III.4 Trade policy and market access

Something approaching a new conventional wisdom has grown up around the relation between trade, economic development, and SDH. Organizations otherwise as divergent in their perspectives as Oxfam and the World Bank apparently agree on the value to developing economies, especially the world's poorest countries, of access to industrialized world markets – sometimes citing figures to the effect that annual gains from complete liberalization of trade would amount to several times the value of development assistance (324;325). Agricultural subsidies, which simultaneously lower prices in domestic markets and enable producers to export at artificially low prices, are a special concern; indeed, the industrialized countries' intransigence with respect to reducing these subsidies contributed to the 2003 collapse of what was supposed to be a "development round" of WTO negotiations that took seriously the imperative of economic development. The best the 2005 Hong Kong Ministerial could agree upon was an end-date of 2013 for agricultural export subsidies (three years later than the majority of the WTO members wanted, at the insistence of the EU whose reforms of its Common Agricultural Policy would have eliminated most such subsidies by then anyway); and agreement on the classification of domestic subsidies that will eventually have to be reduced, though more slowly than developing countries (and even the pre-Ministerial draft text) had urged, and with depth and timing issues still to be resolved. Export subsidies for cotton – the bane of West African cotton producers who have already won two WTO disputes against the US on this issue – must end by 2006, but this agreement actually means little, since domestic subsidies account for 80 – 90 percent of total US support to its cotton growers, and these will not be reduced until and unless agreement on the overall package for domestic agricultural subsidies is reached (326;327).

Recently Birdsall and colleagues (310) have questioned the importance of market access; they argued, unfortunately without supporting documentation, that the effects of agricultural subsidies on international prices of commodities such as cotton are far too small to affect the competitiveness of developing country producers in their own or export markets. While reserving judgment on this argument, it must be acknowledged that the relations between agricultural subsidies as defined by OECD and prospects for development are more complicated than acknowledged by many participants in the

debates.⁴⁰ No one-to-one correspondence exists between the value of subsidies, on OECD's definition, and income lost by agricultural producers outside OECD. Although improved market access in the developing world may increase the incomes of agricultural producers who are already part of the cash economy, it is likely to have little benefit for larger numbers of producers who are primarily oriented toward subsistence, with occasional local market sales – the problem of “two agricultures” (329; see also 330). Thus, the entire issue of agricultural trade and SDH thus requires “a more fine-grained approach, which would differentiate among crops and countries” (331, p. 45).

A more general problem is that international trade rules continue to favour concentration of high value-added elements of global commodity chains within the industrialized world. For example if Ghana exports raw cocoa to the EU, it faces a tariff of just 0.5% but if a Ghanaian firm, rather than a European-based food transnational, turns the cocoa into chocolate, it faces a tariff of 30.6% (332). As this example suggests, improved access to developed country markets for manufactured products could yield very substantial income gains for the developing world (126;333). More generally, multiple ironies surround the relation between contemporary trade policy priorities and the ability of developing countries to meet basic needs related to SDH. At a theoretical level, “the arguments advanced in favour of trade liberalization as a way of facilitating learning and productivity growth call for support and protection in the early stages of large scale, specialized enterprises, not full exposure of them to foreign competition” (126, p. 10). This strategy was adopted, with variations, by countries such as China, Korea and Vietnam that are now held up as exemplars of the benefits of globalization: they opened up their markets to imports selectively as their previously protected industries matured, and adopted intellectual property regimes that favoured domestic producers, just as European and North American countries had done a century earlier (310;334;335). Not only current bilateral and multilateral trade agreements but also informal pressure from the industrialized world may now preclude similar development strategies by later industrializers (336;337).

