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Crisis, Institutions and Political Economy

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International Political Economy Series
Series Standing Order ISBN 978–0–333–71708–0 hardcover
Series Standing Order ISBN 978–0–333–71110–1 paperback

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Global Health Governance

Crisis, Institutions and Political Economy

Edited By

Adrian Kay
Centre for Governance and Public Policy, Griffith University, Australia, and University of Salford, UK

Owain David Williams
Centre for Health and International Relations, Aberystwyth University, UK

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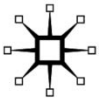

Softcover reprint of the hardcover 1st edition 2009 978-0-230-20591-8

First published 2009 by
PALGRAVE MACMILLAN

Palgrave Macmillan in the UK is an imprint of Macmillan Publishers Limited, registered in England, company number 785998, of Houndmills, Basingstoke, Hampshire RG21 6XS.

Palgrave Macmillan in the US is a division of St Martin's Press LLC, 175 Fifth Avenue, New York, NY 10010.

Palgrave Macmillan is the global academic imprint of the above companies and has companies and representatives throughout the world.

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ISBN 978-1-349-30228-4 ISBN 978-0-230-24948-6 (eBook)
DOI 10.1057/9780230249486

This book is printed on paper suitable for recycling and made from fully managed and sustained forest sources. Logging, pulping and manufacturing processes are expected to conform to the environmental regulations of the country of origin.

A catalogue record for this book is available from the British Library.

A catalogue record for this book is available from the Library of Congress.

10 9 8 7 6 5 4 3 2 1
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List of Abbreviations

AGP	Agreement on Government Procurement
AIDS	Acquired Immune Deficiency Syndrome
AoA	Agreement on Agriculture
API	active pharmaceutical ingredient
APOC	African Programme for Onchocerciasis Control
ART	anti-retroviral therapy
ARV	anti-retroviral
AUSFTA	Australia-US Free Trade Agreement
BRIC	Brazil, Russia, India and China
BWTC	Biological and Toxin Weapons
CAFTA	Central American Free Trade Agreement
CCT	conditional cash transfers
CMH	Commission on Macroeconomics and Health
ComDT	community distributed treatment
CRO	clinical research organisations
CSDH	Commission on Social Determinants of Health
CSO	civil society organisation
DALY	disability adjusted life year
DNA	Deoxyribonucleic acid
DRC	Democratic Republic of the Congo
DSB	Dispute Settlement Body
DSU	Dispute Settlement Unit
EPZ	Export Processing Zones
EU	European Union
FAO	Food and Agriculture Organization
FCTC	Framework Convention on Tobacco Control
FDA	US Food and Drug Administration
FDI	Foreign Direct Investment
FTA	free trade agreement
G8	Group of Eight
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GBD	Global Burden of Disease
GDP	gross domestic product
GHG	global health governance
GHP	global health policies
GKN	Globalization Knowledge Network
GM	genetically modified
GMO	genetically-modified organism

GOARN	Global Outbreak Alert and Response Network
GPG	global public goods
GPPP	Global Public Private Partnerships
HAART	Highly Active Anti-retroviral Therapies
HAI	Health Action International
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Syndrome
IASO	International Association for the Study of Obesity
IBFAN	International Baby Food Action Network
ICER	Incremental Cost Effectiveness Ratio
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICH	International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use
ICMBMS	International Code of Marketing of Breast-milk Substitutes
IDA	International Development Association
IGWG	Intergovernmental Working Group
IHR	International Health Regulations
ILO	International Labor Organization
IMF	International Monetary Fund
INGO	international non-governmental organisation
IO	International Organisations
IOTF	International Obesity Taskforce
IPE	international political economy
IPR	Intellectual Property Rights
ISR	International Sanitary Regulations
LE	life expectancy
LEB	life-expectancy at birth
MAP	The Multi-Country AIDS Program
MDG	Millennium Development Goal
NAC	National AIDS Council
NAFTA	North American Free Trade Agreement
NAMA	non-agricultural market access
NCD	non-communicable diseases
NCE	new chemical entities
NGO	non-governmental organisation
NHS	national health systems
NIH	National Institutes of Health
OCP	Onchocerciasis Control Programme
OECD	Organization for Economic Cooperation and Development
OFC	offshore financial centre
PBS	Pharmaceutical Benefits Scheme
PEAP	Poverty Eradication Action Plan

PEPFAR	President's Emergency Plan for AIDS Relief
PHC	primary health care
PHEIC	public health emergence of international concern
PHM	People's Health Movement
PhRMA	Pharmaceutical Research and Manufacturers of America
PRC	People's Republic of China
PRGF	Poverty Reduction and Growth Facility
PRSP	Poverty Reduction Strategy Paper
PT	Workers' Party
QALY	Quality Adjusted Life Year
R&D	research and development
SAP	Structural Adjustment Program
SARS	Severe Acute Respiratory Syndrome
SDH	social determinants of health
SDT	special and differential treatment
SPS	Sanitary and Phytosanitary Measures
SSA	sub-Saharan Africa
STI	Sexually Transmitted Infections
SWAp	sector-wide approach
TB	tuberculosis
TBT	Agreement on Technical Barriers to Trade
TINA	There Is No Alternative
TRIMS	Agreement on Trade-Related Investment Measures
TRIPS	Trade Related Aspects of Intellectual Property Rights
U5MR	under-five mortality rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNEP	United Nations Environment Program
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
UNSCR	United Nations Security Council Resolution
USSR	Union of Soviet Socialist Republics
USTR	United States Trade Representative
WBCHP	World Bank Country Health Portfolio
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WTO	World Trade Organization
WTP	Willingness to Pay

Acknowledgements

We would like to acknowledge the generous financial support of the *Security, Democracy and Public Policy* Strategic Research Program at Griffith University, which made it possible for almost all the contributors to meet for two days in Brisbane in September 2007. All of those in attendance gained much from this convivial and scholarly exchange in developing their ideas and insights into global health governance. The early and enduring support of Professor Pat Weller at Griffith was much appreciated and critical to completing our project. Thanks are also due to colleagues at the Centre for Health and International Relations at Aberystwyth University for their backing and support. Finally, as co-editors we are grateful to all the authors in this edited book for their critical, open-minded and faithful engagement with the themes and questions that we had set for them.

AK & ODW
February 2009

Notes on Contributors

Jonathan Baker is a research assistant at the Faculty of Law, University of New South Wales.

Simon Barraclough is an associate professor in the School of Public Health, La Trobe University.

Chantal Blouin is a senior associate at the Centre for Trade Policy and Law, Carleton University and a senior fellow at the Canadian International Council.

Ross P. Buckley is Professor of Law at the University of New South Wales.

Lisa Forman is a postdoctoral fellow with the Canadian Institute of Health Research and Munk Centre for International Studies, University of Toronto.

Sophie Harman is a lecturer at the Department of International Politics, City University London.

Alan Ingram is a lecturer at the Department of Geography, University College London.

Adrian Kay is Professor of Public Policy and Management at the University of Salford and Senior Research Fellow at the Centre for Governance and Public Policy, Griffith University.

Ronald Labonté is Canada Research Chair in Contemporary Globalization and Health Equity at the University of Ottawa.

Kelley Lee is Reader in Global Health at the London School of Hygiene and Tropical Medicine.

Hans Löfgren is a senior lecturer at the School of International and Political Studies, Deakin University.

Colin McInnes is UNESCO Chair of HIV/AIDS, Education and Security and Director of the Centre for Health and International Relations at Aberystwyth University.

Simon Rushton is a Research Fellow in the Centre for Health and International Relations, Department of International Politics, Aberystwyth University.

Ted Schrecker is an associate professor at the Department of Epidemiology and Community Medicine, University of Ottawa.

Matthew Sparke is Professor of Geography and International Studies at the University of Washington.

Owain Williams is a research fellow at the Centre for Health and International Relations, Aberystwyth University.

Introduction: The International Political Economy of Global Health Governance

Adrian Kay and Owain Williams

Introduction

In this chapter we seek to provide an overarching theoretical and conceptual framework for the analysis of global health and contemporary global health governance by means of an international political economy (IPE) approach. The chapter, and indeed this volume, is the first major attempt to generate an IPE of global health governance, wherein explanations of contemporary crises in global health and the contested space of global health policies are explicitly rooted in IPE. We seek to offer a corrective to what is a striking poverty of IPE approaches to this fundamental area of globality and human life, an absence which has persisted despite the almost routine linkage of new disease patterns and resource scarcity in healthcare with key features of globalisation (Fidler, 2001 and 2004; Lee *et al.*, 2002). Works on global health governance regularly footnote the centrality of economic globalisation, including how such factors as increased volumes of international trade, investment and finance are having direct and indirect effects on human health, not least in the more rapid transmission of infectious diseases resulting from trade flows and spatial compression. Similarly, and in political terms, scholars and health policy communities are increasingly sensitive to the fact that global health governance is also changing (and has arguably changed from a system of 'international' health governance) because of the increasing influence of a range of International Organisations (IOs) and economic actors with little or no previous health remit (Brown *et al.*, 2006).

This chapter develops an understanding of the relationship between economic globalisation and health in terms of a global system of disease, a concept which gives saliency to the exertion of economic forces (and a concept that we unpack later in this chapter). This global system of disease is both a pressing and novel governance challenge for states and IOs. At the outset of this volume we define 'global health governance' (GHG) as any means or mechanisms used by various public and private actors, acting at

sub-national, national and international levels, that seek to control, regulate or ameliorate this global system of disease. The term encapsulates and encompasses 'highly varied sorts of collective behaviour ranging from local community groups to transnational corporations, from labour unions to the UN Security Council' (Dodgson *et al.*, 2002, p. 6). For this volume, GHG is an umbrella concept that involves a range of governing activities, from the treatment of individual patients through to the social regulation of the structural economic drivers of ill health.

The defining mood of contemporary analyses of GHG is one of failure; a failure in GHG to meet the challenges posed by the scale and variety of problems that constitutes the global system of disease. Current diagnosis of that failure is almost always expressed in terms of a lack of political will; an inchoate health institutional architecture; organisational failure; and resource deficiency. However, this diagnosis lacks any identification of underlying causes. Instead, our IPE perspective gives centrality to economic processes and policies which explain the disjuncture between the challenge of the global system of disease *and* the nature of the response. In fact, key features of the global system of disease and the development of contemporary GHG are both increasingly driven and structured by processes of commodification and liberalisation in global health. These key features of economic globalisation also have concrete institutional and policy manifestations with regard to health, and interact with an enduring ideational alliance of neoliberalism and the bio-medical model to intensify the scope and scale of the global system of disease, whilst simultaneously emasculating the capacity of actors to respond effectively. In this respect we believe that there is a wider political economy of global health that is increasingly market driven, and that only by understanding the structuring role of this political economy can we adequately explain the disjuncture between global health needs and contemporary governance.

This chapter presents a reading of the current GHG literature that highlights two crucial shortcomings. First, whilst the GHG canon has developed alongside and as a result of globalisation, it has largely failed to ground analysis of global health issues and outcomes within the broader political economic project of globalisation. Without this grounding, the GHG literature lacks a conceptual and theoretical basis for understanding how a single global capitalist system affects the governance of health. Secondly, the literature largely portrays GHG as a system that sits outside of and seeks to respond to the particular (new) health problems in the global system of disease. There is a deep-going undercurrent in the corpus of work that views GHG as a discrete area of activity that is still driven by bio-medicine and public health objectives and ambitions. Institutions such as the World Bank, the World Trade Organization (WTO) and International Monetary Fund (IMF) still tend to be viewed as not part of the system of GHG, instead as barriers to health governance. In contrast, contributors to this volume

attest to the centrality of global economic governance institutions in creating a particular neoliberal modality of GHG.

Scholars of GHG tend to construct global health as an objective and measurable category of health status connected to risk factors that are variously cross-border, transnational and/or global in nature. These risk factors are loosely grouped under the heading globalisation, and in such terms globalisation is viewed as generating an equally loose category of global health, that incorporates a specific set of crises and problems that can be characterised as a global system of disease. Importantly, this conception is conjoined with the assumption that the governance of global health (as a set of practices and institutions) is something which sits outside globalisation processes, with the purpose of regulating or ameliorating the adverse consequences of globalisation in terms of a new and pressing distribution of (global) health risk factors. Reflecting the positivism and problem solving approach typical of public health scholarship (Lee in this volume), globalisation is conceived as either a natural, inevitable, or purely economic process whose locus is beyond the space of GHG. GHG is therefore implicitly seen as part of a separate political sphere where responses to globalisation and its associated health risks and disease patterns are developed, with varying diagnoses of success and failure.

We develop an IPE approach to GHG in response to this critique of the existing literature. Whilst great strides have been made towards connecting changes in the contemporary distribution and intensity of health risks with global health outcomes (for example Lee *et al.*, 2002; Cooper *et al.*, 2007; Taylor, 2004), what remains markedly underspecified is how socio-economic variables and economic policies *qua* health risks relate to the wider IPE, neoliberalism and the global system of disease. Importantly, it is only by apprehending these relationships that we can locate GHG in terms of a wider understanding of the causes of global health. For us, GHG is viewed as a contested space which is much broader and deeper than current scholarship acknowledges. Instead of existing in a separate sphere to globalisation, we view GHG as immanent in the critical processes of globalisation and marked by sharp divisions in policy and competing worldviews of global health which have not yet settled or reached an identifiable conclusion.

As Lee argues in this volume, GHG can be characterised by competition between different worldviews or discourses of health which have concrete material and policy manifestations, and are championed by different institutions and coalitions of agencies. These discourses shape GHG and provide the ideational and material basis for understanding how agents mobilise and respond to particular health issues. For Lee these discourses include: economism and its extension to global health policy; the pervasive and enduring influence of the bio-medical model; also new moves to cast health issues such as infectious disease in terms of security and the

language of threat and defence; and the adoption and promotion of human rights based discourses of health (and access to medicines) by civil society organisations (CSOs), states and other actors (Mann *et al*., 1999; Hunt, 2006). These discourses also represent points of fracture and faultlines in contemporary GHG, and reflect the presence of real interests and real power in determining its future direction. They work to shape and constrain health policies, and represent a terrain of what is permissible and 'sayable' about health. However, this chapter argues that one discourse of health is currently ascendant, neoliberalism. As Ingram persuasively argues in the case of HIV/AIDS, the logic and governance techniques of neoliberalism have not only colonised and co-opted a surprising range of actors involved in responding to the HIV pandemic, but also framed the manner in which HIV governance is debated and articulated. Therefore, our IPE of global health is an approach which takes the construction of identities and interests seriously and must take account of the hegemony of neoliberal ideology over health. Neoliberalism is a powerful structuring ideology which sets the parameters within which actors form their identities and interests. And beyond this it embodies a range of policy templates which can be readily applied to the health sector, and are being so.

This chapter makes two analytical steps to present its IPE approach to GHG. The first step recognises that GHG is a constitutive element of the global system of disease and its cognate, the neoliberalisation of health. GHG is one among several complex determinants of global health (Commission on the Social Determinants of Health, 2008) and thus an IPE of global health is analytically prior to an IPE of GHG. Only by understanding that GHG sits within a broader IPE of global health can we articulate the nature of the governance problem and the strong interconnectedness between that problem and the currently attenuated GHG capacity to respond. The second step in our IPE of GHG places the analytical focus on the key tensions, faultlines and competing world views of health involved in GHG. Key faultlines exist where the political economic project of neoliberalism confronts, acts upon, and is acted upon by other political economic projects, such as security, public health, and the welfare state. In this respect neoliberalism is able to 'colonise' different issues and areas of global health in different ways, reflecting its polymorphous and pervasive nature in the broader global political economy and global governance in general (Ong and Collier, 2005).

Whilst the two analytical steps in presenting our IPE of health and health governance are best understood in terms of their co-evolution, interaction and mutual constitution, their separation is heuristic, facilitating an understanding of how the broader political economy of health is structuring GHG. It is certain, for example, that the liberalising policy thrust of the WTO Agreement in Services (as well as other regional and bilateral trade deals) not only reflects a burgeoning global market for healthcare, but also

actively and explicitly seeks to foster its expansion. The WTO service liberalising regime also gives health the legitimacy of being a commodity and service that is subject to free trade rules. This policy momentum is not divorced from the interests apparent in the growth of these markets and the wider IPE of global health and other 'service' sectors. Likewise, while the WTO service regime is ostensibly 'trade-related' it is also clearly systematically 'health-related', and should be understood as part of a system of GHG rather than an exogenous pressure to such a system.

The structure of this chapter follows the two analytical steps set out above. In the first section on neoliberalism and health, we show how the neoliberal project relates to health and how it has affected distribution of health outcomes, risk factors, and the role of global economic structures in driving and shaping what we refer to as a global system of disease. Implicit in the IPE of global health is the insight that a single and all encompassing capitalist system generates externalities in terms of ill health and the global system of disease, via mechanisms such as living and working conditions (or social determinants of health), and the ability of people to access and pay for health and medicines (Commission on the Social Determinants of Health, 2008; Farmer, 2005). This section links the global system of disease to an enduring political economy tradition in which the capitalist system – at different territorial scales – supplies a basis for explaining structural divisions in wealth and poverty, with a crucial corollary in terms of peoples' health status.

The second section of this chapter interrogates the IPE of GHG, presenting the entrance of new and powerful global economic governance actors as diminishing the authority and control of the World Health Organization (WHO). We detect a tangible policy coalescence *vis-à-vis* the direction of global health policies toward commodification of health coupled with the liberalisation of health services and sectors, the steady reconstitution of the embedded liberal welfare state as it relates to health and national health systems (NHS), and its re-orientation to private health markets, private health provision, and corporate driven systems of drug innovation and supply. This analysis informs the structure of the book and section three introduces the different ways contributors have set about the analytical and critical challenge of GHG as a contested space. Chapters interrogate some the most evident counter-tendencies toward liberalisation and commodification such as national security concerns, considerations of state sovereignty over public health and the strong, continued public and union support for welfare models of healthcare provision as well as the enduring legitimacy of bio-medical knowledge and practice.

Neoliberalism and the IPE of health

The processes of the commodification and liberalisation are at the core of the contemporary IPE of health. They have historical roots in the wider

project of neoliberalism of the last three decades (Peet, 2003). The imaginative transformation of health from a concept of individual and public welfare or well-being into a commodity with an economic value and the potential to be traded in markets is characteristic of the universalising logic of neoliberalism. We observe similar patterns of transformation in many aspects of social and personal relations, changing attitudes to collective action, the nature of mutual obligations and the 'public' as well as in notions of time.

Critically, commodification allows health to be valued according to a common economic metric, and therefore able to be traded-off in a policy sense. For us, this is the key ideational dynamic at work in the IPE of health, and once we have variations in health linked to variation in the productive worth of labour, then we have a method of normalising the vastly unequal distribution of health status and access to healthcare resources across the world; processes of commodification direct existing healthcare resources and the development of future resources in favour of the diseases of the global North. The next section of global health policy making sets how economism underpins a policy framework that values health even without a market for health as when, for example, health budgets are allocated using Quality Adjusted Life Years (QALYs).

Liberalisation refers specifically to the marketisation of healthcare, and involves shifting from state modes of governance to the market mode for the distribution of healthcare provision. There is evidence that suggests that liberalisation in healthcare creates inequities in terms of access to health and health outcomes in many developing countries, with the poor unable to afford basic healthcare or medicines (Barrientos and Lloyd-Sherlock, 2000 and 2003; Hutton, 2004; Mackintosh and Koivusalo, 2005). This is also a problem in the United States, where over 50 million citizens do not have health insurance (see Lofgren in this volume). In terms of healthcare provision in Organization for Economic Cooperation and Development (OECD) countries as well as many middle-income countries, liberalisation cannot be interpreted as a simple process of market allocation substituting for public insurance as the state rolls back. This basic dualism in neoliberalism has already been substantially critiqued in discussion of the emergence of the neoliberal state (Jessop, 2002; Harvey, 2005). Contemporary IPE scholarship insists strongly on the general point that markets require creating and then policing/enforcing and this requires state enforcement (Weiss, 1998; Shaw, 2000). The concept of the liberalisation needs finessing for application to the healthcare sectors of advanced industrial countries where marketisation in certain healthcare services involves monopolies or oligopolies in supply alongside various public and publicly subsidised insurance arrangements.

An important aspect of neoliberalism in healthcare is the development of indirect techniques for leading and controlling individuals without being responsible for them. In line with its desire to privatise risk, neoliberal

healthcare states use the technique of responsibilisation; citizens become 'responsibilised' by making them see health risks and outcomes such as illness or disease as their own individual responsibility, with the corollary that the policy problem of health governance is framed as one of encouraging 'self-care'. This mirrors previous phases of neoliberalism in the labour market where the state rescinded previous responsibilities for managing unemployment and poverty, which were instead placed firmly in the domain for which the individual is responsible. We witness responsibilisation in many of the current debates in advanced capitalism over tobacco (Collin, 2004), obesity (Nestle, 2002) and access to medicines; they reveal the dominant neoliberal thrust in health, it is our responsibility to remain free of illness so as to be able to work and to care for our dependants such as children and elderly parents.

Neoliberalism has not affected all aspects of health or health sectors or indeed all countries at a single moment. Initially only some countries (mainly middle- and low-income countries) and some health sectors felt the effects of the early processes of liberalisation and commodification from the mid 1970s onwards. Pertinent for our analysis of GHG is that these changes largely occurred as a result of measures revolving around debt restructuring instigated by the IMF, and to a lesser extent the World Bank (see the chapters by Buckley and Baker, and Harman in this volume; also Cornia *et al.*, 2007). These tendencies and institutional vanguards should be viewed as precursors of a more globalised shift toward neoliberalised health and neoliberal health policies at the international and national levels. This movement has become entrenched via a combination of global health policy emerging from a range of IOs, the growth in reach of clinical services, health management and insurance transnational corporations, and nascent global markets for healthcare. It is also reflected in the changing discourses of health emergent from networks of global policy makers and in global health policies.

There are several reasons why the processes of liberalisation and commodification of health are ascendant. First and foremost, neoliberalism is both pervasive and powerful as policy template in global governance in general, and global health policy has been affected by analogy with and extension from other sectors. Neoliberalism also encompasses a range of legitimatising ideologies or mantras that promote and justify commodification and liberalisation in the case of health. These include the imperatives of competitiveness, efficiency, and consumerism and choice. Second, there is a strong profit motive in the neoliberalisation of health. Healthcare services remains the largest service sector worldwide that remains largely un-privatised, and it is clear from almost three decades in which neoliberal policies have pursued exactly this goal across a range of other industrial and service sectors that the 'exception' of health would be challenged.

The IPE of the global system of disease

There is a long tradition of political economy approaches at the national and international scales relevant to the project of understanding how the global and all-encompassing scale of the contemporary capitalist system relates to health. As yet there has been little engagement with this tradition in contemporary GHG scholarship and one of our ambitions for the volume is to encourage a corrective to this lacuna. Engels' landmark 1844 account of how mid-nineteenth century British industrial capitalism systematically generated externalities in the way of ill-health for the new urban working class (Engels, 1999) contained insights into how industrial capitalism normalised these health externalities, whilst being dependent on their persistence for capital formation and surplus profits. Engels also identified specific categories of disease associated with high rates of child mortality in the cotton mills, and rising rates of communicable diseases in urban slums. His essential insight into the connection between capitalist development, socio-economic conditions and health underpins any IPE of global health. We can see echoes of this link in contemporary work being undertaken on issues as diverse as women's health in Export Processing Zones (EPZs) (Martinez, 2004; Fussell, 2000), or child health in the piece rate textile production lines of the Mumbai slums (Tiwari, 2005).

Of course, what Engels underestimated was the capitalist system's ability to generate mechanisms to ameliorate the negative health externalities of capitalist development. In the middle of the nineteenth century, Rudolf Virchow identified the connections between poor sanitation and disease, and challenged his fellow physicians to look beyond clinical manifestations of disease to recognise and treat poverty and other social factors that underlay ill-health. These insights were central to the beliefs of the 'sanitary reformers' and the subsequent public health movement across industrialised Europe (Freedgood, 2000; Wohl, 1984). The twentieth century witnessed the development of national welfare states that sought to protect individuals against ill-health through insurance schemes, sickness benefits, subsidised access to – or the direct provision of – healthcare. The problem of contemporary GHG is the capacity of groups of states to replicate such protection when the scale of capitalist development is now a single, all-encompassing system.

Doyal (1979) marks an important step from the national to the international scale in a comparative political economy study of health and healthcare. This study of Britain and East Africa reveals how disease and recurrent health crises in the developing world should not be viewed as a 'natural' or an 'accidental' phenomenon, but as a consequence of a particular form of capitalist expansion. The presence of new diseases and poor healthcare in Africa was therefore a direct product of imperial expansion, as much as poor contemporary NHS systems reflected the character of post-colonial capitalism. Likewise, Vincente Navarro's influential *Medicine Under*

Capitalism (1977) used a dependency model to produce a macro-structural account of how underdevelopment of healthcare systems in Latin America was engendered by international capitalism, whilst critiquing industrialisation, bureaucratisation and professionalisation as the motor forces of 'normalising' the ill-health of the poor in the US.

The contemporary global political economy of health is closely linked to the operation of global markets, capitalist production and credit flows (see Schrecker in this volume for a discussion of the impact of credit on global health), and to policies at the national and international level that shape health service provision and access to health. The determinants of the global system of disease therefore have structural economic and policy drivers, as much as they have bio-medical and an individual bases. The political economy of health is anything but accidental or normal *vis-à-vis* the health externalities generated by a wider global capitalist system of social and productive relations. The global system of disease is not forwarded here as an objective category, or as a distinct epidemiologic phenomenon or level of analysis that can be measured or quantified. It is intended rather as a concept that links more closely patterns of health and disease with a single and all encompassing global capitalist system. Much of the GHG literature, whilst seeing the connectedness of trade flows and markets with health outcomes, largely resists any critique of the basic, underlying causal relationship in terms of an IPE of global health (for exceptions see Chopra, 2002; Labonté and Schrecker, 2007).

We can identify several factors that link capitalism with the global system of disease. First, in the manner that globalisation processes such as hyper-mobility, urbanisation, migration, and trade help spread disease, particularly infectious diseases. Second, in the manner that the development of new markets and the structuring of consumer demand create new patterns of non-communicable diseases and recreate older patterns of disease where markets are already established. In both these areas globalisation and global capitalism act as a form of vector for the spread of diseases (communicable and non-communicable), be it rapidly and at a new scale, or via the less rapid routes of markets and changing consumption patterns. Finally, capitalism continues to create and recreate disparities in wealth and income, and these factors have acute effects on health status and the ability of many to access health and medicines as health and health services are commodified.

The global system of disease is characterised by two basic modes of disease transmission. The first of these modes is closely tied with the relationship between non-communicable diseases, economic growth and prosperity, the expansion of certain markets, the structuring of demand, individual choices, and changing consumption patterns. It is perhaps crass to identify this mode of disease transmission exclusively with diseases of prosperity, but the association between global capitalist production,

consumption and mass markets, and the health externalities that this generates is captured by this phrasing nonetheless. Of course, the world's poor are not immune from non-communicable diseases, and many poor people die, for example, from respiratory diseases caused by exposure to wood or dung fire smoke (Delgado *et al.*, 2005), as much as they do in car and pedestrian accidents. GHG literature would point out that manifest health needs faced by those suffering from non-communicable diseases point to the need for more and better governance or regulation. However, it is precisely the powerful combination of bio-medical discourse, individualism (and choice), and interests of global capital that have stymied attempt to regulate internationally a range of potentially harmful products that influence and shape the global system of non-communicable disease. These governance and regulatory failures include the export of toxic waste, food, sugar, salt, and fat content, and even genetically modified (GM) crops. The notable exception to date is the Framework Convention on Tobacco Control, which is perhaps the one example where manifest health needs have trumped and curtailed a powerful array of economic interests associated with a particular market, consumption patterns, and the health affects that a legally traded international product is known to generate.

The second mode of disease transmission is linked to poverty, underdevelopment, the underlying structure and particular spatial characteristics of the global economy, and particularly poor levels of public health infrastructure in many countries (Paluzzi and Farmer, 2005, p. 12). An estimated 50 per cent of all deaths in the developing world result from infectious disease (and 26 per cent of deaths worldwide), with the most prevalent being malaria, water borne diarrhoea, measles, tuberculosis (TB) and HIV/AIDS (Global Health Council, 2006). Whilst statistics indicate that several decades of global economic growth has been accompanied by rising levels of life expectancy, life expectancy in sub-Saharan Africa has fallen (largely due to HIV/AIDS). Moreover, a lack of sanitation, potable water and access to medicines contribute to between 14 and 17 million deaths each year from infectious disease (Global Health Council, 2006, p. 1). The problem of infectious disease is therefore largely specific to the poor and the world's poorest regions, and naturally neither the poverty nor the persistence of the living conditions that kill the victims are accidental or normal. Whilst GHG literature stresses the impact of globalisation in terms of the rapidity or possible pandemic features of global epidemics, it is important to note how little difference globalisation has made in the global distribution of risk and health status, or even the basic access to medicines or treatment. Whilst our vulnerability in the west to pandemic threats has incontestably increased due to globalisation, and this is undeniably an important development that requires attention, governance and planning, brute statistics indicate that by-in-large the global system of disease as it relates to infectious diseases is largely an old problem: poverty causes higher rates of infection and stymies prevention and treatment.

In each mode of disease transmission we can see global capitalism as generating health externalities, not only in terms of production and credit flows, but also in terms of the manner in which that system is responsible for differences in health status and access to health by virtue of the incontestable fact that it is a system that continues to stratify people in terms of wealth and poverty (see Sparke in this volume). In addition, the contemporary neoliberal character of global capitalism has led to the systematic underdevelopment of NHS, both by means of liberalisation measures, basic neglect, or by the imposition of policy templates (from the state or other creditor international agencies) which have capped spending and curtailed healthcare capacity via austerity measures in which health (and education) are usual targets (see chapters by Buckley and Baker, and Harman in this volume).

Global health policy making

In order to articulate an IPE of GHG as an element of the broader IPE of global health we set out above, attention is given in this section to the question of how the activities of IOs are shifting the landscape of contemporary health governance in advanced industrial as well as in middle- and low-income countries. Global health policies are the critical instruments in reshaping how global health is being governed (Lee *et al.*, 2002). We identify two dimensions of global health policy: first the specific prescriptions by IOs for national health systems and second, policies concerning global trade in health-related products and services, including regulation of international healthcare supply chains and international mobility in medical workforces. The two dimensions are distinguished in order to facilitate the exposition of two key features of the IPE of GHG. The first is that the emergence of global health policy is eroding the autonomy of national healthcare systems, and playing a crucial role in rising healthcare costs, rapid but uneven advances in healthcare technology, and a source of influential ideas about public-private mixes in financing and delivery all regularly identified as key drivers of national healthcare reforms. This challenges the literature on the comparative political economy of health policy that sees national health systems as 'closed' and capable of being subjected to national control (Hacker, 2004; Giaimo, 2002; Moran, 1999). The second dimension of global health policy – how IOs are supporting the development of the commodity of health and the international production, distribution and consumption of healthcare services – allows us to tease out the salient aspects of the relationships between specific governing activities at national and global levels and the broader IPE of global health adumbrated in the previous section.

The study of global governance as a general phenomenon tends to focus on often unspecified demand by states for international institutions as solutions to transnational policy problems (Rosenau, 1999). However, in

global health policy there is now the key supply side factor of existing IOs and their autonomous agenda setting activities. This soft power alongside concrete legal and disciplinary powers backing global health policies are key mechanisms of neoliberalisation (Ong and Collier, 2005). For many scholars of IOs, compliance is no longer just a matter of carrots and sticks, or the instrumental use of organisations by key states. Instead IOs 'socialise' states and other actors into compliance, including through benchmarking and other 'ground-up' managerial methods touted by experimentalists in democratic international governance (Barnett and Finnemore, 2004). On matters both mundane and consequential – from the classification of fat-free food products to whether tourists will be warned away from their shores because of Severe Acute Respiratory Syndrome (SARS), to the public procurement of hospital services – those who exercise national authority face severe policy constraints not merely because of globalisation, but also because of globalisation's agents – including the rules and processes promulgated by IOs and other agents of global administrative law (for example see Sell, 2003 on Trade Related Aspects of Intellectual Property Rights (TRIPS)). The domestic politics of health policy is generally the 'low' politics of distribution and allocation; however it is important to note that IO-generated rules do not stay away from subjects that might be characterised as 'high' politics. The United Nations (UN) proclaims what rights governments need to respect for their citizens. Despite article 2(7) of the UN Charter, there is little left of an untouchable, sacred 'domestic jurisdiction'.

The development of a new global health policy is a key catalyst in an increasingly liberalised IPE of GHG. While political economy perspectives dominate approaches to welfare state analysis at the national level (Moran, 2000), work on global health policy has so far been confined to looking at the impacts of policy from one of the Bretton Woods institutions (that is, the World Bank, WTO and IMF) in a national health context (for example Pollock and Price, 2003). This gap in our understanding of global health policy is crucial: we miss the sources of the strong market orientated liberalising thrust (linked with economic globalisation), which is both incrementally changing the landscape of GHG and substantially re-orientating national systems of public health and NHS.

We can see the neoliberalising process in the health sector clearly in global health policy making. The Bretton Woods institutions are creating a new global health policy geared toward the liberalisation of national healthcare systems and the exigencies of a rapidly expanding global marketplace for healthcare related services. Crucially, the Bretton Woods institutions are contesting the long-standing role of the WHO, which with its public health focus sits at the centre of GHG for many scholars. There is only a limited (but influential) literature interrogating this important shift; highlights include Woodward *et al.* (2001), Schrecker and Labonté (2006),

Labonté and Schrecker (2004), Sen (2003), Buse and Walt (2000), Holden (2005) and Deacon (2007). However, it is through this nascent literature that the IPE approach to the analysis of GHG will become fully developed as we gain more cases of the struggle between neoliberalism and alternative health projects.

Whilst each Bretton Woods institution has generated a unique set of policies and institutional mechanisms for reshaping global health, we can see a policy convergence with regard to: (i) the rolling back of state authority over NHS (largely but not exclusively by means of limits on public financing); and (ii) the drive toward health sector liberalisation (largely via the introduction of competition). Importantly, these policies are crucial components of the liberalisation and commodification of healthcare. These twin processes are manifest in the emergence of a global healthcare industry, transnational patterns of investment and international markets in many healthcare services. This is changing substantially the policy context for national systems of healthcare financing and service provision. Global health policy is both affected by and acts upon the process liberalisation of healthcare provision.

In addition to pressures on the twentieth century welfare-inspired healthcare state, the international public health policy frame with its clear focus on the links between poverty and ill-health is also being contested by the emergence of a global health industry and its interest in liberalised trade in healthcare (Leon and Walt, 2000), by demands to restrict public expenditure in some middle- and low-income countries in the interests of 'good' governance, as well as economic analysis that frames population health improvements in terms of increased worker productivity and an elevated rate of Foreign Direct Investment (FDI) inflows (Alsan *et al.*, 2006).

For ease of exposition of the links between global and national health policy, we can break down the notion of 'global health policy' into three areas. These areas are where we can most clearly see a contested global health policy arena between the established WHO and its public health remit, medical expertise and institutional tradition and the Bretton Woods institutions as agents of economic globalisation taking an interest in health. Each of these three areas, outlined below, is the subject of a separate chapter in this volume.

1. The World Bank Country Health Portfolios (WBCHPs) are packages of healthcare financing and health policy reforms for developing countries. The World Bank is the single largest source of healthcare funding for developing countries, offering in excess of US$16 billion in loans between 1970 and 2000. It is able to package policy ideas and money together in a sector and country portfolio 'which would otherwise be unavailable to the Bank's low and middle-income client countries' (Gilbert *et al.*, 2000, p. 51). For some, this represents the assertion of a

liberalised IPE of healthcare where developing countries become markets for primary and secondary healthcare providers from the prosperous North (Sen, 2003; Buse and Walt, 2000). The chapter by Harman deals with this first area in much greater detail.

2. Poverty Reduction Strategy Papers (PRSPs) are documents required by the IMF and World Bank before a country can be considered for debt relief within the Heavily Indebted Poor Country (HIPC) program. They are prepared by the member countries through a participatory process involving domestic stakeholders as well as World Bank and IMF officials. They are seen by critics as imposing a liberalised IPE in areas such as health; for example by limiting public expenditure on healthcare (Gould, 2005; Labonté and Schrecker, 2004; Schrecker and Labonté, 2006). 1999 saw the joint IMF and World Bank launch of the PRSP mechanism as the successor to the popularly maligned Structural Adjustment Programs (SAPs). Despite their evident and well-documented importance both to debt and loan conditions, and thereby to state spending on services and liberalisation measures, PRSPs have received little or no systematic examination with regard to their impact on NHS and health policies (Gould, 2005). For further discussion, see the chapter by Buckley and Baker in this volume.

3. The General Agreement on Trade in Services (GATS) is a treaty of the WTO that entered into force in January 1995 as a result of the Uruguay Round negotiations. The treaty was created to extend the multilateral trading system for manufactured goods under the previous General Agreement on Tariffs and Trade (GATT) to all services including publicly financed and provided healthcare services, that is once a country has agreed to sign up to GATS for a specific service it must treat equally firms from all nations in terms of market access. The chapter by Labonté *et al*. in this volume develops an in-depth analysis of the WTO and health.

The global-national health policy nexus

We have described global health policy making as being the crucible of GHG and as a contested space; it is here that we observe the role of the Bretton Woods institutions in creating a new global health policy that is both responding to as well as catalysing processes of liberalisation and commodification in health. Whilst the GHG literature has generally treated GHG and global health as separate from national health policy, this heuristic separation is no longer tenable. The new global health policy is a key institutional mechanism linking national health policy reforms in both the OECD and, perhaps more directly, in many developing countries to the broader processes of liberalisation and commodification.

There is no single, universal type of NHS that might provide us with a critical case to study the global-national policy nexus in the context of liberalisation; at least 30 years of scholarly effort spent on creating a typology

of NHS for the purposes of comparison is testimony to the essential variations and differences involved. Therefore the global-national policy interaction is inevitably complex as well as temporally and spatially contingent. Nevertheless, in terms of the macro-scale of IPE, we can group common demand and supply side pressures on NHS which provide the context of global health policy making, and in turn delineate the connections from global health policy to national health policy making.

NHS are all experiencing problems and strains in the manner in which health is supplied, particularly in terms of the introduction of competition, burgeoning costs of (now internationally competitive) health professional salaries and medicines, the introduction or availability of new medical technologies, and in the manner in which healthcare is paid for. In both the developed and developing worlds NHS are therefore experiencing similar strains which are the result of political-economic choices in an era of globalisation: rising costs of healthcare; questions of access to healthcare; the requirements of rationing; with many financing systems under severe pressure. Certainly different states are relatively more equipped to deal with these problems of supply than others, at least in the simple terms of the economic resources available to them. Indeed, many developing countries have the additional problem of low existing levels of basic public health infrastructure and sanitation. These structural problems create additional disease burdens, and compete with NHS for the limited resources available. However, in OECD countries public expenditure on health is increasing in excess of the rate of growth of the economy even as competition and privatisation are being introduced to the system of supply, and begs fundamental questions about the role of the state in the new IPE of health. The state is certainly not disappearing as an actor in the supply of healthcare, but its role is altering incrementally nonetheless. In effect, many states (and the public) are underwriting and directly subsidising an increasingly liberalised and privately provided NHS, a transition which is often legitimised by the fact that privatisation ostensibly solves many of the problems of supplying healthcare identified above.

NHS are also experiencing pressures resulting from both global and local systems of demand for health. At the level of states, demand problems are witnessed in terms of user expectations and the income elastic demand for healthcare in an era of a booming world economy. In the latter case, wealth simply produces new sets of diseases, or even the perception that new types of health products and treatments are vital and necessary. Indeed, the health economists' foundational assumption of an unlimited demand for healthcare seems to be robust across time and space. The system of demand for health is now also globalised, particularly when one considers specific health markets such as dentistry and cosmetic surgery, and, more obviously and widely, in the area of pharmaceuticals for which there are often no local alternatives. These globalised markets for

healthcare services and products are thereby reorientating certain sectors of NHS toward a globalising system of demand for health. The globalising structure of demand for health also features in the mobility of health sector professionals, where problems associated with the supply of necessary human resources (arising from training costs and so on) interact with demand (in the form of international differences in wages) to create crises in the many NHS that are being effectively hollowed out of indigenous personnel. The global demand for health also sits uncomfortably with the fact that the poor are less able to pay for, and often need more, a supply of basic healthcare and state funded NHS. This in turn tiers outcomes in the global system of disease, and means that changes in NHS are now more often than not responding to a demand structure that is economically driven rather than by basic health needs.

Importantly, healthcare services have become a major export revenue source for many OECD countries. The consequences of healthcare services, medical technology and medical devices becoming accepted as tradable commodities, and as part of the market rather than as public goods, are that generalised pressures for increasingly liberalised world trade impact directly on the national organisation of healthcare delivery. There is an inchoate literature developing the themes of health sector liberalisation and the degree of national sovereignty that can be retained over NHS (Ollila and Koivusalo, 2002; Sen, 2003; Pollock and Price, 2003; Collin, 2004).

The demand and supply side factors noted above provide the context for the transformation of GHG itself. Global health policies emerging from this system are exacerbating the problems associated with the system of supply, and in many instances in developing countries, actually limiting the policy responses to health crises and directly determining the levels of funding that can be committed to NHS. Global health policies are also introducing competition to NHS, often in specific sectors and in an incremental fashion, and limiting the ability of states to regulate in areas of public health such as product and food standards. Likewise, global health policies are interacting with global demand for health, both in terms of liberalising the global health market and the selective movement of skilled health personnel, and across specific sectors of individual country NHS. Moreover, the WTO's TRIPS has ensured that the movement of key technologies and health products across global markets are protected in terms of pricing, and that monopolies over certain areas fundamental to life can be retained, notwithstanding differentiation in terms of need and ability to pay or the scale of market reach. Moreover the transfer of medical knowledge and research lines can be stymied or actively blocked. In short, GHG and policies are, again, viewed as creating problems, and as central to the crises in the global system of disease and NHS.

We reject geometric metaphor of vertical layers of governance, in which economic activity with profound health impacts takes place unregulated 'above' the nation state. In GHG there is no clean distinction between the national and international; instead GHG is blurred and porous and the edited volume contained accounts of actions by NGOs with international healthcare companies, the agenda of Corporate Social Responsibility in healthcare, IOs activities and so on. This governance is neither state nor non state; not global or local but both; and not really below the state or above it. Instead this is recognition of the transactional nature of GHG. The next section describes how contributors to this volume contribute to understanding this complex, messy GHG.

The structure of this book

This volume is structured in two parts. Part I examines the politics of GHG, understood as the formal international organisational remits with regard to public health. We see this as encompassing an older form of GHG that is associated with international public health traditions and objectives, as well as the emerging security agenda with respect to infectious diseases. Part II represents the alternative worldview of health discussed above, namely a powerful drive towards the creation of liberalised global health markets and the support of a global health industry. Whilst these pivotal dimensions are often indivisible and interact around specific health challenges and global health policies, their separation in the volume is an analytical device for capturing the key tensions apparent in contemporary global governance.

Opening Part I, Chapter 1 by Kelley Lee takes its cue from increased disciplinary convergence on the transformation of international public health to a global public health paradigm. On the one hand, this shift is a reflection of political and economic globalising forces that have fundamentally changed the nature of health problems (spatial mobility, compressions, trade, rapid urbanisation) and the manner in which they are articulated. On the other hand, we currently lack the governance capacities to respond adequately to these new and developing challenges. Lee sees the contemporary international politics of global health as a highly contested space that as yet has reached no identifiable settled set of arrangements.

In Chapter 2, Colin McInnes examines what has been labelled the securitisation of health and a growing body of academic and policy literature that views health, first and foremost, as a national security problem. The chapter describes how this has transformed infectious diseases from principally bio-medical issues requiring technical solutions and health interventions to global issues that now sit at the top table of high politics. In many senses the securitisation of HIV and other infectious diseases can be viewed as a reassertion of the state-based agenda in terms of global health,

with an emphasis on failing states, state capacities, military capability and border controls. Thus the securitisation of infectious diseases provides an exemplar of the tensions apparent in the largely market orientated and liberalising IPE of global health.

The WHO is the principal international organisation with a health governance remit. However, Simon Rushton sets out in Chapter 3 how the WHO has been widely criticised for both having insufficient capacity to respond to global health problems and crises, as well as too much authority over national public health systems. The chapter shows how the case of SARS encapsulated the tensions that lie between the need for effective capacities to deal with pandemics that have no borders, and governance of health at the global level and the obstacles that still stand in its way. Whilst the case shows that infectious disease crises never leave GHG capacity unchanged, the policy learning from such crises often involves reasserting state control at the expense of WHO. The chapter sets out how the state remains a powerful agent in both public health policy and the broader IPE of GHG.

The global fight against HIV/AIDS has acted as a focal point around which the technical, bio-medical, institutional and economic dimensions of GHG have crystallised. Alan Ingram in Chapter 4 shows how this dominant global health issue exemplifies the sharp divide between a manifest health need and global responses to health crises. Despite ostensible and voluble political will to tackle the problem and the creation of institutions, and multi-annual commitments of billions of dollars, the global governance of HIV/AIDS is still characterised not only by a plethora of international organisations (often working in tension with each other) but by the persistence and escalation of the pandemic. The HIV/AIDS case reveals much about the tensions apparent in the contemporary IPE of GHG and why those tensions continue to frustrate an effective system of global governance.

Chapter 5 by Simon Barraclough explores the governance challenges posed by chronic diseases. In terms of the IPE of global health, chronic diseases serve to frame many of the choices and tensions apparent in responses to health challenges. First, many of the diseases (such as obesity, cardiovascular disease, and cancer) are the direct results of individual choice and consumption patterns, making the tension between nationally grounded public health regulations, individual choice, broader global trade flows and changing global consumption patterns apparent. Second, chronic diseases are now overtaking infectious diseases and malnutrition in the mortality and morbidity rates of many middle-income developing countries (and this is already the case across the developed world). Third, chronic diseases bring into play other discrete tiers of global governance and institutions not directly associated with health, such as food regulations and product standards. Barraclough compares the cases of food and tobacco – two of the principal causes of a range of increasingly prevalent chronic diseases. The landmark Frame-

work Convention on Tobacco Control (FCTC) has successfully provided the first tentative move to a system of governance and regulation of a harmful consumer product on a global basis. Could the Convention supply a similar template for action on food?

Matthew Sparke introduces Part II of the book on the economy of GHG by unpacking the concept of economism in Chapter 6. He uncovers three main economisms which act as rationales for the allocation of healthcare resources globally, with material impacts on global health investments and aid flows, state health policies, and in terms of what is conceived as possible with regard to the provision of healthcare. Sparke subjects the intellectual assumptions about the nature and value of health in each of the three economisms to critical analysis and traces their implications for GHG.

Ted Schrecker delineates the direct and indirect affects on health of the international financial system in Chapter 7. Credit is often vital for people who seek to access health and are required to pay, capital flows can have severely detrimental effects on state spending on NHS, and capital mobility further constrains the ability of states to create social, environmental or health policies which might impinge on firms. This 'implicit conditionality' has a role in disciplining states, and is an effective if tacit tool in ensuring conformity to a broadly neoliberal policy paradigm not least in terms of pollution and labour standards to name a few important areas for human health (Griffith-Jones and Stallings, 1995).

Chapter 8 by Ronald Labonté, Chantal Blouin and Lisa Forman provides a critical and in-depth commentary on how ambitions for trade liberalisation have affected access to healthcare. Two agreements are paramount: the WTO's GATS agreement, which locks in privatisation in committed sectors and is likely to increase globally the depth of private financing and provision of health; and the WTO's TRIPS agreement (and more recent 'TRIPS-plus' bilateral and regional agreements) which decreases access to essential new medicines in many parts of the world by extending patent protection. Whilst health services liberalisation is viewed by many as a voluntaristic action for members of the WTO (with GATS recognising the sovereignty of NHS), the services negotiations form part of a broader picture whereby health is being subjected to corporate and liberalising pressures.

In Chapter 9, Ross Buckley and Jonathan Baker focus on how the IMF's governance role as guardian of international fiscal stability has created a pressure in select countries, most notably developing ones, to limit or cap health budgets. The IMF has traditionally viewed inflation as the principal enemy of economic stability and thereby national and global economic growth. Historically, via austerity measures linked with SAPs and latterly PRSPs, the IMF has been instrumental in scaling down national health expenditures and thereby the provision of state based health services. The

chapter will provide an assessment of whether the introduction of PRSPs has significantly altered this picture.

Sophie Harman surveys how the World Bank has become a significant actor in GHG in recent decades in Chapter 10. More recently, the Bank has significantly ramped up its funding of health projects, broadly working on the health-poverty nexus, but particularly in HIV/AIDS programs. However, the chapter evaluates two of the main criticism of the Bank's role in global health. First, the continued strain placed on fragile public health systems by the burden of debt. The second criticism revolves around the Bank's role as a provider of guidance for national economic governance and planning, specifically in terms of how certain services are provided.

Finally, in Chapter 11, Hans Löfgren employs the concept of the competition state to portray the alliance between transnational corporations and state actors in response to the perceived challenge of competitiveness in a global market. The chapter views developed countries as the often active partners in the generation and commercialisation of knowledge and technology as it is applied to health. In particular, huge funding programs as utilised by agencies such as the EU are targeted at biotechnology and nanotechnology, or stem cell and basic life sciences research. However, it is largely a cluster of corporations who commercialise and control that knowledge when it reaches the global market. The chapter explores how an emerging structure of oligopolistic control is further facilitated by national and now globalised rules governing patents. The access to medicines debate and TRIPS have been most concretely expressed in the case of anti-retrovirals (ARVs) and HIV/AIDS. Löfgren reflects on the patent system as representative of a broader structure under which knowledge and technology related to health are being controlled.

