Why Are Some Settings Resource-poor and Others Not? The Global Marketplace, Perfect Economic Storms, and the Right to Health

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ABSTRACT

Analyses of how health system priorities should be set in resource-poor settings are routine in the health ethics and policy analysis literature. Less attention is devoted to asking why some settings are resource-poor and others not. Asking this question must be considered a central task of global health research. Comparison of the relatively meager resources devoted to improving the health of the poor with the sums routinely mobilized for other purposes serves as a basis for ethical reflection and a route into necessary questioning of power imbalances in the world economy. The 2008 financial crisis and related developments underscore the urgency of such questioning, and the value of research and advocacy collaborations (for example, between the human rights and public health research and practice communities) focused specifically on the destructive consequences of the global marketplace for health.

Key words: Globalization; resource allocation; economic conditions; ethics

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If a well-understood process every day caused four or five airliners to crash, the situation would be regarded as a humanitarian emergency. It would dominate the headlines, especially if ways of avoiding the crashes were well known and widely practised in some parts of the world.

Now consider complications of pregnancy and childbirth, which kill 358,000 women per year, overwhelmingly in low- and middle-income countries (LMICs). In Canada, a woman's lifetime risk of dying from complications of pregnancy or childbirth is 1 in 5,600; in sub-Saharan Africa, the world's poorest region, it is 1 in 31.¹ According to one estimate, "for every woman who dies, an estimated 30 women live to suffer severe morbidities including infertility, fistula, and incontinence."²(p. 132) Interventions that would drastically reduce this carnage are demonstrably effective, cost relatively little, and are taken for granted where most readers of this article live.³

Similar observations apply to many other causes of illness and death, with even higher casualty counts. My focus here is on how researchers and practitioners should respond to such everyday emergencies. The most common response in health ethics and system planning is to take the resource constraints as given. So, we routinely encounter analyses of how health system priorities should be set where, for example, only \$0.50/person is spent annually on interventions to reduce maternal mortality, as in sub-Saharan Africa.⁴ It is hard to question the logic of "facing reality" by selecting the least costly interventions for priority support.² However, *this kind of analysis is not enough*. It is also imperative to investigate and challenge the economic systems and political choices that condemn billions of people to short and unhealthy lives – an approach embodied in the work of the WHO Commission on Social Determinants of Health.⁵

In other words, we need to ask *why some settings are resource-poor and others not* – a question deliberately patterned on the title of a

core text in population health.⁶ Asking it, relentlessly and – when necessary – impolitely, must be considered a central task and a professional obligation for researchers and practitioners working in global health, but also as a priority when resource constraints remain unexamined in high-income settings.

HIV/AIDS kills 1.5 million people per year and 19 out of 20 new infections occur in LMICs,⁷ yet we often hear that too much is spent on AIDS prevention and treatment relative to other health-related objectives such as water and sanitation.⁸ Despite recent progress, universal coverage for antiretroviral therapy is not at hand, especially in sub-Saharan Africa. However, a 2008 report published by the Center for Global Development (CGD) did not argue for more resources to improve access. Instead it warned that PEP-FAR, the US program that has financed antiretroviral therapy for a million people, was "hard to justify on investment grounds"; criticized it as a "state supported international welfare program"; and called on the United States to "moderate the expansion of treatment entitlements."⁹ The report's language reveals a widespread underlying logic that distinguishes worthwhile from unworthy expenditures on the health of the world's poor.

Then a financial crisis that originated in the United States swept across the world, generating new claims on public treasuries and new talk about resource scarcity. In May 2010, Médecins Sans Frontières observed that treatment access was already limited in coun-

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tries like Uganda;¹⁰ a *New York Times* article anticipated the consequences. “[F]or most of Africa and scattered other countries like Haiti, Guyana and Cambodia, it seems inevitable that the 1990s will return: walking skeletons in the villages, stacks of bodies in morgues, mountains of newly turned earth in cemeteries.”¹¹ In October 2010, high-income countries committed \$9.2 billion over the next three years to the Global Fund to Fight AIDS, Tuberculosis and Malaria – far below the \$20 billion the Fund estimated it would need to continue to fund existing programs and scale up initiatives that were performing well.¹² The Fund’s activities represent only one element of the concerted program of action that would be needed to achieve the WHO Commission’s objective of “closing the gap in a generation”.

Superficially impressive, the sums in question are dwarfed by the more than \$1 trillion spent each year by the countries of the world on armies and armaments, and on other objectives considered by the powerful to have a higher priority. The financial crisis foregrounded these issues. The overseer of the Troubled Asset Relief Program (TARP) told the US Congress in July 2009 that “funding at risk” – money the US government might not get back – amounted to at least \$2.3 trillion.¹³ Against this backdrop, why are AIDS and safe drinking water considered competitors one with the other, rather than with arms purchases and corporate bailouts?

