

Editor's Introduction

Globalizing Health Politics in the New Century¹

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Introduction

Health is now firmly established on the global political agenda. With varying degrees of prominence, health issues have been discussed at every summit of the G7/G8 since 2001. As noted in Chapter 11, the value of development assistance for health roughly quadrupled between 1990 and 2007 – a quantitative phenomenon that was accompanied qualitatively by the emergence of important new sources of aid (notably the Bill & Melinda Gates Foundation) and channels for disbursing aid (most notably the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria). The years 2010 and 2011 saw no fewer than four major diplomatic meetings on health or health-related issues: the High-Level Plenary Meeting of the UN General Assembly on the Millennium Development Goals (subsequently MDG Summit) in September 2010; the UN High-Level Meeting on AIDS in June 2011; the UN High-Level Meeting on Non-communicable Diseases (NCDs; subsequently NCD Summit) in September of that year; and the World Conference on Social Determinants of Health in Brazil (subsequently WCSDH) the following month. Although it is important not to confuse flurries of meetings with genuine progress toward improving the health of populations, it is also important not to neglect the significance of such events or the political commitment (even at the level of rhetoric) that they reflect.

¹ I would like to express sincere thanks to Kathleen McGovern, the incredibly well-organized research assistant who made possible the completion of this manuscript during a tumultuous time in my professional life; to Ashgate Publishing for their patience in awaiting this volume; and most especially to all contributors for raising the bar with respect to the social scientific study of global health.

The Millennium Development Goals (MDGs) arose from a UN General Assembly resolution passed in the year 2000. Three of the eight MDGs are specifically concerned with health (child health, maternal health and AIDS and other major communicable diseases); progress toward every one of the seven substantive goals, which relate to poverty and hunger, universal education, gender equality and environmental sustainability, has the potential for important positive impacts on population health. (The eighth goal, developing a global partnership for development, is arguably the most important in terms of long-term reductions in health disparities, yet less amenable to assessments of progress with respect to specific outcomes.) The MDG Summit saw announced commitments of more than USD40 billion in support of a strategy for women's and children's health, widely seen as a neglected dimension of the MDGs, although it is not clear how much of that amount genuinely represents 'new money' rather than a repackaging of existing commitments. This is a recurring problem in the quest for good press on development issues, yet from a long-term perspective the fact that governments feel the need to generate attention to the resources they are committing to development is itself significant.

Rightly or wrongly, the MDGs have become a focus for global health and development policy, perhaps because the targets that were developed under the auspices of the UN Secretary General (United Nations 2001) with respect to at least the first seven goals are in theory amenable to quantitative measurement of progress, although it has been argued that necessary precision is unattainable in practice (Attaran 2005). More fundamentally, the modest nature of many of the goals and targets (halving the *proportion* of people worldwide afflicted by extreme poverty and hunger; improving the living conditions of at least 100 million slum dwellers, when the overall number was projected to increase to 1.4 billion in 2020), against the background of a quadrupling in the value of the world's economic product between 1981 and 2005, led some to characterize them as the 'Minimal Development Goals'. Nevertheless, their very existence was and is significant, and provided the opportunity for concentrating governmental, academic and civil society attention.² The MDGs also mean that the international community, again apart from issues of definition, cannot avoid visible engagement with the question of what to do post-2015. Many chapters in this volume contribute to our understanding of how that engagement may unfold.

AIDS became an international issue relatively early in the short history of the epidemic, as reflected by the establishment in 1996 of the Joint United Nations Programme on HIV/AIDS (UNAIDS).³ As noted in Chapter 8, this happened at

² As for instance in the case of the Countdown to 2015 initiative (<http://www.countdown2015mnch.org/>) that has tracked progress on maternal, newborn and child health. This is a partnership of 23 universities or university faculties, civil society organizations (CSOs), UN agencies, bilateral aid agencies, professional organizations, the World Bank, *The Lancet*, the ubiquitous Bill & Melinda Gates Foundation and NORAD.

