

Denaturalizing scarcity: a strategy of enquiry for public-health ethics

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Abstract Most scarcities that underpin health disparities within and among countries are not natural; rather, they result from policy choices and the operation of social institutions. Using examples from the United States of America: the Chicago heat wave and hurricane Katrina, this paper develops “denaturalizing scarcity” as a strategy for enquiry to inform public-health ethics in an interconnected world. It first describes some of the resource scarcities that are of greatest concern from a public-health perspective, and then outlines two (not mutually exclusive) lines of ethical reasoning that demonstrate their importance. One of these involves the multiple relationships that link rich and poor across national borders in today’s interconnected world. The paper then briefly describes ways in which globalization and the associated institutions are linked to health-threatening scarcities. The paper concludes that denaturalizing scarcity represents a valuable alternative to mainstream health ethics, directing our attention instead to why some settings are “resource poor” and others are not.

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Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.

Why “denaturalizing scarcity”?

In 1995, a heat wave resulted in the deaths of more than 500 people in Chicago, United States of America (USA). Eric Klinenberg’s “social autopsy” of this episode points out that “the processes through which Chicagoans lost their lives followed the entrenched logic of social and spatial divisions that governs the metropolis”.¹ People in Chicago’s poorest neighbourhoods, also with some of the highest proportions of African-Americans as the result of a history of racial segregation, were least likely to have, or be able to afford, air conditioning. In particular, realistic fear of crime kept the elderly socially isolated and barricaded into their homes, while a downsized city government failed to link residents with services that could have saved their lives. In 2005, the impact of hurricane Katrina on New Orleans brought to worldwide attention the deadly mix of racial and economic segregation, failure to invest in adequate flood-control measures despite ample warnings, and the presumption that everyone could afford to get in a car and drive to safety. When the storm hit, those who did not have this option, over-

whelmingly poor and African-American, were effectively abandoned as refugees in their own country.^{2,3}

The impacts of the heat wave and the hurricane were not natural, any more than the inability of people in wheelchairs to get around buildings without ramps and elevators is natural. Here, I adapt the title of Klinenberg’s study (*Denaturalizing Disaster*)¹ to the study of scarcities of resources to provide health care or to remove causes of illness by addressing social determinants of health. These scarcities are rarely natural, in the sense that they originate in circumstances outside human control. Far more common, in the words of Calabresi & Bobbitt’s *Tragic Choices*,⁴ are situations in which “scarcity is not the result of any absolute lack of a resource but rather of the decision by society that it is not prepared to forgo other goods and benefits in a number sufficient to remove the scarcity”. The starting point of my argument is that to conduct responsible policy analysis: “We must determine where – if at all – in the history of a society’s approach to the particular scarce resource, a decision substantially within the control of that society was made as a result of which the resource was permitted to remain

scarce. ... Scarcity cannot simply be assumed as a given”.⁴ Denaturalizing scarcity is a strategy for applying this insight to research, policy analysis and advocacy.

On the affordability of saving (and taking) lives

What kinds of scarcities are at issue? In the context of high-income countries, consider the USA’s failure to provide health insurance for more than 40 million people, with predictable medical and financial consequences. On one estimate, providing health coverage for the uninsured would cost US\$ 100 billion a year: a huge sum, yet just half the annual cost of the country’s military adventure in Iraq.⁵ Using a measure designed for cross-national comparisons, the prevalence of child poverty in the USA is 10 times as high as it is in Norway.⁶ The difference matters for public health, not only because of the long-term importance of early childhood development⁷ but also because an economic gradient in health status is evident even in the richest societies, although generally less steep in more egalitarian ones.^{8,9} Such situations direct our attention to na-

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Ted Schrecker

tional choices and priorities that make resources scarce for some purposes, but abundant for others.

