

COMMENTS

Global governance of health: a minefield of contradictions and sectional interests

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The almost universal application of policies that promote integration of the globe through trade in goods and services and liberalised flow of finances - loosely termed "globalisation" - has also necessitated development of fairly elaborate global structures of governance. In the health sector this manifests itself as global health governance, i.e. global structures that attempt to govern issues related to health that transcend national boundaries.

Coordination and cooperation between countries on matters of global health (or international health, as it was then known) have existed well into the past as well. Some of the earliest concerns had to do with those related to spread of infectious diseases. Over a period this led to the adoption of some of the first international regulations related to health, such as quarantine measures and mandatory norms on vaccination.

In earlier centuries, international regulations related to health were structured to protect the interests of the colonising powers. When the era of colonisation became history, international regulations were structured in a more egalitarian framework. In the health sector this was reflected in 1948 in the birth of the World Health Organisation (WHO) and its stewardship of global health policies. It was also reflected in the International Labour Organisation (ILO) promoting global standards on occupational safety and health protection. The General Agreement on Tariffs and Trade (GATT), adopted in 1947, and the International Sanitary Regulations (adopted by the WHO in 1951 as the International Health Regulations) included provisions aimed at balancing interests of health and trade. The WHO promoted global efforts to improve health in developing countries, through such strategies as promoting the right to health, Health for All, the Essential Drugs List, and the International Code on the Marketing of Breast Milk Substitutes.

In recent decades, issues under the purview of global health have moved far beyond the physical spread of diseases. Since the early 1980s, the global architecture of governance, trade and economics has come to be informed by globalisation, and consequently national decision making and national policies are often subject to global influences. This is true in the health sector as well (1) and the advent of globalisation marks a shift in institutions and structures that govern health at a global level.

The use of the term "global" instead of "international", when discussing issues of health that go beyond national boundaries, is in itself significant. "International health" held the connotation that national concerns and policies formed the bedrock of policies about supranational issues, while "global health" appears to start from the premise that global issues largely supersede national policies, concerns and priorities.

It is possible to identify four major developments in the last three decades that have had a profound impact on the structures and processes of global health governance. The first is the emergence of the World Bank as a major player in the arena of health governance in the 1980s. Second, the growing importance of global trade in international relations, and its impact on health in different situations across countries, has led to a major role for the World Trade Organisation (WTO) and regional and bilateral trade agreements in global health. Third, private foundations (such as the Bill and Melinda Gates Foundation) entering through public private partnerships and other avenues, have become big players in global health issues. The fourth development is the demise of the World Health Organisation as the premier organisation in the area of global health governance. While all the four are somehow linked, each has arisen in specific contexts that are analysed below.

The World Bank's foray into the health sector

The World Bank was set up in the wake of the Second World War to resurrect the war-ravaged economies of the developed capitalist countries in Europe. It, however, usurped a much larger canvas for itself after the global economic crisis in the 1970s. By the 1980s, debt-ridden countries in the South (Africa, Latin America and Asia) were facing a virtual collapse of their national economic systems. The Bank (along with its Bretton Woods cousin, the International Monetary Fund) stepped in to resurrect these economies through the now infamous Structural Adjustment Programmes. These programmes were designed to reduce national debt through the promotion of exports (largely of primary produce) and reduction in government expenditure on welfare and social sectors, prominently in areas such as health, education and food security.

In the health sector the issues were sharply focused upon for the first time in 1987 by a World Bank document titled

“Financing health services in developing countries.” The document (2) recommended that developing countries should:

- increase amounts paid by patients for public health facilities;
- develop private health insurance mechanisms;
- expand the participation of the private sector, and
- decentralise government healthcare services (a euphemism for rolling back government responsibility and passing on the burden to local communities).

These recommendations were further “fine-tuned” and reiterated by the Bank’s World Development Report, 1993 titled *Investing in health*. The Bank’s recommendations, almost universally applied by cash-starved developing countries, were later to be almost as universally castigated as a major cause for decline in access to health services in the developing world. The Bank has, since then, tempered its enthusiasm for rollback of public services, but continues to essentially promote the concept that health financing and healthcare provision need to be separated and that the government must not emphasise its leading role as a healthcare provider. In Africa, the Bank continued to press for less government expenditure on welfare and public services through its country-specific “poverty reduction strategy papers.” The Bank’s advantage, which it continues to leverage upon, is that its recommendations are actually conditionalities that are linked to availability of loans to bail out struggling economies in the South. This, in large measure, explains why the World Bank’s ascent as a global player in health governance was so rapid and so pervasive.