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Part I

The Politics of Global Health Governance

1

Understandings of Global Health Governance: The Contested Landscape

Kelley Lee

Introduction

The geographical redistribution of malarious mosquitoes as a consequence of global climate change; the spread of meningococcal disease among pilgrims to the annual Hajj pilgrimage; the spread of resistance as a result of irrational use of antibiotics and other drugs; the implications for access to essential medicines of trade measures protecting intellectual property rights; the worsening of the tobacco pandemic as a result of the global restructuring of the tobacco industry; the weakening of health services in very poor countries as a result of health worker migration – all of these issues, and many others – have come to define a rapidly expanding agenda known as *global health* (Lee and Collin, 2005). Global health is now among the fastest growing fields, as reflected in the rapid expansion of teaching, scholarly research and policy initiatives worldwide.

While the importance of global health is receiving unprecedented attention, there remains widespread dissatisfaction with the existing institutional arrangements underpinning collective actions to address the challenges faced. Global health governance (GHG) has received intense and ongoing scrutiny. Donor governments lament the inefficiencies arising from overlapping mandates, inadequate coordination, duplication of effort, and alleged nepotism within the World Health Organization (WHO) and other international organisations concerned with global health. Developing country governments point to the top-down imposition of donor priorities and high transaction costs in dealing with multiple donors. Civil society organisations (CSOs) draw attention to the lack of transparency and accountability of the World Bank, Gates Foundation and other major players, uncritical proliferation of public-private partnerships, and imbalances in power between health advocates and powerful vested interests. Finally, existing institutions that are currently tasked with addressing global health issues cite the lack of resources, short term commitment by donors, and political interference as fundamentally undermining their capacity to act

(Lee and Fidler, 2007). Overall, there is a strong sense on all sides that GHG is inadequate at best, and dysfunctional at worst (or as the introduction to this volume suggests, the *zeitgeist* is that of failure).

This chapter seeks to reframe current debates on GHG by focusing attention, not on the various manifestations of dysfunction that have become so familiar, but on underlying differences in perspective about what agreed goals should be achieved in global health, and how to pursue them most effectively. Rather than further documenting the symptomatic weaknesses of current institutions, this chapter argues the need to more fully understand how GHG is a contested landscape divided by conflicting ideas, institutions and interests, not only within the realm of global health but within the global political economy as a whole (Cox, 1987). In this sense, any debate about the future of GHG must begin with a critical analysis of the normative basis of its study and practice.

This chapter begins by challenging the strong positivist tradition in the history of public health from which thinking about global health has emerged. Four major perspectives – and the institutions, ideas and interests behind them – are then described as defining much of the contested landscape currently comprising GHG. It is this contested landscape that the remaining chapters of this book seek to illuminate, involving new actors and a powerful array of competing agendas and global health policies (GHPs).

The normative basis of global health

Public health has had a long and, at times, bumpy journey towards clear definition and recognition as a distinct field of study and practice. Enduring notions of public health derive from historic events such as John Snow's famed removal of the Broad Street pump handle to demonstrate its causal connection to a cholera outbreak in London in 1854. Over a century later, the WHO's official declaration of the worldwide eradication of smallpox on 26 October 1977, marked perhaps the greatest achievement in public health history. Such events have contributed to an established notion of public health as a field concerned with such practical matters as sewers and vaccinations.

In reality, there have been ongoing debates about the precise parameters of public health. The most basic distinction is that *clinical medicine* concerns the health of individuals, while *public health* addresses the health of populations. Beyond this, there are wide-ranging perspectives about the determinants of population health, how to promote health and prevent disease, and even what constitutes health. For example, the bio-medical focus of traditional notions of *public health medicine* derives from the medical training of its foot soldiers. In more recent times, as Stanwell-Smith (2001) writes, the distinction between public health medicine and public health has become subtle, with the former giving way to the latter's recognition of the need to address the

broad determinants of health. The definition of public health by Childress *et al.* (2002) succinctly captures the complex range of factors that influence and shape population health:

> Public health is primarily concerned with the health of the entire population, rather than the health of individuals. Its features include an emphasis on the promotion of health and the prevention of disease and disability; the collection and use of epidemiological data, population surveillance, and other forms of empirical quantitative assessment; a recognition of the multidimensional nature of the determinants of health; and a focus on the complex interactions of many factors – biological, behavioural, social, and environmental – in developing effective interventions.

As part of this broadening of public health perspectives, there has been increased attention to ethical and moral issues in public health including the normative debates underpinning decision making and practice. In his review of this rich and growing body of literature, Coughlin (2006) distinguishes between deontological and utilitarian theories of moral reasoning in public health. Deontological (or Kantian) theories 'hold that people should not be treated as a means to an end and that some actions are right or wrong regardless of the consequences'. In contrast, utilitarian theories 'strive to maximize beneficial consequences … the principle of utility is the ultimate ethical principle from which all other principles are derived'.

The extension of public health to the global level has included such ethical and moral reasoning, although such debates have rarely been explicit, and there has been limited analysis of their influence in shaping the global health agenda to date. For this purpose, the remainder of this chapter outlines four key perspectives which have shaped GHG to date: bio-medicine, economism, security and human rights. It is argued that, within each perspective, certain institutions, ideas and interests act as 'push' factors in collective efforts to address global health challenges. In this way, analysis of GHG must go beyond views of global change as 'pull' factors that are responded to objectively and rationally, to understand how normatively-based and contested views of global health have shaped the emerging nature of the GHG landscape.

The bio-medical model: global health as a magic bullet

A wide range of belief systems and disease theories characterised medical practice until the mid nineteenth century, embracing religious ideas, folk medicine and blatant charlatanism (Rosen, 1993). In Europe and, over time, spreading to other parts of the world, this diversity shifted towards a growing acceptance of the bio-medical model. This model was based on the

rapid growth of scientific research, observation and technology from this period which emphasised a mechanical approach to disease and the human body. This led to a focus on physical processes, such as the pathology, bio-chemistry and physiology of a disease. The result is a reductionist approach to health which views illness as resulting from physical causes such as infection or injury. As the introduction to this volume argues, there is also good reason to believe that such atomised, individually grounded and reductionist approach sits neatly with many of the assumptions and policy approaches to health that neoliberalism has generated.

The bio-medical model has undoubtedly brought untold benefits to the diagnosis and treatment of disease by contributing to key understandings of the biology of why disease occurs and how it can be effectively treated. The ascendance and eventual domination of the bio-medical model was driven by key developments in medical knowledge and practice including early public health interventions – the improvement of public sanitation notably water supplies, mass vaccination campaigns, use of antibiotics, mass disease campaigns based on the belief that scientific interventions – drugs, vaccines, bednets – held the key to the improved health of individuals and populations. From this perspective, public health medicine has been seen as firmly located as a sub-discipline of clinical medicine based on the principles of the natural sciences (for example biology, bio-chemistry).

The post Second World War period brought a sense of desire and optimism for improving world health. Medical knowledge and practice was advancing rapidly including the mass production and use of penicillin, streptomycin (to treat tuberculosis (TB)) and other antibiotics. New vaccines offered the potential to prevent and control diseases which caused substantial morbidity and mortality. The identification of the structure of DNA (Deoxyribonucleic acid), the genetic blueprint to the development and functioning of all known living organisms, by Francis Crick and James Watson in 1953 opened up the study of diseases caused by defective genes. As science marched forward, so too did expectations of what international health cooperation could and should achieve. The basic argument is that, with the right scientific tools, health interventions will lead to improvements in population health, and what was needed was the institutional and technocratic bases for achieving international cooperation in these areas on an international level.

Despite efforts by the advocates of social medicine to incorporate a broad approach to health and disease, as incorporated in the definition of health in the Constitution of the WHO as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', the bio-medical perspective remained dominant. The mounting of mass disease campaigns against yaws, malaria, smallpox and other diseases were largely based on the availability of 'magic bullets' or medical technologies (that is insecticides, vaccines, antibiotics). So-called 'vertical programmes'

were mounted that would tackle one disease at a time using this scientific arsenal.

The principles of social medicine enjoyed a revival from the late 1960s amid disappointing health gains from some disease campaigns. There was also increasing awareness of the limited capacity of health services to take over such campaigns in the developing world, casting doubt that they were likely to be time limited. Longer term strategies were recognised as necessary to improve health than the targeting of individual diseases. As part of efforts to tackle the broad determinants of health, defined as 'the range of personal, social, economic and environmental factors that determine the health status of individuals or populations' (WHO, 1998), international health cooperation began to focus on addressing the causal (that is upstream) factors contributing to health status, rather than treating the direct (that is downstream) manifestation of ill-health. The primary health care (PHC) approach and Health for All movement were part of this paradigm shift (see the human rights perspective below).

This revival of social medicine, however, proved relatively short-lived. By the early 1980s, comprehensive PHC had given way to debates about its affordability notably in the developing world. International health policy, driven by 'powerful rivalries' between WHO and the UN Children's Fund (Muraskin, 1998), became deeply divided. As pressures on national health spending by governments intensified – prompted by events such as the oil crisis and global economic recession, and also the rise of neoliberalism – support for targeted interventions known as 'selective' PHC won the day. United Nations International Children's Emergency Fund (UNICEF), along with the Rockefeller Foundation, pushed for the creation of the Task Force for Child Survival, Child Vaccine Initiative and Global Polio Eradication Initiative. Critics argued that this was simply a return to approaches based on a misplaced reliance on 'magic bullets'.

Since the mid 1990s, the bio-medical model has underpinned many new global health initiatives. While disease-focused vertical programs have remained a firm fixture in international health cooperation, the substantial increase in funding since the latter half of the 1990s has largely been to develop technical solutions to address them. The spate of global public-private partnerships, for example, includes a large number of arrangements seeking to develop new vaccines and drugs. Similarly, initiatives such as the Global Fund to Fight HIV/AIDS, TB and malaria, WHO's '3 by 5' Initiative, and the US President's Emergency Plan for AIDS Relief (PEPFAR) all seek to increase the provision of anti-retroviral treatment in the developing world. Laudable as a goal, in itself, critics have argued that the delivery of anti-retrovirals (ARVs) alone overlooks the need to address the underlying social factors enabling the HIV/AIDS pandemic to continue to spread (see Ingram in this volume for a more indepth discussion of HIV strategies and programs). As Anthony Fauci (2007), senior advisor to the Bush Administration, reported,

'For every one person that you put in therapy, six new people get infected. So we're losing that game, the numbers game … [the disease is] running out of control in parts of Asia and Africa.'

Perhaps the most prominent embodiment of the bio-medical model in GHG has been the Bill and Melinda Gates Foundation which is now the largest funder of global health research. It is also very poorly researched and understood. Its Global Health Program concentrates on: (a) access to existing vaccines, drugs, and other tools to fight diseases common in developing countries; and (b) research to develop health solutions that are effective, affordable, and practical. Its major goals of finding a vaccine for HIV/AIDS and eradicating malaria reflect its vision of the grand challenges in global health based on a faith in bio-medical science. However, the Foundation's pursuit of these goals, backed by unrivalled financial resources, has come under increasing scrutiny, not only for potentially distorting the global health agenda towards bio-medical research (Birn, 2005), but according to Arachi Kochi, head of WHO's malaria program, stifling a diversity of views among scientists (McNeil, 2008).

Overall, the bio-medical perspective has remained pre-eminent in international health cooperation, and is firmly embedded in emerging forms of GHG. The singular attractiveness, to funders and their constituents, of developing and applying scientific and technical interventions to tackle major diseases, makes it unlikely that this will change. The limitations of the bio-medical model, when it leads to the neglect of the social factors contributing to health and disease, have been as prominent as its successes.

Utilitarianism in action: the rise of economism in global health

Alongside the bio-medical model, global health has featured a strong streak of utilitarianism in the form of economic rationalism for increasing political attention to, and resources for, certain issues. The economics of healthcare became a key policy issue in both industrialised and developing countries from the 1980s, reflecting shifting ideas about health financing and service provision. In the developing world, the ascendance of the World Bank in health development heralded the spread of neoliberal-based health policy. User fees, contracting out, and private financing were among the policy measures introduced as part of structural adjustment programs (SAPs) (see Harman in this volume for examples of these policies and their effects on specific programs and countries).

The widespread criticism of the policies associated with the so-called Washington Consensus eventually blunted enthusiasm for the indiscriminate downsizing of the state, and introduction of market forces in the health sector, but economic rationalism has remained a core driver of global health policy. A key example of this perspective is the Global Burden of Disease project by Harvard University academics in collaboration with

the World Bank and WHO. The core concept of the first report, published in 1990, was the disability adjusted life year (DALY), a measure:

> to quantify the burden of disease. DALYs for a disease are the sum of the years of life lost due to premature mortality (YLL) in the population and the years lost due to disability (YLD) for incident cases of the health condition. The DALY is a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of 'healthy' life lost in states of less than full health, broadly termed disability. One DALY represents the loss of one year of equivalent full health (WHO, 2008).

In calculating this measurement, now used widely as the means for weighing the relative importance of specific health conditions, higher value was given to individuals, and their years of life lost, who are the most economically productive. Correspondingly, the very young and old are assigned lesser values given that they are seen as less economically productive members of society. This perspective contrasts, for example, with human rights approach which assigns equal value to all individuals regardless of their economic utility. As the editors of this volume suggest, economism is not simply about rationing health, but represents the wider process by which health is commodified. Thus, while it may be argued that measures of the Global Burden of Disease (GBD) may be legitimate bases for policy decisions about the allocation of health resources, its particular normative starting point has become obscured by the quantitative nature of its evidence base.

Another prominent example of this perspective has been the creation of the WHO Commission on Macroeconomics and Health in 2000, composed of 18 of the world's leading economists, public health experts, development professionals and policy makers under the chairmanship of Jeffrey Sachs. Its laudable goal of encouraging increased investment in cost-effective interventions to address major diseases takes as its starting point an economic utilitarian perspective. In an effort to 'change the way the world thinks about health and development', Brundtland (2000) argued that:

> to reach the minds of those who hold sway over real financial and political power, we … have to communicate in a language that these decision makers understand. Good health is intrinsically important in its own right. But we cannot ignore the fact that governments will take more notice when faced with robust evidence showing the true economic impact of avoidable illness.

The evidence put forth by the Commission has been influential in generating support among the Group of Eight (G8) countries for the creation of

the Global Fund to Fight HIV/AIDS, malaria and TB, as well as the prominent inclusion of health in the Millennium Development Goals and International Finance Initiative. As Sachs argued:

> Aid works, when it is practical, targeted, science-based and measurable .... If the donors would help Africa to fight disease and to achieve a Green Revolution as occurred in Asia, we could get past these seemingly endless debates by enabling Africa finally to escape from the trap of extreme poverty (Sachs, 2005).

While increased commitment to tackling these major diseases have been largely welcomed, civil society organisations have raised concerns that the use of economic rationalism has prioritised certain population groups at the expense of others. For example, the longstanding neglect of prevention and treatment strategies for paediatric HIV/AIDS has been attributed in part to the focus on adult populations who are most economically productive. Similarly, countries deemed more economically important to donor governments, notably the so-called BRIC (Brazil, Russia, India and China) countries, receive disproportionate attention. Another criticism of Sachs' theory of development is his neglect of the structural factors underlying poverty led by inequalities in power. As Broad and Cavanagh (2006) write:

> It is not a matter of 'cleaning up' disease; even healthy people are easily pushed back into extreme poverty when the deeper structural roots of poverty are not dealt with. That 'ladder of development' is actually a complex, multidimensional maze of power relations.

In a similar way, economic utilitarianism has underpinned the broader rise of so-called 'Third Way' politics in global health which seeks to find a middle ground between traditional left (state interventionism) and right (*laissez faire* market liberalism) wing politics. Within the health field, this approach has supported the rapid growth of public-private partnerships as a response to perceived failures by the state and market. This political pragmatism, reminiscent of late Chinese Chairman Deng Xiaoping's famous words to reconcile socialism with capitalism ('It doesn't matter what colour the cat is, as long as it catches the mice') has led to global public-private partnerships to address, for example, inefficiencies in the provision of healthcare financing or service provision, and insufficient investment in drug development for neglected diseases. However, the proliferation of Global Public Private Partnerships (GPPPs) to date has far outpaced critical assessment of their appropriateness and effectiveness at fulfilling public interest functions traditionally provided by the state. Questions have also been raised about their accountability, transparency and sustainability (Buse and Harmer, 2007). Overall, these moves toward liberalisation of health markets, the policies which stress partnership with industry and the private sector, and

the vaunting of a so-called middle ground in global health, reflect the steady and incremental ascendancy of neoliberalism in health.

Finally, increased attention to, and resources allocated for, global health since the late 1990s have been focused on selected issues, namely acute and epidemic disease outbreaks with potentially serious economic impacts. The Severe Acute Respiratory Syndrome (SARS) outbreak of 2002–03 demonstrated how public fears of a global pandemic, fuelled by the mass media and scientific uncertainty, can have wide reaching albeit short term economic effects. This can occur regardless of the actual resultant number of cases and deaths. The outbreak led governments, international organisations and major corporations to review their preparedness for such events. This new sensitivity has defined the global response since 2003 to avian influenza and its potential to cause a new influenza pandemic. The public health threat of pandemic influenza, and the need for improved preparedness, is real. The policy measures taken to date, however, aim to minimise the disruption to the global economy rather than protect public health as a whole (Lee and Fidler, 2007, and Rushton in this volume).

In summary, economic utilitarianism has been an influential perspective in contemporary GHG, deployed deliberately or less consciously to raise the priority given to global health issues by ministries of finance, multilateral investment banks, donor governments and the corporate sector. The normative basis of this perspective, notably how it prioritises certain health issues or population groups over others, however, needs to be more fully recognised.

The institutionalisation of fear: the global health security agenda

The first half of the 1990s was a low point in international health cooperation, marked by unprecedented criticism of WHO and declining levels of health sector aid. This was accompanied by sobering statistics about the decline in public health systems worldwide, and the spread of emerging and re-emerging diseases such as HIV/AIDS and TB amid rapid changes resulting from globalisation. For those concerned with health development, a strategy for reengaging policy makers was urgently needed.

This period also witnessed the end of the Cold War which gradually shifted policy attention to defining a 'new security agenda'. Public health leaders recognised this as an opportunity to regain the attention of high-level policy makers. This strategy has been most prominent in the US where growing fears of biological weapons and emerging diseases in the 1990s were heightened exponentially by the events of 11 September 2001. Reports by the Rand Corporation (Cecchine and Moore, 2006) and US National Intelligence Council (2003) added to the links increasingly drawn between security and global health. At the international level, WHO Director-General Gro Harlem Brundtland's diplomatic offensive to raise the profile of

global health sought to locate global health as part of this new security agenda:

> [W]e need to redefine the notion of security in the age of globalization. Today I will be responding to that message by saying: Yes – it is high time to revisit the notion of security and fully appreciate the role of global health for the future of your country and the entire system of international cooperation (Brundtland, 1999).

Her successors have continued this line argument. Recognising the leverage to be gained through the security perspective, the theme for World Health Day 2007 and the *World Health Report 2007* under Margaret Chan was international health security defined in terms of disease outbreaks:

> We live in a world where threats to health arise from the speed and volume of air travel, the way we produce and trade food, the way we use and misuse antibiotics, and the way we manage the environment. All of these activities affect one of the greatest direct threats to health security: outbreaks of emerging and epidemic-prone diseases (Chan, 2007).

As described by McInnes in this volume, the definition of security in global health is in terms of whose security and what this entails. Nonetheless, the term has been effective at raising the profile of selected global health issues, namely acute epidemic infections and biological weapons. This, in turn, has led to greater efforts to strengthen preparedness for public health emergencies such as a potential influenza pandemic or bio-terrorism attack. While some believe that new funding and political priority to this narrow range of global health issue has been useful at leveraging greater commitment to strengthening public health systems as a whole, others remain wary that the security perspective is distorting resource allocation in ways counterproductive to public health goals (Feldbaum *et al.*, 2006). Despite these concerns, the security perspective has remained a powerful influence in GHG, also pointing to the resilience of the state at least in one dimension of the largely liberalising thrust of the contemporary international political economy (IPE) of global health.

Health for all in the global village: social medicine in the 21st century

> It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for (former United Nations Secretary General, Kofi Annan as quoted in WHO, 2002).

A fourth perspective, rooted in the traditions of social medicine, holds that 'the enjoyment of the highest attainable standard of health is one of the

fundamental rights of every human being' (WHO Constitution, 1946). United Nations High Commissioner for Human Rights Mary Robinson (as quoted in WHO, 2002) defined the approach in this way:

> The right to health does not mean the right to be healthy, nor does it mean that poor governments must put in place expensive health services for which they have no resources. But it does require governments and public authorities to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time. To ensure that this happens is the challenge facing both the human rights community and public health professionals.

This perspective is perhaps the most formally embedded in international legal instruments, spurred in large part by atrocities carried out during the Second World War. Health-related legal agreements include the International Covenant on Economic, Social and Cultural Rights (1966), International Convention on the Rights of the Child, and the Alma Ata Declaration on Primary Health Care followed by the Health for All by the Year 2000 initiative agreed in 1978. A human rights approach, led by director of WHO's Global Programme on AIDS Jonathan Mann, was an important impetus for the broadening of international responses to the disease which eventually led to the creation of Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996.

While formally embodied in the above, and other international agreements, advocates of the human rights perspective face persistent challenges in the implementation of health rights. The appointment in 2002 of Paul Hunt as Special Rapporteur on the Right to Health by the UN Commission on Human Rights has been intended to raise attention to the importance of human rights in tackling such public health issues as poverty, neglected diseases, health equity, and discrimination and stigma (Hunt, 2006). The issue of access to essential medicines, for example, has been underpinned by a belief that all people, regardless of ability to pay, are entitled to the drugs needed to maintain health and well-being. Similarly, the People's Health Movement (PHM) has sought to reignite the spirit of this agreement in the wake of persistent global health challenges. Its *Global Health Watch* report has been intended as an alternative, human-rights based perspective, drawing attention to persistent health inequalities.

Conclusion

This chapter begins to describe how contemporary GHG is comprised of diverse and, at times competing, perspectives. While globalisation poses clear challenges for the public health community, the collective actions in response have been influenced by how these perspectives privilege certain interests, institutions and ideas. Much of the literature on GHG has

frequently identified the operational and technical shortfalls of current institutions, highlighting problems of inefficiency and ineffectiveness in the form of poor coordination and duplication of effort, neglect of certain issues or populations, or mismatch of resources with health need (for example 10/90 gap). Other studies have drawn attention to broader issues of global governance such as problems of transparency, accountability, leadership, and appropriate roles by state, market and civil society actors.

This chapter argues that these problems are symptomatic of deeper contestations within GHG among competing perspectives that, more often than not, remain implicit rather than explicit. Four of these perspectives – bio-medicine, economism, security and human rights – dominate contemporary debate. How GHG has been problematised, in turn, varies across these perspectives. For example:

- *bio-medicine* advocates collective, evidence-based, efforts to develop and/or use drugs, vaccines and other interventions to prevent, treat and control major diseases (for example vaccine for HIV/AIDS, eradication of malaria);
- the *security* perspective has led the Bush Administration to define global health, and hence the need for GHG, in terms of protecting strategically important countries from such threats as acute epidemic infections and bio-terrorism through improved disease surveillance (as an early warning system), at the border screening, and homeland defence (for example stockpiling of drugs and rapid response measures);
- *economism* underpins arguments by large pharmaceutical companies for GHG that facilitates market-based incentives for drug research and development including the protection of intellectual property rights;
- the *human rights* perspective define global health in terms of the need to address the 'have nots' disadvantaged, for example, by poverty, gender, age or ethnicity.

It is this diversity, and frequent contestation, among perspectives in global health that can explain the fragmented nature of current institutional arrangements.

From this starting point, an alternative set of questions can be raised about contemporary GHG. Have additional perspectives influenced GHG? What is the relative influence of these perspectives in shaping the global governance of particular global health issues? What interests, institutions and ideas have been privileged by these perspectives? Has the influence of particular perspectives varied over time? How can a more reflexive understanding of these perspectives contribute to current debates about the strengthening of GHG?

Amid an ever crowded global health agenda, the latter question is a critical one. Does the persistence of competing perspectives suggest that collective action will remain elusive or at least ineffectual? A few examples suggest not. Given their normative basis, differing perspectives are likely to persist in global health. Indeed, recognition of the links between health and other key sectors such as trade, environment, education, labour suggests that greater, rather than fewer, perspectives are likely to emerge. Different perspectives, however, can be reconciled behind agreed goals, and deployed strategically to further them. The negotiation of the Framework Convention on Tobacco Control (FCTC) was facilitated, in large part, by the strategic use of arguments underpinned by economism, human rights and bio-medicine. The increased global commitment to HIV/AIDS from the mid 1990s, leading to the initiation of the Global Fund to Fight HIV/ AIDS, TB and malaria by the G8, PEPFAR by the Bush Administration (although security and US foreign policy was more clearly present in this instance), and UNITAID by European governments, has been supported by all four key perspectives. Pates and Johnson (2004) illustrate this combining of perspectives:

> In light of its impact upon virtually all indicators of human well-being—from public health to national security—the global AIDS pandemic presents a quintessential human rights challenge affecting the vital interests of all nations and requiring a comprehensive, human rights-based approach if it is to be brought under control. National security officials therefore can no longer safely deem the advancement of human rights and the rule of law a noble humanitarian aspiration secondary to the vagaries of *realpolitik*. In the age of AIDS, human rights and the rule of law *are realpolitik*. Reducing AIDS-related stigma and discrimination, so that more people will get tested for HIV and receive prevention counselling, is a national security issue. Respecting and enforcing the rights of women, so that they may control their bodies, reject unwanted sexual advances, and insist upon the use of condoms to protect against HIV infection, is a national security issue. Ending modern-day slavery and reducing the spread of HIV by eradicating human sex trafficking is a national security issue. And ensuring access for all to life-sustaining drugs, so that HIV-positive parents may provide and care for their children, is a national security issue. More than mere 'issues', in fact, these challenges are fast becoming national security *imperatives*.

Similarly, Gruskin *et al.* (2007) argue the inherent value of human rights, as well as its utilitarian purpose in public health:

> Increased understanding of human rights is not only of value in itself, but also provides those involved in health planning and care with the

necessary means to create conditions that enable people to achieve optimum health.

The contemporary politics of global health, in short, is a highly contested space that nonetheless does not preclude collective action to achieve agreed goals. The purpose of this book is to illuminate in further detail this contested landscape. As well as more fully understanding this institutional terrain, interrogating the politics of global health in this way will ultimately raise the quality of contemporary debate about strengthening GHG.

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2

National Security and Global Health Governance[1]

Colin McInnes

Introduction

Health is an international issue: disease does not respect national boundaries; international cooperation on health dates back over several centuries. In the wake of the Second World War collaborative efforts were institutionalised with the creation of the World Health Organization (WHO), an organisation specifically tasked with promoting international health. But over the past decade or so the attention paid to this international dimension has increased considerably for two main reasons. The first concerns the processes of globalisation, and includes such diverse themes as the increased ease by which disease may spread, the liberalisation of markets for health products and services, and a sense of shared humanity in the face of suffering from disease. An underlying feature of all these themes is that health no longer stops at the border and that, implicitly, the relative significance of the state has diminished and the potential of 'global health governance' (GHG) increased. The focus of this book is largely with this range of concerns, specifically on the international political economy (IPE) of health and the declining authority of the state in terms of national health systems (NHS) and health policy autonomy. But a second range of concerns have also appeared providing health with a changed international dimension. These relate to the manner in which health issues have increasingly been framed by geopolitics, and specifically by security agendas.

These issues are, however, not entirely separable and discrete from the IPE of health, but should be viewed as part of a system in which different worldviews of health can be seen as in conflict, as overlapping, and as subject to multiple sites of power and agency. In turn, many of the exact same processes of globalisation that have created pressures and new risks which gave rise to a 'worldview' or 'paradigm' of health that stresses both its security and national security dimensions, have also driven the liberalisation of health markets and the rolling back of state authority over public health. In short, the IPE of health and GHG can and should be characterised by

tendencies, policies and processes that are often in apparent tension with each other, reflecting the fact that health is subject of real interests and real power, but which are often responses to the same dilemmas presented by the health and globalisation nexus.

Notwithstanding these caveats and qualifiers, the focus of this chapter is on the centrality of security to contemporary global health and its governance.

In a sense health has always been and will remain a security issue – it has the potential to affect the life, lifestyle and livelihood of every individual on the planet. This perspective of individual well-being is well-established in the bio-medical community; but it also finds resonance in the 'human security' approach, as seen in the 2003 Report of the UN Commission on Human Security (UN Commission on Human Security, 2003). The securitisation of health however refers to the manner in which health security is no longer seen solely at the individual level, but at the national level: as a potential threat to the well-being of states and to international stability. This is a relatively novel development and can be traced back to the second half of the 1990s and early 2000s. In 1996, for example, responding to a perceived threat of disease from overseas, US President Clinton issued a Presidential Decision Directive calling for a more focused US policy. Three years later, the State Department's Strategic Plan for Financial Years 2004–09 talked of health issues in terms of potential threats not only to American citizens but to international security:

> Epidemic and endemic diseases can undermine economic growth and stability, and threaten the political security of nations, regions and the international community … emerging infectious diseases of epidemic or pandemic proportions … pose a serious threat to American citizens and the international community (US Department of State and US Agency for International Development, 2004, p. 76).

In the same year, the CIA prepared a National Intelligence Estimate (published in 2000) which identified a number of risks to US security arising from infectious disease. The report argued that infectious disease posed a risk not only to US citizens (at home and abroad) but also to international stability and to economic growth, placing it firmly in the territory of national security (US National Intelligence Council, 2000). Soon after, in January 2000, the UN Security Council discussed the threat of HIV and AIDS to African security; subsequently in Resolution 1308 the UNSC warned 'that the HIV/AIDS pandemic, if unchecked, may pose a risk to [international] stability and security' including peacekeeping missions; while in June 2001 the General Assembly's Special Session on HIV/AIDS declared the disease a security issue. Following this, health issues began to appear in a number of statements from foreign and security ministers, presenting

health as a potential threat to stability and security; while global health was discussed at a number of Group of Eight (G8) summits (including Genoa, Gleneagles and St Petersburg), in the context of both humanitarianism and security.

Attention to health as a national security concern increased after the terrorist attacks of 11 September 2001 and the subsequent discovery of anthrax spores in letters to US politicians and media. These two events, with one coming on the heels of the other, led to the perception of an increased risk to Western states from bio-terrorism (Levy and Sedel, 2003). In response, public health was incorporated into US homeland security under the Public Health Security and Bioterrorism Response Act (US Congress, 2002; Prescott, 2003), a number of meetings were held which attempted to increase levels of international cooperation, and a variety of reports commissioned (McInnes and Lee, 2006, pp. 12–15). Whether the risk to states from bio-terrorism was exaggerated or not is discussed below, but what is readily apparent is that bio-terrorism was placed much higher on national security agendas, dragging health along with it willingly or not.

Although these two concerns of globalisation and national security co-exist, they do not run in parallel but rather on occasion pull in opposite directions. This is particularly so in the case of the role of the state and of global governance. For many of the proponents of globalisation, the state can no longer be considered as the sole, or perhaps even the most important unit of analysis (Lee, 2003, Chapter 6). Health threats, the provision of healthcare services and the market for pharmaceuticals are increasingly transborder in nature. In terms of health security, this makes defence 'at the border' a near impossibility despite efforts by states to do just that (Coker and van Weezenbeek, 2001). The state can no longer function as a self-contained vessel for health provision (and indeed health security), rather it has become permeable. This is most obviously the case with infectious disease where the processes of globalisation have enabled disease to spread more quickly. The rapid spread of Severe Acute Respiratory Syndrome (SARS) in 2002–03, and especially once the disease began to spread internationally in February 2003, is frequently cited as an example of this phenomenon. By the time the disease came under control in August 2003, 8422 cases had been identified in 29 countries with 908 fatalities (WHO, 2003a, 2003b). SARS also highlighted how the globalised economy was sensitive to health and disease. Although the number of cases and deaths from SARS was small in comparison for instance with tuberculosis (TB) (Zhou and Yan, 2003), global economic losses have been estimated at US$30 billion, with some upper estimates as high as US$100 billion (US National Intelligence Council, 2003). Thus infectious disease not only has the potential to spread widely and rapidly but to cause major economic disruption globally (Price-Smith, 2001).[2] Globalisation has also affected non-communicable disease (see especially Barraclough in this volume). This is most notably the case

with tobacco related illnesses, where free trade mechanisms and the global economy have allowed transnational tobacco companies to greatly expand their sales, particularly amongst developing countries, with the result that the number of tobacco related deaths worldwide has increased substantially over the past decade and a half (Collin, n.d.; McInnes and Lee, 2006).

In contrast, the foreign and security policy community have maintained a robustly state-centric approach: in published statements by foreign ministries there is considerable consistency in prioritising the national interest when discussing health security issues (Cook, 2000, p. 2; UK Foreign and Commonwealth Office, 2003, p. 13; US Department of State and US Agency for International Development, 2004, p. 76; Downer, 2003). It is important to note in this context, however, that the national interest is not seen simply as the promotion of a narrow self-interest; rather self-interest is tempered by two factors. First there is a general recognition that a process of globalisation has occurred and that as a consequence individual – especially Western – states cannot simply divorce their interests from wider global concerns but rather have to balance the two (Cook, 2000, p. 4). Second, from the 1990s the rhetoric of Western governments' foreign policies have displayed an increasing normative element (Chandler, 2003).[3]

There is a sense of the importance of the global good and of humanitarian obligations which complement, inform or may transcend the national interest. Global health is a key feature in this humanitarianism, seen repeatedly in statements from Western political leaders. Paula Dobriansky, US Under-Secretary for Global Affairs in the State Department, stated for example that HIV and AIDS was a global problem and that 'from both a security and a humanitarian standpoint, we cannot sit idly by' (Dobriansky, 2001). The State Department's 2004 Strategic Plan argued that, 'the American people believe that they and their government should be leaders in helping those suffering from natural or manmade disasters – *even when there may be no threat to US security interests*' (US Department of State and US Agency for International Development, 2004, p. 65, emphasis added); while President George W. Bush stated in a major speech on HIV and AIDS that 'if you value life and say every life is equal, that includes a suffering child on the continent of Africa' (Bush, 2003, p. 2). In a similar vein, the UK Foreign Secretary Robin Cook claimed that 'human rights are indeed of little value without freedom from hunger, from want and from disease' (Cook, 1997, p. 2).

This sensitivity to both global and human concerns however should not obscure the continued focus of foreign and security policy communities on the state and – for the purposes of this chapter – the defence of national security and the promotion of international stability. The focus of this chapter therefore is an examination of the national security perspective on global health issues as the second major theme in the internationalisation of health. It discusses the key issues identified in this narrative, and then questions the case made that health is a national security issue. The chapter

also finds resonance with Ingram's work on HIV in this volume, not least in the manner in which efforts to respond to the HIV pandemic have often become a tool of (especially US) foreign policy.

Health issues as national security problems

Three issues have been central to the contemporary development of health as a security issue: the emergence of new infectious diseases and the spread of existing diseases to new geographical areas; the HIV pandemic; and bio-terrorism.

Infectious disease

New infectious diseases have been emerging at an accelerated average of one a year for more than two decades. These include HIV, SARS and H5N1. The increased speed of movement of goods and people, and their rapid interaction over wider geographical areas, means that infectious diseases can spread more quickly and over a greater area than ever before; moreover the emergence of these diseases may also be related to processes of globalisation facilitating the spread of microbes and their rapid evolution. In addition to new diseases, previously contained diseases have begun to spread and have been seen for the first time in the West: in the course of the last decade for example the United States has seen incidences of diseases such as Ebola, West Nile virus and Monkeypox. Finally, new strains of diseases are appearing which are resistant to existing drugs, including antibiotics. Perhaps the most serious of these is TB, with major Western cities such as New York demonstrating a vulnerability to a new form of the disease.

The spread of disease is of course a tragedy for those individuals directly affected. But why is infectious disease now considered a national security issue? Three broad reasons have been articulated by the foreign and security policy community. First, the spread of these diseases could pose a direct threat to the health and well-being of the very people that states are there to protect. And for the first time in perhaps half a century, this includes the populations of Western states. Concerns were first articulated in the late 1990s, most notably by the CIA's 1999 National Intelligence Estimate on the threat from infectious disease. But it was the emergence of SARS in 2002–03 which did most to alert states to the fact that new diseases can spread quickly and uncontrollably, while in the middle of the decade the likelihood of pandemic flu and the possibility of a strain of H5N1 spreading from human to human posed the possibility of deaths from disease on a scale not witnessed in the industrialised world since the Spanish flu. Crucially these concerns arrived at a time when the security community was sensitised to novel threats and risk analysis. The end of the Cold War had produced a 'bonfire of the certainties', allowing consideration of a new and

broader range of risks to replace the military threat of the Soviet Union in the minds of security specialists. Infectious disease therefore could be credibly presented as a real and present danger to the people of a state, including Western states.

Second, a pandemic may cause social disruption and threaten the stability of a state, especially one which is already weak: by eroding confidence in the state's ability to provide a basic level of protection against disease; social inequalities may be highlighted as the rich or privileged obtain access to better drugs or healthcare, potentially leading to public disorder; if large numbers of people die or are unwilling/unable to go to work, public services may be placed at risk threatening the functioning of a state; violence and disorder may appear if the authorities become unable to cope and if groups feel they have nothing to lose. Thus a state may begin to fail. Although disease may not be the sole cause, it may provide the tipping point turning a 'weak state' into a 'failed state'. Moreover this is not simply an issue for the state directly affected. As the United States *National Security Strategy* put it, 'America [and the West] is threatened less by conquering states than we are by failing ones' (The Office of the President of the United States, 2002, p. 1). Third, a large scale epidemic may also contribute to economic decline by: forcing increased government spending on health as a percentage of GDP; reducing productivity due to worker absenteeism and the loss of skilled personnel; reducing investment (internal and external) because of a lack of business confidence; and by raising insurance costs for health provision. For the state involved, the costs may be highly significant, but in a globalised world the effects may be felt around the world. The relatively short-lived SARS outbreak of 2002–03 led to less than a thousand deaths – individually tragic but, compared to annual deaths from HIV/AIDS, TB or malaria, statistically relatively insignificant; but the loss in trade and investment was calculated in tens of billions of US dollars for the economies in Asia. The macroeconomic effects of a major epidemic may therefore be very significant, threatening to make the relatively affluent poor and the already poor poorer, with a consequent impact upon the ability of states and individuals to provide for their security and well-being.

HIV and AIDS

In its 2007 annual report on the spread of HIV and AIDS, Joint United Nations Programme on HIV/AIDS (UNAIDS) concluded that an estimated 33.2 million people worldwide were living with the disease, the overwhelming majority (22.5 million) in sub-Saharan Africa (UNAIDS, 2007). The HIV and AIDS pandemic has not only led to widespread humanitarian concerns, but – uniquely for a single disease – has been identified as a security issue, most significantly by the UN Security Council. The claims made in 2000 by the Security Council in Resolution 1308 set the agenda for the subsequent debate on HIV and AIDS as an issue of national security.

The effects of the disease on economies and on governance have been consistently highlighted by a range of commentators. HIV and AIDS is claimed to create particularly severe economic problems because of the cumulative effects of the disease over a number of years and because of its disproportionate impact upon workers in what should be the most productive period of their lives (UN Secretariat, 2003, pp. xiii and xiv; International Crisis Group, 2001, pp. 9–13). Such economic decline may increase income inequalities and poverty, exacerbating or creating social and political unrest. HIV infection rates are unusually high amongst skilled professionals (including civil servants, teachers, police and health workers) and young adults, threatening 'the very fibre of what constitutes a nation' (International Crisis Group, 2001, p. 1). Democratic development may be harmed if societies become polarised as a consequence of HIV and AIDS, if disaffection with the political process sets in, or as a consequence of aid-dependency. The stigma of AIDS may also lead to exclusion from work and/or society, creating alienation, fatalism and anger amongst people, especially young people, living with HIV and AIDS. These people may become prone to criminal violence or to following violent leaders (US National Intelligence Council, 2000; Justice Africa, 2004).

The high rates of HIV infection amongst security forces, including the military, is also frequently cited as a cause for concern. In sub-Saharan Africa in particular, infection rates amongst the military are often cited as being especially high, with a number of militaries experiencing rates above 50 per cent. Moreover, during periods of conflict it is believed that the risk of infection may be as much as 50–100 times that of the civilian population. The consequences of this include its impact on combat readiness, military performance, morale and defence budgets (as money is diverted to caring for HIV positive military). If military effectiveness is reduced as a result of HIV, or even if it is perceived to have been affected, then states may be at greater risk from internal conflict or external aggression. Moreover there is some evidence to suggest that conflicts may be prolonged either to defer the return of HIV positive troops, or to enable them to gain sufficient money (legally or otherwise) to allow them to purchase antiretroviral therapies (ARTs) (Elbe, 2002, 2003; International Crisis Group, 2001; Heinecken, 2003; UNAIDS, 2003). A related issue concerns the impact of HIV on peacekeepers, who may be at increased risk from infection since many of the world's conflicts are in regions with a high prevalence of HIV. They may also act as vectors for the spread of the disease, especially since the top ten contributory nations to peacekeeping operations include states with high HIV prevalence rates (UNAIDS, 2003, p. 6).

Finally, concern has been expressed that conflict may act as a vector for the spread of HIV. Soldiers, already a high risk group, are willing to engage in even more risky behaviour in conflict regions; incidents of sexual violence increase in conflict; combat injuries may be treated in the field with

infected blood; health education and surveillance may be poor in zones of conflict; soldiers returning from conflicts may bring HIV with them; conflicts create migration which may facilitate the spread of HIV; and refugee camps may have poor health education and access to condoms, but are also areas where sexual violence is rife. In addition, HIV may act as a disincentive to end conflicts because of fears that troops from low prevalence areas may act as a Trojan horse for the spread of the disease on their return (UNAIDS, 2003).

Bio-terrorism

The idea of using biological agents (or pathogens) as a weapon of war to cause disease is not new. During the Cold War, concerns were sufficient as to lead to arms control negotiations. These attempted to limit the development and use of biological weapons and culminated in the 1972 Biological and Toxin Weapons Convention (BWTC). In the early to mid 1990s, however, concerns increased as a result of intelligence reports following the break up of the Soviet Union. Political and economic instability in the region, accompanied by growing lawlessness and the rise of organised criminal groups, raised fears that materials were being sold to terrorist organisations and 'rogue states'. The relatively low costs compared to other 'weapons of mass destruction' and their comparative ease of use made them not only a cheap alternative to nuclear weapons for states but accessible by sub-state groups including terrorist organisations. Moreover the use of biological weapons by Iraq against its Kurdish population in 1988; the attempt by followers of Rajneesh Bhagwan to spread salmonella in the United States; and the attack on the Tokyo subway using sarin by the Aum Shinrikyo cult in 1995; all suggested a willingness to use such weapons.

The attacks of 11 September 2001 however and the mailing of anthrax spores in the United States soon after, led to a step change in the level of concern. The covert and potentially global nature of terrorist activities, the relative ease with which materials to produce such weapons could be acquired, and the comparative simplicity of their use, led to Western governments identifying this as a major threat to national security (McInnes and Lee, 2006, pp. 12–15). Initially anthrax preoccupied popular attention, understandably so given the mailing of anthrax spores to US Congressional and media offices. But fears of other infectious agents were soon raised. High amongst these was smallpox, already a concern of the US government which had ordered 40 million doses of vaccine in April 2001. These heightened concerns led to a range of activities to protect national security from bio-terrorist attacks, including: new legislation to improve cooperation between public health and the security services; closer inspection of goods at point of entry; better global surveillance mechanisms; and the stockpiling of vaccines. In addition a wide range of studies were commissioned by governments and other organisations into how best to meet a bio-terrorist

attack. The unifying themes of these actions were that the risk of attacks on the West had greatly increased, and that public health would play a key role in defending against such attacks.

The idea of health as a national security problem

Despite this developing policy interest in health as a national security problem, reflected in a growing academic literature (Prescott, 2003; McInnes and Lee, 2005, 2006; Price-Smith, 2001; Fidler, 2003; Elbe, 2002, 2003; McInnes, 2006; Garrett, 2005; Altman, 2003; Ostergard Jr., 2002; Schneider and Moodie, 2002; Tripodi and Patel, 2002), the subject has remained for the most part under-conceptualised. Stefan Elbe has produced a powerful analysis of the potential positive and negative effects arising from the securitisation of HIV and AIDS (Elbe, 2006); while in earlier works, Kelley Lee and I began to address questions of what issues may be considered part of this agenda and what might be considered the referent object (McInnes and Lee, 2005, 2006; Lee and McInnes, 2003). What appears to be missing however is an examination of the *idea* of health as a national security issue. What are the key reasons why health might be considered to be a threat to national security, and are these credible? This section begins to examine these questions. An examination of policy statements and the literature on the subject suggest three broad reasons as to why health might be a national security issue. Health issues pose potential threats to: international stability; internal security; and the lives of large numbers of individuals.

Health and international stability

Health issues may be considered as posing a threat to international stability for four reasons. First, health crises may have dramatic effects on the global economy (and again this key feature of the securitisation of health overlaps with interdependent features of the global economy). That health crises may have detrimental economic effects has been long understood – through making people less productive, discouraging investment and forcing a transfer of resources into healthcare and support. The global, or macro-economic effects of health however have recently received considerable attention (Sachs, 2001). This is to a large extent fuelled by concerns over the manner in which globalisation has both tightened the links between economies worldwide and made the spread of infectious disease easier. An epidemic may therefore lead to reduced economic growth in areas not directly affected by the disease or even in worst case scenarios trigger a global recession, increasing levels of poverty and creating stress on lifestyle and livelihood amongst even the wealthy states. Second, poverty and poor health may lead to migration as people seek a better, safer life elsewhere. Migration flows not only risk spreading disease, but may act as de-stabilising forces in a region. Third, militaries may be at increased risk from some sex-

ually transmitted diseases. Militaries have spent decades attempting to educate soldiers on the dangers of sexually transmitted diseases.[4] In the modern era better health education and antibiotics appeared to have reduced this problem to manageable proportions, however the emergence of HIV and AIDS changed the picture dramatically. Not only was this disease incurable, but it appeared to affect militaries disproportionately, impacting upon their performance and readiness with a consequent effect on national security. Finally, disease – and in particular HIV and AIDS – may affect the willingness of states to send troops on peacekeeping missions. This was a key element in the UN Security Council's discussion on HIV and AIDS and at the heart of United Nations Security Council Resolution (UNSCR) 1308 (UN Security Council, 2000). Concerns have also been expressed at the willingness of nations to receive peacekeepers if they fear that troops may bring high rates of HIV infection into a country with them.

The problem with these four arguments is that the causal relationship between an adverse health effect and international stability is questionable, and/or the empirical evidence to support the claim is suspect or missing. On the macroeconomic effects of poor health, for example, how sensitive is the global economy to changes in health status? When economies are affected, such as during the outbreak of SARS in 2003, are the effects long term, or are they quickly overcome? And where is the evidence that international stability is affected by this? On migration, although there is a growing awareness of this as a security issue (Weiner, 1992–1993; Graham and Poku, 2000), health does not appear to be a key driver in people leaving their homes. Rather poverty, famine and conflict appear to be much more significant causes of mass migration. Of course health is a significant factor in migration flows – as migrants may suffer from poor health because of the lack of infrastructure, and will make health demands on recipient countries, and may spread disease – but it is not clear that poor health is a cause of migration. Third, although there was some evidence at the turn of the decade that militaries were unusually susceptible to HIV infection, and a number of plausible reasons were offered for this, the picture now appears more nuanced. Empirical evidence is no longer so clear cut (nor arguably ever was), while AIDS awareness campaigns have been instituted (not least by UNAIDS) which have the potential to massively reduce HIV infection rates amongst militaries (McInnes, 2006, 2007), although independent research has questioned how effective the campaigns have actually been (Yeager *et al.*, 2000). The link between a military weakened by disease and resultant state instability/insecurity is also unclear. Again empirical evidence is lacking for this causal claim, while the literature on the causes of war remains contested over the issue of military weakness. The best that may be said is that, if insecurity emerges, then a weakened military may be less able to cope than one which has not been affected by poor health. Finally, research on the global spread of HIV and AIDS does not support the

argument that peacekeeping is an important vector in the spread of the disease. With the exception of Sierra Leone, there appears to be little or no linkage between UN peacekeeping missions and high prevalence. Major missions in Kosovo, Ethiopia/Eritrea, the Democratic Republic of the Congo (DRC), East Timor and Kosovo either fail to correspond to significantly increased HIV prevalence rates, or if such rates do increase they may be explained by other causal factors. Nor do longstanding peacekeeping missions appear to have provoked an unusually high HIV prevalence (McInnes, 2006, 2007).[5] What also remains unclear is the extent to which peacekeepers have become infected with HIV while on operational tours of duty – data on this is simply not readily available (UNAIDS, 2003, p. 25). Lacking such data, claims about the dangers remain unproven.

Health and internal security

Public health specialists have long recognised that disease, and in particular epidemics, have consequences beyond the individuals affected. Society may also be affected in far reaching ways, much more so than that of a reduction in population from untimely death. Two consequences in particular might have an impact upon the internal security of a state. First, if the economy is damaged then divisions between rich and poor may be exacerbated. Increased levels of poverty may breed discontent and provide a fertile ground for entrepreneurs of violence. Second, confidence in the government or in the state more generally may be damaged if public health services are unable to cope. The social contract between a state and its citizens is at risk if the state cannot provide a basic degree of protection; disillusionment and alienation may set in if large numbers start dying and as prospects of survival diminish; absenteeism and high levels of morbidity may rip gaps in the fabric of society. Thus poor health, and in particular epidemic diseases, may pose a security risk to states.

