Health Policy and Planning Advance Access published August 16, 2012

Published by Oxford University Press in association with The London School of Hygiene and Tropical Medicine *Health Policy and Planning* 2012;1–10

doi:10.1093/heapol/czs071

Interrogating scarcity: how to think about 'resource-scarce settings'

Ted Schrecker

Bruyère Research Institute and Department of Epidemiology and Community Medicine, University of Ottawa, 43 Bruyère Street, Ottawa, ON, K1N 5C8, Canada. Tel: +1-613-612 8485. E-mail: tschrecker@sympatico.ca

Accepted 10 May 2012

The idea of resource scarcity permeates health ethics and health policy analysis in various contexts. However, health ethics inquiry seldom asks—as it should—why some settings are 'resource-scarce' and others not. In this article I describe interrogating scarcity as a strategy for inquiry into questions of resource allocation within a single political jurisdiction and, in particular, as an approach to the issue of global health justice in an interconnected world. I demonstrate its relevance to the situation of low- and middle-income countries (LMICs) with brief descriptions of four elements of contemporary globalization: trade agreements; the worldwide financial marketplace and capital flight; structural adjustment; imperial geopolitics and foreign policy. This demonstration involves not only health care, but also social determinants of health. Finally, I argue that interrogating scarcity provides the basis for a new, critical approach to health policy at the interface of ethics and the social sciences, with specific reference to market fundamentalism as the value system underlying contemporary globalization.

Keywords Resource allocation, scarcity, health ethics, globalization, justice

KEY MESSAGES

- It is not enough to consider how to set priorities in 'resource-scarce settings'; health ethics and health policy analysis must consider why some settings are resource-scarce and others not.
- Scarcities of resources in low- and middle-income countries, in particular, must be understood with reference to the ways in which economic activity has been reorganized across national borders (globalization), and the choices driving that reorganization.
- Interrogating scarcity is a valuable strategy not only for developing that understanding, but also for examining how the values of market fundamentalism infuse the construction of scarcity in specific policy contexts and showing that neither disease causation nor health ethics can be separated from politics.

Introduction

The idea of resource scarcity permeates health ethics[1] and health policy analysis, whether the context is the micro-level of selecting interventions in a clinical setting, the meso-level of allocating resources within a regional organization, or the macro-level of choosing among options for reducing the global burden of disease. Consider three real-life situations:

(1) Researchers select the most cost-effective package of interventions to reduce maternal mortality in 'resource-scarce settings' based on per capita budgets as low as US$0.50 per year for maternal health (Prata *et al*. 2010). The need for such interventions is acute: approximately 350 000 women die every year in pregnancy and childbirth, almost exclusively in low- and middle-income countries (LMICs) (Abou Zahr *et al*. 2010; Hogan *et al*. 2010).

(2) A questionnaire distributed by ethics researchers asks participants at a Canadian government conference on public health ethics to respond to this hypothetical: 'You are the Medical Officer of Health[2] of a large health unit that

must make dramatic budget cuts. You need to decide how to cut services and programs' (Pakes and Upshur 2007).

(3) Critics of the US$8–10 billion per year spent worldwide on AIDS prevention and treatment argue that the amount is excessive because so much less is spent on such health-related objectives as providing clean water in developing countries (Cheng 2008) and that lives are being lost because spending on AIDS programmes 'takes resources away from other diseases' (Easterly 2009).

The first two exercises may be operationally valuable to health service managers who have little control over the resources available to them, and as a result face troubling decisions. However, operational value in such settings is not the only objective of ethical inquiry, and such exercises and similar ones aimed at setting priorities for treating other conditions including breast cancer (Eniu *et al*. 2006) and multidrug-resistant tuberculosis (Nathanson *et al*. 2006) in 'resource-scarce settings' rarely ask, in a formulation patterned after the title of a standard text in population health (Evans *et al*. 1994), why some settings are resource-scarce and others not.[3] In the third situation, the zero-sum assumption that the quantum of financial resources available for improving the health of the poor through development assistance is somehow fixed and immutable, in a world where (for instance) the US Department of Defense spends US$1.5 billion *daily,* is not questioned.

A leading global health researcher has perceptively described failure to ask such questions as ''public health machismo,'' the idea that ''someone has to make the decision who lives and dies''...' (J Y Kim, quoted in Petryna and Kleinman 2006: 6). I describe asking where scarcities come from and who makes the decisions that create and maintain scarcities of resources for health as interrogating scarcity. Interrogating scarcity, relentlessly and when necessary impolitely, is a central task and a professional obligation for health ethics and health policy analysis in all settings that are characterized by major, socio-economically patterned disparities in health. The contemporary preoccupation with priority-setting is disturbing in its failure to recognize this imperative.

In the second section of the article I explain the rationale for interrogating scarcity and briefly explore its application within the limits of a single political jurisdiction. However, I am mainly concerned to demonstrate the relevance of the strategy to issues of justice across national borders, as 'global health has come to occupy a new and different kind of political space that demands the study of population health in the context of power relations in a world system' (Janes and Corbett 2009: 168). This demonstration, which comprises the third section of the article, involves not only health care, but also social determinants of health: the conditions of life and work that make it easy for some individuals to lead long and healthy lives, and all but impossible for others. I take as given the adequacy of the evidence base assembled by the World Health Organization Commission on Social Determinants of Health (2008) and other authors (Yong Kim *et al*. 2000; Birn *et al*. 2009; Labonté and Schrecker 2011). Those who doubt the adequacy of this evidence base, despite the near ubiquity of socio-economic gradients in health, will simply need to hold their doubts in abeyance as they read on. (The central ethical issue here relates to the choice of a standard of proof, a topic that merits an article on its own.) In the final section, I argue that interrogating scarcity provides the basis for a new, critical approach to health policy at the interface of ethics and social sciences, with specific reference to the neoliberalism or market fundamentalism that is the value system underlying contemporary globalization.

Scepticism about scarcity

Resource scarcities that confound efforts to reduce health disparities by providing health care or eliminating causes of illness are rarely natural or absolute, in the sense exemplified by shortages of compatible donor organs for transplantation or (in a hypothetical example) of a geologically rare mineral that cannot be synthesized and has no substitute in the manufacture of a life-saving medical device. Far more common, in the words of Calabresi and Bobbitt's *Tragic Choices*, are situations in which 'scarcity is not the result of any absolute lack of a resource but rather of the decision by society that it is not prepared to forgo other goods and benefits in a number sufficient to remove the scarcity' (Calabresi and Bobbitt 1978: 22). Their remarkable book focused on the various mechanisms that societies adopt to make life-and-death choices and to rationalize, sometimes to camouflage, the underlying ethical presumptions.

