



Global Social Policy Forum

Editors' Introduction: Globalization and Social Determinants of Health

In May 2005, the World Health Organization (WHO) set up the Commission on Social Determinants of Health to explore social and structural factors that lead to ill health and influence the ability of people to lead healthy lives or gain access to necessary health care. The concept of social determinants of health is a very broad one. It goes much further than the remit of ordinary health policies to include, in the words of the Commission's website, 'unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems'. Health – at population level – is shaped at least as much by social determinants of health outside the health care system as it is by medical care. We thus cannot consider health policies in isolation from structural characteristics of societies that define the social conditions in which people live and work. Social determinants of health (SDH) are therefore inextricably linked with social policies and issues of social development.

This forum explores and highlights different aspects of globalization and social determinants of health. Focussing on country and regional levels, Krishna Soman's discussion of social transformations in the villages of West Bengal dramatically illustrates the gender dimension of social stratification as it affects access to SDH, sometimes with fatal consequences. Guillermo Cruces and Daniel Titelman argue that globalization-related transformations in Latin America's labour markets raise with renewed urgency the question of how to move beyond Bismarckian, employment-related social insurance models to turn 'labour markets into universal, dynamic gateways to social protection' – specifically, the need for 'guaranteed and universal health-care coverage'.

Moving to the global frame of reference, Jody Heymann and Rachel Kidman's contribution emphasizes the need to use international institutions to improve working conditions and to ensure equal access to education across

countries and populations, offering the intriguing idea of a fund for education along the lines of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. Patrick Bond and Zoë Wilson note the challenge of reconciling ecological imperatives with social justice in the management of escalating demands on the world's water resources. And Rene Loewenson contrasts promising innovations to improve access to SDH at the national level with the lack of institutional mechanisms at the international level to mobilize and apply resources effectively in support of global public health.

Globalization influences the structures of societies where we live and the choices that people can or cannot make, notably by creating and reinforcing various forms of social inequality. The contributions to this forum combine to state the case for understanding globalization's impacts on national social policy, and for developing institutions and mobilizing resources in support of an equity-oriented global social policy.

For further information: WHO Commission on Social Determinants of Health (http://www.who.int/social_determinants/en/).

TED SCHRECKER, RON LABONTE

University of Ottawa, Canada

MERI KOIVUSALO

Globalism and Social Policy Programme (GASPP), Finland

Please address correspondence to: Ted Schrecker, Associate Professor, Department of Epidemiology and Community Medicine, University of Ottawa, Faculty of Medicine, One Stewart Street, Room 216B, Ottawa, ON K1N 6N5, Canada. [email: tschreck@uottawa.ca]; Ron Labonte, Canada Research Chair in Contemporary Globalization and Health Equity, One Stewart Street, Room 216A, Ottawa, ON K1N 6N5, Canada. [email: rlabonte@uottawa.ca]; Meri Koivusalo, Globalism and Social Policy Programme (GASPP), P.O. Box 220, Helsinki, Finland, FIN-00531. [email: meri.koivusalo@stakes.fi]

KRISHNA SOMAN

Calcutta University, India

Social Dynamics of Women's Health: Reflections from India

(KRISHNA SOMAN is Associate Professor of Public Health at the Institute on Development Studies Kolkata, Calcutta, India.)

International concerns for protection and promotion of people's health in developing countries in the face of 'globalization' came up with strategies for minimizing the negative impacts of 'economic adjustment' in the 1980s and later for ensuring health equity. The Commission on Macroeconomics and Health, though it recognized that health is indispensable to development, missed out the processes of how the changing dynamics of global economic

and geopolitical environment undermine or improve health. The World Health Organization, however, limited its focus on the health systems. Squaredly, the global exercises emphasized basic incomes, living standards, health and nutrition of the vulnerable including the poor or stressed more the health systems rather than the social determinants of health (Labonte and Schrecker, 2006).

My observations on the health culture of a people in transforming villages of West Bengal – a state located in eastern region of India – revealed certain social dimensions to people's health and indicated that it is shaped within the dynamics of the institutions they dwell in. For instance, in stratified villages of Bengal, women's health is an outcome of their existence in the patriarchal structures of the society and family. Larger economic, social and political changes continuously influence the resource base and traditional norms and ideology in the family that forms the intra-familial power relations. This, in turn, shapes the valuation of women's labour and access to nutrition, rest and health care in the family. A survey of reported illness conducted in the late 1990s among 2320 women and men aged 15 years and above age revealed gender differentials against women in prevalence and burden of illnesses across socio-economic strata. Further, the gender gap widened with increasing deprivations within the families (Soman, 2002).

Given the worse state of health and higher burden of ill health among women as compared to men across the socio-economic strata, health care for women was marked by delayed access and poor quality. The delay was contributed by women as well as their families. While women practised self-denial and restrained expressions of their needs as a norm of their subservient status in patriarchal families, their families did not take initiatives, as women's labour was critical for security and survival of the families. After crossing the hurdles of delay however, when women are able to seek care, they receive a worse deal in health care as compared to men in corresponding socio-economic categories (Soman, 2002).