³ For a remarkably unvarnished official history of that organization's first ten years, see Knight (2008).

a time when, in the United States in particular, the spread of HIV infection was coming to be viewed by much of the foreign policy establishment as a threat to security. One of the most prominent good-news stories in global health is the more than tenfold increase between 1998 and the end of 2009 in the number of people living with HIV infection who are receiving antiretroviral therapy (World Health Organization, UNAIDS and UNICEF 2010). The complex political background to that accomplishment includes trans-nationally coordinated civil society activism and direct confrontations with the power of the pharmaceutical industry. The 2011 High-Level Meeting on AIDS adopted a Political Declaration (United Nations General Assembly 2011) – not in any way a binding commitment⁴ – that cited the HIV epidemic as a ‘global emergency’ and an ‘unprecedented human catastrophe inflicting immense suffering on countries, communities and families throughout the world’ (¶ 7–8), and voiced ‘deep concern that funding devoted to HIV and AIDS responses is still not commensurate with the magnitude of the epidemic’ (¶ 14). The appropriateness of this concern is underscored by the view, within the United States at least, that the ‘ballooning entitlement burden’ of AIDS treatment spending in low- and middle-income countries (LMICs) represents a ‘state supported international welfare program’ that is ‘hard to justify on investment grounds’ (Over 2008), and by the fact that total donor support from 15 governments, including that of the US, for AIDS treatment and prevention in 2010 dropped by 10 per cent from its 2009 level (Kates, Wexler, Lief, Avila and Gobet 2011).

The MDGs make no specific mention of NCDs, and the NCD Summit (convened by the General Assembly) was an overdue effort to increase the attention devoted to NCDs on the international stage (Beaglehole et al. 2011). Development assistance is an imperfect proxy for the importance attached to an issue by countries that occupy the commanding heights of the world system, although its significance in recipient countries, at least when health systems are involved, is hard to overstate. Although estimates of dollar amounts vary, it is clear that NCDs have received only a fraction of the donor funding directed to communicable diseases like AIDS, or even to maternal, newborn and child health (MNCH), although the contribution to the burden of illness in LMICs is comparable (Nugent and Feigl 2010; Institute for Health Metrics and Evaluation 2011) – and the prevalence of NCDs such as cardiovascular disease, cancer and diabetes is increasing rapidly in most such countries, leading to the phenomenon of a double burden of disease. Explanations include the persistent misconception that NCDs are diseases of affluence (Ezzati et al. 2005) and the lack of widespread political mobilization of the kind that influenced responses to AIDS and, more recently, to MNCH. In advance of the NCD Summit, networks of global health professionals expressed hope for agreement on supporting a limited number of priority interventions in the areas of tobacco control, dietary salt intake, diet and physical activity, alcohol control and multi-

⁴ Leaving aside the problematic nature of bindingness in international law – a problem that is especially acute with respect to human rights treaties (see Chapter 14).

drug combinations for people at high risk of cardiovascular disease.⁵ Concern was also being expressed that trans-national corporate interests, including the food processing and alcohol industries as well as pharmaceutical firms concerned about proposals to expand access to essential medicines, were shaping the negotiating positions of high-income countries in the pre-conference drafting sessions where the real diplomatic action takes place (Stuckler, Basu and McKee 2011; Cohen 2011).

The WCDH, organized by WHO, was the outcome of a sequence of events that began in 2005 with WHO's establishment of a Commission on Social Determinants of Health (see Chapter 13). That initiative reflected an accumulation of research evidence that many of the most important influences on health involve the conditions of life and work rather than just the operation of health systems, and are deeply rooted in the structure of social arrangements and the unequal distributions of power and resources that shape those arrangements. Even within national borders, using this insight effectively as the basis for specific policies and interventions faces formidable barriers not only because of the implied (and sometimes explicit) threat to existing economic and political interests, but also because of administrative requirements for coordination among elements of government, many of which are not primarily concerned with health, and, in some cases, the difficulty of mobilizing effective political support. These problems are multiplied at the international level, where no organized constituencies for action on social determinants of health are comparable to (for example) the medically oriented, disease-focused organizations⁶ comprising the NCD Alliance that was launched in 2009. In their absence, a tiny unit within the cash-strapped Geneva secretariat of WHO organized the conference while following up in other ways on the Commission's recommendations and a subsequent World Health Assembly resolution of support. It is also interesting to note the disjuncture between the Commission's holistic approach and the behavioural, individualized interventions advocated in advance of the NCD meeting (Beaglehole et al. 2011) – a shopping list indistinguishable from the approaches to health education and promotion fashionable in many high-income countries *circa* 1980.

The preceding discussion can only hint at the institutional complexity of contemporary global health politics. If dissertations have not already been started about these events, their antecedents and significance, they soon will be. Further complexity is introduced by the effects on health on developments such as global environmental change (see Chapter 5) and the financial crises that are, for the moment, an inescapable corollary of global financial integration (Hopkins 2006; Schrecker forthcoming). The point is to demonstrate the close connection of health outcomes to international policy and politics, and also to suggest the theoretical challenges thereby presented for conventional frames of reference in the study of

⁵ See in particular Beaglehole et al. (2011) – 44 authors writing in *The Lancet*, a journal whose role as a node in physician-dominated transnational elite networks would merit a chapter in itself if this volume were considerably larger.