In the context of this article, as suggested by the three examples that introduced it, 'resources' in the first instance are usually financial or budgetary. The budgets in question may be public budgets for health care provision; they may also be the straitened budgets of households impoverished by structural economic change, for which prerequisites of healthy living are unaffordable. And my aim is not to provide a genealogy of the concept of scarcity that links its current form to the work of early economic theorists like Adam Smith and Thomas Malthus (e.g. Xenos 1987; Boal and Martinez 2007; Samuel and Robert 2010) by way of twentieth-century microeconomics (Fine 2010; Samuel and Robert 2010). Neither do I offer a critique of the unreflective use of the concept that is routine in environmental politics (Enzensberger 1974; Hartmann 2001; Hartmann 2010), although I refer to some such critiques in the final section of the article. My aim is more modest: demonstrating the indispensability of Calabresi and Bobbitt's injunction that: 'We must determine where – if at all – in the history of a society's approach to the particular scarce resource a decision substantially within the control of that society was made as a result of which the resource was permitted to remain scarce.... *Scarcity cannot simply be assumed as a given*' (Calabresi and Bobbitt 1978: 150–1; emphasis added).

Examples and potential applications are abundant. I completed the penultimate version of this article in a jurisdiction that hosts the largest treatment and research complex in the United States and possibly the world: the towering Texas Medical Center (Figures 1 and 2), offering and advertising world-class treatment for those with enough private wealth or private insurance. At the same time, one in four Texas residents, the highest percentage in the country, had no health insurance in 2009 (US Census Bureau 2011). Political leaders in the United States have chosen to leave provision of health insurance to the market, with a residual publicly

Figure 1 One of several buildings comprising the M.D. Anderson Cancer Center, Texas Medical Center, Houston (photo: author)

Figure 2 Texas Children's Hospital, Part of the Texas Medical Center, Houston (photo: author)

financed (but often for-profit) sector, and to accept both the high overall costs of health care that result and the corollary inadequacy of provision for the un- and under-insured who experience delayed or denied treatment, easily avoidable complications and often premature death (Reynolds 2010).

The distinctive US approach, and the political arrangements sustaining it, underscore the connection between resource scarcity in health care settings and political choice. Texas, and the United States, could easily afford to provide health insurance coverage for all their residents. On one estimate, providing coverage for all uninsured US residents would have cost US$100 billion a year before the financial crisis hit: just half the annual direct cost of the country's military adventure in Iraq (Leonhardt 2007) and a small fraction of the sums that the US government was able to place at risk, in short order, to bail out financial institutions (Barofsky 2009). Most other high-income countries provide health insurance to all, or nearly all, of their population, often with superior results in terms both of crude outcome measures like life expectancy and of the steepness of socio-economic gradients in health (see e.g. Murray *et al*. 2006; Hertzman and Siddiqi 2008).

Calabresi and Bobbitt's injunction directs our attention to such variables (an oversimplified list) as a long history of opposition to so-called socialized medicine on the part of the medical profession, the private insurance industry and large segments of the business community; and a regime of election financing that magnifies the influence of such interests (Center for Public Integrity 1995a; Center for Public Integrity 1995b; Center for Public Integrity 1996; Quadagno 2004). It also directs our attention to the revenue side of the equation. Texas is one of a few states that collect no state income tax, and federal income tax reductions during the first decade of the 21st century reduced national government revenues by more than US$2 trillion, with half the resulting increase in after-tax incomes accruing to the richest 1% of taxpayers (Citizens for Tax Justice 2009). Claims that providing access to health care would be unaffordable cannot be isolated from political choices about the level and incidence of taxation.

These insights do not apply only to rich countries. In 2001, the member states of the African Union (AU) committed themselves, without setting a target date, to increasing public spending on health to 15% of their general government budgets. Ten years later, only 6 of 53 AU member states had achieved this target, with important consequences in terms (for instance) of continued high rates of maternal and newborn mortality (Committee of Experts of the 4th Joint Annual Meetings of the AU Conference of Ministers of Economy and Finance and ECA Conference of African Ministers of Finance Planning and Economic Development 2011). AU finance ministers had the previous year actually urged abandonment of the

health spending commitment (Njora 2010). In contrast to the situation in high-income countries, no one would seriously suggest that most African governments, even were they to live up to the Abuja commitment, are able on their own to finance even minimally adequate health care for their populations (Sachs 2007). However, this is not the end of the story. Just as in far richer countries, using available resources and fiscal capacity to protect health, especially the health of the poor, is often not high on the agenda of the elites that dominate choices about public budgets even under conditions of formal democracy.

In an interconnected world, Calabresi and Bobbitt's focus on the origins of scarcity in decisions 'substantially within the control' of a given society does not go far enough. Over the past few decades globalization, '[a] pattern of transnational economic integration animated by the ideal of creating self-regulating global markets for goods, services, capital, technology, and skills' (Eyoh and Sandbrook 2003: 252), has introduced new influences on scarcity as it is invoked and experienced within national borders. Critical choices may now be made by corporate managers, portfolio investors or bureaucrats in multilateral financial institutions half a world away; their priorities, in turn, create new incentive structures for domestic actors. The section of the article that follows expands on these points, in a way that is necessarily stylized and selective.[4]

Globalization and scarcity in an interconnected world

Uruguayan-born essayist Eduardo Galeano (2000: 166) describes globalization as 'a magic galleon that spirits factories away to poor countries'. Reorganization of production and many forms of service provision across multiple national borders over the past few decades (Dicken 2007) has placed jurisdictions into intense competition to attract foreign investment and contract production. A senior official of the US Department of the Treasury during the Reagan–Bush era described the competition more graphically than is usual in the academic literature: 'The countries that do not make themselves more attractive will not get investors' attention. This is like a girl trying to get a boyfriend. She has to go out, have her hair done up, wear makeup....' (David Mulford, quoted by Henwood 1993). Combined with a doubling in the size of the global workforce as India, China and the transition economies opened to foreign investment, the effect has been to generate strong downward pressure on wages and working conditions. In particular, the threat of 'exit' (to a lower-cost jurisdiction) has shifted the balance of power decisively in favour of corporate managements. Distributional conflicts are no longer contained within national borders and governments in many LMICs find it attractive to attract investment by way of 'the discipline of labour' (Amsden 1990). A number of additional processes can be identified as contributing to scarcities of resources for health in LMICs. Only some are described here, since my intention is not to offer a comprehensive critique of globalization based on its effects on health, but to show the value of a particular way of studying it.

