GLOBALIZATION, HUMAN RIGHTS, AND THE SOCIAL DETERMINANTS OF HEALTH

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ABSTRACT
Globalization, a process characterized by the growing interdependence of the world’s people, impacts health systems and the social determinants of health in ways that are detrimental to health equity. In a world in which there are few countervailing normative and policy approaches to the dominant neoliberal regime underpinning globalization, the human rights paradigm constitutes a widely shared foundation for challenging globalization’s effects. The substantive rights enumerated in human rights instruments include the right to the highest attainable level of physical and mental health and others that are relevant to the determinants of health. The rights stipulated in these documents impose extensive legal obligations on states that have ratified these documents and confer health entitlements on their residents. Human rights norms have also inspired civil society efforts to improve access to essential medicines and medical services, particularly for HIV/AIDS. Nevertheless, many factors reduce the potential counterweight human rights might exert, including and specifically the nature of the human rights approach, weak political commitments to promoting and protecting health rights on the part of some states and their lack of institutional and economic resources to do so. Global economic markets and the relative power of global economic institutions are also shrinking national policy space. This article reviews the potential contributions and limitations of human rights to achieving greater equity in shaping the social determinants of health.

INTRODUCTION TO THE ISSUES
Globalization, a process characterized by the growing interdependence of the world’s people, involves the integration of economies, culture, technologies, and governance. To date, however, the opportunities resulting from globalization under the dominant neoliberal model have been largely asymmetrical. Globalization has disproportionately benefited the countries and economic entities with greater resources and the power to shape the rules under which the international economic system functions. Economic inequalities have risen significantly since the early 1990s as a result of increasing concentrations of income, resources, and wealth both between and within countries.1

Linked with these economic changes, the past 25 years of intensified market integration have also featured a

slowdown or reversal in many health improvements, particularly in poor countries, and growing health inequalities. The health gap between the worst and best off groups is growing. Wealthy populations are increasingly healthier and living longer while poorer populations have higher rates of illness and are dying at a younger age.

Globalization affects health outcomes in several ways, one of which is through its impact on the structure and functioning of health systems and its effects on access to health services. A strong and effective health system is fundamental to a healthy and equitable society. However, the neoliberal paradigm views health systems and services as commodities, that is inputs to productivity and economic growth and sources of potential revenue, rather than as public and social goods. Neoliberal ideology also puts forward a conception of a minimal government with most social services provided by the private sector. Multilateral institutions like the World Bank have promoted a market-oriented concept of the health sector that favors reductions in public sector spending along with the introduction of user fees and other cost recovery measures that decrease access to health care for the poor. Consequently globalization has been associated with the weakening of the health systems in middle- and low-income countries. A recent publication of the World Health Organization (WHO) laments that in too many countries health systems are on the point of collapse, or are accessible only to particular groups of the population. In addition, neoliberal trade policies can limit access to and increase the cost of health inputs. For example the World Trade Organization’s (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) requires all members to introduce patent protection on pharmaceuticals which excludes generic competition thereby tends to drive up drug prices.

Globalization’s impact on power, resources, labor markets, the social structure of countries, policy space, trade, and financial flows also reshape the social determinants of health, usually in a problematic direction. Briefly, the social determinants of health are the conditions in which people live and work and that affect their opportunities to lead healthy lives. The recent emphasis on the social determinants of health reflects the increasing understanding that the health of populations, communities, and individuals requires more than the availability of medical care. Analysts have become more aware of the vital role of non-health inputs, like the availability of safe water, sanitation systems, and sufficient nutritious food, to health outcomes. At the same time work in social epidemiology, social medicine, and medical sociology has shown that the social, cultural, economic, political, and living conditions of the population are equally important, sometimes even more so, in determining the health status of populations.

Research conducted by the Globalization Knowledge Network for the World Health Organization’s (WHO) Commission on Social Determinants of Health identifies several, often interacting, pathways leading from globalization to changes in the social determinants of health with detrimental consequences for health equity:

- Perhaps most importantly, given the strong and pervasive links between poverty and health, globalization has rendered many poor people in low income countries even poorer. According to WHO, ‘Poverty wields its destructive influence at every stage of human life, from the moment of conception to the grave. It


11 Labonté, Schrecker et al., op. cit. note 2.


13 Birdsall, op. cit. note 1.
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conspires with the most deadly and painful diseases to bring a wretched existence to all those who suffer from it.\(^\text{14}\) Trade liberalization, the lowering of barriers to imports, and the global reorganization of production also tend to increase the economic vulnerability of large numbers of poor people.\(^\text{15}\)

- **Globalization is gradually leading to the emergence of a global labor market characterized by growing inequalities between skilled and unskilled workers both within and across national borders. Global economic integration and the development of a global labor force are generating increased pressures for labor market ‘flexibility’ with detrimental effects on economic security for many workers. As countries compete for foreign investment and outsourced production, the need to appear ‘business friendly’ affects their ability to adopt and implement labor standards protecting workers’ interests, strict health and safety regulations, and redistributive social policy.\(^\text{16}\)**

- **Gender inequality damages the physical and mental health of girls and women in many different ways. The interplay between gender systems and structural processes related to globalization often disadvantage women and girls and thereby affect their health status. Feminization of work forces related to globalization has gone hand in hand with a tendency to relegate women to lower paid, less desirable jobs, with them continuing to bear primary responsibility for unpaid work in the household. The narrowing of policy space with its reduction in funds for health and education has also had a negative impact on the well-being of women and girls.\(^\text{17}\)**