⁶ World Heart Federation, International Diabetes Federation, Union for International Cancer Control, and International Union against Tuberculosis and Lung Disease.

international relations. The threat of HIV infection to the national security of powerful actors in the international system, once invoked as a justification for concern, was almost certainly overblown; national economies and societies devastated by the epidemic have proved surprisingly resilient. States in sub-Saharan Africa and indeed elsewhere are failing or on the brink of failure for many reasons, but AIDS is not among them. Yet despite the fact that 19 out of every 20 new HIV infections occur in LMICs, the epidemic remains a focus of attention. The continued salience of global health is even more challenging to realist perspectives when other causes of illness or death are involved. David Fidler, a leading student of the global health diplomacy (GHD) exemplified by the four meetings just described, notes:

Although political and economic connections and interactions between the United States and India are increasing, neither national health nor economic prosperity in the United States depends on whether India controls obesity related diseases, and vice versa. Neither security nor the protection of human rights in the European Union depends on whether countries in sub-Saharan Africa control diseases driven by tropical climatic conditions or local water or air pollution because these disease threats pose no real danger to populations in the European Union. (Fidler 2011, 36)

Familiar invocations of global interconnectedness have clear limits; conversely the presence and persistence of MNCH, NCDs and social determinants of health on international agendas indicates the extent to which health foreign policy (a term considerably more inclusive than GHD) has moved beyond considerations of national interest that are central to the realist perspective on international relations.

How should social scientists approach the study of these developments? In an article decrying the predisposition of international relations scholars toward 'academic sectarianism' in which competing research traditions seldom communicate meaningfully with one another, David Lake asked readers to:

[I]magine the contributions that we as scholars could make if we devoted our professional and intellectual energies to studying things that matter. Imagine reorganizing our research and professional associations around problems, not approaches. Imagine as well a graduate seminar not organized around research traditions but topics like Global Climate Change, Growth and Development, Economic and Political Inequality, and Genocide and Political Violence. The seminar discussion could then focus on 'what do we know?' rather than 'what are the central tenets of this particular sect?' (Lake 2011, 471)

The eclectic nature of the contributions to this book shows that many investigators concerned with the study of health on a global scale are already doing (or at least trying to do) what Lake recommends. The selection of contributions to this book also reflects the need for trans-disciplinarity in the study of large, complex problems

of the kind to which Lake refers. International relations, political economy (my own home discipline), and even the social sciences as a whole will not have all the relevant answers. This is particularly true of global health, where at least some knowledge of relevant life sciences is indispensable. No one can talk sensibly about AIDS policy and politics for very long without at least a basic understanding of the etiology of HIV infection and the mechanisms of transmission, although social scientists have occasionally tried. So have countless politicians, sounding even sillier. The initial reaction of some readers to several chapters may be: 'This isn't about international relations.' No, it isn't, at least in a sense that will be immediately familiar to readers of *International Studies Quarterly*. That's the point. Their initial reaction may also be: 'This isn't about health, it's about economics and politics.' I and many, although perhaps not all, contributors to this volume view those as in practice inseparable.

History and Perspectives

Historian Monica Green based the book's first chapter on a university course organized along lines of which Lake would almost certainly approve. Grounding her analysis in a thorough understanding of the specifics of communicable disease transmission, she argues first of all for a time frame that is radically longer than many of us are accustomed to, starting about 10,000 years ago (giving new meaning to the Braudelian idea of *la longue durée*) with 'the beginnings of human agriculture and settled society'. She draws on advances in life sciences such as an 'epidemiologically rich genomics' that underscores the importance of animal-human transmission. Green's trenchant analysis of the interplay between biology and culture, and its implications for the response to specific communicable diseases, compares and contrasts responses to leprosy in the nineteenth century and HIV/AIDS in the late twentieth century. Green concludes with three injunctions for global health researchers, each of which also has implications for public health practice in the field: (1) think about more than one disease at a time; (2) historicize everything, a point revisited in different ways in Chapters 2, 9 and 10; (3) take 'global' seriously, drawing on disciplines as disparate as anthropology and genomics. Green's breadth of reading and demonstration of the practical relevance of history are only two of the reasons to envy her students, and to hope that her course is somehow syndicated or otherwise enabled to reach a much larger audience.

