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HEALTH AS FREEDOM: ADDRESSING SOCIAL DETERMINANTS OF GLOBAL HEALTH INEQUITIES THROUGH THE HUMAN RIGHT TO DEVELOPMENT

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ABSTRACT
In spite of vast global improvements in living standards, health, and well-being, the persistence of absolute poverty and its attendant maladies remains an unsettling fact of life for billions around the world and constitutes the primary cause for the failure of developing states to improve the health of their peoples. While economic development in developing countries is necessary to provide for underlying determinants of health – most prominently, poverty reduction and the building of comprehensive primary health systems – inequalities in power within the international economic order and the spread of neoliberal development policy limit the ability of developing states to develop economically and realize public goods for health. With neoliberal development policies impacting entire societies, the collective right to development, as compared with an individual rights-based approach to development, offers a framework by which to restructure this system to realize social determinants of health. The right to development, working through a vector of rights, can address social determinants of health, obligating states and the international community to support public health systems while reducing inequities in health through poverty-reducing economic growth. At an international level, where the ability of states to develop economically and to realize public goods through public health systems is constrained by international financial institutions, the implementation of the right to development enables a restructuring of international institutions and foreign-aid programs, allowing states to enter development debates with a right to cooperation from other states, not simply a cry for charity.

Despite decades of support for international development programs, the persistence of poverty has remained an unsettling reality for billions around the world, limiting developing countries in creating the social conditions necessary for the health of their peoples and generating vast inequalities in health both within and between countries. While economic development in developing countries is necessary to support underlying determinants of health (most prominently through poverty reduction and comprehensive primary health systems), asymmetries in power within the international economic order constrict developing countries in their ability to develop economically and provide public goods for health. Domestic law alone, especially when framed in individualistic

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terms, cannot rise to meet the collective challenges posed by globalized economic markets. This article proposes that states codify, in international human rights law, an ethical framework for ameliorating social determinants of health, providing an institutional mechanism for developing states to realize global health and social justice goals through the human right to development.

This article concludes that a right to development framework – operating through national and global health systems – can reform development processes to reduce global poverty and thereby address underlying determinants of health. In reaching this conclusion, this article first reviews the connections between increasing economic development and improving public health, building the case that developing countries' ability to develop and provide for underlying determinants of health has been constrained through:

1. Loan conditionalities under the neoliberal model of economic development, coupled with 'selective' health interventions, that have constrained states' abilities to build comprehensive primary health systems (social determinants of health *within* countries); and
2. Asymmetries in power within the international economic order that have enabled developed countries to fashion economic institutions to their own advantage (social determinants of health *between* countries).

Based on the weaknesses of an individual right to health in addressing global health inequities under a rights-based approach to development, we find that a collective human right to development would prove a more powerful legal framework to create a just and equitable international economic order for the improvement of health in developing countries.

GLOBAL HEALTH AND DEVELOPMENT: ECONOMIC DEVELOPMENT AS AN UNDERLYING DETERMINANT OF HEALTH

In what are now developed countries, the decline of absolute poverty has proven instrumental in raising health outcomes such as life expectancy and infant mortality.[1] While disparities in chronic conditions persist in developed countries, diseases of poverty have ostensibly been eradicated.[2] Yet, at the end of the 20th century, 1.2 billion people worldwide (approximately 20% of the global population) continued to live on less than $1/day, with nearly half of the world's population (2.8 billion) living on less than $2/day.[3] The health consequences of this extreme poverty remain dire: 14% of the global population (826 million) is undernourished, 16% (968 million) lacks access to safe drinking water, and 40% (2.4 billion) lacks basic sanitation.[4] As a result of this entrenched poverty, developing countries continue to experience high rates of infectious illnesses, shortened lifespan, and diminished quality of life.

Given the close connections between conditions of absolute poverty (defined as a deprivation of basic needs, including food, water and sanitation)[5] and maladies associated with these conditions (manifested most directly in infant mortality), absolute poverty can therefore be viewed as the primary underlying social determinant of poor health in developing countries as well as a 'fundamental cause'[6] of health inequalities between developed and developing countries. As a fundamental cause of poor health, the link between absolute poverty and health cannot be broken merely by addressing the proximal causes of ill-health in poor countries (e.g. dehydration from diarrhea) or implementing programs that address only one sector of the health system. Rather, what is needed is a systemic intervention that can address the totality of underlying determinants of health through the amelioration of absolute poverty. While debates persist as to the relative contribution of socio-economic improvements (living standards),[7] social mobilization,[8] or

[1] A.R. Omran. The Epidemiologic Transition: A Theory of the Epidemiology of Population Change. *Milbank Mem Fund Q* 1971; 49(4): 509–538; S.H. Preston. The Changing Relation Between Mortality and Level of Economic Development. *Population Stud* 1975; 29(2): 231–248; E.S. Golub. 1994. *The Limits of Medicine: How Science Shapes our Hopes for the Cure*. New York: Times Books, Random House.

[2] M. Marmot. 2004. *The Status Syndrome: How Your Social Standing Directly Affects your Health and Life Expectancy*. London: Bloomsbury Publishing.

[3] World Bank. 2001. *World Development Report 2000/01: Attacking Poverty*. (Overview chapter). Available at: http://siteresources.worldbank.org/INTPOVERTY/Resources/WDR/overview.pdf: [Accessed 16 Aug 2008].

[4] T.W. Pogge. Human Rights and Global Health. *Metaphilosophy* 2005; 36(1/2): 182–209.

[5] Marmot, *op. cit.* note 2.

[6] B.G. Link & J. Phelan. Social Conditions as Fundamental Causes of Disease. *J Health Soc Behav*. 1995; 35: 80–94: 85.

[7] T. McKeown. 1979. *The Role of Medicine: Dream, Mirage, or Nemesis?* Princeton, NJ: Princeton University Press; Golub. *op. cit.* note 1.

