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Advancing health equity in the global marketplace: How human rights can help☆

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ABSTRACT

The WHO Commission on Social Determinants of Health (CSDH) ascribed health disparities within and between countries to "a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics." This article analyzes the relevance of the international human rights framework (IHRF) to the Commission's goal of reducing health disparities with reference to both social scientific and legal scholarship. We begin with an overview of the IHRF, demonstrating its potential as a challenge to the normative foundations of the emerging global economic order. We then survey the research literature on mechanisms to ensure accountability for realization of health-related rights, emphasizing the potential effectiveness of making human rights enforceable through the courts, and the special need for mechanisms to hold countries and international institutions accountable for obligations related to the human right to health. We conclude by identifying three key directions for further research, policy and advocacy: comparative human rights litigation, specifically the willingness of courts to address broad policy and budgetary issues; the conditions under which governments legislate or constitutionalize economic and social rights; and how rich, powerful countries affect economic and social rights outside their borders.

Introduction

The report of the WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation*, challenged the international community to eliminate the "toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" that results in health inequities (Commission on Social Determinants of Health, 2008). A background paper for this Commission identified the international human rights framework (subsequently IHRF) as "the appropriate conceptual structure within which to advance towards health equity through action on SDH" (Solar & Irwin, 2007, p. 8), but the Commission did not explore this approach. Subsequently a post-Commission report to WHO also recommended use of the IHRF as a priority for further study (Östlin et al., 2009).

In this article we first provide an overview of the IHRF and demonstrate its value as a challenge to the normative foundations of the emerging global economic order. We then survey the research literature on mechanisms to ensure accountability for realization of health-related rights, focusing on the national level but also addressing supranational institutions, and conclude by identifying key areas for further investigation. This article contributes to the literature by elaborating on the little-studied question of how the IHRF can contribute to addressing the consequences of economic globalization and its associated norms of "market fundamentalism" by way of the social determinants of health.

Background: the international human rights framework (IHRF)

A human right to health exists in international law by way of a series of treaties, the most expansive and important of which is the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of ICESCR (United Nations, 1966) recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (subsequently, for convenience, the right to health) and mandates that states parties – countries that have ratified the instrument – provide for maternal and child health; improve environmental and industrial hygiene; ensure prevention, treatment and control of "epidemic, endemic, occupational and other diseases"; and "create conditions which would assure to all medical service and medical attention in

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the event of sickness". Of special relevance to SDH are other provisions of ICESCR, related *inter alia* to rights to healthy and safe working conditions; social security; protection and assistance to the family; the right to an adequate standard of living including food, clothing and housing; and the benefits of scientific progress. Provisions relevant to health and SDH can also be found in other global human rights treaties such as the International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1965), the Convention on the Elimination of All Forms of Discrimination Against Women (United Nations, 1980) and the Convention on the Rights of the Child (United Nations, 1990), as well as in a series of regional human rights treaties.

Under international law, primary responsibility for implementing human rights rests with national governments, although their duties may extend outside their own borders, notably through the obligation under Article 2(1) of the ICESCR to extend "international assistance and co-operation, especially economic and technical". Ratification means that states are responsible to *respect, protect*, and *fulfill* the rights set out in the relevant treaties (Maastricht Conference, 1998, p. 694). Understandings of the right to health have broadened over time, led by the UN Committee on Economic, Social and Cultural Rights (CESCR), a treaty monitoring body that receives and comments on periodic reports from states parties and interprets the provisions of ICESCR by way of (non-binding) general comments. In 2000 the Committee issued General Comment 14 (GC 14) on Article 12 (Committee on Economic, Social and Cultural Rights, 2000), which interprets the right to health as extending beyond the availability of timely and appropriate health care to incorporate access to underlying determinants of health such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, healthy occupational and environmental conditions, and access to health-related education and information, including sexual and reproductive health (Committee on Economic, Social and Cultural Rights, 2000, ¶ 11, 17). GC14 further emphasizes the special obligations of the state to provide for the satisfaction of the health needs of those whose poverty, disabilities, or background make them the most vulnerable (Committee on Economic, Social and Cultural Rights, 2000, ¶ 20–27). Relevant to health, the Committee also adopted a general comment on the right to water (Committee on Economic, Social and Cultural Rights, 2003) the importance of which cannot be overstated: diarrhoeal diseases killed more than a million children each year *circa* 2000, and lack of safe drinking water and sanitation contributes to the high incidence of numerous diseases among both children and adults (Prüss, Kay, Fewtrell, & Bartram, 2002).

