Introduction: The Best of Times, the Worst of Times?

Contradictions abound in today’s global health policy landscape. The UN General Assembly’s commitment to achieving the Millennium Development Goals (MDGs) represents a ‘first’ in terms of international agreement on a specific development agenda. Three of the MDGs are explicitly health-related, and four others directly address crucial social determinants of (ill) health. In 2005, health was central to two high-profile syntheses of research evidence on development policy: the reports of the Commission for Africa, set up by the British government in advance of the Gleneagles G8 Summit, and the UN Millennium Task Force (UN Millennium Project, 2005; Commission for Africa, 2005). Among other findings, each report called for an approximate doubling of the industrialized world’s development assistance spending, notably on health-related objectives. At the very least, these two reports have shifted the burden of proof away from those who advocate increased development assistance, assigning it instead to sceptics who invoke the limited “absorptive capacity” of recipient countries (which is, in large measure, itself a consequence of past resource scarcities) or insist that health systems and social provision must be “sustainable” in the sense that they do not rely on external resources.1

1 An overview of these and similar positions is provided by Schieber et al. (2006). For critical analyses see e.g. Paluzzi & Farmer (2005); Ooms (2006). Underlying the arguments of some
Against the background of the simple arithmetic of limited resources in developing countries,² the sceptics should now explain how meaningful improvements in population health can be achieved in the absence of such financial transfers.

These developments are just part of a broader shift in policy analysis and research orientations away from equating health with health care, and toward examining their origins in social and economic situations that make it easy for some to protect their health, and all but impossible for others. In 2005 the World Health Organization established a multinational Commission on Social Determinants of Health, defining these to include unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems. The Commission has provisionally adopted health equity, “defined as the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically,” as “a cornerstone for the Commission’s normative framework” (Solar & Irwin, 2005:4-5). This step is noteworthy not only for its content, but also for its clear statement of substantive values, as distinct from process criteria like Daniels’ principles of accountability for reasonableness (Daniels, 2000).

The MDGs, however, are modest when measured against the sheer magnitude of unmet basic need.³ Leaving aside problems in measuring progress towards the Goals and associated targets (Attaran, 2005), the progress that can be measured has been uneven; especially in sub-Saharan Africa, the MDGs are unlikely to be met (Wagstaff et al., 2003; World Bank &

² Economist Jeffrey Sachs, who chaired the Millennium Project, estimates that sub-Saharan countries where incomes are low and government institutions are weak might be capable of generating US$50/capita in total public revenue. “This tiny sum must be divided among all government functions .... [T]he health sector is lucky to claim $10 per person per year out of this, but even rudimentary health care requires roughly four times that amount .... Foreign aid is therefore not a luxury for African health. It is a life-and-death necessity” (Sachs, 2007). The argument is not relevant only to sub-Saharan Africa, although that region has been the focus of Sachs’s recent research.

³ The MDG poverty reduction target involves reducing by half between 1990 and 2015 the proportion of the world’s people living below the World Bank’s contentious $1/day poverty line (actually, about $1.50 in today’s funds). Philosopher Thomas Pogge (2004) has commented on the modesty of this target when viewed against a background of expanding global affluence. Another MDG target involves improving the lives of 100 million slum dwellers per year by 2020, yet it is estimated that if present trends continue, 1.4 billion people worldwide will be living in slums in that year (UN Millennium Project Task Force on Improving the Lives of Slum Dwellers, 2005).
International Monetary Fund, 2007). Since many health-related MDG targets are stated as national averages, a country might attain them without improving the situation of the most disadvantaged groups (Moser et al., 2005; Gwatkin, 2005). The World Bank estimates that the number of people living in absolute poverty, surely the most basic barrier to minimal good health, has declined worldwide from 1.2 billion in 1990 to approximately 1 billion today (World Bank, 2007b; accessed May 5, 2007). However, questions have been raised both about the quality of data supporting the World Bank’s estimates of poverty trends and about the realism of its definition of absolute poverty, especially in the major metropolitan areas where a growing proportion of the world’s people live (Satterthwaite, 2003; Reddy & Pogge, 2005).

Rhetoric aside, preliminary figures show that development assistance spending in 2006 fell relative to 2005, a year in which spending was inflated by one-shot debt relief for Iraq and Nigeria (OECD, 2007). High levels of foreign debt have been recognized for at least 20 years as a constraint on the ability of developing country governments to meet basic needs, yet in every region of the developing world except sub-Saharan Africa the annual cost of servicing external debt far exceeds receipts from development assistance (Labonté & Schrecker, 2007:figure 2). The international community, if there is such a thing, has yet to endorse an algorithm for debt cancellation that assigns priority to meeting basic needs rather than repaying creditors. Development assistance continues to be reduced to countries that are receiving long-overdue debt relief under the 2005 Multilateral Debt Relief Initiative, even as that initiative continues to exclude many heavily indebted countries where poverty is high and access to health services is limited (Hurley, 2007). And whatever criticisms have been made of how the Global Fund to Fight AIDS, Tuberculosis and Malaria operates, it is discouraging that the industrialized world’s flagship global health initiative remains seriously underfinanced (Banati et al., 2006; Global

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4 As our colleague David Sanders points out, in sub-Saharan Africa the high percentage of many government budgets accounted for by development assistance means that any drain on scarce financial resources to service external debt represents a serious constraint. This is not true only of sub-Saharan Africa, yet countries like Haiti continue to be ineligible even for the inadequate debt relief initiatives that have become available since the mid-1990s.