In the chapter that follows another historian, Anne-Emanuelle Birn, shortens the time frame somewhat and moves to a finer-grained level of analysis. She situates tropical medicine (still featured in the name of one of the world's leading research institutions, the London School of Hygiene and Tropical Medicine) with reference to a colonial project that exploited labour on a massive scale, but also required some protections for the health of colonists. Domestically, she links the industrial revolution and its immense human costs to the 'the emergence

of modern public health' – a linkage that has also been emphasized by Simon Szreter (1999) in discussing the relevance of nineteenth century public health politics in England for contemporary LMICs. In the twentieth century these two patterns of thought and practice converged. The Rockefeller Foundation, financed by a fortune made in the industry central to that century's economic history,⁷ played a crucial role in that process (at least in the western hemisphere) and shaped the agenda of international health policy and practice, especially in the years preceding World War II, but Birn shows that many other actors were already involved. Readers should consult her other published work (cited in the bibliography) for more extensive detail, and consider contemporary parallels to her conclusion that international health in earlier stages of its development was 'focused on disease control to facilitate conquest and occupation, increase worker productivity in factories, mines and plantations in metropolitan and colonial settings, fend off epidemic unrest, and ensure a smooth and uninterrupted trade system'.

In Chapter 3, political scientist Sara Glasgow examines the internal presumptions of public health discourse on NCDs, focusing on 'the risk mentality'. Risk is a pervasive concept in contemporary social policy and the analysis thereof, with some authors claiming to identify the phenomenon of 'risk society' (Beck 1992). Few have reflected seriously on the politics behind recasting various social processes in terms of risk – for instance, on how the risk society concept was used in the United Kingdom as a basis for attacking the redistributive aims of the welfare state as old-fashioned and outmoded (Giddens 1998, chapter 4). Glasgow, a notable exception, argues persuasively that epidemiologists' focus on risk factors defined in individualized terms has led public health research and practice to neglect structural influences on those behaviours. She proceeds to argue that many social scientists working on global health issues neglect 'the latent political norms that suffuse the supposedly objective science of public health', ignoring the fact that public health cannot be value-free. This is both an overdue critique of epidemiology and an admonition to social scientists studying the politics of health within and across national borders. The contrast between the highly individualized, risk factor-oriented approach guiding the September, 2011 NCDs meeting – WHO's web page (World Health Organization 2011; accessed September 3, 2011) reduced the issues to four diseases (cancer, cardiovascular diseases, chronic obstructive pulmonary disease and diabetes) and four risk factors (tobacco use, unhealthy diet, harmful use of alcohol and physical activity) – and the approach of the Commission on Social Determinants of Health underscores the value of Glasgow's analysis.

Chapter 4 is the only one explicitly organized around the perspective of a single discipline. This was my idea, because anthropologists have been singularly effective in making the connections between macro-level social and economic processes and

⁷ An obvious parallel can be drawn with the emergence of the Bill & Melinda Gates Foundation as a major actor in global public health; it can be argued that the products and activities of Standard Oil and Microsoft were of comparable significance in successive waves of industrialization.

health outcomes and experiences at the individual, household and community level. Vinh-Kim Nguyen's chapter combines an anthropologist's scepticism about universals with a succinct thematic overview of critical definitions of, and approaches to, the unavoidably contested concept and phenomenon of globalization.⁸ Appropriately, in my view at least, the overview is grounded in political economy and emphasizes globalization's tendency to magnify inequalities. He further inquires into how relations between knowledge and power are reproduced in global health research and practice, in an important complement to Glasgow's analysis that asks 'how the body is located within historical and social relations', and ends with a number of more specific applications of anthropological analysis to such phenomena as therapeutic power ('the power to manage misfortune', in the author's memorable phrase) and commodification of the body. Understandings of how the latter process is inextricably linked with the underlying logics of globalization have been particularly enriched by the work of anthropologists on topics as diverse as the globalization of the clinical trials industry (Petryna 2009) and the emergence of a trans-border trade in human tissues and organs (Scheper-Hughes 2004; 2005).

Issues and Challenges

Any comprehensive inventory of global health issues and challenges that are appropriate topics for social science inquiry would require far more space than is available here. For that reason, some relatively familiar issues like SARS, pandemic influenza and tobacco control are dealt with rather briefly, and in the context of larger questions and debates. The focus is on issues that either have received insufficient attention in the study of global health politics (like global environmental change, and the interface between neo-liberalism and the treatment of health as a security issue) or raise important theoretical or methodological issues (like globalization's influence on social determinants of health at the metropolitan scale, or how the Foucauldian concept of biopolitics can inform understandings of the situation of poor countries and racialized populations in the world economy).