Like all human rights treaties, the rights contained within ICESCR are established as universal, meaning that they apply to all persons in all places as a means to promote a life of human dignity. While some moral/cultural relativists dispute the possibility of achieving a universal conception of human rights, it is noteworthy that approximately three-quarters of the world's sovereign states, a total of 160 countries (as of April 2010), have ratified ICESCR (United Nations, 2010), including most of the Asian countries whose political leaders (but not civil society advocates) have sometimes claimed that human rights are anchored in Western liberal values. The universality of economic and social rights also rests on their role in grounding a minimum set of prerequisites (capabilities) that are essential to human functioning, of which social determinants of health such as adequate nutrition, safe water and shelter are among the most basic (Nussbaum, 2000, chapter 1).

Realization of economic and social rights is unavoidably contingent on the availability of resources. This point is recognized in ICESCR Article 2(1), which requires each state party "to take steps … to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant." This is often referred to as the progressive realization principle. However the Committee has stipulated that states parties have an immediate obligation to fufill some obligations, including to ensure the satisfaction of a "minimum core content" of each economic, social, and cultural right (Committee on Economic, Social and Cultural Rights, 1990, ¶ 10). GC14 has an extensive list of core obligations related to the right to health, insisting that that "a state party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations … which are non-derogable" (Committee on Economic, Social and Cultural Rights, 2000, ¶ 47). Implementing these core obligations even – perhaps especially – in a low- or middle-income country would "require an activist, committed state party, with a carefully honed set of public policies related to the right to health" (Chapman, 2002, p. 205).

Market fundamentalism and human rights

This view of states' obligations for respecting and protecting human rights, including the right to health, contrasts dramatically with contemporary economic policy wisdom. Over the past few decades, most countries have become integrated into a global marketplace characterized by reduced barriers to trade in goods and services and dramatic increases in the volume and speed of cross-border investment flows. Production has been reorganized across multiple national borders (Dicken, 2007), leading to intensified interjurisdictional competition for foreign direct investment and contract production, and the worldwide financial marketplace has exposed governments, especially those of low- and middle-income countries, to destabilizing disinvestment and capital flight (Schrecker, 2009b). In response both to external pressure, exemplified by the structural adjustment conditionalities of the World Bank and International Monetary Fund and the "implicit conditionality" (Griffith-Jones & Stallings, 1995) demanded by investors, and to the interests of powerful domestic constitutencies, policies in countries rich and poor alike have been shaped by a set of doctrines variously described as neoliberalism, neoliberal globalization or market fundamentalism (Somers, 2008), the term used here.

Market fundamentalism presumes that markets are the appropriate basis for organizing most areas of economic and social life, and assigns a heavy burden of proof to those who propose alternative social arrangements (Harvey, 2005; Somers, 2008). Numerous illustrations can be found in the policy prescriptions of the World Bank (Akin, Birdsall, & de Ferranti, 1987; Holzmann & Jörgensen, 2001; World Bank, 1993, chapter 3), an agency that has been an active promoter of the global marketplace in its role as provider of development finance and source of technical expertise on development policy issues (George & Sabelli, 1994; Goldman, 2007; Lee & Goodman, 2002). Market fundamentalism also represents an algorithm for restructuring state institutions, at levels ranging from the national to the local (Peck & Tickell, 2002; Ward & England, 2007), in ways that make them more 'market-friendly'. The idea of a global self-regulating market governing social and economic affairs shifts responsibility for social provision away from the state and towards individuals and households (Hacker, 2004), legitimizing the reduced role of the state and the elimination of even limited entitlements by redefining citizenship in terms of labour market participation and 'responsible' consumption (Ruiters, 2006, 2009). Thus, market fundamentalism challenges not only the existence of particular economic and social entitlements apart from market relations, but also the extent to which a "right-to-have rights" (Somers, 2008) is recognized.