[8] S. Szreter. Commentary: Rapid Economic Growth and 'the Four Ds' of Disruption, Deprivation, Disease and Death: Public Health Lessons from Nineteenth-Century Britain for Twenty-First-Century China? *Tropical Med. & Int'l Health* 1999; 4(2): 146–152.

health technologies[9] in directing 20th century advances in global health, most global health researchers would agree that developing countries could provide far more effectively for the health of their populations if they had additional economic resources and apportioned those resources toward meeting the basic needs of their populations.

Social determinants of health within countries: neoliberalism, selective health care, and the deterioration of public goods for health

Enduring conditions of absolute poverty in the world can largely be attributed to the incomplete success of the original international development project to bring about anticipated improvements in the human condition, compounded by a slowdown and reversal of gains since the 1980s under the neoliberal economic model. Increasingly throughout the 1980s and 90s, a package of neoliberal economic 'reforms,' referred to as the 'Washington Consensus,'[10] began to challenge the global development consensus established in the aftermath of the Second World War, imposing a radical form of 'market fundamentalism' on developing countries.[11] Whether created by the International Monetary Fund (IMF), the World Bank, or trade agreements (usually in exchange for loan-based debt assistance), most development-seeking states have been pressed toward specific economic 'reform' strategies – including marketization, liberalization, privatization, and decentralization – that aim to free their developing economies from 'excessive state intervention.'[12] These mandated cuts under loan conditionalities have had the effect of de-emphasizing the role of the state and the provision of public goods in development,[13] dismantling Keynesian (or demand-side) post-War economic policies.[14]

Likewise, the goals of public health promotion have recently shifted from improving living standards in countries. The 1979 Alma Ata Declaration on Primary Health Care was the culminating document of an overarching consensus that recognized the necessity of equitable socioeconomic development in order to build sustainable, comprehensive primary health care systems and to allow for the widespread improvement of public health in the developing world.[15] However, parallel with the genesis of neoliberalism was the growth of 'selective' primary health care, known in its most recent incarnation as the GOBI (Growth-monitoring, Oral-rehydration, Breast-feeding, and Immunization) approach to global health.[16] In sharp contrast to the broad, horizontal vision of health laid out at the Alma Ata Conference, the contemporary GOBI approach to health emphasizes narrow, vertical interventions that alleviate immediate suffering but fail to create the underlying conditions necessary to bring about sustained improvements in public health outcomes.[17] Building on this approach, current international health aid continues to be geared toward vertical interventions for specific high-profile diseases, rather than comprehensive public health systems.[18]

One of the most prominent harms of this combination of economic neoliberalism and the GOBI approach – pressing individual treatments and individual responsibility for health – has been the deterioration of public goods for health. Because public goods are both non-rivalrous (consumption by one individual does not diminish the consumption available to others) and non-excludable (it is difficult or impossible to exclude others from the benefits of the public good), they produce collective externalities (benefits or harms) that can only be realized for a society as a whole.[19] The presence of these externalities is thought to justify and necessitate government intervention to support these collective benefits, as 'providing

[9] Preston, *op. cit.*, note 1.

[10] J. Williamson. A Short History of the Washington Consensus. Paper commissioned by Fundación CIDOB for a conference *From the Washington Consensus towards a new Global Governance*, Barcelona, September 24–25, 2004. Available at: http://www.iie.com/publications/papers/williamson0904-2.pdf [Accessed 13 Aug 2008].

[11] J. Stiglitz. 2002. *Globalization and Its Discontents.* New York, NY: W. W. Norton & Company: 74.

[12] J. Gershman & A. Irwin. 2000. Getting a Grip on the Global Economy. In *Dying For Growth: Global Inequality and the Health of the Poor*. J.Y. Kim & J.V. Millen, eds. Monroe, ME: Common Courage Press: 11–43: 22.

[13] Ibid.

[14] R. Mishr. 1999. *Globalization and the Welfare State*. Northampton, MA: Edward Elgar Publishing Ltd: 5–6.

[15] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 Sep. 1978, art. VII.3. In *Primary Health Care: Report of the International Conference on Primary Health Care* 1978. Geneva: WHO.

[16] M. Cueto. The Origins of Primary Health Care and Selective Primary Health Care. *Am J Public Health* 2004; 94: 1864–1874.

[17] Ibid.

[18] L. Garrett. The Challenge of Global Health. *Foreign Aff*. 2007; 86(1): 14–38; D.T. Halperin. 2008. Putting a Plague in Perspective. *New York Times* 1 Jan.: A19.

[19] R. Feachem & J.D. Sachs. 2002. *Global Public Goods for Health: The Report of Working Group 2 of the Commission on Macroeconomics and Health*. Geneva: World Health Organization. Available at: http://whqlibdoc.who.int/publications/9241590106.pdf [Accessed 28 April 2008]; J.E. Stiglitz. 1995. The Theory of International Public Goods and the Architecture of International Organizations. Background Paper No. 7, Third Meeting, High Level Group on Development Strategy and Management of the Market Economy 1–9 UNU/WIDER, Helsinki, Finland (8–10 July).

public goods is now viewed as one of the central responsibilities, indeed, one of the central rationales, for government.'[20]

Many health determinants are driven by public goods: shared social, environmental, and structural factors such as clean water and air, food, housing, energy, sanitation, education, employment, wealth, health care infrastructures, social stability, and security from violence and discrimination.[21] Public health systems – defined broadly as governmental infrastructures for the public's health, including 'all the activities whose primary purpose is to promote, restore, or maintain health'[22] – are best positioned to provide these public goods for health,[23] fulfilling the 'conditions in which people can be healthy.'[24] Given this linkage, the building of health system capacity is increasingly seen as instrumental to alleviate harmful social determinants of health (e.g. lack of clean water, inadequate nutrition)[25] by assuring the provision of public goods necessary for individual health capabilities[26] and beneficial public health outcomes. Thus, the public health system is seen as a public good itself,[27] leading to shared positive externalities – in this case, health for all.