Trade agreements provide essential legal infrastructure for global reorganization of production, and may effectively 'constitutionalize' it by creating formidable economic and legal obstacles to reversing trade liberalization and other elements of market-oriented economic policy (Grinspun and Kreklewich 1994; Schneiderman 2000).[5] In 1995, the world entered a new era of trade policy with the creation of the World Trade Organization (WTO) regime and its binding dispute resolution procedures; since then, bilateral and regional trade and investment treaties that often go beyond the provisions of the WTO framework have proliferated. The content of these agreements routinely reflects the unequal bargaining power of the parties, arising in the first instance from differences in market size: access to the US market (for instance) is more significant for a small economy like Ecuador or Guatemala than its domestic markets will ever be to the US or European Union. These disparities affect not only the negotiation of trade agreements but the conditions under which parties make use of dispute resolution procedures (Stiglitz and Charlton 2004).

Major losses of livelihood can sometimes be traced directly to competition from low-cost, perhaps highly subsidized imports newly permitted into an LMIC market (Jeter 2002; Atarah 2005; Buechler 2006; de Ita 2008); workers and agricultural producers are, if not impoverished, driven into precarious employment or the informal economy. Tariffs are among the easiest forms of revenue for governments to collect, which is why at least until recently they were a major element in LMIC revenue streams, and still are for some countries. Tariff reductions undertaken as part of trade liberalization slashed these revenues, arguably compounding the effects of competition for investment. The treasuries of some low-income countries, in particular, still have not recovered (Baunsgaard and Keen 2005; Glenday 2006; Baunsgaard and Keen 2010), leading to reduced fiscal capacity for public spending on areas such as education and health, although detailed country-specific assessments are hard to find.

More visible and familiar are effects on access to essential medicines associated with requirements for harmonizing intellectual property (IP) protection under the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) (Correa 2009). As originally drafted, TRIPS would have enabled pharmaceutical manufacturers to charge whatever price the traffic would bear by eliminating existing legal options to issue compulsory licenses, produce generic versions, or import these from elsewhere. Several years of negotiation post-1995 led to official reinterpretations that restored some of these options, but cumbersome and complicated procedures impede their use (Haakonsson and Richey 2007; Kerry and Lee 2007; Muzaka 2009). Of equal concern is the tendency of the United States, in particular, to negotiate IP provisions that go beyond TRIPS in bilateral and regional agreements, undermining flexibilities previously negotiated and creating new barriers to producing or importing essential medicines at affordable prices (Roffe *et al*. 2008; Shaffer and Brenner 2009; Muzaka 2011). For a cash-strapped LMIC public sector health system, and for the majority of the population in countries where most medicines are still paid for out-of-pocket, the link between globalization, scarcity and health could not be clearer.

Trade agreements often incorporate provisions facilitating the flow of investment across borders, and limiting the regulation of such flows. Such provisions along with competitive financial deregulation, especially in the United States and the United Kingdom, have led to the emergence of a ***worldwide financial marketplace*** in which considerable power has shifted from national polities to a global capital market that 'now has the power to discipline national governments . . . . These markets can now exercise the accountability functions associated with citizenship: they can vote governments' economic policies in or out, they can force governments to take certain measures and not others' (Sassen 2003: 70; see generally Schrecker 2009). In the aftermath of Mexico's 1994–95 financial crisis, a former head of the International Monetary Fund (IMF) described the consequences for governments that fail to manage their economies in accordance with the priorities of this 'global, cross-border economic electorate' (Sassen 2003: 70) as 'swift, brutal and destabilizing' (Camdessus 1995).

Along with the growth of private banking (Anon 1990) and the multiplication of opportunities to manipulate prices charged in trade between firms that are part of the same corporate organization, the global financial marketplace facilitates ***capital flight***: a process in which domestic elites shift their wealth out of a jurisdiction, sometimes but not always illegally, in search of higher returns and lower risks. Capital flight is of special importance for understanding scarcity in LMICs because it deprives nations of desperately needed resources that could be used for investment in development or health (Helleiner 2001). To indicate the magnitudes involved, Ndikumana and Boyce (2011) estimate the value of capital flight from 33 sub-Saharan countries plus imputed interest between 1970 and 2008 at US$944 billion (in 2008 dollars), much of this figure related to straightforward looting through misappropriation of loans and trade misinvoicing. They estimate that on average 60 cents of every dollar received from external lenders left those countries as flight capital *in the same year*, and that the resulting reduction in public spending on health was responsible for 77 000 infant deaths per year in 2005–07 (Ndikumana and Boyce 2011: 82). Further, capital flight has often magnified sovereign debt crises that ushered in an era in which many countries lost control of their domestic policies to the World Bank and the International Monetary Fund (IMF).

Structural adjustment entered the development policy lexicon in the early 1980s, when the World Bank and IMF—institutions dominated by the G7 countries—began large-scale loan programmes to ensure that indebted LMICs could repay their external creditors. The urgency of such lending grew after 1982, when the possibility of Mexican default on loans made by US banks threatened the stability of financial systems in the industrialized world. Loans were conditional on a relatively standard package of policies emphasizing deregulation, privatization of state-owned firms, reduction of domestic government spending, trade liberalization with the aim of prioritizing production for export and elimination of controls on foreign investment. The ostensible aim was to create conditions for sustained economic growth in countries where they were applied. By the mid-1980s, informed observers were critical of this expectation (see e.g. Lever and Huhne 1985: 64); in retrospect, it is clear that the measures were designed to protect creditor interests, and also to advance a larger project of refashioning the world economy on investor-friendly lines (Przeworski *et al.* 1995: 5; Babb 2002: 1).

Resulting economic dislocations and domestic austerity measures often had destructive effects on livelihoods and other social determinants of health, which were demonstrated as early as 1987 by a ten-country UNICEF study (Cornia *et al.* 1987). Subsequent reviews of the evidence have found a preponderance of negative effects on health (Breman and Shelton 2007; Stuckler and Basu 2009) and probably understate these effects because, except in the most drastic cases, it is hard to capture the long-term health consequences of deteriorating socio-economic conditions using epidemiological standards of proof (Pfeiffer and Chapman 2010). Opportunities for capital flight often meant that the costs of adjustment were borne primarily by those who did not have the option of shifting their assets out of the country; publicly financed rescues of collapsing domestic banks (Halac and Schmukler 2004; Mannsberger and McBride 2007) are a case in point. Thus, the adjustment process imperiled the livelihoods (and opportunities to lead healthy lives) of many while wealth and economic opportunity were shifted upward to the few.