What is lacking, however, is the empirical evidence to support this argument. With HIV/AIDS in particular, a number of states now have very high levels of infection, especially in sub-Saharan Africa. These are also amongst some of the poorest nations on earth. Yet there is little evidence to date that high HIV prevalence has created de-stabilising pressures threatening the security of the state. Nor is the causal link between disease and state insecurity necessarily apparent. As UNAIDS itself admitted: 'Defining the risk that the [AIDS] epidemic poses to stability and security … is challenging as it is difficult to distinguish the impact the epidemic may have from other factors that influence state crises and conflict' (UNAIDS, 2003, p. 9). Probably the most sophisticated attempt at establishing a causal relationship is the Jaipur paradigm of Tony Barnett and Alan Whiteside (Barnett and Whiteside, 2000). This begins by making a distinction between susceptibility (those factors which make a society more or less likely to experience high prevalence rates of HIV/AIDS) and vulnerability (the extent to

which a society will be affected by HIV/AIDS). Crucially it is not susceptibility which determines vulnerability, but two other factors: social cohesion, and the level and distribution of wealth and income within a society. If Barnett and Whiteside are correct, then large numbers of states which have a high prevalence of HIV may not be at risk from instability. It is only if such states also have *both* low social cohesion *and* high levels of poverty/unequal distribution of wealth that they may be at high risk of instability. But even if the Jaipur paradigm is incorrect, then it remains unclear the extent to which HIV may only prove destabilising if it can exacerbate existing tensions in a state, and if so how serious such tensions must be for HIV/AIDS or any other disease to trigger instability.

The threat to life

That people die from disease or poor health is unfortunate, but this is not in and of itself sufficient to constitute a security issue for the state. Rather it is a matter for health services and, in some areas of the world, development and aid agencies. It could be argued that when the number of people at risk reaches exceptional levels, then this moves health into the realm of national security, not least because the effective operation of the state may be at risk. However, the level at which an event becomes sufficiently extraordinary to be considered a security issue however is not definable objectively, for example as a percentage of the population; rather it is determined intersubjectively on a case-by-case basis (Buzan *et al*., 1998). The state may play a key role in this process of framing public health emergencies as threats to national security.

So a key feature for the purposes of this section is that the cause is exogenous to the state – in other words, that it comes from the outside and can be represented as an external threat. Three health issues seem both to meet this necessary condition of externality and breach the threshold of being outside the ordinary: the spread of existing diseases such as Ebola or West Nile virus to new states; the emergence of new, potentially pandemic diseases such as SARS and human-transmissible H5N1; and bio-terrorism. Of these, probably only the second has the potential to kill very large numbers of people in a state, especially a Western state. But it is not the level of morbidity that matters, but the sense of risk. Thus in the 1990s when Ebola first appeared in the United States, the level of concern far outran what might have been assumed from the number of people realistically at risk from the disease. Similarly concerns over bio-terrorism may be overstated. Despite the comparatively recent use of biological weapons in Iraq and Japan, and the attempt to use salmonella in the United States, there remain doubts both over how easy it is for sub-state groups to gain access to, or produce effective weapons and over how easy it is to use them in a manner which might cause significant loss of life (McInnes and Lee, 2007; Dando, 2005). The failure to discover such weapons in Iraq only

added to doubts over whether the extent of the problem had been overstated.

In terms of impact therefore, one can distinguish between the perception of an issue as a health threat and its likely impact upon the state. With both the spread of existing diseases and bio-terrorism, it is clear that people may be at risk; but it is unlikely that these numbers would match those of a major epidemic. What is also crucial to note here is that the concerns are primarily those of Western states, where perhaps the idea of being at risk from disease or from large scale terrorist atrocities is relatively novel. Much more significant in terms of potential morbidity is the emergence of new diseases with the potential to become pandemics. But as with the previous section, it is difficult to see how this will necessarily destabilise a state.

Conclusion

This chapter began by suggesting that in addition to the theme of the globalisation of health, a second theme, that of securitisation, has developed over the past decade. In many ways these themes are inextricably linked in the broader political economy of health. Making the claim that health is a (national) security issue is a powerful move to make. It is to claim that health is not a technocratic issue, nor even a straightforward political issue, but rather that it is something exceptional with a high degree of risk to the state and to international stability. This high degree of risk renders it worthy of exceptional measures. These may involve increased resources, new legislation, or other special measures designed to address the problem. Securitising health however is a two-edged sword, risking as much as it might gain (Elbe, 2006). For the purpose of this chapter though, what is important is not so much the relative advantages and disadvantages of securitising health, but identifying the manner and rationale for health being presented as a security issue. The chapter began by identifying which issues have dominated this debate, and then proceeded to examine the arguments presented as to why these issues are security issues. In so doing a number of points emerge which stand in contrast, to a greater or lesser extent, to the theme of globalisation pursued elsewhere in this book.

First, it is clear that it is not 'health' that has been securitised, but rather a limited range of health issues. The health security agenda as presently constituted is highly restrictive and in this sense contrasts with the theme of globalisation. Moreover it is not an agenda based on health needs, but on the sense of risk to the state, and in particular to Western states. This causes disquiet amongst some health professionals, who see the potential for the health agenda to be skewed away from their concerns and towards those of the national security community. Many states, such as Brazil remain resistant to the securitisation move (see Rushton in this volume). For others there is an advantage in bringing health issues to a wider policy audience,

one which has significant political purchase and the ability to generate international action.

Second, although the WHO has talked of 'global health security', the security agenda remains very much international rather than global. It is about cooperation between states for national benefit rather than a sense of health issues transcending state competencies and interests. To a certain extent this helps to explain the restrictive agenda – the health issues identified as security issues are those which pose a risk (directly or indirectly) to the major players in international security. It can also help to explain the measures taken to mitigate the risks involved: national legislation such as the US 'bio-terrorism act', national action such as the stockpiling of drugs, and limited forms of international cooperation such as the sharing of information. There is little sense of state sovereignty being overtaken here; states remain firmly in control of both the agenda and actions taken to address issues.

Third, perception and in particular the sense of 'dread' plays an important part in risk assessment and in identifying health issues as security issues. Thus endemic diseases such as TB and malaria, or non-communicable diseases over which a degree of control exists (tobacco or obesity related diseases) do not excite the interests of the security community. But novel threats over which the sense of control is limited, such as threats from terrorists using biological weapons or from new infectious diseases, generate much more concern as security risks. The health issues identified above as security issues share a sense of dread and of a lack of control. This sense may be misplaced, but that does not mean that it does not have an important impact in the minds of decision makers.

Fourth, health as a security issue remains under-conceptualised and lacking a robust basis for the claims made. The previous section identified three main arguments which are used to justify the claim of health as a security issue; but none of these appear particularly robust when examined. Of course, it is necessary for policy planners to think ahead, scan the horizon and identify what may develop as risks in the future so that action now may avert or reduce harm done. In this sense policy planners may justifiably point out that the lack of evidence is simply because they are identifying future risks. But this is insufficient to explain the emergence of health as a national security issue. Rather two other factors have contributed to this development. The first of these is the changed security environment, which focuses on disparate risks rather than clear and present dangers, and in which enlightened self-interest and humanitarian concerns form a legitimate part of the agenda. In such an environment, health issues can be legitimately considered in contrast to the more restrictive terms of the Cold War, when immediate military concerns dominated. The second is individual agency, where powerfully placed advocates have used their position to identify health issues as security issues. The driving force behind this shift originated largely within the public health sector, motivated by a desire

to secure greater political attention to global public health needs.[6] The securitisation of health has proved a powerful idea for agencies whose experience and remit lies outside the traditional international security community.

Fifth, despite this increased interest and attention, health issues remain on the periphery of the security agenda, and security on the periphery of the health agenda. This may of course change in the future as a consequence of an extreme event, but at present health as a security issue is a minority concern for the policy community and a minority interest for the academic community. What has changed however is that health is now present as a security issue for both the academic and policy communities. A decade ago this was not the case. Moreover interest and attention is growing. But for the present it remains somewhat on the margins.

The securitisation of health presents a different perspective on the role of the state and global governance. In terms of health and security (and indeed in instances of a range of regulatory and policy areas) although international cooperation may be required on some issues, the state is the referent object and primary actor. This chapter suggests that the case for health as a security issue is problematic. This may offer some hope for the advocates of GHG and greater international control of health issues. If the case for treating health as a security issue proves problematic, then state control may become more relaxed and progress made towards more global action on health. But a warning is required. The fact that health can be presented as a national security issue on such slim evidence may equally be an example of how powerful state interests are – in other words, it is not the strength of the case which has made health a national security issue, but the power of the state which has meant that when health is internationalised, those interests most relevant to the state are highlighted. In these terms, the state (and national security) seems central, rather than peripheral, to a nuanced IPE of global health and GHG. Second, although health may be on the periphery of the security agenda, this agenda may prove to be so powerful that even this peripheral status is sufficient to determine the agenda and what actions may be taken. Third, security is socially constructed. There is no objective measurement for when issues become security issues; rather they are constructed inter-subjectively by actors with a claim to legitimacy (Buzan *et al.*, 1998). What matters therefore is not the degree of risk, but whether key actors can make a case using the vocabulary of security. This has been done, which allows the state to stake a claim as a, if not the most important interested party in international health.

Notes

1 This chapter builds on work conducted with Kelley Lee over a number of years. I would therefore like to acknowledge her substantial contribution to many of the ideas here; responsibility for the arguments and detail remains that of the author.

2 A useful distinction here might be that introduced by Price Smith between 'outbreak events' (such as SARS) and 'attritional processes' (such as malaria and TB). An outbreak event might cause significant short term disruption to the world's economies, but it is only attritional processes which have long term macroeconomic effects.
3 Whether such rhetoric is matched by policy outcomes or whether it just serves as a convenient guise for the national interest has been questioned, but at the very least the normative element has become an established and accepted element of the public discourse on foreign policy.
4 The phenomenon of high Sexually Transmitted Infections (STI) rates amongst militaries stationed abroad has a long history. In the 1830s, one third of British troops in India were hospitalised because of STIs (compared to one in 30 for Indian soldiers), while in the 1960s infection rates amongst US soldiers in Vietnam were nine times those of soldiers in the US, and in Thailand almost half of US soldiers contracted an STI.
5 Data for this comparison was taken from: UNAIDS, *AIDS Epidemic Update: December 2005;* UN DPKO, *Background Note: 31 December 2005* available at http://www.un.org/Depts/dpko/bnote.htm#unmil, last accessed 26 January 2006; US General Accounting Office, *UN Peacekeeping: United Nations Faces Challenges in Responding to the Impact of HIV/AIDS on Peacekeeping Operations* Report GAO-02-194 (Washington DC: US General Accounting Office, 2001).
6 Key players included WHO Director-General Gro Harlem Brundtland, President of the US Institute of Medicine Ken Shine, former World Bank economist Jeffrey Sachs, and former US Ambassador of the UN and President of the Global Business Coalition on HIV/AIDS, Richard Holbrooke.

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3

Global Governance Capacities in Health: WHO and Infectious Diseases[1]

Simon Rushton

Introduction

Infectious disease accounts for around 26 per cent of all deaths worldwide (Global Health Council, 2006) and is one of the prime examples of a globalised issue requiring a global response. AIDS, for example, has contributed to more than 2.1 million deaths in 2007 alone (UNAIDS/WHO, 2007, p. 1). It has been estimated that a new influenza pandemic could kill up to 150 million people (Nabarro, 2005). With the various economic, demographic and technological changes which globalisation has brought the threat appears ever more acute (Saker *et al.*, 2004).

Infectious disease is not, of course, a new problem. Neither is interstate cooperation in this area a novel phenomenon – the first concerted attempt to coordinate international action was as long ago as 1851 (Fidler, 2001). Yet the global governance of infectious disease continues to generate controversy, and in doing so neatly encapsulates some of the tensions inherent in global health governance (GHG) more generally. In particular, any international system designed to reduce the threat posed by the international spread of infectious disease comes into direct conflict with two other sets of political and economic priorities which are central to the contemporary international system: the national interests of individual states (and in particular their concerns over security and sovereignty) and the desire to achieve a liberalise trade regime.

This chapter examines the development of the International Health Regulations (IHR) – and in particular the process of revising them which led to the agreement on a new version of the regulations in 2005, which came into force in 2007. In doing so it investigates the extent to which the regulations – the cornerstone of the contemporary global governance of infectious disease – succeed in reconciling effective global disease control, national interest and free trade. In keeping with the general approach and tenor of this volume, governance in this pressing area of international health can be viewed in terms of a tension or fault line at the heart of the

broader political economy of global health. The state, national interests and security concerns in this instance clearly persist and confront the exigencies of free trade and economic globalisation (in which states also exercise a deal of agency). This results in a form of GHG for infectious diseases which may fail to meet manifest health needs in this critical area (see Kay and Williams in this volume). Questions as to which worldview or discourse 'governs' the relationship between health and globalisation (be it security, free trade or public health/bio-medical 'discourses') are largely implicit and unanswered, whilst generating concrete health policy outcomes. These questions and tensions are not only central to the formation of global health policies and regimes such as the IHR, but also reinforce the argument that contemporary GHG can accurately be represented as a system of governance which is presently inchoate and subject to competing interests and sites of agency and power (see Kay and Williams and also Labonté in this volume).

In this context it has been argued in recent years, most notably by David Fidler, that there has been a major shift in the global governance of infectious disease. Fidler cites the Severe Acute Respiratory Syndrome (SARS) outbreak of 2002–03 and the response of the international community to it as a watershed between the traditional framework (which had persisted since 1851) and a radically new 'post-Westphalian' health governance system (Fidler, 2003a, 2004). Whereas, Fidler argues, 'Westphalian' public health was characterised by the traditional principles of 'sovereignty, non-intervention, and consent-based international law' (2004, p. 47), he claims the new system – institutionalised by the revised IHR – represents a move away from such state-centrism. Non-state actors now play increasingly important roles and are widely recognised as legitimate governance actors (Fidler, 2004, Chapters 3 and 4). For some this is an important step forward in the fight against globalised disease threats. For others it is a potentially dangerous intrusion on state sovereignty (Mack, 2006).

This chapter questions whether the new IHR are indeed as much of a break from the state-centric past as Fidler and others claim. Whilst there is much that is new in the revised IHR many of the features of 'Westphalian Public Health' stubbornly persist. In particular, states and their borders remain central to international efforts to control infectious disease and concerns about the threat posed by infectious disease must always jostle for position with other political, economic and strategic interests. The World Health Organization (WHO) continues to be dominated to a large extent by its member states despite having seen its role increase under the new IHR.

In relation to the tensions between effective infectious disease control and the prevailing norms of liberal free trade, the chapter examines the extent to which the revised IHR are compatible with other international regimes – in particular the World Trade Organization (WTO) trade regime. Whilst strenuous efforts have been made to reconcile the conflicting demands of trade and health, it is not clear that the IHR 2005 has done so

successfully, and this offers insights as to how global health goals and needs are often subordinated to trade and other global economic agendas (see Barraclough, Harman and Labonté in this volume). Although the regulations are intended to respond to the negative health impacts of certain globalisation processes, they attempt to accommodate economic globalisation rather than challenge it. It is too soon to tell how this tension will play out over time, but there is a strong possibility that trade concerns will dominate public health, leading to sub-optimal health outcomes.

The negotiations over the revision of the IHR were a difficult process but they are unlikely to be the end of the issue. Whilst the IHR 2005 in many respects represent a significant advance over the previous regulations they are likely to be the starting point for a period of even fiercer international debate over the global governance of infectious disease.

The global governance of infectious disease

One of the key insights of a now established canon of literature on global governance is the necessity of looking beyond the traditional subjects of International Relations scholarship to understand new modalities of governance: to broaden the frame to encompass more than merely the actions of states and the formal International Organisations (IOs) which they create. As James Rosenau warned:

> understanding is no longer served by clinging to the notion that states and national governments are the essential underpinnings of the world's organization. We have become so accustomed to treating these entities as the foundations of politics that we fall back on them when contemplating the prospects for governance on a global scale, thereby relegating the shifting boundaries, relocated authorities, and proliferating NGOs to the status of new but secondary dimensions of the processes through which communities allocate and frame policies (Rosenau, 1999, pp. 287–288).

The concept of GHG has sought to respond to this problematisation of traditional approaches and to take account of the 'shifting boundaries' and 'relocated authorities' which characterise the post-Cold War world. One of the central distinctions that has been drawn is between 'International Health Governance' and 'Global Health Governance' (Loughlin and Berridge, 2002). The former term refers to the 'traditional' forms of inter-state cooperation on health through diplomacy, treaty-making and the creation of international institutions such as the WHO (activities which Fidler would define as 'Westphalian'). The latter refers to something which transcends this state-centric framework and which has the necessary descriptive and analytical purchase to take into account the new realities of the era of

globalisation. The marked linguistic shift away from 'international health' towards 'global health' in both the academic literature and policy pronouncements gives a clear indication of the impact of globalisation on both the conceptualisation of health as an issue and the willingness of bodies such as the WHO to collaborate with a broader range of international actors (Brown *et al.*, 2006). Thus, it has been widely noted that a range of non-state actors – including other IOs, private corporations and civil society groups – have increasingly come to play important roles in governing global health.

Yet, for better or worse, in many areas of international life, including important areas of health policy, states do remain the key actors and IOs represent the principal site for (and often important actors in) international cooperation. States and IOs create and legitimise the international rules, norms, principles and procedures which constitute the global governance of health. States may not always have the capacity to provide effective responses to global health problems, and they may recognise the need to collaborate with non-state actors in order to achieve their objectives, but their power to set the terms of the debate and to determine the framework within which health is conceptualised as a global issue remains unrivalled. This in many respects is also the case when one considers the capacity of core states to regulate (health) markets, or permit the liberalisation or commodification of specific (health) sectors. Notwithstanding a great deal of rhetoric on the need to respond more effectively to the challenges of globalisation, they are generally keen to oppose any dilution of their authority, especially in matters which inveigh on sovereignty and national security.

This tendency is particularly prevalent in the case of infectious disease. Undoubtedly this is a result of the fact that infectious disease more than any other health issue has historically been linked to notions of security, and in particular to the protection of the domestic population from external threats. Many of the clearest contemporary examples of this tendency originate in the US (for example National Intelligence Council, 2000; Cecchine and Moore, 2006), but such an approach has a long history. Quarantine measures aimed at protection from external threats have been a feature of international travel and trade since at least 1377, the year in which the Venetian Republic introduced an isolation period for ships and land travellers arriving at the port of Ragusa (now Dubrovnik) from plague-affected areas (Gensini *et al.*, 2004). Indeed, the protection of the domestic population and economy from the effects of infectious disease goes to the very heart of what a state is for. As international travel and trade increased a widespread recognition developed that states could not unilaterally defend their borders from the ingress of disease, at least not without isolating themselves from the global economy. The results of this realisation have been seen in a succession of international collaborative measures to

combat infectious disease, from the International Sanitary Conference of 1851 to the IHR of 2005.

Infectious disease is far from the only international issue with the potential to threaten population health. Yet in other areas, from the globalisation of food production to the liberalisation of health services, states have not seen their security as being at stake in the same way. So why is it that infectious disease has come to be framed in security terms when obesity or tobacco-related diseases (to take two globalisation-related health problems) generally have not? The answer to this question is a complex one, centred on the ways in which communities understand and assess risk, which in turn is a product of a number of different factors. McInnes identifies four: immediacy, normality, agency and mass communication (McInnes, 2005, pp. 16–17). Whilst agency ('the ability of an individual to control his/her exposure to hazards') and mass communication (which can either heighten or reduce the perception of risk) vary widely between different diseases, immediacy and normality are central to the construction of infectious disease as a security problem and, as we will see below, to the framing of the IHR. In this sense security and sovereignty are vital elements in understanding the contemporary political economy of health; they are countervailing forces to both unfettered globalisation and global health regulations that might impinge on a state's authority over immediate and severe security threats.

The 2007 World Health Report noted that 'an outbreak or epidemic in one part of the world is only a few hours away from becoming an imminent threat elsewhere' (WHO, 2007, p. 6). The potential consequences or major outbreaks are difficult to ignore. Neubauer (2005, p. 292) has noted that a disease may 'present itself with such threat and virulence that its consequences to existing society cannot be ignored. In the face of this manifest crisis … public health intervention will go to the top of the policy list'. Rapidity of spread and the potentially catastrophic consequences of major outbreaks are, therefore, central. But also important – and central to the IHR – is the fact that the diseases which are seen to constitute security threats are those which come from outside and which are not endemic within the state's territory. It is this combination of novelty, immediacy and severity which tends to lead to security-based responses to disease, and which drove the revision of the IHR.

In practical terms maintaining security is not straightforward. There is a widespread recognition that in a globalised world states cannot rely on creating a 'Maginot Line' to halt disease at their borders. Rather, states need to act collaboratively when outbreaks occur, necessitating both political will and the existence of robust public health mechanisms at international, state and sub-state levels. Security from disease – in so far as such a thing is possible at all – can only be achieved through sustained international cooperation, the coordination of surveillance mechanisms and, when outbreaks

occur, a system for putting in place measures to prevent local crises from becoming global crises. Inevitably this entails reconciling concerns over sovereignty and security with wider public health goals. By the same token, international trade and travel – both important vectors in disease transmission – are also the basis of the global economy.

As a product of these conflicting priorities, the aim of the contemporary infectious disease regime is to put in place rules, policies and processes to mitigate the undesirable disease-related effects of globalisation, and it is not concerned with challenging the status quo on a normative basis. Whilst it is universally recognised as desirable to limit the damage done by infectious disease, this remains only one of a range of competing international priorities and interests. The tensions between the competing priorities of state sovereignty and security, international trade and effective disease control came to the fore during the IHR revision process. Subsequently a further series of debates over the appropriate forms of global infectious disease governance, and the rights and duties of states and other actors engaged in that enterprise, have taken place. Whilst the IHR 2005 are undoubtedly a dramatic step forward as compared with their predecessors, what they ultimately represent is a compromise between the requirements of effective infectious disease control and the perceived interests of the states which created them. These two requirements were not always aligned, and in some instances the latter overrode the former.

Revision of the IHR: new threats, old problems

The immediate ancestry of the IHR lies in the International Sanitary Regulations (ISR) adopted by the fourth World Health Assembly in 1951. In 1969 the ISR were amended and renamed the IHR (WHO, 1983). The IHR 1969 subsequently remained more or less unchanged until the major revisions agreed in 2005.[2] These two versions of the IHR are very similar in the overall framework which they set out. The central purpose is to put in place rules and procedures to allow certain key tasks to be carried out effectively, namely: disease surveillance; outbreak reporting; dissemination of information and; structuring and managing international responses. Through this the IHR were specifically mandated to achieve the maximum possible degree of public health protection while – an important secondary requirement – causing the minimum possible disruption to international trade and transport (Article 2).

The IHR 1969 required the health ministries of member states to notify the WHO within 24 hours of being informed of any case of a disease subject to the regulations occurring on their territory (Article 3). For the purposes of IHR 1969 the only such diseases were cholera, plague, yellow fever and (until its removal from the regulations in 1981) smallpox. States affected by an outbreak of one of these diseases were required to keep the

Organisation informed on a weekly basis of the number of cases/deaths in the preceding week (Article 9). A further notification was required when the affected area was deemed to be free from infection (Article 7). Over time it became increasingly clear that this limited list of notifiable diseases was ill-suited to the proliferating disease threats characteristic of a globalised world economy.

To further compound the shortcomings of the IHR 1969, states did not always fulfil their treaty obligations. The WHO lacked any independent investigatory capacity or mandate, nor did it have sanctions at its disposal when states failed to report a notifiable outbreak, and was thus in Neubauer's terms a 'weak' program of governance relying on state compliance, as compared with 'strong' programs which have the capacity to directly regulate (and sanction) actors (2005, p. 290). Indeed, the lack of enforcement capacity formed the basis of many critiques of the IHR 1969 (see for example Plotkin and Kimball, 1997). Equally problematic were cases in which states did report outbreaks and other states responded in extreme ways prohibited under the regulations. Richard A. Cash and Vasant Narasimhan (2000) have examined two cases in which developing countries did report cases of the relevant diseases to the WHO: a 1994 outbreak of plague in Gujurat, India; and a cholera epidemic in Peru in 1991. In both cases the affected countries fulfilled their obligations under the IHR 1969. On both occasions, however, other states far exceeded the permissible responses, taking measures which included stopping food imports, cancelling flights and issuing travel advisories. Cash and Narasimhan cite estimated economic losses at approximately US$2 billion in the Indian case and US$770 million in trade alone in the Peruvian case (2000, pp. 1362–1363). The disincentives for compliance were obvious.

Despite this, most states did fulfil their obligations most of the time. Indeed, in some instances states went beyond what was legally required of them. At the time of the SARS outbreak of 2003 – an event recognised worldwide as a public health crisis requiring an exceptional response – the IHR 1969 were still in force. Under that regime SARS did not fall within the category of a 'notifiable disease'. Nevertheless, almost all member states willingly reported cases on their territories and cooperated fully with the WHO (Nicoll *et al.*, 2005, pp. 321–322). There was, of course, one exception to this: the People's Republic of China (PRC), which failed at first to report the outbreak and initially resisted international cooperation through the WHO. As Jonathan Watts noted at the time (2003, p. 1708), this was a product of the fact that 'the disease has honed in on the regions where China's political antibodies are least able to cope with criticism: Taiwan, government secrecy, an overemphasis on economic growth, and the gulf between the wealthy urban centres and the poor provinces'. As a result, despite a massive subsequent public health effort, China was the last state to bring the SARS outbreak under control.

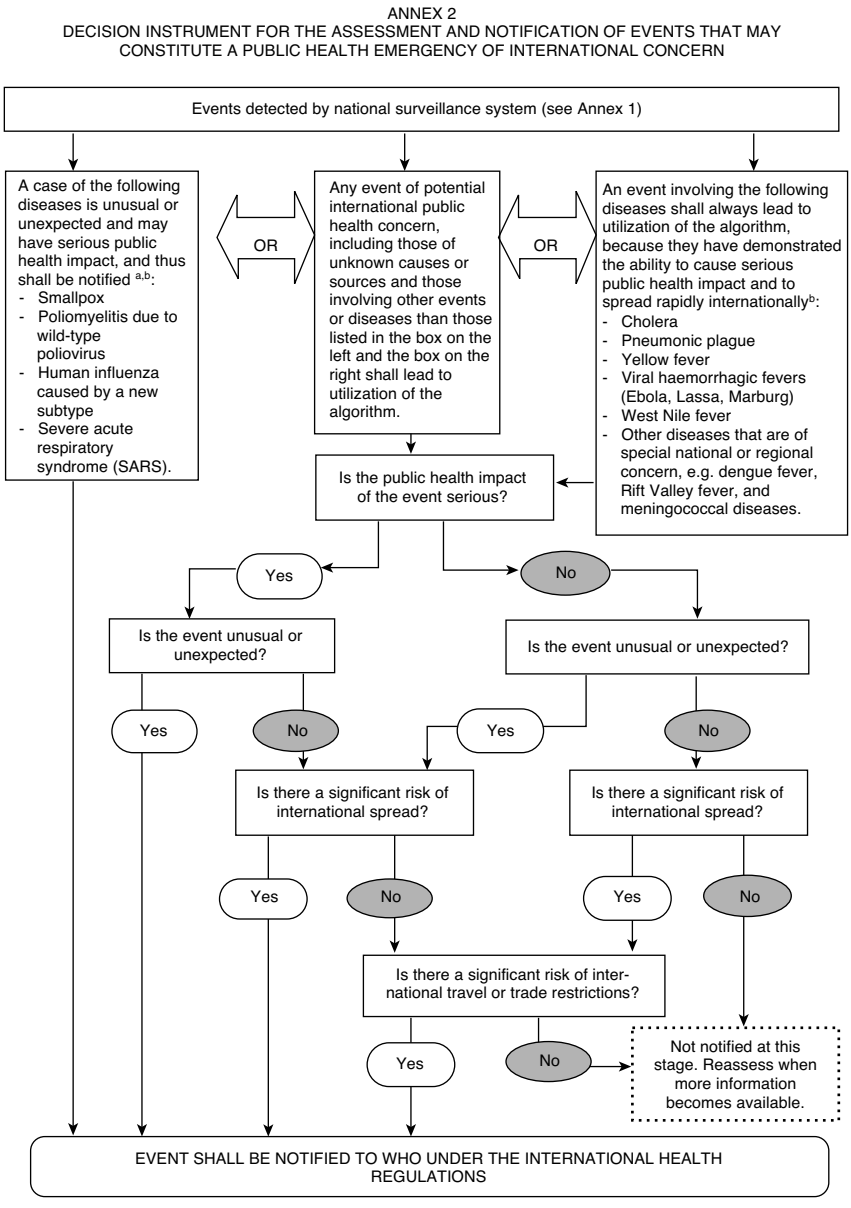
Clearly, then, the ways in which perceived national interests, economic and trade-related concerns and disease control combine and interrelate are highly complex. On the one hand, states have a clear vested interest in the functioning of the international infectious disease regime: but the system only works when states report cases occurring within their territories. As such, international cooperation effectively becomes a means of enhancing national security from disease threats. Nevertheless, under the IHR 1969 this did not always mean that compliance with the IHR overrode other interests, with states in some cases finding that disclosure of a disease outbreak – and the consequences of that disclosure – a threat to their wider political or economic interests (Calain, 2007).

New regulations for a new era

As a result of the widely-noted problems of non-compliance and the limited scope of the regulations, the most significant changes agreed during the revision process related to precisely these issues. The negotiations stretched out over more than a decade. In 1995 the World Health Assembly passed Resolution WHA48.7 calling on the Director-General to begin preparing a revised version of the regulations. A lengthy consultation ensued (for example WHO, 1996, 1998). The process was given a new impetus following the SARS outbreak of 2003 which underlined the deficiencies of the existing system and the need to introduce a more robust set of regulations. There followed a concerted period of regional consultations followed by negotiations within an Intergovernmental Working Group (IGWG) in November 2004 and February 2005. The eventual outcome was a set of regulations which represented a significant step beyond the IHR 1969 in important ways. In particular, meaningful advances were made over two key issues which will be briefly examined here: the range of diseases covered by the regulations and; the mandate given to the WHO to receive and act upon information from non-governmental sources.

During the negotiations it was generally agreed that it was necessary to expand the range of diseases covered by the IHR and to 'future proof' them by allowing them to retain their applicability in the face of future emerging or re-emerging infectious disease threats. Precisely how this should be achieved was a matter of some debate (Calain, 2007, p. 4). The eventual solution was to make all disease events which are classed as a 'public health emergence of international concern' (PHEIC) subject to the regulations. An algorithm was devised for states to employ in determining whether or not a particular event represents a PHEIC and therefore whether or not it is 'notifiable'. This 'decision instrument' divides infectious diseases into three distinct categories: those which are of international concern *per se* (including smallpox, new subtypes of human influenza and SARS); named diseases for which states are required to make a determination according to the decision instrument (including cholera, pneumonic plague and yellow

Figure 3.1 IHR 2005 Decision Instrument



Source: International Health Regulations, 2005, Annex 2.

fever); and other unnamed (and perhaps as yet unknown) disease events which may in future constitute international public health emergencies (see Figure 3.1). As can be seen from the decision instrument, in the latter two categories the affected state is required to give consideration to a variety of issues: whether or not the event is 'serious'; whether it is 'unusual or unexpected'; whether there is a 'significant risk of international spread' and; whether or not there is a 'significant risk of international travel or trade restrictions'.

As a result of this arrangement, states are required to exercise considerably more judgement than was the case with the 1969 version of the IHR. There is a *prima facie* case that the discretion granted to member states will lead to some inconsistency of reporting. Furthermore, states require a considerable amount of information on a disease outbreak in order to be able to utilise the decision instrument effectively. Not all states currently have the required infrastructure at all levels of government to fulfil this surveillance and data-processing requirement within the specified timescales, an issue which will be addressed further below. Significantly, under Article 12 it is not only member states but also the WHO's Director-General who has the power to determine whether a situation constitutes a PHEIC. This hands a considerable amount of authority to the WHO and, in theory at least, this measure has the potential to mitigate any inconsistency in the ways in which states apply the decision instrument.

Another novelty in the IHR 2005 – and the major attempt to circumvent the problem of states failing to fulfil their reporting obligations – is that the WHO is given the explicit authority to respond to information received from non-governmental sources (although in practice this had been happening on an *ad hoc* basis for some years).[3] As Guénaël Rodier – the WHO's director of IHR coordination – noted (2007, p. 428), 'Today, events are often initially reported, not by a Member State, but by non-official sources such as the media, NGOs …, our network of collaborating centres, laboratory networks and partners in the field'. Under the IHR 2005, the WHO is required to pass such information on to the state concerned and to seek verification. But even where the state refuses to cooperate it is in certain circumstances possible for the WHO to disseminate the information to other member states (Article 10(4)). It would therefore be possible for a situation to arise under the treaty where the WHO publishes information about a PHEIC even when the state on whose territory the outbreak has allegedly occurred does not acknowledge the existence of any such event. By the same token, international action can be taken even where states lack the capacity to fulfil their reporting obligations.

So what can we make of these new provisions for identifying and reporting disease events of international concern? The view of Fidler and Gostin (2006, p. 90) is clear: that 'the information and verification provisions privilege global health governance over state sovereignty'. This is certainly

true up to a point. There is now a legitimate basis for the WHO to take action in cases where a state has failed to notify it of an outbreak. Indeed to some extent the WHO has taken on a global surveillance function. Through the development of the Global Public Health Intelligence Network, a search engine developed by Public Health Canada and the WHO, and designed to find online news reports of unusual disease outbreaks, the WHO has begun making use of the internet – a truly globalised information resource – to glean information on significant public health events. And even where a member state disagrees with the Director-General's determination, the state is only given the right to make representations to the 'Emergency Committee', a body composed of experts selected by the Director-General (albeit sanctioned by the member states). The final decision remains with the Director-General (Article 49(5)). Thus the WHO bureaucracy and not the member states has the final authority to issue determinations and recommendations which formally bind member states, and can do so even where such actions are contrary to the expressed wishes of a member state. These provisions, Fidler and Gostin (2006, p. 90) suggest, may help to tilt the balance in favour of compliance with the IHR. In simple terms: if the likelihood is that the outbreak will be reported to WHO in any case, then there is a greater incentive for states to ensure that they are the ones who do the reporting.

There has certainly been a ceding of greater authority to the WHO. These changes also provide the WHO with a considerable degree of 'soft power'. Not only is the organisation both the hub of and a key actor in the global infectious disease surveillance system, it is also given the ability to define what constitutes a crisis, and as a consequence, to some extent at least, to play a part in setting the global agenda in relation to infectious disease. It also allows the WHO to mobilise other techniques (shaming and communicating directly with the domestic constituency of an errant state being two examples of methods found to be helpful in other international regimes (for example Moravcsik, 1995) to further encourage compliance and to bolster the effectiveness of the infectious disease governance system.

There is obviously something to be said for the claim that the IHR 2005 represent something genuinely new. And above and beyond the WHO's newly acquired role in carrying out its own surveillance activities and in deciding whether or not an outbreak falls under the IHR regime, it has been given the task of supporting states in developing the infrastructures necessary to implement the regulations, where necessary effectively 'teaching' states how to run a disease surveillance system.[4] On the flip side, the WHO's role is now far more explicitly defined than it had previously been with, arguably, less scope for it to act on an *ad hoc* basis as it did with the issuing of travel advisories during the SARS outbreak of 2003. The revised IHR therefore both enable and constrain the organisation.

In all of these ways the IHR is a significant break from the past. But does this equate to a fundamental change in the global governance of inter-

national health: has there really been a transition from a 'Westphalian' to a 'post-Westphalian' system? And have the potentially contradictory demands of sovereignty, free trade and effective disease control been reconciled?

It is tempting to get carried away in declaring the dawn of a new era, but it is easy to forget that it is precisely the Westphalian system on which the whole IHR regime rests. The regulations apply only to Public health Emergencies of *International* Concern. With the exception of the diseases specified as automatically notifiable, where there is no risk of international spread, nor a risk of international restrictions on travel or trade, then the outbreak is not classed as notifiable. It may be argued that the logic of globalisation dictates that significant disease events rarely have absolutely no potential international impact, but it remains the case that purely domestic public health events do not fall under the regulations. The IHR, then, are concerned primarily with pathogens crossing borders. Whilst the revised regulations have led states to cede a greater degree of authority to the WHO this has been done in the service of a rather traditional aim: the protection of the nation-state from exogenous disease threats. The IHR regime does not aim to tackle diseases at source. It certainly does not seek to address the economic and social determinants of ill health. Those who drafted the 1851 International Sanitary Conventions would have readily recognised the underlying purposes of the IHR 2005.

Stumbling blocks in the negotiation process: national interests, sovereignty and security

Although there was general agreement on the aims to be achieved, the revision process itself was highly contested with some very traditional *realpolitik* issues coming to the fore. It is worth reflecting on two of these which, taken together, suggest that states are far less willing to place international cooperation on disease control above their other interests than the heralds of the new dawn would suggest.

The question of sovereignty commonly arises in international negotiations, and again the need to balance cooperation with sovereignty became an issue in the revision of the IHR. Reminding his colleagues of this fact in addressing the Second IGWG meeting, the PRC's Ambassador stated that:

> It should be stressed that the WHO, as one of the UN Specialized Agencies, is formed of sovereign states. The negotiation for the revision of the IHR is a negotiation among sovereign states. The IHR can only be widely accepted and its universal applicability ensured when member states have reached a consensus on its revision. For a member state, sovereignty and territorial integrity is of fundamental and utmost importance. Therefore, respect for sovereignty and territorial integrity is the very basis of the IHR and the international cooperation on disease prevention. Nothing in the IHR should harm or compromise the

> sovereignty and territorial integrity of member states. My delegation can only consider to accept a consensus, provided this precondition is met (Zukang, 2005).

Perhaps predictably, the issue of Taiwan's inclusion in the revision process – and its status *vis-à-vis* the regulations themselves – was a major problem for China. This was the continuation of one of the longest-standing political disputes at the WHO[5] and was particularly prominent at the time of the negotiations over the IHR as Taiwan had been one of the territories most severely affected by SARS. In that case the PRC initially prevented the WHO from sending representatives to Taipei, although it ultimately relented. The resulting WHO delegation was the first to visit the island in 30 years (*Wall Street Journal*, 2003). Any hopes that this would lead to a breakthrough in the inclusion of Taiwan in the IHR process, however, were short lived. Taiwan's request to participate in the November 2004 and February 2005 meetings of the IGWG were rejected due to the opposition of the PRC (Chen, 2004). Taiwan is not a signatory of the IHR, and the issue of whether or not the IHR apply to Taiwan is a complex one (although in practice it has pledged to abide by the regulations). Article 3 states 'the goal of their universal application for the protection of all people of the world', but Taipei and Beijing differ in their view as to whether or not this gives Taiwan the right to be treated as a de facto signatory (Fidler and Gostin, 2006, p. 92).

The IHR rely on their universality in order to be effective. As *The Lancet* editorial argued in 2007, 'For the IHR to work, no territory – whether Taiwan or the occupied Palestinian Territory – can be excluded from the global surveillance system' (*The Lancet*, 2007, p. 1763). The obvious irony is that, as Taiwan's closest neighbour, and given the increasing flow of goods and people between the two territories, the PRC is perhaps most at risk from this hole in the global disease surveillance net (Hou, 2007). As such, this is a clear instance of the perceived political interests of one member state having a negative impact upon the development of effective GHG structures. It would seem that geopolitics can as much stymie responses to manifest global health needs as do economic interests and imperatives (see Kay and Williams for a comparison).

There was further controversy during the revision process over the security implications of the IHR, particularly as they related to non-natural PHEICs. In particular there were lengthy negotiations over the extent to which the regulations should apply to releases (whether deliberate or accidental) of biological, chemical and radiological agents. This is an area in which the WHO had a track record, with the first edition of its guidance on responding to biological and chemical weapons having been issued in 1970 (WHO, 1970). Nevertheless, it was one of the most politically controversial areas of negotiation. The inclusion of intentional releases of infectious diseases

under the IHR had the potential to embroil the WHO in some highly sensitive areas, potentially including the investigation of whether or not states were guilty of breaching the Biological and Toxin Weapons Convention. The US and its allies were strongly supportive of the idea that the WHO should take the lead in investigating suspected bio-terror events. This was resisted by developing nations who saw in this both a potentially troubling requirement to provide the WHO with sensitive security information, and a real danger of the organisation's role becoming politicised leading to the downfall of the overall surveillance system (Check, 2005, p. 686). As John Woodall argued in a letter to *The Lancet*, 'If countries should perceive WHO staff or consultants as intelligence agents with a dual responsibility to investigate treaty violations as well as health matters, the result could be unwillingness to report outbreaks at their onset and reluctance to request the help of WHO or permit its entry' (Woodall, 2005).

No agreement was reached. As a result, the WHO's mandate to investigate bio-terrorist incidents is uncertain under the revised IHR. In the event of future incidents of this kind it seems likely that the issue will arise again. In terms of the negotiations, however, the failure to make progress on this matter demonstrates the fact that the states involved were making conscious and deliberate trade-offs between their sovereignty and security concerns on the one hand, and the requirements of effective public health cooperation on the other. Whilst a strong regime for the global governance of infectious disease has certain security benefits for states, it does not automatically trump their other interests. Neither does it remove the potential for international suspicions and jealousies to come to the fore: another running theme through the negotiation process was disquiet about the close relationship between the WHO and the US (in particular the Centers for Disease Control and Prevention) which was seen as having privileged access to WHO's surveillance networks, with further potential security and intelligence implications (Calain, 2007, p. 6).

Reconciling free trade and global health security

As well as requiring the reconciliation of the tensions between sovereignty, security and public health, the revision of the IHR also entailed the striking of a balance between the requirements of an effective disease control system and the potential impact of such a system on international travel and trade. It is clear that these two things lead to potentially contradictory actions on the part of states and other international actors. As noted above, in both their 1969 and 2005 incarnations the overall purpose of the IHR was to maximise public health protection on the one hand, and avoid causing unnecessary interference to international travel and trade on the other.[6] As well as being a difficult tightrope to walk, this brings the WHO into a field in which it is far from the only actor. The WTO has an obvious importance here, perhaps most notably through the Agreement on the Application of

Sanitary and Phytosanitary Measures (SPS).[7] Indeed, Fidler argues that, prior to the revision process and during the IHR 1969's long decline into virtual irrelevance, the WTO became a more important agent in infectious disease policy than the WHO itself (Fidler, 2003b).

Perhaps inevitably, the IHR and the relevant WTO regulations approach the problem of infectious disease from opposite directions. The WTO's primary mission is the negotiation of trade liberalisation agreements. International disease outbreaks have historically interrupted the flow of free trade and thus fall within its remit. The key issue for the WTO – and central to the SPS Agreement – is allowing states the right to put in place measures to protect health but at the same time preventing that from being used as a spurious basis for protectionist trade measures (see Labonté in this volume). The WHO, by contrast, is charged with promoting health, although in the IHR it recognises that this should not be allowed to lead to overly restrictive travel and trade measures which have no scientific basis. There were concerted efforts from an early stage in the revision of the IHR to ensure the consistency of the IHR and the SPS Agreement and to minimise the potential for conflicts between the two. The different perspectives which underlie the two agreements may not, however, lead to agreement over their application to particular cases (Kimball *et al.*, 2004, p. 46).

Article 57(1) of the IHR 2005 provides that 'States Parties recognize that the IHR and other relevant international agreements should be interpreted so as to be compatible. The provisions of the IHR shall not affect the rights and obligations of any State Party deriving from other international agreements'. On the face of it this would appear to provide a legal basis for the primacy of the WTO trade regime over the IHR in cases where the two come into conflict. Furthermore, given the fact that the WTO has a significantly more advanced dispute settlement system in place than the WHO it seems highly likely that a member of the WTO which feels that unduly restrictive measures have been put in place in response to a PHEIC occurring on its territory (and, as we have seen above, such 'over-reactions' have been historically prevalent) would take its case to the WTO. In the past in disputes where health and trade collide the WTO has tended to privilege trade over public health. The case of the European Union (EU) ban on imported beef containing artificial growth hormones, in which the WTO dispute panel ruled against the EU on the basis of the absence of a scientific basis for the ban, was one notable instance of this trend.

Problems yet to come: implementing the IHR

The ongoing process of implementing the IHR will in many ways be as difficult as the revision process. A lack of clarity over the application of the new regulations in specific instances remains and this will undoubtedly be determined through future practice. As is often the case in such situations,

power – both political and economic – is likely to play an important role in structuring outcomes.

Although the regulations have been in force for only a short time there have already been indications that the contestation is beginning. At a meeting of the WHO Executive Board in March 2008, Brazil objected to the use of the term 'global health security' which has been frequently linked with the IHR (although the term does not appear in the regulations themselves). Brazil argued that there is no agreed definition of 'global health security' and that there was not a consensus of support for it within the World Health Assembly (Tayob, 2008). The US and the EU – both of which have strongly backed the concept – had seen a previous attempt (in November 2007) to include it in a draft statement on virus sharing blocked due to the similar concerns of developing countries over the implications of linking health to the concept of security (Tayob, 2008). This issue is indicative of a growing level of debate over who has the power to set the global health agenda, and whose interests mechanisms such as the IHR serve. In broader terms, competing worldviews of health and GHG can be seen to have real world manifestations with concrete health policy outcomes. For those promoting the term, 'global health security' means protecting the world from epidemics like SARS and pandemic influenza. Yet many states lack the ability to protect their citizens from everyday health threats and are concerned that the idea of global health security is being used to push through measures that benefit rich countries and corporate interests but do little for states which are struggling to provide basic health services for their citizens. The dispute between Indonesia and the WHO over the sharing of influenza virus samples showed how such conflicts have the potential to undermine global public health efforts in concrete ways (Fidler, 2008). Similar disputes are foreseeable in cases where the IHR 2005 are put into action.

There are also widely recognised issues surrounding the capacity of states to fulfil their obligations under the IHR 2005. Far more is required of national health authorities than was the case under the IHR 1969. The necessity for many member states, and particularly those in the developing world, to make significant investments in disease surveillance infrastructure was well-known during the negotiation of the IHR revisions and is recognised in the regulations: Annex A of the IHR includes details of 'core capacity requirements for surveillance and response'. The WHO has been given the task of assisting states with the development of the necessary domestic mechanisms without being given anything approaching the necessary resources to do the job. At worst this could lead to a situation where states are forced to divert resources from primary healthcare in order to meet their IHR obligations.

Question-marks also remain over the consequences of non-compliance with the provisions of the IHR. The WHO still lacks an effective enforcement

mechanism, although as noted above the WTO may offer states a more robust dispute resolution system in certain circumstances. There have been some suggestions to deal with this issue. The most concrete of these – which emerged from the Secretary-General's High Level Panel on Threats, Challenges and Change – was the proposal that the UN Security Council should be kept informed of 'any suspicious or overwhelming outbreak of infectious disease' and that, 'if existing International Health Regulations do not provide adequate access for WHO investigations and response coordination, the Security Council should be prepared to mandate greater compliance' (Secretary-General's High Level Panel on Threats, Challenges and Change, 2004, p. 47). Again, any such action could raise difficult questions about whose interests are being served, and whether 'global health security' in practice means ensuring the security of some at the expense of others.

It is worth making two points in this regard, however. Firstly, the new reporting arrangements reduce the reliance of the regime on the willingness of member states to comply and have the potential to lead to quicker notifications of disease events bringing, it is hoped, more timely responses. There is also good reason to hope that most states will abide by the IHR most of the time. Whilst it would be naïve to expect universal compliance the IHR 2005 has certain things going in its favour. For one, the regulations were created in response to a widespread perception of a need (heightened by the experience of SARS) to improve the existing arrangements. States thus have a vested interest in the success of the infectious disease regime, augmented by the increasingly high profile which such threats have gained in recent years. Secondly, states generally comply with their international commitments to a far greater extent than realists would predict, even in the absence of sanctions for non-compliance. States frequently exhibit a general preference for norm-compliant behaviour. The explanations for this vary. On the one hand it may be due to a concern with their international reputation, and as Chayes and Chayes have argued this is fundamental to contemporary understandings of sovereignty that, 'no longer consists in the freedom of states to act independently, in their perceived self-interest, but in membership in reasonably good standing in the regimes that make up the substance of international life' (Chayes and Chayes, 1996). An alternative explanation is that through their very participation in regimes, states internalise the norms which the agreement embodies. Compliance then becomes a routine act – often codified in domestic bureaucratic procedures – rather than a conscious decision.[8] Whichever explanation we favour it is reasonable to expect a relatively good level of compliance with the IHR 2005.

Squaring the triangle? Infectious disease, sovereignty and trade

The IHR 2005 is in many ways a much 'stronger' regime than its predecessor. It imposes more obligations on states and gives new rights and

competencies to the WHO. But this is not the same as saying that it has signalled a major shift away from state-centric approaches, still less that it is a radically new form of governance. States have been responsible for the creation of an enormous number of international regimes in a wide variety of issue areas. The IHR 2005 is a relatively highly developed regime (and, of course, it has the extra status of being an international legal instrument), but it is far from unique. Under the nuclear non-proliferation regime, for example, states give extensive powers to the International Atomic Energy Agency to carry out inspections of nuclear facilities on their territories. These powers are considerably more intrusive than the rights given to the WHO in relation to infectious disease. Govern*ance* without govern*ment* will always lead to disputes over authority, just as happened in the case of SARS where the PRC and others questioned the right of the WHO to issue advisories warning against travel to affected regions. It seems inevitable that similar disagreements will arise in future over the application of the IHR to particular disease events, and over the limits of the rights and duties of both states and the WHO under the treaty.