⁸ On some academic conventions, at this point in the introduction I should have embarked on a discussion of competing definitions of globalization. I have not done so because in my view the definition as '[a] pattern of transnational economic integration animated by the ideal of creating self-regulating global markets for goods, services, capital, technology, and skills' (Eyoh and Sandbrook 2003) is a sufficient starting point; Chapter 4 provides all necessary elaboration; and the process is in any event understood at a level hard for academics to comprehend by those who have lost their jobs as production relocated to Mexico or China or their homes through forcible eviction in the service of 'higher value uses' that enrich real estate capitalists. Both are among the increasingly commonplace manifestations of the process described by Eyoh and Sandbrook.

The focus of the chapters in this section is also, in some cases, far removed from health outcomes and the conventional subject matter of research on health policy and politics. Authors' concern is rather with the economics and politics of a changing world system, and the consequences of that system's dynamics 'on the ground'. In Chapter 4, Vinh-Kim Nguyen refers to Virchow's vision of a social medicine explicitly concerned with such matters as poverty; I would add Bertolt Brecht's memorable 1938 poem 'A Worker's Speech to a Doctor', part of which reads:

The pain in our shoulder comes
You say, from the damp; and this is also the reason
For the stain on the wall of our flat.
So tell us:
Where does the damp come from?

The fundamental message of Virchow, Brecht and the Commission on Social Determinants of Health alike is that health cannot responsibly be understood or considered in isolation from politics and economics – in other words, without asking where the damp comes from and why workers have to live with it while doctors do not. In turn, health outcomes cannot be understood in isolation from global-scale processes like trade and capital mobility, or from the institutions that organize those processes and protect the underlying asymmetries of power and resources.

In Chapter 5, Charmian Bennett and Tony McMichael add a further layer of complexity to the already complicated map of influences on health in a global context. Green demonstrates the importance of understanding the biology of disease-causing organisms; Bennett and McMichael demonstrate the incompleteness of any approach to global health that does not consider the indispensable life support functions provided by the natural environment. They note that 'the form of the requisite research and policy responses can seem far removed from the tidy comfort of reductionist, item-specific research and policy formulation', which ranks as a masterpiece of understatement. Consider the bitter irony they point out that as the international community mobilizes around the MDG of reducing infant and child mortality, most of the 200,000 annual deaths associated with the impacts of climate change occur in children. After a broad overview of major direct and indirect pathways through which global environmental change affects health, they point out the unequal distribution of hazards and benefits: 'those most at risk are often least responsible for the change'. Although they conclude on an optimistic note with a discussion of the win-win character of many measures to reduce greenhouse gas emissions, one wonders whether their optimism is warranted given recent history of intransigence on climate change. The basic analytical point is that global environmental policy (and national policy with global environmental consequences), like trade policy, is relentlessly interest-driven in a world where the distribution of resources and the consequent ability to influence policy is vastly unequal.

Trade policy is, in fact, the subject of the next two chapters. K.S. Mohindra, Raphael Lencucha and Ronald Labonté begin Chapter 6 with a short analytical overview of the mechanisms by which trade liberalization, a key element of globalization, influences health (for a complementary treatment see Blouin, Chopra and van der Hoeven 2009) by way of its effects on individual livelihoods and national opportunities for economic development. They continue with a more detailed investigation of how the emerging regime of WTO treaties and proliferating bilateral and regional trade agreements is affecting the prevalence of NCDs by way of food, tobacco and alcohol. The fact that '[w]hile consumption of these products is often viewed as a lifestyle choice, with public health interventions often targeting individuals, it is at least as much a reflection of corporate production and marketing strategies, government regulation (or lack thereof), and global trade and trade treaty disputes' is not nearly well enough appreciated. Within national policy processes, the individualistic bias of public health discourse and practice identified by Glasgow almost certainly comes into play as well. Despite the qualified initial success of the Framework Convention on Tobacco Control (FCTC), briefly summarized in the chapter, the prospects for an effective framework convention on obesity control, as advocated in a 2011 *Lancet* editorial (*The Lancet* 2011), cannot be considered bright, and indeed the editorial's reference to 'the current tsunami of risk factors' suggests a partial mis-specification of the problem.⁹