At least before 2008 the IMF had become less important as a source of last-resort lending, but remained powerful as a gatekeeper for development assistance and debt relief (Gore 2004). IMF approval is also valued as assurance to private investors that a country's macroeconomic policies are sound (Sachs 1998). Considerable evidence suggests that the era of structural adjustment is not over. IMF policy apprehensions about 'fiscal expansion' (Working Group on IMF Programs and Health Spending 2007), based on textbook microeconomics and public finance, have continued to limit countries' ability to spend on health and education (Ooms and Schrecker 2005; Centre for Economic Governance and AIDS in Africa and RESULTS Educational Fund 2009). For example, IMF insistence on public expenditure ceilings led to a situation in which 'thousands of trained nurses and other health workers remain[ed] unemployed' in Kenya *circa* 2006, and thousands more had left the country in search of work elsewhere, 'despite a health worker shortage across all health programs' (Korir and Kioko 2009: 2).

The history of structural adjustment shows that economic policies and institutions cannot be understood in isolation from ***imperial geopolitics and policy***. The hegemonic role of the United States was captured in a 1990 codification of emerging, market-oriented wisdom as the Washington consensus, responding to a political climate that 'was essentially contemptuous of equity concerns' (Williamson 1993: 1329). By the early years of this century, the aggressive unilateralism of the Bush II administration had moved the concept of US imperialism into the academic mainstream (Falk 2004), and it is useful to view many aspects of globalization's recent history, in addition to the politics of World Bank and IMF-driven economic restructuring, from this vantage point. Consider for example US support for coups d'état in countries like Iran and Guatemala dating back to the 1950s and subsequent assistance to homicidal but market-friendly regimes, like Pinochet's in Chile and various governments and counterinsurgency movements in Central America. President Reagan's Central American

policies led to the deaths of some 200 000 people and drove several times that number into exile, many into subaltern positions as undocumented workers in the United States (see generally Robinson 2003), creating a landscape of social and economic desolation from which many countries in the region are only starting to heal. Reagan administration policies included financing political formations like the right-wing Salvadoran think tank Fundación Salvadoreña para el Desarrollo Económico y Social (Salvadoran Foundation for Economic and Social Development) (FUSADES) in El Salvador, which in 1990 ran advertisements urging foreign investors in the garment industry to hire 'Rosa' at 57 cents an hour. In 1991, Rosa's advertised price dropped to 33 cents an hour (Kernaghan 1997). Thus, we are brought back to Galeano's magic galleon and Mulford's beauty contest, and to the fundamental point that resource scarcities in the context of health policy must always be understood with reference to their origins in political choices and macro-scale social and economic processes.

Market fundamentalism and the construction of scarcity

Interrogating scarcity advances that understanding, but is not a set of substantive principles of justice. Methodologically, the strategy presupposes only Calabresi and Bobbitt's generic scepticism about scarcity. That presupposition distinguishes it from the mainstream approach exemplified by Daniels and Sabin's effort to find procedural solutions to problems of scarcity associated with the operation of private, for-profit managed care organizations in the United States, while not questioning the justice of the basic organization of health care provision and the health care industry (see Figures 1 and 2) (Daniels and Sabin 1997). Such efforts often degenerate into calls for 'practices that can be sustained and that connect well with the goals of various stakeholders in the many institutional settings where these decisions are made' (Daniels 2000: 1300), eschewing questions about the origins of scarcity. Such procedural solutions are worthwhile in a broad range of situations in which the goals of 'stakeholders' are ethically defensible and structural inequalities of power and resources not extreme,[6] but that defensibility cannot be presumed; no procedural algorithm will humanize Sophie's choice. In the international frame of reference, interrogating scarcity normatively implies only a weak, generic cosmopolitanism that regards drivers of scarcity that originate outside the jurisdiction's borders as prima facie appropriate for ethical analysis. In other words, the proposition that we (whoever we are) have obligations related to the health of non-compatriots is not rejected out of hand, but the content and limits of those obligations are not specified.

Interrogating scarcity is thus congruent with (indeed exemplified by) Pogge's powerful argument that global responsibility is inescapable given the nature of historical and contemporary interconnections, as embodied in economic institutions as well as discrete policy choices. His central point is that ethical responsibility for health disparities follows causal responsibility across national borders, in particular with respect to the health damage that is associated with extreme poverty (Pogge 2002; Pogge 2004; Pogge 2005; Pogge 2007b). 'By avoidably producing severe poverty, economic institutions substantially contribute to the incidence of many medical conditions. Persons materially involved in upholding such economic institutions are then materially involved in the causation of such medical conditions' (Pogge 2004: 137).

Pogge's attribution of responsibility depends on the existence of plausible alternative sets of institutions that would be more conducive to reducing or eliminating poverty. As shown in the preceding section of the article, this test is not difficult to meet. One can readily imagine alternative policies of 'adjustment with a human face', in the words of the UNICEF study of structural adjustment impacts cited earlier; a regime of international law in which health-related obligations under human rights treaties would 'trump' demands for macroeconomic policies that exacerbate shortages of health workers and restrict access to essential medicines (Pogge 2007a); or—leaving aside for the moment the formidable political obstacles (Stiglitz and Charlton 2005)—an international trade policy regime 'in which trade rules are determined so as to maximize development potential, particularly of the poorest nations in the world' (Rodrik 2001). Pogge notes the pernicious consequences of the 'resource privilege', which permits rulers to dispose of natural resources within their borders even when they remain unaccountable for the use of the revenues—think of how little revenue from exploitation of oil resources reaches the majority of Nigerians or Angolans—and the 'borrowing privilege', which permits rulers to incur external debts on behalf of subjects who may have no meaningful opportunity to accept or reject these obligations. This latter characteristic of the international order, in particular, could be changed by national policies or multilateral agreements that defined such debts as 'odious' under international law (King *et al*. 2003; Mandel 2006; Ndikumana and Boyce 2011: 84–95).

Interrogating scarcity can therefore provide factual foundations for prescriptive statements about global justice that apply to local situations. It is also a promising basis for research at the interface of ethics and the social sciences that connects global-scale power relations and domestic political choices with the ways in which health-related scarcities are experienced differently, and the options for addressing them framed differently, by various protagonists on the ground. Exemplary work in this vein has been done on water, access to which is a key social determinant of health. In a case study of a particular district in India, Mehta (2007) has shown that scarcities of water must be understood with reference to local histories of human activity, and that the range of remedies considered feasible—in this instance, a contentious major dam project being actively promoted by the World Bank—may be defined by alliances of powerful domestic and external actors. Both Mehta and Mirosa Canal (2004) and Goldman (2007) have connected local constructions of scarcity with the projects of powerful supranational actors, including transnational water utility corporations, as they promote private investment in water service provision. Mehta and Mirosa Canal (2004: 4–7) are also explicit in identifying IMF/World Bank conditionalities as having created the conditions in which private provision of water as a marketed commodity appeared as the only viable solution. A useful parallel can be drawn with the Bank's

aggressive advocacy of market-oriented health sector 'reform' on the basis that private purchase of care or insurance was the norm from which all departures required justification (Laurell and Arellano 1996; Lee and Goodman 2002; Lister and Labonté 2009). Srivastava (2010) makes a similar point about the World Bank's preference for market-based strategies in its role as a major supplier of development assistance for education, emphasizing that 'while developing countries have constrained public budgets, the persistence of scarce resources for education, particularly for basic education, is not a fixed variable. It exists because we let it' (p. 525).