- **Lack of access to safe water is linked with poverty, economic insecurity, and other forms of vulnerability, as well as being detrimental to health outcomes, particularly through causing diarrheal diseases. Like health services, the neoliberal model treats water as a commodity. During the past two decades transnational corporate networks have emerged as major actors in the water sector. International Monetary Fund (IMF) loan agreements with many of the smallest, poorest, and most-debt-ridden countries increasingly include conditions requiring water privatization or full cost recovery policies. Private provision of services to meet basic needs, like water and sanitation, invariably leads to escalating costs and inequitable access.\(^\text{18}\) A market-based approach makes it difficult to expand water service delivery to previously unserved or underserved areas and to set affordable rates.\(^\text{19}\)**

- **Trade reforms that lower trade barriers, as neoliberal ideology advocates, can be damaging to food security in the short and medium term unless countered by policies designed to offset the negative effects.\(^\text{20}\)** Increased global trade in food products is also associated with changes in diet and nutrition in many low and middle income countries away from traditional foods grown locally to store-bought foods, many of which are processed foods. There is some evidence suggesting that the nutrition transition to an ‘obesogenic’ food environment is increasing the prevalence of some chronic disease.\(^\text{21}\)**

- **Declines in public revenues from tariff reductions, the growing burden of public debt, and public policies promoted by multilateral organizations and increasingly adopted by governments constrain the ability of many developing countries to meet basic needs related to public health, education, water, sanitation, and nutrition.\(^\text{22}\)**

In a world in which there are few compelling countervailing normative and policy approaches to the dominant neoliberal ideology underpinning globalization, the human rights paradigm provides a compelling alternative. Some would go farther in characterizing the challenge that human rights poses to globalization. Paul O’Connell argues that it is not possible to be committed to the protection of human rights and at the same time acquiescent in the dominant model of globalization. According to O’Connell, the conditions for the violation of human rights are structurally embedded in the neoliberal globalization program.\(^\text{23}\)

In contrast with neoliberalism’s focus on the market, human rights are based on the recognition of the inherent dignity and worth of the human person and the

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15 Labonte, Schrecker et al., *op. cit.* note 2, pp. 10–11, 46–52.
16 Ibid: 111, 46–52.
18 Katz, *op. cit.* note 5.
20 This observation is from a 2006 study of 15 developing countries by the UN Food and Agriculture Organization, cited in Ibid.
21 Ibid: 68–70.
commitment to better standards of life. The rights enumerated in the various international human rights instruments, including the right to the highest attainable standard of physical and mental health, are understood to be universal in nature, belonging to all persons by virtue of their common humanity. Together they represent a substantive account of the minimum requirements of a life of dignity and establish minimal standards of decent social and government practice. In the human rights paradigm access to health and essential inputs, like water, sanitation, and nutritious food are treated as public goods and entitlements, and not as commodities. Moreover, the rights stipulated in the various human rights instruments impose extensive national and international legal obligations on states that have ratified these documents.

While globalization tends to benefit the most economically advanced and affluent countries, corporations, and individuals, a human rights approach focuses on and seeks to protect the most disadvantaged individuals and groups. Much like the ‘preferential option for the poor’ in liberation theology, human rights confers priority on the fulfillment of the needs of the most disadvantaged and vulnerable. As universal entitlements, the implementation of a right is measured particularly by the degree to which it benefits those who hitherto have been the most disadvantaged and vulnerable and brings them up to mainstream standards. The principle is that an allocation is right prima facie in so far as it contributes to opportunities for equality of well-being.

To foster accountability, an intrinsic element to a human rights approach, there are a variety of types of institutional mechanisms for monitoring, interpretation, and oversight on the international, regional, and sometimes at the national level as well. The international human rights system is the best developed. The United Nations has established a series of human rights treaty monitoring bodies overseeing the performance of states on specific human rights conventions, including a Committee on Economic, Social and Cultural Rights whose purview includes the right to health. In 2002, the UN appointed its first special rapporteur with a mandate to investigate and report on the status of the right to the highest attainable standard of health and make recommendations on measures to promote and protect this right. During his six-year tenure Paul Hunt, a Professor of Law at the University of Essex, used this platform to conduct country missions to assess implementation and identify barriers and to prepare a series of reports operationalizing the right and identifying ways to make the right more effective. In addition, various international organizations have adopted the human rights model for addressing health issues, among them the WHO’s Commission on Social Determinants. Some countries have also incorporated health rights entitlements into constitutional or national law making them potentially judicial.

Nevertheless, the human rights system has many weaknesses that affect the realization of the right to health and other obligations related to the social determinants of health that will be outlined in this article. Although states that ratify or accede to a human rights instrument have a legal obligation to implement its provisions, many countries appear to lack sufficient political will to accord human rights the priority they deserve. Also globalization has affected the capacity of states to implement an effective human rights agenda. This essay reviews the potential contributions and limitations of human rights to achieving greater equity in shaping the social determinants of health.

**HUMAN RIGHTS PERSPECTIVES ON HEALTH**

Beginning with the Universal Declaration, a series of major international human rights instruments enumerate

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24 These standards are identified in the Preamble to the Universal Declaration of Human Rights and then repeated in the preamble to many other human rights documents. Universal Declaration of Human Rights; adopted and proclaimed by the UN General Assembly Resolution 217A(III), 10 December 1948.