However, this paper concentrates on even more dramatic global contrasts between scarcity and abundance and their implications for public health. Per capita spending on health care varies by two orders of magnitude between rich and poor countries, from US\$ 15 per capita in the least developed countries (as defined by the United Nations) where 770 million people live, and US\$ 24 per capita in low-income countries (as defined by the World Bank) where 2.4 billion people live, to US\$ 3687 per capita in high-income countries.¹⁰ In low-income countries, much health-care spending is out of pocket, may not benefit those whose health is poorest or most precarious, and may have catastrophic financial consequences for the household even when it does. The estimated US\$ 40 minimum cost of providing basic health care per person per year is out of reach for many low-income countries, and will remain so for some time without major infusions of external resources.¹¹

Another illustration of the impact of scarcity comes from researchers associated with the Bellagio Study Group on Child Survival, who estimate that a package of interventions costing US\$ 5.1 billion per year would save the lives of 6 million children per year in 42 countries that account for 90% of the global toll of under-5 child mortality.¹² This figure is imprecise (it could be as high as US\$ 8 billion) and it is an underestimate because it includes direct costs but not the costs of maintaining, rebuilding or expanding health systems that in many developing countries are fragile or collapsing. Nevertheless, it suggests an affirmative answer to the question: “Can the world afford to save the lives of 6 million children each year?”¹²

Health-threatening resource scarcities are equally conspicuous with respect to social determinants of health. The World Bank estimates that a billion people worldwide live below its “US\$ 1 a day” poverty line and 2.6 billion, or two-fifths of the world’s people, below the “US\$ 2 a day” threshold.¹⁰ Many commentators argue that these poverty lines substantially understate the true extent of serious deprivation.^{13,14} Approximately 850 million people suf-

fer from chronically insufficient caloric intake.¹⁵ Apart from undernutrition, poverty creates situations in which the daily routines of living are themselves hazardous. More than 850 million people now live in slums, where they are routinely exposed to multiple health hazards;¹⁶ rapid urbanization will increase the number to 1.4 billion in 2020 in the absence of effective policy interventions.¹⁷ Indoor pollution from cooking fires is a major contributor to respiratory disease among the world’s poor,¹⁸ as is lack of safe drinking water and sanitation to infectious diarrhoea and a variety of parasitic diseases.¹⁹ These are just selected demonstrations that “many of the most devastating problems that plague the daily lives of billions of people are problems that emerge from a single, fundamental source: the consequences of poverty and inequality”.²⁰

Why care about scarcity in the context of public health?

Why should we care about resource scarcities that distribute the chance to live a long and healthy life unequally within and among societies? In oversimplified terms, two lines of reasoning, which are not mutually exclusive, can be identified.

First, widespread persistence of unmet basic needs related to health may be regarded as creating at least a *prima facie* case for allocating resources in a way that gives priority to meeting those needs. Henry Shue²¹ captured the essence of this argument 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”. If the quantum of resources available were such that reducing the availability of caviar to a few would not have a meaningful effect on access to black beans (or basic health care, or other social determinants of health) for all, then Shue’s observation would have limited relevance. However, this is not the case. The US\$ 5.1 billion annual cost of child-saving interventions referred to above corresponds to less than four days’ US military spending, and is less than the personal incomes of the United States’ two highest-earning hedge fund managers in 2007.²² Redistributing just 0.9% of

the global economic product would be sufficient to raise the income of all the world’s poor above the World Bank’s US\$ 2 a day threshold.²³ Such comparisons can be dismissed as polemical, but in addition to serving as a resource for ethical reflection they underscore an observation by economist Jeffrey Sachs, who directed a multinational research effort on how to achieve the United Nations’ Millennium Development Goals²⁴: “[I]n a world of trillions of dollars of income every year, the amount of money that you need to address the health crises is easily available”.²⁵

The position that priority should be given to meeting basic health-related needs gains force from the moral arbitrariness of accidents of birth²⁶ that determine (for instance) whether one will be born in Canada, where life expectancy at birth is 80 years, or in Zambia, where it is 38 years. It loses force, for some, because it fails to specify the basis for an obligation to mitigate the consequences of such accidents, especially across national borders. A second line of reasoning, which responds to this challenge, starts from factual evidence of multiple causal connections that link the situations and futures of rich and poor. This position is most closely associated with the work of Thomas Pogge,^{23,27,28} for whom moral responsibility follows causal responsibility (for poverty and other deprivations) within and across national borders, so long as a plausible alternative set of social arrangements or institutions that would be less inimical to poverty reduction and meeting other basic needs is available.