Natalia Ovtcharenko and colleagues provide a summary of controversies in the area of global health politics where corporate influence is probably most familiar and pernicious: the conflict between patents and access to essential medicines. The process that resulted in worldwide harmonization of intellectual property protection under the Trade-Related Aspects of Intellectual Property (TRIPS) agreement has been described as one in which '[i]n effect, twelve corporations made public law for the world' (Sell 2003, 96). The subsequent political economy of intellectual property rights and access to medicine is somewhat more complicated, as some middle-income countries begin to develop pharmaceutical industries with the capacity to move beyond generic production (Shadlen 2007). The authors offer an overview of TRIPS and post-TRIPS efforts to expand flexibilities to enable LMICs to address major threats to population health. Especially interesting in terms of what it shows about the hard politics of global health is their account of efforts to offset these flexibilities with 'TRIPS-plus' provisions in bilateral and regional

⁹ A cautionary note sounded in the introduction to a special issue of the journal *Global Heart* that appeared at the time of the summit is worth quoting at length: 'The challenges [of NCDs] are much farther upstream and multisectoral than other health challenges; what presents as a health issue has its origins in a variety of determinants, and the solutions must incorporate agriculture, the food and beverage industry, and the built environment among others' (Smith and Ralston 2011). A similar note was sounded in the *European Journal of Cancer*, emphasizing 'the human ecology of cancer control' as 'a hugely challenging area for cancer public policy and one that is frequently neglected, in part because of its intrinsic challenge but more so because it forces a dialogue about political ideology and the prioritization of expenditure and efforts in cancer control' (Sullivan and Purushotham 2011, 2377).

agreements (see also Roffe, Von Braun and Vivas-Eugui 2008; Shaffer and Brenner 2009). They conclude on a positive note, with an account of initiatives including patent pooling and the Health Impact Fund that aim to improve access to medicines within the constraints of the current intellectual property regime, correctly noting that the effectiveness of such initiatives cannot yet be assessed.

Health issues are most readily accommodated in foreign policy agendas when they are framed in terms of national security (Labonté and Gagnon 2010). In Chapter 8, Colleen O'Manique provides a brief history of the post-war 'securitization' of global health, noting the tensions between national security as conventionally defined and the 'human security' paradigm that emerged in the 1990s. She identifies the limits of even this apparently kinder, gentler perspective on security in a world influenced by 'the broader neoliberal project of the past three decades'. These limits are illustrated by the recent history of policy responses to HIV and influenza (O'Manique's description of the political economy of domestic responses to the threat of epidemic influenza in southeast Asia is chilling), and generically by the selective focus of the health and security agenda, which ignores the health of those too marginal, economically or geopolitically, to matter much in a larger frame of reference. (This is my formulation, not O'Manique's.) Despite the language of interconnectedness and shared vulnerability, as in the case of the effects of environmental change described by Bennett and McMichael, not all of 'us' are similarly vulnerable. Against the background of an emerging discourse on global health governance (see Chapter 11), O'Manique concludes that: 'Properly framed, a human security perspective asks the basic questions: Governance for whom? Who lives, and who dies? And who decides?'

This question is taken up with special urgency in the following chapter by Rosalind Petchesky, who blends anthropology and political economy using the Foucauldian concept of biopolitics with specific reference to health in Haiti: the poorest country in the western hemisphere, most recently in the headlines following the earthquake of 2010. Petchesky argues that the savage privation experienced by Haitians, and the consequent threats to their health, must be understood with reference to a long history of colonial exploitation and Haitian resistance. To this she adds both a gender dimension, arguing that issues of sexuality have always represented at least a subtext in the history of the country's exploitation, and a devastating critique of contemporary 'aid' efforts before and after the earthquake. In addition to foregrounding the connection between militarization and sexualization, Petchesky's work reminds all those working in the field of global health that the United States and US-based economic interests have a long history of actively destroying opportunities to lead a healthy life for those standing in their way, or just asking the kinds of questions that recur throughout this book. The inexcusable toll of domestic morbidity and mortality following the US invasion of Iraq (Burnham 2006), and its close connection to the attempt at forced neoliberalization of the Iraqi economy (Schwartz 2007), is anything but the historical anomaly as which it is regarded by many of our students and younger colleagues.

Françoise Barten, K.S. Mohindra and I end the section on issues and challenges by taking up the question of 'governance for whom?' in a metropolitan frame of

reference, asking how global economic processes affect social determinants of health at a time of rapid urbanization (in those regions of the world not already highly urbanized), increasing economic inequality, and intensified conflicts over metropolitan space and resources between those connected to the global economy on radically different terms. Urban health researchers or epidemiologists studying place and health seldom consider these macro-scale processes, yet their importance is demonstrated by a poignant example drawn from the experience of one of the authors who now works with the government of El Salvador to redesign health and social provision on equitable, rights-based lines.