Some countries (such as China and India), although not all, have achieved impressive rates of economic growth as a result of embracing the global marketplace. In theory, this should make

resources available for widely shared improvements in population health; in some cases, this appears to have happened at least in the sense that governments such as China's that had accumulated large fiscal surpluses were able to cushion the worst effects of the financial crisis of 2008 by financing major stimulus programs (Morrison, 2009). More generally, market fundamentalism has proved inimical to health equity in multiple ways (Chapman, 2009; Labonté, Schrecker, Packer, & Runnels, 2009). Years of financial austerity have led to a situation in which, in the words of a recent WHO report, health systems "are on the point of collapse, or are accessible only to particular groups of the population" (World Health Organization, 2007), often as a consequence of pressure from the World Bank and International Monetary Fund to make health systems "sustainable" by way of cost recovery through user fees (Lister, 2005; Waitzkin, Jasso-Aguilar, & Iriart, 2007). It has also led to increases in poverty and economic inequality in some regions, resulting both from the growth of insecure and precarious employment and from a retreat from social protection (Labonté & Schrecker, 2007; Schrecker, 2009a). The potential health benefits of substantial poverty reductions in countries like China and Vietnam were undermined by simultaneous marketization of their health systems, which has reduced access to health care for much of the population (van Doorslaer et al., 2006; Dummer & Cook, 2008; Sepehri, Chernomas, & Akram-Lodhi, 2003; Sepehri, Chernomas, & Akram-Lodhi, 2005; Tang et al., 2008), although in 2009 it was reported that China was planning to create a universal health care system (Morrison, 2009).

Perhaps most strikingly in view of the consistent historical contribution of scientific and technological progress to the improvement of population health, econometric analysis carried out for the Commission using data on 136 countries suggested that, on a worldwide basis, the effects of market-oriented economic policies between 1980 and 2000 cancelled out much of the progress towards better health (as measured by life expectancy at birth) that would have resulted from medical progress if social and economic trends had continued their 1960–1980 trajectory (Cornia, Rosignoli, & Tiberti, 2008; Cornia, Rosignoli, & Tiberti, 2009). In two regions, sub-Saharan Africa and the transition economies exposed to full rigours of the global marketplace after the fall of the Soviet Union, such policies contributed to a substantial decline in life expectancy relative to this counterfactual, and in the case of sub-Saharan Africa only half of the loss was explained by the HIV epidemic, itself not unconnected to globalization. Despite data limitations, the authors concluded that "the negative association found between liberalization–globalization policies, poor economic performance and unsatisfactory health trends … seems to be quite robust" (Cornia et al., 2008, p. 79).

For these reasons, serious tensions and conflicts have been identified between market fundamentalism and protection of human rights (Berthelot, 2007; Chapman, 2009; Eide, 2005; Gómez Isa, 2005; O'Connell, 2007;). Because human rights "are predicated on the intrinsic value and worth of all human beings" and "are considered to be universal, vested equally in all persons regardless of their gender, race, nationality, economic status, or social position" (Chapman, 1993, p. 21), the idea of a human right loses meaning if its realization is contingent on an external criterion such as current or future income or purchasing power. This point has important implications for health in a world in which more than a billion people are chronically undernourished (United Nations Food and Agriculture Organization, 2009) and a much larger number struggle daily for survival. In contrast to market-oriented policies, for a human rights approach: "The litmus test … is the extent to which the rights of the most vulnerable and disadvantaged individuals within the community are assured" by any set of policies or institutional arrangements" (Chapman, 1993, p. 23). Crucially, from a human rights perspective the wealth and health of a growing 'middle class' in no way offset or excuse persistent poverty, rising economic insecurity or lack of access to health care elsewhere in a society. This strongly egalitarian characteristic of the human rights perspective is one of the most important reasons to consider it central to efforts to advance health equity, especially against the background of abundant evidence that the rising tide of growth in an internationally integrated economy does *not* necessarily, quickly or automatically lift all boats in ways that are conducive to improving health outcomes (Birdsall, 2006; Cornia et al., 2009; Deaton, 2006).