As shown in the next section of this paper, such plausible alternative arrangements can readily be imagined. The strategy of enquiry is important because unless one rejects *a priori* the position that remediable health-threatening scarcities of resources are a matter of ethical concern, denaturalizing scarcity is in some respects at least *logically prior* to the effort to construct an ethical argument in support of obligations to reduce or eliminate scarcities, within or across national borders. Only after resource scarcities have been identified as the consequence of either specific policy choices or more general social arrangements can appropriate ethical arguments be constructed.

Denaturalizing scarcity and globalization

Denaturalizing scarcity in the international frame of reference starts with understanding globalization: the increasingly dense web of trade and investment flows and institutional relationships that connects people in rich and poor countries.²⁹ Those flows and relationships are “asymmetrical” in multiple dimensions.³⁰

Trade policy provides the most familiar example. Because the relative size of industrialized- and developing-country markets creates major disparities in bargaining power, developing countries may have to give up a great deal in return for market access, especially in the context of bilateral and regional agreements;³¹ for instance, the United States is trying to incorporate provisions that undermine hard-won flexibilities with respect to patent rights and access to essential medicines.³² More generally, global reorganization of production across multiple national borders – facilitated by trade liberalization, but long predating the establishment of the World Trade Organization – has created a situation in which countries must compete for foreign direct investment and outsourced contract production. Although effects on health are not always or unequivocally destructive, the World Bank’s observation that global reorganization of production “mercilessly weeds out those centers with below-par macroeconomic environments, services, and labor-market flexibility”³³ is indicative of the constraints involved.

Many developing countries found themselves unable to service their external debts starting in the early 1980s, for reasons largely outside their control. The International Monetary Fund (IMF), along with the World Bank, offered “structural adjustment” loans to facilitate rescheduling these debts, but the loans were predicated on a package of macroeconomic policies designed primarily to protect recipient countries’ ability to repay external creditors.^{34–36} Structural adjustment also had the effect, probably intentional, of promoting the broader, market-oriented agenda of key Group of Seven (G7) nations at the time.³⁶ The resulting economic dislocations and austerity measures often had destructive effects on

health-care spending and social determinants of health – noted as early as 1987 by a United Nations Children’s Fund (UNICEF) study calling instead for “adjustment with a human face”³⁷ – and were often met with widespread popular resistance.

Although the IMF is now less important as a lender, its influence remains pervasive. Private investors view IMF approval of a country’s macroeconomic policies as an indispensable endorsement, and the IMF and World Bank must sign off on a country’s policies as a condition for many forms of development assistance, including debt relief under the Multilateral Debt Relief Initiative. This process appears to reproduce many earlier forms of conditionality, with an emphasis on rapid integration into the global marketplace.^{38–40} Recently, the IMF’s demand for public-sector wage expenditure ceilings has been criticized for preventing the hiring of badly needed health personnel and teachers, even when the funds are available from development assistance. The IMF first disputed these criticisms, but internal and external assessments confirmed in 2007 that public-sector wage-bill ceilings were often recommended; that IMF projections of future development assistance were consistently low, leading to excessive caution with respect to public expenditure; and that in 29 sub-Saharan countries, IMF strictures meant that just 27 cents of every incremental US dollar in development assistance was budgeted for new programmes, with the balance being used for repaying domestic debt and accumulating foreign-exchange reserves.^{41,42} This is correct as textbook public finance, but potentially destructive of health and education systems that are already fragile.