Despite the promise of development programs for developing countries, current neoliberal economic policy has not resulted in the predicted decreases in poverty[28] and ancillary benefits to public health[29] while leading to greater inequality within states.[30] Though ideologically-charged debates continue to rage about estimated rates of poverty and inequality,[31] a preponderance of empirical evidence suggests that while poverty has decreased substantially in much of East Asia (especially China),[32] poverty reduction in Latin America has stagnated[33] and much of the former USSR, East and Central Europe,[34] and sub-Saharan Africa[35] have regressed. Where poverty reduction has taken place, as in much of East Asia,[36] it has occurred largely in countries that have not followed neoliberal policies,[37] instead pursuing equitable economic growth, with rapidly rising living standards bringing both aggregate and sub-group health indicators to levels that exceed many other developed countries.[38]

In examining the specific health effects of the neoliberal development regime, comparative research of trends in health under different development paradigms has revealed that while the infant mortality rate, under-5 mortality rate, and life expectancy at birth have mostly continued to improve, neoliberal reforms (1980s–90s) have heralded a far slower rate of improvement than

[20] Stiglitz, *op. cit.* note 19, p. 1.

[21] L.C. Chen, T.G. Evans & R.A. Cash. 1999. Health as a Global Public Good. *In Global Public Goods: International Cooperation in the 21st Century.* I. Kaul, I. Grunberg & M. Stern, eds. New York: Oxford University Press: 284–304.

[22] WHO. 2001. *The World Health Report 2000: Health Systems – Improving Performance*. Geneva: WHO: 1. Available at: http://www.who.int/whr/2000/en/index.html [Accessed 28 April 2008].

[23] L.P. Freedman. Achieving the MDGs: Health Systems as Core Social Institutions. *DEV* 2005; 48: 19–24.

[24] Institute of Medicine. 1988. *The Future of Public Health*. Washington, DC: National Academy Press: 7.

[25] Garrett, *op. cit.* note 18; L. Gilson et al. 2007. *Challenging Inequity through Health Systems*. WHO Commission on the Social Determinants of Health, Knowledge Network on Health Systems. Available at: http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf [Accessed 18 Aug 08].

[26] J.P. Ruger. Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law. *Cornell J Law & Publ Pol*. 2006; 15(2): 102–182.

[27] M. Faust & I. Kaul. Global Public Goods and Health: Taking the Agenda Forward. *Bull. World Health Org.* 2001; 79: 869–874.

[28] R.H. Wade. Is Globalization Reducing Poverty and Inequality? *World Dev* 2004; 32(4): 567–589; W. Easterly. 2001. The Lost Decades: Developing Countries, Stagnation in Spite of Policy Reforms 1980–1998. Available At: http://siteresources.worldbank.org/INTRES/Resources/469232-1107449512766/The_Lost_Decades.pdf [Accessed 28 April 2008]; I. Kawachi & S. Wamala. 2006. Poverty and Inequality in a Globalizing World. In *Globalization and Health*. I. Kawachi & S. Wamala, eds. Oxford & New York: Oxford University Press.

[29] A. Breman & C. Shelton. 2006. Chapter 13: Structural Adjustment Programs and Health. In *Globalization and Health*. I. Kawachi & S. Wamala, eds. Oxford & New York: Oxford University Press.

[30] Wade, *op. cit.* note 28.

[31] Wade, *op. cit.* note 28; T. Pogge & S. Reddy. Unknown: The Extent, Distribution, and Trend of Global Income Poverty; 2003. *Social Analysis*. Available at: http://www.socialanalysis.org [Accessed 18 Aug 2008].

[32] World Bank Policy Research Reports. 1993. *The East Asian Miracle: Economic Growth and Public Policy*. New York, NY: Oxford University Press; A. Khan & C. Riskin. 2001. *Inequality and Poverty in China in the Age of Globalization*. Oxford: Oxford University Press; J.E. Stiglitz. 2006. Making Globalization Work. W.W. Norton & Company, Inc.: New York, NY.

[33] J.A. Ocampo. 2006. Latin America and the World Economy in the Long Twentieth Century. In *The Great Divergence: Hegemony, Uneven Development and Global Inequality.* K.S. Jomo, ed. Oxford: Oxford University Press.

[34] J. Stiglitz. 2001. Preface. In *The New Russia: Transition Gone Awry*. L. Klein & M. Pomer eds.: xvii–xxiii; M.G. Field, D.M. Kotz & G. Bukham. 2000. Neoliberal Economic Policy, 'State Desertion' and the Russian Health Crisis. In *Dying For Growth: Global Inequality and the Health of the Poor*. J.Y. Kim & J.V. Millen, eds. Monroe, ME: Common Courage Press: 155–176.

[35] R. Naiman & N. Watkins. 1999. A Survey of the Impacts of IMF Structural Adjustment in Africa: Growth, Social Spending, and Debt Relief. Center for Economic and Policy Research. Available at: http://www.cepr.net/index.php/a-survey-of-the-impacts-of-imf-structural-adjustment-in-africa/#growth [Accessed 28 April 2008].

[36] R. Wade. 2003. *Governing the Market: Economic Theory and the Role of Government in East Asian Industrialization*. Princeton, NJ: Princeton University Press; World Bank Policy Research Reports, *op. cit.* note 32.

[37] J.E. Stiglitz. Some Lessons from the East Asian Miracle. *World Bank Res Obs*, 1996; 11(2): 151–77: see especially 167–169.