5 For illustrations of such algorithms see Hanlon (2000) and Mandel (2006), and cf. the Millennium Project recommendation that: ‘‘Debt sustainability’ should be redefined as ‘the level of debt consistent with achieving the Millennium Development Goals,’ arriving in 2015 without a new debt overhang. For many heavily indebted poor countries this will require 100 percent debt cancellation. For many heavily indebted middle-income countries this will require more debt relief than has been on offer” (UN Millennium Project, 2005: 207-208).
Fund, 2007; Godfrey & Greene, 2007), lacking any guarantee of stable long-term funding and reliant on periodic replenishment meetings where it in effect passes around a hat.

**The Global Marketplace**

Understanding these contradictions, the ethical challenges they present, and the barriers to meaningful policy responses requires recognizing the crucial role played by globalization: specifically, the construction and emergence of a global marketplace. Rich and poor societies alike have been transformed by “a process of greater integration within the world economy through movements of goods and services, capital, technology and (to a lesser extent) labour, which lead increasingly to economic decisions being influenced by global conditions” (Jenkins, 2004:1) – the definition of globalization adopted by the Globalization Knowledge Network of the Commission on Social Determinants of Health. In a forthcoming paper we describe seven, often interconnected elements of globalization that influence social determinants of health: trade liberalization; global reorganization of production and its effects on labour markets; debt crises and resulting pressures for marketization; liberalization of financial markets; restructuring of cities in response to the demands of the global marketplace; changing environmental exposures and demands for natural resources, including locational resources; and marketization of health systems (Labonté & Schrecker, in press a). Here, we identify some features of the global marketplace that are especially important as background for ethical analysis and policy choices.

Perhaps the most basic feature is the “asymmetry” of economic relationships, both within and across national borders, in the global marketplace. Nancy Birdsall, a former World Bank economist who now directs the US-based Center for Global Development, has identified three dimensions of this asymmetry:

- Global markets reward more fully those countries and individuals with more of the most productive assets. (Call this, for simplicity, the market works.)
- In the global economy, negative externalities raise new costs or the vulnerable and compound the risks faced by the already weak and disadvantaged. (Call this, for simplicity, the market fails.)
- In the global economy, existing rules tend to benefit most those countries and individuals who already have economic power. It is natural that the richer and more

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6 The authors are respectively Hub coordinator and chair of this Network. However, all views expressed here are exclusively their own and not those of the Network’s membership, the Commission on Social Determinants of Health or WHO.
powerful manage to influence the design and implementation of global rules – even those rules meant to constrain them – to their own advantage (Birdsall, 2006: 22; see 22-32 for elaboration).

This analysis is accurate and perceptive, yet disturbingly bloodless in that it fails fully to reflect the lived reality of contrasts between abundance and poverty, security and marginalization, both within and across national borders as these contrasts arise from what she calls the “disequalizing” effects of global markets. To give just two examples, such contrasts are central features of the cross-border trade in organs for transplant compellingly described by Nancy Scheper-Hughes (2004) and the buyer-driven commodity chains that are an important element of the new global economic architecture. At the top of these commodity chains are large transnational corporations whose buying power enables them to force suppliers into relentless price competition, often on the basis of cutting labour costs and making employment arrangements more flexible, while the rewards accrue to rich country consumers and shareholders of firms like Wal-Mart, Tesco and Nike. In analytical terms, vulnerability and subordinate status in the global marketplace connect organ sellers in the Philippines; women working in export-oriented garment production and agriculture in India, Mexico or Kenya; former assembly line workers in the US who, post-deindustrialization, work 15-hour days without health insurance delivering mail (Witte, 2004); and others in high-income economies trapped in low-wage, often precarious service sector jobs (Ehrenreich, 2001). For purposes of ethical reflection and policy analysis, the macro-level perspective adopted here is therefore a valuable complement to the ethnographic research and clinicians’ field experience that are essential to comprehending the relevant vulnerabilities ‘on the ground’.

Contemporary (roughly, post-1973) globalization did not ‘just happen’. Rather, it must be understood as resulting from the interaction of technological change and policy choices by the governments of the world’s richest countries (Marchak, 1991; Gershman & Irwin, 2000). This interaction in the United States, the high-income economy hit first and hardest, was

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7 For descriptions and illustrations see e.g. Donaghu & Barff (1990); Korzeniewicz (1992); Gereffi & Korzeniewicz, eds. (1994); Ross, ed. (1997); Raworth (2004); Buechler (2004); Bronfenbrenner & Luce (2004); Milberg (2004); Hearson & Eagleton (2007).

8 A date that represents the start of the first oil supply crisis, the resulting impacts on industrialized economies, and the investment of ‘petrodollars’ in high-risk loans to developing countries that contributed to the early stages of the developing world’s debt crises. However, identifying a precise starting point is less important than recognizing that some time in the early 1970s the world economic and geopolitical environment changed decisively, so that (for instance) by 1975 the Trilateral Commission was warning of a “Crisis of Democracy” in the industrialized world (Crozier et al., 1975).
captured in a Business Week feature on job losses associated with corporate downsizing: “A global economy, rousting American employers from business-as-usual management, demands such change; rapidly evolving technology allows it” (Hammonds, 1994:77). Some other high-income economies were able to respond to the new environment differently, but none was able to ignore it. The debt crises that confronted many developing economies starting at the end of the 1970s, which were themselves embedded in new forms of economic interconnectedness, gave the economic superpowers an opportunity to export and promote the global marketplace on terms advantageous to investors and financial institutions based within their own borders.