A more subtle dynamic of “implicit conditionality”⁴³ operates when governments are constrained by capital hypermobility in global financial markets. Economic crises that reduce the value of national currencies by 50% or more, and spread unemployment and economic insecurity, exemplify what a former managing director of the IMF has called the “swift, brutal and destabilizing” consequences that ensue when policies are not “deemed basically sound” by investors.⁴⁴ Less dramatically, financial markets’ anticipation of redistributive domestic policies can

lead the governments in question, e.g. Brazil’s during the first term of the Workers’ Party and South Africa’s post-1994, to accept high unemployment and limited social expenditure^{45,46} – “dismal development and excellent macroeconomic outcomes”, in the words of one observer of South Africa.⁴⁷ Thus, a sophisticated researcher warns that “those societies most in need of egalitarian redistribution may have, in terms of external financial market pressures, the most difficulty achieving it”.⁴⁸ The global financial marketplace further facilitates patterns of capital flight that contribute to shortages of resources for development in entire regions, such as sub-Saharan Africa.^{49,50}

These dynamics, and many others described more extensively elsewhere,^{29,51} suffice to demonstrate that in today’s global economy, resource scarcities that threaten health are – like those in the specific contexts of the Chicago heat wave and the New Orleans hurricane – anything but natural. They are the outcomes of decisions that could have been made differently and, in particular, of social institutions that could be designed differently.²³

Informing philosophy and practice

Some philosophers concede that health-related resource scarcities give rise to ethical obligations within national borders, yet argue that despite the moral arbitrariness of the accidents of birth referred to earlier, obligations that would entail global redistribution of resources can only exist within a previously established framework of institutional associations and political accountabilities analogous to the nation-state. They further assert that no such framework exists on a global scale.⁵²

Moellendorf counters persuasively that both the historical record (for instance of colonialism and its legacies) and today’s multiple cross-border economic connections, such as foreign direct investment flows and the reach of the IMF, constitute a “global association” sufficient to give rise to claims of distributive justice across borders.⁵³ Indeed, it is perverse in the extreme to reject the existence of health-related ethical obligations that cross national borders simply *because* no mechanisms exist to hold powerful social institutions, and the key actors within them,

Ted Schrecker

accountable for scarcities they cause or perpetuate, perhaps half a world away. The situation would seem, rather, to call for an intensified effort to create such mechanisms where they do not exist, and improve the effectiveness of the imperfect institutions of international governance (such as the framework of human rights law)⁵⁴ that are available. Expanding on these possibilities would require a separate paper.

Certainly, accepting the existence of duties of international justice related to the causes of health disparities does not define the scope of the relevant obligations. Denaturalizing scarcity will not resolve that debate, but can contribute usefully in the context of increased policy attention to health equity: the

absence of disparities in health that are unfair, unavoidable and systematically related to social (dis)advantage.⁵⁵ Critical and informed study of policies and institutions that affect the distribution of opportunities to lead a healthy life, both within and across national borders, lends strong support to the position of the Commission on Social Determinants of Health that: “The vast majority of inequalities in health, between and within countries, are avoidable and, hence, inequitable”.⁵⁶ Mainstream health ethics usually accept scarcity as given and adaptation as imperative: for instance, by proposing substantive criteria or procedural algorithms for setting priorities in “resource-poor settings”.

Denaturalizing scarcity asks, instead, why some settings are consistently and fatally resource poor and others are not. It is therefore an indispensable foundation for a public-health ethics that lives up to the historical tradition of public-health practice by searching for the root causes of illness and injury. ■

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Résumé

Dénaturalisation des pénuries : une stratégie d'enquête pour une éthique de la santé publique

La plupart des pénuries à la base des disparités sanitaires au sein d'un même pays ou entre des pays différents ne sont pas naturelles ; elles résultent plutôt de choix politiques et du fonctionnement d'institutions sociales. A partir des exemples américains de la vague de chaleur de Chicago et de l'ouragan Katrina, le présent article développe le principe d'une dénaturalisation des pénuries en tant que stratégie d'enquête pour fournir une base factuelle à l'élaboration d'une éthique de la santé publique dans un monde interconnecté. Il commence par décrire certaines des pénuries de ressources les plus préoccupantes d'un point de vue de santé publique et

ébauche deux lignes de raisonnement éthique (ne s'excluant pas mutuellement), qui démontrent leur importance. L'une d'elles fait intervenir les multiples relations qui relient riches et pauvres à travers les frontières nationales du monde interconnecté actuel, ce qui permet ensuite à l'article de présenter brièvement les imbrications entre globalisation et institutions associées conduisant à des pénuries menaçantes pour la santé. En conclusion, l'article affirme que la dénaturalisation de la pénurie représente une alternative intéressante à l'éthique sanitaire classique, en attirant notre attention sur les raisons pour lesquelles certains pays sont « pauvres en ressources » et d'autres non.