Further comparative research on scarcity in the context of social determinants of health—including water and education, but also such factors as food security, adequate income and access to health care itself—will clearly be useful. The examples just cited indicate that contemporary constructions of scarcity must be situated with reference to what Somers (2008) has called market fundamentalism (in preference to neoliberalism, the more familiar terminology but confusing to North American audiences), the institutions that promote it and its local particularities. Market fundamentalism presumes that markets are the normal and natural basis for organizing almost all areas of human activity; assigns a heavy burden of proof to those who would organize human interactions on any other basis; and tends to define citizenship in terms of participation in markets, as a producer and (informed) consumer. Market fundamentalism is the value system at the core of contemporary globalization (Harvey 2005; Ward and England 2007), and infuses the construction of scarcity in many public policy contexts. In addition to the illustrations already provided, Lurie *et al*. (2008) observe, without evident appreciation of the irony, that health care organizations in the United States often insist that a 'business case' needs to be made for interventions to reduce health disparities, based on their anticipated return on investment. A 2008 think tank report characterized the US President's Emergency Program for AIDS Relief, which has financed antiretroviral therapy for a million people, as a 'state supported international welfare program' that was 'hard to justify on investment grounds' (Over 2008). And Ruiters (2006; 2009) interprets policies that provide free, but seriously inadequate minimal increments of water and electricity to the poor in South Africa, thereafter charging users on a cost-recovery basis with disconnection automated through installation of prepaid meters, as a strategy of social control concerned with inculcating a 'payment morality' (in the words of the Department of Finance), while implicitly conceding that domestic poverty can only be managed rather than substantially reduced.

This discussion may appear to have wandered far from issues of health, but that is not the case if the frame of reference includes social determinants of health, as it should. Rather, inquiry into how scarcities are constructed and maintained returns health policy to the insights of an earlier era, notably Virchow's about the importance of political as well as pathological causes of disease. Against today's background of financial markets with global reach and widespread invocations of the need for austerity in which governments are seldom challenged as they ritualistically turn their pockets out and complain that the cupboard is bare, neither disease causation nor health ethics can sensibly be separated from politics and economics. Redefining the scope of health ethics and health policy analysis will inevitably encounter objections based on the impracticality of interrogating scarcity, or at least its irrelevance to daily operational contexts. The appropriate reply comes from feminist scholar Catharine MacKinnon (1987: 70), addressing the limits of incremental approaches to eliminating sex discrimination: 'You may think that I'm not being very practical. I have learned that practical means something that can be done while keeping everything else the same'.

Acknowledgements

An earlier version of this argument was presented at the Conference on Setting an Ethical Agenda for Health Promotion, Institute for Law, Ethics & Society, University of Ghent (September 2007). Comments of participants in subsequent seminars in the Studies in National and International Development speaker series, Queen's University (October 2007); the Hillman Series on International Health and Development, Faculty of Medicine, University of Ottawa (October 2007); the Department of Sociology Colloquium Series (University of California – Santa Cruz, March 2008) and the Munk Centre for International Studies, University of Toronto (October 2009) did much to strengthen the argument, as did the comments of two anonymous reviewers.

Funding

Partial financial support was provided by Canadian Institutes of Health Research grant 79153. Support for open access publication was provided by the University of Ottawa Author Fund in Support of Open Access Publishing.

Conflict of interest

None declared.

Endnotes

[1] An admittedly ambiguous term, which I take to include prescriptive or normative analysis of how decisions that affect health should be made both in clinical settings and in the broader universe of settings that are relevant to public or population health.

[2] In Canada, a Medical Officer of Health is a physician and the senior public servant in a municipal or regional public health organization that provides a range of preventive and protective interventions, including assuming responsibility for communicable disease control in the event of outbreaks; such units do not usually provide clinical services.

[3] Wellington (2000, Chapter 1) makes this point with reference to the dilemma in moral reasoning presented by Lawrence Kohlberg, in which a poor man is faced with the choice between stealing a drug he cannot afford or watching his wife die for want of the drug. Discussing Carol Gilligan's restatement of the dilemma, Wellington points out that neither Kohlberg nor Gilligan asks a rather obvious question: why does the drug cost so much? The answer takes us into the realm of the international political economy of intellectual property rights, scientific research and the political power of the pharmaceutical industry.

[4] For more extensive treatments see, for example, Yong Kim *et al.* (2000); Labonté *et al.* (2009); Gill and Bakker (2011).

[5] The investor-state dispute resolution provisions (Chapter 11) of the North American Free Trade Agreement are a case in point.

[6] In particular, no 'stakeholder' must be able to define the permissible limits of discussion or to terminate the deliberation altogether—as for instance when corporate managers threaten to relocate production to another jurisdiction in response to demands for adequate livelihoods and elimination of exposure to workplace hazards, or the propertied can use the prospect of capital flight to limit redistributive policies.

References

Abou Zahr C, Ali M, Boerma T *et al.* 2010. *Trends in Maternal Mortality: 1990 to 2008: Estimates developed by WHO, UNICEF, UNFPA and The World Bank*. Geneva: World Health Organization. Online at: http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf, accessed 26 July 2012.

Amsden A. 1990. Third World industrialization: 'Global Fordism' or a new model. *New Left Review* **n182**: 5–31.

Anon. 1990 January 27. How BCCI grew and grew. *The Economist* 84.

Atarah L. 2005. *Playing Chicken: Ghana vs. the IMF*. Oakland, CA: Corporate Watch. Online at: http://www.corpwatch.org/article.php?id=12394, accessed 26 July 2012.

Babb S. 2002. *Managing Mexico: Economists from Nationalism to Neoliberalism*. Princeton, NJ: Princeton University Press.

Barofsky N. 2009. *SIGTARP Quarterly Report to Congress, July 21, 2009*. Washington, DC: Office of the Special Inspector General for the Troubled Asset Relief Program (SIGTARP). Online at: http://www.sigtarp.gov/Quarterly%20Reports/July2009_Quarterly_Report_to_Congress.pdf, accessed 26 July 2012.

Baunsgaard T, Keen M. 2005. *Tax Revenue and (or?) Trade Liberalization*. IMF Working Paper WP/05/112. Washington, DC: International Monetary Fund. Online at: http://www.imf.org/external/pubs/ft/wp/2005/wp05112.pdf, accessed 26 July 2012.