[38] Ibid.

prior decades.[39] In examining this causal relationship, a panel study of 68 developing countries has found that worsening under-5 mortality was significantly correlated with economic instabilities linked to neoliberal globalization, including financial crises, fluctuations in global commodity prices, and unemployment following liberalization of imports.[40] Further, qualitative assessments of the effects of neoliberal economic policy have linked worsening health outcomes to health system deterioration through neoliberal health sector reforms – the privatization of public health care services, the imposition of user fees, and the retrenchment of the state's welfare functions.[41] Thus, despite the necessity of economic development – if properly framed – in building health systems to address underlying determinants of health, the development necessary for health is being undertaken through programs that undercut the ability of the state to provide for the public's health.[42]

Social determinants of health between countries: power asymmetries in the international economic order

While free trade has been propounded as the primary solution to global poverty, buttressing the purported benefits of neoliberal structural adjustments and offering the promise of open markets for developing country production, World Trade Organization (WTO) rules have evolved in a way that allow the economic interests of the developed world to predominate,[43] benefiting financial interests at the expense of public health. Developing countries have long relied on primary commodities as their main exports, the prices of which are particularly volatile and subject to declining terms of trade over time. An effort to respond to this 'primary commodity trap'[44] was made through the import-substitution industrialization schemes of the 1950s and 60s, protecting 'infant industries'[45] in order to allow them to develop until they would be able to compete in international trade (a process that was reengineered in the 1980s and 1990s in East Asia's promotion of industrial exports).[46] In contrast to import-substitution, neoliberalism has operated under the belief that governments should have no involvement in industrial policy,[47] promoting instead a set of policies that have proved damaging to national regulation and detrimental to the economic interests of developing countries.[48] Because the present neoliberal system of international trade is not truly 'free,' developed countries have been able to shape disproportionately the terms of trade to their advantage, enabling them to maintain import protections even while forcing developing countries to eliminate their barriers to trade.[49] Furthering these power assymetries the institutional voting rules embedded in the constitutions of international financial institutions (IFIs) give preference to wealthier states over those that are economically 'weak,'[50] with each country possessing an individual share of votes relative to its economic size,[51] allowing economic lending and development policy to be pursued in a fashion that serves the interests of the more powerful members.[52]

Although a 'post-Washington Consensus' has recently emerged – stressing the state as a guiding force for development, the socialization of risk, and the

[39] G. Cornia & L. Menchini. *Health Improvements and Health Inequality during the Last 40 Years.* Research Paper, 2006; 10. Available online at: http://www.wider.unu.edu/publications/working-papers/research-papers/2006/en_GB/rp2006-10/_files/78091769993299557/default/rp2006-10.pdf [Accessed 18 Aug 2008].

[40] P.Guillaumont, C.Korachais & J. Subervie. How Macroeconomic Instability Lowers Child Survival. Presented to *WIDER Conference on Advancing Health Equity*, September 29–30; 2006. Available at: http://www.wider.unu.edu/publications/working-papers/research-papers/2008/en_GB/rp2008-51/_files/79432550435258521/default/rp2008-51.pdf. [Accessed 18 Aug 2008].

[41] B. Schoepf, C. Schoepf & J.V. Millen. 2000. Theoretical Therapies, Remote Remedies: SAPS and the Political Ecology of Poverty & Health in Africa. In *Dying for Growth: Global Inequality & the Health of the Poor*. J.Y. Kim et al., eds. Monroe, ME: Common Courage Press: 91–125: 109–112; J.Y. Kim et al. Sickness Amidst Recovery: Public Debt and Private Suffering in Peru. In ibid: 127–153: 109–112.

[42] L.C. Chen & G. Berlinguer. 2001. Health Equity in a Globalizing World. In *Challenging Inequities in Health: From Ethics to Action*. T. Evans et al., eds. New York: Oxford University Press: 34–44.

[43] Stiglitz, *op. cit.* note 32: pp. 78–79. J. Stiglitz & A. Carlton. 2005. *Fair Trade for All: How Trade Can Promote Development*. Oxford; New York: Oxford University Press.

[44] Globalization and Health Knowledge Network. *Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution*. Final Report to the Commission on Social Determinants of Health: p. 32. Available at: http://www.who.int/social_determinants/resources/gkn_final_report_042008.pdf [Accessed 13 Aug 2008].

[45] Stiglitz, *op. cit.* note 32, p. 70.

[46] Stiglitz, *op. cit.* note 37, pp. 157–158.

[47] Ibid.

[48] H.J. Chang. 2003. *Kicking Away the Ladder: Development Strategy in Historical Perspective*. New York, NY: Anthem Press.

[49] Stiglitz, *op. cit.* note 32, p. 85.

[50] J.E. Stiglitz. 2003 Democratizing the International Monetary Fund and the World Bank: Governance and Accountability. *Governance: An International Journal of Policy, Administration, and Institutions*; 16(1): 111–139.

[51] Ibid.

[52] N. Woods. 2006. The Globalizing Mission. In *The Globalizers: The World Bank, the IMF and their Borrowers*. N. Woods, ed. New York, NY: Cornell University Press.

democratization of international institutions[53] – neoliberal policy reforms remain firmly embedded in the global institutional architecture, making this emerging 'consensus' more theoretical than real. Without significant IFI and WTO reforms in line with this emerging development consensus (as proposed herein through a right to development), this new consensus cannot succeed in improving health.

REVITALIZING PUBLIC HEALTH SYSTEMS THROUGH INTERNATIONAL LAW: THE HUMAN RIGHT TO DEVELOPMENT AS A FRAMEWORK FOR ADDRESSING SOCIAL DETERMINANTS OF HEALTH

The existence of these inequalities in health and development indicators within and between countries does not in itself provide evidence that the international economic order is unjust. If global health inequalities are the result of 'extra-social factors' – genetic handicaps, natural disasters, corruption or other factors proximal to national institutions – then the variations in health and development outcomes across countries may be unequal, but not inequitable (the latter encompassing the unjust nature of inequality).[54] However, drawing on studies finding that the present international economic system violates the negative duty of the developed world 'not to contribute to or profit from the unjust impoverishment of others,'[55] we argue that global health inequalities are indeed inequitable as they largely result from asymmetrical power relations in the global economic order that allow powerful developed states with limited accountability to carve out global economic rules to the advantage of their economic interests and to the disadvantage of states' social determinants of health. As described by Joseph Stiglitz:

> Today . . . we have a system that might be called *global governance without global government*, one in which a few [international] institutions – the World Bank, the IMF, the WTO – and a few players – the finance, commerce, and trade ministries, closely linked to certain financial and commercial interests – dominate the scene, but in which many of those affected by their decisions are left almost voiceless.[56]

In this sense, economic globalization can be said to have advanced at a faster pace than political globalization, allowing only those states and institutions with the economic means and technical expertise to frame the system.