The picture of first contact health care for chronic ailments (that persisted for more than three months) among the population was marked by marginal utilization of primary health care networks (25%). In contrast, while utilization of private institutions was overwhelming (70%), one-third of these institutions were in the informal sector that included self-trained healers using modern medicine and religious rituals. The poor largely took recourse in such informal private institutions. Entangled in the patriarchal family dynamics, women across socio-economic categories got a worse deal. Though they utilized the private sector as intensely as their men, it was overwhelmingly informal institutions where they first reported for treatment (Soman, 2002). This nature of health care utilization is likely to perpetuate a divide in the quality of care. It is appalling that women were forced to even choose or accept death as a consequence of gender differentials. Women like Sabitri, Dhuli, Khuti have been few illustrations of this. Neither the local

media nor the law was found to capture or address such gender implications under their respective purviews. They interpreted incidents of suicide by or murder of women as results of family feud or 'insanity' in a medico-legal sense (Soman, 1997a).

In families, women confront ill health within the boundaries of restrictive patriarchal/social norms. These norms, internalized by the members of the family including women, create situations where various complexities and limitations are accommodated and absorbed by women at the cost of their own right to expression and life. Besides, women also provide emotional support and extra physical labour whenever their husband or other members of the family fall ill. In addition, their practice of self-denial makes them give up their minimum share of food in the family, compromising nutrition, rest or leisure and health care. The gender restrictive social norms thus act as critical factors in determining women's health at family level. Its importance is often overlooked in the discourses of socio-economic or healthcare development. Nevertheless, inklings of change are visible in situations where women either challenged and broke the barrier of restrictive norms or the family dynamics changed to create conducive environment for such change (Soman, 1997a).

Larger economic, social and political transformation in the region touched lives of women across generations lightly following that of their men. Change or shifts in women's lives however small, cannot be denied but these are yet to touch the core of patriarchal relations that are rooted in division of labour influencing productive-reproductive roles of women, their control over resources and responsibility for production in the social arena to men. It is observed that the family dynamics are influenced by a set of social and economic mediators.

In points of time, mediators of change, which are both economic and social in nature, influenced the family dynamics. While women's employment, education, physical mobility and age at marriage appeared to have influenced lives of women in earlier generation, forces such as information through mass media, profit oriented culture and commercialization came at a later stage, adding to the complexities of the earlier forces. Simultaneously, men's attitude and social aspirations to live the lives of their 'upper class models' played a vital role in this transformation. All these forces influenced the intra-familial relationships, women's productive and reproductive roles, labour, self-esteem and moulded the objective conditions of health. The nature and intensity of the influences however, varied in socio-economic strata (Soman, 2006).

Some of the major policies have attempted to address certain issues in health, nutrition and population development but overlooked the gender issues. For instance, the policies on health and population are narrow in perspectives and focus upon women's biological reproduction (Government of India [GOI], 2000, 2002). Compared to these, the policy on nutrition adopted a wider perspective of development and nutrition security but missed out on the gender implications (GOI, 1993). Deviating from these, the policy on empowerment of women outlines various dimensions and complexities of

women's lives and identifies potential areas for empowerment. This in turn, points to the dire need for viewing women's life as a dynamic whole. Simultaneously, interconnections between policies emerge as a prerequisite for addressing the issues of women's health and empowerment. Though the state of West Bengal has witnessed the encouraging presence of women in the political institutions at various levels and in varying proportions, ground experiences of the women members point out that they are often subjected to complex negotiations within and beyond the institutions (Bagchi, 2004). Women fight patriarchy within and beyond families. In employment, they are largely engaged in the unorganized sector where they are subjected to adverse terms and conditions at work. Initiatives of economic empowerment through formation of community based 'self-help groups' offer women access to some economic incentives. Whether and how these political and economic interventions are to empower women to deal with their own ill health and health care better is a question that is yet to be answered.

Health is a way of life. My observations are neither general nor complete. Yet, they do indicate that in a large span of time, the health culture of a people is rooted in social, economic and political contexts. Understanding the social determinants and processes that influence conditions of health and health care practices requires special care in studying 'globalization' processes that pose a threat to women's space, status and health.

REFERENCES

- Bagchi J. (ed.) (2004) *The Changing Status of Women in West Bengal 1970–2000: The Challenge Ahead*. New Delhi: Sage.
- Government of India (GOI) (1993) *National Nutrition Policy*. New Delhi: Department of Women and Child Development, Ministry of Human Resource Development.
- Government of India (GOI) (2000) *National Population Policy 2000*. New Delhi: Department of Health and Family Welfare.
- Government of India (GOI) (2002) *National Health Policy*. New Delhi: Department of Health and Family Welfare.
- Labonte, R. and Schrecker, T. (2006) 'Globalization and Social Determinants of Health: Analytic and Strategic Review Paper', 11 March, Institute of Population Health, Canada.
- Soman K. (1997a) 'Picture of Women's Health: Three Stories', *Economic and Political Weekly* (22 February): 396–8.
- Soman K. (1997b) 'Social Dynamics of Women's Health: A Study of Bolpur Block in the District of Birbhum', PhD thesis, Jawaharlal Nehru University, India.
- Soman K. (2002) 'Rural Health Care in West Bengal'. *Economic and Political Weekly* (29 June): 2562–4.
- Soman K. (2006) 'Women's Health and Work: A Shared Relationship', in J. Arunachalam and U. Kalpagam (eds) *Development and Empowerment: Rural Women in India* (pp. 192–224). India: Rawat Publications.