Resumen

Desnaturalizar la escasez: estrategia de indagación para una ética de salud pública

La mayoría de las escaseces que dan lugar a disparidades sanitarias en los países y entre ellos no son naturales; antes bien, se deben a decisiones de política y al funcionamiento de las instituciones sociales. Utilizando ejemplos extraídos de los Estados Unidos de América, concretamente la ola de calor sufrida por Chicago y el huracán Katrina, en este artículo se da forma al concepto de “desnaturalización de la escasez” como estrategia de indagación que fundamente la ética de salud pública en un mundo interconectado. En primer lugar se describen algunas de las situaciones de escasez de recursos más preocupantes desde una perspectiva de salud pública, y a continuación se exponen dos

líneas de razonamiento ético (no incompatibles) que demuestran su importancia. Una de ellas guarda relación con los numerosos vínculos que ligan a ricos y pobres a través de las fronteras nacionales en el mundo interconectado de hoy día, y en este sentido el artículo describe la manera en que la mundialización y las instituciones asociadas están vinculadas a escaseces que amenazan la salud. Se llega a la conclusión de que la desnaturalización de la escasez es una valiosa alternativa a la ética sanitaria dominante, obligándonos a determinar las razones de que unos entornos sean «de recursos escasos» y otros no.

ملخص

نزع السمة الطبيعية عن الندرة: استراتيجية للتحقق من وجود الضوابط الأخلاقية في الصحة العمومية

البحثية استخدام السمة الطبيعية عن الندرة كاستراتيجية للتحقق من وجود الضوابط الأخلاقية في الصحة العمومية في ظل عالم مترابط. وتبدأ الورقة البحثية بوصف بعض أوجه ندرة الموارد الباعثة على قلق بالغ من منظور الصحة العمومية، ثم تحدد خطين (لا يمنع وجود أحدهما وجود

إن معظم حالات ندرة الموارد التي تؤدي إلى التفاوت الصحي داخل البلدان، وفيما بينها ليست بفعل الطبيعة، وإنما تنجم عن الاختيارات السياسية، وطرق تشغيل المؤسسات الاجتماعية وباستخدام أمثلة من الولايات المتحدة الأمريكية كإعصار كاترينا، والموجة الحارة في شيكاغو تظهر هذه الورقة

هذه الورقة إلى أن نزع السمة الطبيعية عن الندرة يمثل بديلاً ذا قيمة لتوحيد الأخلاقيات الصحية، ويوجه اهتمامنا بدلاً من ذلك إلى سبب (شح الموارد) في بعض المناطق دوناً عن غيرها.

الآخر) من الاستدلالات الأخلاقية التي توضح أهميتهما. ويتضمن أحدهما العلاقات المتعددة التي تربط بين الفقراء والأغنياء عبر الحدود الوطنية في ظل عاملنا المترابط. ثم تصنف الورقة بإيجاز السبل التي تؤدي إلى ارتباط العولمة، والمؤسسات المتأثرة بها، بحالات الندرة التي تهدد الصحة. وتخلص