The negotiation process showed that the concerns of states about sovereignty and security in some cases overrode their interest in establishing an optimal disease control regime. The ways in which the IHR relate to international trade rules, norms and procedures is equally problematic. Neither of these tensions has been resolved, and neither is likely to disappear in the foreseeable future. We can expect more rather than less disagreement as the implementation process moves forward and new cases arise. Such disputes are nothing new for the WHO. Throughout its history its work has been hampered by the political manoeuvrings of states and by charges that it is itself a politicised body.

This should not be taken to mean that the IHR 2005 are not a significant step forward in the global governance of infectious disease. Recent years have brought a definite shifting of authority towards the WHO, and the infectious disease regime has been considerably strengthened. Yet states remain the most powerful agents in the governance of infectious disease, and are still fundamental to the broader political economy of GHG. What we have witnessed is not a revolution, but rather an attempt to adapt the current governance structures to better equip them to deal with the contemporary problem of infectious disease. Whether that attempt is successful, or whether a more fundamental embrace of GHG principles will be required, remains to be seen.

Notes

1 I am grateful to Adam Kamradt-Scott, Owain Williams, Adrian Kay and the participants in the conference on 'The Crisis of Global Health Governance: Challenges, Institutions and Political Economy' (Griffith University, Brisbane, 4–5 September 2007) for comments on earlier drafts of this paper.

2 There were slight amendments made to the IHR in 1973 (relating to cholera) and again in 1981 (which removed smallpox from the regulations following its eradication). However, the regime remained essentially unchanged.
3 The Global Outbreak Alert and Response Network (GOARN) was formally launched in 2000, and even before that the WHO regularly made use of non-state information sources.
4 Whilst this instance of an IO having a potential role in reforming the domestic structures of its own member states is a notable one, it is not unique. See, for example, Finnemore, 1993.
5 China has effectively excluded Taiwan from engaging in formal international health cooperation since 1972 despite the backing of the US for Taiwan's case. See Siddiqi, 1995, Ch.16.
6 The wording has remained almost the same. The purpose of the 1969 IHR was 'to ensure the maximum security against the international spread of diseases with a minimum interference in world traffic'. In the 2005 revision this was changed in only minor ways: 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade' (WHO, 1983, p. 5; WHO, 2008, p. 10).
7 For a comparison of the provisions of the SPS and the IHR see: WHO, 1999.
8 The 'norm life-cycle' is the most well-developed model of this phenomenon. See Risse and Sikkink, 1999.

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4

The International Political Economy of Global Responses to HIV/AIDS[1]

Alan Ingram

Introduction

Global responses to HIV/AIDS have shifted considerably since the mid 1990s. The development of combination anti-retroviral therapy (ART), which can extend significantly the lives of people living with HIV, was central to this. While ART rapidly became available to many of those in need within richer countries, leading to dramatic reductions in AIDS deaths, it was generally considered too expensive and too complicated for poor and middle-income countries, where around 90 per cent of people living with HIV were located. An increased focus on preventing transmission was considered to be the only viable way to address the epidemics of poor countries, leaving millions of people infected with HIV to die of AIDS.

By the end of the 1990s, the division between long term survival in Western states and death in poor countries had emerged as a flash point for global politics, leading by the mid 2000s to an expanded international response. As late as 2004 it was estimated that only around 100,000 people in sub-Saharan Africa (around two per cent of those in need in the world's most heavily affected region) were receiving ART (WHO, 2007). But by this point the expanded global response was beginning to feed through, aided by evidence that ART could work in resource poor settings, increased political will and donor funding, and steep decreases in the cost of first line drugs for ART. By December 2006, it was estimated that 2,015,000 people living with HIV were receiving ART, some 28 per cent of the 7.1 million estimated to be in need in poor and middle-income countries. But while access to treatment (and services for prevention and care) has been expanded, and the total number of people living with HIV worldwide appears to be stabilising, the lack of access to treatment, prevention and care and continuing new infections mean that the virus continues to take a heavy toll; the stabilisation of overall prevalence simply indicates an approaching balance of death. In 2007 an estimated 2.5 million more people became infected with HIV and an estimated 2.1 million died of

AIDS-defining illnesses, 76 per cent of them in sub-Saharan Africa, adding to the more than 20 million who have already died (UNAIDS, 2007). At a global level HIV continues to outpace the response to it.

A number of authors have drawn connections between the progress of HIV/AIDS and the advances of neoliberal globalisation, the dominant political economic dynamic of the period in which HIV/AIDS has become a global phenomenon (Barnett and Whiteside, 2006; Farmer, 2005; Kim *et al.*, 2000; Lee and Zwi, 1996; O'Manique, 2004). The hollowing out of public health and welfare under structural adjustment combined with other social, economic and political dislocations combine to deepen the vulnerability of many. Marketisation and liberalisation brought increased mobility, urbanisation and extra-local connectivity to many regions, helping the virus to spread. These complex multiscalar processes layered through a variety of longer term post-colonial crises to produce differentiated profiles of risk and vulnerability, centered on southern Africa but with distinct concentrations in many places and groups outside. While the geography of the HIV/AIDS pandemic can by no means be explained entirely by recourse to political-economic forces (Halperin and Epstein, 2004; Epstein, 2007; Whiteside, 2008), neoliberal globalisation has been a powerful influence on its social determinants, a shaper of the uneven distribution of vulnerability to infection, illness and death (see Kay and Williams in this volume). As Colleen O'Manique (2004) has suggested, HIV/AIDS is in significant ways 'globalization's pandemic'.

Some analysts have also connected the manifest inadequacies of early global responses with the dominance of the neoliberal paradigm, and this reflects, in part, arguments developed in this volume that a crises in global health governance (GHG) is inextricably linked with the wider neoliberal project (Poku, 2002), in particular around the marginalisation of health, welfare and social citizenship in structural adjustment and its successors and the maintenance and extension of intellectual property rights in the face of human suffering. What has so far received less scholarly attention is the relationship between neoliberal globalisation and the shift towards an expanded global response to HIV/AIDS since 2000. A number of narrative accounts of this period reflect and draw on the perspectives of key actors (for example Behrman, 2004; Council on Foreign Relations, 2005; D'Adesky, 2004; Epstein, 2005; Lewis, 2006; Morrison, 2000), but there has been little theoretically informed analysis which has aimed to situate expanded global HIV/AIDS relief in relation to the international political economy more generally (for a similar view see Hein and Kohlmorgen, 2007). Diagnosing the tensions and synergies between the international political economy (IPE) and global HIV/AIDS relief at this level might enable a deeper understanding of the future of HIV/AIDS relief and the predicaments of GHG more generally.

This chapter argues that transnational social movement mobilisation around HIV/AIDS and against neoliberal globalisation, primarily sparked by inequities in access to ART, was crucial in producing the shift to an expanded global

response. This was further supported by particular kinds of expert knowledge which enabled a more integrated (and compelling) global picture of the pandemic and a discursive shift in the terms in which the significance of the pandemic was understood. Yet rather than effecting a fundamental shift in the dominant political-economic coordinates of globalisation, this has led to a complex accommodation between HIV/AIDS relief and different dimensions of neoliberalism. That is, despite the ostensibly humanitarian goals embodied in the scaling up of relief, and the apparent transition to a more robust form of GHG in relation to the pandemic, neoliberalism still informs the logic and nature of responses to the crises, and often in a manner which the introduction to this volume describes as its polymorphous and colonising character.

While HIV/AIDS activism has confronted aspects of the neoliberal project (such as the Trade Related Aspects of Intellectual Property Rights (TRIPS) agenda) directly, the institutions charged with forwarding that project have adopted the fight against HIV/AIDS as their own, and actors involved in the fight from more activist positions have at times aligned with and made use of neoliberal logics in the service of HIV/AIDS relief. Thus, global HIV/AIDS relief today can be characterised in significant respects (for example in its reliance on ideas and technologies of surveillance, transparency, competition, entrepreneurialism and partnership) as itself neoliberal. Meanwhile, the basic principles of commodification, marketisation and privatisation (as embedded in the Bretton Woods institutions and the bilateral and free trade deals increasingly being promoted by core states) remain largely in place and militate against the construction of inclusive health and welfare systems that will be needed to turn the course of the HIV/AIDS pandemic and improve health in the poorest countries in particular.

In order to explore these issues further the second part of the chapter presents a brief theoretical outline and background discussion. This conceptualises HIV/AIDS relief in relation to broader trends in the IPE, emerging forms of global governance, and the bio-political dimensions of HIV/AIDS relief. The chapter then draws on this conceptualisation to reconsider the story of the shift towards expanded global HIV/AIDS relief, suggesting that this can be understood in significant part in terms of a cycle of social movement mobilisation against neoliberal globalisation, and the resultant governance innovations and policy initiatives by a range of actors. It then considers certain features of global responses, dwelling on the changing nature of the engagement of the US in the fight against HIV/AIDS, and identifies their synergies and tensions with different dimensions of neoliberalism. The concluding section draws on this analysis to outline some important issues for the future IPE of HIV/AIDS relief.

Overall the chapter argues that while considerable steps have been made in responding to HIV/AIDS internationally, the relations between HIV/AIDS relief and neoliberal globalisation are multidimensional and somewhat

ambivalent. This holds implications for the next phases of HIV/AIDS relief and how we think about the connections between GHG and wider socio-economic structures and processes (Thomas and Weber, 2004). On one level, neoliberal assumptions are certain to shape the grounds on which the future of HIV/AIDS relief is constructed. At the same time, the chapter suggests that a shift from humanitarian intervention towards a greater approximation of health for all will require the establishment of a rather different kind of relationship between health and the IPE from that which has been evident within the dominant neoliberal project.

Globalisation, governance and bio-politics

As D'Adesky (2004, p. 27) writes, the field of global HIV/AIDS policy is one of 'under-the-table-fights and competing agendas', where gains can be temporary and easily reversed and it is certainly the case that efforts to respond to HIV/AIDS have involved contention among a diverse and sometimes surprising range of actors, interests and ideologies, sparking counter-strategies, adaptation and transformation. Crucially, they have been linked to broader questions of politics and economics and to claims to global leadership, and reflect the wider contestation in GHG that frames this book. What this chapter seeks to do is contextualise this process by emphasising the ways in which expanded global HIV/AIDS relief has emerged in relation to broader struggles around neoliberal globalisation and shifts in hegemonic strategy, and to consider what the implications of this might be.

In keeping with the broader arguments of the book, the chapter does not understand neoliberalism as a unitary or monolithic formation, but rather a polymorphous social phenomenon that is concretised in a variety of ways. One of these is clearly around the principles of commodification, marketisation, privatisation and liberalisation as expressed in structural adjustment and the increasing coherence of the Bretton Woods institutions as mechanisms of economic globalisation in the post-Cold War era. This dynamic has, too, clearly relied on the recruitment of a wide range of private and public actors and institutions to neoliberal rationalities. Yet while neoliberalism has provoked a variety of social crises, it is a mark of its ability to colonise social relations that solutions to them have also increasingly been articulated in broadly neoliberal terms, via ideas of network governance, partnership and entrepreneurialism, and underpinned by diverse technologies of surveillance, transparency and competition. While the implications of neoliberal restructuring on welfare states, health systems and on social inequalities have produced rather clear dividing lines of politicisation, the politics of neoliberal rationality more generally are often more fuzzy and ambiguous. Ong and Collier (2005, p. 17) are thus well-justified in stating that: 'Neoliberalism today remains a pervasive form of political rationality whose formal and "global" character is allowing it to

enter into novel relationships with diverse value orientations and political positions'. In developing this argument further the chapter weaves together three main conceptual threads.

The first (inspired by neo-Gramscian and Marxian accounts in IPE and geography, see Cox, 1981, 1983; Agnew and Corbridge, 1995; Harvey, 2003; Peet, 2003) is informed by a focus on successive restructurings of the global economic and geopolitical order. Thus, global HIV/AIDS relief can be situated according to various temporalities and spatialities that have combined to produce the geography of the present, and which include the legacies of colonialism and the Cold War, as well as the consequences of debt and the restructuring of neoliberal globalisation. For example, the collision of apartheid and capitalism and the problems of transition to a neoliberal post-apartheid South Africa has produced complex drivers for epidemics in that country and its regional neighbours (Campbell, 2003). In similar terms, contemporary HIV/AIDS relief in Nigeria should be seen not just in terms of the specificities of its present day state and society, but the longer range impacts of colonialism (Okonta and Douglas, 2003); the construction of an indebted and crisis-ridden 'petro-state' (Watts, 2006); and the gutting of the country's welfare state, pharmaceutical industry and pharmacies under structural adjustment (Peterson, forthcoming). The belated and partial responses of Russia and Ukraine to their ominous and growing HIV/AIDS problems can be related to deep-seated problems in Soviet state and society as well as the post-Soviet crisis and collapse induced by shock therapy, and an uneasy engagement with the question of how to govern problems that, like HIV/AIDS or injecting drug use, have significant transnational dimensions. The tendency of subsequent rounds of post-adjustment policy making to lock in structural adjustment has meant that rather than a break with neoliberalism, global HIV/AIDS relief can be seen as a further iteration of the processes by which territories and populations are constructed and incorporated into globalising relations and networks.

Just as the nature of the HIV/AIDS epidemics faced by countries varies, so too does the ability and willingness of their powerholders and societies more generally to address them. At a very broad and imperfect level, contrasts can be made between high-income countries that have been in a position to deal with their epidemics in a near-comprehensive manner (though they may not do so); middle-income countries that have actively developed strategies to pursue comprehensive strategies against HIV/AIDS (for example Thailand and Brazil); middle-income countries that have been slow to gear up their responses to early and mid-epidemics (notably South Africa, Russia, China and India); low-income countries that have achieved some success against HIV/AIDS (for example Senegal, Uganda); and low-income countries where the pandemic has run largely unchecked, with devastating consequences (for example Swaziland, Malawi, Zimbabwe). Further differentiations can be traced to the structural position of countries with regard

to the pharmaceutical industry, World Trade Organization (WTO), International Monetary Fund (IMF) and World Bank regimes, their dependence on foreign aid, and the nature of their political systems, civil societies and cultural, sexual and gender norms.

Against this background, the chapter focuses on how institutions of global governance and donor states have responded to the politicisation of HIV/AIDS. As well as work in GHG literature, this thread is informed by studies of hegemonic policy discourse (Peet, 2002) and social movements (Tarrow, 1994, 2001). The nature of GHG has changed considerably in the post-Cold War period. There have been shifts in funding streams among international organisations (IOs) (particularly World Health Organization (WHO) and the World Bank) away from regular budgets (subject to collective discussion) towards discretionary donor support (which responds to donor preferences). Associated with this has been a shift towards infectious disease control and single disease interventions at the expense of health system strengthening. As philanthropic and other private sources of funding and initiative (such as the Gates Foundation and the Clinton Foundation) have come online, the nature of accountability has become more complex and blurred (Buse and Walt, 2002). The entry of numerous new actors mean that accounts of global governance in relation to HIV/AIDS now need to include states (including their foreign policy, trade and development agencies), the Bretton Woods institutions, other components of the UN system, corporations, think tanks, private foundations, non-governmental organisations (NGOs), activists, celebrities, faith-based organisations, medical researchers and practitioners, and wider social movements. Cycles of contention and institutional innovation have drawn these actors into shifting and asymmetric relationships of contention and collaboration that constitute 'the fight against HIV/AIDS' itself.

The third conceptual thread deals with the ways in which global HIV/AIDS relief is bio-political, in that it addresses the very meaning, constitution and administration of life itself in ways which, furthermore, can also be characterised as neoliberal (Ong and Collier, 2005). Thus, analysts have begun to consider (after Foucault) how risk, surveillance, bodies, subjectivities and populations are being brought together in new regimes of governmentality around HIV/AIDS (Elbe, 2005; Nguyen, 2005, n.d.). This is evident, for example, in the consequences of work by UNAIDS following its creation in 1996 to create a more integrated and authoritative global picture of HIV/AIDS as a pandemic. While this new formation of surveillance enabled stronger political claims to be made about the urgency of international action, it also created a focus for contestation about what was for some the disproportionate attention being granted to HIV/AIDS compared to other problems. Similarly, while 'die-ins' and other interventions by HIV/AIDS activists problematised the relationship between pharmaceutical capital, trade policy, intellectual property protection and the lives and

deaths of millions of people in poor countries (Behrman, 2004; Comaroff, 2007), the emergence of corporate philanthropy and branding has created a field in which particular formations of capital seek relegitimation in relation to HIV/AIDS relief. This, like the adoption of the fight against HIV/ AIDS as a key component of US foreign policy, signals the extent to which HIV/AIDS has become a touchstone for questions of global order.

The implications of these perspectives are to qualify the conventional narrative according to which neoliberalism has contributed to a 'hollowing out' of the state. Such a narrative is both inadequate to describe the transnational political alignments through which neoliberalism has been forwarded and the extent to which it has relied on state power for its implementation. As Kay and Williams argue in this volume, in terms of global health policies and governance, and in the changing nature of national health systems (NHS), the state has not withered away in the face of liberalising and marketising pressures on health, rather its function has changed and is changing. But in the present case it also obscures the complex formations of public and private actors which HIV/AIDS relief is generating and their associated dynamics of power and legitimacy.

Transnational activism and the politicisation of HIV/AIDS

HIV/AIDS emerged as an issue of international concern in a climate of late Cold War geopolitics, welfare state retrenchment, neoliberal structural adjustment, and moves towards asymmetric capitalist restructuring and integration under the direction of the IMF, World Bank and WTO (Peet, 2003). Early scientific contention, linked with political skepticism, denial and distortion, served to inhibit significant responses, even as the rise of HIV/AIDS was fuelled by the downsizing of welfare states and health systems. At the same time, HIV/AIDS was gaining some institutional expression and commitment at an international level. The work of Jonathan Mann at WHO (and later at Harvard) was a key catalyst to this process, bringing a measure of urgency and integration to the understanding of HIV/AIDS as a global problem. But personal and bureaucratic tensions over leadership and funding soon emerged between Mann, the US and the WHO, leading to institutional fragmentation (Poku, 2002; Behrman, 2004). Meanwhile, the early panics in Western countries about the potential extent of their epidemics had been subsiding, and the much more serious epidemics in sub-Saharan Africa were taking place in regions that were either excluded from global circuits of capital, media attention and geopolitical interest, or highly dependent within them. The end of the Cold War, the collapse of the USSR, and events in Yugoslavia dominated the international agenda. From the perspective of global power centres, HIV/AIDS was still seen as relatively marginal to the post-Cold War order.

However, during the 1990s the broader contours of neoliberal globalisation and the role of the Bretton Woods institutions increasingly became the subject of social movement mobilisation and critique in ways that eventually connected with HIV/AIDS activism. As evidence of the scale of the pandemic continued to accumulate, such networks (which reached some way into institutions of global governance themselves) increasingly began to connect with, and prompt and draw episodic strength from, national campaigns and political opportunities around HIV/AIDS and other development and health issues, thus becoming part of a serious transnational challenge to neoliberal globalisation itself (Tarrow, 2001).

Connections between the international intellectual property rights (IPR) regime, the interests of pharmaceutical capital and particular states became a focal point and stimulus for these mobilisations. As the potential of combination therapies to counter HIV/AIDS became known in the 1990s, the inequity of the contrast in availability between rich countries on one hand and poor and middle-income countries on the other became a focus for mobilisation within and between them. One key moment was the 1996 AIDS Conference in Vancouver, at which the efficacy of ART was publicised. Here demands were also raised that the drug companies lower their prices and that universal access to the new treatment be achieved (Behrman, 2004, pp. 132–133). In response to a lack of action from donor countries, pharmaceutical companies and IOs, HIV/AIDS and intellectual property activists began to campaign much more concertedly on international access. Transnational networks began to form, with links between the US and South Africa being particularly important. The defence of drug prices and patent rights by pharmaceutical companies and the US government in particular became a focus for activists deploying new repertoires of contentious collective action (Tarrow, 1994) framed in terms of corporate greed and irresponsibility, human rights and social justice rather than healthcare or public health alone (Behrman, 2004; D'Adesky, 2004).

A second source of opposition to the IPR regime emerged via a number of middle-income countries where incorporation into the neoliberal order was producing a range of tensions and crises. Particular issues surfaced in countries seeking to export or import the new anti-retroviral drugs and therapies much more cheaply as part of national HIV/AIDS programs: South Africa, India, Brazil and Thailand. As they began to make moves in this direction, they too ran up against the international intellectual property system and the willingness of patent-holding pharmaceutical companies and their home governments to threaten and implement punitive actions against any moves they deemed inimical to their interests, as evidenced by the court case brought by 39 pharmaceutical companies in response to South Africa's Medicines Act of 1997 (Olesen, 2006).

This mobilisation gained further impetus from the development of certain kinds of surveillance and expert knowledge, which shifted the understand-

ing of HIV/AIDS as a problem within global governance networks and enabled new political claims to be advanced (Peet, 2002). On one level, work done by Joint United Nations Programme on HIV/AIDS (UNAIDS) to integrate and standardise country level data on HIV/AIDS allowed the production of more credible global estimates of the state of the pandemic from 1998 onwards (Behrman, 2004). Second, evidence emerging from field studies (for example from projects run by Médecins sans Frontières and Partners in Health) began to challenge the prevailing wisdom that HIV/AIDS was too difficult to treat in poor countries, and that such treatment was not cost effective (in the process demonstrating that terms such as 'cost effective' were themselves socially, politically and geographically constructed, and not just economically given) (Farmer *et al.*, 2001; Kim *et al.*, 2000).

This convergence between transnational social movement activism and expert knowledge fuelled an intense cycle of protest between 1998 and 2001, which reached a high point at the Durban International AIDS Conference of 2000, where the legitimacy of the global order was called fundamentally into question (Olesen, 2006). This cycle brought a wide variety of actors (treatment access activists; debt, trade and aid campaigners; human rights workers; government bureaucracies; legislatures; judiciaries; lawyers; corporations; lobbyists; IOs; and the media) into a dynamic network of contention and collaboration that drove the next stage of HIV/AIDS relief.

However, while the outcome of this cycle was a repositioning of HIV/AIDS as an issue for IPE, this did not take place entirely on the terms suggested by activists. A key part of this repositioning concerned the linking of HIV/AIDS with dominant ideologies of neoliberalism and security. Thus, the WHO's Commission on Macroeconomics and Health (CMH), chaired by Jeffrey Sachs, sought (with some success) to promote a discursive shift within the Bretton Woods institutions and donor countries towards the proposition that rapidly scaled up investments in a selected bundle of health interventions in poor countries could enable those countries to overcome otherwise insurmountable barriers to economic growth and inclusion in the global economy (CMH, 2001; Gomez, 2003; Waitzkin, 2003a, 2003b). Similarly, key actors within UNAIDS and the Clinton administration sought (again with some success) to change the way countries viewed the significance of HIV/AIDS as a national and global problem by positioning HIV/AIDS as an issue of security (Council on Foreign Relations, 2005; Behrman, 2004). Thus, HIV/AIDS was claimed to be significant because it could affect human, national and international security at the same time, and, it was said, threatened to destabilise entire regions, some of strategic significance (National Intelligence Council, 2000, 2002). By the end of 2000, HIV/AIDS had been reframed in terms of fundamental questions of global order (see McInnnes in this volume for an account of the 'securitisation' of HIV).

Responses: adaptation, innovation, fragmentation

Around this time numerous actors were becoming engaged in a period of institutional adaptation and innovation, from which emerged the current landscape of HIV/AIDS relief. While activist mobilisations targeted the asymmetrical nature of particular governance arrangements (in particular the IPR regime), neoliberal rationalities and techniques were also mobilised in support of HIV/AIDS relief.

One early source of response was the drug companies themselves. Besides legal and political action, drug companies sought to forestall HIV/AIDS activism by recourse to charity. While they continued to lobby for enforcement of patents and the maintenance of pricing arrangements, pharmaceutical corporations began drug donation programs, with five companies joining five United Nations (UN) agencies in the Accelerating Access Initiative in 2000 (D'Adesky, 2004). However, these could never cover the scale of need in poor countries, did nothing to address the cost of drugs, and were subject to fierce criticism on the grounds that UNAIDS was legitimising the very actors who were to blame for the inability of poor countries to access essential medicines (Poku, 2002).

The issue of access to medicines also emerged in inter-state forums that were negotiating forthcoming rounds of trade liberalisation. While the outcome of these negotiations did not lead to a fundamental shift in the trajectory of neoliberal integration, the Doha Declaration on the TRIPS Agreement and Public Health, reached at the November 2001 WTO Ministerial and subsequent amendments reaffirmed the rights of countries to exercise flexibilities under TRIPS in order to increase access to medicine (Khor, 2007).

However, it was market entry by generic producers in non-Western countries combined with intense lobbying and mobilisation that was crucial in actually forcing prices down. Prices began to fall sharply after the Indian drug company Cipla called the bluff of the major manufacturers in February 2001 by offering drugs to MSF for US$360 per patient per year (against the cost of US$10,000 for patented drugs).[2] Subsequent market entry by generic competitors further drove down drug costs, enabling the expansion of access to treatment to a much greater extent. It also elicited further negotiation from Western drug companies and concessions on tiered pricing. Here again particular kinds of neoliberal surveillance have enabled response to HIV/AIDS. A key example of this is the systematic collection and dissemination of information relating to drug pricing and procurement undertaken by actors such as Médecins sans Frontières (MSF, 2007). This contrasts with the efforts exerted by the US to prevent the creation of an integrated database of prices for HIV/AIDS drugs.[3] The key challenge was not so much to the principle of market competition as the asymmetric arrangements through which markets had been structured to that point. The idea of expanding access via open market-based competition between multiple producers based on freely avail-

able, standardised price information subject to regular surveillance could hardly be more neoliberal.

Shifts were also underway within the World Bank, which during the 1990s had supplanted WHO as the main influence in global health policy. Just as it was coming under increasing attack from development campaigners, the Bank initiated the Multi-Country HIV/AIDS Program for Africa, which in September 2000 offered US$500 million in flexible and rapid loans to African governments to assist in scaling up their responses, followed by a further US$500 million in International Development Association (IDA) financing in 2002. Although this program and the Doha Declaration were significant, neither addressed the basic problematic issues with the Bretton Woods institutions: their governance arrangements and dominant policy frameworks. HIV/AIDS was treated as something that could be addressed by limited, conditional redistribution and a partial (and hard won) exception to overarching frameworks. Meanwhile debt repayment and structural adjustment were forwarded via new modalities and disciplinary techniques such as the Highly Indebted Poor Country (HIPC) initiative and Poverty Reduction Strategy Papers (PRSPs), and increased convergence among the Bretton Woods institutions themselves (see Kay and Williams, Labonté *et al.*, Harman, and Buckley in this volume). Despite these adaptations in response to HIV/AIDS, the policy space for health and development therefore remained constrained, reflected in concern that macroeconomic frameworks are still leading countries to constrain spending in ways that inhibit the response to HIV/AIDS and the development of broad based health systems (UNAIDS, 2007, p. 9; Ooms *et al.*, 2007).

While efforts to shift the Bretton Woods institutions on key issues relating to health and development found limited success, other parts of the UN system addressed the pandemic in different ways. In 2000, the initiative of key foreign policy advisers within the Clinton administration led to a special session of the Security Council, which adopted Resolution 1308 on HIV/AIDS as a potential threat to international peace and security (Behrman, 2004). The Millennium Summit adopted the fight against HIV/AIDS as one of the Millennium Development Goals, with the aim of halting and reversing the spread of HIV/AIDS ('and other diseases') by 2015. The growing sense of HIV/AIDS as an exceptional humanitarian, developmental and security challenge helped to secure a special session of the General Assembly in July 2001, which led to a Declaration of Commitment to combat the pandemic in a comprehensive manner. In April 2001 Kofi Annan called for an international fund backed by US$7–10 billion per year (a massive increase in funding) from donors to finance the fight against HIV/AIDS.

The Global Fund to Fight HIV/AIDS, tuberculosis (TB) and malaria was created in ways that reflected both a push by a range of actors for institutional fixes and a variety of neoliberal techniques of governance. Opposition (particularly from the new Bush administration) to locating the fund

within the UN system led to its creation as an independent foundation. With UNAIDS, WHO and other agencies concerned about the new division of labour (and in effect the creation of new modalities of GHG), the Fund was established as a financing mechanism and not an implementing agency. Reflecting the rise of ideas of participation and partnership, the Fund also adopted a somewhat pluralistic approach to its own governance, including representatives of recipient countries and civil society as voting board members alongside donor governments, philanthropic entities and the private sector (including the pharmaceutical industry). Programs would be orchestrated within countries by Country Coordinating Mechanisms that would also include a range of actors. Reflecting its emphasis on a technocratic and technical approach, the Fund would respond to programs proposed by countries rather than those determined by donors, and subject to approval by a Technical Review Board, rather than policy conditions. Concern with surveillance and discipline were evident in the approach to disbursement which was to be conditional on performance and reviewed by external agencies such as private accountancy firms. While the Fund therefore incorporated a number of innovations in the governance of global HIV/AIDS relief, it has never received the funding levels initially called for: pledges from 2001–2004 reached US$3.4 billion, and funds pledged through 2010 stand between US$3.2 billion (for 2008) and US$2.4 billion (2010).

These developments, together with increases in US funding (discussed below) are widely credited with ushering in a phase of 'scaling up' and 'rolling out' access to treatment (and to some extent other services) in the fight against HIV/AIDS. In 2002 WHO sought to catalyse international efforts further by declaring a target of reaching three million people in poor countries with ART by the end of 2005. In 2005 the Group of Eight (G8) set the goal of 'universal' access to treatment, prevention and care, a goal subsequently endorsed by states at the UN World Summit of that year. As a range of problems became evident in scaling up treatment access, further efforts have been made to coordinate and mobilise international and state-level action (UNAIDS, 2006). The intensity of these efforts and the diversity of actors now involved (including corporate and philanthropic initiatives such as the Global Business Coalition to Fight HIV/AIDS, TB and malaria, (Product) Red and the Gates Foundation) indicate the extent to which HIV/AIDS relief has become not just a signature project of global governance, but a field in which fundamental issues of global legitimacy and power are played out.

With this in mind, it is worth reflecting further on the role of the US in global HIV/AIDS relief. The fight against HIV/AIDS has gained momentum in a period where the nature of US global engagement has been subject to profound questioning, challenge and change. The relations between the IPE of HIV/AIDS and the US state have been structured by a variety of actors, interests and discourses, among which the pharmaceutical companies (which

feed into policy through the United States Trade Representative (USTR) system, lobbying networks, think tanks and the media) were initially by far the most influential. The US position began to shift in some respects in the later stages of the Clinton presidency, with an executive order signed alongside the African Growth and Opportunity Act (which otherwise defended patents to the hilt) preventing US government agencies from undermining African states trying to access anti-retroviral drugs. Vice President Gore in particular also supported the idea that the pandemic represented a threat to international and US national security interests, which had been coalescing within parts of the administration (Behrman, 2004, pp. 228–230). However, while incremental increases in funding were secured, decisive action of the kind being demanded by activists to increase access to treatment was not forthcoming and neoliberalism remained at the core of the administration's geopolitical imagination.

The new Bush presidency did not inspire much confidence among HIV/AIDS activists. The candidacy of the incoming president had been supported by donations from Big Pharma, and Bush's advisor Karl Rove was reported to have close ties to major pharmaceutical corporations. In early 2001, and i n anticipation of the South African court case, Bush threatened to remove Clinton's executive order on African drug access. Furthermore, parts of Bush's conservative and evangelical Christian support base held notoriously reactionary views on personal moral responsibility for HIV/AIDS. The Bush administration, it seemed, would not be sympathetic to the cause of global HIV/AIDS relief, and its leading players seemed committed to prioritising more conventional ideas of international security and economic interest.

A number of things happened to change this. In response to these initial ominous signs, further rounds of domestic and international activism rapidly placed HIV/AIDS back on the agenda of the administration. Many evangelicals (partly through their own missionary work) were also increasingly coming to see helping people suffering from HIV/AIDS (in Africa in particular) as a moral imperative (Epstein, 2005). Yet while its early funding pledges amounted to a doubling of funding over the Clinton administration, the amounts were still far below the quarter or third share of US$7–10 billion per annum that had been widely adopted as the standard for a fair US contribution. But though the administration remained substantially behind the position reached in transnational activist networks around what was necessary to address the pandemic, it was beginning to shift.

A key factor in this was the invasion of Iraq. As they were planning the invasion, it seems that administration officials were also casting around for a countervailing humanitarian program (Morrison, 2007) just as those responsible for developing US global HIV/AIDS policy were starting to think about much greater funding levels (Behrman, 2004). Furthermore, just as the security discourse around HIV/AIDS had suggested that AIDS

relief could support other security goals, the strategic significance of Africa was being re-evaluated (positively) as potential energy supplier and (negatively) as potential haven for al Qaeda following 11 September 2001 and terrorist attacks in Kenya in 2002. Stabilising vulnerable populations and regions in Africa and insulating them from terrorist networks rose as a policy priority (CSIS, 2005). Sensing the prospect of big contracts, pharmaceutical companies rallied round to lobby for a significant program (Dietrich, 2007). In his 2003 State of the Union speech, two months before the invasion of Iraq, Bush called for a 60 per cent increase in US funding to provide US$15 billion over five years for the President's Emergency Plan for AIDS Relief (PEPFAR), and set goals for treatment access, prevention and care.

PEPFAR is highly significant for the global governance of HIV/AIDS for many different reasons. At US$18.8 billion committed between 2003 and 2008, it has contributed in that period between a third and half of all foreign aid for HIV/AIDS. This in itself has brought considerable influence over what has become an important terrain for global legitimacy, but the way the program has been designed, organised and implemented has been highly contested. First, the great majority of funds have been disbursed bilaterally rather than through the Global Fund, contributions to which have been capped by authorising legislation to one third of total international pledges or US$1 billion. This has led to questions about politicisation and fueled debates about US unilateralism. The majority of PEPFAR funds have been targeted to 15 'focus countries'. While the rationale for focus country selection has never been made entirely clear, among them are larger African states with large numbers of people living with HIV, but also allies in the war on terror and/or energy security (Kenya, Nigeria, Ethiopia, South Africa, Tanzania, Uganda). While PEPFAR has engaged a very diverse range of partners for implementation, the Pentagon itself is channeling funds to programs focused on military forces (an effect of the security discourse on HIV/AIDS). While these geopolitical issues have remained largely unpoliticised, they potentially raise further questions about the implications of the encounter with security discourse (Elbe, 2005; Ingram, 2007). They also illustrate how the discourse of security and the power of states (particularly the US) can still exercise authority over the direction and ethos of contemporary GHG (see McInnnes and Rushton in this volume for similar perspectives).

However, corporate agendas were never far from the heart of PEPFAR. IPR debates have been played out within PEPFAR itself, with questions about whether PEPFAR was geared more towards US pharmaceutical and corporate interests rather than public health goals. Initially, treatment funds could only be used for the purchase of drugs and commodities approved by the US Food and Drug Administration, rather than WHO, thereby excluding foreign-produced generics and biasing the program toward US on-patent drugs. While an expedited clearance procedure for anti-retrovirals

was agreed in 2004, it was slow to gear up (United States Government Accountability Office, 2004), and questions were raised about whether the scale of PEPFAR's impact in the focus countries will serve as a basis for future US policy initiatives in trade and intellectual property, and in securing emerging markets for pharmaceuticals and other commodities (Buse and Walt, 2002).[4]

The emergency nature of the program and the rapidity with which resources have infused focus countries have strained the limits of the neoliberal managerial techniques and governance standards in foreign aid. Evaluations and investigations have called into question PEPFAR's transparency and accountability and its systems for monitoring and evaluation (Bernstein and Hise, 2007; International Consortium of Investigative Journalists, 2006; US Institute of Medicine, 2007). These issues have also emerged more generally in the push for rapid scale up and roll out, a function of the framing of the pandemic as a humanitarian emergency. This has given rise to a form of what Nguyen (n.d.) calls experimentality, where the emergency nature of the situation legitimises massive interventions in advance of evidence of their effectiveness, in turn generating a perpetual search for 'lessons learned'.

Finally, PEPFAR has produced tensions within the bio-politics of HIV/AIDS relief around the relative roles of public health science and religious belief. The authorising legislation for PEPFAR contained earmarks and provisions (inserted by conservative and evangelical legislative interests) and supported priorities that are contrary to international guidelines. All partner organisations had to adopt a policy explicitly denouncing prostitution and human trafficking (despite the impact of this on attempts to engage vulnerable populations); 'abstinence' and 'be faithful' interventions were privileged (despite their questionable effectiveness); the promotion of condom usage was undermined (despite its proven effectiveness); and though President Bush exempted PEPFAR from the Mexico City rule prohibiting assistance to organisations discussing abortion, the rule has inhibited the integration of HIV/AIDS relief and sexual and reproductive health services (Avert, 2008; United States Government Accountability Office, 2006; US Institute of Medicine, 2007). PEPFAR has furthermore channeled significant resources to organisations with little prior experience and expertise in global health, but which have supported these positions.

PEPFAR therefore holds multiple implications for the GHG. On one hand it reflects increased engagement by the US in a central global health issue and has brought resources and commitment that has been welcomed in many quarters. But the price of this has been to inject much of the ideological and political-economic baggage of US foreign and domestic policy into global health, triggering international scientific and diplomatic opposition, and further rounds of social movement mobilisation, for example at the 2004 AIDS conference in Bangkok (Bowtell, 2004; Gill, 2004). While US

engagement has been of a sufficient scale to shift the course of HIV/AIDS relief and exert a significant degree of influence over it, it has not catalysed an international response adequate to the scale of the challenge, compounded the fragmentation of GHG, and left wider political-economic questions about health, development and globalisation largely untouched.

Although PEPFAR has created problems for global governance, it is certainly critical to the future of HIV/AIDS relief. In May 2007, in advance of the G8 summit, President Bush called for the program to be extended for another five years (to 2013). While these and other issues were being contested as legislation authorising a second phase came before Congress in 2008, the uncertainty over future funding levels (Zeitz, 2007) suggests a looming rationalisation of global HIV/AIDS relief and attendant conflicts over priorities.

Conclusion: the future landscapes of global HIV/AIDS relief

The expanded response to global HIV/AIDS relief has emerged at a time when, despite modifications to dominant frameworks, ideas of the right to development and health for all remain fundamentally in tension with the neoliberal project as advanced through the Bretton Woods institutions. Yet, as the chapter has sought to demonstrate, HIV/AIDS relief has not emerged in simple opposition to neoliberalism, but has become bound up with it in a variety of ways that reflect its polymorphous, colonising and pervasive character. The expanded response has involved the development of new institutions and practices that reflect neoliberal rationality, evidenced in the centrality of international transparency and surveillance to UNAIDS and the Global Fund. But while these institutions are key players in HIV/AIDS relief, and while the Global Fund exerts considerable disciplinary influence over recipient countries, they are themselves conditioned by the preferences and foreign policy agendas of their donors and other parts of the UN system. Plurality and incipient tendencies towards fragmentation are endemic features of the global governance of HIV/AIDS.

HIV/AIDS has also been positioned in terms of key questions about the nature of global order. In this regard the chapter has considered how HIV/AIDS relief has been caught up in struggles to relegitimate US hegemony. On the one hand the ideas that the US should act as a more responsible global leader and that its security interests were threatened by the pandemic have been productive arguments for HIV/AIDS activists who have sought to lever up foreign aid and political will. On the other, HIV/AIDS relief has also become linked to more instrumental ideas of global power projection and legitimacy that have remained largely in the background of debates around HIV/AIDS relief itself. The fact that these latter dimensions have not been politicised in any overt way is perhaps a reflection of tacit accommodations through which the global response is held together.

By 2007 a significant shift in global responses to HIV/AIDS was evident. According to WHO, in 2006 more than two million people worldwide were receiving ART, with more than 1.4 million of these in Africa. However, this meant that only 28 per cent of the people estimated to be in need of treatment were receiving it. Moreover, financing is inadequate, unpredictable and often too short in duration (UNAIDS, 2006; Zewdie *et al.*, 2007) and WHO has stated that 'it is unlikely that the current global rate of scale up will be able to keep up with the ever-increasing need' (2007, p. 46). With no vaccine solution in prospect, treatment demand growing and the costs of treatment rising, discussions are turning back towards prevention. This will intensify the bio-political contestations around HIV/AIDS relief, as increasing attention is focused on issues such as the role of concurrency of multiple sexual partners, the effectiveness of male circumcision and the potential of technical fixes like anti-HIV microbicides that (unlike condoms) would supposedly be under female control.

As far as treatment goes, there is still a deep division over the question of intellectual property rights and their relationship to access to treatment in middle-income and poor countries. Just as a measure of flexibility had apparently been obtained via the WTO, the US and European Union (EU) are turning to bilateral and regional free trade agreements (FTAs) and the World Intellectual Property Organization (WIPO) as a way of promoting geopolitical and economic interests. The evidence so far suggests that FTAs invariably contain 'TRIPS-plus' clauses that further narrow the policy space around access to medicines (as argued by Labonté in this volume), in essence locking in patent advantages and profitability from future rounds of drug development. Intellectual property issues continue to be contested by Brazil and Thailand, middle-income countries that are financing universal access to treatment from domestic sources. They have invoked TRIPS flexibilities on public health grounds in relation to treatment, against considerable industry and US diplomatic pressure. Brazil also rejected a proposed PEPFAR prevention program in order to maintain the integrity of its HIV/AIDS policy. However, few low-income and aid-dependent countries have the ability to resist dependent relations in this way.

The push towards universal access has also revealed many problems embedded within the wider international political economy of health: the weakness of many countries' healthcare systems and the scale of the deficit in trained health personnel being among the most immediate. However, these problems are unlikely to be solved by further moves towards commodification and liberalisation; indeed, if anything the opposite is more likely to be the case. Furthermore, while the rapidity of the scale up has transformed the situation in many settings, bringing many benefits in the short term at least, the impact on poorer countries' ability to develop sustainable, inclusive and comprehensive health systems remains open to question (McCoy *et al.*, 2005). The global response to HIV/AIDS to date,

because of its partial and provisional nature, looks more like a humanitarian intervention than a step towards health for all. Potentially depoliticising neoliberal rationalities of participation, partnership and entrepreneurialism, as well as an orientation towards technocracy (manifest in the emergence of experimentality and a widespread preoccupation with 'what works'), are also evident in global responses.

At the same time, mobilisations around HIV/AIDS so far have been at the leading edge of social movement innovation. They have forged links across diverse domains and have created new transnational subjectivities: the AIDS activist; the treatment access campaigner; the person living with HIV/AIDS. HIV/AIDS activists have also found allies within existing institutions. In this sense a heterogeneous transnational activist network can be said to exist across NGOs, scientific institutions, government departments, development agencies and IOs. Moreover, the production of knowledge about HIV/AIDS involves multiple practices and epistemic communities that develop, publish and debate findings in a manner that, while not autonomous from power dynamics, is at least relatively pluralistic.

Nevertheless, the power of this network and social mobilisations around it should not be exaggerated. The ability and opportunity to participate in this community is not evenly distributed; there is a geography to HIV/AIDS mobilisations, and they come with their own particular interests. Furthermore, mobilisation is not solely determined by activist capabilities; it is also dependent on political opportunities, which activists play only a partial role in forging. While the crisis of globalisation in the late 1990s and early 2000s was rich in political opportunities and potential alliances, the turn towards scaled-up HIV/AIDS relief presents a more ambiguous landscape, where the proliferation of actors, new alliances and heightened appreciation of the complexity of the pandemic are all modulating the terrain for political action.

Notes

1 Thanks are due to Adrian Kay and Owain Williams for their constructive comments on earlier versions of this chapter. My understanding of neoliberalism and its implications for global health and for HIV/AIDS relief has benefited from conversations with Owain Williams, Vinh-Kim Nguyen, Kris Peterson, Susan Craddock and Gerry Kearns, to all of whom I am particularly grateful.

2 In 2007 MSF estimated that the cost of one year's course of first line triple ART (but not associated diagnostic, monitoring and support) could be as low as US$99.

3 In 2001 the US sought at the World Health Assembly to block the creation of just such a database (http://www.commondreams.org/news2001/0517-18.htm).

4 This issue was raised at a panel on the anthropology of global health at the conference Antropologies des cultures globalisées: terrains complexes et enjeux disciplinaires, Quebec City, November 2008.

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5

Chronic Diseases and Global Health Governance: The Contrasting Cases of Food and Tobacco

Simon Barraclough

Introduction

For some years, the World Health Organization (WHO) has been concerned at the rapidly increasing burden of non-communicable diseases (NCDs) and regards their prevention as a major challenge for global public health. Major NCD risks are related to diet and physical activity and include 'high blood pressure, high concentrations of cholesterol in the blood, inadequate intake of fruit and vegetables, overweight or obesity, and physical inactivity'. One of the most significant risks for NCDs is tobacco use (WHO, 2004, p. 2).

Tobacco control was the subject of WHO's first, and to date only multilateral treaty, the Framework Convention on Tobacco Control (FCTC) which formally entered into force in 2005. The FCTC is an important historical development in global health governance (GHG): it has served permanently to locate tobacco within a global health agenda; stimulated governments and civil society to a commitment to domestic action on tobacco control; suggested a regulatory template for national legislation, engendered intersectoral and international cooperation; and established a forum for deliberations on continuing control.

In the case of diet and NCDs, momentum for a global governance response has been growing, but the form that it should take is contested and is to develop into any formal treaty action along the lines of the FCTC. The Global Strategy on Diet, Physical Activity and Health, promulgated by WHO in 2004 after several years of consultations and deliberations, has observed that:

> Unhealthy diets and physical inactivity are thus among the leading causes of the major noncommunicable diseases, including cardiovascular disease, type 2 diabetes and certain types of cancer, and contribute substantially to the global burden of disease.

> The prevalence of overweight and obesity is increasing in developing countries and even among low income groups in richer countries … Factors that increase the risk of noncommunicable diseases include elevated consumption of energy-dense, nutrient-poor foods that are high in fat, sugar and salt; and reduced levels of physical activity […] Of particular concern are unhealthy diets, inadequate physical activity and energy imbalances in children and adolescents (WHO, 2004, p. 2).

The Global Strategy has been endorsed by the World Health Assembly and calls upon member states to institute national policies and programs. Is such an instrument sufficient to galvanise global action or is there scope for some of its content to be negotiated into a convention along the lines of the FCTC? To what extent can the template of the FCTC be used to address the global challenges associated with overeating, the marketing of inappropriate foods and inadequate physical activity?

In keeping with the overall theme of this book, our concern in this chapter is to explore the potential of GHG to counter the growing global health burden of obesity and overweight. In so doing, the recent example of the FCTC will be used to compare and contrast health issues associated with food with those relating to tobacco use. The exploration will seek to identify which elements of the FCTC, and the process for its development and adoption might profitably be applied to the problem of controlling the harmful effects of food production and marketing. In so doing, both similarities and obvious differences between the cases of food and tobacco must be recognised. Both tobacco and obesity may be regarded as forms of pandemics. Tobacco use and its associated harm to health has spread to the developing world. Similarly, as the WHO Global Strategy on Diet, Physical Activity and Health has stressed, rising rates of cardiovascular disease and obesity rates are major problems in low- and middle-income countries. As the introduction to this volume argues, these shifts are bound up with the development of global markets for these products, and are therefore health problems which are inextricably bound up with and resultant from economic globalisation and trade. Labonté persuasively argues in this volume, the exigencies of free trade more often than not trumps health concerns, at least over a range of potentially (and actually) harmful products.

As is the case with tobacco, it is major transnational processed food corporations which have been blamed for using sophisticated marketing techniques to create a global demand for their products and bring about a cultural shift among consumers. This chapter will therefore consider which sorts of international instrument might serve to further international action on food and obesity, as well as the commercial interests which have and are likely to continue to block more effective GHG in this pressing area. The potential content of such international instruments is also discussed. Consideration is also given to the question of institutional leadership and

coordination of global action on diet, physical activity and health. Finally, these issues serve to cast light on the broader tensions apparent in the contemporary system of GHG, not least between the power of firms and markets and that of manifest health needs. We must also recognise that the term 'governance' may be applied not only to a system of authoritative regulation, but also to a process of direction, influence and guidance. A broad definition of governance, may include 'highly varied sorts of collective behaviour ranging from local community groups to transnational corporations, from labour unions to the UN Security Council' (Dodgson *et al.*, 2002, p. 6). For these reasons, thinking of authority over the future direction of governance responses to NCDs purely in terms of international public health bodies, or as free from wider interests in the global political economy, is clearly insufficient and misleading.

Existing international governance relating to food: the Codex Alimentarius

Longstanding and elaborate international governance concerned with food already exists, but has been largely concerned with protecting the health of consumers through developing standards on safety and purity, as well as with facilitating international trade and ensuring that standards are used fairly in such trade (WHO, 2002, p. 7). The Codex Alimentarius (commonly known as the Codex), is a subsidiary organisation of the Food and Agriculture Organization (FAO) and WHO. It provides the multilateral framework for food safety, offering the harmonisation of normative regulatory standards on a consensual basis (Garcia and Carruth, 2006). The framework of the Codex includes standards for the maximum levels of pesticides, residues, additives and contaminants and procedures for the management and surveillance of food safety. Standards for labelling are also part of the framework, covering such issues as allergens, nutritional value, weights and measures, use-by dates, and information relating to organic, halal and kosher status. In addition, commodity and product standards for defining food products or how they are produced are included, as are those for describing the quality of food products (Joint FAO/WHO Food Standards Program cited in Garcia and Carruth, 2006, p. 408). Significantly for the problem of obesity and overweight, the brief the Commission includes standards for sugars, fats, oils, processed vegetables and fruit.