Please address correspondence to: Krishna Soman, Institute of Development Studies Kolkata, Calcutta University Alipore Campus, 5th Floor, 1 Reformatory Street, Kolkata – 700027, India. [email: krishna_soman@rediffmail.com]

GUILLERMO CRUCES

Centro de Estudios Distributivos, Laborales y Sociales, Argentina

DANIEL TITELMAN

United Nations Economic Commission for Latin America and the Caribbean, Chile

Challenges for Health and Social Protection in Latin America

(GUILLERMO CRUCES is currently with CEDLAS [Centro de Estudios Distributivos, Laborales y Sociales], Buenos Aires, Argentina. Research for this article was performed while with the Development Studies Unit of the United Nations' Economic Commission for Latin America and the Caribbean, Santiago, Chile; DANIEL TITELMAN is with the Development Studies Unit of the United Nations' Economic Commission for Latin America and the Caribbean, Santiago, Chile. The views expressed here are those of the authors and do not represent those of ECLAC or the UN.)

Among the many new challenges that arise from globalization, the task of providing inclusive and universal social protection is especially demanding, since it requires Latin American societies to find new and original ways to respond both to the challenges from the new global order and to older and well-known problems of social exclusion.

The main reason why solidarity-based social protection mechanisms need to be rethought is that the labour market has not lived up to expectations (Economic Commission for Latin America and the Caribbean [ECLAC], 2006). The Bismarkian welfare-state model that was advanced as a paradigm for social protection at the end of the Second World War was based on the notion of a labour-based society, where the State in turn provided universal coverage of basic services and formal education. This presupposed an ideal situation of full and increasingly formal employment as the basis for a social protection system that would gradually provide increasing benefits to the workforce.

This model, which relied on formal employment as its foundation, has always been a partial one in Latin America. Evidence in this respect includes high unemployment rates (over 10% in 2003–4) and the size of its labour markets' informal sector (47% of total employment at the start of this decade). Moreover, despite a wave of reforms, contributory coverage in the region actually declined between 1990 and 2003 (ECLAC, 2006). The decrease in contributory social security coverage can be attributed to a series of factors, such as the increased weaknesses and volatility of economic growth, as well as structural reforms and increases in the levels of informality and the precariousness of employment.

Thus, despite the Latin American and Caribbean region's long-standing tradition of social insurance, only a fraction of its workers are or have been covered by contributory social protection schemes. The region has not succeeded in turning its labour markets into universal, dynamic gateways to social protection.

While the promotion of decent employment is a key factor for social protection policies (International Labour Organization [ILO], 1999), any reversal in today's labour market dynamics is unlikely to occur in the short or

medium term. Protection from the risks associated with a possible loss of income, health, ageing or other factors cannot thus be confined to the contributory mechanisms offered by formal employment. The main challenge at this point is to reassess the concept of solidarity as it relates to social protection in its entirety, both within and outside the labour market, and then, on that basis, to redesign transfer mechanisms within an integral concept of solidarity so that the protection from risks is not unavoidably linked to socio-economic conditions.

Against this backdrop, effective protection in health requires that the region's systems evolve towards guaranteed and universal health-care coverage, as the only way to overcome the limitations of labour markets and the social determinants of health. This is by no means an easy task. Health systems in the region are facing both emerging challenges, from demand shifts driven by demographic, epidemiological and technological change, and older ones, which stem from the region's long-standing shortcomings in terms of access to services, human and financial resources.

Over and above the specific characteristics of each country, a number of common criteria need to be taken into account for health sector reforms. The ability to expand health care coverage and access will largely be determined by the way health systems and health services provision are organized. While optimal coverage of social risks implies a move towards universal compulsory insurance systems, greater access relates mainly to the enhancement of traditional public-sector health services.

The effective and equitable protection of health risks in Latin America requires a better integration of health systems to provide integrated solidarity (ECLAC, 2006). These systems encompass a wide range of financing, insurance, regulation and service-delivery mechanisms and institutions. The functions involved are usually coordinated through a public health system, a social security system and the private sector. The differing ways in which these three subsectors are coordinated and interlinked give rise to different forms of operation and thus to different dynamics in terms of health-sector coverage, equity and efficiency.

While contributory and non-contributory financing are interrelated in the region's countries in different ways and to differing degrees, greater integration between social security and the public system can increase the synergies between the two, raising the level of financing available for solidarity purposes and enhancing equity (Londoño and Frenk, 1997). Furthermore, articulation of this type can have a positive effect on efficiency by promoting a fuller utilization of installed capacity and rationalization of resource use (Titelman and Uthoff, 2005). Given that most of the region's countries have only limited tax revenues and that social security health care contributions are a major source of financing, the integration of contributory and non-contributory financing is the way forward for most countries in the short and medium term.

Their integration can be carried out in many ways (Cetrángolo et al., 2006). The region possesses a great variety of institutional mechanisms for this purpose, ranging from the financing of public healthcare provision exclusively out of general tax revenues, to systems in which there is a degree of integration between contributory financing and the national budget, as shown by reforms in Brazil, Costa Rica and Colombia, among others. These examples can inform the reform processes in the majority of countries in the region that have little or no integration or linkage between the sectors. Whatever route is chosen, progressively greater integration and linkage between the social security health care system and the public system is vital for improving the management of people's health risks, boosting the supply of services and enhancing the equity of coverage.

Finally, a vital complement to the organization of national insurance schemes, health policies must strengthen public health activities, and boost the coverage of primary care. Recent efforts in the region, detailed in ECLAC (2006), have effectively extended access to health care coverage to lower-income populations and remote rural areas. This is an important aspect not only because better access to health goods and services improves the health of the population, but also because it constitutes a first port of call for an integrated health system, rationalizing the use of resources.