The WTO steps in

The WTO agreement in 1995 replaced the General Agreement on Tariffs and Trade (GATT). The much larger scope of the WTO can be understood from the fact that when GATT was established in 1947, there were 23 contracting parties, and its mandate was limited to trade in goods. Today, the WTO has 153 members (3) (who account for 97% of world trade), and includes trade in goods and services and the protection of intellectual property rights. The earlier trade regime under GATT had marginal impact on the health sector, while the WTO, through the TRIPS agreement and the General Agreement on Trade in Services (GATS), directly affects health governance. In addition, the acceleration of trade liberalisation after the signing of the WTO also has significant impacts on the broader determinants of health - viz. the negative impact on food security and livelihoods in developing countries as a consequence of the effects of the Agreement on Agriculture, which forms part of the WTO agreement (4).

Since 1995, the WTO has become the major international forum for debate and resolution of conflicts in the area of major health-related policies or policies that have an impact on health. The WTO’s ability to intervene in global health issues is of a much higher order than that of the WHO, as the WTO agreement is a binding agreement with clear commitments made by contracting parties. The WTO imposes a “rule-based system” and adherence to these rules is exercised through

a dispute settlement mechanism. The dispute settlement mechanism allows member countries to use trade sanctions to enforce rulings against member states that fail to comply with its decisions. In contrast, the WHO does not have mechanisms that can force member countries to abide by decisions it takes. Thus, for example, health-specific legal agreements that have been endorsed by member countries in the WHO -- such as the Framework Convention on Tobacco Control or the revised International Health Regulations 2005 -- do not contain compulsory dispute settlement and enforcement provisions.

The final agreement signed by countries, called the WTO Agreement, is a long list of about 60 agreements, annexes, decisions and understandings. Four of these have a direct effect on health governance:

Technical Barriers to Trade (TBT): This agreement is designed to protect human, animal, plant and environmental health (e.g., a WTO member can enact a domestic regulation that limits the use of a potentially toxic substance in cosmetics and thereby restrict or ban trade in such substances). These restrictions have to be based on available scientific information, and should be “least trade restrictive.” Both the TBT and SPS (below) demonstrate what has been called “trade creep” -- a process in which trade rules limit how national governments can regulate their domestic health and environment related affairs.

Sanitary-Phyto-Sanitary Measures (SPSM): This agreement allows members to restrict trade by measures aimed at mitigating health risks (e.g. to ensure food safety and protection of human life from plant- or animal-carried diseases), but the measures have to be justified based on scientific evidence. The agreement has been used in ways that discriminate against developing countries. This is done by demanding higher standards of safety (that may not really be justified) for traded products, in effect acting as barriers to products from developing countries. The European Union (EU), for example, has imposed a tougher standard than any other nation on aflatoxin contamination of dried fruits and nuts, resulting in an anticipated loss of US\$ 670 million a year in agricultural export revenues for African countries (5).

Trade Related Intellectual Property Rights (TRIPS): The TRIPS Agreement requires members to establish minimum standards for protecting and enforcing intellectual property rights. It is unlike other WTO agreements in that it does not promote “free” trade, but protects intellectual property rights (in the form of patents), mostly held by companies or individuals in rich countries. Health concerns about TRIPS centre on the role of extended patent protection on access to antiretrovirals and other essential drugs. The agreement has been the major contributor in compromising access to anti-retrovirals in low-income countries, and has been instrumental in the catastrophic HIV/AIDS epidemic sweeping across many parts of the globe.

General Agreement on Trade in Services (GATS): This agreement imposes limited general obligations on members, who are free to choose which services to open up and which

modes of services to liberalise. It was conceived as a vehicle for the expansion of business opportunities for multinational service corporations, almost all based in high-income countries. Service businesses include healthcare itself, health insurance, education, and water and sanitation services. The experience with privatisation of public services and utilities in the last decades has generated extensive debates regarding the negative effects on the poor. These experiences have been promoted, not by a GATS regime but by policy changes in individual countries. What the GATS agreement seeks to do is to institutionalise such changes on a global scale. This would prevent countries from reversing such policies even when they feel it is prudent to do so, or when popular movements are capable of forcing such reversal.

Governance of global trade, with the consequent impact of health governance, now goes much beyond the WTO. The failure of the WTO to accommodate interests of all countries, and the repeated visible collapse of the ministerial negotiations, has prompted developed countries to look for other channels to promote global trade. Consequently, regional and bilateral trade agreements are an increasingly important part of trade and health governance. From 1990 to 2007, the number of such agreements notified to the WTO increased from 20 to 159. At present, over 250 regional and bilateral trade agreements govern more than 30% of world trade. An emerging concern related to such agreements is that they can include provisions that go beyond the WTO's provisions. In many cases, these agreements do not include the flexibilities and health safeguards available under the TRIPS agreement and can impose onerous terms in other areas as well (6). A case in point is the Indo-EU trade agreement that is at present being negotiated, where several provisions being demanded of India by the EU would impose regulations requiring stricter norms of intellectual property protection. These provisions also seek to liberalise areas such as government procurement (viz. for the public distribution system and for procurement of medicines for the public health system).