Since the establishment of the Codex Alimentarius Commission (the central administrative body of the Codex) in 1963, more than 200 regulatory standards, 40 codes and guidelines, 500 recommended maximum levels for food additives and 2,700 for pesticide residues have been formulated (Braithwaite and Drahos cited in Garcia and Carruth, 2006, p. 393). Such substantial collective action on the part of member states demonstrates both an obvious commitment to the global governance of food and

their ability to negotiate standards in a collective way. This at least supplies grounds for believing that there is scope for the Commission to deal with some of the issues concerned with obesity and overweight, notwithstanding that these areas have never been central to the body's mission. Moreover, it is also clear that any movement toward this type of change is highly likely to be contentious, given the Codex's clearly articulated concerns with balancing the interests both of food industries and consumers, as well as its commitment to facilitating the global food trade. It is significant that WHO wishes to see greater participation of the health sector in the development of Codex standards, recommendations and guidelines (WHO, 2002, p. 2), an inclusion which would possibly indicate a movement toward the inclusion of global health goals into the only major international regulatory framework for food in existence. However, and in contrast to the case of tobacco control, it is clear that action on food and obesity will require a forum with a wide engagement with health since this health problem embraces multiple human behaviours, including physical activity, in contrast to the single act of tobacco use.

The Framework Convention on Tobacco Control as an exemplar for global action on other health problems

The example of the FCTC has prompted consideration of the potential for a similar instrument to deal with other commodities associated with global morbidity and mortality. Such a reflective and adaptive process was evident in the origins of the FCTC itself, since the model used by its original proponents had been the framework convention-protocol approach previously applied in the field of environmental law (Roemer *et al.*, 2005, p. 936). For example, alcohol has almost the same impact as tobacco upon the global burden of disease; and according to Room, elements of the FCTC might be applied to an international alcohol control agenda (Room, 2006). Likewise, in the case of diet and nutrition Yach *et al.* see merit in using the template of the FCTC to further the development of national policies, but emphatically assert that a 'treaty approach is not warranted for food-related deaths and disease' (Yach *et al.*, 2003, p. 276). Commenting upon this rejection of a treaty approach for food-related deaths and disease, Daynard notes many similarities between the issues surrounding the labelling and promotion of processed foods and the protection of children and adolescents with those dealt with by the FCTC. This leads him to question why a similar treaty for food should not be considered (Daynard, 2003, p. 292).

Current literature on the possibility of extending the example and regulatory approach of the FCTC to food and diet is therefore divided by a range of approaches. Chopra and Darnton-Hill (2004) concede that it will be more difficult to negotiate international instruments dealing with obesity than was the case with tobacco, but nevertheless advocate the development of

international standards. In her WHO-commissioned survey of the global regulatory environment relating to the marketing of food to children Hawkes notes that while the FCTC is not directly relevant to food, it has 'indirect implications for food policy in that both require comprehensive and multi-sectoral approaches at global and national levels' (Hawkes, 2004, p. 55). Oxford Vision 2020 (an academic consortium formed to counter the global pandemic of chronic disease and now known as the Oxford Health Alliance), drew on the historic lessons from tobacco control, including those from the FCTC, in its thinking on dealing with threat of unhealthy diets and insufficient physical activity (Yach *et al.*, 2005).

The authors of a technical paper reviewing evidence concerning the promotion of food to children conclude that the phenomenon demonstrated a transnational problem '*par excellence*' which required global action (WHO, 2006, p. 39). Whilst conceding 'profound differences' between food and tobacco, they proposed that:

> ... an international agreement is sought akin to the FCTC, but with the aim, not of eliminating or disabling food marketing to children, but of making it healthier (WHO, 2006, p. 4).

Tobacco and food as health issues: similarities and differences

There several similarities between the historical development of control tobacco use and contemporary efforts to deal with overweight and obesity. Especially in the earlier phases of tobacco control, health advocates faced coalitions of interest between tobacco producers, advertising corporations, and national and international agencies promoting particular agricultural products. Indeed, the World Bank once lent money to further tobacco production in developing countries. As with tobacco, the food and beverage industries are dominated by major transnational corporations which have succeeded in placing their brands into global culture. Nestle, Altria and ConAgra Foods were the three leading food processing corporations at the start of this millennium (Lang and Heasman, 2004, p. 153). In the case of the Altria group (which includes Kraft), there is a direct connection with tobacco since this group was previously known as Philip Morris.

Transnational corporations such as McDonalds, Coca Cola, Pepsi, KFC and Pizza Hut dominate the global fast food and soft drink market. Such enterprises have had a long history of vigorous and successful promotion of their products. As Hawkes has noted, the marketing activities of these corporations are 'aggressive, comprehensive, and aim to create demand by changing traditional drinking and eating habits' (Hawkes, 2002, p. iii). Chopra and Darnton-Hill accuse transnational corporations of 'convincing people to consume more, and more highly energy dense, foods through relentless advertising and ubiquity of outlets' (Chopra and Darnton-Hill,

2004). Certainly, both 'Global Tobacco' and the transnational food and beverage corporations have been the targets of ideologically based animosity on the part of some health promotion advocates. Global tobacco brands, most notably 'the Marlboro man', as well as brands such as Coca Cola, Pepsi Cola, McDonalds and KFC are portrayed as symbols of the negativities of globalisation. On a cultural level, they are regarded as conduits of Westernisation (and more specifically Americanisation), responsible for altering traditional food preferences, displacing traditional foods, and establishing a uniform global taste for salty, sugary and fatty foods. The image of Colonel Sanders and the symbol of McDonalds' 'golden arches' are to be found on the streetscapes of most cities in the world, bearing physical testimony to the ascendency of the global fast food industry. Prior to local and international controls on tobacco promotion, cigarette brands occupied a similar symbolic place.

Of particular concern in the regulation of tobacco promotion was the problem of promoting tobacco use to youth. While maintaining that smoking was an adult activity and strongly endorsing prohibitions on the sale of their products to minors, tobacco corporations nevertheless vigorously sought the custom of the 'younger smoker' through such devices as the sponsorship of sporting events, popular music concerts, television programs, the operation of music shops and even the use of tobacco brands and trade marks on clothing and popular music shops. There are clear parallels in food and beverage promotion. As Hawkes has documented, food and beverage corporations have employed a variety of promotional mechanisms. Major sporting events, including the World Cup and Olympic Games have been sponsored by Coca Cola and McDonalds. Other mechanisms have included advertising during children's television viewing times, school-based sponsorship and product promotion, Internet marketing and product placement in films and television. Special children's products, such as the McDonald's 'Happy Meal' or KFC's 'Chicky Meals' have been offered, along with a free or price-discounted toy. Cultural figures from literature, comic strips, film and television have been appropriated for promotional purposes. McDonalds has used Snoopy, Pooh Bear and characters from Sesame Street and Walt Disney Productions in various markets. KFC was able to use Warner Brothers' Looney Tunes characters in Malaysia. Pepsi Cola promoted a Britney Spears concert in Thailand. Coca Cola acquired marketing rights to Harry Potter (Hawkes, 2002). More recently, as the present author has observed in Australian supermarkets, the character of Shrek has appeared on the packaging of Kellogg's Froot Loops breakfast cereal, snack bars, and Campbells Soup.

Concern about negative consequences of marketing food to children has given rise to civil society monitoring and action groups in several countries. Such moves parallel those taken against the tobacco industry. Several jurisdictions have introduced guidelines and even regulations. In her global

survey on the regulatory environment on marketing food to children, Hawkes notes it is evolving rapidly and that many countries have instituted laws, statutory guidelines and self-regulatory codes (Hawkes, 2004, p. 57). To date, however, legislative action to control food advertising to children has been based upon individual jurisdictions. As with the case of tobacco control, national and global coalitions of civil society organisations (CSOs) have emerged to advocate national and international action on obesity and its health consequences. The Global Alliance for the Prevention of Obesity (known by the shorter title of the Global Prevention Alliance) was convened by the International Association for the Study of Obesity (IASO) and its London-based International Obesity Taskforce (IOTF) in collaboration with the World Heart Federation, the International Diabetes Federation, the International Paediatric Association, and the International Union of Nutritional Sciences. The chair of the International Obesity Taskforce also led the UN Millennium Commission mission which reported on nutri-tional challenges in the 21st century. In addition to collaborating with WHO, developing various national coordinating groups and offering technical and policy support, the Global Prevention Alliance is advocating that WHO member states adopt an international code governing the marketing of food and beverages to children (Rigby and Baillie, 2006, p. 1630).

IOTF and IASO, in collaboration with Consumers International (a global peak body for national consumer organisations) have produced a proposal for an international code on marketing foods and non-alcoholic beverages to children (see Figure 5.1). The Code has been commended by these organisations to the World Health Assembly. This document shares a number of concerns with the FCTC in advocating the need to control the advertising of unhealthy products and proposing means of achieving this. The Code therefore provides a ready example of the type of specific protocol for a specific issue which might form an element of a broader framework for governance discussed in the final section of this chapter. It is significant that the rationale for the recommendations refers to international instruments, notably the UN Convention on the Rights of the Child (as multilateral treaty) and the non-binding European Charter on Countering Obesity (International Association for the Study of Obesity, Consumers International and International Obesity Taskforce, 2008).

Public image and good publicity has also been important to both the tobacco and the food and beverage industries. In pursuit of the legitimacy associated with corporate social responsibility, tobacco corporations have established benevolent foundations. For example in Malaysia, British American Tobacco sponsors cultural events, social development projects, scholarships for needy students and even a shelter for women subjected to domestic violence (Barraclough and Morrow, 2008). Similar efforts to obtain a favourable public image are evident in the case of the major fast food and beverage manufacturers, which have supported a variety of charitable projects. For

Figure 5.1 Proposal for an International Code on Marketing of Foods and Non-alcoholic Beverages to Children

Article 1. **Aim**
This Code aims to protect present and future generations from the damaging health, social and economic consequences of consumption of energy dense, nutrient poor foods high in fat, sugar or salt, and to promote responsible food marketing to children that supports the Global Strategy on Diet, Physical Activity and Health by restricting the marketing of these products to children.

Article 2. **Scope**
This Code applies to all forms of food marketing to children.

Article 3. **Definitions**
"Brand" means any name, logo, slogan or Trademark associated with or owned by the food company.
"Children" means people under the age set by Member State legislation and in any case, no less than 16 years old.
"Commercial operators" means all industries that have a role advertising or promoting food and non-alcoholic beverages.

Article 4. **Energy dense, nutrient poor foods high in fat, sugar and salt**
4.1. There should be no marketing to children of energy-dense, nutrient poor foods that are high in fat, sugar or salt and brands associated with such foods.
4.2. (1) Categorisation of energy-dense, nutrient poor foods that are high in fat, sugar or salt and brands associated with such foods for the purpose of implementing this Code should be based on dietary recommendations established by WHO11 and defined by nutrient profiling.
4.2. (2) WHO should propose an international approach to the categorisation of energy-dense, nutrient poor foods that are high in fat, sugar or salt within a year of the adoption of these recommendations.

Article 5. **Broadcast marketing**
5.1. When determining which media containing broadcast advertisements and promotions the restriction laid down in Article 4.1. should apply to, both the absolute number of children likely to be watching or listening and the number of children as a proportion of the overall audience should be taken into account.
5.2. This restriction should include, but is not limited to, all advertisements and promotions broadcast between the hours of 06.00 and 21.00.

Article 6. **Non-broadcast marketing**
6.1. When determining whether non-broadcast marketing techniques are aimed at children, and thus prohibited under Article 4.1, the following factors should be taken into account:
(a) the overall presentation, features, content, form and manner
(b) the language, colours and images used
(c) whether children are represented
(d) the target audience of the media or place in which the promotion is seen

Figure 5.1 Proposal for an International Code on Marketing of Foods and Non-alcoholic Beverages to Children – *continued*

(e) whether children are potential recipients of the promotion in significant numbers regardless of the target audience
(f) the use of people, personalities, celebrities, their associates or other persons or individuals whose name or image may be familiar to or appeal to children
(g) the use of cartoon characters including brand owned and licensed
(h) the inclusion of free gifts, toys or collectible items with appeal to children
(i) the inclusion of competitions, vouchers or games with appeal to children
(j) the shape or novelty value of the food or food packaging
(k) sponsorship of materials, products, people, events, projects, cultural, artistic or sporting activities or places popular with children or with a significant child audience

6.2. Products that are clearly produced for consumption on special occasions and are clearly special treats (for example birthday cakes, confectionery for cultural or religious festivals) may be exempted from Article 6.1.

6.3. Settings where children are gathered should be free from commercial inducements to consume energy-dense, nutrient-poor foods that are high in fat, sugar or salt. Such settings include but are not limited to nurseries, schools, school grounds and pre-school centres, playgrounds, family and child clinics and paediatric services.

Article 7. **Indirect advertising to parents or adults**

7.1. Energy-dense, nutrient poor foods that are high in fat, sugar or salt or brands associated with such foods should not be promoted to adults responsible for children as being suitable for children. This includes stating, suggesting or implying:
(a) that an adult who purchases such a food is a better, more intelligent, more caring or more generous adult than one who does not do so;
(b) that the child they are responsible for, when fed these products, will be more intelligent and gifted; or
(c) that a balanced and varied diet cannot provide adequate quantities of nutrients in general.

Article 8. **Interpretation**

8.1. The spirit as well as the letter of this Code applies.

8.2. This Code lays down minimum standards only. Parties are encouraged to implement measures going beyond those required by this Code, and nothing in this Code should prevent a Party from imposing stricter requirements ensuring a higher level of human health, provided that such requirements are compatible with international law.

8.3. In setting and implementing their public health policies Parties should act to protect these policies from commercial and other vested interests of commercial operators in accordance with national law.

Figure 5.1 Proposal for an International Code on Marketing of Foods and Non-alcoholic Beverages to Children – *continued*

Article 9. **Implementation**

9.1. Governments should take action to give effect to all provisions of these recommendations through the adoption of legislation, regulation or other statutory measures.

9.2. Commercial operators should honour and apply all relevant provisions of this Code.

Article 10. **Monitoring and enforcement**

10.1. Monitoring and application of this Code lies with governments acting individually and collectively through the WHO.

10.2. Independently of any other measures taken to implement this Code, manufacturers of products within the scope of this Code should regard themselves as responsible for monitoring their marketing practices according to the provisions of this Code, and should take steps to ensure that their conduct at every level conforms to it.

10.3.1. Non-governmental organisations, professional groups, institutions and individuals concerned should be encouraged to draw the attention of governmental authorities and manufacturers and other relevant operators to activities which are incompatible with the provisions of this Code, so that appropriate action can be taken.

10.3.2. This encouragement may include but is not limited to according consumers a private right of action to challenge violations of the Code.

10.4. Commercial operators within the scope of this Code should inform each member of their marketing and advertising personnel of this Code and their responsibilities under it.

10.5. In accordance with Article 62 of the Constitution of the WHO, Member States should communicate annually to the Director-General information on action taken to give effect to this Code.

10.6. The Director-General should report annually to the World Health Assembly on the status of implementation of this Code and the World Health Organization should, on request, provide technical support to Member States preparing national legislation or regulations, or taking other appropriate measures to implement this Code.

Source: International Association for the Study of Obesity, Consumers International and International Obesity Taskforce, 2008.

example, in some countries Ronald McDonald House provides accommodation for the families of children warded in hospitals. Unlike tobacco corporations, which have for many years been declared anathema to United Nations (UN) agencies and programs, global food and beverage manufacturers have engaged in philanthropic projects with such bodies as United Nations Development Program (UNDP), United Nations International Children's Emergency Fund (UNICEF) and Joint United Nations Programme on HIV/AIDS (UNAIDS) (Hawkes, 2002, p. 30).

Another noteworthy parallel between the tobacco and the food and beverage industries is their consistent advocacy of the desirability of self-regulation in place of industry regulation. Both have claimed that they are capable of ensuring the socially responsible marketing of their products. Both introduced their own codes of conduct relating to the promotion of their products. For example, in Australia the Coca Cola Company has announced its commitment to 'responsible policies in the schools and the marketplace' and has provided information on the kilojoule content of its drinks. The company has also stressed its support for 'programs that encourage physical activity and education' (see www.makeeverydropmatter.com.au). For its part, McDonalds has introduced a range of lower fat products, which qualify for the symbol of approval from the National Heart Foundation. Several food corporations have declared their intention voluntarily to reduce their use of transfats (*The Age*, 13 March 2007). Several companies have also indicated they will revise their practices of advertising to children. A spokesman for Kraft observed '[t]here is a big push coming and those not on board with health and wellbeing will be left behind' (*The Age*, 10 June 2007). However, self-regulation by these industries is also a reflection and reaction to piecemeal national efforts to regulate the sector, and perhaps the fear that national regimes could pave the way for a global counterpart. It would seem here that lessons have been learned.

In the case of tobacco, self-regulation came after it was clear that legislative controls were well underway in many countries and would be a central concern of the FCTC. Moreover, the tobacco corporations had largely lost their credibility after being implicated in active moves to undermine the tobacco control activities of WHO. As Eriksen has lucidly argued, the 'illegal and repugnant behaviour of the tobacco industry' as well as the dangers of second hand tobacco smoke did much to further the cause of tobacco control (Eriksen, 2006, p. 753). WHO has eschewed contact with tobacco corporations. Indeed, in her 2007 address to the World Health Assembly, WHO Director-General Dr Margaret Chan reported that she was speaking with the executives of a variety of industries but would never be on speaking terms with the tobacco industry (Chan, 2007). By contrast WHO regards food corporations as potential partners, has committed itself to a dialogue with the transnational industry (WHO, 2004, p. 11) and acknowledges that '[c]ooperative relationships with industry have already led to many favourable outcomes related to diet and physical activity' (WHO, 2004, p. 13).

Other more tangential but nonetheless striking parallels are worth exploring. Tobacco products may also be regarded as wasting money, especially where tobacco-related expenditure represents a significant proportion of total household expenditure, as is the case in low-income households. Similarly, some of the elaborately packaged and heavily advertised pro-

cessed foods and carbonated drinks represent expenditure which can be ill-afforded by poorer households in both developed and developing countries. In terms of value-added products, the potato crisp has turned a cheap potato into a commodity selling at the same price per unit or higher as beef and fish. Processed foods can also be wasteful of energy and water and therefore disproportionately contributing to carbon emissions as well as diverting resources from the production of healthy foods.

However, there are a range of dissimilarities between the cases of tobacco and food. Most notably, the use on a single occasion of a tobacco product is harmful to health, while this is not so in the case of foodstuffs. Fats and sugars are a necessary part of a balanced diet. It is excessive consumption and a lack of physical activity which lead to overweight and obesity. The FCTC devotes an entire article to exposure to tobacco smoke. However, there is no equivalent to passive smoking the case of the consumption of unhealthy foods. In counterpoint, Krueger *et al.* regard the addiction of smokers to be similar to compulsive eating disorder in which food is used for gratification (Krueger *et al.*, 2007, p. 167). Eriksen suggests that it may be argued that some people are addicted to certain foods, but questions whether this is comparable to the experience of smokers and the manipulation of the nicotine content of some of their products by tobacco companies (Eriksen, 2006, p. 754). While identifying parallels between smoking and becoming fat, Krueger *et al.* make the important distinction between tobacco use as a single behaviour and the multiple behaviours (most notable consumption and exercise) contributing to obesity (Krueger *et al.*, 2007, p. 166).

The FCTC: a template for action on food and obesity

Notwithstanding the differences between the cases of tobacco and food, the FCTC provides a potential template for action to counter the global problem of obesity. In this section, consideration is given to how pertinent sections of the Framework have applications to action on food. In so doing, it is important to note that the FCTC has both domestic and international ramifications since it not only obliges states to regulate tobacco within their own jurisdictions, but also to take action relevant to trade and advertising. It must also be recognised that the FCTC has both obligatory content as well as non-binding recommendations.

The FCTC (Article 4) contains general principles calling for information about the health consequences of using tobacco and exposure to tobacco smoke to be available to all and affirming the need for international cooperation, particularly in the transfer of technology, knowledge and financial assistance. In addition, the need for the participation of civil society in controlling tobacco was asserted. In fact similar general principles are already to be found in the Global Strategy on Diet, Physical Activity and Health which

stipulates several areas for international cooperation, acknowledges the vital role of civil society and whose second objective is to:

> increase overall awareness and understanding of the influences of diet and physical activity on health and of the positive impact of preventative interventions.

As can be seen in Figure 5.2, the general obligations of the FCTC have parallels to the case of diet and physical activity.

Figure 5.2 General Obligations of the FCTC with Applicability to Food, Diet and Activity

FCTC General Obligations	*Parallels in the Global Strategy on Diet, Physical Activity and Health*
Develop, implement and periodicallyupdate and review comprehensive multisectoral national control strategies, plans and programs	'[E]ncourage the development, strengthening and implementation of global, regional, national and community policies and action plans to improve diets and increase physical activity' (WHO, 2004, p. 4). 'Governments are encouraged to draw up national dietary guidelines […]' (WHO, 2004, p. 6).
National coordinating mechanism	'Governments are encouraged to set up a national coordinating mechanism that addresses diet and physical activity within the context of a comprehensive plan for noncommunicable disease prevention and health promotion' (WHO, 2004, p. 6).
Legislation	Legislation to support national strategies, policies and action plans (WHO, 2004, p. 6).
Cooperation with competent international and regional intergovernmental organisations	Recognises interaction with FAO and UNICEF in preparing the Strategy. Identifies the need for coordinated work among organisations of the UN system and intergovernmental bodies. Plans cooperation with UN Economic and Social Council, International Labor Organization (ILO), United Nations Educational, Scientific, and Cultural Organization (UNESCO), World Trade Organization (WTO) regional development banks, and the UN University (WHO, 2004, p. 12).

The FCTC contains a number of specific articles concerned with controlling tobacco and discouraging its use, many of which have applicability to the problems of unhealthy foodstuffs.

Price and tax measures to reduce consumption (Article 6)

Under this article of the FCTC, governments are encouraged to use tax and price policies to contribute to the 'health objectives aimed at reducing tobacco consumption'. This article does not set expectations, and respects the 'sovereign right' of each nation to determine its own taxation policies. However, parties to the FCTC are required to provide details of the rates of taxation for tobacco products and trends in consumption as part of their periodic reports to the Conference of the Parties of the Convention. A similar provision relating to food might countenance making unhealthier foods more expensive and healthier foods cheaper by varying sales taxes or imposing a dedicated levy for certain types of food considered to be especially damaging to health. As the Global Strategy notes, several nations already use fiscal measures to 'influence availability of, access to, and consumption of, various foods' (WHO, 2003, p. 89).

Regulation of the content of tobacco products (Article 9)

This article allows parties of the Convention to act in concert to adopt and implement measures for the testing and measuring of the contents of tobacco products and for their regulation. In terms of the content of food products, there is scope for the Strategy's goal of ultimately eliminating transfatty acids in foods (WHO, 2003, p. 4) to be incorporated in a multilateral agreement. Consideration might also be given to limiting the levels of salt and free sugars in certain processed foods and snacks.

Regulation of packaging and labelling (Article 11)

Parties are required to introduce measures to ensure that a tobacco product is not promoted by means that are 'false, misleading, deceptive or likely to cause an erroneous impression about its characteristics, health effects, hazards or emissions' or that a 'particular tobacco product is less harmful than any other'. The terms 'low tar', 'light', 'ultra light' and 'mild' are specified in reference to the latter concern. This article also calls for health warnings describing the harmful effects of tobacco use to be included on the outside packaging and labelling of tobacco products. Cigarette companies manipulated the labelling of their products to imply that 'low tar' and 'light' brands carried fewer risks. Similar manipulation is possible with the labelling of food and drink which, in some cases carries terms such as 'low fat', 'salt reduced' and 'added sugar'. Products with high sugar content could still be labelled as having 'no added sugar', while such products could also be labelled as being 'low fat'. Moreover, there are increasing demands from food and drink manufacturers to be able to include health claims in their labelling and advertising.

In this vein the Global Strategy notes that:

> Consumers require accurate, standardized and comprehensive information on the content of food items in order to make healthy choices. Governments may require information to be provided on key nutritional aspects, as proposed by the Codex Guidelines on Nutrition and Labelling (WHO, 2003, pp. 7–8).

Given that many food brands are global and are part of a substantial international trade, there is a need to have international standards relating to information about nutritional content and also health claims, which are increasingly being used as part of marketing. The Global Strategy insists that health-related messages related to food 'must not mislead the public about nutritional benefits or risks' (WHO, 2003, p. 8).

The need for global monitoring of labelling was illustrated in the case of Ribena blackcurrant drink, a global brand promoted for its nutritional qualities. The packages of ready-to-drink Ribena were found to contain incorrect claims about Vitamin C content, as well as misleading claims about the comparative Vitamin C content of oranges. The transnational corporation GlaxoSmithKline was obliged to correct these claims and alter its testing procedures. (See *The Sunday Age*, 13 May 2007, p. 11).

Education, communication, training and public awareness (Article 12)

The FCTC gave prominence to the need to strengthen public awareness of tobacco control issues, including the need for educational programs about the health risks and adverse environmental consequences of tobacco use. It is also recognised the need to train health, community workers, and those in other sectors, to make them more aware of tobacco control issues. The Global Strategy calls upon governments to provide accurate and balanced information for consumers and to ensure availability of appropriate health promotion and education programs, noting that a 'sound basis for action is provided by public knowledge and understanding of the relationship between diet, physical activity and health, of energy intake and output, and healthy choice of food items' (WHO, 2003, p. 7). The Strategy also refers to the need for clear public messages on the 'quantity and quality of physical activity sufficient to provide substantial health benefits' (WHO, 2003, p. 9). There is also a commitment on the part of WHO to support the training of health professionals about 'health diets and an active life' (WHO, 2003, p. 11).

Advertising, promotion and sponsorship (Article 13)

Here the Global Strategy affirms:

> Food advertising affects food choices and influences dietary habits. Food and beverage advertisements should not exploit children's inexperience

> or credulity. Messages that encouraged unhealthy dietary practices or physical inactivity should be discouraged, and positive, healthy messages encouraged (WHO, 2003, p. 7).

As we have seen above, there are some ready parallels between the ways in which tobacco corporations historically sought to promote their goods through appropriating personalities and images from popular culture and sport, and the devices used by food and beverage corporations. There are also concerns that food and beverage corporations have developed undesirable linkages with schools in order both to build legitimacy for their brands and to increase sales. The Global Strategy states that:

> Governments are encouraged to adopt policies that support healthy diets at school and limit the availability of products high in salt, sugar and fats (WHO, 2003, p. 9).

As occurred with the FCTC, there is scope for a global instrument on diet and physical activity to include guidelines such as the Proposal for an International Code on marketing of Foods and Non-Alcoholic Beverages to Children, thereby gaining the agreement of signatory states to institute statutory controls on advertising and promotion of food and beverages to children. The issue of cross-border advertising must also be dealt with, since individual nation states have a limited capacity to prevent it.

Illicit trade (Article 15)

This item is related to smuggling, which has direct consequences for the effectiveness of fiscal policies on tobacco, and hence for levels of consumption. This article stressed the imperative for international cooperation on trade-related matters in order to achieve effective domestic control. When applied to food, similar trade controls could be imposed to prevent the export of low quality, unhealthy foodstuffs such as turkey tails and fatty lamb back straps to economically poorer nations. The Codex Alimentarius Code of Ethics for International Trade in Food stipulates that consumers are entitled to 'wholesome food' and that no food should be traded which renders it harmful to health. Such principles could be expanded upon in any instrument concerned with obesity and overweight. Cassels has described the 'onslaught of imported foods' and the associated serious rates of obesity in Micronesia, noting that turkey tails, regarded as inedible in the USA since they are composed of gristle and fat, are imported and widely eaten in Micronesia (Cassels, 2006, p. 4). As the Global Strategy emphasises, national food policies should 'be consistent with the protection and promotion of public health' (WHO, 2003, p. 8).

Nation states have found common cause in prohibiting the international trade in endangered species and the body parts of such animals. There is

therefore the potential to impose trade restrictions on the body parts of animals that endanger the health of the human species.

Research, surveillance and the exchange of information (Article 20)

As with the FCTC, a strong theme in the Global Strategy is the need for research and surveillance and for the sharing of information between member states. The fourth objective of the Global Strategy is:

> to monitor scientific data and key influences on diet and physical activity; to support research in a broad spectrum of relevant areas, including evaluation of interventions; and to strengthen the human resources needed in this domain to enhance and sustain health (WHO, 2003, p. 4).

Monitoring and surveillance should include 'dietary habits, patterns of physical activity and interactions between them, nutrition-related biological risk factors and contents of food products' (WHO, 2003, p. 10). The Strategy also calls for the promotion of applied research and the evaluation of the efficacy and cost-effectiveness of national disease-prevention programs. The need for more information from developing countries is also emphasised (WHO, 2003, p. 10). More recently, the European Charter on countering obesity has stipulated, a process is needed in order:

> To develop internationally comparable core indicators for inclusion in national health surveillance systems. These data could then be used for advocacy, policy-making and monitoring purposes. This would also allow for regular evaluation and review of policies and actions and for the dissemination of findings to a wide audience (World Health Organization Europe, 2006, 3.2).

As occurred with the FCTC, an instrument concerned with diet, physical activity and health could take the general *desiderata* of the Global Strategy to a more formal level with signatory states committing themselves both to establishing monitoring and research agencies, and to reporting data.

Cooperation in the scientific, technical and legal fields and the provision of related expertise (Article 22)

The FCTC recognised disparities between member states in their capacity to deal with the scientific, technical and legal ramifications of the Convention and provided for international cooperation to assist those states lacking adequate financial and human resources. Such cooperation would also be necessary for any instrument dealing with food and physical activity.

Institutional arrangements and dispute resolution

The FCTC also provides a possible model for the institutional infrastructure of any similar treaty relating to food and diet. The treaty provided for a 'conference of the parties' to oversee a secretariat, establish a budget and review the implementation of the Convention. Such institutional arrangements allow for the refinement of research and data collection and the promotion of strategies, plans and programs. They also enabled other UN, intergovernmental and non-government organisations (NGOs) to be involved. Finally, there are provisions for settling disputes through arbitration.

The functions of multilateral instruments

Before exploring what kind of global agreement or regime on diet and physical activity is likely to be most feasible, it is useful to examine both the types of instruments available for use and the functions of multilateral instruments. Under Article 2, one of the functions of WHO is 'to propose conventions, agreements and regulations, and make recommendations with respect to international health matters'. In addition, it may 'develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products'.

In furthering these functions, three types of instruments may be employed:

- Binding conventions or agreements agreed to by a two-thirds majority of member states but applying only to member states which accept them (see Article 19);
- Non-binding recommendations (see Article 23);
- Binding regulations, subject to acceptance of individual member states (see Article 22).

An essential difference between treaties and other instruments is that the former are agreements between nation states and, under the principle of *pacta sunt servanda ('agreements must be kept')*, carry with them the expectation that they will be honoured within the system of international law. By contrast, instruments such as codes of conduct and global strategies may involve non-state actors and do not carry the weight of international law. Moreover, such binding instruments are usually easier, and require less time, to negotiate since they do not require the complex diplomatic, legal and constitutional processes associated with formal treaties. As Taylor argues, since they are binding under international law, treaties can provide a legal foundation for health commitments between nations and the institutions and processes for complying with international norms, including strengthening the capacity of states to implement legal obligations (Taylor, 2002, p. 976).

Yet, international instruments should not merely be evaluated in terms of the effectiveness of their regulatory content. Certainly they have an

important regulatory function, identifying substances and actions that are prohibited, providing templates for smaller states which might lack the human and financial resources to develop regulatory frameworks individually. However, even where their regulatory functions are less-than-optimal, such instruments may perform a range of other valuable functions. These include raising awareness about a particular issue, placing it in a global context, providing legitimacy for proponents of action to deal with particular problems, and encouraging linkages between state agencies and civil society. In addition, Bodansky (1999, pp. 35–36) identifies social learning, mobilisation and internalisation as important functions of treaties. Through their engagement with the treaty process, states which might not accept the gravity of a particular problem or regard a response as too expensive will be brought to understand why it is in their interests to comply. This social learning is achieved through research cooperation, information exchange and inter-states dialogue.

The treaty process also serves to mobilise individuals and groups within states in support of its goals. A particular issue is highlighted when it is discussed at an international forum and advocates can cite resolutions and treaty provisions in support of their positions. Treaty provisions can also become internalised within the national legal and bureaucratic systems of states. In some states, the treaty may be legally enforceable, once it is ratified. In general, the existence of the treaty will provide advocates within relevant bureaucracies with a further justification for their actions.

What is clear is that whatever route may result in closer regulation of food to meet manifest health needs, WHO is likely to be the pivotal international agency in facilitating the change. As in the case of the FCTC, WHO has already spearheaded global action on diet and physical activity. While conceding the need to cooperate with other organisations of the UN System, WHO has asserted that it 'will provide the leadership, evidence based recommendations and advocacy for international action to improve dietary practices and increase physical activity, in keeping with the guiding principles and specific recommendations contained in the Global Strategy' (WHO, 2004, p. 11). The 1996 WHO European Ministerial Conference on Countering Obesity, in promulgating a charter to counter obesity, recognised the capacity of the Codex Alimentarius 'within the limits of its remit' to contribute, acknowledged the roles of various UN agencies and bodies (FAO, UNICEF, the World Bank, ILO), as well as global and regional organisations (the Council of Europe and OECD) but unequivocally asserted that WHO 'should inspire, coordinate and lead the international action' (WHO Europe, 2006, 2.4.5).

Given that diet and physical activity involve such a wide health perspective and touch upon such a range of issues, and that WHO together with FAO established the Codex Alimentarius, there can be little doubt that WHO's leadership claim is legitimate and that this would extend to any future

move towards binding agreements between its member states. As Taylor has observed in general terms:

> WHO is the only public international organization that brings together the institutional mandate, legal authority and public health experience for the codification of treaties that principally address global health concerns (Taylor, 2002, p. 978).

Conclusion: is there a need for some form of binding global instrument and what are the options for such an agreement?

The discussion in this chapter has found many similarities between the experience of tobacco control and efforts (both past and possible future) to promote and protect health in the field of diet and physical activity. Some of these are clearly evident in the strategic thinking surrounding the development of the WHO Global Strategy on Diet, Physical Activity and Health. At the current historical juncture a number of pressing questions are faced in the battle to tackle NCDs, specifically pertaining to the type of regime that might be developed. Are non-binding instruments sufficient in the case of diet and physical activity or should elements of the strategy be incorporated into some form of binding agreement, as provided for in the Constitution of WHO? Should such a treaty be merely concerned with broad frameworks and general commitments or should it seek to incorporate an internationally accepted regime of regulation for the marketing and promotion of food and drink?

Resolution 57.17 of the World Health Assembly of the WHO has endorsed the Global Strategy on Diet, Physical Activity and Health. This document calls upon member states, commercial entities and NGOs to consider a variety of measures to foster healthier diets, reduce the consumption of unhealthy foods and beverages, and increase physical activity. Some of these measures include regulation of food content and the commercial promotion of food products. It also invites member states to coordinate their policy making and implementation and to involve corporations and civil society in these activities. There is a specific commitment on the part of WHO to engage with transnational food corporations in support of the aims of the Global Strategy. Finally, the Global Strategy advocates international cooperation between inter-governmental agencies, between member states and within geographical regions. At least three types of possible regime and system of GHG seem possible.

Persuasive governance would make use of the existing Global Strategy (and subsequent revisions) as a non-binding instrument to raise consciousness and elicit action on the part of governments, civil society and transnational corporations. The Global Strategy, as a WHO initiative, has the legitimacy of its endorsement by the World Health Assembly, and is the result of extensive consultations. Most significantly, while recognising particular cultural influences in different nations and societies, it also takes a global

approach to the problems of overeating and inadequate physical activity, seeking to bring together not only the national governments, but also international intergovernmental agencies, civil society and transnational commercial corporations. Precisely because it is not a formal treaty between nation states, it is able to include all players in the complex interactions of food, physical activity and health. Certainly such persuasive governance would be in keeping with WHO's current thinking, since the organisation has articulated no intention of seeking to negotiate a binding international agreement on food, along the lines of the FCTC. Such a consensual, consultative and persuasive approach is less likely to excite the strident opposition of commercial interests and particular nations with a trade agenda.

Yach *et al.* see considerable potential in persuasive governance, particularly with regard to the targets of regulation: the large food corporations. In contrast to the obstructionist behaviour of the tobacco corporations, which sought to undermine control policies, they regard the food corporations as 'part of the solution' which must be part of partnerships to achieve positive goals such as optimal diets and greater levels of physical activity. In contrast to the regulatory approach of the FCTC, the more complex policy area of food and nutrition will require the use of incentives and partnerships. Indeed, some multinational food corporations have already modified the fat, salt and sugar content of their products and have also decided to withdraw from school-based marketing activities (Yach *et al.*, 2003, pp. 276, 285 and 287).

When considering whether or not a binding regulatory approach is appropriate it should be noted that the original proposal for a multilateral treaty under the auspices of WHO was met with a counter suggestion from WHO officials for a revised proposal for either a non-binding code of conduct along the lines of the International Code of Marketing of Breast-milk Substitutes (ICMBMS) or a treaty under the UN (Roemer *et al.*, 2005, p. 937).

However, it must be recognised that the experience of the ICMBMS, introduced in 1981, has led to a continuing scepticism in some quarters about the value of non-binding agreements. The Code carries with it a history of conflict between breastfeeding advocates and the global food corporation Nestle, official opposition by the then government of the USA and continuing violations by the marketers of infant formula. The Nestle corporation had lobbied against restrictions on the promotion of infant formulas, the US government had declined to accept the ICMBMS claiming that it violated the US Constitution, while the US State Department was concerned that it might set a precedent for controlling the marketing of pharmaceutical drugs (Nestle, 2002, pp. 152–153). Global monitoring of adherence to the Code revealed numerous violations (Nestle, 2002, p. 153).

Lee considers the example of the Code and suggests that:

> reliance on voluntary codes alone to regulate the behaviour of powerful and well-resourced transnational corporations, without sufficient atten-

> tion to implementation and enforcement, is likely to be ineffective (Lee, 2006, p. 44).

A second option for GHG in this area has also been suggested. Bearing in mind such caveats, in the case of the marketing of food and beverages, especially to children, there is clearly scope for WHO to negotiate *selective nonbinding regulation* along the lines of the ICMBMS. The Proposal for an International Code on Marketing Foods and Non-alcoholic Beverages to Children provides a ready opportunity for the World Health Assembly to instigate such global regulation on a specific aspect of the obesity and overweight problem. Member states could be invited to endorse such a code and establish national monitoring committees to oversee its operation. Commercial corporations would be asked for formal commitments to abide by its content. In recent years corporate social responsibility has become an important issue on the governance of major companies. It is possible that today's generations of chief executive officers will be more receptive to a *modus vivendi* with WHO than was the case with the ICMBMS more than a quarter of a century ago. Moreover, the damaging boycotts organised by global civil society groups against Nestle and Kraft undoubtedly remain in the corporate memory.

While conceding that international instruments like the FCTC will be more difficult to negotiate, Chopra and Darnton-Hill favour international standards on such things as marketing unhealthy foods, advertising in schools, packaging and labelling. They also note the disappointing past record of voluntary codes, including the ICMBMS (Chopra and Darnton-Hill, 2004).

However, any attempts to develop a comprehensive third type of governance architecture – *binding regulatory governance* in the field of diet and health – is likely to face formidable political and practical obstacles, as well as challenges relating to the evidence in support of proposed regulation. WHO maintains that strategies to deal with diet, physical activity and health need to be based upon 'the best scientific research' (WHO, 2004, p. 14). In the case of tobacco, lobbyists for the industry rejected growing the scientific evidence of the health risks associated with its consumption, until the industry eventually conceded a causal link. In the case of obesity and overweight, causal relationships associated with the advertising of food and beverages are likely to be the subject of continuing vigorous contestation in the part of commercial interests. Pressure was brought to bear by the 'sugar lobby' when WHO was developing its recommendation on nutrition and preventing chronic diseases. The scientific basis of WHO's recommendations on the daily intake of sugar was questioned, leading some observers to make comparisons with the tactics of the tobacco industry (Hagmann, 2003).

On the question of the influence of marketing on the diets and health of children, Hawkes reports disagreements between different studies and authorities. A WHO/FAO expert panel concluded that 'the heavy marketing

of fast food and energy-dense micronutrient-poor foods and beverages is a 'probable' causal factor in weight gain and obesity' (Hawkes, 2004, p. 1). A review commissioned by the Food Standards Agency of the United Kingdom found that advertising affects dietary habits and food choices. By contrast, a food industry-sponsored report denied a causal relationship between advertising and obesity (Hawkes, 2004, p. 1).

A major obstacle to common regulatory action on the content and marketing of food and beverages is the global ascendency among most governments in the world of neoliberal ideas hostile to the regulation of mercantile activity and supportive of de-regulation, self-regulation and trade liberalisation. As Keane has observed in the case of the United Kingdom:

> Healthy eating is clearly a political issue and the majority of 'information' about food and health is driven by commercial considerations, particularly in terms of advertising and product descriptions and, more implicitly by the government's reluctance to intervene in the 'freedom' of the market. This reluctance is in contrast to highly interventionist policies pursued in relation to food production [...] (Keane, 1997, p. 179).

The neoliberal ideological outlook endorses the libertarian values in social policy and is therefore supportive of measures focusing upon the individual, rather than populations (see Kay and Williams in this volume). Such an outlook also regards individuals as responsible for choosing what and how much they eat within a market offering a variety of products. Parents, rather than an intrusive 'nanny state' should empower their children to be discerning consumers and should also decide what they should, or should not, eat or drink. Moreover, for those concerned about their weight there is a market offering diverse products and services to enable them to deal with their particular problems. Exactly these types of libertarian objections to tobacco regulation eventually collapsed in the face of the obvious economic burden of smoking and the need to protect non-smoking individuals from the risks and annoyance of passive smoking, the obvious efforts of tobacco corporations to recruit children, and their involvement in attempts to subvert health promotion directed against tobacco. However, libertarian values relating to food are likely to be more enduring. Demands to curtail individual choices about food and physical activity touch upon fundamental freedoms about how people live. Nevertheless, as in the case of tobacco, economic arguments may be used to portray the costs of obesity and overweight as a societal burden, thereby partially removing the problem from being exclusively associated with the individual.

That food is an internationally traded commodity presents further challenges to regulation. As Chopra *et al*. have pointed out the WTO has facilitated the penetration by food exporters of markets in developing countries (Chopra *et al*., 2002, p. 954). Any regulations touching upon the inter-

national trade of foodstuffs, including the banning of exports of manifestly unhealthy foods such as turkey tails, would need to be reconciled with the provisions of GATT and the WTO (in a similar logic to that forwarded by Labonté *et al*. in this volume). Transnational food corporations represent an even more economically powerful set of interests than the tobacco corporations and formidable players in global policy. As Nestle has argued in her study of the US experience, major food corporations have enormous financial and human resources with which to exert formidable influence upon political decision-makers and regulators (Nestle, 2002). In an example with parallels to the tobacco industry's efforts to influence WHO action in tobacco, in 2003 the US Sugar Association was reported to have threatened to lobby the US Congress to withhold future funding to WHO as part of the lobby group's efforts to influence WHO recommendations in sugar consumption (Hagmann, 2003). In 2004 two global interest groups, Infact, a corporate accountability organisation which had participated in negotiations on the FCTC and the International Baby Food Action Network (IBFAN), which monitors adherence to the ICMBMS, expressed concerns that global food corporations, with the support of the US government, were trying to undermine the WHO Global Strategy on Diet, Physical Activity and Health. These organisations saw parallels with the lessons from the FCTC process and infant feeding regulation debates and demanded transparency and safeguards relating to conflicts of interest in WHO's relationships with commercial organisations (Infact and IBFAN, 2004).

Transnational and major food corporations might also object to regulatory measures on the grounds that they are unfairly selective in targeting the activities of larger corporations. Throughout the world, small-scale producers and vendors of fatty and salty foods are to be found. In developing countries they often operate within the informal sector. For example, in Malaysia, traditional breakfasts of *nasi lemak* (rice cooked in coconut milk and served with fried peanuts, an egg, curried chicken and cucumber) compete with McMuffins, waffles and other Western breakfast offerings. In South Africa, local and global hamburger chains are to be found near to simple stalls offering *salomis* (oil-rich bread filled with curry) and various deep-fried products. In the United Kingdom the local fish and chip shop offers deep fried products, often liberally sprinkled with salt. Such foods are not part of any marketing scheme and their sale would therefore not be affected by codes of conduct relevant to the major corporations.

Legal complications are also likely in different jurisdictions. As the FCTC frequently reiterated, regulatory measures on advertising and promotion were subject to the particular constitutional principles of each nation state becoming a party to the treaty. The constitutional provisions governing freedom of speech would therefore provide immunity from a range of regulatory controls for the many global corporations operating out of the United States of America. There are also likely to be legal difficulties in efforts to

introduce comprehensive regulation. Would, for example, having different sized drink containers constitute an invitation to 'upsize' in a fast food outlet? Would children's playgrounds have to be removed from fast food restaurants in order to comply with controls on sales promotions to children?

Perhaps a middle path between efforts to negotiate a comprehensive multilateral 'food control treaty' and reliance upon nonbinding instruments might be suggested by original thinking of the progenitors of the FCTC who envisaged the treaty in incremental terms, anticipating that 'over time countries will negotiate and conclude protocol agreements – separate treaties – designed to implement the goals of the framework convention' (Roemer *et al.*, 2005, p. 936). Through the gravitas of a formal treaty, such a path would obtain global endorsement of the goals of the Global Strategy while also reinforcing political will on the part of national governments. A broad framework for governance would also introduce expectations of compliance in the development of comparative indicators, sharing of data, reporting on the progress of national policy development and international cooperation. The existence of a treaty endorsing the goals of the Global Strategy would also strengthen the advocacy position of health ministries and civil society. The negotiation of specific protocols to deal with specific issues, such as food and beverage advertising to children and 'healthier food' labelling, would serve to further raise consciousness and develop the policy agenda.

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Part II

The Economy of Global Health Governance

6

Unpacking Economism and Remapping the Terrain of Global Health[1]

Matthew Sparke

> We are in transition from what seemed a relatively stable, state defined and structured world of international health to a diffuse political space of global health. We need to analyse to what extent the political ecosystem that inhabits this space transfers power and to whom. We need to map the epistemic communities and the multitude of networks and their spheres of influence (Ilona Kickbusch, 2003).
>
> The microbe is nothing; the terrain everything (Louis Pasteur, 1890).

Introduction

By connecting the topics of global health and global governance this book invites a whole series of questions about how different practices, structures and philosophies of governance configure the 'global' in global health. How do they map the terrain of the 'global'? What do they prioritise as 'global' problems and 'global' solutions? And how does the space of 'global health' – its inclusions, exclusions and underlying implications about shared global ties – relate to the more general political-economic ties of globalisation? Economism – the core focus of this chapter – presents both openings and obstacles for any attempt to answer such questions. According to the *Oxford English Dictionary* 'economism' describes 'a belief in the primacy of economic causes or factors'. In academic arguments and polemics today the term further implies that an insistence on such primacy is either theoretically essentialist or ideologically interested. Whether used to condemn an approach to explanation or an approach to governance, the implication is that the stress on economic factors or economic rubrics is reductionist and inadequate. It is increasingly clear, however, that using 'economism' in this way as a polemical category of condemnation is itself reductionist and inadequate. It risks obscuring the actual force of particular economic policies in globalised regimes of governance, and it meanwhile abstracts important arguments over how the political and economic interconnect in the world at large into entirely

academic and epistemological issues. To be sure, there have been some important theoretical and empirical correctives to these tendencies, correctives that explore both the economic rethinking of government and economic remaking of the state that happen when politics comes to be dominated by economics (for example Brown, 2003; Tabb, 2004; and Teivainen, 2002). However, none so far have focused specifically on the implications for rethinking and remaking 'global health governance' in the context of economic globalisation. This is what the present chapter aims to do.