The human right to development offers an extant legal framework by which to restructure this system to meet global justice imperatives for health. The right to development – working through a vector of rights and obligations – can address interconnected social determinants of health within countries, obligating governments and the international community to scale-up public health systems, while reducing inequities in health between countries through poverty-reducing economic growth.

Birth of a human right to development

There exists a longstanding critical discourse that examines the ways in which the global system operates to the disadvantage of developing states, particularly through the prevailing international trade regime.[57] Beginning in the 1930s, when the Bretton Woods Institutions (IMF and World Bank) were being constructed and the International Trade Organization (ITO) (precursor of the WTO) was being conceptualized,[58] this critical theory became formalized into a movement for a New International Economic Order (NIEO), which brought its demands to a Special Session of the UN General Assembly in 1974.[59] The concerns of the NIEO movement, organized through the Non-Aligned Movement and a group of 77 developing countries (known as the G-77), centered on the volatility of commodity prices on the world market and a desire for an international trade system that would help moderate these effects, among other systemic inequities in the global economic regime.[60] Despite the

[53] J.E Stiglitz. 1998. *More Instruments and Broader Goals: Moving Toward the Post-Washington Consensus*. The 1998 WIDER Annual Lecture. Available at: http://www.globalpolicy.org/socecon/bwi-wto/stig.htm [Accessed 13 Aug 2008]; B. Fine, C. Lapavitsas & J. Pincus, eds. 2001. *Development Policy in the 21st Century: Beyond the Post-Washington Consensus*. London: Routledge.

[54] P. Braveman & S. Gruskin. Defining Equity in Health. *J Epidemiol Community Health* 2003; 57: 254–258.

[55] T. Pogge. 2002. *World Poverty & Human Rights*. Cambridge, MA: Polity Press: 197.

[56] Stiglitz, *op. cit.* note 11, pp. 21–22 [emphasis in original]

[57] E.g. I. Wallerstein. 1976. *The Modern World-System: Capitalist Agriculture and the Origins of the European World-Economy in the Sixteenth Century*. New York: Academic Press; A.G. Frank. 1979. *Dependent Accumulation and Underdevelopment*. New York: Monthly Review Press.

[58] J.L. Love. 2001. *Latin America, UNCTAD, and the Postwar Trading System*. 1–2. Available at: http://www.stanford.edu/group/sshi/Conferences/2001-2002/GlobalTrade2001/love.PDF [Accessed 29 April 2008].

[59] R.E. Gordon & J.H. Sylvester. Deconstructing Development. *Wis Int'l L J* 2004; 22(1): 1–98.

[60] Ibid: 33–35; Love, *op. cit.* note 56.

ultimate failure of this movement to alter international economic relations[61] (and ultimately an intensification of the same detrimental policies that the movement critiqued under the neoliberal development model), the NIEO movement was successful in pressing for a collective human right to development, which was ultimately codified in the Declaration on the Right to Development, adopted by the United Nations in 1986.[62]

The first article of the Declaration on the Right to Development proclaims the substance of and justification for a right to development:

> The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in and contribute to and enjoy economic, social, cultural, and political development, in which all human rights and fundamental freedoms can be fully realized.[63]

With this language driving discourse on the right, the integrity of the right to development as a universal and unalienable human right was reaffirmed in the Vienna Declaration and Programme of Action in 1993.[64] Building from this, with the appointment of an Independent Expert on the Right to Development in 1994, burgeoning discourses on the human right to development have the potential to frame a body of international law to shape the global system in a manner that provides fairly and equitably for social determinants of health through sustainable public health systems.

Limitations of an individual right to health as a rights-based approach to development

Previous attempts to consider the public health ramifications of development under a human rights framework have largely focused, with limited success, on reforming globalized economic processes through a rights-based approach to development under the individual right to health.[65] The United Nations legislatively embodied the economic and social parameters of the right to health in 1966 in Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), codifying 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[66] However, bounded by the disciplinary constraints of medicine, the resource constraints of the principle of progressive realization, and the individualistic constraints of the human rights regime, the right to health has remained normatively incapable of speaking to neoliberal development policy's denigration of social determinants of health.[67] Belying the lofty language of 'the highest attainable standard of health' in the ICESCR, the right to health has been advanced as an individual right, focusing on individual access to health services at the expense of collective health promotion and disease prevention programs through public health systems.[68] Despite recent attempts to expand the normative content of the right to health through General Comment 14 to the ICESCR,[69] seeking to interpret the individual right to health to encompass social determinants of health, the expansive language of General Comment 14 is insufficient to establish a collective right to public health systems under the ICESCR. Because this interpretation lacks the detailed explanatory reasoning necessary to create national policy on determinants of health outside of health ministries, it has faced criticism for 'going far beyond what the treaty itself provides and what the states parties believe to be the obligation they have accepted.'[70] As a result of limitations on this reinterpretation of the ICESCR and on the synoptic purview of the U.N. Special Rapporteur on the Right to Health, this constrained right to health – while

[61] Gordon & Sylvester, *op. cit.* note 57.

[62] Ibid.

[63] Declaration on the Right to Development. 1986. GA Res. 41/128, adopted 4 Dec. 1986, UN GAOR, 41 Sess., Annex, UN Doc. A/RES/41/128

[64] Vienna Declaration and Programme of Action. 1993. UN GAOR. *World Conference on Human Rights.* Art. 1. p 10, UN Doc. A/CONF.157/23.

[65] P. Braveman & S. Gruskin. Poverty, Equity, Human Rights and Health. *Bull World Health Org* 2003; 81: 539–545.

[66] International Covenant on Economic, Social and Cultural Rights. Adopted 16 Dec. 1966. GA Res. 2200 (XXI), UN GAOR. 21st Sess. Supp. No. 16. Art. 2. UN Doc. A/6316 (1966), 993 UNTS 3, 8.

[67] B.M. Meier. Advancing Health Rights in a Globalized World: Responding to Globalization Through a Collective Human Right to Public Health. *J Law Med Ethics* 2007; 35: 545–555.