“An alliance of the international financial institutions, the private banks, and the Thatcher-Reagan-Kohl governments was willing to use its political and ideological power to back its ideological predilections” (Przeworski et al., 1995:5; see also Woods, 2006). In particular, structural adjustment programs that responded to conditions attached to loans from the World Bank and the International Monetary Fund (IMF) involved domestic policies of privatization, deregulation, removal of subsidies for such essential goods as food and fuel, and reorganization of economic priorities around enhancing the competitiveness of exports. Viewed through the conceptual lenses of contemporary North American bioethics, such programs look a lot like large-scale social experiments on non-consenting populations, often with demonstrably damaging effects on their health and well-being (e.g. Cornia et al., eds., 1987; Sparr, ed., 2000; Breman & Shelton, 2001).

In 1990, economist John Williamson described a “Washington Consensus” on the acceptable elements of macroeconomic policy in the developing world (Williamson, 1990); the term reflected the role of US as leading promoter of the global marketplace. The consensus incorporated *inter alia* fiscal discipline; tax ‘reform’; financial and trade liberalization, notably including openness to foreign direct investment; privatization of state enterprises and deregulation of domestic markets. By 1993, Williamson acknowledged the ideological dimensions of the consensus and its relation to underlying power structures, noting that he had “deliberately excluded from the list anything which was primarily redistributive, as opposed to having equitable consequences as a byproduct of seeking efficiency objectives, because [he] felt the Washington of the 1980s to be a city that was essentially contemptuous of equity concerns” (Williamson, 1993: 1329). He was right of course, and this primary concern with

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9 Cf. Przeworski’s observation (1993:51) that: “Every time I apply for a government research grant, I am required to sign a form declaring that I will not experiment on human subjects. I wish governments had to do the same.”
economic efficiency, at least as rhetorical cover for the objective of maximizing returns to private investors whatever the social costs, continues to define much of the context for development policy. Likewise, the geopolitical influence and military power of the United States and a limited number of allies remain central to supporting and (where necessary) coercing globalization. New York Times writer Thomas Friedman is unapologetic about the enforcer role. “The hidden hand of the market will never work without a hidden fist – McDonald’s cannot flourish without McDonnell Douglas, the builder of the F-15 [jet fighter aircraft]. And the hidden fist that keeps the world safe for Silicon Valley’s technologies is called the United States Army, Air Force, Navy and Marine Corps .... Without America on duty, there will be no America Online” (Friedman, 1999). Friedman’s understanding of globalization is actually more nuanced than these macho posturings would imply, but they do help to explain why recognition of the United States as an imperial power in the nineteenth century sense is now firmly established in the mainstream of social scientific commentary (see e.g. Falk, 2004).

Globalization increases economic inequality: in other words, it magnifies the asymmetries that make the global marketplace problematic in the first place. The global labour market created by the reorganization of production across multiple national borders widens disparities in labour incomes and economic opportunities between those who have or can acquire globally valuable and relatively scarce skills (‘human capital’) and other labour market participants who do not or cannot. This phenomenon has been accentuated by the approximate doubling of the global labour force as a result of the recent integration of India, China and the transition economies, which is credited by some observers with exerting worldwide downward pressure on wages (Woodall, 2006). Trade liberalization has accelerated global reorganization of production, but a new international division of labour instantiated by the relocation of labour-intensive textile and garment manufacturing to low-wage export processing zones was described 20 year ago, long before the completion of the Uruguay round and the establishment of the World Trade Organization (Fröbel et al., 1980; German publication 1977).

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The World Bank, which is normally a reliable cheerleader for globalization, nevertheless anticipates in its 2007 *Global Economic Prospects* report that the operation of labour markets will increase economic inequality in countries accounting for 86 percent of the developing world’s population over the period until 2030, with the “unskilled poor” being left farther behind (World Bank, 2007a:67-100) just as they were in previous decades by the changing labour markets of the industrialized world (Nickell & Bell, 1995). Conversely, in some industrialized countries a new stratum of the “working rich,” defined at least in part by the global marketability of their human capital, is emerging at the very top of the economic pyramid (Duménil & Lévy, 2004; Piketty & Saez, 2006) even as the labour incomes of the majority of the population stagnate or decline and insecurity becomes pervasive (Mishel et al., 2007; Yalnizyan, 2007). This stylized description neglects shifts in national income shares from labour to capital that can be attributed at least in part to globalization’s downward pressure on wages, but suffices to make the point.

Apart from direct effects on income, globalization shifts power and influence to owners of internationally mobile financial assets. The shift can be illustrated with two examples, each interestingly enough drawing on observations by Williamson. Recent studies indicate that because of very high levels of income inequality in Latin America, even modestly redistributive policies would be more effective in reducing poverty than many years of solid economic growth (Paes de Barros et al., 2002; de Ferranti et al., 2004). Effects on social determinants of health would be even more substantial if poverty reduction by way of direct transfers were complemented by policies to improve access to publicly financed education and health care. Williamson observes that although “levying heavier taxes on the rich so as to increase social spending that benefits disproportionately the poor” is conceptually attractive, “it would not be practical to push this very far, because too many of the Latin rich have the option of placing too many of their assets in Miami” (Williamson, 2004:13). Opportunities for capital flight constrain domestic policy by giving the owners of such assets multiple votes, not just one.

On more general questions of macroeconomic policy, Williamson claimed in 2002 that the basic elements of the Washington Consensus “have continued to gain wider acceptance over the past decade, to the point where Lula has had to endorse most of them in order to be electable” (Williamson, 2002). But why? Development policy scholar Peter Evans points out that investor apprehensions led to a 40 percent decline in the value of Brazil’s currency before the elections that brought the Workers’ Party (PT) to power. After the elections, “[t]he PT
chose to suffer low growth, high unemployment and flat levels of social expenditure rather than risk retribution from the global financial actors who constitute ‘the markets’ (Evans, 2005:196; citation omitted).\textsuperscript{11} The experiences of Mexico in 1994-95; Thailand, South Korea and Indonesia in 1997-98; and Argentina in 2001-02 show how drastic that retribution can be: “swift, brutal and destabilizing,” as the IMF’s managing director said in the aftermath of the Mexican crisis (Camdessus, 1995).