The region has reached a point in its history where it is called upon to make the transition from a set of social policies to a social protection system that integrates those policies. The experience of the 1990s have taught us that sustainable and legitimate processes will only thrive when debated openly and in an informed manner, as done in this *Global Social Policy* Forum.

REFERENCES

- Cetrángolo, O., Cruces, G. and Titelman, D. (2006) 'Social Protection and Health Systems in Latin America and the Caribbean', paper presented at the WIDER Conference on Advancing Health Equity, Helsinki, Finland, September.
- Economic Commission for Latin America and the Caribbean (2006) *Shaping the Future of Social Protection: Access, Financing and Solidarity*. Santiago: ECLAC, LC/G.2294(SES.31/3)/I.
- International Labour Organization (ILO) (1999) 'Decent Work: Report of the Director General', paper presented at the International Labour Conference, 87th Session, Geneva, June.
- Londoño, J.L. and Frenk, J. (1997) 'Structured Pluralism: Towards an Innovative Model for Health System Reform in Latin America', *Health Policy* 41(1): 1–36.
- Titelman, D. and Uthoff, A. (2005) 'The Role of Insurance in Social Protection in Latin America', *International Social Security Review* 58(2–3): 43–69.

Please address correspondence to: Guillermo Cruces, CEDLAS (Centro de Estudios Distributivos, Laborales y Sociales), Departamento de Economía, Facultad de Ciencias Económicas, Universidad Nacional de La Plata (UNLP-Argentina), Calle 6 e/47 y 48 Piso 5 Oficina 516 1900 La Plata, Provincia de Buenos Aires, Argentina. [email: gcruces@depeco.econo.unlp.edu.ar]; Daniel Titelman, CEPAL, Naciones

Unidas, Casilla 179D, Avenida Dag Hammarskjold, N 3477, Santiago de Chile.
[email: daniel.titelman@cepal.org]

JODY HEYMANN
McGill University, Canada

RACHEL KIDMAN
McGill University, Canada

Creating a Healthier Version of Globalization

(JODY HEYMANN is Professor in the Faculties of Medicine, and Arts, as well as Founding Director of the Institute for Health and Social Policy at McGill University, Montréal, Canada; RACHEL KIDMAN is a lecturer at the Institute for Health and Social Policy at McGill University, Montréal, Canada.)

We have strong evidence that population health is overwhelmingly determined by social conditions (Frank, 1995). How healthy your life is, when you'll get sick, and when you'll die is much more likely to be determined by how wealthy or poor you are, your working conditions, housing conditions, social supports, food available, and your environment than by your medical care.

Labor, Social Conditions and Health

Millions currently labor under conditions that damage their health and their children's health. The harmful effects of unsafe working conditions include more than 2m deaths a year from occupational injuries and illness (International Labour Organization [ILO], 2005). Working conditions also threaten the health of family members. The Project on Global Working Families found two-thirds of low-income working parents were forced to choose between leaving sick children home alone or losing needed pay and jobs when they took time off from work (Heymann, 2006).

Importantly, labor conditions are a key determinant of poverty and economic inequality – two of the largest social determinants of population health. Even in affluent countries, such as the USA, living in a federally-designated 'poverty area' carries with it a mortality risk 1.7 times greater than in the general population (Haan et al., 1987). Moreover, income inequality coupled with poverty can explain about a quarter of the variation in mortality across US states (Kennedy et al., 1996). Inequality's impact on health, beyond poverty, has been thoroughly documented in the Whitehall Study, a study of 20,000 British civil servants, among other studies (Marmot et al., 1984). Among middle-aged men, those in the lowest occupational class in Whitehall (i.e. clerical and manual workers) had mortality rates three and a half times as great as workers in the highest class (i.e. senior administrators). In poor countries, the extent and consequences of material deprivation are markedly magnified. Malnutrition alone contributes to over half (52.5%) of all

pre-school aged deaths globally each year (Caulfield et al., 2004). In 2002, the WHO estimated that unsafe water and sanitation accounted for approximately 1.7m deaths, almost exclusively in the developing world (World Health Organization, 2002).

Globalization as a Key Determinant of Social Conditions

No force is more dramatically reshaping social determinants of health today than globalization. Globalization is both transforming many of the social conditions that have the greatest impact on health and reshaping our ability to implement public policies and programs that improve the social conditions underlying health. A central aspect of this is globalization's impact on labor conditions, poverty and inequality. The critical question is whether globalization's net impact on these conditions is good or bad.

One of the greatest impacts of recent globalization has been the increasing flow of production across borders. Companies that do not care about working conditions can now readily move their jobs to the country with the lowest labor costs. In the absence of global standards, companies that do care about working conditions have trouble competing in the same market.

As a result of these economic conditions, there has been increasing pressure placed on workers to accept lower wages and fewer benefits to keep their jobs. In countries with better working conditions, millions of jobs have been lost – often eventually replaced with lower paying and lower benefits jobs. Until recently, nations commonly protected workers by mandating fair working standards within their borders. But in the new global economy, competition for capital investment and jobs has led nations to compete for jobs by relaxing important protections.

At the same time, the argument has been made that both the poorest and middle-income countries are benefiting as they receive more jobs – from manufacturing shirts to software development to reading x-rays. The evidence to date is limited, but suggests globalization's probable impact has been to lessen absolute poverty while at the same time increasing inequalities.

We have seen a global reduction in the number of people living in the worst poverty (a decrease from 1.2bn in 1990 to 1.1bn a decade later), largely due to improved economies in India and China (World Commission on the Social Dimension of Globalization, 2004). This does not necessarily indicate trade liberalization always benefits the poor. In fact, evidence from a study of 52 less-industrialized economies found the poor benefited most in countries where trade and capital flows were more regulated (Weller and Hersh, 2004).