References

1. Klinenberg E. Denaturalizing disaster: a social autopsy of the 1995 Chicago heat wave. *Theory Soc* 1999;28:239-95. doi:10.1023/A:1006995507723
2. Dreier P. Katrina and power in America. *Urban Aff Rev Thousand Oaks Calif* 2006;41:528-49. doi:10.1177/1078087405284886
3. Hartman C, Squires GD, eds. *There is no such thing as a natural disaster: race, class, and hurricane Katrina*. New York: Routledge; 2006.
4. Calabresi G, Bobbitt P. *Tragic choices*. New York: WW Norton; 1978. pp. 22, 150-1.
5. Leonhardt D. What \$1.2 trillion can buy. *New York Times* 2007; 17 Jan. Available from: <http://www.nytimes.com/2007/01/17/business/17leonhardt.html> [accessed on 9 June 2008].
6. *Child poverty in rich countries 2005*. Florence: UNICEF, Innocenti Research Centre; 2005.
7. Irwin LG, Siddiqi A, Hertzman C. *Early child development: a powerful equalizer – final report of the Early Child Development Knowledge Network* [to the WHO Commission on Social Determinants of Health]. Vancouver: Human Early Learning Partnership, University of British Columbia; 2007. Available from: http://www.who.int/social_determinants/resources/eecd_kn_report_07_2007.pdf [accessed on 9 June 2008].
8. Siddiqi A, Kawachi I, Berkman L, Subramanian SV, Hertzman C. Variation of socioeconomic gradients in children's developmental health across advanced capitalist societies: analysis of 22 OECD nations. *Int J Health Serv* 2007;37:63-87. PMID:17436986 doi:10.2190/JU86-457P-7656-W4W7
9. Phipps SA, Burton PS, Osberg LS, Lethbridge LN. Poverty and the extent of child obesity in Canada, Norway and the United States. *Obes Rev* 2006;7:5-12. PMID:16436098 doi:10.1111/j.1467-789X.2006.00217.x
10. HNPStats [on-line]. World Bank Health Nutrition & Population Program. Available from: <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTDATASTATISTICSHNP/EXTHNPSTATS/0,,menuPK:3237172~pagePK:64168427~piPK:64168435~theSitePK:3237118,00.html> [accessed on 9 June 2008].
11. Ooms G, Damme WV, Baker BK, Zeitz P, Schrecker T. The "diagonal" approach to global fund financing: a cure for the broader malaise of health systems? *Globalization and Health* 2008;4:6. Available from: <http://www.globalizationandhealth.com/content/4/1/6> [accessed on 9 June 2008].
12. Bryce J, Black RE, Walker N, Bhutta ZA, Lawn JE, Steketee RW. Can the world afford to save the lives of 6 million children each year? *Lancet* 2005;365:2193-200. PMID:15978927 doi:10.1016/S0140-6736(05)66777-3
13. Reddy SG, Pogge TW. *How not to count the poor*, version 6.2. New York: Columbia University; 2005. Available from: <http://www.undp-povertycentre.org/publications/poverty/HowNOTtoountthePoor-SANJAYREDDY.pdf> [accessed on 9 June 2008].
14. Satterthwaite D. The Millennium Development Goals and urban poverty reduction: great expectations and nonsense statistics. *Environ Urban* 2003; 15:179-90. doi:10.1177/095624780301500208
15. *The state of food insecurity in the world 2006*. Rome: United Nations Food and Agriculture Organization; 2006. Available from: <ftp://ftp.fao.org/docrep/fao/009/a0750e/a0750e00.pdf> [accessed on 9 June 2008].
16. Unger A, Riley LW. Slum health: from understanding to action. *PLoS Medicine* 2007;4:e295. Available from: <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0040295&ct=1> [accessed on 9 June 2008].
17. UN Millennium Project Task Force on Improving the Lives of Slum Dwellers. *A home in the city*. London: Earthscan; 2005.
18. Rehfuess E. *Fuel for life: household energy and health*. Geneva: WHO; 2006. Available from: <http://www.who.int/entity/indoorair/publications/fuelforlife.pdf> [accessed on 9 June 2008].
19. Prüss A, Kay D, Fewtrell L, Bartram J. Estimating the burden of disease from water, sanitation, and hygiene at a global level. *Environ Health Perspect* 2002;110:537-42. PMID:12003760