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a right to health. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), generally considered to be the most expansive and authoritative delineation of the right, recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and to that end mandates that state parties to the Covenant, the countries that have ratified this instrument, take steps to provide for: the reduction of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure medical service and medical attention to all.\(^{30}\)

There are related provisions on the right to health in other international human rights instruments that apply the requirements of the right to health to specific communities and groups, including the International Convention on the Elimination of All Forms of Racial Discrimination,\(^ {31}\) the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),\(^ {32}\) and the Convention on the Rights of the Child.\(^ {33}\) According to the WHO, every country is now party to at least one international instrument encompassing health-related rights.\(^ {34}\) In addition, the right to health is enumerated in regional human rights instruments, such as the European Social Charter,\(^ {35}\) the African (Banjul) Charter on Human and Peoples’ Rights,\(^ {36}\) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.\(^ {37}\)


nondiscrimination and equal treatment in access to health care and the underlying determinants of health\(^{45}\) and the special obligations of the state to provide for the satisfaction of the health needs of the most vulnerable whose poverty, disabilities, or background make them the most vulnerable.\(^{46}\)

General Comment 14 sets forth four criteria to evaluate whether obligations related to the right to health are being realized: availability, accessibility, acceptability, and quality. Availability refers to the extent to which the facilities, goods, personnel, and services required for the fulfillment of the right to health are available in sufficient quantity for the population within the state. Accessibility has four overlapping dimensions: (1) non-discrimination, whether the facilities, goods, and services are accessible to all without discrimination on any of the prohibited grounds; (2) physical accessibility, the extent to which the facilities, goods, and services are within safe physical reach for all sections of the population, especially vulnerable and marginalized groups; (3) economic accessibility, whether the goods, services, and facilities related to the rights are affordable for all, including socially disadvantaged groups; and (4) information accessibility, whether the population has the right to seek, receive, and impart information relevant to the right. Acceptability is a measure of whether health facilities, good, and services are culturally appropriate and respectful of ethical standards. Quality is the parallel need for health facilities, goods, and services to be scientifically and medically appropriate and of good quality.\(^{47}\)

States that ratify or accede to human rights instruments become legally responsible for their implementation. Most countries in the world have ratified the three key international human rights instruments enumerating the right to health. Only two UN member countries, Somalia and the United States, have not ratified the Convention on the Rights of the Child. A few additional members – the Holy See, Qatar, Sudan, Nauru, Niue, and Palau – have not become state parties to the Convention on the Elimination of Discrimination Against Women. Of UN member countries, 155 are state parties to ICESCR and 38 are not, again including the United States.\(^{48}\)

There is now a consensus that all human rights have three elements or kinds of duties for the states that are a party to them – to respect, protect, and fulfill the rights enumerated therein.\(^{49}\) The duty to respect is not actively to deprive people of a guaranteed right. Another way to put this is that states are under obligation to refrain from directly or indirectly interfering with the enjoyment of a right by denying or limiting access, blocking equal treatment for all people, or enforcing discriminatory practices. For example, a government is required to respect the right to health by abstaining from enforcing discriminatory practices that would deny or limit equal access for all persons to curative and palliative health services, including prisoners or detainees, minorities, asylum seekers, and illegal immigrants. The duty to protect is the state’s obligation not to allow other entities to deprive its people of the guaranteed right. For example, a government has a responsibility to prevent others within their jurisdictions, including corporations, from infringing the right to health, for example by failing to enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries. The duty to fulfill requires the state to work actively to implement the requirements of a right and to that end to establish laws, institutions, and policies, and make the necessary investments. For example, fulfillment of the right to health requires the establishment of an appropriate infrastructure providing widespread access to health services.

One of the factors limiting the effectiveness of health-related obligations is that article 2 (1) of ICESCR permits the full realization of its enumerated rights to be accomplished gradually as resources permit. Known as the principle of ‘progressive realization,’ this qualification acknowledges that full and immediate realization of all economic, social and cultural rights will generally not be able to be achieved in a short period of time, particularly in poor countries.\(^{50}\) The progressive realization benchmark implies that valid expectations and concomitant obligations of state parties are not uniform or universal but, instead, are relative to levels of development and available resources. The Committee argues that state parties have an obligation to take ‘deliberate, concrete, and targeted’ steps intended to move as expeditiously and effectively as possible towards the goal of full implementation,\(^{51}\) but the complex metric of what this requires for states at differing levels of resources and development has

\(^{45}\) Ibid: para. 18.

\(^{46}\) Ibid: paras. 20–27.

\(^{47}\) Ibid: para 12.

\(^{48}\) These figures are computed from the lists on the UN Treaty Body Database. Available at http://www.unhcr.ch/tbs/doc.nsf/newhvstatbytreaty?OpenView&Start=1&Count=250&E... [Accessed 17 Oct 2008].

\(^{49}\) The Committee on Economic, Social and Cultural Rights has used this classification in writing several of its general comments, including General Comment No. 14.