Global public private partnerships

A new family of global initiatives that have a major impact on global health governance are Global Public Private Initiatives (GPPIs). In the past two decades several hundred such initiatives have been launched, with over 100 in the health sector alone. The genesis of these GPPIs is fairly recent, dating back to the 1990s. GPPIs came to be developed based on an understanding that multilateral co-operation in the present globalised world could no longer adhere to the older principle of multilateralism that primarily involved nation states. Global partnerships were, thus, imbued with a new meaning, that involved not just nation states, but also other entities, including, prominently, business organisations such as pharmaceutical companies that work through the medium of the market. These new partnerships were further promoted by philanthropic foundations, largely located in the United States, such as the Rockefeller Foundation and the Bill and Melinda Gates Foundation. Partnerships with the private sector and civil society are thus held up as the way

to achieve what governments and the United Nations cannot manage alone (7).

This new approach was reflected, for example, in the call issued at the World Health Assembly in 1993 (8) to

mobilize and encourage the support of all partners in health development, including non-governmental organisations and institutions in the private sector, in the implementation of national strategies for health for all.

GPPIs need to be viewed in the context of an attempt to address the obvious failure of the market to deliver services and goods where most required, i.e. to the income and resource poor, while at the same time staying within the boundaries of neoliberal economic policies. They address what neoliberal economists describe as "market failures", but at the same time do not question the fundamental faith in the ability of the market to regulate the global flow of goods and services.

While GPPIs engaged in product development have received the maximum publicity, there are several forms of GPPIs in the health sector, as described below (9).

Product development: Partnerships involved in the discovery and/or development of new drugs, vaccines or other health products.

Improving access to health products: Collaborations focused on improving access and/or increasing the distribution of currently available drugs, vaccines or other health products addressing diseases and conditions neglected in target countries.

Global coordination mechanisms: Alliances that serve as mechanisms for coordinating multiple efforts to ensure the success of global health goals - often for a particular disease/condition and involving some combination of the other approaches.

Public advocacy, education and research: Collaborations focused on advocacy, education, or research on health issues.

Regulation and quality assurance: Initiatives working towards improving the regulatory environment and product quality, appropriate use of and access to effective health products that address diseases and conditions neglected in target countries.

While there has been no systematic evaluation of the impact and viability of GPPIs in the health sector, there have been several evaluations of specific GPPIs. Based on these evaluations some major concerns are beginning to emerge. The gross under-representation of Southern stakeholders in the governance arrangements of GPPIs, coupled with the Northern location of their secretariats, is reminiscent of imperial approaches to public health. GPPIs are seldom integrated in the health systems of the recipient countries and this has major implications for the sustainability of programmes, after a particular GPPI runs out its course or starts reducing support. GPPIs can allow transnational corporations to exert influence over agenda setting and

political decision-making by governments. Some partnerships can distort competition, because they provide the corporations involved with an image advantage, and also support those involved in opening up markets and help them gain access to governments (10). It is problematic for the UN to collaborate with partners whose activities contravene the UN Charter and UN norms and standards or whose activities are seen as detrimental in a particular sector. Some such instances include collaboration between the United Nations Development Programme and Shell and Coca Cola; Nestlé's involvement in the Global Compact; partnerships between the United Nations Educational, Scientific and Cultural Organization and Microsoft; and the United Nations Children's Fund's partnership with McDonald's (in 2002) (7). One can also add to this the various pharmaceutical transnational corporations who achieve legitimacy through working in GPPIs even as they cause countless deaths by denying access to their patented products at affordable prices.

The World Health Organization: time to reclaim its mandated role

As we discussed earlier, the WHO's leadership in global governance issues has been seriously compromised through the usurpation of its mandate by multiple agencies - the World Bank, the WTO, GPPIs, etc. Increasingly, there is a tendency to characterise the WHO as a "technical" agency that should concern itself only with issues related to challenges of communicable disease control and the development of biomedical norms and standards.

The WHO faces three key challenges, related to its capacity, legitimacy and resources. Its legitimacy has been seriously compromised because of its inability to secure compliance of its own decisions, which are reflected in the various resolutions passed at the World Health Assembly. Developed countries which contribute the major share of finances for the functioning of the WHO have today a cynical disregard for the ability of the WHO to shape the global governance of health. They see the member state-driven process in the WHO (where each country has one vote) as a hindrance to their attempts to shape global health governance, and prefer to rely on institutions such as the World Bank and the WTO, where they can exercise their clout with greater ease.