20. Paluzzi JE, Farmer PE. The wrong question. *Development* 2005;48(1):12-18. doi:10.1057/palgrave.development.1100114
21. Shue H. Environmental change and the varieties of justice. In: Hampson F, Reppy J, eds. *Earthy goods: environmental change and social justice*. Ithaca, NY: Cornell University Press; 1996. pp. 9-29.
22. Taub S. Alpha's top moneymakers. *Alpha Magazine* 2008, 15 April. Available from: <http://www.iimagazine.com/Article.aspx?articleID=1914971&HideRelated=1&SearchResult=1> [accessed on 9 June 2008].
23. Pogge T. Severe poverty as a human rights violation. In: Pogge T, ed. *Freedom from poverty as a human right: who owes what to the very poor?* Oxford: Oxford University Press; 2007 pp. 11-53.
24. *Investing in development: a practical plan to achieve the Millennium Development Goals*. UN Millennium Project. London: Earthscan; 2005.
25. Sachs J. Achieving the Millennium Development Goals: health in the developing world. Speech at the: *Second Global Consultation of the Commission on Macroeconomics and Health*. Geneva: WHO; 2003. Available from: <http://www.earth.columbia.edu/sitefiles/File/about/director/pubs/CMHspeech102903.pdf> [accessed on 9 June 2008].
26. Ruger JP. Ethics and governance of global health inequalities. *J Epidemiol Community Health* 2006;60:998-1002. PMID:17053290 doi:10.1136/jech.2005.041947
27. Pogge T. Human rights and human responsibilities. In: De Greiff P, Cronin C, eds. *Global justice and transnational politics*. Cambridge, MA: MIT Press; 2002. pp. 151-95.
28. Pogge T. Recognized and violated by international law: the human rights of the global poor. *Leiden J Int Law* 2005;18:717-45. doi:10.1017/S0922156505002980
29. Labonté R, Schrecker T. Globalization and social determinants of health: the role of the global marketplace (part 2 of 3). *Globalization and Health* 2007;3:6. PMID:17578569 doi:10.1186/1744-8603-3-6
30. Birdsall N. *The world is not flat: inequality and injustice in our global economy*. WIDER Annual Lecture 9. Helsinki: World Institute for Development Economics Research; 2006. Available from: http://www.wider.unu.edu/publications/annual-lectures/en_GB/annual-lectures/ [accessed on 9 June 2008].
31. Shadlen KC. Exchanging development for market access? Deep integration and industrial policy under multilateral and regional-bilateral trade agreements. *Rev Int Polit Econ* 2005;12:750-75. doi:10.1080/09692290500339685
32. *U.S. trade policy guidance on WTO declaration on access to medicines may need clarification*, GAO-07-1198. Washington, DC: United States Government Accountability Office; 2007. Available from: <http://www.gao.gov/new.items/d071198.pdf> [accessed on 9 June 2008].
33. *World development report 1999/2000: entering the 21st century*. New York: Oxford University Press; 1999. p. 50.
34. Milward B. What is structural adjustment? In: Mohan G, Brown E, Milward B, Zack-Williams AB, eds. *Structural adjustment: theory, practice and impacts*. London: Routledge; 2000. p. 24-38.
35. Babb S. The social consequences of structural adjustment: recent evidence and current debates. *Annu Rev Sociol* 2005;31:199-222. doi:10.1146/annurev.soc.31.041304.122258
36. Woods N. *The globalizers: the IMF, the World Bank, and their borrowers*. Ithaca, NY: Cornell University Press; 2006.
37. Cornia GA, Jolly R, Stewart F, eds. *Adjustment with a human face, vol. 1: Protecting the vulnerable and promoting growth*. Oxford: Clarendon Press; 1987.
38. Cheru F. *Economic, social and cultural rights: the highly indebted poor countries (HIPC) initiative: a human rights assessment of the Poverty Reduction Strategy Papers (PRSP)*, E/CN.4/2001/56. Geneva: UN Economic and Social Council; 2001. Available from: [http://www.unhcr.ch/Huridocda/Huridocda.nsf/O/d3b348546ad5fb91c1256a110056aca4/\\$FILE/G0110184.pdf](http://www.unhcr.ch/Huridocda/Huridocda.nsf/O/d3b348546ad5fb91c1256a110056aca4/$FILE/G0110184.pdf) [accessed on 9 June 2008].