In order to move beyond the pitfalls of polemic and abstraction the following pages unpack and distinguish three different types of economism as they relate to global health governance. These three types are identified in terms of their broad-brush discourses about capitalist markets as: 1) the economism of *market fundamentalism*; 2) the economism of *market foster-care*; and 3) the economism of *market failure*. The three labels are useful heuristically, but, more than this, their simplicity as buzzword formulations about markets also captures something of the real-world resonance and power of each economism as an influential economic discourse about the world. It is precisely this influence that the following pages seek to explore in terms of the remapping of global health. The mapping concept-metaphor is exact because, it is argued here, each economism also assumes and activates a distinct 'imaginative geography' of globalisation that then frames and visualises the terrain of global health in a distinct way. The notion of imaginative geographies (which heralds from historical and humanistic literatures) may itself appear epistemologically nebulous and abstract, if not altogether inappropriate in relation to the urgently embodied challenges of today's global health crises. However, taking inspiration from the physician-anthropologist Paul Farmer's powerful critique of the 'geography of blame' framing Haiti's devastatingly embodied experience of AIDS (Farmer, 1992), the thesis in what follows is that different imaginative geographies of the 'global' not only distinguish the different kinds of economism as modes of representation, but also have profound, life and death consequences for how global health problems are framed as 'global' (or not) and how global health governance is conceptualised and practiced in response. Historically it is clear that preceding regimes of health governance have been characterised by their own distinctive spatial assumptions about the geographies of health, including the territorial sweep of infection and vulnerability, as well as the spatial organisation of medical and public health interventions. City spaces, colonial control zones, 'natural regions' and national-state territories, have all served in this way as influential historical-geographical horizons for visualising both health challenges and arenas for medical action. However, in the context of economic globalisation, and specifically in relation to today's increasing extension and entrenchment of pro-market 'neoliberal' approaches to government, these older geographical horizons are being revised and reterritorialised. They

have by no means been replaced altogether, and the place of the nation-state as an influential imagined community of health and sickness continues to shape health governance in obvious ways. Indeed, as the basic 'unit' of health statistics, as the taken for granted 'community' wherein sickness and health are understood as communally related, and as the epidemiological 'population' of record that is counted, compared and considered for control in international health planning, the nation-state with its borders and internal administrative areas is still a very prominent space amidst the overlapping spatial frameworks of health governance around the world. But none of this alters the basic fact that, as Kelley Lee has emphasised, 'new spatial configurations of health and disease are emerging as a consequence of globalization' (Lee, 2003, p. 6; see also Lee, this volume). Moreover, the global reterritorialisation of governance driven by market-based globalisation has also obviously led to a series of reappraisals of the national territorialisation of health governance. As market-forces have come to both open and curtail access to healthcare across the transnational spaces regulated by free-trade agreements, concepts of health citizenship have also been transnationalised in uneven and contradictory ways. In turn new global norms for inclusion in and exclusion from health interventions have been established based on varying visions of how disease, health and socio-economic ecologies intertwine globally. All these developments have involved distinctive forms of reterritorialisation, remapping and retitling. And even the terminological take-off of 'global health' and 'global health governance' as academic terms (see Figure 6.1) can be

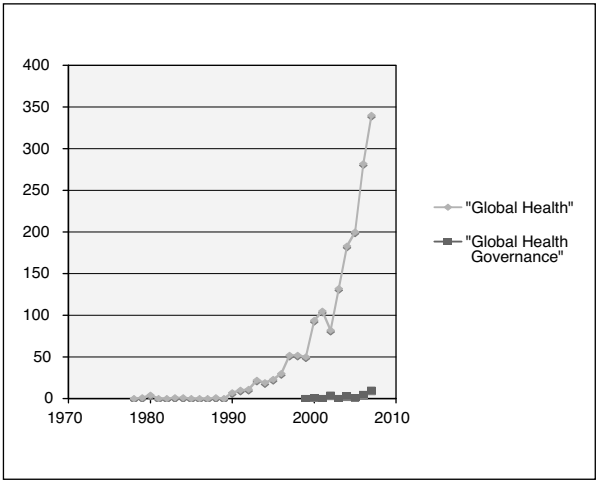


Figure 6.1 The Use of 'Global Health' and 'Global Health Governance' as Registered in Web of Science Citations

understood in this way as a reflection of the 'new political space' noted by Ilona Kickbusch (2003, p. 197). Thus, to quote a telling use of 'landscape' language from *The Lancet*, 'as the importance of global and supra-national determinants of health increases, so does that of global public health institutions.... The time has come for a significant rationalization of the global-health landscape' (McCoy *et al.*, 2006, p. 2179).

Other commentaries on particular features of the actually emerging global health landscape highlight how it is mainly being remade (if not rationalised) by transnational market actors and institutions (including, according to an influential corporate consultancy, transnational medical tourists: see McKinsey, 2008). In a particularly notable instance, a recent landmark assessment of the new 'social and institutional geographies' of pharmaceutical governance notes thus that: 'Elements in this new ecology include the World Bank, the World Trade Organization, and TRIPS, and a host of international and national regulation and law, which set the terms of pharmaceuticals' worldwide and regional circulation. This institutional ecology moves within and across more traditional, territorially bounded apparatuses of governance' (Petryna *et al.*, 2007, p. 6). Reviewing many such changes to the geography of health governance more generally, it fast becomes clear that key amongst the global determinants driving the reterritorialisation are the pro-market transformations of governance that scholars of globalisation explain in terms of neoliberalism (Harvey, 2005), marketised constitutionalism (Gill, 2003) and the transnational entrenchment of economic governance (Tabb, 2004). All sorts of new private sector actors, non-governmental organisations (NGOs) and global philanthropies have come to populate this new market-made landscape. But, as shall be documented below, the actual remapping of health governance itself reflects the ways these global actors, along with older national and international agencies, are interpreting the underlying economic forces of change.

Unpacking the three economisms

What then are the three dominant forms of economic interpretation and argument used to connect debates over global health and global governance in the context of economic globalisation?

The first is the most dominant and egregious kind of economism we see today, the neoliberal economism of *market fundamentalism*. It is as common as it is unquestioned, as political as it is economic, and as entrenched in public policy as it is normalised in the micro-economics classroom. For the same reasons it now functions as the hallmark and working discourse of the globally dominant system of business-led and market-based governance. It is neo*liberal* because it returns to the free-market *laissez-faire* liberalism of nineteenth century liberals, but after, and hence the *neo*, the development and decline of the welfare-state liberalism of the twentieth century. At

intergovernmental meetings of the Group of Eight (G8), World Bank, International Monetary Fund (IMF) and World Trade Organization (WTO), as well as at a plethora of business meetings such as the World Economic Forum, market fundamentalists continue to denounce 'big government' while adapting the underlying axiom of free market rule to a wide variety of global challenges, infectious diseases such as HIV/AIDS, malaria and tuberculosis (TB) often among them.

Whatever the place and whatever the problem, market fundamentalists repeatedly assure their audiences that it is jobs, growth and the efficiency of the liberated invisible hand that will ultimately save all of humanity. Good health, it is argued, is dependent on good growth, entrepreneurial innovation in pharmaceuticals, and the market delivery of these innovations to global health consumers. Poor health, by contrast, is seen as a result of poor integration into the networks of global capitalism. Out of these arguments comes in turn the policy assertion that only by integrating the poor economically into the global free market system is it also possible to include them finally in a fully global community of universal good health. Contrastingly, but quite tellingly, in practical policy-making arguments over global health governance the economism of market fundamentalism leads not to inclusionary but instead exclusionary stipulations about healthcare rationing predicated on 'cost-recovery' policies and 'cost-effectiveness' analysis. It is true that while IMF/World Bank emphases on cost-recovery have come with a much criticised insistence on austerity, user fees and healthcare cut-backs (see Weber, this volume), cost-effectiveness analysis is often seen as less punitive and exclusionary, being presented as just a rational economic calculus for determining funding priorities in the context of limited resources. However, along the way the elaborate algebra of Quality Adjusted Life Years (QALYs), Incremental Cost Effectiveness Ratios (ICERs) and Willingness to Pay (WTP) metrics simultaneously reflect and reinforce the ways market fundamentalists turn care for human life into care for human capital.

The second economism is also contradictory, and in many ways is equally neoliberal in its guiding assumptions about the inherent efficiencies of individual choice-maximising behaviour, market-based governance and capitalist growth. However it also contrasts with, and thereby compensates for, the economism of market fundamentalism insofar as it argues that certain areas of global governance can only function efficiently, sustainably and humanely when capitalist markets are made more accessible, and the poor and unhealthy are more adequately prepared for integration. This is the economism of *market foster-care*, and it tends to guide calls for targeted global health interventions for those without access to the so-called bottom rung of the global economic ladder. Global health crises in these foster-care accounts are explained in terms of a 'poverty trap' that is itself explained in part by the sickness of the poor themselves. In other words, while market

fundamentalists point a huge explanatory arrow that says good growth will lead to good health, market foster-care interventionists turn this arrow around to argue in often equally simplified ways that removing obstacles of ill-health will give the poor the vitality they need to climb the ladder of growth. For advocates of this foster-care work it is envisaged as providing the medical interventions that will ultimately enable the poor in particular places to pull themselves up previously unreachable rungs of economic development. The work of foster-caring for poor others (who are also repeatedly represented as children in need of tutelage) becomes seen in this way as a therapeutic focus on the weak spots of a global body coded as having curable place-based pathologies. Accordingly, foster-care interventionists can come into the pathological places presented by so-called poverty traps and prescribe cures based on the idea that relief from disease and high infant mortality are real rungs on the ladder out of poverty. A notably bio-medical vision of care is thus twinned with an economic instrumentalism to fashion a therapeutic as well as a so-called enlightened and self-interested investment in the health of the global economy itself.

The third economism abandons global economic ladder metaphors altogether, replacing them with vocabularies and interventions better attuned to the recriminations of those who report being rung-out rather than rungless in the context of globalisation. It is an economism that is based on critiques of both market fundamentalism and market foster-care, and, as such, focuses instead on the double standards and suffering that signal *market failure*. The primary marker of market failure according to this kind of economism is economic inequality. Health inequalities are tied thus to economic inequalities, and effective responses to health crises and medical pathologies are linked in turn to effective reevaluations and treatments of political-economic pathologies too. Yet while inequality is the common economic reference point in such accounts linking market failure and health failure, it is a reference point that leads in two very different sorts of direction when it comes to health policy analysis and intervention. The economism of market failure is for this reason much less singular and ultimately much less economistic than the economism of market fundamentalism and the economism of market intervention. It can certainly lead to predictive 'black-box' approaches to epidemiological explanation that turn economic inequality into an instrumental independent variable explaining health disparities in and between particular nation-states. However, it can also lead to much broader transdisciplinary and transnational efforts to tease out the complexity of the causal connections by examining the diverse political, economic and historical forces that come together across borders to overdetermine unequal health outcomes around the world. While such transdisciplinary efforts may begin from the same territorial statistics pointing to strong correlations between economic inequality and reduced life expectancy in particular nation-states, states, provinces, counties and cities, the transnational attention to territory-

transcending, multi-factor historical-geographical processes leads ultimately to an epistemological problematisation of economic correlation as a stand-alone instrumental guide for health governance. It is in such moments of problematisation that we can witness in turn a critically transnational remapping of the *terrain* of global health in relation to the unevenness of global economic development.

Economic base-mapping for global health

If the outline of each economism is now clear, the way each one in turn outlines the terrain of global health is not. How do each of these economisms provide an economic base-map that frames how the global in global health is understood?

Market fundamentalism and the flattening of global space

The base-mapping of market fundamentalism is so prevalent today and so established as a common-sense imaginative geography of our supposedly 'borderless world' that it does not need extensive elaboration. Its most common spatial metaphor is 'the level playing field' and in the symptomatic sound-bite of *New York Times* globalisation guru Thomas Friedman it presents us with a simple global vision: namely that *The World is Flat* (Friedman, 2005). Friedman's flattening is meant to function as a jocular 'new world order' return to 1492 and the world's most famous discourse of Discovery (although, he does not address the contemporary implications of the global spread of disease in the original age of Discovery). Posing as a latter day Columbus on a trip to Infosys in India, Friedman charts a freshly flattened new world of free-market opportunity, a world where, amongst other things, outsourced medical analysis in India and Australia is depicted as introducing efficiencies and cost-savings into medical treatment in America. For Friedman 'There Is No Alternative' to this flattened world, and his appeal to the conjoint 'inescapability' and 'inevitability' of the level playing field in turn indicates the political bull-dozing work he wants the imaginative geography to accomplish. In short, it helps him naturalise neoliberal norms and pro-market reforms as the only options available for governance in a flat world. Notwithstanding all the uneven development unleashed by this *laissez-faire* approach to governance, the flattening invoked by Friedman has for the same reasons become a commonplace of TINA-touts all around the world (for more on the contradictions of touting 'There Is No Alternative', see Sparke, 2006).

The most obvious and extensive way in which the flat world base-map delineates global health governance is through free trade legislation itself. Whether negotiated at a global level through the GATT turned WTO agreements, or at a regional level such as represented by the EU, North American Free Trade Agreement (NAFTA) and Central American Free Trade Agreement

(CAFTA), or even just bilaterally as in the recent US–Singapore free trade agreement, free trade rules are fundamentally premised on the principles of removing tariff and non-tariff barriers to trade. To pick one such free-trade regime that has had especially far-reaching implications for global health, the WTO's Trade Related Aspects of Intellectual Property Rights (TRIPS) preamble provides a typical rendition of the flattening vision. '*Members Desiring,'* it begins in italics,

> to reduce distortions and impediments to international trade, and taking into account the need to promote effective and adequate protection of intellectual property rights, and to ensure that measures and procedures to enforce intellectual property rights do not themselves become barriers to legitimate trade … Hereby agree (WTO, 2008).

The TRIPS agreements that follow the preamble show that when flat-world desires for barrier free transnational market spaces are put into the official language of trade accords they create new legal landscapes that constitutionalise the profit-making rights of transnational businesses while simultaneously straitjacketing what national and local governments can do to regulate the marketplace (Labonté and Schrecker, 2007). Not only are the production and distribution of free medicines and cheap generic drugs curtailed this way, but, if we also consider other WTO rules relating to trade in services (GATS) and Sanitary and Phytosanitary Measures (SPS), a vast variety of other important public health measures are controlled and conditionalised too. From direct government provision of healthcare, to national procurement programs, to subsidised pharmaceutical research, to the regulation of toxic pesticides and carcinogenic additives, to the application of precautionary principles to risky foods, to the enforcement of environmental clean-up laws, the forms of health governance that thereby become re-regulated by free-trade law is long indeed (see Labonté *et al*., this volume). Moreover, considering the case of NAFTA's Chapter 11 with its rules allowing private companies to sue national governments for actions 'tantamount to expropriation', we also can note that, as well as making it difficult for governments to ban toxic chemicals and waste (McCarthy, 2004), the agreement's legal level playing field also features a remarkable neoliberal lock-in mechanism that makes it impossible for liberal-left politicians to *reverse* neoliberal reforms, including the privatisation of health services, enacted by pro-business governments (Sparke, 2005, Chapter 3). Overall, this 'disciplinary neoliberalism' – to use Stephen Gill's critical term – is what makes the flat world base-map a legal reality (Gill, 1995 and 2003).

The imaginative geographies of connection and disconnection enframed by the flat 'borderless world' vision may at first blush seem merely metaphorical. But when repeatedly put to work to make arguments over the best approaches to global health, the geographic metaphors and relentlessly

repeated 'solutions' they inspire become considerably more practical and consequential on the geographic ground. The sort of globalist enthusiasm for market-based solutions expressed by, for example, *The Economist* is just as common in the more specialised reports written by and for global health professionals themselves (on the neoliberalisation of World Health Organization (WHO) reports in particular, see Navarro, 2000). Especially in areas where scientific innovation and drug development are involved, the advocates of free market openness, good commercial governance and a global level playing field are never far away (although, to use the fluvial metaphor that runs in and across the vision of the level playing field, they sometimes advocate upstream governmental support to protect downstream profits, see Rajan, 2006). For instance, Chapter 3 of a recent UN sponsored report on *Genomics and Global Health* makes the connections very clear in the course of outlining why corporate intellectual property rights must be protected as part of allowing the private sector to play its invisible hand in genomics innovation. The chapter seeks thus to summarise the

> specific actions that are needed to foster the rule of law and to create a level playing field for entrepreneurship, as well as to improve access to financing and the availability of skills and knowledge. It notes that a level playing field, access to finance, and knowledge and skills are key factors within the domestic private sector (Acharya *et al.*, 2004).

Of course, from the point of view of the critics of neoliberalism such level playing field rhetoric rests on a giant contradiction: that, by privatising scientific innovation and turning it into intellectual property, the advocates of market-led global health cut off life-saving innovations from all those suffering from the sicknesses of poverty and dispossession. Cheap generic copies of genomic pharmaceuticals, for instance, will clearly be very hard to produce if the 'rule of law' is used to 'level the playing field for entrepreneurship' and keep medicines in the locked cabinets of for-profit dispensaries. And if poor populations are unable to pay for for-profit medicine, then the medicines they need are hardly likely to be the highest priority for innovation by big pharmaceutical companies for whom lifestyle drugs for wealthier westerners promise much larger returns.

Given that the authors of the *Genomics and Global Health* report were working in a UN Millennium Development Goals Task Force, the contradictions between their level playing field language and the inevitable exclusion of the poor from expensive genomics therapies seems all the more deep and disconcerting. However, for elite market fundamentalists themselves the contradictions are not so much ethically troubling as useful in their arguments against egalitarian health ethics. Indeed, if one reviews the global health related reports of free-market think tanks such as the *American Enterprise Institute*, the contradictions of the UN agencies struggling to

develop global health policy in the context of neoliberalism only help illustrate the baseless ethical idealism of setting health inequality reduction goals in the first place (and for an unfortunate academic replay of the same anti-ethics arguments see Fidler, 1999). Criticising the 'Faux Forecasts' of UNICEF and the WHO, one recent *American Enterprise Institute* report thus makes the market fundamentalist case that estimates of the need for Artemisinin-based Combination Therapies for malaria were economically irrational because they were based on idealist ethics about equal treatment for the world's poor. 'Forecasting by UNICEF and WHO is based on need,' the author complained, 'which is qualitatively different than what economists call "effective demand".'

> This means that production estimates – driven as they are by unrealistic expectations – may be higher than effective demand. … WHO and UNICEF are of course health cheerleaders, aiming for higher spending but bearing no cost for wildly unrealistic projections (Bate, 2007).

Such reports do not have a problem squaring such complaints about unrealistically egalitarian global health goals with their own cheer-leading for a global level playing field: cheer-leading which, as we have seen, works by visioning a more globalised and leveled plain in the particular *economic* interests of cross-border business, profit-making and property rights. Wishful thinking on the part of the market's player-managers, it would seem, is not so economically irrational as wishful thinking on the part of the WHO. Moreover, this double standard helps in turn to explain why the market fundamentalist appeals for inclusion through global markets can so easily be coupled with the 'cost-effectiveness' calls to exclude the world's poor from high-cost treatments. Another recent *American Enterprise Institute* report, for instance, makes the case that Highly Active Anti-retroviral Therapies (HAART) are not an economically rational treatment for the world's poor living with AIDS all the while arguing that the best way forward is to keep the playing field level for pharmaceutical companies by maintaining a research and development climate that is 'conducive to and propitious' for business.

> HAART interventions still look like a problematic health care choice. This is because there remain vastly more cost-effective channels through which to extend life in low-income areas … Above all else, it is research and development – especially in the pharmaceutical area – that promises the potential for recasting the cost-benefit calculus for HIV/AIDS treatment for low-income populations. To grasp this potential, of course, we must maintain a climate, for both business and universities that is conducive to and propitious for research and innovation (Eberstadt, 2004).

It is in such moments of market fundamentalist double-speak that we come face to face with the 'strange beast' identified by Paul Farmer in his 2001

Preface to the paperback edition of *Infections and Inequalities*. 'Market utilitarianism,' he argued there,

> is a strange beast, since it seems to permit all sorts of inefficiencies so long as they benefit the right people – namely, the privileged. Confident claims about what is cost-effective and what is not should be viewed with some suspicion by those bent on providing quality care to the destitute sick (Paul Farmer, 2001, p. xxiv).

Moving forward with the critical suspicion demanded by Farmer it remains nonetheless imperative to examine how the development of cost-effectiveness analysis by health economists differs from the overt political posturing of free market think-tanks. This is important because for many practitioners the purpose of such analysis is to maximise the health benefits that can be developed from limited health funding. To use an economical axiom of the field that also illustrates the attendant tendency to take health budgets as 'given', the 'emphasis is not on more money for health but on more health for money' (Murray and Frenk, 2000, p. 1699). Approaching cost-effectiveness analysis with this overt agnosticism about overall levels and forms of funding also mutes market fundamentalist posturing. It means that proponents do not always assert a fundamentalist faith in good economic growth growing funds and private provisions for good health. Nor do they necessarily invoke the neoliberal policy argument that cost-effectiveness demands cost savings and thus cost-reducing cuts in publicly funded health services as part of a more general pro-market global development policy (see Arnesen and Kapiriri, 2004; Grosse *et al*., 2007). Their economic calculus, in the vocabulary of an influential WHO guide to Generalized Cost Effectiveness Analysis, instead involves identifying 'allocative inefficiencies' within a 'given' budget for a 'given' population (Edejer *et al*., 2003). Still, in the end, cost-effectiveness analysis with its practical ties to healthcare rationing in market-based systems, repeatedly capsizes (Bastian, 2000) or otherwise cancels-out (Farmer, 2005) ethical invocations of health as a basic human right, replacing them with a de-contextualised and thus methodologically flattened landscape of health services as commodities as metrics.

While the economism in cost-effectiveness analysis often leads – as Farmer and others have complained – to a revisioning of global health citizenship in the narrow budgetary terms of just those who are 'QALY-fied' to pay, this is not necessarily always the case. Indeed, outside of the wealthy west and its prudential metrics of human capital, cost-effectiveness analysis can also be employed in examining the health deprivations of all those who cannot pay. Of course, for market fundamentalists the health problems of such impoverished communities are easy to understand. They are obdurate isolationists holding out in the slow world valleys of capitalist disconnection. However, for the many other analysts who see a need for market foster-care

such convenient and comfortable alibis for inaction are inadequate. They still believe in global capitalist connections as a basis for global health and they sometimes turn to cost-effectiveness analysis to determine which sorts of connection should be prioritised, but they work with mental maps more attuned to the place-based geographies of disconnection. It is to their calls for market foster-care and to their proposed treatments for the pathologies of places deemed disconnected that we now turn.

Market foster-care and the pathologisation of place

While the flat world vision turns geography into a history of connection – albeit, *à la* Friedman, a stupendously hasty history of overnight globalisation sometime in the late 1980s – the calls for market foster-care turn history into imaginative geographies of disconnection. To do this they pathologise particular places as 'poverty traps', a form of place-based pathologisation that, while less comforting than market fundamentalist alibis, still offer a way out, indeed an economical out, from more radical critiques of global structural violence. It cannot be stressed enough, however, that the market foster-care calls to intervene in particular places of poverty and poor health are often made with great sincerity. While the corporate social responsibility reports of the big drug companies too often seem like self-interested public relations stunts, and while shifts by the G8 finance ministers and IMF economists often appear like reluctant and retarded responses to public pressure, the embrace of interventionist ideas and health improvement goals by a wide range of doctors, NGOs and UN agencies is much more urgent and earnest. Their commitment to designing healthcare interventions to relieve the sickness and suffering of the world's poor is not questioned in this section. The question and analytical entry point here is instead with the distinctive approach to imagining the geography of global health that informs their commitment and shapes their market-foster-care approach to global health governance. Taking aim at particular diseases in particular places, this approach has led to a verticalisation of health governance with targeted bio-medical programs against specific diseases being justified in the geographically-partitioning terms of lifting people out of poverty traps and fostering their ascent of the global development ladder. As this approach is adopted and implemented by a widening circle of global health agencies and NGOs, its imaginative geography of partitioned and pathologised poverty traps is becoming just as powerful and globally consequential as the flattening figured by the market fundamentalists. For the same reason, therefore, its distinctive, and, as will now become clear, *selective* vision of the terrain of global health calls out for critical examination.

In his best-selling book *The End of Poverty* (Sachs, 2005), Jeffrey Sachs seeks to introduce a new attention to the uneven geography of what he calls 'poverty traps'. 'A large number of the extreme poor,' he explains, 'are caught in a poverty trap, unable on their own to escape from extreme

material deprivation. They are trapped by disease, physical isolation, climate stress, environmental degradation, and by extreme poverty itself' (Sachs, 2005, p. 19). Sachs argues thus that new forms of foster-care intervention are necessary to enable those who are unable to help themselves climb out of these traps of poverty. He calls this correction of *laissez-faire* orthodoxy 'Clinical Economics', and he deliberately models its diagnostic terminology and methodology on clinical medical practice. 'Development economics is not like modern medicine,' he says, 'but it should strive to be so' (Sachs, 2005, p. 75). What this means in practice for Sachs involves treating individual countries like individual patients, abandoning the one-size-fits-all fundamentalism of the IMF, and replacing it with a detailed 'differential diagnosis' of each country's discrete national situation. At the center of such diagnosis Sachs in turn puts great emphasis on the need for detailed poverty maps that can be used in conjunction with a thorough mapping of the physical geographical challenges facing particular countries to determine how best to build new ladders out of old poverty traps (see also Sachs, 2008, pp. 178–179).

Sach's argument about how to do development differently is not a radical repudiation of neoliberal structural adjustment. Like Friedman, he still believes that 'second and third world strategies failed, and needed to be reoriented to a global, market-based international economic system' (Sachs, 2005, p. 81). In such terms, the shift from market fundamentalism to market foster-care hardly seems revolutionary. Yet, if we focus in on the transformed imaginative geography of global health it represents and if we track in turn the more general invocation of similar imaginative geographies in policy-setting commentary on the need for global health interventions, the consequences are far-reaching. With Sachs as chair, for instance, the WHO Commission on Macroeconomics and Health came to consensus precisely through its new attention to the geography of poverty traps. 'We found that the health crisis in Africa and other impoverished regions was indeed causing a poverty trap,' explains Sachs. 'Massive proportions of the poor are sick and dying, and sick people are unable to generate income and pay taxes. Without household incomes and with bankrupt governments, health systems have collapsed and epidemics are running unchecked' (Sachs, 2004). Having thereby diagnosed the pathology, the Commission was led to a newly interventionist approach to health governance too. 'To break this vicious cycle, the rich countries would have to help' (Sachs, 2004). As Sachs and others try to explain this need for help to other agencies of global governance, the justifications for intervention are in turn predictably made in terms of making investments in order to make the world safe and secure for economic globalisation. 'By helping these countries rise above extreme poverty, we would also enable them to become stable neighbors and trading partners instead of havens of terror, disease, unwanted mass migration, and drug trafficking' (Sachs, 2004). Such appeals to recouping a return

on investment reflect the wider links between market-foster-care economism and the financialised global governance vocabulary in which individual countries are ranked like so many regional mutual funds in terms of risk and return. However, beyond the return on investment rhetoric, the deeper appeal of the call for global health investments lies in the imaginative geography of the poverty trap itself: the pathological place that needs fresh funding for health in order to return it to productivity, growth and secure integration into the global economy.

Sachs no doubt would insist that his own approach to geography is empirical and ecological, not imaginative at all. He presents detailed maps and charts documenting the problems facing countries located in landlocked, mountainous and tropical terrain, and like other fashionable environmental determinists such as Jared Diamond (who effusively praised *The End of Poverty* on the back-cover), he suggests that such focus on empirical environmental conditions actually provides an objective and non-ideological starting point for development. However, the very fact that this approach resonates with a wider enthusiasm about environmental determinism should provide pause, as too should the way in which the arguments turn the so-called natural environment into an independent variable. This is not because environmental influences can be discounted. But rather because the determinist discourse obscures the ways in which such environmental influence is, as a wide range of geographical research has consistently shown, everywhere intertwined with political and economic influences that co-constitute and mediate what is experienced as 'environmental' (Braun and Castree, 1998; Dalby, 2002; Newman, 2005; Peet and Watts, 1996). Natural hazards and environmental catastrophes, for example, are only violently destructive of lives and livelihoods under structurally violent political and economic conditions (Watts, 1983; Peluso and Watts, 2001). Likewise, the poverty traps that Sachs tends to naturalise are unnaturally pre-conditioned by all sorts of political and economic forces, and these, far from being just local endogenous ecologies of vulnerability, all involve complex local-global historical geographies of development and underdevelopment (Lawson, 2007). This is why the environmental conditions on which Sachs places such emphasis as explanations of poverty – on being landlocked, mountainous, tropical, and so on – also introduce so many wealthy counter-examples: Austria is landlocked, Switzerland is mountainous, and Singapore is tropical. More soberingly, there are many extremely poor countries such as Haiti where it has been the problem of *not* being landlocked – of having been instead at the very center of trans-Atlantic triangular trade – that has been so damaging: creating the conditions for plantation slavery, counter-revolutionary repression and neocolonialism that subsequently allowed diseases (tropical and non-tropical, both) to have such devastating consequences (Farmer, 1992, 2006).

As Paul Farmer has explained in much more detail, the example of Haiti highlights how important it is to interrogate naturalised geographies of

blame. Unfortunately, though, this is precisely what the environmental determinism in market-foster-care economism denies as an analytical possibility (even as Farmer is cited by Sachs as a 'saint of global health', 2005, p. 205). By pathologising poor places as places with poor environments, sickness and self-reinforcing poverty traps – where, in short, a sick environment begets a sick population, a sick economy, and thus a still sicker environment – the imaginative geography of market-foster-care hides the historical geography of dispossession. It replaces a dynamic and longitudinally discerning approach to geography with the sorts of snap-shot diagnoses and bench-marking more commonly found in business journal rankings of the so-called 'business climate' – itself an uncanny inversion of an environmental metaphor as economic code.

One of the most eloquent, and, as Paul Farmer himself puts it in a supportive foreword, 'magisterial' attempts to call for a form of foster-service approach to global health is Edward O'Neil's recent book, *Awakening Hippocrates: A Primer on Health, Poverty, and Global Service* (O'Neil, 2006a). Published by the American Medical Association and praised profusely by some of the leading advocates of global health, the text also came out with a companion volume entitled, *A Practical Guide to Global Health Service* (O'Neil, 2006b). Together the two books provide both a chart and guide for intervention, or what O'Neil imagines himself as 'a map and compass through which many will find their way to service' (2006a, p. xix). The emphasis on global service itself is obviously also a complete rejection of *laissez-faire* orthodoxy. O'Neil is critical of trickle-down development ideology, of structural adjustment policy and the one-size-fits-all neoliberalism of the traditional Washington Consensus; he argues with moral fervour against the inequalities of global capitalism; and he generally avoids invocation of some shamanic hand of free-market healing. He has also evidently put much personal energy and self-sacrifice, including considerable care work in Belize and Kenya, into the project of developing and advocating interventionist global health policies. However, for exactly the same reason, his adoption of imaginative geographies of pathological poverty traps demands all the more attention. It demonstrates how strong the vision is in deflecting attention from global pathologies of power even in the work of someone who is personally committed to fighting the impact of such pathology as it is embodied on the ground. It also reveals how market-foster-care discourse looks likely to be translated more generally in writing aimed at a broad medical audience. And relatedly, *Awakening Hippocrates* indicates how influential this economism seems set to become as a guide map for visualising the terrain of global health work in the contemporary moment.

At first the argument of *Awakening Hippocrates* appears alert to the dangers of blaming the victim. Early on O'Neil cautions against focusing 'erroneously on corruption when trying to understand why poor countries remain poor'

(O'Neil, 2006a, p. 15). Instead, he follows Farmer in emphasising the pathogenic effects of economic inequality and in graphically describing the horrific personal suffering resulting from poverty. However, as his analysis of the causes of inequality proceeds, the familiar outline of the imaginative geography of pathology also comes into focus. First the concept of the 'poverty trap' is introduced (p. 16). Then Jeffrey Sachs makes several star turns first to emphasise how poverty and global isolation are linked, and then to insist in O'Neil's efficient summary that 'concentrations of wealth don't make people poor' (p. 174), or, as Sachs is quoted as saying himself: 'My own analysis doesn't suggest that the reason that poor people are poor is that rich people are rich. I think rich people are rich because they developed technology successfully to address a lot of challenges and because they were lucky enough not to have some of the ecological barriers that the poor have' (p. 174).

'To a large extent,' explains O'Neil, 'global poverty is determined by climate and location. In a study published in *Scientific American*, economist Jeffrey Sachs and colleagues showed that merely by looking at a map, once could predict a country's wealth' (p. 244). It is this global map of poverty that subsequently does doubly duty as a global health map too. Tropical countries are doomed to poor agriculture and insect infestations, while temperate countries are said to benefit from good summers for growing food grains and healthily cold winters that eliminate insects bearing malaria, dengue and yellow fever. Sachs is thus quoted as saying that 'winter could be considered the world's most effective public health intervention' (p. 245). O'Neil concludes this expedient medical geography lesson by saying Sachs also proved Adam Smith right on the bad luck of being landlocked, and, through this neoliberal reprise to the original liberal linking of land and luck, returns us once more to the map that so rightly, instrumentally and predictably explains poverty based on location. 'Where one's country sits geographically determines to a great extent how poor one will be' (p. 246).

Taken altogether O'Neil's arguments exemplify how depoliticising the imaginative geography of pathological places can become. Here is an advocate of global health service who deeply cares about the embodied violence of economic inequality, but yet who is also guided away from an analysis of global structural violence through his use of an imaginative geography that highlights the pathologies and poverty traps of particular places. The depoliticising power of this map is especially clear when one reflects on the narrative progression of the book which moves from clear acknowledgment of global-local domination near the start to an increasingly obfuscatory insistence on the environment as an independent ecological variable explaining poverty and thus bad health in particular places later on.

The pathologisation of place works thus as what James Ferguson – an anthropologist especially attuned to depoliticising accounts of African

poverty – calls an *anti-politics machine* (Ferguson, 2006, pp. 50–68). In place of extended political-economic analyses of dispossession (and what is undoubtedly its ecological as well as market-mediation), it substitutes an environmental determinism twinned with a moralism that insists that those in more gifted locales have a quasi-religious duty to help out those who are environmentally unlucky. O'Neil's own Christian messianism exacerbates this moralism (also bringing Bono into the inspirational chorus), and there are other concerns that might be raised about how this messianism is itself tied to a US-nationalism and masculinism in the book's references to US military 'service' and all-male list of inspirational examples. However, it is the way in which O'Neil maps out the pathologisation of place, and, in particular, the way his environment-as-independent-variable explanations abstract away from transnational processes of dispossession, that makes *Awakening Hippocrates* such an illustrative indicator of the wider market-foster-care mapping of the terrain of global health.

While *Awakening Hippocrates* aims at explaining the non-medical contexts that necessitate medical action, the World Bank's 2007 *Healthy Development* signals a new focus on medical action as a way of addressing non-medical problems. The poverty trap is in this sense the meeting point of these converging forms of thinking about global health, and the way out of this place of pathology is predictably conceptualised by the World Bank (along with other global governance agencies such as the OECD and UN) in terms of bringing health to impoverished populations so that they can climb the ladder of economic development, compete globally, and enjoy the good health of good growth. There is a clear transition away from the old World Bank austerity order: an order that often involved demands for cost-cutting in health services in order to balance budgets and control inflation as a condition of debt rescheduling (Gloyd, 2004, and Harman this volume). But with the 2007 *Healthy Development* strategy the World Bank does more than just revise its earlier tendency to sacrifice health for growth. It instead portrays good health policies as the very foundation for good economic growth: the vicious cycle and sickness of the poverty trap is transformed into a new vision of a virtuous cycle in which good health boosts good growth which in turn creates a route out of poverty.

Taken on its own – and therefore ignoring the difficulty of implementing the new strategy in the context of ongoing insistence in World Bank Poverty Reduction Strategy Papers (PRSPs) on paying off old debts (Harman, this volume) – the market-foster-care philosophy of *Healthy Development* represents a notable revision to structural adjustment orthodoxy and the normal neoliberal edicts about increasing private provision and market competition. NGO complaints about the pro-privatisation emphases of earlier drafts evidently played a role in shaping the final report, and ironically one of the most important outcomes of these revisions is the strategy's argument for fostering more centralised governmental control over the multitudinous global

scattering of non-governmental health interventions (McCoy, 2007). However, the main goal of *Healthy Development* still remains a form of foster-care for the market, and this care, moreover, is routinely imagined as being administered on a country by country basis. Particular problems of health in particular countries become reinterpreted thus as place-specific impediments to economic expansion because of the ways in which they diminish human capital and discourage inward investment into the particular places under examination.

In other institutions of global governance beyond the Bank, the emphasis on the market-improving outcomes of health-oriented foster-care is also a common feature. WHO policies and the UN's Millennium Development Goal initiatives often echo the same basic idea that targeted relief from poor health will help the poor climb the ladder of market-led global development. Increasingly, though, such commentary is becoming more critical of market failures, especially when it is articulated by non-governmental agencies who do not need to worry about alienating Washington Consensus consensualists. A good example of this hybrid economism between market-foster-care and market failure was recently provided by Joe Cerrell, the Director of Global Health Policy and Advocacy for the Gates Foundation. In a speech entitled 'Making Markets Work' that was published on the IMF's website, Cerell (2007) offered what was at once an indictment of market failure and an explanation of how he sees private sector health funding providing a compensatory form of foster-care. From the perspective of theorists of neoliberal managerialism his argument for intervention may still seem market-based and entrepreneurial in its formulations about leveraging private sector innovation. Similarly, it is clearly associated with a targeted and vertical bio-medical approach to intervention that many public health specialists argue is limited by its geographical and epidemiological selectivity, as well as by its tendency to use private labour market incentives that can further undermine already insecure public health systems in countries desperately trying to hold on to well-trained local health professionals (McCoy *et al.*, 2006, p. 2180). Yet limited as they may be, Cerell's criticisms of market failure are no less real or consequential. They also clearly lead to an emphasis on global public goods, and by doing so offer insight into other, much more transnational, imaginative geographies of global health associated with more radical critiques of market failure. It is to these critiques and their geographies that we now turn.

Market failure and the pathology of inequality

Whereas market fundamentalists see a looming flat world of healthy growth, and advocates of market-foster-care see particular places of pathology in need of bio-medical treatment, critics of market-failure map the terrain of global health with an acute sensitivity to how economic inequalities reflect and reproduce the failure of markets to provide health for all. Such attention to inequality can clearly serve as an antidote to both flattening and

pathologising imaginative geographies. By treating economic inequality itself as a form of pathology, it makes it possible to see the vast asymmetries that exist amidst global economic interdependencies while also enabling much more nuanced analyses of how local patterns of health and affliction are codetermined by political-economic forces. However, approaches to understanding inequality as a pathogenic force take two quite different forms, and each of these forms involves in turn its own distinct imaginative geography of the terrain of global health. The first approach to examining the health effects of inequality treat it as an *independent variable* that can itself explain poor health in space specific populations. The second approach, by contrast, conceptualises inequality as a *symptom* of more systemic economic processes that produce health vulnerabilities *in* and, just as importantly, *across* different spaces. Both discourses are animated by ethical concerns with inequality as an affront to human rights, and both also therefore involve appeals to universal human rights and allied ideals about how good health ought to be a birthright globally. But when it comes to explaining how inequality curtails improvements in global health, the two imaginative geographies implicated in the two explanatory approaches to inequality serve as very different guides to the global terrain. By first outlining the *inequality as independent variable* approach and turning next to accounts of *inequality as symptom*, we can compare and contrast these guides while also tracking how each one also leads to distinct epistemological and political implications about economism itself.

The most expedient and, indeed, economic way of expressing the argument that economic inequality can function as an independent variable that predicts ill-health is with a formula.

$$LE_{si} = \alpha_0 + \alpha_1 \, Gini_{si} + \alpha_2 \, X_{si} + \varepsilon_{si} \text{ (Zimmerman, 2008)}$$

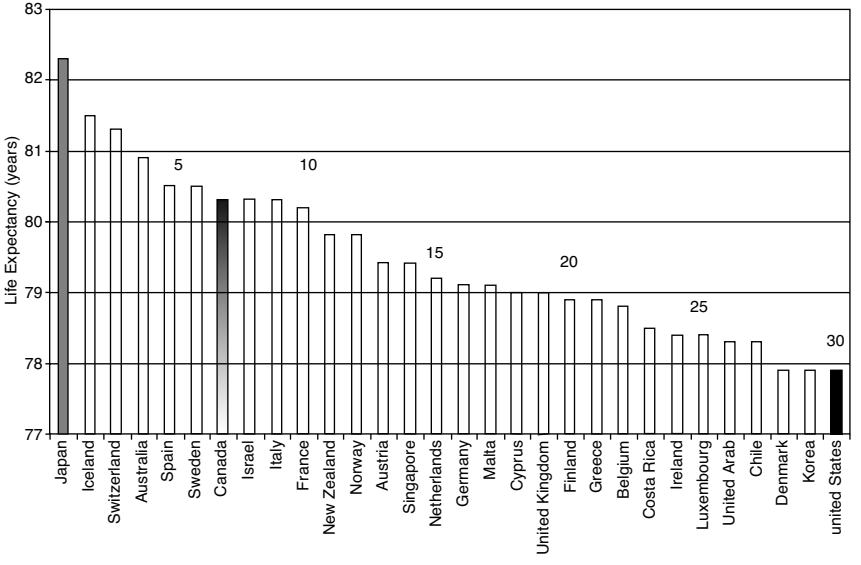
Life expectancy (LE in this example), or some other health metric such as infant mortality, can be expressed in this way as a product of an adjusted measure of economic inequality in a given population, the Gini coefficient, plus various controllable covariates. Following the work of Richard Wilkinson (1992, 1996 and 2002), a large empirical literature now exists that establishes the basis for such formulae in fact, revealing a strong negative or inverse relationship between inequality and health in empirical data sets, including data sets from richer countries that have passed through the so-called epidemiological transition and eliminated most mortality due to infectious disease (Kawachi *et al*., 1999; Subramanian and Kawachi, 2003; Wolfson *et al*., 1999).

It is important to underline that the implication of such studies goes beyond the straightforward association of absolute poverty with poor health (the latter being a more fundamental pattern that continues to be documented even by scholars who are skeptics about the explanatory implications of inequality, *for example* Wagstaff and Doorslaer, 2000). The point is

that inequality in and of itself is associated with lowered health standards for populations. As an intervention in epidemiology this has been critical precisely because it shifts attention to a certain sort of market failure at a population level. By moving the epidemiological focus away from health failures of a more personal kind – alcoholism, obesity, drug use, or even the supposed individual failure of being poor – it highlights instead how addressing systemic socio-economic inequalities can do much more than individualistic changes to improve overall population health.

Transformed into a normative argument about social change, the prescription of the inequality-predicts-poor-health argument is also clear. 'Economic justice is the medicine we need.' So summarises Stephen Bezruchka (2001 and 2006), a University of Washington public health professor who has become especially effective at communicating the health costs of inequalities to a wider public. One way he has done so is by reusing the representational rubrics of country-competitiveness rankings. As we have seen in prior sections, putting countries in league tables often ends up pathologising place and localising blame. However, used in conjunction with an argument against the pathologies of inequality itself, such rankings have been assembled by Bezruchka to create a form of global health Olympics (see Figure 6.2).

Figure 6.2 Health Olympics 2005



Source: Population Health Forum, n.d.

In this way he can point to the market-mediated failure of the US – which spends the most money on healthcare but ties for 30th place in the global health Olympics – while simultaneously upholding other, more egalitarian models of population health as bar-setting benchmarks for 'gold' in global health standards. Such subversion of business competitiveness rankings seems to represent a particularly creative way of representing arguments about market failure in a global context that remains dominated by the competitive logics of market fundamentalism. However, just as with cost-effectiveness research on 'given' populations, the rankings of the global health Olympics are limited to the extent that they remain prisoners of the proximate. Based on *national* health and income distribution statistics, and calling attention to correlations between these statistics within discrete *national* spaces, the rankings remain unable to address the ways in which *transnational* processes of exploitation and dominance might also codetermine differences in health outcomes. Japan's 'gold', for instance, may well reflect the fact that it has less income inequality than the US, but it also may be an outcome of the ability of Japanese corporations to generate income and good pensions for Japanese citizens while outsourcing some of the most exploitative and hazardous parts of commodity production to other Asian countries (see also Bezruchka and Namekata, 2008).

More generally the literature charting how economic inequality and poor health are correlated *within* discrete statistical spaces remains imprisoned by an epistemology focused on finding space specific independent variables in contexts shaped by historically changing and globally interdependent forms of codetermination and overdetermination. As health economist Fred Zimmerman has pointed out with mathematical precision, 'as long as there are some potential confounders that have not been or cannot be measured and included in analyses, this research endeavor will be hung over with question marks' (Zimmerman, 2008, p. 1886). The most common question mark of all, of course, concerns *why* exactly inequality predicts poor health. Expressed as an equation, the causal connections underpinning the association are only ever presented in the form of a black box. Moreover, when scholars such as Wilkinson attempt to go inside this black box and create hypotheses that might account for the correlations, their approach is often held captive to an individualising epistemology that seeks to track the ties through the psychosocial link of stress. They argue that even small economic inequalities cause stress and thus lower average life expectancy. By pointing to famous studies such as Michael Marmot's (on the lower life expectancy of lower ranking Whitehall civil servants), they reason thus that inequality-induced physiological stress in turn induces vulnerability to premature death (Wilkinson, 2002; Marmot, 2001). No doubt there is some explanatory significance in these ties (Sapolosky, 2005), but, as other critics point out, they tend to obscure wider power relations of class and market-mediated exploitation (Muntaner and Lynch, 2002). This makes it

hard to break out of the epistemological prison of the proximate. Thus even when investigators of the health-inequality association attempt to socialise their accounts with further attention to the so-called social capital, social cohesiveness and social goods that shape the effects of inequality, the analyses still remain unable to address market-mediated processes that transcend the spaces of different statistical populations. One unfortunate outcome of this is that there is a built-in tendency in the method to return to blaming the victim, suggesting that it is country-specific and population-wide deficits in social capital that account for poor health outcomes rather than, for example, the market fundamentalist austerity policies enforced by neoliberal elites (for evidence of the latter argument, see Navarro and Shi, 2002). This problem highlights in turn another wider weakness in the literature on inequality and health: namely its neglect of the processes, including the often transnational processes, that actually produce inequalities. Given the well-documented rise in in-country inequalities that has accompanied the global expansion and entrenchment of pro-market models of governance (ILO, 2004; Harvey, 2005; Wade, 2004), this is an especially limiting lacuna (but see Bezruchka, 2000). It is not without reason, then, that Vincente Navarro, one of the world's leading scholars of neoliberalism and public health, has complained that:

> Missing from this literature are analyses of *how* and *why* the social inequalities within and among societies are generated and reproduced, and *how* the socioeconomic and political forces responsible for this situation are affecting the quality of life of our populations (Navarro, 2002, p. 1).

Approaching global health with the attention Navarro demands to how inequalities develop in and between societies around the world clearly does not mean abandoning inequality as a socio-economic focus for analysis (Marmot, 2007). However, it does demand a reconceptualisation of inequality as a product of complex, historically-changing and often globe-spanning processes. In short, it means treating inequality as a symptom rather than as an independent variable. Not surprisingly perhaps given the familiarity in health research with the complex causal mechanisms underlying medical symptoms, the symptomatic approach and the associated medicalisation of economic metaphors has proved especially inspirational to global health scholars concerned with answering the sorts of how and why questions posed by Navarro. Thus a growing number of books are emerging with titles that reflect a keen sensitivity to how illnesses and inequality emerge in tandem as symptoms of more complex and space-spanning socio-economic pathologies. *Dying for Growth* (Kim *et al.*, 2000), *Sickness and Wealth* (Fort *et al.*, 2004), and *Health and Illness in an Increasingly Unequal World* (Wermuth, 2003), all reflect this symptomatic approach to inequality in important global health texts, as too do the titles of at least two of Paul Farmer's influential books: *Infections and Inequalities* (Farmer, 2001) and *Pathologies of Power* (Farmer, 2005). Farmer,

of course, has led the way in charting this more globally searching approach to inequality, and, while his NGO *Partners in Health* has been funded by market fundamentalists and while Farmer himself has been beatified by market-foster-care interventionists for his work as a physician to the poor, his written analyses provide some of the best and most sophisticated maps we have of how market failures contour the terrain of global health.

To be sure, Farmer has been criticised by anthropologists for not going far enough to socialise and complicate economistic explanations of affliction (see the responses in Farmer, 2004). It seems at times that his sensitivity to the cultural politics of blame and culturalist excuses for substandard care lead him thus to downplay the ways in which racial violence and gendered violence overdetermine the economic imperatives of structural violence. But he does still clearly examine racialised and gendered inequalities too, and while describing these forms of oppression in terms of power 'inequalities' risks reifying power as a quasi-economic commodity that can be hoarded and withheld, it can equally open post-economistic pathways for examining these same relations as profoundly social determinants of health globally. This is exactly what enables Farmer's embodied but global remapping of the terrain of global health. Sometimes following Farmer, sometimes not, this is also clearly what a growing number of global health researchers are doing as they too explore local examples of socio-economic inequality as symptoms and thus entry-points into mapping multi-dimensional global pathologies of power. Vinh-Kim Ngyuen and Karine Peschard have thus documented in detail how anthropologists and other ethnographic scholars have contributed to studying affliction as a form of embodied inequality in the context of global neoliberalism. 'Ethnographies on the terrain of this neoliberal global health economy,' they note, 'suggest that the violence of this inequality will continue to spiral as the exclusion of poorer societies from the global economy worsens their health' (Nguyen and Peschard, 2003, p. 447). In a different way, but with epidemiological attention to mapping some of the same terrain, Nancy Krieger notes that as social epidemiologists have turned to examine the diverse diseases associated with socio-economic inequalities their work has also prompted new multi-dimensional spatial depictions and eco-social analyses (Krieger, 2001, p. 671). And meanwhile, other scholars studying the global inequalities embodied in particular diseases such as AIDS suggest that simple one-dimensional visions of 'global health' risk ignoring the material conditions of those who suffer most. Contrasting AIDS in South Africa with the very different experience of the disease in the US, Mark Heywood argues thus that: 'Today the notion of global health is a misnomer' (Heywood, 2002, p. 218).

For the many researchers, activists and policy-makers who want to end the misnomer and make global health a reality, the entry point of inequality has also proved clarifying and productive in remapping the terrain of global health governance too. The People's Health Movement (http://www.phmove-

ment.org/cms/) and a host of health activists meeting at gatherings such as the World Social Forum (Sparke *et al.*, 2005), have thus moved far beyond treating economic inequality as an independent variable that policy-makers must simply correlate and chart in relation to population life expectancy. By treating it as a symptom instead, and by tracing its formation as both globally produced and locally embodied, they have thereby sought to revitalise a global vision of 'health for all' while also outlining all the many social determinants that present obstacles to realising the hopes articulated in 1978 at Alma Ata (now Almaty in Kazakhstan). This has led on the one side to various restatements of the health for all vision, including the 1986 Ottawa Charter, its more recent renewal in Bangkok, and rearticulation in the People's Health Charter (People's Health Movement, 2008). And this in turn has clearly been one of the important inspirations behind one of the most universal and inclusive revisionings of global health citizenship by the WHO that has yet been seen: namely, the finely critical 2008 report of the Commission on the Social Determinants of Health (2007).