Acceptance of market-oriented policies combined with no more than incremental redistribution looks like a technical choice that is ethically and politically neutral: they are the only ones that ‘work.’ This appearance of neutrality obscures a far-reaching redefinition of citizenship rights, which are increasingly held not by individuals as members of a polity but rather by transnational corporations and players in the global financial markets by virtue of their property rights. “These markets can now exercise the accountability functions associated with citizenship: they can vote governments’ economic policies in or out, they can force governments to take certain measures and not others” (Sassen, 2003:70; see generally Sassen, 1996). To some degree, investors have always had this power within a market economy, but the stage on which that power can be exercised is now global rather than national. This shift in scale has crucial implications for the outcome of distributional conflicts.

**Health in the global marketplace**

Much is now known about how to reduce the worldwide toll of readily preventable illness and death among the poor and otherwise marginalized. Spending an estimated $5.1 billion annually to make a core set of 23 treatment and prevention interventions universally available in countries where 90 percent of child deaths occur, along with making the additional investments needed to provide or rebuild the associated health system infrastructure, could prevent the death of six million children under five each year (Bryce et al., 2005). WHO’s Commission on Macroeconomics and Health estimated that routinely providing basic interventions costing $34 per person per year and comprising “a rather minimal health system” could save “at least 8 million lives each year by the end of this decade” (Commission on Macroeconomics and Health, 2001; emphasis in original). Compare this $34 figure with the fact that in countries where more...

than a billion of the world’s people live, annual per capita spending on health is $14 or less (World Bank Health, 2007; accessed May 9, 2006) – and much of that spending does not benefit the poor, however defined. Like Birdsall’s discussion of asymmetry, these statistics are bloodless; they need to be understood on conjunction with (for example) Paul Farmer’s eloquent descriptions of clinical practice in Haiti, Mexico and Russia (Farmer, 2003). At the risk of grotesque oversimplification, such observations and similar ones that identify (for example) the roughly 800 million people whose health is compromised by chronically insufficient caloric intake (United Nations Food and Agriculture Organization, 2006) are ethically significant for at least two reasons.

First, the persistence of unmet basic needs in a world of unprecedented abundance, where the resources available to a rich global minority for discretionary consumption sometimes appear limitless, may be regarded as sufficient in itself to create an obligation to reallocate resources and redesign policies in order to give priority to meeting basic needs. Philosopher Henry Shue (1996:10) has captured this argument succinctly with the observation that: “One person’s desire for an additional jar of caviar is not equal in urgency to another person’s need for an additional bowl of black beans.” Whether the context is limited by national borders or transcends them, the key element here is the ethical priority of needs over wants in authoritative resource allocations … and the wants in question include those satisfied by the £5 billion widening of Britain’s M1 motorway (Jowit, 2007) and the destructive US military adventure in Iraq, now estimated to cost $200 billion a year (Leonhardt, 2007).

Second, an increasingly dense web of trade and investment flows and policy influences that are the defining characteristic of globalization links rich and poor across national borders. The operation of those flows and influences is a logical starting point for identifying past and current causal responsibility: who makes what happen, how, and to whom? This observation is at the core of Thomas Pogge’s argument about responsibility for the global persistence of poverty (Pogge, 2001; Pogge, 2002; Pogge et al., 2005), which can apply with similar force to other forms of disadvantage that have consequences for health. “Given these connections,” concludes Pogge, “our failure to make a serious effort toward poverty reduction may constitute not merely a lack of beneficence, but our active impoverishing, starving, and killing millions of innocent people by economic means” (Pogge, 2001:15).

The arguments are not elaborated here with the academic thoroughness philosophers would demand. Specifically, we have not examined the nature of obligations to others who are
separated from ‘us’ by national borders as well as chasms defined by economic abundance and scarcity, although we return to this issue briefly at the end of the paper. In the global marketplace, such arguments do not matter very much. Individuals, populations and indeed entire countries are important only by virtue of, and in proportion to, their role as actual or potential producers, consumers or locations for natural resource extraction. “[P]eople merely surviving in places like Bangladesh and across vast stretches of Africa are superfluous from the standpoint of the market. By and large, we don’t need what they have; they can’t buy what we sell” (Gardels, 1993). The author of this comment might have added that, as sources of low-cost labour, they are potentially valuable but also largely interchangeable and in abundant supply. Especially in a rapidly urbanizing world, it is worth emphasizing that "superfluous" populations are not necessarily separated from us by physical distance or national borders. Manuel Castells has argued that districts whose residents are not part of the “process that connects advanced services, producer centers, and markets in a global network” can become “irrelevant or even dysfunctional: for example, Mexico City’s colonias populares (originally squatter settlements) that account for about two thirds of the megapolitan population, without playing any distinctive role in the functioning of Mexico City as an international business centre” (Castells, 1996:380-381). Thus, globalization means large metropolitan areas will contain substantial “local populations that are either functionally unnecessary or socially disruptive” (Castells, 1996:404). Generalizing from this example is precarious: not all metropolitan areas integrate into the global economy in the same way. Nevertheless, multiple forms of enclave development characterized by radical divisions between the included and excluded, of the kind brilliantly identified by Ferguson (2005) in his discussion of extractive development in Africa, are likely to be characteristic of contemporary globalization in the future even more than in the present.