Two sets of superficially technical issues, which are not the only two that matter in this context, suffice to illustrate the importance of careful evaluation of the relation between trade policy and SDH, as measured both at the level of national economic performance and in terms of differential effects on specific groups. First, Special and Differential Treatment (SDT) has been a feature of the world trading system since the early postwar years, and offers important opportunities for leveling the playing field between rich and poor countries. However, the SDT provisions of GATT were seriously weakened, in terms of their value for developing economies, with the advent of the WTO. Intense lobbying by African and Asian countries led to a commitment by WTO members in 2001 to review ‘all Special and Differential provisions...with a view to *strengthening* them and making them more precise, effective and operational’ (338, ¶144, emphasis added). But what should count as strengthening? The fundamental question is whether SDT provisions should be considered temporary measures to facilitate the integration of developing economies into today's trade policy regime, or whether “the bottom-line question for the WTO should be what it can do to facilitate development, not what it is willing to allow to ease adjustment” (339, p. 300). Unfortunately, the Hong Kong Ministerial failed to offer much clarification on this point. While the Ministerial Declaration creates a new developed country obligation to provide

⁴⁰ This discussion draws, in particular, on (204;328;329)

duty- and quota-free market access to all goods from least developed countries (LDC) by 2008, it also allows developed countries that “face difficulties” in doing so (meaning stiff competition with their domestic goods) to restrict this to 97 percent of tariff lines. The remaining 3 percent on which developed countries could erect border barriers could conceivably be used to block product areas that account for almost all of an LDC’s exports. Agreement was reached to proceed with a so-called “Swiss Formula” for reducing tariffs on non-agricultural products, which requires less-than-full-reciprocity in reduction commitments from developing countries but nonetheless denies them the opportunity to raise or lower tariffs over time across different sectors as they develop their domestic capacities. Further concerns arise from the proliferation of bilateral and regional trade negotiations and agreements (340, ch. 2), where disparities in bargaining power and resources may be even more glaring; “WTO-plus” provisions emerging from these settings may vitiate the gains in terms of market access and domestic policy flexibility that African countries, and others in the developing world, are able to secure within the WTO framework (341).

Second, the emergence of institutions and norms of global governance related to human rights raises the question of how potential tensions and conflicts with international trade policy and law will be resolved. The final (2003) report of the United Nations’ Special Rapporteurs on globalization and human rights concluded that “it is necessary to move away from approaches that are ad hoc and contingent” in ensuring that human rights are not compromised by trade liberalization (342, ¶25). The increasing salience of the right to health within international political institutions is shown by the appointment in 2002 (renewed in 2005) of a UN Special Rapporteur on the right to health, whose first report adopted an expansive approach focussed on “two interrelated themes: the right to health and poverty ... and the right to health, discrimination and stigma” (34). A subsequent addendum to the report that dealt specifically with the WTO regime recommended *inter alia* “that urgent attention be given to the development of a methodology for right to health impact assessments in the context of trade” (35, ¶74). Arguably, the challenge of right to health assessments is best viewed as part of the larger imperative of balancing the objectives of trade agreements and other social objectives such as poverty elimination (72). The need for such a balance is implied by widespread references to the trade negotiations that began in 2001 as a “development round,” yet achieving it is likely to require “a fundamental departure from the system of mercantilism [in trade negotiations] towards a collectively agreed global social welfare function. However, there has been almost no discussion, let alone agreement, on what that function should be” (343, p. 496).

III.5 Global public goods for health (GPGH) ⁴¹

In common use, the phrase “public good” is often associated with the common welfare, or with such value-based goals as social equity, social justice and environmental sustainability. Its definition in economic theory is more precise: a *private good*⁴² is one whose individual consumption is both excludable (my use of the good is not dependent on others’ use) and rivalrous (my use of the good could preclude use by another). Conversely, a *public good* is one that is non-excludable (the classic illustrations are the

⁴¹ Portions of this section of the paper are adapted from (71).