Baunsgaard T, Keen M. 2010. Tax revenue and (or?) trade liberalization. *Journal of Public Economics* **94**: 563–77.

Birn A-E, Pillay L, Holtz TH. 2009. *Textbook of International Health*. Oxford: Oxford University Press.

Boal I, Martinez D. 2007. Specters of Malthus: scarcity, poverty, apocalypse – Iain Boal in conversation with David Martinez. Online at: http://www.counterpunch.org/2007/09/11/specters-of-malthus-scarcity-poverty-apocalypse/, accessed 26 July 2012.

Breman A, Shelton C. 2007. Structural Adjustment Programs and health. In: Kawachi I, Wamala S (eds). *Globalisation and Health*. Oxford: Oxford University Press, pp. 219–34.

Buechler S. 2006. São Paulo: outsourcing and downgrading of labour in a globalizing city. In: Brenner N, Keil R (eds). *The Global Cities Reader*. London: Routledge, pp. 238–45.

Calabresi G, Bobbitt P. 1978. *Tragic Choices*. New York: W.W. Norton.

Camdessus M. 1995. The IMF and the Challenges of Globalization–The Fund's Evolving Approach to its Constant Mission: The Case of Mexico. Address at Zurich Economics Society 95/17. Washington, DC: International Monetary Fund. November 14. Online at: http://www.imf.org/external/np/sec/mds/1995/mds9517.htm, accessed 26 July 2012.

Center for Public Integrity. 1995a. Well-healed: inside lobbying for health care reform, Part I. *International Journal of Health Services* **25**: 411–53.

Center for Public Integrity. 1995b. Well-healed: inside lobbying for health care reform, Part II. *International Journal of Health Services* **25**: 593–632.

Center for Public Integrity. 1996. Well-healed: inside lobbying for health care reform, Part III. *International Journal of Health Services* **26**: 19–46.

Centre for Economic Governance and AIDS in Africa, RESULTS Educational Fund. 2009. *Evidence of the Impact of IMF Fiscal and Monetary Policies on the Capacity to Address HIV/AIDS and TB Crises in Kenya, Tanzania and Zambia: A Synthesis Report of Three Country Case Studies*. Washington, DC: RESULTS. Online at: http://www.results.org/uploads/files/IMF_Synthesis_Report.pdf, accessed 26 July 2012.

Cheng M. 2008, January 18. AIDS experts wonder if focus is right. *Associated Press*.

Citizens for Tax Justice. September 8, 2009. *The Bush Tax Cuts Cost Two and a Half Times as Much as the House Democrats' Health Care Proposal*. Washington, DC: Citizens for Tax Justice. Online at: http://www.ctj.org/pdf/bushtaxcutsvshealthcare.pdf, accessed 26 July 2012.

Commission on Social Determinants of Health. 2008. *Closing the Gap in a Generation: Health equity through action on the social determinants of health (final report)*. Geneva: World Health Organization. Online at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf, accessed 26 July 2012.

Committee of Experts of the 4th Joint Annual Meetings of the AU Conference of Ministers of Economy and Finance and ECA Conference of African Ministers of Finance Planning and Economic Development. 2011. *Investment in health is an investment in economic development*. E/ECA/COE/30/5/Rev.1. February 24. Addis Ababa: United Nations Economic Commission for Africa. Online at: http://www.uneca.org/cfm/2011/documents/English/Investment-inHealth.pdf, accessed 26 July 2012.

Cornia GA, Jolly R, Stewart F (eds). 1987. *Adjustment with a Human Face, Vol.1: Protecting the Vulnerable and Promoting Growth*. Oxford: Clarendon Press.

Correa C. 2009. Intellectual property rights and inequalities in health outcomes. In: Labonté R, Schrecker T, Packer C, Runnels V (eds). *Globalization and Health: Pathways, Evidence and Policy*. New York: Routledge, pp. 263–88.

Daniels N. 2000. Accountability for reasonableness. *British Medical Journal* **321**: 1300–1.

Daniels N, Sabin J. 1997. Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers. *Philosophy and Public Affairs* **26**: 303–50.

de Ita A. 2008. *Fourteen Years of NAFTA and the Tortilla Crisis: Americas Program Special Report*. January 10. Washington, DC: Americas Program, Center for International Policy. Online at: http://www.cipamericas.org/archives/1101, accessed 26 July 2012.

Dicken P. 2007. *Global Shift: Reshaping the Global Economic Map in the 21st Century*. New York: Guilford Press.

Easterly W. 2009. Human rights are the wrong basis for healthcare. *Financial Times*. October 12.

Eniu A, Carlson RW, Aziz Z *et al.* 2006. Breast cancer in limited-resource countries: treatment and allocation of resources. *The Breast Journal* **12**(Suppl. 1):S38–53.

Enzensberger HM. 1974. A critique of political ecology. *New Left Review* **n84**: 843–31.

Evans RG, Barer ML, Marmor TR (eds). 1994. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*. Hawthorne, New York: Aldine DeGruyter.

Eyoh D, Sandbrook R. 2003. Pragmatic neo-liberalism and just development in Africa. In: Kohli A, Moon C, Sørensen G (eds). *States, Markets, and Just Growth: Development in the Twenty-first Century*. Tokyo: United Nations University Press, pp. 227–57.

Falk R. 2004. *The Declining World Order: America's Imperial Geopolitics*. London and New York: Routledge.

Fine B. 2010. Economics and scarcity: with Amartya Sen as point of departure? In: Mehta L (ed). *The Limits to Scarcity: Contesting the Politics of Allocation*. London: Earthscan, pp. 73–91.

Galeano E. 2000. *Upside Down: A Primer for the Looking Glass World*. New York: Picador.

Gill S, Bakker I. 2011. The global crisis and global health. In: Benatar S, Brock G (eds). *Global Health and Global Health Ethics*. Cambridge: Cambridge University Press, pp. 221–38.

Glenday G. 2006. *Toward Fiscally Feasible and Efficient Trade Liberalization*. Durham, NC: Duke Center for Internal Development, Duke University. Online at: http://www.fiscalreform.net/library/pdfs/Glenday_paper_May_18,_2006_SA_%20rev.pdf, accessed 26 July 2012.

Goldman M. 2007. How ''Water for All!'' policy became hegemonic: the power of the World Bank and its transnational policy networks. *Geoforum* **38**: 786–800.

Gore C. 2004. MDGs and PRSPs: are poor countries enmeshed in a global-local double bind? *Global Social Policy* **4**: 277–83.