In the global marketplace, the most immediate concern for most governments is not how to meet the basic needs of the “functionally unnecessary,” but rather how to keep them from getting in the way of progress, at minimal cost. Concretely, this may involve clearing out the poor from valuable locations in order to build new housing and offices for more desirable residents and users, as defined by income and connection with the new economy. This goal

12 It is also one of the core questions for a research network on Health in an Unequal World: Global Ethics and Policy Choices, funded by the Canadian Institutes of Health Research, on which the authors are both principal investigators.
has been accomplished with bulldozers in Mumbai (Appadurai, 2000; Lakshmi, 2005) and, in somewhat less dramatic fashion, in cities in the industrialized world where gentrification and the creation of tourism and entertainment destinations have become primary development strategies. Official responses to Hurricane Katrina may represent an attempt to use the storm’s devastation to achieve the same results as Mumbai’s bulldozers. Alternatively, social policy regimes may acknowledge that the best economic future many people can anticipate is “no more than getting by,” and seek their acquiescence using disincentives: jail or an existence “so uncomfortable that any job will be preferable to it” (Murray, 1984:176-7). This was the recommendation of Charles Murray, an intellectual progenitor of Clinton-era US welfare ‘reforms’ which are perceptively compared to structural adjustment programs in at least one recent article (Schleiter & Statham, 2002). Murray proposed a scaling back of social provision more radical than what was eventually implemented: cutting off all economic transfers of any kind, including the Medicaid program of health insurance for the extremely poor, to working age adults (pp. 227-8).

The term “market fundamentalism,” ironically coined by George Soros, is appropriate in this context (Somers & Block, 2005). So, too, is privatization: an insightful discussion by two Canadian legal scholars (Fudge & Cossman, 2002) expands the concept to include not only as the sale of state assets, but formal policies and officially promoted but informal norms related to responsibility for social provision. Political scientist Jacob Hacker (2004) has specifically identified “privatization of risk” as an element of welfare state retrenchment in the US; it is evident although less advanced in many other high-income countries as well. Outside the industrialized world, a more explicitly fundamentalist view is evident in the World Bank’s

13 These actions arguably reflect national priorities that led the authors of a recent United Nations Development Programme report to comment that: “Were India to show the same level of dynamism and innovation in tackling basic health inequalities as it has displayed in global technology markets, it could rapidly get on track for achieving the MDG targets” (United Nations Development Programme, 2005:30-31).

14 Important material on the North American context is provided by Fainstein & Judd (1999); Eisinger (2000); McCarthy (2002); Smith (2002); Newman (2002); Hollands & Chatterton (2003); Newman (2004) and many other sources. In Britain, note the Thatcher government’s establishment of the London Docklands Development Corporation, in part to overcome resistance from the local council to its chosen approach to waterfront redevelopment. “[T]here was a fundamental conflict about the kind of area that [Southwark] would be. The council’s priorities were to preserve traditional land uses and activities employing the existing working-class population; LDDC, however, saw the future in terms of an informational economy and was determined to attract jobs in activities serving this and to build homes for the predominantly middle-class people who would work in it” (Buck et al., 2002:64).
remarkable social protection sector strategy document, which advocates “a new conceptualization of social protection that is better aligned with current worldwide realities” (Holzmann & Jörgensen, 2001:1). The Bank defines the goal of social policy not as provision for basic needs, still less with reference to Marshallian notions of social citizenship, but rather as social risk management: helping households “to smooth their consumption patterns” in response to exogenous events ranging from natural disasters to financial crises (Holzmann & Jörgensen, 2001:vii-ix). The initial presumption is that: “In an ideal world with perfectly symmetrical information and complete, well-functioning markets, all risk management arrangements can and should be market-based (except for the incapacitated) (Holzmann & Jörgensen, 2001:16). Governmental intervention to help the non-incapacitated poor is justified only when market failures arise from the fact that poor households “are more vulnerable than other population groups because they are typically more exposed to risk and have little access to appropriate risk management instruments” (Holzmann & Jörgensen, 2001:p 10). Further research on how the Bank’s perspective on social protection has actually influenced national policies would be useful, especially since the Bank has only recently begun a retreat from market fundamentalism, dating back to the mid-1980s, in its approach to health system design and health insurance.16

Global obligations, global evasions?

The context for contemporary global health policy, then, is one in which individuals, households, and national economies are expected to ‘earn their keep’ in the global marketplace; the shift of power from polities to investors creates pressure for policy convergence toward what political scientist Philip Cerny has called a competition state. Along with minimizing the drag on progress created by the functionally unnecessary, “[t]he main focus of the competition state is the promotion of economic activities, whether at home or abroad, which will make firms and sectors located within the territory of the state competitive in international markets” (Cerny, 2000:136). These activities should be taken to include education policies that provide a work force with the marketable skills necessary to attract and retain investment in the so-called knowledge economy. To the extent that health is considered relevant at all, the underlying

15 As noted earlier, it is essential to recognize that such “realities” are in fact created by the actions and expectations of investors newly empowered by seamless global financial markets.
16 For a critical overview see Lister (2005).
presumption, despite authoritative warnings from such scholars as Angus Deaton (2006), appears to be that over the long run health will improve with economic growth, and that short-run declines in health status must be accepted as the price of progress. This raises an important ethical question: how long is too long for the losers to wait for the (presumed) benefits? An odd reticence to address this question is evident in most academic literature and in official pronouncements. Meanwhile, ways of making the case for global health while not directly challenging the values of the global marketplace have achieved increasing prominence.