Such questions are sometimes dismissed as polemical; I consider them an indispensable basis for ethical reflection. And since the bailouts responded to what was correctly described early in the history of the crisis as a hostage-taking by the financial services industry,¹⁴ it is essential also to ask how repetitions can be averted and costs recovered from those who made fortunes in financial manipulations that created the crisis, rather than being socialized through long periods of public sector austerity in countries such as Greece, Ireland and the United Kingdom. Expenditure cuts will themselves have health consequences; in the UK, they are likely to magnify health disparities between rich and poor that are already wider than at any point since the Great Depression.¹⁵

Investigating the origins of resource scarcity in this way leads inexorably to the WHO Commission’s conclusion that “changes in the operation of the global economy” represent a prerequisite for reducing health disparities.⁵ Having sounded vaguely utopian in August 2008, by October the Commission appeared remarkably prescient.¹⁶ Over the past few decades, most of the world has been drawn into the global marketplace, often on terms dictated by the world’s most powerful countries. Corporate investors can search the world for cheaper and more flexible workers, often increasing economic inequality in countries rich and poor alike¹⁷ and driving growing numbers of people into global “survival circuits”¹⁸ of low-wage jobs and remittances that reach into countries like Canada and the United States.^{18,19} Deregulated financial markets have enabled domestic elites and foreign investors alike to shift assets into safe havens offshore, creating crises that have plunged millions into poverty. Even the anticipation of such crises creates a powerful constraint on the social policies of elected governments.²⁰

The 2008 crisis originated in a combination of financial deregulation with a new and ingenious way of extracting resources from households (the securitization of high-risk mortgages) that “moves faster than extracting profit from lowering wages.”²¹ As with many other aspects of globalization, first and worst affected by the crisis are people who had no control over the events that generated it –

for example, the additional 265,000 infants and 1.2 million children under 5 who may die between 2009 and 2015.²² A similar divide between cause and consequence is evident at the epicentre of the crisis: by mid-2009, more than a million US schoolchildren were homeless or at imminent risk of homelessness, and one in four children lived in a household that was receiving food stamps.^{23,24} An expanding body of evidence suggests that the crisis was not an isolated event, but a manifestation of a new and distinctively predatory form of capitalism.²⁵ Other dimensions include large-scale purchases of land in LMICs to produce for affluent foreign consumers elsewhere²⁶⁻²⁸ and the expanded role of large institutional investors in speculative trading in agricultural commodity markets.^{29,30} Food price increases in 2007-2008 worsened the effects of the financial crisis for millions of households,³¹ leading to a rise in chronic undernutrition.³² Some development scholars now anticipate a “triple crisis” involving interactions among financial volatility, food insecurity and climate change that will exacerbate existing patterns of privation.³³

International relations scholar Richard Falk has called for “a regulatory framework for global market forces that is people-centred rather than capital-driven.”³⁴ One promising response relies on human rights – specifically, economic and social rights as elaborated in political theory and codified in international law.^{35,36} An expanding body of research shows that human rights have great potential as an instrument for reducing health disparities,³⁷ with one study of South Africa, Brazil, India, Nigeria and Indonesia concluding that “legalizing demand for [economic and social] rights might [*sic*] well have averted tens of thousands of deaths in the countries studied ... and has likely enriched the lives of millions of others.”³⁸ (p. 303)

Conceptually, human rights challenge the neoliberal presumption – central to contemporary globalization – that markets are the normal and natural basis for organizing economic and social life. Historical sociologist Margaret Somers captures the importance of this challenge,³⁹ offering the response to Hurricane Katrina as a parable. When the hurricane hit and the long-neglected levees broke, evacuation plans presumed that everyone had access to an automobile. Those who could afford to do so packed up the car and drove to higher ground. Those who could not were left to fend for themselves as refugees in their own country. “Unable to fulfill their side of the newly marketized exchange called citizenship, the left-behind of New Orleans ... did not elicit much concern at any level of government because with their social exclusion they were no longer recognized as moral equals. They had become a surplus, superfluous, and disposable population” (p. 72).

Katrina had nothing to do with globalization, but what was true of “the left behind” in New Orleans is true on a larger scale throughout the world as economies and societies experience the perfect economic storms associated with exposure to the global marketplace.

The focus on human rights directs our attention back to national governments, since for the moment such rights require national or subnational initiative to have legal force. In rich countries and poor, the global marketplace magnifies incentives for governments to neglect their most vulnerable populations – those of greatest concern from a human rights perspective. On issues of social and economic policy, the human rights and public health research and practice communities have seldom interacted. The urgency of such

collaborations cannot be overemphasized. As world-scale juxtapositions of wealth and poverty become routine in the high-income world,^{18,19,40} even public health practitioners concerned mainly with 'acting locally' in their quotidian work environments will confront the consequences of globalization, as global processes define divisions of power and opportunity that penetrate the communities they serve.

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RÉSUMÉ

Dans les travaux publiés sur l'éthique de la santé et l'analyse des politiques, on trouve couramment des analyses de l'établissement des priorités des systèmes de santé dans les milieux pauvres en ressources. On consacre cependant moins d'attention à se demander pourquoi certains milieux sont pauvres en ressources et d'autres non. Or, poser cette question devrait être une tâche centrale de la recherche en santé mondiale. Nous avons comparé les ressources relativement maigres qui sont consacrées à améliorer la santé des pauvres avec les sommes importantes que l'on réunit systématiquement dans d'autres buts, et nous en avons fait la base d'une réflexion éthique et une voie vers un questionnement nécessaire des déséquilibres de pouvoirs dans l'économie mondiale. La crise financière de 2008 et ses répercussions soulignent l'urgence d'un tel questionnement, ainsi que l'utilité des collaborations entre les chercheurs et les défenseurs des droits (p. ex., entre les communautés de recherche et de praticiens en droits humains et en santé publique) qui portent spécifiquement sur les conséquences dévastatrices du marché international pour la santé.

Mots clés : mondialisation; allocation de ressources; économie; éthique