Grinspun R, Kreklewich R. 1994. Consolidating neoliberal reforms: ''free trade'' as a conditioning framework. *Studies in Political Economy* **43**: 33–61.

Haakonsson SJ, Richey LA. 2007. TRIPs and public health: the Doha Declaration in Africa. *Development Policy Review* **25**: 71–90.

Halac M, Schmukler SL. 2004. Distributional effects of crises: the financial channel [with comments]. *Economía* **5**: 1–67.

Hartmann B. 2001. Will the circle be unbroken? A critique of the project on environment, population and security. In: Peluso N, Watts M (eds). *Violent Environments*. Ithaca, NY: Cornell University Press, pp. 39–62.

Hartmann B. 2010. The ghosts of Malthus: narratives and mobilizations of scarcity in the US political context. In: Mehta L (ed). *The Limits to Scarcity: Contesting the Politics of Allocation*. London: Earthscan, pp. 49–66.

Harvey D. 2005. *A Brief History of Neoliberalism*. Oxford: Oxford University Press.

Helleiner E. 2001. Regulating capital flight. *Challenge* **44**: 19–34.

Henwood D. 1993. Impeccable logic: trade, development and free markets in the Clinton era. (economic policy of Pres. Bill Clinton) (Cover Story). *NACLA Report on the Americas* **26n5**: 23–28.

Hertzman C, Siddiqi A. 2008. Tortoises 1, Hares 0: How comparative health trends between Canada and the United States support a long-term view of policy and health. *Healthcare Policy* **4**: 16–24.

Hogan M, Foreman K, Naghavi M *et al.* 2010. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. *The Lancet* **375**: 1609–23.

Janes CR, Corbett KK. 2009. Anthropology and global health. *Annual Review of Anthropology* **38**: 167–83.

Jeter J. 2002 April 22. The dumping ground: as Zambia courts western markets, used goods arrive at a heavy price. *Washington Post*.

Kernaghan C. 1997. Paying to lose our jobs. In: Ross A (ed). *No Sweat: Fashion, Free Trade, and the Rights of Garment Workers*. London: Verso, pp. 79–93.

Kerry VB, Lee K. 2007. TRIPS, the Doha declaration and paragraph 6 decision: what are the remaining steps for protecting access to medicines? *Globalization and Health* **3**: 3.

King J, Khalfan A, Thomas B. 2003. *Advancing the Odious Debt Doctrine: CISDL Working Paper.* Montréal Centre for International Sustainable Development Law, McGill University. Online at: http://www.dette2000.org/data/File/odious_debt_CISDL.pdf, accessed 26 July 2012.

Korir JK, Kioko U. 2009. *Evidence of the Impact of IMF Fiscal and Monetary Policies on the Capacity to Address the HIV/AIDS and TB Crises in Kenya.* Cape Town: Centre for Economic Governance and AIDS in Africa. Online at: http://www.cegaa.org/resources/docs/Products/Synthesisreport_FINAL[1].pdf, accessed 26 July 2012.

Labonté R, Schrecker T, Packer C, Runnels V (eds). 2009. *Globalization and Health: Pathways, Evidence and Policy*. New York: Routledge.

Labonté R, Schrecker T. 2011. The state of global health in a radically unequal world: patterns and prospects. In: Benatar S, Brock G (eds). *Global Health and Global Health Ethics*. Cambridge: Cambridge University Press, pp. 24–36.

Laurell AC, Arellano OL. 1996. Market commodities and poor relief: the World Bank proposal for health. *International Journal of Health Services* **26**: 1–18.

Lee K, Goodman H. 2002. Global policy networks: the propagation of health care financing reform since the 1980s. In: Lee K, Buse K, Fustukian S (eds). *Health Policy in a Globalising World*. Cambridge: Cambridge University Press, pp. 97–119.

Leonhardt D. 2007. January 12. What $1.2 Trillion Can Buy. *New York Times*.

Lever H, Huhne C. 1985. *Debt and Danger: The World Financial Crisis*. London: Penguin.

Lister J, Labonté R. 2009. Globalization and health systems change. In: Labonté R, Schrecker T, Packer C, Runnels V (eds). *Globalization and Health: Pathways, Evidence and Policy*. New York: Routledge, pp. 181–212.

Lurie N, Somers S A, Fremont A *et al.* 2008. Challenges to using a business case for addressing health disparities. *Health Affairs* **27**: 334–38.

MacKinnon C A. 1987. *Feminism Unmodified: Discourses on Life and Law*. Cambridge, MA: Harvard University Press.

Mandel S. 2006. *Odious Lending: Debt Relief as if Morals Mattered*. London: New Economics Foundation. Online at: http://www.reformwatch.net/fitxers/210.pdf, accessed 26 July 2012.

Mannsberger J, McBride JB. 2007. The privatization of the Mexican banking sector in the 1990s: from debacle to disappointment. *International Journal of Emerging Markets* **2**: 320–34.

Mehta L. 2007. Whose scarcity? Whose property? The case of water in western India. *Land Use Policy* **24**: 654–63.

Mehta L, Mirosa Canal O. 2004. *Financing water for all: behind the border policy convergence in water management*. *IDS Working Papers 233*. Brighton: Institute of Development Studies, University of Sussex.

Murray CJL, Kulkarni SC, Michaud C *et al.* 2006. Eight Americas: investigating mortality disparities across races, counties, and race-counties in the United States. *PLoS Medicine* **3**: e260.

Muzaka V. 2009. Developing countries and the struggle on the access to medicines front: victories won and lost. *Third World Quarterly* **30**: 1343–61.

Muzaka V. 2011. Preferential Trade Agreements: 'TRIPS-plus' provisions and access to affordable medicines. In: den Exter A (ed). *International Trade Law and Health Care: In Search of Good Sense*. Rotterdam: Erasmus University Publishers, pp. 63–80.

Nathanson E, Lambregts-van Weezenbeek C, Rich ML *et al.* 2006. Multidrug-resistant tuberculosis management in resource-limited settings. *Emerging Infectious Diseases* **12**: 1389–97.

Ndikumana L, Boyce J. 2011. *Africa's Odious Debts: How Foreign Loans and Capital Flight Bled a Continent*. London: Zed Books.

Njora G. 2010. African finance ministers dismiss development declarations. *Pambazuka News* **478**. Online at: http://pambazuka.org/en/-category/comment/63894, accessed 26 July 2012.

Ooms G, Schrecker T. 2005. Viewpoint: expenditure ceilings, multilateral financial institutions, and the health of poor populations. *The Lancet* **365**: 1821–3.

Over M. 2008. Prevention failure: the ballooning entitlement burden of U.S. global AIDS treatment spending and what to do about it. Working Papers 144. Washington, DC: Center for Global Development. Online at: http://www.cgdev.org/files/15973_file_Presidential_AIDS_Policy_FINAL.pdf, accessed 26 July 2012.