In 2001, the Commission on Macroeconomics and Health called for a several-fold increase in development assistance for health, arguing that in addition to being an intrinsic value improved health is also a potential contributor to economic development (Commission on Macroeconomics and Health, 2001). Low-cost measures to improve population health can lead to a virtuous circle of increased earnings and reduced risk of “medical poverty traps” (Whitehead et al., 2001) at the household level, corresponding to higher economic growth at the regional or country level. This position is reinforced by estimates of the drag on economic growth associated with, in particular, malaria and HIV/AIDS (Sachs & Gallop, 2001; Brown, 2004). Thus “investing in health for economic development,” the subtitle of the Commission’s report, entered the policy lexicon and became a theme of WHO activity … but appears to have had limited influence on development policy more generally. Development assistance for health has increased, from $6 billion at the start of the decade to roughly $12 billion in the most recent year for which figures are available, but is not close to the $22 billion expenditure on country-level programs alone by 2007 that the Commission recommended.

17 A position that has been stated explicitly with reference to the transition economies of central and eastern Europe by a team of World Bank economists (Adeyi et al., 1997).
18 An important exception is the statement 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” (Gomory & Baumol, 2004:430).
19 Such estimates are highly imprecise, and in some conditions and countries the impact of disease on economic growth may actually be positive, as noted below with respect to the case of AIDS in South Africa.
20 Existing mechanisms for delivering assistance are far less effective than they could be in many respects, which are not further explored here as this is an administrative question not central to our argument.
The shortfall in development assistance may be explained by the fact that economic development outside a donor country’s own borders is not in itself a high priority unless benefits to domestic constituencies can be identified with some credibility. This is the core conundrum of development assistance policy in general. A more basic ethical problem with the concepts and vocabulary of investing in health is that they leave open the question of whose health to invest in, and why. Economically, some people’s health is much more important than others’, based e.g. on individuals’ future prospects as workers or consumers. Stated another way, dramatic variations in the rate of return on investments in health can be anticipated depending on how priorities are set. Although more research is needed on the extent to which such triages operate in national health policy, scholar-activist Patrick Bond argues that they provide part of the explanation for the South African government’s notorious intransigence with respect to providing antiretroviral therapy: AIDS is, after all, “killing workers and low-income consumers at a time when South African elites in any case are adopting capital-intensive, export-oriented accumulation strategies” (Bond, 2001:179-182).

Certainly, analogous if milder forms of triage can be observed in the age-differentiated policies of the “social investment state” in countries like Canada (Jenson & Saint-Martin, 2003).

What shared interests arise from links between health and security? Especially since September 11, 2001, appeals to security have special resonance. Saying that “better health for anyone, anywhere on earth, benefits everyone else” (Global Forum, 2002:35) is vacuous. It is somewhat more plausible that “even those who are well-off feel insecure in a polarized world” (Cheru & Bradford, 2005: 12), but little evidence exists that such feelings lead to support for efforts to reduce polarization. Have effective political pluralities emerged to support

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21 Considerations of domestic political economy are probably involved, as well. South African economist Nicoli Nattrass (2004) notes that: “Two of the three leading South African macroeconomic models predict that the pandemic will increase per capita income because the impact will be greater on population numbers than on economic growth.” Thus, “the elite may consider it in their best interests to do very little of significance to halt the epidemic or alleviate its consequences. Those with the economic means to protect themselves and their families against HIV infection … and who have access to medical schemes to treat themselves and their loved ones if they become infected, may think their interests are better served by a scenario in which very little is done. They may privately calculate that they stand to benefit more as individuals from a set of policies that prioritise economic growth and minimise taxation than they would from a social response that includes universal access to HAART and entails higher taxation and spending cuts in other areas” (p. 88, citation omitted).

22 In fairness to the authors, this is one of the few simplistic statements in a generally sophisticated discussion of the need for comprehensive reforms to institutions for financing development and for global decision-making.
redistributive social policies for meeting basic needs in (for instance) Johannesburg or São Paulo, two of the world’s most violent and unequal metropolitan areas? Opportunities for disease transmission are doubtless increased by rapid, low-cost air travel. However, actual danger to most people in high-income countries is limited to a small range of diseases, such as SARS and influenza, which can be easily transmitted through casual contact before symptoms develop. Not surprisingly, much attention in those countries is now being devoted to domestic responses to an influenza pandemic. Potential impacts where poverty is widespread, health systems are already fragile and the immune systems of a substantial proportion of the population may be compromised receive far less attention, and the resources devoted to preventing and treating diseases that mainly afflict the poor such as malaria remain catastrophically inadequate (Narasimhan & Attaran, 2003). Here as in setting priorities for health research, credible risks to the rich will always receive far more attention.

Thus just as investing in health raises the question of whose health is most important, appeals to security raise the question of whose security is at stake, and with reference to what kinds of threats – a question elaborated upon in Colleen O’Manique’s (2004) critique of the “securitization” of HIV/AIDS. AIDS may be the single most devastating communicable disease outside the industrialized world, meriting far greater commitments of resources for all kinds of reasons, but when a United Nations panel makes a thoughtful set of recommendations for mobilizing responses that include not only disease-specific interventions but also rebuilding health systems throughout the developing world, yet calls for the Security Council to work with UNAIDS on HIV/AIDS “as a threat to international peace and security” (Secretary-General’s High-level Panel, 2004:¶ 67), neither motivations nor intended beneficiaries are clear. Is the primary concern with people in low-income countries whose risk of infection is exacerbated by subordinate positions societies that are integrating into global economy (De Vogli & Birbeck, 2005)? With the much lower risk of infection for almost everyone in the industrialized world? Or with uncertainty about returns to investors in countries with high prevalence of HIV infection (Rosen et al., 2003)?