Changes in inequalities have been mixed under globalization. Inequalities between nations may have declined, as suggested by a study of global inequality trends between 1981 and 1997 (Ghose, 2004). However, a United Nations WIDER study of trends in inequality demonstrated that in 48 of the 73 countries studied, within countries inequalities rose (Cornia and Kiiski, 2001).

Moreover, inequalities appear to be most pronounced in sectors directly affected by trade agreements. After the introduction of trade liberalization policies in Brazil, wages in sectors engaged in trading fell relative to wages in non-traded sectors (Arache et al., 2004). Further, the Brazilian study found that the marginal returns of a high school education or less decreased in the post-liberalization period. Similar trends have been observed in Columbia and Mexico: since the adoption of trade liberalization policies, wage inequalities between skilled and unskilled workers have grown dramatically (Attanasio et al., 2004; Hanson, 2003).

Tools at Hand

Ultimately, the question should not be whether a human being is better off in a sweatshop working 100 hours a week or unemployed, or whether a preschool child is better off home alone while parents work or in a family that cannot afford food. The question needs to be: can we come up with a better version of globalization?

In its current form, globalization has extensive regulation of property rights, but little regulation of working conditions. Moreover, while there are exhaustive systems for measuring the growth of currency and capital, there is utterly inadequate information on the effect of different choices we make about globalization on poverty and inequality. While presenting real threats to health, the global economy also presents the possibility of setting a floor of decent social conditions globally. Organizations like the World Trade Organization are influencing national economic behavior more substantially than any previous form of governance with global participation. The problem lies not with globalization's potential, but with its execution.

Within globalization's framework, we need to address poverty and inequality. At its core, this means improving wages and the working conditions that make work sustainable and determine income for most families – and increasing educational opportunities which determine future earnings potential across generations. There are important global foundations we can build on for each of these priorities.

In the area of labor conditions, for nearly a century the ILO has brought together businesses, workers and governments to forge agreements on basic decent working conditions. Their grave limitation, however, has been in their ability to enforce these conventions. We need to ensure that equal enforcement teeth are put behind the quality of workers' lives in a global economy as are already behind property protections. This can be done through a variety of mechanisms, ranging from linking trade and labor agreements to providing countries with preferential economic opportunities when they improve labor conditions voluntarily, as Cambodia did with the Better Factories Initiative.

At the same time, we need to invest in ensuring equal access to education across countries and populations. As in the case of labor, there is already substantial global agreement on the goals. The UN's first Millennium Development Goal is eradicating extreme poverty and hunger, followed by a second goal of achieving universal primary education. Yet the world is far from achieving either. Moreover, the funding is not available to provide substantial assistance to the poorest countries in achieving this. The Global Fund for AIDS, TB and Malaria has demonstrated that creative mechanisms can bring together global donors with nationally-led action plans to address major problems. It's long past time that we had a similar substantial fund for early childhood, primary and secondary school education.

If globalization's success is measured in ways that include reducing poor working conditions, poverty and inequality – all primary determinants of health – as key indicators, the possibilities for real and lasting human development and population health are enormous. The alternative – a worldwide race to achieve an uncertain goal completely divorced from the welfare of the majority of the world's population – is unsustainable.

REFERENCES

- Arache, J., Dickerson, A. and Green, F. (2004) 'Trade liberalization and Wages in Developing Countries', *The Economic Journal* 114: F73–96.
- Attanasio, O., Goldberg, P. and Pavcnik, N. (2004) 'Trade Reforms and Wage Inequality in Colombia', *Journal of Development Economics* 74(2): 331–66.
- Caulfield, L., De Onis, M., Blössner, M. and Black, R.E. (2004) 'Undernutrition as an Underlying Cause of Child Deaths Associated with Diarrhea, Pneumonia, Malaria, and Measles', *American Journal of Clinical Nutrition* 80(1): 193–8.
- Cornia, G. and Kiiski, S. (2001) 'Trends in Income Distribution in the post-World War II Period: Evidence and Interpretation', United Nations University World Institute for Development Economics Research.
- Frank, J. (1995) 'Why Population Health?', *Canadian Journal of Public Health* 86(3): 162–4.
- Ghose, A. (2004) 'Global Inequality and International Trade', *Cambridge Journal of Economics* 28: 229–52.
- Haan, M., Kaplan, G. and Camacho, T. (1987) 'Poverty and Health: Prospective Evidence from the Alameda County Study', *American Journal of Epidemiology* 125: 989–98.
- Hanson, G. (2003) 'What has Happened to Wages in Mexico since NAFTA?: Implications for Hemisphere Free Trade', National Bureau of Economic Research.
- Heymann, J. (2006) *Forgotten Families*. New York: Oxford University Press.
- International Labour Organization (2005) 'World Day for Safety and Health at Work 2005: A Background Paper', accessed 9 March 2006, http://www.ilo.org/public/english/bureau/inf/download/sh_background.pdf.
- Kennedy, B., Kawachi, I. and Prothrow-Stith, D. (1996) 'Income Distribution, Socioeconomic Status, and Self-rated Health: A US Multi-level Analysis', *BMJ* 312: 1004–7.