From remapping global health to remaking global governance

While the People's Charter for Health represents a vision of global health governance by non-governmental critics of market failure, its advocates have not hesitated from attempting to challenge formal agencies of global health to take up its global political-economic vision. 'Although some would argue that issues such as trade and financial markets fall outside the remit of the WHO,' they argue, 'we believe that the WHO should advocate changes to the macroeconomic and political determinants of ill-health if we are to reduce child and maternal mortality, achieve universal access to antiretroviral treatment, and allow all countries to pay their health-care workforce an adequate living wage' (McCoy *et al.*, 2006, p. 2179). No doubt such calls to remake global health governance resonate deeply with all critics of market failure whether they be concerned with inequality as an independent variable or as an interdependent symptom. However, we should briefly reflect in closing on the ways in which the playing field of global health nevertheless remains set up against them.

For the market fundamentalists who claim that the playing field is flat, the advantages of claiming that the free market knows best and there is no alternative are enormous. As we have seen, the inconvenience of having to exclude the poor from treatment because of their ineffective demand can be concealed by appeals to global flattening even as it is used as an argument against the unrealistic ethics of health for all. Meanwhile for the advocates of market-foster-care it is the challenges of poverty traps and endogenous ecologies of ill-health and economic malaise that are the real problems. They do not so much want to change the global marketplace as enable more places to join it by intervening and removing the burden of

disease. These are ethically accountable alternatives to the unaccountable market fundamentalist ideology of *laissez-faire*. However, as we have also seen above, by setting palliative goals, pursuing these goals with a biomedical bias in vertical and privately-funded interventions, and pathologising particular places along the way, advocates of market-foster-care do not consistently address the deep global pathologies identified by critics of market failure. What they do however do with remarkable success is colonise the language and landscapes of 'alternatives' in global health. As critics of market failure continue their efforts to repossess this landscape for the globally dispossessed, it will be useful to have better, more reflexive understandings of the maps being used by all the different disputants. Hopefully this chapter contributes these, as well as a convincing argument that these mappings matter in actually shaping the terrain and thus the possibility of real global health.

Notes

1 My thanks to Griffith University's *Democracy, Security & Public Policy* Strategic Research Program for supporting the Brisbane conference on global health governance at which this paper was first presented. My thanks to Kelley Lee for her encouraging comments in Australia and for alerting me to the history of tropical disease in London. In addition, I am grateful to all the ideas shared by students in my Spring 2008 graduate class on Global Health at the University of Washington.

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7

The Power of Money: Global Financial Markets, National Politics, and Social Determinants of Health

Ted Schrecker

Introduction

In the second half of 2008, two events occurred that are, individually and together, highly significant for the future of global health. First, in August 2008 the World Health Organization (WHO)'s Commission on Social Determinants of Health (CSDH) released its final report (Commission on Social Determinants of Health, 2008; for a brief summary, see Marmot and Friel, 2008; Marmot *et al.*, 2008). The 19-member Commission, established in 2005, began its extraordinary report with the observation that: 'Social injustice is killing people on a grand scale'. The concepts of health equity and socioeconomic gradients in health were central to the Commission's unequivocally normative analysis. Health equity was defined with reference to the absence of systematic differences in health that are avoidable by reasonable action … and the Commission considered *most* such differences to be avoidable and therefore inequitable (Commission on Social Determinants of Health, 2007, p. 1). Socioeconomic gradients in health are disparities in health outcomes related to various indicators of social (dis)advantage; such gradients are ubiquitous, not only between countries but also within them. The Commission's perspective on such gradients is worth quoting at length:

> The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrange-

ments, and bad politics (Commission on Social Determinants of Health, 2008, p. 1).

Importantly, the report further recognised that '[i]mplementation of the Commission's recommendations is critically dependent upon changes in the functioning of the global economy' (Commission on Social Determinants of Health, 2008, p. 76, and see generally chapters 3, 11 and 15).

Second, in September 2008 a financial crisis precipitated by the collapse of the US sub-prime mortgage market, which began in 2007, spread rapidly around the world. Stock markets plunged, high-income economies and those of many developing countries were plunged into recession, and governments pledged literally trillions of dollars in direct subsidies and credit guarantees to rescue collapsing financial institutions, including some of the largest in the world. One immediate outcome was to bring home to people in high-income countries what many elsewhere in the world had known from bitter experience for at least a generation: their lives could be transformed and their livelihoods wiped out by events in financial markets over which they had absolutely no control, and whose workings they did not understand.

In an October 2008 speech at the UN General Assembly (Chan, 2008), WHO Director-General Margaret Chan was forthright in linking the two *problématiques*. Noting that *The Economist*, in a generally laudatory review, had commented that the Commission 'seems, at times, to be baying at the moon when it attacks global imbalances in the distribution of power and money', she asked in reply: 'Let me ask you: how does this statement sound right now, with the global financial system on the verge of collapse? Is it not right for health and multiple other sectors to ask for some changes in the functioning of the global economy?'

It is too soon to assess the effects of CSDH's activities; my aims here are far more modest. 'Financialisation' has been identified as a dominant trend in the operation of many national economies, and especially the global economic system, over the past few decades (Epstein, 2005). Because of the consequences of the operations of today's financial markets for social determinants of health (SDH) – the conditions of life and work that make it easy for some people to lead long and healthy lives, but all but impossible for others – I argue that those markets must be understood as forms of 'governance' in the context of global health, even though they do not operate through institutional frameworks analogous to the World Trade Organization (WTO), and often do not require formal coordination (see discussion in chapters by Kay and Williams, and Lee in this volume). The crisis of 2008 suggested new vulnerabilities, potentially along with new opportunities for building domestic political alliances in support of 'redistribution, regulation and rights' as constraints on the operation of the market.[1] At the same time, both the earlier experience of developing

countries with the caprices of financial markets and the crisis of 2008 suggest that policy outcomes must be understood in terms of the interplay of global flows of finance with domestic political allegiances that are themselves reflective of globalisation.

The disciplinary role of financial markets: disinvestment and crises

A simple comparison suffices to indicate the extent of financialisation worldwide. While the total value of foreign direct investment (FDI) flows (to build new production facilities or acquire existing assets) in 2007 was US$1.8 trillion (United Nations Conference on Trade and Development, 2008), the *daily* value of foreign exchange transactions on the world's financial markets – a useful indication of the volume of global financial flows – was estimated in 2007 at over US$3.4 trillion (Bank for International Settlements, 2008, p. 88). What is noteworthy about this comparison is not only the vastly greater volume of portfolio investment, but also the speed with which financial assets can now be moved around the globe because of the interaction of advances in information processing and telecommunications technology. The global financial marketplace, however, did not 'just happen' as a serendipitous spinoff of the information revolution. It must be understood as arising as well from factors including decisions by some of the world's most powerful governments to deregulate (Helleiner, 1994; Girón and Correa, 1999), partly in order to gain a competitive advantage for their own financial services industries, and sustained insistence by the International Monetary Fund (IMF) that low- and middle-income countries reduce or remove controls on capital flows (Stiglitz, 2004).

As a result, investors have often been able to impose 'implicit conditionalities' (Griffith-Jones and Stallings, 1995) on developing countries, the effects of which are similar to those of the more familiar, and more extensively researched, explicit conditionalities attached to loans from the IMF and the World Bank (see for example Cheru, 1999; Milward, 2000; Babb, 2005). As Sassen has pointed out, owners of mobile assets traded in financial 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, p. 70; see generally Sassen, 1996).

The most dramatic sanction backing up such implicit conditionalities is the prospect of financial crises triggered by rapid short term capital outflows. Notable examples of such crises occurred in Mexico in 1994–95, several south Asian countries in 1997–98, and Argentina in 2001–02 – in each case driving down the value of national currencies relative to the US dollar by 50 per cent or more within a few months, and plunging millions of households into poverty and economic insecurity. In the Mexican case,

immediate erosion of Mexicans' purchasing power, apart from the wealthy and a minority of employees paid in US dollars (DePalma, 1995), was compounded by wage reductions, restructuring of employment relations and public sector austerity measures needed to restore investor confidence (Dussel Peters, 2000; Cypher, 2001; Soederberg, 2004, pp. 48–54). In the Asian financial crisis of 1997–98, Thailand's and Korea's currencies similarly lost about half their value, with even greater depreciation and more serious economic impacts in Indonesia (Martinez, 1998; Kittiprapas *et al*., 2006). Again, economic decline was disproportionately felt by the economically vulnerable, notably in the form of sharp declines in wages (World Bank, 2000, chapter 2) – an outcome all but guaranteed by the greater mobility of capital, relative to labour, in the contemporary world economy.[2] In Indonesia and Thailand, these effects were 'exacerbated by the initial insistence of the IMF that governments return a fiscal surplus of 1 percent of GDP' (Hopkins, 2006, p. 354; see also Bullard *et al*., 1998; Desai, 2003, pp. 212–241). In Korea, IMF loans were associated with what has been called an effective takeover of the country's economy, involving drastic market-oriented restructuring that led to a short term decline in growth, a quadrupling of unemployment and, arguably, a longer term shift in income and bargaining power from labour to capital (Crotty and Lee, 2005a, 2005b).

Brazil provides an especially instructive case because of demonstrable effects on domestic social and economic policy. Investor concern about the stability of all developing country currencies in the wake of the south Asian crisis and subsequent Russian events early in 1998 led to a selloff of Brazilian assets that forced a currency devaluation even though connections between Brazil's economy, and the economic lives of most Brazilians, with events in south Asia or Russia were minimal (Gruben and Kiser, 1999; Goldfajn and Baig, 2000; Desai, 2003, pp. 136–155). Subsequently, concern about the policies that might be adopted by the Workers' Party (PT), which appeared likely to win the 2002 election, led major US financial institutions to warn clients against investing in Brazil, with some recommending rapid disinvestment (Santiso, 1999). A Deputy Governor of the Central Bank of Brazil between 2000 and 2003 describes a remarkable correlation between the PT's lead in opinion polls and the risk premium demanded on Brazilian government bonds (Goldfajn, 2003). In order to assuage the concerns of foreign investors, in September 2002 all the presidential candidates agreed on the terms of an IMF lending package most of which would be disbursed after the election.

The noted development scholar Peter Evans describes the consequences as follows: 'Having experienced a 40 percent fall in the value of Brazil's currency in the course of a few months', the last stage of a longer term decline that drove the Real from a value of R1.32/US$1 in January 1999 to R3.46/US$1 in July 2002, that is to say shortly before the IMF announcement, the PT 'chose to suffer low growth, high unemployment and flat

levels of social expenditure rather than risk retribution from the global financial actors who constitute 'the markets' (Evans, 2005, p. 196, citation omitted; see also Morais and Saad-Filho, 2005; Amann and Baer, 2006, pp. 221–223; Paiva, 2006; Koelble and Lipuma, 2006, pp. 623–625). Indeed, the Brazilian government not only kept interest rates high and inflation low but also ran an even larger primary budget surplus (that is, a surplus before debt service obligations are taken into account) than demanded by the IMF.

As in the south Asian case, the role of the IMF in Brazil suggests that understanding the influence of financial markets and institutions on SDH is likely to be hampered by too-rigid taxonomic distinctions between explicit and implicit conditionalities; these are best viewed as complementary elements, sometimes sequential and at other times contemporaneous, of a substantively coherent apparatus of governance that reflects the interests and priorities of the owners of financial assets. Further, in the cases discussed as in other instances of rapid disinvestment, investors were behaving rationally given the 'macroeconomic fundamentals' of the countries in question, and the IMF was incorporating into its policy prescriptions the dogma of textbook macroeconomics and public finance. The resulting power shift, identified by Sassen, was succinctly described by Michel Camdessus, then managing director of the IMF, in the aftermath of the collapse of the Mexican peso in 1994–95 as:

> Countries that successfully attract large capital inflows must also bear in mind that their continued access to international capital is far from automatic, and the conditions attached to that access are not guaranteed. The decisive factor here is market perceptions: whether the country's policies are deemed basically sound and its economic future, promising. The corollary is that shifts in the market's perception of these underlying fundamentals can be quite swift, brutal, and destabilizing (Camdessus, 1995).

Camdessus' observation is notable for its author as much as for its content, which is now widely acknowledged.

Not all countries are equally exposed to such sanctions. When assessing the risks of investing in high-income economies, investors care mainly about inflation and the size of the government deficit or surplus. For the so-called emerging market countries, which are regarded as less creditworthy, they pay attention as well to a much larger range of indicators (Mosley, 2003). One of the most accomplished investigators of how financial markets actually work therefore warns that 'those societies most in need of egalitarian redistribution may have, in terms of external financial market pressures, the most difficulty achieving it' (Mosley, 2006, p. 90). As shown in Section 4 of the chapter, foreign portfolio investors are not the only source of such pressures.

Financial crises and social determinants of health

First, however, it may be useful to explain what all of this has to do with health. Paluzzi and Farmer have succinctly summarised a point made at length in the CSDH final report, and by many other researchers (for example Yong Kim *et al.*, 2000; Farmer, 2003), with their observation that 'many of the most devastating problems that plague the daily lives of billions of people are problems that emerge from a single, fundamental source: the consequences of poverty and inequality' (Paluzzi and Farmer, 2005, p. 12). The extent of these problems can be gauged from the fact that according to the most recent World Bank estimates, in 2005 1.4 billion people were living in extreme poverty – defined as an income of US$1.25/day or less, adjusted for purchasing power parity, in 2005. Roughly half the world's people (3.1 billion) were living below a higher poverty line of US$2.50/day (Chen and Ravallion, 2008). These figures reflect modest progress in reducing poverty over a period (1981–2005) during which the value of the world's economic product quadrupled (Schrecker *et al.*, 2008), and do not take into account either the effects of rapid food price increases in 2007 or those of the financial crisis of 2008.

Financial crises are likely to undermine health in the first instance by slowing or reversing economic growth, increasing poverty and economic insecurity both directly and indirectly. Griffith-Jones and Gottschalk (2004) estimate the gross domestic product (GDP) losses from financial crises in Argentina, Brazil, Indonesia, Korea, Malaysia, Mexico, Thailand and Turkey at US$1.25 trillion over the period 1995–2002. As an example of the damage done to household income by wage reductions and unemployment, an Argentine study found that after the currency collapse '78% of households surveyed experienc[ed] real income declines in 2002 and 63% suffer[ed] a real income fall of 20% or more' (McKenzie, 2004, p. 721). Poverty in Mexico increased drastically as a result of the 1994–95 crisis (Cypher, 2001, p. 32). Comparing financial crises in ten countries, van der Hoeven and Lübker (2005) showed that employment consistently recovers more slowly than GDP in the aftermath, prolonging the damage to household incomes and well-being. Impacts of financial crises may be worsened by austerity measures, which as noted earlier reduce public expenditures on healthcare and social protection, and by contractionary economic policies. In countries with substantial external debt burdens, a further issue arises from the fact that the value of external debt obligations denominated in dollars or other hard currency climbs with any devaluation, potentially creating further pressures for domestic austerity (Koelble and Lipuma, 2006).

Despite recent interest in SDH, relatively little research has worked through these channels of influence to document the actual health outcomes of financial crises. In November 1998 representatives from developing countries identified financial crises as an obstacle to domestic policies

aimed at increasing vaccination coverage among children (World Health Organization, 1998). A World Bank study identified increases in anemia among Mexican children and deteriorating indicators of maternal nutrition following financial crises in Indonesia, as well as reduced rates of school enrolment that might be damaging to longer term economic opportunities (World Bank, 2001, pp. 164–165). A review of social impacts of economic crises in Thailand, Indonesia, the Philippines, Malaysia and Vietnam, drawing on data sources beyond the usual official and quasi-official statistical indicators, identified a range of impacts on SDH including increases in crime, child prostitution and violence against women, although both data availability and the severity of reported impacts varied widely across countries (McGee and Scott, 2000). A Korean national survey found substantial increases in morbidity, and decreases in health service utilisation, following the 1997 currency crisis (Kim *et al.*, 2003). A more recent summary of research on the economic crisis of 1997–98 in Indonesia, Malaysia and Thailand (Hopkins, 2006) described a reversal of past health gains and a deterioration in such indicators as undernutrition, household spending on healthcare, and public spending on health. The deterioration appears to have been less severe and shorter lived in Malaysia, which explicitly rejected the neoliberal prescriptions of the IMF in favour of capital controls (see also Cornia, 2006).

Importantly, relying on evidence of short term impacts on health and such variables as nutrition and school attendance is likely to lead to substantial underestimates of the long term effects of financial crises, which may (for example in the case of childhood malnutrition or long term damage to maternal health) be irreversible both within and across generations. Importantly as well, the Brazilian example and the SDH perspective indicate that the operations of global financial markets are relevant to developing countries not only because of the damage done by financial crises, but also because of the constraints they may impose on the ability of national and sub-national governments to implement the redistributive policies that are so desperately needed if such countries are to meet the basic health-related needs of their citizens. At the same time, the analysis requires more texture, since the actions of foreign investors are not the only drivers of the dynamic that leads to immiserisation by way of financial crises or their anticipation (see also chapters by Buckley and Harman in this volume).

The disciplinary role of financial markets: capital flight

'The markets' are an abstraction. Their verdict on a country's policies is simply the resource-weighted aggregation of choices made by asset owners and managers with broadly similar interests and motivations, including not only those in London, New York and Geneva but also an increasing number of rich households in many low- and middle-income countries. As

long ago as 1990, the then-emerging private banking industry was described by *The Economist* as 'essentially the business of taking deposits from rich individuals living in the third world' (Anon, 1990). Although most of the world's so-called high net worth individuals (those owning more than US$1 million in financial assets) still live in Europe, North America and the Asia-Pacific region, the fastest growth in both the number of such individuals and the amounts of wealth they held in 2005 and 2006 occurred in Africa, the Middle East and Latin America (Capgemini and Merrill Lynch, 2005, 2006 and 2007). Indeed, globalisation has rendered analytical distinctions between 'international' and domestic investors, in terms of their interests and opportunities for portfolio choice, increasingly tenuous. John Williamson, who codified the so-called Washington Consensus on development policy, recently underscored this point by commenting that 'levying heavier taxes on the rich so as to increase social spending that benefits disproportionately the poor' is conceptually attractive in Latin America, but 'it would not be practical to push this very far, because too many of the Latin rich have the option of placing too many of their assets in Miami' (Williamson, 2004). This is a sobering observation about a region with some of the world's greatest inequalities in income and wealth, where even modest redistributive policies would do more to reduce poverty reduction than many years of robust economic growth (Paes de Barros *et al.*, 2002; de Ferranti *et al.*, 2004).

Williamson described capital flight as: 'mechanisms by which residents of a country seek to evade domestic social control over their assets by transferring them abroad' (Ndikumana and Boyce, 1998, p. 199; see also Beja, 2006, p. 265). The appropriate definition of capital flight is a matter of some debate; an alternative definition refers to '*illicit* disguised expatriation of money by those resident or taxable within the country of origin' (Murphy *et al.*, 2007, p. 16). This definition reflects the fact that a primary motivation for capital flight, although far from the only one, is tax avoidance or evasion.[3] Although such illicit transactions[4] are an important component of capital flight, and explain much of the difficulty in estimation, this definition is too restrictive (*cf.* Loungani and Mauro, 2001, p. 690): it would capture the dynamic identified by Williamson only if the transfers of assets to which he refers were illegal, and ultimately distracts attention from the problem of economic policy competition among jurisdictions in order to avoid perfectly legal relocation of hypermobile assets by their owners.

The magnitude of capital flight and the problems it poses for social and economic policy are relevant to discussions of the SDH for several reasons. As Williamson's comments suggest, anticipation of capital flight may constrain redistributive policies and, in particular, limit opportunities for progressive taxation. Capital flight deprives countries of financial resources that may be desperately needed for investment in their own economic development, often a necessary – although not a sufficient – condition for widely shared improvements in living standards. Perhaps most pernicious

is the relation between capital flight and the debt crises that began for many developing countries late in the 1970s, and often continue to plague them today despite belated and partial multilateral debt cancellation (Hurley, 2007). In 1987, in what remains one of the most thoughtful discussions of how global financial markets figure in the larger transformation of the world's economic system,[5] economic historian Thomas Naylor concluded that: 'There would be no "debt crisis" without large-scale capital flight' (Naylor, 1987, p. 370). In the same year Rodriguez (1987), writing with specific reference to several Latin American countries, elaborated on the regressive distributional effects of capital flight occurring simultaneously with foreign borrowing that, in effect, socialises the accumulation of offshore assets by private firms and individuals, who are the only actors with that option. As Weeks subsequently noted: 'The passive acceptance of debt service by most Latin American governments requires a class analysis to be explained: the upper classes incurred the debt, while for the most part the lower classes paid it off' (Weeks, 1995, p. 126).

Debt-financed accumulation of wealth by elites, for which mechanisms to facilitate capital flight are a prerequisite, is a long-standing problem. For example at the end of 2001, while Argentina was undergoing an economic collapse that saw the peso lose more than 60 per cent of its value against the US dollar and GDP decline by 11 per cent in 2002, it was estimated that the value of assets held abroad by Argentine residents equaled the total value of the country's foreign debt (Centro de Estudios Legales y Sociales, 2003). Subsequently, *The Economist* (Anon, 2005) suggested that this would be true even after taking into account the effects of a settlement negotiated between the Argentine government and its creditors on terms relatively favourable to Argentina. The problem has also been identified in sub-Saharan Africa (SSA), a region that includes many of the world's poorest countries: Ndikumana and Boyce (2003) calculated that between 1970 and 1996, 'roughly 80 cents on every dollar that flowed into the region from foreign loans flowed back out as capital flight *in the same year*' (p. 122, emphasis added). Capital flight thus contributed to Africa's status in the late 1990s as the region of the developing world whose residents held the highest proportion of their private wealth outside the region (Collier *et al.*, 2001). More recent calculations (Boyce and Ndikumana, 2008) put the value of capital flight from 40 SSA countries between 1970 and 2004, including imputed interest earnings, at US$607 billion – a figure that is roughly *three times* the value of those countries' external debt obligations. Using similar methods, Beja (2006) estimated the accumulated value of flight capital from Indonesia, Malaysia, the Philippines and Thailand over the period 1970–2000 at US$1 trillion; the flight in question occurred not only during periods of financial crisis, as might have been expected, but also during periods of economic growth and stability. And Loungani and Mauro (2001) estimated the value of capital flight from Russia post-1994 at US$15–20 billion per year, or

approximately US$100–US$150 per capita. This figure is nothing short of astonishing when compared with Russia's GDP/capita of US$1770 in 2000, and although the hypothetical may be implausible one nevertheless wonders how much less painful and health-destructive the Russian experience of the last 15 years (Field *et al.*, 2000; Shkolnikov *et al.*, 2004) might have been if the country's newly minted multimillionaires had somehow been prevented from shifting their wealth abroad during the 1990s.

This discussion leads to several tentative conclusions. From the practical perspective of development policy, generic measures to curb capital flight, which have themselves proved elusive, may need to be complemented by specific accountability mechanisms attached to debt cancellation and development assistance if they are to be effective in meeting basic health-related needs – assuming, for the sake of argument, that this is in fact the objective sought by donors. Otherwise, the fungibility of finance may mean that resources in question simply continue to be appropriated by elites for their own enrichment. From the analytical perspective of political economy, similarities between the opportunity structures and actions of foreign and domestic investors underscore the extent to which financial capital has become stateless, at least in the sense that the citizenship or country of residence of its owners is a poor predictor both of portfolio choices and of political allegiances. The immediate operational significance of this observation is that although it is analytically convenient to discuss capital flight as a distinct phenomenon, the policy impacts of capital flight are all but indistinguishable from those of 'disengagement' by foreign investors – a point that was succinctly acknowledged by Ernesto Zedillo in 1987, before he moved on from the Bank of Mexico to a higher-profile job (Zedillo, 1987, p. 178).

Globalisation, domestic politics and SDH

Further complicating the picture, one cannot presume that conditionalities dictated by financial markets or multilateral institutions represent the most serious constraint on domestic policy choices. Even leaving aside the cases of governments that are frankly predatory in their quest to enrich leading political figures and their allies,[6] such choices must be understood in terms of a complex interplay between domestic class structures and allegiances (including, for instance, the alliances or shared interests of 'domestic' and international investors) and such external constraints, always mediated by domestic political institutions. Domestic class structures and possibilities for political action are in turn influenced by multiple elements of globalisation, perhaps most conspicuously the worldwide reorganisation of production across multiple national borders in what the World Bank has called an 'open production environment' that 'mercilessly weeds out those centers with below-par macroeconomic environments, services, and labor-market

flexibility' (World Bank, 1999, p. 50). Against this background, postwar compromises between capital and labour in many high-income countries are crumbling and may be difficult to replicate elsewhere in the world, because the class tensions that such compromises historically addressed need no longer be resolved within national borders. Rather, they now play out against a background of the dramatic increase in labour supply associated with integration of much of the population of India, China and the transition economies into the global labour force (Bronfenbrenner and Luce, 2004; Woodall, 2006; Freeman, 2007) and implicit or explicit threats of disinvestment, capital flight and relocation of production to lower-cost jurisdictions.

A further dynamic, the importance of which has almost certainly been underestimated, is the effect on political allegiances of increases in economic inequality within national economies, driven by the divergent labour market prospects of the more and less 'skilled' (see for example Reich, 1991; Nickell and Bell, 1995; World Bank, 2007, pp. 67–100). This has interrelated material and cognitive dimensions. The former are exemplified by the expansion of a 'middle class' in many low- and middle-income countries, which may or may not share economic interests with the less fortunate segments of the population that still constitute a majority. The latter are suggested by the observation of veteran Belgian politician Frank Vandenbroucke that '[t]o the extent that skill has become more important as an explanatory factor of quite visible wage inequalities, such inequalities come to have a more "biographical" character: they seem to be more related to personal history and qualifications than to class as traditionally understood' (Vandenbroucke, 1998, p. 47).

Detailed exploration of these issues requires country-specific analyses that cannot be undertaken here. Their importance for understanding policies that affect SDH can be illustrated by way of a stylised, necessarily superficial discussion of recent social policy initiatives and their limitations in Brazil, Chile and Mexico. To some extent, the case example is opportunistically chosen based on the availability of recent research. However, it is also useful to note that both Brazil and Mexico experienced recent financial crises, preceded by long periods of structural adjustment. Chile experienced an earlier and more violent variant of market-oriented social restructuring in the aftermath of the 1973 military coup; the importance of this 'softening-up' for Chile's subsequent trajectory is often ignored by contemporary authors. In each case, external influences contributed to the appeal of neoliberal policies to domestic constituencies as the only ones that 'worked'.[7]

Recent social policy innovation has emphasised conditional cash transfers, or CCTs: programs of small, means-tested cash transfers to the desperately poor (Mexico's Oportunidades, Brazil's Bolsa Família, and Chile Solidario) that are tied to performance on such measures as ensuring school attendance, health checkups for children, or keeping children out of child labour. Among

the advantages claimed for such programs is that, unlike many more conventional social protection mechanisms, they ensure that scarce resources will benefit those most in need and give priority to children (for example rather than the elderly, as in the case of pensions). Latin American CCTs have led to short term improvements in health indicators (Gertler, 2004; Lagarde *et al.*, 2007) and modest reductions in poverty and economic inequality (Soares *et al.*, 2007), albeit from historically high levels (in most countries in the region) that were exacerbated by two decades of economic integration. However, some researchers warn that their longer-term impact is likely to be limited in the absence of policy attention to such basic determinants of livelihood as employment opportunities (Parrado, 2005; Hall, 2006; Molyneux, 2007; Teichman, 2008), lest young people's opportunities continue to be limited 'to the lower rungs of the metropolitan labour markets' (Molyneux, 2007, p. 73). Ideologically, CCTs' emphasis on targeting the 'poorest of the poor' to enhance their children's human capital (Molyneux, 2006; Hall, 2006) is thoroughly congruent with an individualistic, market-oriented policy vision that expects even the poorest to earn their way out of poverty, however unrealistic that may be given globalisation's effects on labour markets. A further, related presumption is that poor households require incentives to avoid a 'culture of dependency'[8] and need 'supervision' if they are to behave appropriately,[9] thereby assigning primary responsibility for poverty to the poor – a core theme of neoliberal discourse in poor societies and rich alike[10] – rather than to structurally entrench inequalities and the power relations that sustain them.

In an analysis that is exemplary in its attention to the interplay of external and domestic constraints, Teichman (2008) situates Mexican and Chilean CCTs in a political context that includes not only the prospect of capital flight but also labour movements that have been seriously weakened by globalisation (*cf.* Hershberg, 2007), and the ongoing costs of a huge publicly financed bailout of politically well-connected bankers during the 1995 financial crisis in Mexico. She observes that 'resisters to a new redistributive settlement may include not just the business community, but also upper and middle-income groups … along with technocratic allies within the state' (p. 447) whose links with the World Bank and the Inter-American Development Bank were forged during the era of structural adjustment (Teichman, 2007). At best, Teichman concludes, CCTs 'are able to garner a very grudging societal consensus' that falls far short of support for 'sufficiently redistributive policy outcomes' (Teichman, 2008, p. 456).

A broadly similar analysis would appear applicable to Brazil, where the 2002 concession to IMF standards of macroeconomic management has been identified as crucial to the ability of the PT's presidential candidate, Luiz Inácio (Lula) da Silva, to appeal successfully to a diverse electoral coalition that included some highly privileged elements of Brazilian society (Morais and Saad-Filho, 2005). Lula's reelection in 2006, in which he was

able to consolidate his appeal to some of the poorest Brazilians – a success that was not reflected in the PT's legislative standings – has been attributed in part to the benefits conferred on these marginalised constituencies by Bolsa Família (Hunter and Power, 2007). However, reflecting the precariousness of support for progressive social policies in Brazil, in December 2007 the country's Senate voted against renewing the tax on financial transactions that provided a substantial part of the funding for Bolsa Família. At the time it was envisioned that this loss might be offset at least temporarily by the solid revenue situation of the Brazilian government as a result of strong economic growth (Alvares de Azevedo e Almeida, 2008), but the economic events of 2008 called that prospect into question.

The point here, to recapitulate, is that external pressures from financial markets cannot be assumed to constitute the limiting constraint on contemporary economic social policy even under definitions of formal democracy; this question can only be answered on a case-specific basis. However, it is important to focus attention not only on contemporary class structures and political allegiances, but also on their historical underpinnings; and there, we may find that pressure from financial markets has been very important indeed.

Conclusion: what did September 2008 change?

The financial crisis that burst into the open in 2008 showed that any serious discussion of social determinants of health must include reference to the operations of financial markets, and confirmed the wisdom of earlier observations that identified financial stability, in particular avoidance of financial crises, as one of a limited number of genuinely global public goods (GPGs), and one that is seriously undersupplied by existing institutions (Griffith-Jones, 2003). Innovative mechanisms to increase the supply of this public good had been proposed (see for example Eichengreen, 2004); some appeared relatively simple conceptually although requiring high levels of coordination and shared objectives among multiple national governments.

In some respects, the crisis resembled episodes like those discussed earlier in the chapter in its demonstration of global interconnectedness, and of the destructive effects that events originating in the financial system can have on the livelihoods of those who are far removed, in both geographical and economic terms. However, in contrast to those episodes, at least in its earlier stages the crisis did not appear to reflect rational choices by investors about the risks associated with a particular national economic environment or policy direction. Instead, it resulted from a disregard of financial risk by investors and regulators in one country (the United States) that has to be regarded as at least partly irrational, in conjunction with a longer term tendency to relax regulation of the domestic financial services industry[11] and to neglect enforcement even of those regulations and quasi-official

standards that remained in place. The collapses at the start of the decade of firms like Enron and WorldCom, as a result of accounting practices that were unquestionably fraudulent, were an earlier result of the domestic deregulatory impulse.[12] US firms and regulatory institutions were not of course the only culprits, but it is fair to say that financial deregulation in the United States was a necessary cause of the events of 2008. Stated another way, the crisis is best understood with reference to the absence of any institutions of governance capable of preventing the United States from wrecking a substantial portion of its own financial system, with massive negative externalities that quickly spread within its own economy and around the world, revealing what the Bank of England with masterful understatement referred to as 'underappreciated, but potent, interconnections between firms in the global financial system' (Bank of England, 2008, p. 9).

For many developing economies, the combination of declining demand for exports with the prospect of disinvestment and capital flight may lead to the undoing of recent, modest gains in reducing poverty and economic insecurity followed by a lost decade of development progress. As in previous periods of economic adjustment in response to externally generated adversities, negative health effects could be compounded by domestic austerity measures; it is not clear that development assistance providers will be willing and able to compensate for such measures, given pressures to prioritise economic recovery within their own borders, or to address urgent contemporaneous health-related issues such as a food production crisis that arguably results from long term underinvestment in developing country agriculture (United Nations Conference on Trade and Development, 2009, pp. 26–27). By November 2008, on a conservative estimate high-income countries had committed at least US$5 trillion in cash and credit guarantees to bail out collapsing firms and provide economic stimuli in the hope of offsetting the effects of the crisis (Gee, 2008).[13] Unless the resumption of growth is rapid and robust, it is possible that few of these costs will be recovered through tax revenues, raising the prospect of public sector budget constraints that persist long after the immediate crisis because of accumulated debt burdens. National governments in high-income countries could increase the possibility of recovering costs using a range of strategies, such as demanding preferred shares that can be converted to equity as the price of rescues. They could in theory insist on accountability of rescued firms in terms of social objectives, or at the very least demonstrable contributions to economic recovery, as well as financial viability. At this writing, it is not clear that they will attempt to do so; indeed, it is not clear that they have the necessary bargaining power given the consequences (for instance) of financial system collapse of a kind that was at least temporarily averted in September 2008. As noted in *Le Monde Diplomatique*, the power relations that led to the financial commitments made then were essentially those of a hostage taking, with the livelihoods of millions hanging in the balance (Lordon, 2008). A further

question involves the extent to which governments are limited not by the bargaining power of firms seeking rescue, but rather by a legacy of received neoliberal economic policy wisdom that is implacably hostile to direct public ownership, on the grounds of its purported inefficiency and market-distorting effects.

In the international frame of reference, the crisis has lent urgency to arguments not only for reform of financial regulation (see for example D'Arista and Griffith-Jones, 2008), but also for broader efforts 'to create a truly inclusive system of global economic governance' (United Nations Conference on Trade and Development, 2009, p. 32). It remains to be seen how seriously such arguments will be taken, although the body of knowledge about SDH can be a compelling source of evidentiary support. Powerful nations like the United States, responding to fierce resistance from their own financial services industries, will probably be reluctant to relinquish enough control over their policies to render meaningful international financial regulation possible, however strong the intellectual case for doing so. More fundamentally, it remains to be seen whether serious potential exists for going beyond calls for coordinated macroeconomic management, which requires few challenges to the values of the marketplace, to the more fundamental reform of reorienting the priorities of economic management itself around what the chair of CSDH has called 'a vision of the world where people matter and social justice is paramount' (Marmot, 2005, p. 1099). The events of 2008 underscored the importance of that vision for a world in which all have the opportunity to lead long and healthy lives. If such a vision is to be realised, where will the necessary leadership come from?

Notes

1 The 'three Rs' rubric was proposed in a paper by the Finnish social policy research Unit STAKES on social policy developments since the United Nations' 1995 Social Summit in Copenhagen (Deacon *et al.*, 2005). It was adopted as a generic organising principle for policy responses to globalisation by one of the nine Knowledge Networks that supported the work of the Commission on Social Determinants of Health (Labonté *et al.*, 2007).

2 The World Bank's observation that the crisis 'demonstrated the flexibility of labor markets in developing countries' because wages rather than employment declined (World Bank, 2000, p. xi) is somehow less than reassuring, especially since 'the average [Indonesian] household [was] found to have increased total household labour hours by 25 hours per week in response to the crisis' (McKenzie, 2004, p. 720).

3 The significance of this motivation is arguably reflected in the value of assets held in offshore financial centres (OFCs), perhaps the iconic institution of the global financial marketplace, which was estimated at US$5–7 trillion in 2007 (Ramos, 2007) although for obvious reasons precision is elusive. In 2007, the most recent year for which figures are available at this writing, US$740 billion worth of US securities, or 7.6 per cent of the total value of all foreign holdings of US securities, were held by 'residents' of the tiny Cayman Islands, one of the

more notorious OFCs. Despite problems with the attribution of ownership, this serves as an indication of the importance of at least one OFC (Department of the Treasury, Federal Reserve Bank of New York, and Board of Governors of the Federal Reserve System, 2008, p. 10).

4 Carried out for instance by manipulating transfer prices of exports and imports: see for example Zdanowicz *et al*., 1999; de Boyrie *et al*., 2004; Pak, 2006.

5 A more recent treatment of some of these themes is provided by Palan, 2003.

6 In recent experience such cases conspicuously include resource-rich African countries such as Nigeria, Angola and the Democratic Republic of the Congo (formerly Zaire). Predatory rulers are aided by financial institutions that facilitate capital flight (Ndikumana and Boyce, 1998; Jerome, 2005; Boyce and Ndikumana, 2008) and provide abundant opportunities to conceal the true ownership of assets, and by an international community that rarely questions a 'borrowing privilege' that permits even the most corrupt and repressive rulers to incur debts that their subjects will be called upon to repay (Pogge, 2002).

7 See Fourcade-Gourinchas and Babb, 2002 for a discussion of neoliberalism in Mexico and Chile that is insightful in many respects, but pays insufficient attention to such influences.

8 In the words of a laudatory article in *The Economist* (Anon, 2008).

9 In the words of an unpublished Brazilian evaluation cited by Hall (2006, p. 25).

10 *Cf*. the title of the 1996 legislation that dismantled income support under the Aid to Families for Dependent Children program in the United States: the *Personal Responsibility* and *Work Opportunity* Reconciliation Act (emphases added).

11 On the relation between deregulation and the spread of securitisation, which was a key contributor to the increased vulnerability of financial institutions, see Soederberg, 2004, pp. 98–100; United Nations Conference on Trade and Development, 2009, pp. 8–11. For a more general commentary on the role of US deregulation, see Kapadia and Jayadev, 2008.

12 For a useful summary of these developments and a critique of subsequent legislative responses, see Skeel, 2005.

13 As the United States' contribution, this estimate included only the US$700 billion value of the Troubled Asset Relief Program approved by Congress. This was only a small part of the total value of subsidies and credit guarantees provided by the US government, estimated for Bloomberg News later in November at US$7.7 trillion (Pittman and Ivry, 2008).

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8
Trade and Health[1]

Ronald Labonté, Chantal Blouin and Lisa Forman

Introduction

Human societies have long histories of trade with each other, although it is one marked by conflict as much as by equanimity; witness the forced opening of the closed economies of China (by the British in the 19th century) and Japan (by the USA in the early 20th century). Competition since the rise of capitalism has been the theoretical underpinning of trade, albeit one that gives frequent rise to monopolies and oligopolies which undermine the very market principles – and the win-win efficiency of comparative advantage – upon which trade is supposed to work its economic magic. Disease, too, has long followed trade routes, from the infectious pandemics of past (and now future recurrent) times, to the chronic ills associated with the global diffusion of unhealthy lifestyles and health destructive products.

That is the broad, stylised sweep of history upon which this chapter rests. But an historical account is not its intent as fitting with the overall contemporary thrust of the political economy of health developed in this volume. This chapter seeks to answer two simple questions: how does our contemporary era of increasingly 'free' global trade affect equity in health, and how do the rules (the governance) of this trade tip the health scales in one direction or the other? If, as this chapter argues, there are potentially grave health equity concerns with the current regime of global trade rules, it becomes necessary to examine what reforms are needed to create a healthier global trading system. Such reforms extend beyond trade itself to the necessity of creating and expanding more accountable systems of global governance predicated on rights, regulation and redistribution.

The market's invisible hand has no glove

There is nonetheless a compelling and widely-held argument for why increased trade liberalisation is good for all of us. The core of this argument is that liberalisation leads to economic growth which generates new wealth

that lifts increasing numbers out of poverty (Dollar, 2001, 2002; Dollar and Kraay, 2002), with health improving as poverty declines. Trade's newly enhanced wealth can also be taxed for investments in human capital, creating more productive and skilled workers and spurring the economy to ever-greater growth conjured by the market's *virtuous* and invisible hand.

Evidence for this sanguine assessment is that during the 1980s and 1990s 'globalisers' (those countries whose trade/gross domestic product (GDP) ratio increased since 1977) grew faster than 'non-globalisers' (those countries whose ratio did not). Therein lies a definitional problem: countries held up as model high-performing globalisers (China, India, Malaysia, Thailand and Viet Nam) actually started out (and ended up) as more *closed* economies than those whose growth stalled or declined during this period, most of which were in Africa and Latin America. The supposed non-globalisers were already more *open* economies; they also traded globally as much, if not more, than the globaliser group (Birdsall, 2006). They stalled for reasons other than lack of global market integration, with some arguing that it resulted from their premature and ill-conceived integration into the global economy, largely a result of the developing world debt crisis and the liberalisation conditionalities of subsequent structural adjustment programmes managed by the international financial institutions (Cornia *et al.*, 2007). While most econometric studies find that trade liberalisation on average is associated with better growth, this positive relationship 'is neither automatically guaranteed nor universally observable' (Thorbecke and Nissanke, 2006).

The same caveat applies to the assumption that trade-related growth inevitably trickles down to lift people out of poverty, thus improving their health. It is now widely accepted that world poverty is decreasing, although concerns exist about the reliability of data on incomes and household assets and the appropriateness of the World Bank's definitions of poverty (Reddy and Pogge, 2005). Excluding China, where the accuracy of poverty data has been questioned (Reddy and Minoiu, 2005) and where half of the poverty reduction resulted from domestic agricultural reforms *before* the country began to liberalise trade (Chen and Ravallion, 2004), the number of global poor actually rose by 30 million at the US$1/day level and by 567 million at the US$2/day level. As one World Bank development economist concluded: 'It is hard to maintain the view that expanding external trade is … a powerful force for poverty reduction in developing countries' (Ravallion, 2006).

A contentious tale of ladders and asymmetries

This last point is the most pertinent since China and other successful late industrialisers exercised trial-and-error in the timing and depth of their trade liberalisation (Akyüz, 2005; Rodrik, 2005). Ha-Joon Chang, an economic

historian, is one of many who argue that contemporary trade rules, by shrinking national policy space, will prevent other low- and middle-income countries from adopting at least some of the dirigiste policies used successfully by developed and emerging market economies at their equivalent stage of development (Chang, 2005, see also Lee, 2006). He refers to this as 'kicking away the ladder', an apt metaphor given that the 'trade is good for us' story combines its imagery of trickle down with that of slow steps up an overly-determined ladder of growth.

This loss of policy space risks a furthering in what Nancy Birdsall of the US-based Centre for Global Development describes as globalisation's historic asymmetries. Birdsall shows how 'global markets are inherently disequalizing, making rising inequality within developing countries more rather than less likely' (Birdsall, 2006). She identifies three related reasons for this trend:

1. The global marketplace rewards countries that already have abundant productive assets (financial, land, physical, institutional and human capital).
2. Market failures, such as financial crises, create negative externalities that disproportionately burden low- and middle-income countries with the least resources to deal with them.
3. Globalisation's rules favour the already rich (both countries and people within them) because they have more resources and greater ability to influence the design of the rules. Disparities of resources and bargaining power in trade negotiations within and outside the framework of the World Trade Organization (WTO) are an important case in point, as we shall later see (Jawara and Kwa, 2003; Stiglitz and Charlton, 2005).

She is also right. There has been an increase in income inequality in all regions since 1980, apart from a small handful of high-income Organization for Economic Cooperation and Development (OECD) countries where rising market inequalities have been offset by social transfers and public programs (Kenworthy and Pontusson, 2005). Rising income inequalities also have health-dampening effects. A regression analysis comparing worldwide life-expectancy at birth (LEB) from 1980 to 2005 (the decades of most intense trade liberalisation) with a counterfactual projection of trends from the 1960–1980 period found that increases in income inequality reduced potential gains in LEB by 0.77 years (Cornia *et al.*, 2007).

Not all of this recent rise in inequality can be attributed to trade liberalisation. Neither can the loss of national policy space, a term we use to refer to characteristics of the international economic, political and legal environment that constrain national governments' abilities to adopt policies that promote health equity. Other key aspects of globalisation that shrink this space are structural adjustment conditionalities (now embodied in the

Poverty Reduction Strategy process) required by the International Monetary Fund (IMF) and World Bank for loans, grants or debt relief (see Buckley and Harman in this volume). Indeed, these conditionalities (which included requirements of liberalisation, privatisation, de-regulation, cost-recovery for public services and public expenditure ceilings) were imposed most severely on the very group of countries that failed to grow over the past 25 years (Latin America and Africa). These conditionalities required, and sometimes still do, tariffs cuts that exceed those agreed upon in multilateral WTO negotiations. As the introduction to this volume argues, coalescence between the policies and priorities of these institutions is now a marked feature of the global political economy, not least as it relates to trade and health.

Less well-recognised but similarly entwined with trade and financial market liberalisation is the increased ease and speed with which money can move around the world, creating an 'implicit conditionality' (Griffith-Jones and Stallings, 1995, and Schrecker in this volume). Systemic shifts in labour markets and the role of potential financial crises in disciplining domestic policies are two examples. The global reorganisation of production abetted by trade liberalisation 'mercilessly weeds out those centers with below-par macroeconomic environments, services, and labor-market flexibility' (World Bank, 1999). 'Labor-market flexibility' is code for reduced union and workers' rights, and this manifests primarily in entrenched increases in 'non-standard' (insecure, part-time, precarious) forms of employment (DiTomaso, 2001; Gringeri, 1994; Hammonds *et al.*, 1994; Uchitelle *et al.*, 1996).[2] Such forms of work are associated with increased negative health outcomes (Marmot and Bobak, 2000; Sen, 1997; Wilkinson and Marmot, 2003; Polanyi *et al.*, 2004). Recurrent financial crises, in turn, have seen national currencies lose half their value or more and are the extreme consequence of the hypermobility of portfolio investment that has followed liberalisation of capital markets. Anticipation of such a crisis means that even governments with strong commitments to egalitarian domestic policy directions may have to temper these commitments in order to maintain their credibility with international creditors. Development policy scholar Peter Evans points out that 'the major banks' aversion to the possibility of redistributive developmentalism' led to a 40 per cent decline in the value of Brazil's currency in the run-up to elections that brought the Workers' Party (PT) to power. After the elections, '[t]he PT chose to suffer low growth, high unemployment and flat levels of social expenditure rather than risk retribution from the global financial actors who constitute "the markets"' (Evans, 2005).

Shrinking policy space meets diminishing policy capacity to create greater economic insecurity

Recognising trade agreements as one of several elements within a larger project of neoliberal globalisation does not make understanding how such

agreements affect health unimportant. Trade agreements have three general ways in which they can (and do) affect health negatively. The first way, already mentioned, is by limiting the range of policy instruments available to governments. The second way is by reducing the capacities of governments to implement policies that abrogate existing trade rules. Capacity, here, refers to the financial resources governments have available to fund health and social programs. One axiom of trade liberalisation is the reduction or elimination of tariffs on imports. Despite years of such reductions, tariffs remain an important source of public revenues in many developing countries (Khattry and Rao, 2002; Aizenman and Jinjarak, 2006; Baunsgaard and Keen, 2005). In theory, governments should be able to shift their tax bases from tariffs to sales or income taxes. In reality, most low-income countries have been unable to do so (Glenday, 2006). For a majority of these countries there has been a net decline in overall public revenues with obvious implications for reduced public expenditures on health, water, social services and other public health initiatives.

The reasons include the informal nature of their economies, with large subsistence sectors making income taxation difficult (Glenday, 2006; Khattry and Rao, 2002); and the lack of institutional capacity for effective revenue collection when taxation is more administratively complex than collecting tariffs at the border. Middle-income countries have fared better, but in general trade liberalisation has translated into a reduced capacity of national governments to support public expenditures in health, education and other sectors. High-income countries, with already well-established taxation systems and existing public infrastructures, have been able to move away from tariffs revenues with minimal loss in fiscal capacity.

The third general way in which trade liberalisation affects health outcomes is in increasing economic insecurity (Boix, 2002; Burgoon, 2001; Garrett, 1998; Gunter and van der Hoeven, 2004; Hayes *et al.*, 2002; Rodrik, 1997; Rodrik, 1998). Put simply, and in keeping with Birdsall's general global analysis, trade liberalisation creates winners and losers within domestic economies. Workers and producers in the sectors that were protected from foreign competition may see their revenues decrease or their employment disappear when tariffs or regulatory barriers are removed. The negative impacts are not limited to one-time adjustments to trade reforms. Displaced workers have to move to other sectors which may lack jobs or require a different set of skills (Torres, 2001). One poignant example of how this insecurity leads to negative health outcomes is the sharp rise in the suicide rate among cotton farmers in the Warangal District in Andra Pradesh, India (Sudhakumari, 2002), and in Maharashtra (Mishra, 2006). In 1991, the Indian government changed agricultural policy to encourage farmers to produce commodities for exports such as cotton. However, due to the high volatility of world market prices in cotton, the absence of any domestic insurance programs, a decline in state support for rural activities

and problems with the local credit markets, many cotton farmers became heavily indebted and increasingly desperate.

Liberalisation's three general outcomes – shrinking policy space, diminished policy capacity and increased economic insecurity – combine to make it difficult if not impossible for low- and (at least some) middle-income countries to mitigate the adjustment costs of integrating into global markets that are dominated by more competitive and advanced economies. Simply put, these countries lack the fiscal abilities to fund the social protection programs (for example public health insurance, public education, unemployment insurance, job retraining) that have been shown to be the only effective buffers to globalisation's inherent asymmetries (Blouin *et al.*, 2007). Importantly, their potential to turn this situation around is undermined by many existing trade treaties and by the negotiating positions of high-income nations in the WTO.