\(^{51}\) Committee on Economic, Social and Cultural Rights, op. cit. note 39, para. 31.
never been operationalized. It is also notable, especially in light of the pressures of the World Bank and the International Monetary Fund on many states to cut back on investments in social services, that the Committee has stated many times, including in relationship to the right to health, that retrogressive measures are not permissible.52

To compensate for the limitations of the progressive realization standard, Article 2 (1) mandates that each state party ‘take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of available resources.’ This formulation underscores the importance of international financial aid and technical assistance to the total pool of resources available to specific states for implementing the rights in the Covenant. It also implies that the human rights responsibilities of states, particularly those with greater financial and technical resources, extend beyond their borders. International assistance and cooperation is usually discussed in terms of levels and types of monetary contributions and the type of technical assistance required. But various human rights sources and authorities have a far broader conceptualization. According to Paul Hunt, international assistance and co-operation should not be understood as only encompassing financial and technical assistance. He also believes that it includes a responsibility to work actively toward equitable multilateral trading, investment, and financial systems conducive to the reduction and elimination of poverty.53

In addition, the Committee has established that there is a ‘minimum core content’ with regard to each economic, social, and cultural right that state parties are obligated to fulfill immediately54 and not subject to resource constraints.55 According to the Committee, even in times of severe resource constraints, the vulnerable members of society ‘can and indeed must be protected by the adoption of relatively low-cost targeted programs.’56

The general comment on the right to health enumerates an extensive list of core obligations requiring states parties to:

(1) ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
(2) ensure for everyone access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure their freedom from hunger;
(3) ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
(4) provide essential drugs as defined by WHO’s Program on Essential Drugs;
(5) ensure equitable distribution of all health facilities, goods, and services;
(6) adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population and giving special attention to vulnerable or marginalized groups, that is devised and periodically reviewed on the basis of a participatory and transparent process with mechanisms, such as indicators and benchmarks, by which progress can be closely monitored.57

In addition, the Committee identifies another set of obligations of comparable priority that include the following responsibilities:

(1) to ensure reproductive, maternal (pre-natal and post-natal) and child health care;
(2) to provide immunization against the community’s major infectious diseases;
(3) to take measures to prevent, treat and control epidemic and endemic diseases;
(4) to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
(5) to provide appropriate training for health personnel, including education on health and human rights.58

Taken together this list of core obligations imposes quite a comprehensive mandate. If realized, the core obligations would guarantee access to key social determinants of health, including access to nutritious food, basic shelter, housing and sanitation, an adequate supply of safe and potable water, and education and access to information concerning health. Other components focus on requirements related to the health infrastructure and

52 Committee on Economic, Social and Cultural Rights, op. cit. note 39, para. 32.
54 Committee on Economic, Social and Cultural Rights, op. cit. note 51, para. 10.
55 Ibid: para.11.
services, such as their equitable distribution, the provision of immunization against relevant major infectious diseases, the obligation to take measures to prevent, treat and control epidemic and endemic diseases, and provision of appropriate training for health personnel. In addition, states are directed to adopt and implement a national health strategy and plan of action addressing the health concerns of the whole population.

How feasible and reasonable is this set of core obligations? Can all countries, including the poorest ones, even if so committed, achieve these objectives within a relatively short period of time? In 2003, the WHO Commission on Macroeconomics and Health estimated that a minimum of US$34 to $40 per person would be required to finance a package of cost-effective public health and clinical interventions appropriate for low-income countries and to achieve the health-related Millennium Development Goals. This package includes some, but certainly not all, of the health services identified as core obligations, and none of the other health inputs related to the social determinants of health. At that time health expenditure in 29 poor countries was between US$1 and US$9 and in another eight it was US$23 or less. Reaching the minimum investment goal would therefore require a major reallocation of resources, estimated to be equal to about 15 percent of government expenditure. However, for many of the poorest countries with the worst health outcomes, severe constraints on their resources make this very difficult. Nor does it seem likely that other sources of funding will come forward to make up the deficit.

HUMAN RIGHTS APPROACH TO THE DETERMINANTS OF HEALTH

As described above, the general comment on the right to health recognizes the importance of inputs to health, such as nutritious food, basic shelter, housing and sanitation, an adequate supply of safe and potable water, and education. In addition, there are provisions related to the social determinants of health in other parts of the ICESCR, including the following:

• Like other human rights instruments, Article 2(2) forbids any form of discrimination based on race, color, sex, language, religion, political opinion, national or social origin, property, or birth and Article 3 ensures the equal rights of men and women.

• Article 6 recognizes the right to work and Article 7 to the enjoyment of just and favorable conditions of work, including safe and healthy working conditions;

• Article 9 enumerates the right of everyone to social security, including social insurance;

• Article 10 outlines the obligation to provide the widest possible protection and assistance to the family, including to mothers before and after childbirth and children and young persons;

• Article 11 stipulates the right of everyone to an adequate standard of living including adequate food, clothing, and housing;

• Articles 13 address the right of everyone to education, one component of which is that primary education shall be compulsory and free of charge; Article 14 sets a timeline requiring states to have a plan to realize this goal within two years of becoming a party to the ICESCR;

• Article 15 includes the right to enjoy the benefits of scientific progress and its applications.

For some of these rights, the Committee has adopted a general comment setting forth related core obligations. These include the following:

• The general comment on the realization of universal primary education, while not specifically using the term core obligation, reiterates the requirement in Article 14 for countries to adopt a detailed plan of action for the progressive implementation of universal, compulsory, and free primary education within a reasonable number of years.