Ted Schrecker

39. Gore C. MDGs and PRSPs: are poor countries enmeshed in a global-local double bind? *Global Social Policy* 2004;4:277-83. doi:10.1177/146801810400400302
40. Brock K, McGee R. *Mapping trade policy: understanding the challenges of civil society participation*. IDS working paper 225. Brighton, Sussex: Institute for Development Studies; 2004. Available from: <http://www.ids.ac.uk/ids/bookshop/wp/wp225.pdf> [accessed on 9 June 2008].
41. *The IMF and aid to sub-Saharan Africa*. Washington, DC: Independent Evaluation Office, International Monetary Fund; 2007.
42. Working Group on IMF Programs and Health Spending. *Does the IMF constrain health spending in poor countries? Evidence and an agenda for action*. Washington, DC: Center for Global Development; 2007.
43. Griffith-Jones S, Stallings B. New global financial trends: implications for development. In: Stallings B, ed. *Global change, regional response: the new international context of development*. Cambridge: Cambridge University Press; 1995. pp. 143-73.
44. Camdessus M. *The IMF and the challenges of globalization – the fund's evolving approach to its constant mission: the case of Mexico. Address at Zurich Economics Society*. Washington, DC: International Monetary Fund; 1995. Available from: <http://www.imf.org/external/np/sec/mds/1995/mds9517.htm> [accessed on 9 June 2008].
45. Evans P. Neoliberalism as a political opportunity: constraint and innovation in contemporary development strategy. In: Gallagher K, ed. *Putting development first: the importance of policy space in the WTO and IFIs*. London: Zed Books; 2005. pp. 195-215.
46. Koelble T, Lipuma E. The effects of circulatory capitalism on democratization: observations from South Africa and Brazil. *Democratization* 2006;13:605-31. doi:10.1080/13510340600791913
47. Streak JC. The GEAR legacy: did GEAR fail or move South Africa forward in development? *Dev South Afr* 2004;21:271-88. doi:10.1080/0376835042000219541
48. Mosley L. Constraints, opportunities, and information: financial market–government relations around the world. In: Bardhan P, Bowles S, Wallerstein M, eds. *Globalization and egalitarian redistribution*. New York and Princeton: Russell Sage Foundation and Princeton University Press; 2006. pp. 87-119.
49. Ndikumana L, Boyce JK. Public debts and private assets: explaining capital flight from sub-Saharan African countries. *World Dev* 2003;31:107-30. doi:10.1016/S0305-750X(02)00181-X
50. Collier P, Hoeffler A, Pattillo C. Flight capital as a portfolio choice. *World Bank Econ Rev* 2001;15:55-80. doi:10.1093/wber/15.1.55
51. Labonte R, Blouin C, Chopra M, Lee K, Packer C, Rowson M, et al. *Towards health-equitable globalisation: rights, regulation and redistribution*. Final report of the Globalization Knowledge Network [to the WHO Commission on Social Determinants of Health]. Ottawa, ON: Institute of Population Health, University of Ottawa; 2007. Available from: http://www.who.int/social_determinants/resources/gkn_final_report_042008.pdf [accessed on 9 June 2008].
52. Nagel T. The problem of global justice. *Philos Public Aff* 2005;33:113-47. doi:10.1111/j.1088-4963.2005.00027.x
53. Moellendorf D. *Cosmopolitan justice*. Boulder, CO: Westview; 2002. pp. 31-9.
54. Nygren-Krug H. *25 questions and answers about health and human rights*. Geneva: WHO; 2002. Available from: <http://www.who.int/hhr/NEW378710MSOK.pdf> [accessed on 9 June 2008].
55. Solar O, Irwin A. *A conceptual framework for action on the social determinants of health*. Geneva: WHO (Commission on Social Determinants of Health); 2007. Available from: http://www.who.int/entity/social_determinants/resources/csdh_framework_action_05_07.pdf [accessed 9 June 2008].
56. *Achieving health equity: from root causes to fair outcomes* [interim statement]. Geneva: WHO (Commission on Social Determinants of Health); 2007. pp. 2. Available from: http://libdoc.who.int/publications/2007/interim_statement_eng.pdf [accessed on 9 June 2008].