Each focus implies quite distinct policy prescriptions. In a world of deepening chasms between winners and losers from globalization, winners are likely to interpret most appeals to security as arguments for more effective cordons sanitaires; industrialized country policies of excluding HIV-positive immigrants are a case in point. Simplistic claims that poverty and economic insecurity breed terrorism, even if accurate (and this can only be assessed on a case-
by-case basis), may not stimulate efforts to eliminate the underlying conditions. More probable responses involve demonization as threatening ‘others’ of people already marginalized by poverty or illness, and new forms of fortification and containment analogous to the gated communities to which the affluent worldwide retreat in increasing numbers.23

Politics: Can Globalization be Humanized?

The preceding analysis multiple identified tensions between the values embodied in the global marketplace, and actively promoted by powerful governments and multilateral institutions, and the prospects for equitable and widely shared improvements in population health. Among other tasks, we attempted in a preliminary way to identify homologies in the operations of the global marketplace in rich and poor countries. We further indicated that appeals to shared interests that do not challenge the logic of the marketplace, although they may be both factually well grounded and effective in a limited number of cases, have important shortcomings as conceptual foundations for humanizing globalization.

To understand the political implications of this point, it is useful to start from Simon Szreter’s account of public health measures that eventually reversed a precipitous decline in life expectancy in industrial cities that were the crucibles of industrialization in nineteenth century England. These measures, in particular investments in clean water and sanitation, required a “cross-class political alliance” between a newly enfranchised working class and an emerging mercantile and industrial bourgeoisie (Szreter, 1999; see also Szreter, 2003). That alliance, he claims, was at least partly founded on the self-interest of the industrial bourgeoisie in the health of its workers. Drawing on more recent history, Szreter correctly identifies the establishment of twentieth century welfare states as the crucial variable enabling the coexistence of rapid economic growth, despite its unavoidable social dislocations, with widely shared improvements in health status (Szreter, 2003) ... and it is axiomatic that welfare state development has required maintenance of political coalitions and an element of class compromise, primarily although not exclusively between organized labour and the owners of capital.

Here is where globalization collides with the prospects for reducing health inequities. Former US cabinet secretary Robert Reich has described divergent life trajectories in globally

23 For a sampling of the extensive literature see Blakely & Snyder (1997); Caldeira (2000); Coy & Pöhler (2002); Jürgens & Gnad (2002); Le Goix (2005); Mycco (2006); Álvarez-Rivadulla (2007).
integrated labour markets in terms of the “secession of the successful” (Reich, 1991). In much of the industrialized world, the interests of the working rich intersect with those of the rest of the population mainly by way of insatiable demand for low-wage, service sector workers; little evidence can be observed of solicitude for these workers’ health and well being. Perhaps more importantly, the workers whose health and productivity were of concern to the more enlightened industrialists of the nineteenth century are still essential to the process of capital accumulation. However, they now work in Kenyan call centres, Bangladeshi garment factories or Chinese electronic component assembly plants ... and they are in oversupply, often effectively competing against one another and against workers in the higher-wage jurisdictions from which production has been relocated or outsourced. This description is oversimplified, but it usefully underscores the extent to which global reorganization of production has enabled capital to escape the imperative of resolving conflicts with labour over the social wage and the division of productivity gains within national boundaries. Sometimes the health of the working class may be of concern to local managers, as in the case of provision of antiretroviral therapy to employees of major firms in South Africa. However provision varies from firm to firm, and may depend on the status of the employee; in any case recent research indicates that the extent of employer provision has been substantially overstated (Connelly & Rosen, 2005).

The World Bank has projected the emergence of a “global middle class” if its anticipations about economic growth in the developing world are correct: “in 2030 more than a billion people in developing countries,” as compared to 400 million in 2000, will buy cars, engage in international tourism, demand world-class products, and require international standards for higher education.” Even if this happens, what are the potential consequences for social policy where it does? The Bank’s view is that “[a]s average incomes rise, the number of poor will shrink and the tax base will grow, making effective assistance easier to provide and social safety nets a viable remedy for increasing inequality” (World Bank, 2007a:69). But will the new middle class want to share? The question is critical if countries experiencing rapid growth are to avoid what Szreter calls the four D’s of disruption, deprivation, disease and death. Answers will vary from country to country, but based on the discussion in earlier sections of this paper at least two sets of reasons exist for scepticism.

First, external pressures exist on governments to maintain credibility with financial markets and to avoid capital flight on the part of domestic asset owners. These pressures extend to maintaining competitiveness for foreign direct investment and export markets,
constraining to a greater or lesser degree both labour market policy and taxation to finance social expenditure. Sometimes this constraint may be exaggerated: pleading that ‘globalization made us do it’ can help governments defend policies the real objective of which is to protect powerful domestic interests. Findings from research on the extent to which globalization can be blamed for welfare state retrenchment in high income countries are equivocal, depending in large measure on the indicators chosen (Pierson, ed., 2001; Swank, 2001; Swank, 2005 but cf. Genschel, 2002; Genschel, 2004; Hacker, 2004), and it should not be assumed that low- and middle-income countries enjoy comparable policy flexibility. Capital flight in search of economic stability, lower taxes or higher returns; the ability of financial markets to devastate a nation’s currency and economy; and the relocation of manufacturing operations from low-wage jurisdictions to even lower-wage ones, as with the shift from Mexico to China, are all real and extensively documented phenomena (Labonté & Schrecker, in press a).