- Marmot, M., Shipley, M. and Rose, G. (1984) 'Inequalities in Death: Specific Explanations of a General Pattern?', *Lancet* 5(1): 1003–6.
- Weller, C. and Hersh, A. (2004) 'The Long and Short of it: Global Liberalization and the Incomes of the Poor', *Journal of Post-Keynesian Economics* 26(3): 471–504.
- World Commission on the Social Dimension of Globalization (2004) *A Fair Globalization: Making it Happen*. Geneva: ILO.
- World Health Organization (2002) *World Health Report 2002: Reducing Risks, Promoting Healthy Life*. Geneva: WHO.

Please address correspondence to Jody Heymann, Institute for Health and Social Policy McGill University, 1130 Pine Avenue West, Montréal, QC, H3A 1A3, Canada. [email: Jody.heyman@mcgill.ca]; Rachel Kidman, Institute for Health and Social Policy, McGill University, 1130 Pine Avenue West, Montréal, QC, H3A 1A3, Canada. [email: Rachel.kidman@mcgill.ca]

PATRICK BOND

University of KwaZulu-Natal, South Africa

ZOË WILSON

University of KwaZulu-Natal, South Africa

A Water Policy Revolution?

(PATRICK BOND is Professor at the University of KwaZulu-Natal School of Development Studies in Durban, South Africa; ZOË WILSON is Post-Doctoral Research Fellow at the University of KwaZulu-Natal School of Development Studies in Durban, South Africa.)

Do we require a social-consciousness revolution – comparable to growing awareness of climate change achieved (albeit partially) (Gore, 2006; Stern, 2006) – regarding our species' threat to the global water system? Not only are underground freshwater removal rates and other hydrological ecosystem stresses at untenable levels, but also life-threatening inequities in access to water persist (United Nations Development Program [UNDP], 2006; United Nations Education, Scientific and Cultural Organization [UNESCO], 2006). Lack of access to safe water is typically correlated to poverty, economic insecurity, ill health and other forms of vulnerability (Barlow and Clarke, 2002; Gleick, 2005; Global Health Watch, 2005; Shiva, 2002).

Status quo water/sanitation delivery systems are not effective under these conditions, especially in urban/peri-urban slums, which will soon house the world's majority (Davis, 2005). To be sure, conventional large-scale water and sanitation management systems improved health outcomes during the 20th century, especially in the industrialized countries. But the need for equity and ecological sustainability has increased the importance of new thinking in the sector. Many research agencies, academic institutions and multilateral funders, as well as water-rights activists, agree that a major paradigm shift in water management is overdue, and are looking towards new subsidization systems and technological and management packages that can improve access, efficiency and sustainability.

From the standpoint of subsidization, the two major dilemmas are equitable access and the need for incentive structures to achieve water conservation and adequate infrastructure investment. Yet the standard market-oriented policies dominant from the 1980s until recently meant water was often mainly treated as a consumer good, to be priced with reference to considerations of micro-economic efficiency – i.e. to ‘Get the prices right’ by reducing or eliminating cross-subsidization from large users to smaller users. The typical World Bank (2000) mandate for even low-income African water managers was to ‘Ensure 100% recovery of operation and maintenance costs’ (even where capital subsidies may be permitted). As *The Economist’s* (2003) survey on water declared, ‘Throughout history, and especially over the past century, it has been ill-governed and, above all, colossally underpriced’. Public sector fiscal austerity and the quest for new investment opportunities had, during the 1980s–1990s, created powerful new transnational water utility corporations, and stimulated government support for the private provision of water services.

At the same time, the World Water Forum met every three years beginning in the early 1990s, and was joined by the Global Water Partnership (the World Bank, UN Development Program and Swedish aid); the Marseilles-based World Water Council (founded by Suez, Canadian aid and the Egyptian government and joined by 300 private companies, government ministries, and international organisations); the International Private Water Association (privatization firms plus the World Bank, US Credit Export Agency and Overseas Private Investment Corporation and the European Bank for Reconstruction and Development); Mikhail Gorbachev’s Green Cross (in ongoing dispute with Council of Canadians over global-scale water rights and property rights in the UN); Aquafed (a federation set up by a former Suez managing director); and the World Panel on Financing Infrastructure chaired by Michel Camdessus.

But this powerful establishment bloc did not solve the problem of access, leading many transnational corporations to exit Latin American, African and Asian markets with horror stories of lost investments and social protest. In South Africa, a cholera outbreak and rising grassroots protests compelled the government to offer a free lifeline supply of water to all, followed by incrementally higher amounts to penalize luxury users. (‘Free Basic Water’ has so far been unevenly implemented [Bond, 2006].)

From the standpoint of technologies and management packages, older national and municipal systems are in advanced states of decay all over the world, requiring hundreds of billions in investments. Failures of conventional systems have, more generally, spurred a shift towards ‘Integrated Water Resource Management’, which takes as the primary scale the catchment area, i.e. a geographic zone defined by hydrological features rather than by patterns of human settlement. This scalar shift has sparked interest in new technologies (such as ecosan dry sanitation), institutional partnerships and decentralized management. In rural areas, in particular, closed-loop ecologically-sound water

and sanitation innovations are being introduced at a rapid rate. As public-private partnerships hit the limits of affordability and social acceptability in the Third World, a range of innovative new arrangements are flooding the scene (Wilson, 2006), including alternative PPP partnerships: 'public-public' (two or more state delivery agencies cooperating usually across scale such as catchment-municipal), public-people (in communities with residents playing a greater role) and (with unions) public-worker (Transnational Institute, 2005).