[68] B.M. Meier & L.M. Mori. The Highest Attainable Standard: Advancing a Collective Human Right to Public Health. *Colum Hum Rts L Rev* 2005; 37: 101–147.

[69] E.g. *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health*. General Comment No. 14. UN ESCOR. Comm. on Econ., Soc. & Cult. Rts. 22nd Sess. Agenda Item 3. pp. 43–44, UN Doc. E/C.12/2000/4 (2000). Available at: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?Open Document [Accessed 30 April 2008].

[70] K. Gorove, Office of the Legal Advisor, US Dept. of State, Remarks at the Ninety-Eighth Annual Meeting of the American Society of International Law: Shifting Norms in International Health Law. *Am. Soc'y Int'l L. Proc*. 2004; 98: 18–20; M.J. Dennis & D.P. Stewart. Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health? *Am. J. Int'l L.* 2004; 98: 462, 494.

providing accountability for individual health services[71] – has not broken into development discourse, enabling neoliberalism's legacy of deteriorating national public health systems.[72] In this normative vacuum, the right to development offers a collective means by which to serve the goals of the individual right to health in responding to globalized economic forces.[73]

The right to development – an international framework for development policy

Whereas the right to health is enshrined as an individual right,[74] the right to development, as a collective right,[75] views development itself as a right. With neoliberal development policies impacting entire societies, this collective right to development can enable both states and international actors to realize underlying social determinants of health, supporting public goods that can only be achieved at the collective level through the shared benefits of public health systems.[76]

Principles of global social justice – including duties to do no harm, to reconstruct, and to assist[77] – support the need for reform of the global institutions that perpetuate poverty and insalubrious social conditions in the developing world. In operationalizing this cosmopolitan vision of global health justice, the right to development provides a legal and institutional framework to actualize the ethical principles laid out by global justice theorists, focusing states simultaneously on improving the social determinants of health within countries and reducing inequities in health between countries.

Improving Social Determinants of Health within Countries

In addressing underlying determinants of health through health systems, the right to development can be said to operate as a 'vector' of individual economic, social, cultural, civil, and political 'component' rights. As a vector, the right to development is not merely an umbrella right that is the sum of all individual rights; rather, it is a composite right through which all these interconnected rights are realized together under an integrated framework. For Arjun Sengupta, the UN Independent Expert on the Right to Development:

> It is convenient to describe [the right to development] in terms of an improvement of a 'vector' of human rights, which is composed of various elements that represent the different economic, social, and cultural rights as well as the civil and political rights. The improvement of this vector, or in the realization of the right to development, would be defined as the improvement of some – or at least one – of those rights without the violation of any other rights.[78]

Thus, the right to development integrates a range of individual rights to achieve equitable 'human development' through its underlying determinants.

Infant mortality provides an instructive illustration of the operationalization of the right to development vector [see Figure 1]. The infant mortality rate of a state relies on the realization of a number of constituent rights, many of which are unrelated to child health and even unrelated to health itself – including maternal education,[79] potable water and sanitation,[80] housing, and nutrition,[81] as well as women's sexual and reproductive health[82] – thereby implicating an overlapping series of interconnected positive and negative rights. What becomes clear from this example is that tackling these underlying determinants of health separately would be, due to their integrated and interdependent nature, both inefficient and counterproductive. Overcoming these difficulties, the right to development takes a 'holistic approach' to rights

[71] H.V. Hogerzeil et al. Is Access to Essential Medicines as Part of the Fulfillment of the Right to Health Enforceable through the Courts? *Lancet*. 2006; 368: 305–311.

[72] Paul Hunt. 2003. *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*. Report of the Special Rapporteur. UN ESCOR Comm'n. on Hum. Rts. 59th Sess. Agenda Item 10. p.51. UN Doc. E/CN.4/2003/58 13 Feb. 2003.

[73] R. Falk. 2002. Interpreting the Interaction of Global Markets and Human Rights. In *Globalization and Human Rights*. Alison Brysk, ed. Berkeley, CA: University of California Press.

[74] Ibid.

[75] P. Alston. Conjuring up New Human Rights: A Proposal for Quality Control. *Am J Int'l L* 1984; 78(3): 607–621.

[76] J.P. Ruger. Health and Social Justice. *Lancet* 2004; 364: 1075–1080.

[77] J. Dwyer. Global Health and Justice. *Bioethics* 2005; 19: 460–475.

[78] A. Sengupta. 2003. *Development Cooperation and the Right to Development.* Working Paper No. 12. François-Xavier Bagnoud Ctr. for Health & Human Rights: Harvard Sch. of Pub. Health: 3. Available at http://www.hsph.harvard.edu/fxbcenter/FXBC_WP12-Sengupta.pdf. [Accessed 30 April 2008].

[79] J.C. Caldwell. Education as a Factor in Mortality Decline: An Examination of Nigerian Data. *Popul Stud* 1979; 33: 395–413.

[80] S. Cairncross & V. Valdmanis. 2006. Water Supply, Sanitation and Hygiene Promotion: Chapter 41. In *Disease Control Priorities in Developing Countries*. Jamison et al., eds. Available at: http://www.dcp2.org/main/Home.html. [Accessed 30 April 2008].

[81] R.E. Black, S.S. Morris & J. Bryce. Where and Why are 10 Million Children Dying Every Year? *Lancet* 2003; 361: 2226–2234.

[82] A. Rosenfield & D. Maine. Maternal Mortality- A Neglected Tragedy: Where's the M in MCH? *Lancet* 1985; 2: 83–85.