Responses

Such efforts, mainly on a national or international scale, are the focus of the last set of chapters. Most authors in this section on policy responses write from experience not only as researchers but also as high-level global health politics protagonists. Ilona Kickbusch held numerous senior positions in WHO's European regional office and subsequently in Geneva. Rick Rowden worked for many years with the development policy civil society organization (CSO) ActionAid, specializing in critiques of the International Monetary Fund (IMF)'s approach to development. Sir Michael Marmot, perhaps best known as the leader of the two ground-breaking Whitehall studies of the health of British public servants, subsequently chaired the WHO Commission on Social Determinants of Health; his co-authors, Ruth Bell and Sharon Friel, were members of the small secretariat that worked with Marmot on drafting the Commission's final report. Audrey Chapman, who directed the Science and Human Rights Program of the American Association for the Advancement of Science for 15 years, also participated in drafting the UN Committee on Economic, Social and Cultural Rights' General Comments (key interpretive documents) on both the right to health (General Comment 14) and the right to water (General Comment 15).

Hein and Kickbusch provide a succinct overview of today's complex landscape of global health politics, including a fourfold increase in the value of development assistance for health since 1990; the rise of new categories of institutions such as the Global Fund, trans-national CSOs and networks such as Countdown 2015 that link CSOs with UN agencies and other institutions; and the emergence of new players in old categories. The Bill & Melinda Gates Foundation is the most obvious member of the latter group; as noted earlier there is nothing new about influential foundations based on one private fortune. One of the more interesting manifestations of this new organizational complexity was establishment of the H8 or Health 8 in 2007 in an effort to accelerate progress toward the health-related MDGs; it comprises senior officials of four UN agencies including WHO; the World Bank; the Global Fund; Global Alliance for Vaccines and Immunization (GAVI); and the Gates Foundation. Among the authors' observations, the fact that 'health is one of the largest industries worldwide' perhaps deserves special attention; this

point is likely to be more familiar to researchers who work on domestic health policy issues than to those whose focus is primarily international. On a brighter note, they suggest that the emerging organizational complexity may represent the emergence of new understandings of global democracy, meaning 'more than an equal representation of governments in international institutions', and global citizenship.

Rick Rowden argues that advocacy in support of global health must expand its frame of reference to include a critique of current Washington consensus models of development policy, including a reconsideration of the value of interventionist (neoclassical economists would say protectionist) industrial policies, of a kind today's high-income countries routinely adopted at earlier stages of their journey to prosperity. He is especially critical of the equation of poverty reduction with development, and of the IMF's insistence on low inflation and other forms of macroeconomic orthodoxy, regardless of their well-established human costs. This is not a new critique; as early as 1987 a landmark UNICEF report documented the destructive costs of 'structural adjustment' policies promoted by the IMF as the price of debt restructuring, with specific reference to the health and well-being of children (Cornia, Jolly and Stewart, eds 1987). What is new, and imperative, is Rowden's insistence that those whose advocacy efforts have heretofore been focused on the health sector, as it is now described, broaden their efforts to situate health in the context of alternative trajectories for economic development – with a special focus on how policies of countries like the United States and of the international financial institutions influence those trajectories and the distribution of the benefits of growth.

A similar message, although stated in different terms, is conveyed by Bell and colleagues in their description of the genesis of the CSDH and responses to its findings. They situate the Commission's work as, in many respects, a return to the 1978 Alma Ata commitment to Health for All in the year 2000, which 'foundered during the 1980s in an era of politically motivated market liberalisation', and summarize the report's findings with special emphasis on the ubiquity of socioeconomic gradients in health and their origins in social processes and political choices.¹⁰ They describe as an 'extraordinary synchronicity' the fact that the Commission's report was released in August 2008, two months before a serious global financial crisis demonstrated the perils of unregulated economic interconnectedness need for reforming the rules that govern the world economic order. The next-to-last section of their chapter is a participants' account of how the Commission's report was received by governments, notably those of the United Kingdom and the European Union, but also those of some LMICs. Even within national borders, the 'whole of government approach' that the Commission correctly identified as essential to integrating social determinants of health into public policy is difficult; the difficulties multiply internationally, for reasons of political economy (some of which are suggested throughout the Issues and Challenges section of the

¹⁰ Those who have not read the Commission's full report, readily available on-line, are strongly encouraged to do so.

book) as well as reasons of organizational complexity described in Chapter 11. Bell and colleagues were 'optimistic about the prospects for the initiatives ... that are driving the social determinants of health agenda forward'; as noted in the Coda, events at the World Conference on Social Determinants of Health might have been read as dampening that optimism somewhat.