Realizing health-related human rights: domestic performance

How seriously do national governments take their responsibility for discharging the human rights obligations they have accepted? A recent study of 194 countries identified 72 indicators of the extent to which health systems and policies incorporated "right-to-health features" (Backman et al., 2008). The study found, for instance, that only 56 of the 160 countries that have ratified ICESCR had legally recognized the right to health, and 88 countries "did not have in place an adequate health information system for maternal deaths, suggesting that their health systems are seriously deficient in terms of both the right to health and relevant WHO building blocks." Serious deficiencies were found not only in monitoring and accountability mechanisms at the national level, but also – for many indicators – in the availability of necessary data.

This finding underscores the importance of investigating the effectiveness of mechanisms of accountability (Potts, 2008; Riedel, 2009; Yamin, 2009) in ways that generate improvement in realization of rights. Such human rights mechanisms exist at the international, regional, and state levels, but they often lack the capacity to impose effective sanctions for violations and non-realization of obligations. However, many governments have entrenched human rights in legislation in a form that is justiciable (enforceable through the courts) in response to claims by individual rights-holders (Eide, 2007; Gloppen, 2008). A rapidly expanding literature addresses economic and social rights litigation and its effectiveness, Human rights litigation to improve access to essential medicines in 12 countries was found most likely to be successful when relevant principles were entrenched in domestic legislation or in national constitutions, directly or by explicit incorporation of relevant treaty provisions (Hogerzeil, 2006; Hogerzeil, Samson, Casanovas, & Rahmani-Ocora, 2006). A study (Gauri & Brinks, 2008) of litigation related to the right to health and education (with cases involving health far more numerous) in South Africa, Brazil, India, Nigeria and Indonesia concluded that "legalizing demand for [social and economic] rights might [*sic*] well have averted tens of thousands of deaths in the countries studied in this volume and has likely enriched the lives of millions of others" (Brinks & Gauri, 2008, p. 303). Another compilation surveyed the justiciability of economic and social rights in 13 countries across the income spectrum, reaching less categorical conclusions but nevertheless emphasizing the potential value of justiciable economic and social rights (Langford, 2008b).

Writing rights into law may be a necessary condition for effective implementation, but it is unlikely to be sufficient. The effects of litigation depend on a complex of factors involving not only the legislative background but also the receptivity of courts, the political history of economic and social rights claims, and the mobilization of civil society. Even when litigation is successful in the sense that the issue is resolved at least partly in favour of rights claimants, direct impact may be limited. In the widely cited *Grootboom* case in South Africa, involving resistance to forced resettlement, the reluctance of the court to direct the government to execute its decision,

compounded by governmental resistance to implementation, meant that five years "after the judgment [the litigants] are still located in crowded, unsanitary conditions … with highly inadequate services" (Liebenberg, 2008, p. 99; Berger, 2008, p. 76–81), reflecting a frequent contrast between the impact of a court decision on litigants and its broader consequences. In another widely cited South African case, courtroom success in obtaining a ruling directing public provision of antiretroviral therapy was met by prolonged intransigence on the part of the government, requiring a national campaign and a variety of subsequent court actions to enforce compliance (Liebenberg, 2008).