• According to the text of the general comment on the right to food, the Committee considers that the core content of this right implies the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, acceptable within a given culture, and accessible in ways that are sustainable and do not interfere with the enjoyment of other human rights.

• Core obligations outlined in the general comment on the right to work include the requirements of (1) ensuring the right of access to employment, especially for disadvantaged and marginalized individuals and groups; (2) avoiding any measures that result in discrimination and unequal treatment in the private and public sectors of disadvantaged and marginalized

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individuals and groups; and (3) adopting and implementing a national employment strategy and plan of action that addresses the concerns of all workers on the basis of a participatory and transparent process and includes indicators and benchmarks by which progress can be measured and periodically reviewed.\(^{62}\)

- The Committee’s general comment on the right to social security stipulates core obligations including (1) to ensure access to a social security scheme that provides a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care, basic shelter and housing, water and sanitation, foodstuffs, and the most basic forms of education; (2) to ensure the right of access to social security systems or schemes on a non-discriminatory basis, especially for disadvantaged and marginalized individuals and groups; (3) to protect existing social security schemes from unreasonable interference; (4) to adopt and implement a national social security strategy and plan or action; (5) to take targeted steps to implement social security schemes, particularly those that protect disadvantaged and marginalized individuals and groups; and (6) to monitor the extent of the realization of the right to social security.\(^{63}\)

- Additionally, in 2002, recognizing that water is a limited natural resource and a public good fundamental to life and health, the Committee adopted a general comment on the right to water.\(^{64}\) The core obligations assigned to state parties include to ensure: (1) access to the minimum essential amount of water that is sufficient and safe for personal and domestic uses to prevent disease; (2) the right of access to water and water facilities on a non-discriminatory basis, especially for disadvantaged and marginalized groups; (3) physical access to water facilities or services that are at a reasonable distance from the household; and (4) equitable distribution of all available water facilities and services. The list of core obligations also addresses the need to develop a national water strategy and plan of action with a method to monitor progress.\(^{65}\)

As in the case of the core obligations outlined in the general comment on the right to health, the realization of these core obligations would go a long way to ameliorating the effects of globalization, but obviously this is not happening. This article has already mentioned one problem with the implementation of core obligations – the role of resource availability. The final section of this article will discuss other limitations constraining a human rights approach.

HUMAN RIGHTS AND POLITICAL MOBILIZATION

The human rights approach stresses the need for empowerment, participation, and accountability so that people can take control over their lives. Consistent with this vision, human rights obligations have served as a source of inspiration, a focal point, and an organizing strategy for civil society activists around health and other economic and social rights. A broad range of issues with health implications, as for example water privatization, oil contamination, exploitation of indigenous lands, and the impact of trade agreements on access to medicine, are now being contested as rights issues.\(^{66}\) Coalitions of human rights, labor, and environmental groups now lobby trade negotiators, demonstrate at WTO Ministerial Conferences, and monitor WTO developments on health-related issues.\(^{67}\) Arguably, as Christopher Jochnick observes, ‘The real potential of human rights lies in its ability to change the way people perceive themselves vis-à-vis the government and other actors. A rights framework provides a mechanism for re-analysing and renaming “problems” as “violations,” and, as such, something that need not and should not be tolerated.’\(^{68}\)

In the past ten years, the human rights movement has expanded and become more involved with the protection and promotion of economic and social rights, including and particularly the right to health. Paul Hunt notes, ‘As

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\(^{65}\) Ibid: para. 37.

\(^{66}\) Yamin, *op. cit.* note 10.


never before, civil society – especially in low-and-middle-income countries – is engaging with health and human rights. Something approximating a health and human rights movement is developing. The People’s Health Movement, a global organization with national chapters that seek to promote social transformation and the right to health, recently launched a global ‘Right to Health and Healthcare Campaign.’ Médecins Sans Frontières, Partners in Health, Doctors for Global Health, and other humanitarian organizations of health professionals are increasingly using human rights as an advocacy tool.

Many human rights organizations are going beyond the traditional human rights techniques of ‘naming and shaming’ to adopting more policy-relevant approaches, including the application of indicators, benchmarks, and impact assessments. In countries with relevant legal or constitutional health entitlements, human rights norms has provided grounding for legal efforts, sometimes supported by public advocacy and mobilization, to oppose cut backs or the failure to provide health entitlements.

Campaigns to improve access to essential medicines constitute one example of these initiatives. In 2001, a global campaign led by Oxfam, Médecins Sans Frontières, and other organizations, which collected some 250,000 signatures on a petition, convinced the Pharmaceutical Manufacturers of South Africa to withdraw its legal suit, filed on behalf of 39 major drug companies, to forestall implementation of the South African government’s 1997 Medicines Act, which would allow the country to import cheap alternatives to branded medicines. Pressure from nongovernmental organizations concerned with the access of poor countries to essential medicines contributed to the formulation of the Doha Declaration on the TRIPS Agreement and Public Health and the subsequent decision (August 2003) allowing countries producing generic copies of patented drugs under compulsory license to export these drugs to countries with little or no manufacturing capacity.