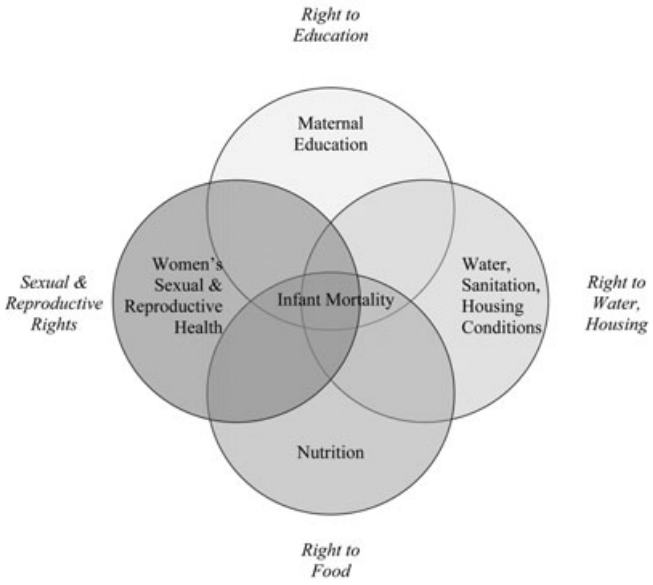

Figure 1. Infant Mortality: Example of the Right to Development Operating as a 'Vector' of Rights for the Improvement of Health

realization,[83] whereby the fulfillment of one right is seen to affect the realization of others and create a net effect that is greater than the sum of its individual parts. As such, this approach accounts for the direct and indirect ways in which human rights interact intersectionally and inter-sectorally,[84] providing a comprehensive interdisciplinary framework for addressing the interconnected underlying social conditions that limit health capabilities and human flourishing.[85]

As the realization of these interdependent rights of the right to development vector remains resource-dependent, this process of development necessarily includes economic growth as an element in easing a state's resource constraints.[86] However, economic growth must be carried out in way that does not deteriorate or violate any of the component rights in the vector.[87] Whereas proponents of neoliberal economic policies often claim that there exists an inherent growth/equity trade-off in economic development (implemented through economic growth for the wealthy 'trickling-down' to the poor),[88] the right to development encourages economic development that is explicitly poverty-reducing, wherein states assist the least well-off first and thereby reduce inequality through growth. In keeping with the 'capabilities approach' to human rights, this approach views economic growth as a means to an end, not an end in itself, with human development measured in terms of its health achievements, such as life expectancy and infant survival.[89] To achieve these reforms, representatives of states could utilize the right to development to raise international duties when negotiating with international organizations over lending conditionalities, ensuring that development policies will promote – rather than harm – health rights through equitable growth during economic reform.

Social determinants of health between countries: Reforming development policy through international obligations

Recent theorizing on global social justice has focused on what developed countries 'owe' to developing countries in terms of aid or charity.[90] However, since the ability of states to develop and to fulfill their human rights obligations domestically is constrained by the actions and institutional arrangements of the international community, the implementation of the right to development would require a restructuring of IFIs and foreign-aid programs, allowing states to enter development debates with a right to cooperation from other states in public health, not simply a cry for charity. As a collective right, the right to development obligates the international community toward its fulfillment, allowing for a restructuring of global economic relations for fair trade and increased participation from poor countries.[91] While it is clear that states bear the 'primary responsibility' to ensure the right to development, there is a critical duty of international

[83] M. Robinson. 2005. What Rights Can Add to Good Development Practice. In *Human Rights and Development: Towards Mutual Reinforcement*. P. Alston & M. Robinson, eds. Oxford & New York: Oxford University Press: 27.

[84] L.A. Crooms. Indivisible Rights and Intersectional Identities Or, 'What Do Women's Human Rights Have to Do with the Race Convention?' *Howard L J* 1997; 40: 619–640.

[85] Ruger, *op. cit.* note 26.

[86] Sengupta, *op. cit.* note 76; D. Beetham. 2006. The Right to Development and its Corresponding Obligations. In *Development as a Human Right: Legal, Political, and Economic Dimensions*. B.A. Andreassen & S.P. Marks, eds. Cambridge: Harvard University Press. 79–80.

[87] Ibid.

[88] Stiglitz, *op. cit.* note 32, p. 27.

[89] A. Sen. 2001. *Development as Freedom*. Oxford & New York: Oxford University Press; Ruger, *op. cit.* note 26; J.P. Ruger. Rethinking Equal Access: Agency, Quality and Norms. *J Global Pub Health* 2007; 2(1): 86–104.

[90] P. Singer. What a Billionaire Should Give – and What Should You? *New York Times* 17 Dec 2006: 8–9.

[91] B.M. Meier & A. Fox. Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health. *Hum Rights Q* 2008; 30: 259–355.

cooperation in the realization of rights where it is beyond the control of the state to create an environment conducive to rights fulfillment, either because the international community has blunted the state's reach or because the causes of harm are international in scope.[92]

With regard to this obligation beyond the state, the Declaration on the Right to Development emphasizes the crucial importance of international cooperation. Addressing a duty akin to a duty 'to reconstruct',[93] states bear a duty pursuant to Article 2 of the Declaration 'to co-operate with each other in ensuring development and eliminating obstacles to development . . . and fulfill their duties in such a manner as to promote a new international economic order based on sovereign equality, interdependence, [and] mutual interest . . .'[94] Given this International Obligation, scholars have found collective duties on the international community, with obligations on developed states (both within their respective jurisdictions and extraterritorially) to act in a way that alters unjust institutional structures,[95] including trade regimes that encourage developing states to open their markets to goods while maintaining subsidies in developed states; patents that constrain access to needed technologies in the developing world; IMF policies that burden developing states with long term debts at inflated interest rates; and capital market liberalizations that leave developing states vulnerable to speculative flows and financial crises.[96] As a collective right possessing international obligations, the right to development can be invoked to alter these institutional structures that obstruct the national development and distributive policies necessary for the public's health.[97]

The right to development may be imposed directly on international institutions where human rights norms are codified into the foundational documents of IFIs or embedded in the jurisprudence of their adjudicatory mechanisms.[98] Through the right to development, states can use international law to reform these institutional rules to make voting and membership structures more egalitarian and thus more responsive to the public health needs of developing states. Alternatively, the right to development may be implemented indirectly through the obligations of states to abide by human rights norms when voting and participating within these organizations, entering trade negotiations[99] and engaging dispute resolution mechanisms,[100] as well as to realize the long-proposed Tobin Tax on trade in currencies across borders.[101]