Where justiciability of economic and social rights is established as a matter of law, courts may hesitate to render decisions that will have major policy and budgetary implications for government. In South Africa, which despite extensive economic and social rights provisions in its constitution has not ratified ICESCR, courts have rejected the applicability of minimum core obligations, claiming that they "are not institutionally equipped to make the wide-ranging factual and political enquiries necessary" to intervene in larger issues of public policy (Liebenberg, 2008, p. 82–86). This recurrent theme in the literature on economic and social rights litigation can be interpreted in at least two ways, which are not mutually exclusive. It may reflect judicial deference to the priorities of elected, and therefore presumptively legitimate, governments. (Interestingly, the argument that courts should defer to legislative enactments is seldom encountered with respect to the property rights that are central to market fundamentalism.) Alternatively, courts may be unwilling to challenge existing concentrations of wealth and privilege as required by the human rights perspective's emphasis on the rights of the most vulnerable and disadvantaged.

Legal action may nevertheless have important consequences for broader policy directions. A discussion of the *Grootboom* case, for example, points out that it "led to the establishment of emergency housing funds in many municipalities and was used to protect large numbers of informal settlers from eviction orders" (Brinks & Gauri, 2008, p. 339). Other cases, including a series of education rights cases in Indonesia that indirectly contributed to a substantial increase in government spending on education and midday school meals in several Indian states provided as a response to right-to-food litigation, as well as the rollout of the South African AIDS treatment program, provide indications of substantial impact (Brinks & Gauri, 2008, p. 324–325). These findings are fully consistent with earlier comparative research findings that the policy significance of human rights treaty ratification depends on domestic political institutions and on the role of civil society organizations (Neumayer, 2005).

Realizing health-related human rights: international mechanisms

The protective effects of legislative entrenchment of social and economic rights may link domestic outcomes and national governments' relations with supranational institutions. A series of rulings by the Hungarian Constitutional Court found that many elements of an austerity program implemented by the Hungarian government, in response to conditionalities attached to an IMF loan sought in order to facilitate rescheduling of external debts (many incurred before the collapse of the Soviet bloc in 1989), were impermissible under the terms of the Hungarian constitution. Scheppele (2004) argues that the rulings not only reduced the adverse effects on social determinants of health as felt by the poor and otherwise economically vulnerable, but also shifted bargaining power away from the IMF and towards the domestic opponents of Fund conditionalities. The IMF, a staunch advocate of the "rule of law," could hardly continue to insist on austerity programs that had been ruled unconstitutional. "Strong court decisions on social rights can provide elected politicians with bargaining chips in their negotiations with IFIs," also increasing the perceived legitimacy of those politicians in new and fragile democracies (Scheppele, 2004, p. 1924). The transferability of this finding remains to be tested, but it serves as an important counterpoint to research on the more proximal consequences of social and economic rights litigation, especially because IMF conditionalities have been implemented in a one-size-fits-all fashion in most low- and middle-income countries irrespective of country specificities and existing conditions.

Such examples aside, if mechanisms of accountability are weak at the national level, they are even more fragile and inadequate internationally. Especially striking is the emergence of a set of supranational institutions – the World Trade Organization (WTO) and its dispute resolution bodies – for enforcing trade rules while international human rights institutions often remain confined to 'naming and shaming.' The contrast is disturbing because of the accumulating evidence that trade policy can have significant negative effects on health, in terms not only of access to essential medicines – the most widely publicized area – but also of financing of health systems, access to livelihood, and loss of public revenues (Blouin, Chopra, & van der Hoeven, 2009; Labonté, Blouin, & Forman, 2009; Smith, Chanda, & Tangcharoensathien, 2009; Smith, Correa, & Oh, 2009). Periodic review by CESCR of reports submitted by states parties has historically been compromised by the superficiality and biased nature of information provided by national governments (when they comply with their treaty obligations at all) and by the limited evidence base available to the Committee, which is reliant on submissions by UN specialized agencies and from civil society organizations given its lack of an independent research capacity (Chapman, 1996).