At the same time, some water, health and human rights advocates in civil society are wary of excessive emphasis on decentralization or value pricing, understanding water as best managed by the state in the public interest – despite their sometimes uneven track records. Such advocates have instead stressed 'public goods' and 'merit goods' – such as disease mitigation and gender equity – associated with expanding the existing water grids, and changing the price structure to one based on an adequate and free universal supply accompanied by penalties for excessive water consumption, all under public and community/labour management in which workers and residents assist with system improvement, social marketing, leak identification, needs assessment and other facets of design and implementation. As in the South African case, this will require a revolution in cross-subsidization strategies and the mobilization of major new financial resources for treatment and supply. It will also require a paradigm shift among policy makers to make socially responsible practices ecologically sustainable.

Technical modalities will vary with the specific context, but the overall challenges are to reduce pressures on global use of freshwater supplies, improve water quality, reduce ecosystem degradation, and ensure equitable access to those currently without adequate potable water and sanitation. To do so will require new technological and management approaches, new water use and treatment practices, a free basic water allotment/subsidization policies, capacity building in the sector and targeted investments, and more explicit linkages to health, gender equity, environmental sustainability and other social objectives that the market does not typically factor into price calculations.

The challenge for the variety of establishment forces around the World Water Forum and the counter hegemonic Peoples World Water Forum (2004) is to establish a more effective dialogue to work through the technical questions of pricing, scale, institutional arrangements and sustainability, before this revolution can begin to bear fruit in the sphere of politics and public health.

REFERENCES

- Barlow, M. and Clarke, T. (2002) *Blue Gold: The Fight to Stop the Corporate Theft of the World's Water*. New York: The New Press.
- Bond, P. (2006) 'Water Commodification: Can Human Rights Trump the Market?', *Asian Exchange* 22(1): 39–61.
- Davis, M. (2005) *Planet of the Slums*. London: Verso.
- Economist, The (2003) 'Survey of Water', (19 July).

- Gleick, P. (2005) *The World's Water 2004–2005: The Biennial Report on Freshwater Resources*. Washington, DC: Island Press.
- Global Health Watch (2005) *Global Health Watch*. London: Zed Books.
- Gore, A. (2006) *An Inconvenient Truth*. Davis Guggenheim, director. Paramount Classics, distributor. [Film]
- People's World Water Forum (2004) Declaration of the People's World Water Forum, New Delhi.
- Shiva, V. (2002) *Water Wars: Privatization, Pollution and Profit*. Boston: South End Press.
- Stern, N. (2006) *Stern Review on the Economics of Climate Change*. London: Her Majesty's Treasury.
- Transnational Institute (2005) *Reclaiming Public Water*. Amsterdam: Transnational Institute.
- United Nations Development Program (UNDP) (2006) *Human Development Report 2006, Beyond Scarcity: Power, Poverty and the Global Water Crisis*. New York: Palgrave Macmillan.
- United Nations Educational, Scientific and Cultural Organization (UNESCO) (2006) *World Water Development Report 2: Water a Shared Responsibility*. New York: Berghahn Books.
- Wilson, Z. (2006) 'Water: A Global Contestation (Debate with Patrick Bond, Fadia Daibes Murad, Sanjeev Khagram, Alessandro Palmieri, Carlos Vainer and Patricia Wouters)', in M. Kaldor et al. (eds) *Global Civil Society 2006/7*. London and New Delhi: Sage.
- World Bank (2000) *Sourcebook on Community Driven Development in the Africa Region: Community Action Programs*. Washington, DC: Africa Region.

Please address correspondence to Patrick Bond, Room F199 Memorial Tower Building, Howard College, University of KwaZulu-Natal, Durban, South Africa. [email: bondp@ukzn.ac.za]; Zoë Wilson, Howard College, University of KwaZulu-Natal, Durban, South Africa. [email: jzoewilson@gmail.com]

RENE LOEWENSON

Training and Research Support Centre, Zimbabwe

Is a Brave New World of Social Equity Possible?:

Claiming the Dawn ...

(RENE LOEWENSON is with the Training and Research Support Centre in Harare, Zimbabwe.)

The December 2006 World Institute for Development Economics Research of the United Nations University (UNU-WIDER) report on the World distribution of Household Wealth is the latest reminder of the widening global inequalities in the opportunities for health. The January 2007 World Social Forum in Nairobi Kenya is the latest reminder of the demand for alternatives. Rasna Warah writing for the Nation in Nairobi asks, 'Is a brave new world of social equity possible?'

Closing differences in health between social groups calls for action on the social determinants of health; that is on the causes that lie in the social

conditions in which people live and work, and the policies and socioeconomic and political contexts that generate these conditions. The determinants are largely not complex, and addressing them is within the scope of our technical, social and economic capacities. They include, for example, employment, safe housing, water and sanitation, adequate and healthy food, a nurturing family environment, freedom from violence, sexual choice, safe and pollution free community environments and access to health and welfare services. The challenge lies upstream in policy choices, resource allocations and the socioeconomic and political contexts that shape them.

So do human needs and social development matter in policy choice? Drawing from history, it could be judged that human security mattered for populations in Europe after the Second World War. Delivering on human security was identified as important for peace, and was the basis for the spread through Europe of national systems of social insurance and public services to address freedom from want.