Human rights considerations have also played an important role in domestic and international campaigns by AIDS activists. Recognizing that low income countries highly affected by AIDS are unable to finance AIDS treatment themselves, AIDS activists pressured the international community to create the Global Fund to fight AIDS, Tuberculosis and Malaria. The Fund has been characterized as ‘nothing other than a tool for compliance with the transnational obligation to fulfill an essential part of the core content of the right to health.’ The political declaration adopted by governments at the June 2006 UN General Assembly High Level Meeting on AIDS affirms that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic and on this basis commits the global community to pursue all necessary efforts to scale up country-driven, sustainable, and comprehensive responses for prevention, treatment, care, and support, with the full participation of people living with HIV and vulnerable groups. It also reiterates the commitment made in Doha that ‘access to medication is one of the fundamental elements to achieve the right to health, and the WTO TRIPS Agreement does not and should not prevent States from taking measures now and in the future to protect public health.’

In a landmark case in South Africa, the Treatment Action Campaign and the AIDS Law Project sued the government to make nevirapine, an antiretroviral, available to women giving birth in public hospitals and clinics in order to prevent mother-to-child transmission of AIDS citing the constitutional guarantees to access to health care. They won their case in the Constitutional Court in 2002, but the Court declined to exercise supervisory jurisdiction. Continuing its policy of AIDS denial, the Mbeki administration refused to implement the decision. In response to this intransigence the Treatment Action Campaign launched a public campaign that successfully pressured the government into making antiretrovirals universally available through the public health system.

69 Paul Hunt, op. cit. note 10, p. 2.
72 Ibid: paras. 59–89 provide an overview of cases that have been brought in recent years.
79 Minister of Health and Others v Treatment Action Campaign and Others (No2) 2002 (5) SA 721 (CC).
These civil society initiatives, while important, are as yet still limited in their impact. Until recently, major international human rights nongovernmental organizations like Amnesty International and Human Rights Watch focused almost exclusively on civil and political rights. They are beginning to address issues related to the right to health but slowly and very selectively. Even more significantly, health professionals have generally failed to appreciate the human rights dimensions of their work, possibly because their education does not expose them to human rights approaches. Therefore few health professionals have used health-related rights as an instrument to seek more equitable policies and programs.80

LIMITATIONS OF HUMAN RIGHTS AS A COUNTERWEIGHT TO THE IMPACT OF GLOBALIZATION

This article has put forward a view that a human rights approach offers an alternative and compelling paradigm to the neoliberal ideology of globalization. Nevertheless, the normative principles and legal obligations related to the right to health and the social determinants of health outlined in this paper have significant limitations in their effectiveness in countering the impact of globalization. Otherwise globalization would not be having such a devastating impact on health and the social determinants of health. Many factors reduce the potential counterweight human rights might exert, including and specifically the nature of the human rights approach, weak political commitments to promoting and protecting health rights on the part of some states, and their lack of institutional and economic resources to do so. Global economic markets and the relative power of global economic institutions are also shrinking national policy space. This section will present a brief overview of these limitations.

The human rights model focuses on states as the primary, often exclusive, duty bearer for the fulfillment of human rights. In a globalized world, non-state actors – particularly transnational corporations and international institutions – may have considerable power, sometimes even more than the governments with whom they interact. The human rights community has sought ways to extend the purview of human rights in order to deal with the impunity of non-state actors, but generally without a great deal of success. One way the human rights paradigm does so is by assigning governments the responsibility of protecting the rights of citizens from violations of their rights by third party actors, including transnational corporations. Whether governments are motivated and able to do so, however, is at issue in a global system in which corporations sometimes have greater resources and power than their host governments. Complicating the equation, corporations are not recognized as subject to international law. Attempts to expand international law to cover private actors directly therefore usually take the form of voluntary agreements. One recent example is Paul Hunt’s draft human rights guidelines for pharmaceutical corporations in relationship to access to medicines.81 Judging from some of the posts on websites, this admirable initiative has apparently received an unenthusiastic reception from some of the major pharmaceutical corporations.82

Human rights advocates have also sought to influence the policies, practices, and operations of various international organizations, particularly international financial institutions and the WTO, particularly through leveraging the human right obligations of member states. The Committee often reminds states parties, particularly from developed countries, of the need to do all they can to ensure that the policies and decisions of those organizations are in conformity with their obligations to the Covenant.83 And the Committee offers similar advice to poor countries which are the recipients of aid, underscoring the importance of integrating human rights, including economic, social and cultural rights, in the formulation of their Poverty Reduction Strategy Papers.84

The human rights community has also argued that the realms of trade, finance, and investment are not exempt from human rights principles, as for example, in the Committee’s 1998 statement on Globalization and Economic, Social and Cultural Rights.85 But there is no basis

80 Paul Hunt, op. cit. note 70, paras. 44–47.
81 www2.ohchr.org/English/issues/health/right/docs/draftguid150508.doc [Accessed 17 Oct 2008].
82 See, for example, the letter from Merck posted on the Business and Human Rights Resource Center website, www.business-humanrights.org/...unintforgs/unintergovernmentalorgs/un/unspecialrapporteurnrighttohealth [Accessed 17 Oct 2008].
85 Statement of the Committee on globalization and its impact on the enjoyment of economic, social and cultural rights. Official Records of
for this claim in international law, and the World Bank and WTO generally view human rights promotion as extraneous to their mandates.