A second mechanism for achieving accountability at the international level, likewise for the moment only by way of moral suasion, involves the designation of independent experts or special rapporteurs by the UN Human Rights Council (before 2006 the Commission on Human Rights) to interpret and investigate the status of particular rights and make recommendations on measures to improve their performance. These thematic "mandate holders," in UN terminology, have included special rapporteurs on globalization and human rights, the right to the health, the right to food, adequate housing as a component of the right to an adequate standard of living, effects of the illicit trade in toxic wastes, and human rights obligations related to safe drinking water and sanitation as well as independent experts on human rights and extreme poverty and on the effects of foreign debt on economic, social and cultural rights.

Paul Hunt, the first special rapporteur on the right to health (2000–2008), repeatedly emphasized the importance of engaging with economic policy – for instance, by insisting on the need to develop assessment tools to ensure compatibility between the provisions of trade agreements and the health-related human rights obligations of WTO member countries (Hunt, 2004, 2006). A former special rapporteur on education was especially critical of the imposition of user fees for primary education, and engaged in an ongoing dialogue with the World Bank about its support for such policies (Tomasevski, 2005). She also linked high levels of external debt with inadequate resources for education and argued that human rights obligations must be integrated into negotiations on debt relief (Tomasevski, 2002, ¶ 17). A former special rapporteur on the right to housing argued that macroeconomic factors – including limited returns from trade liberalization, financial volatility, increased land speculation, austerity measures demanded by the World Bank and IMF, and privatization of public services – compromised "the role and capacity of States to provided adequate resources and other provisions which are often necessary in fulfilling economic, social and cultural rights" (Kothari, 2002, ¶ 51; see web Table 1 for

additional illustrations). Recently, the independent expert on extreme poverty and the special rapporteur on housing have emphasized that governments must not use the financial crisis as a justification from retreating from human rights obligations, and indeed that the crisis underscores the importance of such obligations (Rolnik, 2009; Sepúlveda Carmona, 2008). Indeed, investment in human rights such as employment and education has the potential to redress not only the negative effects of the crisis, but also the crisis itself by stimulating aggregate demand and economic activities that can result in economic recovery and growth. Although the degree of reliance on social science research varies, collectively these documents assemble valuable evidence of the effects of the global marketplace on health-related human rights (Wilson, 2009).

Directions for research, policy and advocacy: what is to be done?

We have identified three directions for future research, policy and advocacy. *First*, if courts are meaningfully to recognize economic and social rights related to health, they will need to trespass on the sacred ground of governments' budgetary priorities, the political terrain on which "the maximum of available resources" is ultimately defined, thereby challenging state invocation of resource limitations (Yamin, 2009, p. 13). Multidisciplinary methods for audits of public policies by civil society organizations to assess their compliance with obligations related to economic and social rights have already been developed (Balakrishnan & Elson, 2008), and the 2007 annual report of the UN High Commissioner for Human Rights emphasized the need for scrutiny of budgetary processes and priorities (United Nations High Commissioner for Human Rights, 2007, ¶ 57–75). In the context of a general need for more comparative research on human rights litigation (Gloppen, 2008, p. 21), special attention should be paid to influences on courts' willingness to direct other branches of government. Relatedly, research is needed on why few cases challenging broad policy directions on human rights grounds appear to have been brought before courts, notably regarding privatization of health care and health-related social services (Langford, 2008a, p. 18–19; Forman, 2008). It is possible to posit the existence of negative feedback loops in which judicial caution discourages such challenges, and the resulting policy choices are thereby exposed to critical scrutiny neither in the courts nor within the broader political process that is ultimately determinative of the extent to which human rights are realized in practice.