Global justice theorists have made the case that there exists a negative duty of the developed world to provide increased charitable assistance to poor countries (in the form of a global resource dividend[102] or through a provision of a 'fair share' of the burden of global poverty),[103] and that there exists a positive 'duty' through economic transfers of the developed world 'to assist' the developing world.[104] Deriving from the Universal Declaration of Human Rights and subsequently the ICESCR, which finds in Article 2 that states must take steps 'individually and through international assistance and co-operation' progressively to realize all economic, social, and cultural rights,[105] the right to development has been interpreted as codifying the right of states to make claims of reciprocal obligation against other states, as duty-bearers of the right to development.[106] With the massive influx of funds going toward health and health-related development projects, it is more critical than ever that this aid be utilized effectively. The World Health Organization (WHO), as 'the only organization with the political credibility to compel cooperative thinking' around global

[92] A. Sengupta. 2006. The Human Right to Development. In *Development as a Human Right: Legal, Political, and Economic Dimensions*. B.A. Andreassen & S.P. Marks, eds. Cambridge, Mass.: Harvard University Press; F. Kirchmeier. 2006. *The Right to Development – Where Do We Stand?* Dialogue on Globalization. Available at http://library.fes.de/pdf-files/iez/global/50288.pdf. {Accessed 21 Aug 2008]: 11–12.

[93] Dwyer, *op. cit.* note 78, pp. 470–473.

[94] *Declaration on the Right to Development*, GA Res. 41/128, *adopted* 4 Dec. 1986, UN GAOR, 41 Sess., Annex, UN Doc. A/RES/41/128 (1986). Available at: http://www.unhchr.ch/html/menu3/b/74.htm. [Accessed 30 April 2008].

[95] M.E. Salomon. 2006. International Human Rights Obligations in Context: Structural Obstacles and the Demands of Global Justice. In *Development as a Human Right: Legal, Political, and Economic Dimensions*. B.A. Andreassen & S.P. Marks, eds. Cambridge. Mass: Harvard University Press: 99–101.

[96] Beetham, *op. cit.* note 87.

[97] Salomon, *op. cit.* note 95.

[98] S.I. Skogly. 2001. *The Human Rights Obligations of the World Bank and the International Monetary Fund*. London: Cavendish Publishing.

[99] J. Dine. 2005. *Companies, International Trade and Human Rights*. Cambridge, UK: Cambridge University Press.

[100] K. Lee, K. Buse & S. Fustukian, eds. 2002. *Health Policy in a Globalising World*. Cambridge, UK: Cambridge University Press.

[101] M. Haq, I. Kaul & I. Grunberg, eds. 1996. *The Tobin Tax: Coping with Financial Volatility*. New York & London: Oxford University Press.

[102] Pogge, *op. cit.* note 55.

[103] Singer, *op. cit.* note 90.

[104] Dwyer, *op. cit.* note 78, pp. 473–474.

[105] *International Covenant on Economic, Social and Cultural Rights*. Adopted 16 Dec. 1966, GA Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, Art. 2, UN Doc. A/6316 (1966), 993 U.N.T.S. 3, 8 Art. 2(1).

[106] S.P. Marks. 2006. Obligations to Implement the Right to Development. In *Development as a Human Right: Legal, Political, and Economic Dimensions*. B.A. Andreassen & S.P. Marks, eds. Cambridge, Mass: Harvard University Press.

health policy,'[107] has a central role in ensuring that health aid is channeled into projects that strengthen health systems (rather than siloed into vertical, disease-specific programs),[108] an obligation that could be institutionalized by integrating the work of the WHO Commission on Social Determinants of Health[109] through the recently-proposed Framework Convention on Global Health,[110] creating a lasting legacy of in international law for global health governance.

Yet, while increased international aid is an important element in easing resource constraints in poor countries, a 'second big push'[111] (in the absence of widespread structural reforms) cannot jump-start economies out of 'poverty traps'.[112] An international legal mechanism to coordinate action around existing health aid and address underlying social determinants of health (i.e., equitable economic development and public health systems) would offer a means for developing states to reshape the international economic order to create a level playing field and promote economic growth for health. While there is likely to be resistance to introducing reforms to the global institutional architecture, the right to development was designed with this purpose in mind and is therefore best suited for the task of harnessing development processes to create sustainable improvements in health and well-being.

[107] Garrett, *op. cit.* note 18, p. 22.
[108] D. Fidler. Constitutional Outlines of Public Health's 'New World Order'. *Temple L Rev* 2004; 77: 247–290.
[109] WHO. Commission on Social Determinants of Health. Available at: http://www.who.int/social_determinants/en/. [Accessed 30 April 2008].
[110] L.O. Gostin. Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health. *Geo. L.J.* 2008; 96: 331–392.
[111] W. Easterly. The Big Push Déjà Vu: A Review of Jeffrey Sachs's The End of Poverty: Economic Possibilities for Our Time, *J Econ Li.* 2006; XLIV(March): 96–105
[112] J. Sachs. 2005. *The End of Poverty: Economic Possibilities for our Time*. New York, NY: Penguin Press: 19–20.

CONCLUSION

The necessity of reform to the international economic system has been laid out elsewhere, with global social justice scholars and development economists making the case for institutional reform at the international level to bring about greater justice and fairness in economic relations between rich and poor countries. In implementing these reforms the right to development constitutes a viable human rights foundation and legal mechanism to bring about changes to the economic order that will facilitate equitable growth, poverty reduction, and, through the building of primary health care systems as envisioned in Alma Ata, sustained improvements in social determinants of health and human flourishing in the developing world.

Unlike an individual right to health, which is normatively constrained in of addressing underlying social determinants of health through economic development and public health systems, a collective human right to development, operating as a vector of individual rights, can provide for the public goods necessary to ensure that economic growth improves health. Through the framework of the right to development, there can be a revitalized call to reconceptualize public health systems as core social institutions that define the very experience of poverty and development, scaling up the provision of underlying determinants of health to realize the highest attainable standard of health.

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