Does the same hold true globally today? The UN agenda today of freedom from want, freedom from fear and freedom to live in dignity is heavily weighted in practice towards a focus on 'freedom from fear' in some (wealthier) parts of the world, and on 'freedom from want' in other (poorer) parts. While Nobel Peace Laureate Desmond Tutu stated in January 2007 that threats to peace and security are directly linked to the poverty that drives people to desperation, the role of solidarity as a basis for human security globally appears to be tenuous. Global policy commitments abound – they appear in the International Covenant on Economic, Social and Cultural Rights (CESCR) (1976), the 1995 Summit and Commission for Social Development, the UN decade for the eradication of Poverty (1976–2006) and the Millennium Development Goals. However the means to deliver on these commitments are contested, and often subject, with negative consequences, to the primacy of free trade.

Some of the most basic elements associated with successful 20th-century measures for human development – redistributive states, national solidarity systems for social insurance, universal publicly organized social services and enforceable social rights – are being unbundled in countries, even while the global debates take place. Further, the national cooperation achieved in some countries between states and citizens to effectively use taxes, organize public services and regulate private markets to provide for human security does not exist today at the global level, except in localized initiatives.

Laurie Garrett points out in 'The Challenge of Global Health'¹ that more money is being directed toward pressing health challenges than ever before. However, in the absence of effective tax and regulation of global financial and trade flows, the resource outflows from the poorest parts of the world exceed such inflows, while households and public revenues struggle with the consequences of increasingly insecure and informal jobs. In the absence of coherent policies and institutional mechanisms for applying global resources to public

health, global funds applied through disease focused programmes with short-term targets inadequately address the provision of public services and public workers needed to ensure that children are in school, fed and immunized. Such shortfalls in proven mechanisms for human development at global level make the gap between commitments and implementation predictable.

These matters are already being debated globally, including within UN platforms such as the Economic and Social Council (ECOSOC) and the UN General Assembly. However the debates are slow, the steps taken not yet decisive, and, as the Helsinki Process of review of global governance pointed out, there is a 'compliance' deficit as international institutions are failing to implement decisions they make. Emergency responses to acute epidemics like Severe Acute Respiratory Syndrome (SARS), perceived external threats, whether human, military or germ, or struggles for daily survival preoccupy public consciousness, often reinforced by international media.

The paths to social equity are, however, also being debated nationally and within civil society. While attention will be focused in January on civil society debates at the World Social Forum (WSF), developments within countries are also important for global policy, particularly where they connect regionally and internationally. Vincente Navarro and colleagues analysing Organisation for Economic Co-operation and Development (OECD) countries for a 50 year period, point to the critical importance of pro-redistributive governing party ideology and sustained application of these policies over extended periods for action on social determinants of health and health outcomes (Navarro et al., 2006). For example, the shift in the South American political map to a diverse centre left has already opened opportunities for policy and institutional change and energized policy debate on issues directly related to the social determinants of health, such as food sovereignty, access to safe water, social housing and public services. The reform of the Brazilian national health system, for example, towards a national comprehensive public sector centred health service (the SUS) predicated on constitutional obligations to universal access in health is one important sign of this policy and institutional change.

The extent to which policy and intervention in these more enabling environments is able to address the causes of ill health and close inequalities in health – promoted by civil society, and informed by knowledge – will not only be important for the people of that region. It will be important for direction of global debates and changes. Ecuador President Rafael Correa referred in his inaugural presidential speech in January 2007 to 'the night of neoliberalism passing'. The challenge IPS journalist Gustavo Gonzalez issued in response has relevance to those seeking to tackle the root causes of the significant inequalities in health in the current global environment – to claim the dawn.

NOTES

1. <http://www.foreignaffairs.org/20070101faessay86103-p0/laurie-garrett/the-challenge-of-global-health.html>

REFERENCE

Navarro, V., Muntaner, C., Borrell, C., Benach, J., Quiroga, A., Rodriguez-Sanz, M. and Palarin, M. (2006) 'Politics and Health Outcomes', *Lancet* 368(9540): 1033–7.

Please address correspondence to Rene Loewenson, Director Training and Research Support Centre, Box CY2720 Causeway, Harare, Zimbabwe. [email: rene@tarsc.org]

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It hardly needs emphasis that People's Science Movements (PSMs) in India have been very unique and such movements are not witnessed yet elsewhere although science popularization / science communication movements were witnessed in USA, Europe and Australia. As a study of unique social phenomenon catching up our academic fascination, the paper first tried to characterize the phenomenon of PSM; second, tried to locate such a phenomenon in its socio-historical contexts. Lastly, the phenomenon is empirically studied through the analysis of five extensive case studies of various types of People's Science Women's health in India can be examined in terms of multiple indicators, which vary by geography, socioeconomic standing and culture. To adequately improve the health of women in India multiple dimensions of wellbeing must be analysed in relation to global health averages and also in comparison to men in India. Health is an important factor that contributes to human wellbeing and economic growth. Learn about women's health - medical, health and wellness for women - from female anatomy to infertility and menopause. Women's lives have changed over the centuries. Historically, life was particularly difficult for most women. Aside from the numerous dangers and diseases, women became wives and mothers often when they were just emerging from their own childhood. Many women had a large number of pregnancies which may or may not have been wanted. In the past, childbirth itself was risky and frequently, led to the death of the mother. Women's health in India is an issue that needs attention. Sadly, in India irrespective of the worldwide commitment, women from the poorer classes and downgraded areas experience differential access to health care conveniences. In this post, we will discuss about factors affecting women's health in India, health status of women in India and women health issues in India. Instagram Account: sonalid3. Research on women's status has discovered that the commitments Indian women make to families often are ignored, and rather they are seen as financial burdens. Here are some of the most common health