Another factor is that the narrow and sometimes excessively legalistic understanding of the right to health held by many in the human rights community does not accord sufficient importance to the role of the social determinants of health. Although the right to the highest attainable standard of health as interpreted by the Committee in its general comments and by the work of the Special Rapporteur is an inclusive right, extending to underlying determinants of health, many in the human rights community continue to equate the right with the availability of medical care. Paul Hunt has lamented that there is a ‘definite tendency in some Governments, international organizations and elsewhere to devote a disproportionate amount of attention and resources to medical care at the expense of the underlying determinants of health.’

Other human rights advocates go even further in drawing a distinction between a rights-based understanding of the determinants of health and the delineation of the content of the right to health. Building on the work of Paul Hunt and others, Alicia Yamin emphasizes that rights-based approaches to health comprise more than packages of goods and services and necessarily link health protection to broader human rights commitments as well as to the social determinants of health. Yamin’s conception of rights-based approaches also encompasses issues of social well-being and ultimately human suffering. Yamin, however, foresees that applying this broader understanding of the right to specific public health issues will create a challenge for traditional human rights advocacy organizations and will require new forms of evidence and argument, new forms of engagement with governments and other actors, and new ways of thinking about human rights work. Doing so, would make human rights a more effective counterweight to the negative effects of globalization.

Importantly, some states have weak commitments toward implementing their human rights obligations, and one influential government, the United States, even dismisses the status of economic and social rights, including the right to health, as not being real human rights. Although, as noted, the vast majority of states have ratified or acceded to at least one of the major human rights instruments addressing the right to health, this does not necessarily mean they fulfill the requirements specified therein. There is a vast disparity between rhetorical affirmations of acceptance of various rights and their implementation. Although the UN human rights system, the Committee, and members of the human rights community speak about human rights instruments imposing binding legal obligations, many states consider the requirements outlined in the international human rights instruments that they have ratified, particularly in the sphere of economic, social, and cultural rights, to be more in the nature of aspirational commitments. While human rights bodies have developed an expansive interpretation of specific rights over time, including and specifically the right to health, many states have minimalist conceptions of what these rights entail and may not consider the understanding given in the general comments to be authoritative. Also, my experience in dealing with government officials in several developing countries suggests that the policymakers with control over relevant subject areas covered by the ICESCR may not even be aware of the country’s human rights commitments, let alone motivated to abide by them.

Yet another factor limiting the effectiveness of human rights obligations in countering globalization is that the same dynamics related to globalization that affect the social determinants of health also reduce the ability of many governments to protect and promote human rights. As the Committee reflected in diplomatic language in its Statement to the Third Ministerial Conference of the WTO on Globalization, Official Records of the Economic and Social Council, Supplement No. 2, UN Doc. E/1999/22-E.C.12/1998/26: chap. VI, para. 515. The implementation of human rights, particularly such a complex and expansive right as the highest attainable standard of health, requires an activist government with a wide range of capabilities, not the minimalist government favored by neoliberal ideology. Various UN special rapporteurs, among them Miloon Kothari, the UN special rapporteur on the right to adequate housing, have detailed how macroeconomic factors associated with globalization reduce the resources available for social spending on essential social services

The UN human rights treaty bodies tend to use diplomatic language in characterizing the situation, but some of the special rapporteurs have been blunter. Katerina Tomasevska, 2003, for example, during her tenure as the special rapporteur on the right to education, was critical in her reports and especially in her book: Education Denied: Costs and Remedies. New York & London: Zed Books.

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that are integral to fulfilling economic, social and cultural rights. Privatization of essential social services, like water delivery, also impedes the implementation of human rights obligations related to ensuring the availability and affordable cost of services to vulnerable groups and reduces or eliminates the accountability, transparency, and opportunities for the participation of the community in decision making that are essential components of the human rights approach.

As noted above, globalization has taken a major toll on health systems, particularly in developing countries. Years of low financing of health systems, partly as a result of the pressures to privatize health services imposed by international financial institutions and partly due to the crushing debt burden on many poor countries, have significantly weakened public health institutions in these countries. A recent WHO report links unacceptable low outcomes across much of the developing world and the persistence of deep inequities in health status in all countries to failing or inadequate health systems. It seems questionable, therefore, whether most governments, particularly in poor and middle income states, have the institutional and infrastructure capabilities and medical and health staff to meet the requirements imposed by the right to health.

Recently, substantially greater resources for health improvements in poor countries have become available from external sources, including bilateral and multilateral development assistance, private foundations like the Bill and Melinda Gates Foundation, and/or from private-public partnerships. Most of this funding, however, has been targeted for specific diseases, like for example the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the Global Polio Eradication. This vertical approach to investment in disease-specific programs generally imposes short-term targets at the expense of strengthening the overall health infrastructure. Efforts to meet these targets may result in a shift of priorities and resources within the health system and the recruitment of essential health personnel or their reassignment from other roles further weakening the health infrastructure.

The shortage of well-trained trained health workers, made more acute by an accelerated brain drain from developing to developed countries, which is in part a byproduct of a global health labor market, has severely reduced the capabilities of health systems in many poor countries. According to WHO, 57 countries, mostly in sub-Saharan Africa, but also including India, Indonesia, and Bangladesh, face crippling health workforce shortages. The International Organization for Migration estimates that developing nations spend $500 million each year to educate health workers who then leave to work in North America, Western Europe, and South Asia. This loss imposes a severe burden on health systems already weakened by epidemics, insufficient resources, and shortages of health workers.