Pakes B, Upshur R. 2007. *Ethical Analysis in Public Health Practice (questionnaire)*. Toronto: Joint Centre for Bioethics, University of Toronto.

Petryna A, Kleinman A. 2006. The pharmaceutical nexus. In: Petryna A, Lakoff A, Kleinman A (eds). *Global Pharmaceuticals: Ethics, Markets, Practices*. Durham: Duke University Press, pp. 1–32.

Pfeiffer J, Chapman R. 2010. Anthropological perspectives on structural adjustment and public health. *Annual Review of Anthropology* **39**: 149–65.

Pogge T. 2002. *World Poverty and Human Rights*. Cambridge: Polity.

Pogge T. 2004. Relational conceptions of justice: responsibilities for health outcomes. In: Anand S, Peter F, Sen A (eds). *Public Health, Ethics and Equity*. Oxford: Clarendon Press, pp. 135–61.

Pogge T. 2005. Severe poverty as a violation of negative duties. *Ethics & International Affairs* **19**: 55–83.

Pogge T. 2007a. Montréal Statement on the Human Right to Essential Medicines. *Cambridge Quarterly of Healthcare Ethics* **16**: 97–108.

Pogge T. 2007b. Severe poverty as a human rights violation. In: Pogge T (ed). *Freedom from Poverty as a Human Right: Who Owes What to the Very Poor?* Oxford: Oxford University Press, pp. 11–53.

Prata N, Sreenivas A, Greig F, Walsh J, Potts M. 2010. Setting priorities for safe motherhood interventions in resource-scarce settings. *Health Policy* **94**: 1–13.

Przeworski A, Bardhan P, Bresser Pereira LC *et al.* 1995. *Sustainable Democracy*. Cambridge: Cambridge University Press.

Quadagno J. 2004. Why the United States has no national health insurance: stakeholder mobilization against the welfare state, 1945–1996. *Journal of Health and Social Behavior* **45**: 25–44.

Reynolds T. 2010. Dispatches from the Emergency Room. *New Left Review new series* **n61**: 49–57.

Robinson WI. 2003. *Transnational Conflicts: Central America, Social Change, and Globalization*. London: Verso.

Rodrik D. 2001. *The Global Governance of Trade as if Development Really Mattered*. New York. United Nations Development Programme. Online at: http://www.lse.ac.uk/collections/globalDimensions/seminars/trade/UNDPtrade.pdf, accessed 26 July 2012.

Roffe P, Von Braun J, Vivas-Eugui D. 2008. A new generation of regional and bilateral trade agreements: lessons from the US-CAFTA-DR Agreement. In: Blouin C, Drager N, Heymann J (eds). *Trade and Health: Seeking Common Ground*. Montréal: McGill-Queen's University Press, pp. 41–89.

Ruiters G. 2006. Social control and social welfare under neoliberalism in South Africa cities: contradictions in free basic water services. In: Murray MJ, Myers GA (eds). *Cities in Contemporary Africa*. Houndmills: Palgrave Macmillan, pp. 289–308.

Ruiters G. 2009. Free basic electricity in South Africa: a strategy for helping or containing the poor? In: McDonald DA (ed). *Electric Capitalism: Recolonising Africa on the Power Grid*. London: Earthscan, pp. 248–63.

Sachs J. 1998. The IMF and the Asian Flu. *American Prospect* **37**: (March–April).

Sachs JD. 2007. Beware false tradeoffs. *Foreign Affairs*. Online at: http://www.foreignaffairs.com/fa_subcontent/64088/67237, accessed 26 July 2012.

Samuel S, Robert J. 2010. Water can and ought to run freely: reflections on the notion of ''scarcity'' in economics. In: Mehta L (ed). *The Limits to Scarcity: Contesting the Politics of Allocation*. London: Earthscan, pp. 109–26.

Sassen S. 2003. Economic globalization and the redrawing of citizenship. In: Friedman J (ed). *Globalization, the State, and Violence*. Walnut Creek, CA: AltaMira Press, pp. 67–86.

Schneiderman D. 2000. Investment rules and the new constitutionalism. *Law and Social Inquiry* **25**: 757–87.

Schrecker T. 2009. The power of money: global financial markets, national politics, and social determinants of health. In: Williams OD, Kay A (eds). *Global Health Governance: Crisis, Institutions and Political Economy*. Houndmills: Palgrave Macmillan, pp. 160–81.

Shaffer ER, Brenner JE. 2009. A trade agreement's impact on access to generic drugs. *Health Affairs* **28**: w957–68.

Somers M. 2008. *Genealogies of Citizenship: Markets, Statelessness, and the Right to Have Rights*. Cambridge: Cambridge University Press.

Srivastava P. 2010. Privatization and Education for All: Unravelling the mobilizing frames. *Development* **53**: 522–8.

Stiglitz J, Charlton A. 2004. Common values for the Development Round. *World Trade Review* **3**: 495–506.

Stiglitz J, Charlton A. 2005. A Development Round of Trade Negotiations? In: Bourguignon F, Pleskovic B, Sapir A (eds). *Annual World Bank Conference on Development Economics–Europe 2005: Are We on Track to Achieve the Millennium Development Goals?*. New York: Oxford University Press, pp. 31–60.

Stuckler D, Basu S. 2009. The International Monetary Fund's effects on global health: before and after the 2008 financial crisis. *International Journal of Health Services* **39**: 771–81.

US Census Bureau. 2011. *Health Insurance Historical Tables*. Online at: http://www.census.gov/hhes/www/hlthins/data/historical/index.html, accessed 26 July 2012.

Ward K, England K. 2007. Introduction: Reading neoliberalization. In: England K, Ward K (eds). *Neoliberalization: States, Networks, People*. Oxford: Blackwell, pp. 1–22.

Wellington A. 2000. *The ethics of owning ideas: intellectual property and applied ethics*. Ph.D. dissertation, Graduate Program in Philosophy, York University.

Williamson J. 1993. Democracy and the ''Washington Consensus''. *World Development* **21**: 1329–36.

Working Group on IMF Programs and Health Spending. 2007. *Does the IMF Constrain Health Spending in Poor Countries? Evidence and an Agenda for Action*. Washington, DC: Center for Global Development. Online at: http://www.cgdev.org/doc/IMF/IMF_Report.pdf, accessed 26 July 2012.

Xenos N. 1987. *IV. Liberalism and the Postulate of Scarcity. Political Theory* **15**: 225–43.

Yong Kim J, Millen JV, Irwin A, Gershman J (eds). 2000. *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, ME: Common Courage Press.