In the final substantive chapter, Chapman points out that a range of human rights instruments, many of them binding as a matter of international law on states that have ratified them, address access to health care and social determinants of health. After an overview of the relevant international legal framework, she summarizes current interpretations of the right to health, which encompass far more than just access to health care. She then describes the limitations of the international human rights framework, including the fact that 'the narrow and sometimes excessively legalistic understanding of the right to health held by many in the human rights community does not accord sufficient importance to the role of the social determinants of health' but also the 'relative powerlessness of human rights institutions' as compared, for instance, with the World Bank and the WTO regime. She concludes by citing the value of a human rights approach to health as both a normative framework and a source of political mobilization, 'in a world in which there are few countervailing normative and policy approaches to the dominant neo-liberal ideology underpinning globalization'. My own view is that the importance of this point cannot be overstated, in the context of contemporary political discourses in which it is sometimes difficult even to imagine what historical sociologist Margaret Somers (2008), after Arendt, has called 'the right to have rights' independent of the marketplace.

Resources and Institutions: Questions for the Future

Without writing another book, it is possible to identify two general sets of questions or challenges for health in a globalizing world, and for social scientists working in the area.

The first involves resources, first of all for health systems although as the Commission on Social Determinants of Health and social epidemiologists remind us they are only part of the picture. One study estimated that USD112 billion to USD251 billion more would be needed between 2009 and 2015 simply to ensure that health systems in low-income countries were capable of meeting the health-related MDGs (Taskforce on Innovative International Financing 2009). Additional development assistance was identified as a priority, but so, too, was mobilizing more financing from domestic sources. Many sub-Saharan African countries (which accounted for 33 of the 49 countries in the study just cited) were, as of 2010, far from meeting a commitment made in 2001 by member states of the African Union to increase public spending on health to 15 per cent of general government spending. In fact, a meeting of African Union finance ministers repudiated the so-called Abuja Declaration in March 2010, only to see it reaffirmed by heads of

government (as before, without any target dates) at the African Union summit in July of that year. The protection of health, especially the health of the poor, is merely one competitor among many for policy attention and state resources, just as it is in wealthier countries, and the politics of resource allocation for health and health-related social protection in LMICs remains understudied.

A focus on development assistance should not divert attention from other aspects of the world economy that drain resources from health and development in LMICs. One of the most important of these is capital flight, in which the wealthy and well-connected shift assets out of economies where they are desperately needed for investment in health and development in order to improve their returns and avoid taxation, regulation or the prospect of devaluation (see generally Schrecker forthcoming). As just one illustration of the importance of capital flight, in 2011 academic economist Léonce Ndikumana (a former senior researcher with the African Development Bank and the United Nations Economic Commission for Africa) and colleague James Boyce published the culmination of many years' research on capital flight from sub-Saharan Africa (Ndikumana and Boyce 2011). Their assessment, based on a restrictive definition of capital flight that includes only illicit flows, was that between 1970 and 2008 the value of flight capital from the region – plus imputed interest, on the assumption that the money shifted out of the region was earning at least a small rate of return in its offshore home – was \$944 billion, or roughly the value of the region's entire economic product in 2008. Another perspective is provided by the observation that the annual value of capital flight from sub-Saharan Africa between 2000 and 2008 was twice the amount of additional aid pledged to the region, albeit not delivered, by the G7 at the Gleneagles summit in 2005 (Ndikumana 2010). External debt remains a debilitating constraint on public policy in many LMICs despite successive debt relief initiatives and has long been recognized as a consequence, in part, of the ease with which deregulated financial markets facilitate capital flight (Naylor 1987; Schrecker 2009b). The problem of resources for health and development, in other words, is very much a problem of the unequal distribution of power and opportunities within the world system, and the replication of those inequalities within national borders.

Resources are not a problem only for LMICs, of course. The situation of WHO, functioning on a frozen core budget and therefore highly dependent on discretionary contributions from donors, is a case in point. In an earlier commentary, contributor Ilona Kickbusch and a colleague described that fact that the Gates Foundation now spends more each year on health than the amount available for WHO's core operations as 'a scandal of global health governance' in which WHO member states 'are giving up their major instrument to drive health policy and ensure health security' (Kickbusch and Payne 2004, 10–11). We must recall, however, that the instrument was given up voluntarily by national governments with other priorities – as Hein and Kickbusch remind us, 'in a world with numerous centres of power, many of which are not committed to improving global health governance'.