Second, more research is needed on the conditions under which governments incorporate economic and social rights into legislation and constitutional provisions. Forman (2008) has applied a three-stage model from the international relations literature, in which norm emergence is followed by broad acceptance ("norm cascades") and then norm internalization (Finnemore & Sikkink, 1998), to the gradual expansion of the right of access to essential medicines in the face of patent harmonization under the WTO regime. However neither this model nor a five-stage "spiral model" (Risse, Ropp, & Sikkink, 1999) that has been applied to the extension of so-called civil and political rights in developing and transition countries is necessarily adequate to explain the legislation of economic and social rights. Certainly the role of external influences varies depending on the case at hand. Even if one accepts the contentious conclusion that US foreign policy has often acted as a positive influence on the diffusion of civil and political rights (Risse et al., 1999), this cannot be said of economic and social rights. The US has not ratified ICESCR and has consistently opposed recognition of, for instance, access to food as a human right (United Nations Food and Agriculture Organization, 2002, Annex II). Indeed, the development policy wisdom promoted by the United States in the 1980s, widely referred to as the Washington Consensus, reflected a policy orientation "essentially contemptuous of equity concerns" (Williamson, 1993, p. 1329). Further, many jurisdictions in which litigation involving economic and social rights has been most extensive, such as South Africa, Brazil and Indonesia, entrenched such rights as part of new or extensively revised constitutions during transitions from authoritarian rule. The transferability of these countries' experiences to the larger universe of countries may be limited by the difficulty of constitutional revision in the context of less dramatic political changes; this represents yet another important area for future inquiry.

Third, given the recent history of global economic integration, more research is needed on how the acts, policies and omissions of rich, powerful countries affect economic and social rights outside their borders. Against an historical background of the destructive consequences of structural adjustment policies, this point is illustrated by a controversy that erupted *circa* 2003 over public expenditure ceilings (notably for health care and education) included in multi-year macroeconomic plans prepared by low-income countries for World Bank and IMF approval, in order to secure financing both from those institutions and from other sources (Hammonds & Ooms, 2004; Ooms & Schrecker, 2005). The rationale for these requirements, the widespread use of which was documented in an IMF report released in 2007 (Independent Evaluation Office, International Monetary Fund, 2007), was that such "fiscal expansion" might be inflationary and lead governments to run deficits if the aid financing temporarily available to support them were to dry up in the future. A human rights perspective, in contrast, would assess World Bank and IMF policies in light of the international assistance obligations specified in Article 2(1) of ICESCR. This implies, most immediately, an obligation on the part of shareholder governments, notably the G7 governments that hold close to an absolute majority of votes at both the World Bank and the IMF (Buira, 2004), to oppose Bank and IMF policies that might interfere with that realization (Hammonds & Ooms, 2004). Over the longer term, it is important to consider more far-reaching governance reforms: for example, linking market access to compliance with core labour standards in a way that does not permit disguised protectionism on the part of the high-income countries (Barry & Reddy, 2006), or establishing a dispute resolution procedure under which countries would be exempt from trade sanctions under the WTO regime or any other bilateral or regional trade agreement if they could defend an otherwise impermissible trade policy with reference to their human rights obligations.

The market fundamentalist paradigm is now in tatters at the intellectual level. The financial crisis of 2008 highlighted the vulnerabilities associated with financial interconnectedness and lack of regulation in the financial sector, threatening to undo the modest gains of the preceding decade or more with respect to poverty and under-nutrition (Ruel, Garrett, Hawkes, & Cohen, 2010; United Nations Conference on Trade and Development, 2009; United Nations Food and Agriculture Organization, 2009). Meanwhile, the contrast between such outcomes in a world of unprecedented abundance and the formal protections available under human rights law emphasizes the ironic paradox that such protections are often least likely to be available where they are most desperately needed. However, the contrast does not demonstrate the irrelevance of human rights to the objectives of the Commission on Social Determinants of Health. Rather, it serves to emphasize their theoretical strength as a challenge to the norms of the global marketplace and the importance of collaboration between those working in human rights and in social determinants of health to define common objectives and develop research programs and advocacy strategies for moving from compelling theory to effective practice.

Appendix. Supplementary data

Supplementary data associated with this article can be found in the online version, at doi:10.1016/j.socscimed.2010.06.042.

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