In a global system, many states, particularly poor ones, have significant constraints on both their ability and their freedom to implement human rights obligations or, to describe the situation in another way, global market integration is shrinking national policy space. The Globalization Knowledge Network defines policy space as the extent to which national decision-making for health and the social determinants of health can be made without subordination to considerations such as economic growth, maintaining payments to external creditors, or complying with trade agreement conditions when these impose health-negative effects. However a different viewpoint has also been put forward, namely that some states may use these seeming conflicts between the demands of global institutions and national commitments strategically as a way to avoid their obligations. Shalini Randeria disagrees with globalization theorists who describe the state as being rolled back as a rule-making or rule-enforcing agency. Instead, she characterizes some state level governments in her own country of India as ‘cunning states’ which capitalize on their perceived weakness under the globalization regime in order to render themselves unaccountable both to their citizens


and to international institutions. Although she is not specifically addressing human rights obligations, it is plausible that something of the same dynamic may be relevant in some situations.

Nevertheless, there are real limits on national policy space in a globalized economic system. Trade agreements are one source. For example, WTO disciplines already in place or under negotiation through multilateral trade agreements restrict the ability of poor and middle-income countries to favor domestic industries with a potential for rapid growth in the way that high-income countries managed their process of industrialization. The deleterious effects of provisions of the Agreement on Trade-Related Intellectual Property Rights (TRIPS) and bilateral TRIPS plus agreements on the availability, cost, and development of pharmaceuticals in low and middle income countries has been a subject of considerable concern.

The emergence of social and health services as areas of global commercial activity under the provisions of the General Agreement on Trade in Services (GAT) is also likely to be problematic for the functioning of health services and other public services related to the social determinants of health. Compounding this situation, few low income countries have sufficient capacity and expertise to assess the potential impacts of new trade agreements on health and the social determinants of health so as to be able to negotiate terms that would confer the policy space needed to promote health.

The conditions (conditionalities) required by international financial institutions for low-income countries to be eligible for loans and debt restructuring reduce the resources available for essential services and thus for implementing core human rights obligations. Under ‘structural adjustment,’ the economic model current from the early 1980s until the late 1990s, the IMF and World Bank imposed austerity policies on borrowers, ostensibly to end their fiscal imbalances. A 1996 World Bank study examining the social dimensions of structural adjustment confirms that there was a consistent reduction in public health expenditures in most sub-Saharan African countries that had been subject to structural adjustment mechanisms. More recently, the World Bank has moved from structural adjustment to a nominal focus on poverty reduction, but there is often little practical change regarding the constraints imposed on poor countries. Rigid ceilings on public health and other social services expenditures imposed by the Bank’s Medium-Term Expenditure Frameworks continue to hamper adequate funding for economic, social and cultural rights. Almost all of the Poverty Reduction Strategy Papers (PRSPs), national planning frameworks, that are now a precondition for Bank concessional lending include or refer to an existing Medium-Term Expenditure Framework. Once included in an agreed PRSP, countries cannot adapt the limits on funding even if a new essential need arises. Currently the IMF uses the concept of ‘fiscal space’ or ‘fiscal sustainability’ as a rationale requiring developing countries to divert billions of dollars of foreign assistance into reserves (US$58 billion in Africa in 2004) instead of spending the funds to improve health or educational services. Further, the Bank encourages countries not to seek the maximum international assistance necessary to provide essential social service if its analysis suggests that additional assistance could have negative macroeconomic implications.

Several analysts have expressed concern about the failure of the PRSP process to take the right to health into account. Paul Hunt cites a 2002 WHO preliminary study of 10 full PRSPs and three interim PRSPs, which found that none even mentioned health as a human right. Nor did they provide much evidence of efforts to adapt national health strategies to meet the needs of the poorest groups: very few of these PRSPs incorporated any health indicators that could monitor the impact on poor people or geographic regions; no PRSP included plans to include poor people in a participatory monitoring process. He amplifies these concerns in some preliminary comments

102 Ooms & Hammonds, op. cit. note 76, p. 3.
103 Ooms & Hammonds, op. cit. note 103.
on the Niger’s 2002 Poverty Reduction Strategy. Nor is it clear as to whether the PRSP process recognizes the incompatibility between instituting a sustainable cost recovery system for essential drugs and the human rights goal of making essential drugs available to those living in poverty. An analysis of the public expenditure budgeting in the health care sectors of Mozambique, Rwanda, and Uganda, as provided for in the PRSP process, similarly concludes that current PRSPs make it impossible to fund public health at a level that satisfies the requirements of core obligations.

When there are conflicts between the demands imposed by the WTO, IMF, or World Bank and the requirements necessary to realize human rights obligations, virtually all governments tend to neglect their human rights commitments. The ability of the WTO to impose trade sanctions and the IMF and World Bank to eliminate their eligibility for loans offers incentives to do so. In contrast, international human rights institutions often have few, if any, comparable sanctions. Most still rely on ‘naming and shaming’ to promote accountability.

CONCLUSION

The human rights paradigm points in the right direction. Nevertheless, it does not compensate for the devastating effects of globalization on the social determinants of health. The hope for the future is that human rights will inspire more effective civil society efforts to counter the deleterious impacts of globalization on health. It is sometimes observed that human rights are claimed through mobilization from the bottom and not granted from the top. One can only hope that campaigns against the health effects of globalization will give rise to successful efforts to reclaim human rights and to reshape the social determinants of health in the era of globalization.

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