⁴² “Good” here usually means a service rather than a good in the physical sense.

order created by traffic lights and, from the days before GPS, the safety benefits of lighthouses) and, in pure form, is non-rivalrous (my use of the traffic light or lighthouse in no way impairs your use of it). Although health itself is not generally regarded as a public good, there are numerous public goods *for* health, with control of communicable diseases and the production of knowledge in the health sciences being the paradigmatic examples. Both would be drastically undersupplied if provision were left entirely to private markets. Few pure public goods exist, and public policy choices, which may vary over time, often determine the balance between private and public characteristics of a good (344;345). Sound equity-related reasons may exist for treating “goods” related to health – for example, public health infrastructure – *as if* they were public goods: thus, public health infrastructure can be considered “a foundational access good required to enable consumption of” other public goods for health (346, p. 9-15; 347). (Access goods are goods or services that are required to take advantage of a public good, such as GPS receivers in the case of satellite navigation signals or access to immunization in the case of communicable disease control).

Within national borders, a more or less well established machinery of government exists for making such choices. The choices are not always equitable and mechanisms of decision-making and implementation are not always effective. Internationally, the lack of a global government means that many kinds of public goods relevant to health are seriously undersupplied, raising important issues of health equity. A recent effort by WHO to identify GPGHs (45) concluded that many public goods for health are regional, rather than global,⁴³ and opted for a strategy emphasizing “three broad areas: the production, dissemination and use of knowledge; policy and regulatory regimes; and health systems, which are key *access goods*” (349, p. 270-1, emphasis in original). Policy and regulatory regimes are of special importance to SDH, as “intermediate GPGs” that provide some of the functions of a supranational government by way of international agreement and coordination (350). The Framework Convention on Tobacco Control (FCTC) arguably represents such an intermediate GPGH, and one of the first legally binding international health agreements that could, if ratified, become a model for future ‘global health governance’ strategies – perhaps in the area of diet and nutrition.

International legal regimes and instruments (treaties and other forms of international agreement) are potentially even more significant in other areas superficially unrelated to health. For instance, the consequences of financial crises for SDH underscore the need for new institutional arrangements to maintain international financial stability (351;352). Arguably, financial stability represents a public good (353); almost beyond dispute is the fact that achieving it will require more robust and effective structures of multinational governance than are now available. Finally, since scientific knowledge is a quintessential public good⁴⁴, a need exists for substantial increases in the global budget for research on diseases of the poor, who do not constitute a market that offers rates of return high enough to attract private financing (293), and on public health policy measures that are intrinsically not amenable to commercialization.

⁴³ As in the case of malaria control (348, p. 23).

⁴⁴ Unless access is restricted by mechanisms such as intellectual property rights, financial barriers such as the cost of journal subscriptions, or lack of information infrastructure.

IV. Next steps: the Knowledge Network work plan

At the first meeting of the Globalization Knowledge Network (Ottawa, February 2-4, 2006), it was agreed that the following list of research syntheses would comprise the major input into the work of the KN.

A. Globalization and socially determined health conditions and risks

1. Interrogating the evidence base for recent globalization links with income, wealth, health convergence/divergence ⁴⁵
2. Globalization and innovations in global governance for the social determinants of health

B. Key processes of globalization that affect social determinants of health

3. National and international labour markets and social determinants of health
4. Trade liberalization
5. Financial liberalization, financial crises, global financing, and governance

C. Key health determining services/resources

6. Impacts of globalization on policy space, political structures and processes
7. Globalization and health systems change (health reform)
8. Health human resources and global migration
9. Globalization and food/nutrition transitions
10. Water and sanitation

However, at this writing the list of papers is still being finalized, and further modifications are possible. The reader is further cautioned that nothing should be inferred from the omission of particular topics or regions from this list, because a considerable amount of overlap exists between the remit of the Globalization KN and other KNs, notably those addressing urban settings, health systems, gender, and employment and working conditions. The process of developing work plans that will ensure comprehensiveness and appropriate transdisciplinarity while minimizing duplication of effort is still under way.

⁴⁵ It was provisionally decided to fold a previously proposed paper on globalization and social determinants of health in eastern Europe and the former Soviet Union into this paper, although writers' group responsible for this paper may propose once again dividing the tasks into two papers as its planning proceeds over the coming weeks. Focus on the experience of this particular region was initially proposed in response to a specific request by one of the Commissioners.

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