Second, globalization may affect domestic social policy choices as it changes class structure and political allegiances by ‘disconnecting’ winners and losers. Stated another way, globalization cannot be understood in isolation from domestic social and economic transformations; the latter are strongly influenced by the former. This effect helps to explain proliferating challenges to the welfare state in the industrialized world, and lack of attention to it is a major oversight in recent literature on this topic. Elsewhere, consider the new middle class’s preferences in one very specific respect: transportation. Experience in cities including São Paulo, Mumbai and Jakarta has been that – very much like their counterparts in North America – the middle class favours suburbanization and the building of roads for private cars rather than the provision of more effective and affordable public transportation (Leaf, 1996; Alcantara de Vasconcellos, 1997; Pucher et al., 2005). This is perhaps a proxy for the position of the middle class with respect to a broader range of social policies, and auto-centred settlement patterns are major contributors to the “secession” identified by Reich in countries where they are far advanced.24

This discussion addresses domestic policy; prospects for meaningful global redistribution are even more uncertain, since they require confronting the issue of international or global redistribution.

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24 The commitment to automotive travel in the US has been described as “so fundamental ... that its importance is perhaps understated by imagining it to be the Twenty-seventh Amendment to the Constitution. It is an inarticulate provision, but it sounds like: ‘In order to reach democratic liberty, purchase a car, purchase a home away from the sight of poor people, and turn the ignition key to your right’” (Rae, 1999:190).
justice both intellectually and politically. Although elaborating the relevant arguments would require an additional paper, we concur with Ruger that “[g]lobal actors and institutions ... are obligated to remedy global inequalities that exist in affluence, power, and social, economic and political opportunities” (Ruger, 2006). Indeed, many essential policy elements of a more equitable international economic order have been identified (Paluzzi & Farmer, 2005; Labonté & Schrecker, 2007; Labonté & Schrecker, in press b), and our own work on the G8 and population health incorporates the proposition that these countries, as the most powerful on the world stage, have a special responsibility in this regard (Labonté & Schrecker, 2004; Labonté & Schrecker, 2006; Schrecker et al., 2007; Labonté & Schrecker, 2007). The noted international relations scholar Richard Falk has observed that “[g]lobal justice, no matter how it's conceived, seems distant from the realities of international life” (Falk, 2000:21) because it involves simultaneously rethinking a long-standing presumption against holding the governments of nation-states accountable to any external authority and questioning the supremacy of the global marketplace. Because politics is usually about interests at least as much as obligations, distinctive challenges arise for policies that offer few or no benefits to clienteles within a country's borders. The challenges are especially acute in a world saturated by the norms of privatization, and where solidarity (if the term is understood at all25) is eroding even with respect to one’s national compatriots.

Donna Haraway warned a decade ago that “[w]e are losing effective social imaginaries” concerning alternatives to the global marketplace (Harvey, Haraway et al., 1995:519). The idea of an imaginary is evocative and important, blending vocabulary and imagination and recognizing the close relationship between the two. As a strategy for reconstructing those imaginaries, elaborating on the details of policy agendas like “redistribution, regulation and rights” (Deacon et al., 2005) – the rubric proposed in a follow-up to the 1995 Copenhagen Social Summit – is vital. To give the reconstruction a chance of being meaningful in policy terms, investigation is also needed of why some elected governments, and therefore presumably some polities, are more receptive to such agendas than others. Development assistance is just one dimension of, and an imperfect proxy for, a government’s overall

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25 This is not just a throwaway comment. The word “solidarity” is frequently used in continental European discussions of health system design and social policy, even by governments of the centre-right, yet it is never referred to in a documentary analysis of 36 Canadian health system reform studies and proposals generated during the 1990s (Giacomini et al., 2004).
perspective on development policy and global governance as they affect health. Governments that spend comparable proportions of their country's national income on development assistance may do so in ways that have drastically different outcomes. Nevertheless, it is probably useful to know why a fourfold variation exists among G7 countries\textsuperscript{26} in the proportion of national income spent on development assistance, and the variation is even wider among high-income countries as a whole. Further, some countries appear to have taken a broader leadership role in humanizing globalization. Examples include the Helsinki Process on Globalization and Democracy (Helsinki Process on Globalisation and Democracy, 2007), hosted jointly by the governments of Finland and Tanzania,\textsuperscript{27} and the positions on development and equity taken by the new Norwegian government. Norway's official policy is now to oppose development conditionalities that promote privatization, support only trade policies that will not prevent poorer countries from developing into “welfare societies” similar to Norway's own, and take a leadership role in seeking “new global financing sources that can contribute to a redistribution of global wealth and the strengthening of the UN institutions” (Government of Norway, 2006). Norway has pursued this objective through, for instance, hosting the second plenary meeting of the multilateral Leading Group on Solidarity Levies to Fund Development (Norwegian Ministry of Foreign Affairs, 2007); at the meeting group members considered options for implementing a Currency Transaction Development Levy and addressing the destructive effects of tax evasion and tax competition.

We have not studied these cases in detail, and are therefore cautious (for instance) about generalizing from the Norwegian experience given the country's oil wealth, relative homogeneity and long social democratic tradition. The cases are cited as sources of hope and important avenues for future research in a policy landscape that often appears highly inhospitable - a landscape in which ethical disengagement is not an option. Nevertheless, those of us who are convinced as advocates and humanists that direct challenges to the priorities of the global marketplace are imperative must be prepared for a certain willing suspension of disbelief as social scientists.

\textsuperscript{26} The Russian Federation, although now a member of the G8, is no longer a substantial supplier of development assistance.

\textsuperscript{27} An illustrative work product that addresses some issues raised in this paper is Helsinki Process Secretariat, ed. (2005).
References