As with many other UN organisations, the WHO's core funding has remained static because of a virtual freeze in the contributions of member states. Its budget amounts to a tiny fraction of the health spending of high-income member states (11). In addition, a large proportion of the WHO's expenditure (about 80%) comes in the form of conditional, extra-budgetary funds that are earmarked for specific projects by contributing countries. For example, the Bill and Melinda Gates Foundation is today one of the largest single funders of the WHO, contributing more than most member countries. The recently concluded Executive Board of the WHO (in January 2011) discussed a paper by the WHO Secretariat that talked about the crisis in the WHO's finances (12). Today the WHO is sustained

through a financing system that undermines coherent planning and which forces WHO departments and divisions to compete with each other (and other organisations) for scarce funds. The consequence of this is that health priorities are distorted and even neglected to conform with the desires of donors and the requirement to demonstrate quick results to them. The WHO is in danger of being compromised because of conflict of interest issues that arise because of contradictions between the constitutional mandate of the WHO and the interests of individual donors (11).

As a consequence of the above, the WHO is inadequately equipped to reclaim its leadership role in global health governance. At the global, regional and country level, WHO offices are weak and inadequately resourced compared to the country-based offices of other international organisations and development agencies.

Need to restructure global health governance

Clearly, the global governance of health is a minefield of contradictions. It is shaped by multiple agencies and by multiple interest groups. In a globalised world this is evidently a cause for concern. While tools designed to mitigate ill health and disease are now available as never before, access to such tools is a bigger problem than ever before. A nation state driven process, premised on principles of equity, justice and sharing, is an urgent requirement if global governance of health is to be restructured to address this problem. Country governments, especially from the South, need to take the lead in rescuing global health governance from the clutches of sectional interest groups.

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Comments on the National Health Research Policy

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Health research is an important component of the process for reaching the goal of Health for All expressed in the Alma Ata Declaration. Today, 33 years after the Declaration, the goal is best expressed in terms of health systems that can provide universal access to comprehensive healthcare as well as action on social determinants of health to reduce the burden of disease and promote good health (1). The goals of health research would be:

- to better understand the causes of disease and the determinants and factors contributing to both good and ill health, including the immediate, biomedical factors and the larger social and environmental determinants of disease;
- to develop drugs, vaccines, diagnostics, prosthetics and other technologies for preventing disease, promoting good health and for curative, palliative and rehabilitative care; and
- to contribute to developing health programmes and health systems that use resources efficiently, are effective in reducing the disease burden and relieving suffering, and allow greater autonomy to communities, families and individuals in decision making on health.

The first two goals require considerable inputs from basic sciences and the third requires inputs from social and management sciences and all of them require adequate knowledge generation capacity in the health sciences. A National Health Research Policy would be a useful instrument to promote health research in order to achieve the goals of Health for All (2). The current national health research policy draft is an important development in this direction. However, more clarity and focus are needed before this document can become a guide to action.

Health systems research and health research systems

There is a disturbing trend in the draft document to use "health systems research" and "health research systems" side

by side, without adequately differentiating between these as two entirely different concepts. Health systems research is an important and much neglected dimension of health research systems, and there is an urgent need to develop this area in India. The organisation I work in is devoted entirely to health systems research, and for that reason, also, I would emphasise this component. Still, in terms of investment, health systems research is only a part of health research systems. It may attract only a small part of the total funds that flow into health research (3). A health research policy document should not lose sight of the larger area of biomedical research that it must guide. If, on the other hand, the aim is to have a policy for accelerating and giving direction to research in health systems, a health systems research policy would be welcomed, but it should not be equated with the whole of health research.

India's position in the research world

Biomedical research into disease, its causation and its treatment is not nation-specific. True, there are national priorities, but in very limited areas. Research into cancer, or cardiovascular disease, or diabetes and other metabolic diseases is part of one seamless international effort, and any health research policy in India must ensure that India aspires to be a leading contributor to such research. It is not about winning Nobel Prizes, though our failure to appear in the list of Nobel laureates need not be dismissed out of hand.

As we move, either unwisely or due to a lack of options, from process patents to product patents, we can renegotiate our position - and, indeed, the overall interests of developing nations for generic drugs and new drugs on affordable costs - only if we are in a position to contest the generation of new knowledge itself (4). Today our strength is in reverse engineering and in the Indian drug industry's ability to manufacture any molecule at very affordable costs. But the