From the general to specific: trade treaties' direct effects on policy space and capacity

This brings our chapter's consideration to the first of the WTO agreements: the General Agreement on Tariffs and Trade (GATT). GATT negotiations began after the Second World War to coordinate a reduction in trade barriers that had been re-erected by industrialised countries during the interwar period to combat high unemployment.[3] Developing countries played little role in them until the 1980s and 1990s, and there was no requirement for reciprocal trade concessions on their part.

This lack of developing country reciprocation is referred to as 'special and differential treatment' (SDT), which comprises legal provisions in different GATT and WTO agreements that allow developing countries to deviate from agreed upon trade rules and commitments. Broadly speaking, in the days of the GATT, developing countries were only expected to cut tariffs or other measures to an extent consistent with their level of development, financial and trade needs. Developed countries were expected to offer each other reciprocal tariff and other cuts. In cases of balance of payments problems or injury to infant industries, developing countries were further allowed to take defensive action such as raising tariffs above their bound levels or introducing quotas to limit imports. Developed country members also agreed to give priority to cutting tariffs and other barriers facing products of particular export interest to developing countries and, with the addition of the 'Enabling Clause' in 1979, were able to offer imports from developing countries differential and more favourable market access.

The Uruguay Round (1986–1994) of negotiations that gave birth to the WTO in 1995 coincided with a new sense of engagement by developing countries in the multilateral trade regime. This was due perhaps to the collapse of the Soviet Union, the rise and dominance of neoliberal economics

in most countries' treasury departments, and the simple absence of any trading alternatives for economic growth. It was associated in some countries with a shift to more open economies and a commitment to trade liberalisation as a source of economic growth and poverty reduction. At the same time there was increased pressure from industrial countries for developing countries to assume similar obligations. Only in the case of the least developed countries was the earlier GATT approach of non-reciprocity extended. In sum, SDT shifted from a development tool (to ensure trade liberalisation supported development) to being an adjustment tool (to help developing countries meet their WTO trade liberalisation obligations) (Tortora, 2003; ICTSD, 2003). This new international trading regime severely limits national development strategies by making a number of economic policy instruments 'illegal' (Das, 2000; Lee, 2006).

The potential resulting loss of developing country policy flexibility and capacity is now playing out in WTO negotiations over what is referred to as 'NAMA', or non-agricultural market access. NAMA negotiations will require all WTO member nations to 'bind' their tariffs on all imported non-agricultural goods and to agree to a formula for their reduction and eventual elimination. Developing countries will be allowed to bind their tariffs at a higher rate than developed nations, although the formula for calculating the binding rate being lobbied by the USA and the European Union (EU) would require developing countries to cut their bound levels by almost 70 per cent, as against reductions for high-income countries of around 40 per cent (ICTSD, 2007c). While least developed and smaller low-income countries would be exempt from these NAMA commitments or given lesser obligations for an undisclosed extended period, Khor warns that the result nonetheless 'will accelerate the deindustrialisation process that is already under way in many developing countries' (Khor, 2007).

From a health equity perspective, low- and middle-income countries should be granted much greater flexibilities for tariffs reductions until they have developed adequate alternative systems of revenue collection. And there are potentially dramatic and inequitable costs and benefits involved. A recent World Bank study of estimated benefits from a completed Doha Develop-ment Round pegged gains (projected to 2015) of US$79.9 billion to developed (high-income) countries, and only US$16.1 billion to the rest, a figure that amounts to about a penny a day for people in developing countries (Gallagher, 2007a). The impact of NAMA tariffs losses under high-income country proposals, in turn, are estimated at US$38 billion for developed nations but a whopping US$63.4 billion for developing ones (Gallagher, 2007a). The two sets of figures are not directly comparable, and there is considerable theoretical and empirical debate over how to quantify the costs and benefits of trade liberalisation. Nonetheless, such estimates caution that ongoing global market integration through less restrictive cross-border trade may increase, and not decrease, global economic inequalities with negative implications for health equity.

Agreements with direct health effects

Tariffs reductions under NAMA negotiations may have the greatest long term effect on health equity, but many other agreements also have known or potential effects. Two in particular attract the most attention for their direct health effects: the General Agreement on Trade in Services (GATS) and the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). A third, the Agreement on Sanitary and Phytosanitary Measures (SPS), is also contentious.

The GATS Agreement

Services are assuming an increasingly important economic role in most high- and some middle-income countries. The GATS is designed to increase trade in all forms of such services. There are four 'modalities' of this trade (with examples from health services):

1. cross-border delivery of services (laboratory analyses, telehealth)
2. consumption of services abroad (health/medical tourism)
3. commercial presence (foreign investors in private health insurance or facilities)
4. presence of persons (special GATS visas for temporary movement of health workers from one country to another).

The GATS is a complex agreement with 'top-down' requirements that include progressive liberalisation, meaning a country must commit to further services liberalisation over time, and 'bottom-up' options, which allow countries to choose which sectors to liberalise and under what terms. Of key concern is the impact of liberalisation of services trade in sectors important to health: healthcare, education, water and sanitation. Health and other 'essential' public services meet basic human needs in a way that many other services do not; and commitments made under the GATS essentially lock in commercialisation of health services. Measures to increase private investment and provision in health services are often justified on the basis that they 'free up' public resources for more effective and targeted provision to the poor. The weight of evidence, however, finds the opposite: commercialisation in health services or insurance creates inequities in access (Barrientos and Lloyd-Sherlock, 2000; Barrientos and Lloyd-Sherlock, 2003; Bennett and Gilson, 2001; Cruz-Saco, 2002; Hutton, 2004), and also in health outcomes (Koivusalo and Mackintosh, 2005). The level of commitment under GATS in health services remains fairly low (Adlung and Carzaniga, 2006), although developing countries made a disproportionate share of GATS commitments in 1995 and often included fewer limitations than those specified by high-income countries. While negotiations have slowed, new draft 'disciplines' for countries with sectors committed under GATS are placing further restrictions on government regulatory flexibilities.

Governments may still want to experiment with commercialisation in some components of their health systems. But until governments have demonstrated their ability to regulate private investment and provision in health services in ways that enhance health equity, they should avoid making any commitments in binding trade treaties. It is not clear that any government, anywhere in the world, has met this test. There are further political and ethical considerations associated with the GATS, underscored by the South African experience. One of the last acts of that country's apartheid regime was to commit to fully liberalise trade in health services. The post-apartheid government subsequently passed national legislation guaranteeing certain health rights by requiring *inter alia* needs-testing before service providers can set up shop in different parts of the country. Intended to improve equity in access, this provision violates its GATS commitments, leaving the country vulnerable to costly disputes (Sinclair, 2005). Such an outcome – while still only potential – leads some to call for cancelling all existing GATS commitments on health services and removing health services from the scope of subsequent negotiations (Woodward, 2005).

The TRIPS Agreement

The TRIPS introduced global minimum standards for the protection of intellectual property rights, making extensive provision for their domestic and multilateral enforcement. Before TRIPS, international law did not provide a set of universal, harmonised standards for intellectual property rights (Trebilcock and Howse, 2000), nor did international mechanisms for their enforcement exist. Intellectual property protection was highly variable from country to country: over 40 countries provided no patent protection for pharmaceuticals, many provided only process and not product patents, and in many others the duration of patents was much less than 20 years (World Health Organization, 2001).

The primary impact of TRIPS has been to drive up drug prices in countries introducing drug patents (Abbott, 2002; Bloche, 2002; Correa, 2002). When patents expire and generic entry occurs prices fall sharply (Scherer, 2000) coming much closer to marginal production costs (Caves *et al.*, 1991). Developing countries face the harshest negative impacts, where the majority of individual drug expenditure is out-of-pocket (Velásquez *et al.*, 1998) and medicine procurement is often the greatest single public expenditure on health (World Health Organization, 2004b). The full implementation of TRIPS by 2016 will especially affect developing countries that depend on importing generic versions of currently patented medicines (Scherer and Watal, 2001).

TRIPS does permit exceptions and limits to patents for public health needs, including parallel imports where countries import cheaper patented medicines and compulsory licensing where countries can manufacture or import generics under strict conditions (TRIPS, Articles 6 and 31). The use

of these flexibilities, however, has been highly contested and constrained by corporate litigation and governmental trade sanctions. This contestation motivated developing countries to advocate for a Ministerial Declaration to clarify the legality of TRIPS flexibilities at the Doha round of WTO trade negotiations in 2001. Accordingly, the Doha Ministerial Declaration on Public Health states: 'We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health … We affirm that the Agreement can and should be interpreted and implemented in a manner supportive of a WTO member's right to protect public health and, in particular, to promote access to medicines for all.'[4]

The Doha Declaration also called for an expeditious solution to the problem posed by the TRIPS requirement that compulsory licensing shall be, 'predominantly for the supply of the domestic market'. This requirement particularly affected least developed countries without local manufacturing capacity. In August 2003, after protracted negotiations, the WTO General Council released its decision on this problem, which was later formalised as an amendment to TRIPS. While growing numbers of countries (including Malaysia, Indonesia, Zambia, Zimbabwe, and Mozambique) have successfully issued compulsory licenses for anti-retroviral medicines, to date not a single country has exported medicines produced under compulsory license. In 2007, Canada became the first producer country to enter into an export agreement with an importing country (Rwanda, for a triple antiretroviral (ARV) drug), although observers and the generic company itself contend that the process is too cumbersome in terms of complexity, cost, and limited duration, to serve its intended end (Hestermeyer, 2007). Other factors also account for limited uptake of this provision, including persistent corporate and governmental threats of legal or economic sanctions. For example, when Thailand issued compulsory licenses on ARVs in 2006, the pharmaceutical company, Abbott, withdrew seven of its drugs from the country (although it later backtracked on this), and the US Trade Representative placed Thailand on its 301 Priority Watch List, citing 'a weakening of respect for patents' given the Thai Government's decision to issue compulsory licenses (Flynn, 2007; Irvine, 2007).

The pharmaceutical industry argues that the strict protection of patents is critical for ensuring the profits that enable companies to recoup massive research and development (R&D) costs that in turn provide the incentive for further R&D (Grabowski, 2002). Yet many of the central claims for strong patent protection in poor countries have been contested and considerably undermined. As a recent WHO Commission on this issue noted in its final report, 'where the market has very limited purchasing power, as is the case for diseases affecting millions of poor people in developing countries, patents are not a relevant factor or effective in stimulating R&D and bringing new products to market' (World Health Organization, 2004a). If patents in poor countries are not necessary to sustain the innovation of

new medicines, this raises valid questions about the justifications for requiring them, particularly since TRIPS considerably restricts governmental autonomy to ensure access to affordable essential medicines, with serious consequences for human life. Yet governmental action to ensure access to medicines is recognised as a core duty under the broad canon of international human right to health. To this extent, the impact of TRIPS on access to medicines should be seen as raising serious human rights concerns; and at a minimum the use of TRIPS flexibilities should be seen as a human rights necessity. As of November 2007, however, the WHO's Intergovernmental Working Group on Public Health, Innovation and Intellectual Property Rights still lacked agreement on whether the right to health should be balanced with trade or should take precedence over commercial interests.

The Agreement on Sanitary and Phytosanitary Measures

The third agreement with direct health implications, the SPS, defines the permissible scope of public health measures affecting trade in agricultural goods and food products. Its basic intention is to prevent measures ostensibly established for a public health purpose from being merely a disguised and unfair restriction on free trade (or a non-tariff barrier). The SPS requires additional conditions that go beyond the basic WTO principle of non-discrimination (that is treating foreign 'like' products identically to those produced domestically), key being that national regulations on food and agricultural products must conform to defensible scientific criteria. WTO dispute panels to date have interpreted these rules to the benefit of exporters, effectively determining the scientific merits of competing studies without necessarily the expertise to evaluate the evidence.

The best known SPS case with clear-cut health ramifications was an EU ban on foreign beef that contained artificial growth hormones that may be carcinogenic. Because use of these hormones was forbidden in Europe, this policy was non-discriminatory. The dispute panel ruled against the ban, however, because the EU had failed to undertake its own complete scientific risk assessment and international standards had already been set for five of the six hormones in question (ICTSD, 2004a). The SPS prefers government regulations to be based on international standards, specifically those of the Codex Alimentarius Commission, a joint Food and Agriculture Organization (FAO)/World Health Organization (WHO) Food Standards Program. What the dispute panel ignored is that the Codex adopted a 'safe' level of hormone use by a very narrow vote of 33 to 29, with seven abstentions (only country representatives are able to vote) (Sullivan and Shainblum, 2001; Charnovitz, 2000); and that Codex itself has been criticised for having an overwhelming majority of corporate scientists with very limited participation by civil society organisations (CSOs) (Lee *et al.*, 2007). Standards-setting and risk assessments are not only 'scientific;' they are also political and contested, particularly in cases of uncertainty. In adhering narrowly to the

requirement for a risk assessment, the decision placed the burden of proof on the EU to show that hormone-treated beef imports were unsafe, rather than on the USA and Canada, who brought the dispute forward, to show that they were safe.

In 2006 the EU lost another SPS dispute brought forward by the same set of countries (the USA, Argentina and Canada), this time concerning genetically-modified organisms (GMOs). Part of the dispute involved outright GMO bans by many EU nations. The counter-argument was that EU member nations' bans were in keeping with the Cartagena Protocol on Biosafety and the Convention on Biological Diversity, that is, they exercised the so-called 'precautionary principle'. This defense was rejected for two reasons: first, in the panel's opinion, sufficient evidence for scientific risk assessment studies existed (again, the EU was chastised for not having undertaken such an assessment of its own); and second, dispute panels did not have to consider other international conventions in their rulings (such as the Cartagena Protocol) unless all parties to the dispute were also parties to these conventions (ICTSD, 2007a).

Agreements with indirect health effects

Three less well-known WTO agreements can have indirect effects on health equity. The Agreement on Trade-Related Investment Measures (TRIMs) prevents countries from attaching performance requirements (such as minimum levels of local content) to approvals of foreign investment. While prone to 'crony capitalism' by corrupt officials, such requirements have also been used strategically to aid certain sectors or regions to improve economically, with potentially positive health externalities. Removal of these requirements is of more benefit to high-income investors than to people living in low- or middle-income countries (Greenfield, 2001). The TRIMs agreement presently retains considerable flexibilities that do not exist in a large number of much more aggressive bilateral investment treaties, many of which contain provisions similar to Chapter 11 in the regional North American Free Trade Agreement (NAFTA) (Peterson, 2004). This Chapter infamously allows private investors to launch trade-related suits against foreign governments if their regulations are viewed as conflicting with trade rules. At the same time, and indicative of the capriciousness with how trade rules can be interpreted, a WTO dispute panel in 1998 determined that TRIMs requirements applied to investment regulations on domestic, as well as, foreign investors (Lee, 2006), a clear intrusion into sovereign national policy-making completely unrelated to foreign trade or investment. High-income countries also continue to press for an expanded WTO agreement on investment in the wake of the defeat of the OECD's Multilateral Agreement on Investment in 1998; and it is worth noting that Mode 3 of GATS (commercial presence) is effectively an investment treaty for foreign service providers.

The Agreement on Technical Barriers to Trade (TBT) covers regulations on goods that governments invoke for purposes of security, health or environmental protection. The TBT requires that such regulations not create 'unnecessary obstacles to international trade' and that any alternative measure that is 'less-trade restrictive' must be implemented (Das, 2000). These terms are ambiguous and their interpretation in trade disputes has been left to trade, rather than to public health, experts.[5] The TBT also precludes governments from imposing import restrictions on products whose process and production methods involve environmental pollution or hazardous workplace conditions that exceed standards in their own country.

The Agreement on Government Procurement (AGP) requires governments to use only 'commercial considerations' when awarding contracts for purchases or services. Currently a plurilateral or optional agreement with few countries signed on, mandated WTO negotiations on a new agreement on transparency in government procurement are part of the Doha Development Round, and can be seen as a first step towards a multilateral AGP. This would eventually prevent governments from giving preferential treatment to domestic suppliers in its purchase or service contracts, or imposing equity-criteria in these contracts that otherwise could be used to reduce regional or group disparities in employment opportunities.

The Agreement on Agriculture

The most acrimonious debates in global trade revolve around the Agreement on Agriculture (AoA) and the continuing high level of subsidies provided by producers in the EU and USA to the economic detriment of farmers in low- and middle-income countries. The AoA commits WTO members to reduce tariffs and to phase out subsidies to farmers and to food exporters. The agreement gave WTO members a ten-year implementation period (which ended 31 December 2004) during which agricultural supports were exempt from trade actions under WTO rules on subsidies, tariffs and dumping.[6] Developing country negotiators charge that continuing US, EU and Japanese agricultural tariffs and subsidies hinder trade-related growth and poverty-reduction in developing countries. Estimates of these annual losses for developing countries range between US$20 and US$60 billion (ICTSD, 2004b), although net benefits to developing countries of fully liberalised agricultural trade have recently been estimated at only US$9 billion annually (Gallagher, 2007b).

A July 2004 WTO 'framework agreement' to begin phasing out subsidies may remedy this impasse, but its details are still in negotiation. The framework agreement allows the USA to retain a US$180 billion increase in domestic farm subsidies announced in 2002, as long as it can show that they do not affect current levels of agricultural production. In the lead-up to the expiry of the AoA ten-year implementation period, Brazil successfully challenged US cotton and EU sugar subsidies under the AoA. In 2007

Canada and Brazil initiated new challenges to a broad range of US subsidies. More such challenges are expected if WTO members fail to reach a deal under the 2004 framework agreement.

Most of the benefits of US and EU agricultural subsidies accrue to a small number of wealthy landowners or corporate farms. Many farmers receive some benefit, however, and their lobbying and voting pattern have proved powerful in preventing much headway in reducing overall subsidy levels. The AoA itself complicates things. The agreement has a number of 'boxes' describing different types of subsidies. 'Green' box subsidies are considered wholly permissible, 'blue' box subsidies require some reductions and 'amber' box subsidies clearly violate AoA rules. Through clever shifts in how it defines its subsidy programs, the USA and EU in recent years have moved most of their agricultural support from 'amber' to 'blue' or 'green' boxes, meaning that any deal reached under the framework agreement is unlikely to affect dramatically the overall scale of subsidy support.

High-income countries also retain substantial tariffs on agricultural imports from low- and middle-income countries, with tariffs rising (an 'escalation' in trade argot) as food products are 'value-added' for example, a lower tariff on raw cocoa but a higher tariff on chocolate bars. This practice allows manufacturers in high-income countries to reap most of the economic benefits in food processing. It is also a vital area where food exporting countries can gain ground; negotiations are stuck, however, on how much tariffs should be lowered by WTO members. There is general agreement that developed countries should have a higher level of obligation (that is a deeper set of cuts), but all developing countries will also be required to lower their import tariffs. This could have harmful effects on their local market economies and domestic food security, especially since many low-income countries already lowered their food import tariffs to qualify for structural adjustment loans (FAO, 2006).

Health in dispute and governance in question

The WTO is rare amongst multilateral institutions in having formal dispute settlement processes backed up with enforcement procedures. The WTO's Dispute Settlement Unit (DSU) has two distinct arms. The first arm is the Dispute Settlement Body (DSB) comprised of representative of all WTO members, which attempts a diplomatic solution to disputes between members. Failing that, an ad hoc panel of three trade experts agreed upon by the disputants is established. *Amicus curiae* ('friends of the court') briefs from outside interveners, usually public interest civil society groups, may be accepted as background material but this at the discretion of each individual dispute panel. The second arm is the Appellate Body, comprised of seven trade and legal experts appointed for four years; this group decides on appeals against the findings of a dispute panel. Only after its decision is

adopted by consensus by the DSB is it final. The dispute settlement process is considered the WTO's most innovative governance feature, bringing a more rules-oriented approach to settling mercantile quarrels. If a WTO member is found to have violated a trade rule, it must change its policies. If it does not, the disputing member can impose retaliatory sanctions equal to the estimated value of the loss caused by the broken trade rule. These sanctions do not have to affect the same kinds of goods involved in the trade dispute and are often designed to have maximum political impact. This inequitably penalises domestic producers who may be abiding completely by WTO rules, while letting off those who caused the trade dispute in the first place.

Civil society critics have posited an almost arrogant dismissal of health and environmental concerns by WTO dispute panels; and the long litany of lost health and environmental disputes lends credence to this position. Both the GATT and the GATS (and even TRIPS in a slightly different form) agreements allow exceptions for measures 'necessary to protect human, animal or plant life and health' (GATT article XX(b), GATS XIV(b)). Dispute panels have applied a very stringent necessity test to these exceptions. An early WTO dispute involving an EU ban on imports of Canadian asbestos is one of the only clear-cut cases in which health concerns trumped trade imperatives. Significantly, the dispute panel found that the EU ban was discriminatory since asbestos was 'like' the glass fibres permitted for insulation use in the EU, and ruled in favour of Canada. The Appellate Body, however, considered the extensive evidence of asbestos's harmful human health effects and allowed the EU ban to stand. This has led some observers to claim that health is well-considered by WTO dispute panels (Bloche, 2002).

The recent case study of Brazil's attempted ban on imports of European used and retreaded tires indicates that trade *may* not necessarily trump health or environmental protection, if national protection rules are applied consistently. In this case, the EU successfully challenged Brazil's ban, noting that the country allowed small amounts of used tire imports from some of its neighbours. Brazil countered that it had too many used tires already, which were filling with water and becoming breeding grounds for malaria-transmitting mosquitoes and other insect-borne diseases, notably dengue and yellow fever. It also pointed out that it was legally obliged under other agreements to permit the imports from its neighbours. The panel agreed with Brazil but ruled with the EU, intimating that, had Brazil's restrictions on imports of used or retread tires been more forceful and broader in scope, they might have qualified for exemption. Brazil is presently rewriting its national legislation to comply with the panel's ruling, and so reinstate its ban on EU retread tires. The EU meanwhile successfully appealed the panel ruling it won arguing it didn't go far enough, undermining Brazil's ability to re-enact a ban at some point in the future (ICTSD, 2007b; World Trade Organization, 2007).

The language of WTO exceptions for human and environmental health is itself part of the reason for the ambivalent positions taken towards protection by most dispute panels. The degree of interpretation required with these exceptions is compounded by the absence of health or environmental experts having any effective involvement in the dispute settlement process. Trade treaties may be singular in having effective enforcement mechanisms, but far from alone in multilateral treaty obligations, notably respecting the environment and human rights. There are fewer health-specific international treaties – the Framework Convention on Tobacco Control (FCTC) being one – but even here there are potential conflicts between health and trade that should not be left to trade experts to rule upon.

There is little reason to be optimistic of such an option in the short term. The WTO is nominally democratic (operating on the basis of unanimity and one country, one vote), and a more equitable governance structure than that of its two multilateral sisters, the World Bank and IMF, where decision-making power is directly related to its members' economic power. However, the complexity of simultaneous negotiations across multiple areas and the limited financial and human resources available to developing (and especially least developed) countries results in gross inequities in bargaining power. Outcomes unsurprisingly conform closely to the interests of developed countries or in stalemate (Lee *et al.*, 2007). Nor does the WTO score well on 'good governance' criteria of transparency and accountability (Blagescu and Lloyd, 2006). This is partly because in practice most substantive discussion takes place outside formal structures through a complex series of meetings, such as 'mini-ministerials' and 'green room' meetings, to which only the most powerful countries are invited. Based on interviews with WTO negotiators, trade policy researchers Fatoumata Jawara and Aileen Kwa (Jawara and Kwa, 2003) observe that closed negotiations are the preferred mode, with decisions often made without full approval by low- and middle-income countries. Other instances exist of questionable pressures exerted, and inducements offered, by the US and EU delegations, including the use of aid as a bargaining chip. The highly technical nature of many discussions further contributes to the lack of transparency of procedures (Narlikar, 2001; South Centre, 2003). This complexity, as well as costly implementation requirements on the part of most developing countries, furthers the asymmetries in trade negotiating power.[7]

It is no surprise, then, that for many observers the actual governance of the WTO defaults to 'relative market size' as the 'primary source of bargaining power':

> Weaker states are coerced by the powerful into agreeing with the consensus. Should the powerful not get their way, they threaten to move

the issue to another forum or threaten to create a new organization, and the proposals by the weak are often ignored (Karns and Mingst, 2004).

This began to change when the Seattle Ministerial in 1999 collapsed in disarray, mostly a result of developing countries beginning to organise against the hegemony of the developed nations' agenda. The Doha Ministerial in 2001 gave birth to the Development Round, although this again collapsed when developing countries walked out of the 2003 Cancún Ministerial over (persisting) developed country intransigence on reducing agricultural subsidies. There is now a proliferation of different negotiating 'groups' or blocs of nations within the WTO, varying by issue, geography and economic size. Developing countries in the aggregate, led by the three rising powerhouses of China, India and Brazil, have shown an unwillingness to accept the unequal terms of trade that characterised the Uruguay Round. There is considerable doubt if the Doha Development Round will even complete and, with those doubts, concerns loom over the viable future of the WTO itself. Another collapse in negotiations in 2008 emphasises such concerns. To those who regard the WTO the third member of neoliberal globalisation's unholy trinity, alongside the World Bank and the IMF, this would be a good thing. We are not amongst those. If anything, the impasse of power now stalling the WTO is a sign that multilateralism holds more potential for equitable outcomes than other forms of negotiation. The alternative, already being enacted by the USA and EU, is to increase bilateral and regional free trade agreements, in which smaller, weaker economies have much less bargaining power. Most of these are WTO-plus (notably TRIPS-plus) in that their provisions require a greater loss of developing country policy flexibilities than that required by WTO agreements (see also Ingram in this volume). As more of these are negotiated, and if a majority of WTO developing country members eventually agree to them, it will be hard for developing countries to argue against their terms becoming the 'floor' for multilateral WTO trade agreements.[8]

Conclusion: a matter of regulation, rights and redistribution

If the WTO survives, it needs radical surgery. To give it credit, WTO transparency has improved in recent years as has its engagement with other multilateral institutions and CSOs. But public health presence in WTO and other trade treaty negotiations remains weak. This paucity of engagement extends to most national governments, who routinely have business representatives on their trade advisory committees but not civil society or public health representatives. According to the US-based Centre for Policy Analysis on Trade and Health, US trade advisory committees for agreements pertinent to health have 42 business representatives (from the drug, tobacco, alcohol, food and health insurance industries) but only 1 (on tobacco) from a public health agency (CPATH, 2007).

Moreover, the very logic of the WTO needs an overhaul, for which there is no shortage of suggestions. Some of these are laced throughout this chapter, but a consolidated short list would look something like this:

- *Place development, not trade, at the centre of the treaties*. While this is purportedly the goal of the WTO it is not embedded in its treaty structure. Approaches to this issue within the present WTO treaty structure include: strengthening the SDT provisions; an end to demands for tariffs reductions from developing (and especially smaller- or lower-income developing) nations until viable alternative tax systems and competitive industries are in place; real market access to developing country exports by developed nations; addressing the multiple and long-standing implementation issues faced by developing countries; and an end to new treaty negotiations until these issues are resolved. Some analysts have called for more systemic changes to the treaty structure itself, including an obligation on developed countries to negotiate non-reciprocal market access and subsidies for developing countries outside of any other trade treaty negotiations (Lee, 2006). Only when such negotiations were complete would multilateral negotiations on other trade treaties be allowed to proceed. A similar, if more dramatic, approach would be the creation of new WTO agreements on tariffs and subsidies specific to development goals.
- *Shrink the scope of existing agreements*. This includes removing governance of intellectual property rights from the WTO and placing it (as it once was) under the purview of the World Intellectual Property Organisation. This would render derogation of Intellectual Property Rights (IPRs) a matter of diplomacy rather than of retaliatory trade sanctions. Negotiations in trade in health services should also be postponed, at least until there is evidence of effective flanking policies that governments can and have implemented to regulate increased private sector involvement for health equity outcomes. The same applies to services basic to the right to health such as education, water/sanitation and housing. This removal would not preclude trade in these services, but does not bind governments to irreversible market opening policies. Other arguments have been made for similarly removing treaties associated with investment, standards and government procurement. If this proves politically impossible, the 'single undertaking' requirement of the WTO could be relaxed so that these become plurilateral (optional) agreements (Collier, 2006), perhaps using the GATS agreement as a model (in which countries are bound only by the sectors they specifically choose to liberalise).

  Shrinking the scope of WTO agreements applies equally to the efforts of some civil society groups and developed countries to load trade treaties with additional obligations related to labour and environmental standards. A long-festering issue (one on which this chapter's lead author has changed opinion a few times), these 'social clauses' would bring the

weight of trade sanctions to bear on compliance with other multilateral conventions. Sound in ethical intent, the practice could too easily lend itself to 'back-door' protectionism in which developed countries – with greater resources for fuller compliance – could close its borders to goods from countries with fewer resources and lesser compliance (Khor, 2007). Rather than use the teeth of the WTO to chomp down on countries that fail in their obligations, it would be better to increase the power of those organisations (such as the International Labor Organization (ILO), United Nations Environment Program (UNEP), FAO, WHO and the Secretariats responsible for multilateral environmental agreements) with the specialised knowledge to make good adjudications.

- *Incorporate provisions for derogation from trade rules for purposes of meeting obligations under human rights treaties*. The role of the WTO as perhaps the most effective existing institution for supra-national economic regulation raises questions about how the trade policy regime interacts with the international human rights framework, which is not linked to comparable multilateral implementation and enforcement institutions. The UN Special Rapporteurs on globalisation and human rights concluded that, 'it is necessary to move away from approaches that are ad hoc and contingent' in ensuring that human rights are not compromised by trade liberalisation (Oloka-Onyango and Udagama, 2003).

  Despite the rhetorical importance given to human rights in global geopolitical debate, and commitments through the United Nations by all countries to adopt a human rights-based approach to development, no single dispute panel at the WTO has yet to consider a human rights argument in its deliberations (Harrison, 2007). One of the ideas vetted by the World Commission on the Social Dimensions of Globalization, for example, was to refer disputes based on developing countries' development goals to a panel of development/health/human rights experts to determine if the abrogation of trade treaty rules was necessary to achieve the stated purpose. These could be extended to incorporate their actions to reach the MDGs or to fulfil their obligations under the right to health. A less demanding reform would make *amicus curiae* briefs from health, human rights and/or development experts compulsory in such instances, and a requirement on the part of dispute panel to state publicly any disagreements with these experts' findings.

These suggestions, while not exhaustive, speak to some aspects of the 'matter of regulation and rights'. The third matter, redistribution, is more urgent yet likely more difficult to achieve. This chapter began by critiquing the argument that liberalisation, as one key leg of neoliberal globalisation's project of market integration, necessarily succeeds in promoting growth or reducing poverty. It can, and it depends. Some of what it depends upon is policy flexibilities now being systematically removed by trade treaties. But

even assuming these flexibilities are retained, there are real environmental and health limits to growth, at least as it continues to occur.

Such a radical rethink of trade and human survival requires that we move to a redistributive global system of governance that eventually becomes some form of government (that is a politic that is directly accountable to people as global citizens). An economic case can be made for this, since redistribution is far more effective and efficient in reducing poverty than is economic growth. Recent calculations for Latin America (de Ferranti *et al.*, 2004; Jubany and Meltzer, 2004; Paes de Barros *et al.*, 2002) conclude that even a little redistribution of income through progressive taxation and targeted social programs would go farther in terms of poverty reduction than many years of solid economic growth. Similar calculations have projected the same trend on a global scale, noting the growth's growing *inefficiency* in reducing poverty: 'Between 1990 and 2001, for every $100 worth of growth in the world's income per person, just $0.60 is contributed to reducing poverty below the $1-a-day line, 73 percent less than even in the lost decade for development, the 1980s' (Woodward and Simms, 2006).

The World Commission on the Social Dimensions of Globalization (World Commission on the Social Dimension of Globalization, 2004) and the Helsinki Process on Globalisation and Democracy (Helsinki Process on Globalisation and Democracy, 2007) are two recent multilateral efforts to advocate a new form of globalisation that both recognises redistributive social obligations and incorporates new institutions for global governance. Although cautious about the merits of a currency transaction tax, the UN High-level Panel on Financing for Development (Zedillo *et al.*, 2001) stressed the need for new sources of development financing, and proposed the establishment of an International Tax Organisation as a starting point for limiting tax competition and evasion. A more recent initiative, focused on a specific set of policy instruments, is the Leading Group on Solidarity Levies to Fund Development, established at the 2006 Paris Conference on Innovative Development Financing Mechanisms. The second plenary meeting of this group, hosted by Norway in February 2007 (Norwegian Ministry of Foreign Affairs, 2007), considered not only taxes on air travel – already implemented by a number of countries (Farley, 2006; Ministries of the Economy, 2006) – but also research commissioned by the Norwegian foreign ministry on a currency transaction tax (Hillman *et al.*, 2006), and on policy options to address tax evasion and tax competition (Murphy *et al.*, 2007).

Stated bluntly the systems of global governance established after the last World War to prevent economic inequities and mercantilist nationalisms from fanning another have proved inadequate (Lee *et al.*, 2007). Not all blame for our more tenuous world can be placed on trade. But unless trade treaties function better to enhance equity in health and its determinants, and permits governments the flexibilities to intervene in markets to correct

for the inequalities that accompany trade, we will face an increasingly polarised, insecure and unhealthy world.

Notes

1 This Chapter draws heavily from the work of the Globalization Knowledge Network (GKN), chaired by the Ronald Labonté, which undertook narrative research syntheses on a range of globalisation phenomena for the WHO's Commission on the Social Determinants of Health (2006–2008). The contributions of all members of the GKN are gratefully, if anonymously, acknowledged. Individuals who merit specific mention are Ted Schrecker (GKN Coordinator), Kelley Lee, Chantal Blouin (also a co-author on this chapter), Mickey Chopra, Corinne Packer, Mike Rowson, David Woodward, Patrick Bond, Giovanni Andrea Cornia, Carlos Correa, Corinna Hawkes, Meri Koivusalo, John Lister, Vivien Runnels, David Sanders, Kirsten Stoebenau, Sebastian Taylor and Zoë Wilson, all of whom contributed to the drafting of the GKN's Final Report. Financial support for the GKN's work was provided by Health Canada and the WHO. Much of the material in the early sections of this chapter is adapted from the Final Report of the GKN (R. Labonté, C. Blouin, M. Chopra, K. Lee, C. Packer, M. Rowson, T. Schrecker, D. Woodward *et al*. (2007) *Towards Health-Equitable Globalization: Rights, Regulation and Redistribution, Globalization Knowledge Network Final Report to the Commission on Social Determinants of Health* (Ottawa: Institute of Population Health, University of Ottawa)).

Sections of this chapter also appeared in slightly different form in 'Glossary of the World Trade Organisation and Public Health: part 1 and part 2' (R. Labonté and M. Sanger (2006) *Journal of Epidemiology and Community Health*, 60, 655–661 and 61, 738–744). Ronald Labonté is supported by the Government of Canada's Canada Research Chairs program. Lisa Forman is supported by the Canadian Institutes of Health Research and Comparative Program on Health and Society at the Munk Centre for International Studies.

A version of this chapter was presented at the second meeting of the 'Health in an Unequal World' research network meeting, 24 January 2007; funded through a grant by the Canadian Institutes of Health Research.

2 While a comparative study found that trade openness correlates with a lower incidence of reported violations of core labour standards (Neumayer and De Soysa, 2005b, 2006), the study's design precludes any assessment of causality and its authors caution that 'it is quite likely, that globalisation boosts the bargaining power of capital at the expense of labour, which would put downward pressure on outcome-related labour standards such as wages, working times and other employment conditions' (Neumayer and De Soysa, 2005a). It is one thing to have a right *de jure* and quite another to have the bargaining power to exercise it *de facto*.

3 It is significant that the benefits of gradual tariffs reduction were seen in the context of Keynesian economics and the prominent role it gave to government interventions into the economy, particularly in debt-funded countercyclical spending. Liberalisation under the WTO has taken place in a context of neoliberal economics which truncates the role of government in the economy, and seeks to reduce government debt and spending regardless of economic cycle (Collier, 2006).

4 Doha Declaration, para. 4.

5 The WHO has observer status in deliberations pertaining to both the SPS and TBT agreements, but this does not extend to intervening in panel disputes. It has only *ad hoc* observer role in the committees dealing with intellectual property rights and services. It has no status on the WTO's General Council, Committee on Government Procurement, or working parties on GATS rules, domestic regulation, and transparency in government procurement, in spite of the potential importance of negotiations in these areas to national health systems. The problems of presence and substantive expertise were highlighted by the post-Doha and TRIPS Council negotiations. According to Raghavan, while economic diplomats discussed which diseases in which developed countries constituted a public health problem, the representative of WHO was not permitted to offer advice or even to attend the meetings (Raghavan, 2000).
6 'Dumping' refers to exports that enter markets at less than 'normal' prices. Another WTO agreement covers this practice, allowing members to impose countervailing measures, such as tariffs, if they believe dumping is occurring. This provision has most often been used by wealthier countries to reduce imports of goods (primarily agricultural and textile) from developing countries where labour costs are substantially cheaper and to give these countries a comparative advantage (Das, 2000; Lee, 2006).
7 As one measure of this complexity: China's accession document to the WTO was over 900 pages long, and required China to amend 570 pieces of legislation and over 1,000 central government rules and regulations (Karns and Mingst, 2004). As another: the costs of implementing their less onerous obligations under WTO agreements for least developed countries are estimated at more than their annual development budgets (Finger and Schuler, 2001).
8 The 2006 Democrat majority in both US houses of government has led to some potentially significant shifts in bilateral trade policy in that country, essentially loosening much of the TRIPS-plus language in them so that they are more WTO-equivalent, and making compliance with labour rights and some environmental agreements core obligations subject to disputes and trade retaliation (ICTSD, 2007d).

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9

IMF Policies and Health in Sub-Saharan Africa

Ross P. Buckley and Jonathan Baker

Introduction

Health matters. It is a fundamental human right[1] which supports economic development (Kimalu, 2001, p. 2), and although globalisation is not new (Sen, 2001), its impact on health is being increasingly scrutinised (Labonté and Tor Gerson, 2005, p. 157). Generally, trade liberalisation is welfare-enhancing because it promotes economic growth and this should, other things being equal, lead to less poverty (for a brief discussion of this assumption see Labonté in this volume). Conventional wisdom suggests (and there may be some utility in the claim) that a virtuous cycle can therefore arise in which growth promotes health which in turn promotes more growth (Labonté and Tor Gerson, 2005, p. 161): less poverty and the opportunities growth brings for greater expenditures on healthcare should both contribute to improved heath outcomes (Labonté and Tor Gerson, 2005, p. 160). At least ostensibly, the Bretton Woods institutions have sought to manage the unfolding of this virtuous cycle globally, not least by policies that have globalised free trade, sought to control (government) debt, and shape policies for better fiscal and economic management of countries. Their role in global health governance (GHG) and global health policies, therefore, would not on the surface appear automatic or obvious. However, as this chapter argues, in the case of the International Monetary Fund (IMF) this is clearly not the case, and the agency has had both a direct and indirect impact on the national health systems (NHS) of many developing countries and the ability of the poorest to access healthcare.

Kay and Williams argue in the introduction to this volume, there has also been a striking degree of policy coalescence between the Bretton Woods organisations, not least in their treatment of health. In many senses the power of the IMF over GHG is closely bound to the World Bank (see Harman in this volume). Structural Adjustment was the name given to the policy prescriptions the World Bank ('the Bank') and the IMF or 'the Fund' (Samba, 2004, p. 1) developed in response to the Debt Crisis that commenced in late

1982 and afflicted Latin America and Sub-Saharan Africa. Once the Debt Crisis erupted, the Fund rapidly assumed the role of crisis-response coordinator and required compliance with its economic policies as a precondition of receiving its and the Bank's assistance. Through the implementation of Structural Adjustment Programs (SAPs) the Bank and Fund sought to achieve sustained economic growth in recipient countries.

This chapter will assess the impact of SAPs and their successor, the Poverty Reduction Strategy Papers (PRSPs), on health expenditures and outcomes in Sub-Saharan Africa. Case studies are undertaken of Tanzania, Uganda and Ghana. At the core of our analysis is not economics in general, but one particular form of economism, that being market fundamentalism. This entails a largely uncritical belief that markets are always, invariably, the most efficient devices to achieve service delivery, and especially in poor countries with weak institutions and governance architectures. However, while there is very little evidence to support this assumption, it is exactly this belief or variant of market fundamentalism that gave rise to SAPs. Reviewing the two principal policy instruments that have been applied to developing countries over a time period since the Debt Crisis of the early 1980s supplies the necessary background for understanding the context of the Fund's impact on GHG and the political economy of global health.

Structural Adjustment Programs

SAPs generally included the following elements, for which the Fund was roundly criticised (Buckley, 1999, Chapter 2; Woodroffe and Ellis-Jones, 2000, p. 2). Generally the programs focused on the reduction of government expenditures as a baseline policy approach, with currency devaluation also being employed to encourage exports and rectify trade deficits. Importantly, and in terms of health and NHS, SAPs often insisted on the implementation of fee-for-service regimes in education and healthcare; and, more widely, on the promotion of free market principles to stimulate efficient allocation of resources. These state-restrictive measures (or 'rolling back' policies) were further supported by the privatisation of state-owned enterprises and general reduction of government interference in the national economy. Liberalisation of sectors (including healthcare) were also often bound to new rights of establishment for foreign firms, which found resonance not only in the stated goals of the Uruguay Round of the General Agreement on Tariffs and Trade (GATT), but also in the specialised instruments of the emerging World Trade Organization (WTO) regime, such as the Trade-Related Investment Measures Agreement. SAPs thereby sought enhanced access for foreign firms to domestic markets, and an elimination of import controls and other trade barriers. Other policy requirements of the SAPs included: the removal of restrictions on free currency

exchange (convertibility); an elimination of subsidies and price controls; the General downsizing of government; and the expansion of tax base and strengthening tax collection mechanisms.

Recipient countries of IMF assistance were required to accept IMF advisers in their Treasury and Ministry of Finance offices who could insist on adherence to the policies listed above. Countries which required IMF assistance often suffered from large budget and trade deficits, rapid inflation, and capital flight (Ohkubo, 2006). They are rarely in an empowered position from which to argue against the policy prescriptions of the Fund (Ohkubo, 2006). Thus the conditionalities placed on assistance often lead to wholesale disciplining measures which effectively liberalised and restructured recipient country economies and public services in what were often very short timeframes. Nonetheless, there was often considerable resistance by recipient countries to the Fund's imposition of its views – a resistance that in the implementation stage works against the effectiveness of Fund-mandated reforms. IMF policies are accepted, at least in a superficial, formal sense, because recipient nations believe they have no choice in the matter.

There have been numerous criticisms of SAPs by a wide range of commentators, principally from NGOs and academe (Stiglitz, 2002; George, 1990, pp. 143, 187 and 235; Bello, 1999). The most common criticisms are that SAPs deepened poverty and increased the gap between the rich and poor; undermined national sovereignty and imposed a Western neoclassical economic model that is inappropriate for the low- to middle-income countries. While SAPs focused on macroeconomic structural reform, they neglected and exacerbated other socio-economic problems, not least in failing to address the needs of the poor. In broad and simple terms, SAPs tended to harm the poor, and often led to cuts in health, education, and welfare expenditure in countries where the baseline of provision (by the state) was already often very low to start with. Indeed, a study on SAPs carried out by Harvard University concluded that, 'the required reductions in public expenditures were imposed on system(s) which were already failing to meet basic social needs' (Ismi, 2004, p. 19).

Poverty Reduction Strategy Papers

PRSPs were introduced in 1999 in response to the global outcry at the failure of SAPs to reduce poverty significantly (Sanchez and Cash, 2003, p. 13). PRSPs were much vaunted as being a new tool for poverty reduction, debt relief, and access to funding from donors. According to the IMF, 'PRSPs are prepared by the member countries through a participatory process involving domestic stakeholders as well as external development partners, including the World Bank and the International Monetary Fund' (IMF, n.d.). PRSPs outline the economic, social, and structural programs to be used to reduce poverty (Steward and Wang, 2003, p. 4). Instead of focusing on macroeconomic

stability and growth like SAPs, PRSPs, as their name suggests, were to put poverty reduction at the core of the nation's economic policies. It would seem that the Fund had therefore responded to criticism and transformed itself, and one would expect some foregrounding of poverty and health programs in its new policy canon, not least as the PRSPs were brought on stream at a time when the Millennium Development Goals (MDGs) (and other pro-poor global governance initiatives) were being developed.

Once approved, the PRSP forms the basis for future funding (Sanchez and Cash, 2003, p. 13). Potential recipients of debt relief under the Heavily Indebted Poor Country (HIPC) Initiative and the IMF's Poverty Reduction and Growth Facility (PRGF) are required to produce a PRSP to be eligible (Steward and Wang, 2003, p. 5). That the primary policy focus of PRSPs was to be poverty reduction is evidenced by the requirements that they include a number (or checklist) of important considerations (Sanchez and Cash, 2003, pp. 13–14). A poverty assessment should be conducted that identifies the poor and where they live and analyses the constraints to faster growth and poverty reduction. Moreover, clear, costed priorities for macroeconomic, structural and social policies together with targets, indicators and outlines of systems for monitoring and evaluating progress should be factored in. A description of the participatory process used to develop the PRSP, describing the format and outcome of consultations, and the impact consultations had on the design of the strategy and a discussion of the role of civil society in the monitoring and implementation process, were important vehicles for ensuring consultation and transparency.

However, despite these broad changes in form and process from SAPs, we and a range of other critics believe that the substance of the economic development policies promoted in developing countries have changed little. Indeed, while SAPs were designed to achieve stability and long term growth, poverty reduction was not pursued directly because it was assumed it would result from economic growth. This is a perfect example of the 'market fundamentalism' analysed by Sparke in this volume. The IMF's working assumption throughout the 1980s and 1990s was that growth would lead to reduced poverty and improved healthcare automatically by the operation of the market. At least on the surface it would appear that the primary objectives of PRSPs were poverty reduction and thereby growth – and therefore a converse causal assumption about development (Gottschalk, 2004, pp. 10–11). Yet many commentators argue that the PRSPs promote the priorities of the International Financial Institutions (the IFIs) rather than of the poor (Sanchez and Cash, 2003, p. 9). The IMF guidelines for constructing PRSPs have strong neoliberal assumptions, which result in less government intervention in markets and reduced public spending, particularly on education, healthcare and social welfare. These reductions in public spending, virtually inevitably, lead to a weakening or removal of the social 'safety nets' needed by the most vulnerable members of society

– namely women, children, rural populations, and the poor. Before focusing on the specific impact of the IMF on NHS in select African case studies, we seek to flesh out how market fundamentalism and economism have continued to dominate the Fund's policies, and how in general terms health is articulated in the context of its poverty reduction strategies and economic development policies.

Considering the role of the IMF

Surveillance, financial assistance and technical assistance are cited as the Fund's three main functions these days (International Monetary Fund, 2004). For countries with an IMF program in place, the Fund has direct input into the fiscal and monetary policy settings of the country. While now an established practice, this was not part of the IMF's original role. The IMF was founded to assist countries in managing their fixed exchange rates by providing funds and technical advice (Stiglitz, 2002, p. 15). However, as developed nations moved away from fixed exchange rates in the 1970s, much of the IMF's original mission disappeared. With the inception of the Debt Crisis in 1982 the Fund moved quickly to secure the role of crisis coordinator and today its role is managing crises in emerging markets, countries and conducting the surveillance, financial assistance and technical assistance that aims to avert these crises.[2]

The policies through which the IMF tries to achieve these goals have been subject to increasing criticism in recent years. For example, a United Nations Development Program (UNDP) study (Kovach, 2006, p. 2) has argued that inflation rates associated with healthy economic growth should range from five to ten per cent or higher, and an inflation rate of less than five per cent can have a harmful impact on an economy. Yet a recent study by Oxfam International reported that 16 out of 20 countries within IMF programs in place had inflation targets of less than five per cent (Kovach, 2006, p. 2).

Periods of rapid economic growth in Continental Europe, the USA and Japan were historically associated with large programs of public expenditure and budget deficits. Yet the current policies of the IMF deny countries the ability to borrow domestically to fund productive programs due to deficit caps. In short, the IMF is hostage to neoliberalism and economic rationalism. Its policy prescriptions, though well-meaning, are shackled by the very restrictive lens through which all options are considered.

In practice, IMF policies worsen inequalities by removing subsidies and price controls on basic goods and services. The introduction of user fees work against poverty reduction but are necessary to fit within the macroeconomic framework IMF ideology compels to instil in recipient countries (Possing, 2003, p. 7).

The apparent change of IMF policy from SAPs to PRSPs discussed in the section above is, on one view, more an effort to rescue the Fund from its

crisis of legitimacy (Dor, 2007, p. 1) than to respond to the needs of the poor in poor countries (Samba, 2004, p. 3). In the main, critics have focused on how, if the IMF is to play a more constructive role in developing countries, it needs to provide greater fiscal flexibility to permit increases in government spending so as to assist countries in meeting the MDGs. The IMF should also refrain from requiring trade liberalisation and privatisation as loan conditions because such policies are yet to demonstrate clear poverty reduction effects (Kovach, 2006, p. 1). Finally, many have argued that the IMF needs to look to itself first, and further alter its own institutional setup. Notwithstanding the changes in late 2006 to member countries' voting rights, developed countries continue to exercise an influence over the Fund that is not proportional to their number or need. Furthermore, the Fund needs to decentralise further and employ more staff with social science backgrounds (Kovach, 2006, p. 2) in order to properly conceptualise strategies for both poverty reduction and economic growth. These deficiencies and critiques have a direct bearing on how the IMF has dealt with NHS and global health, with its general failings having specific impacts on these areas.

The IMF and healthcare

Consistent with its ideology, the IMF views healthcare as a service better provided by the private sector. The organisation has championed at least four policy mechanisms by which the delivery of healthcare services in whole or part has been transferred from the public sector to the private sector (and often in some combination of all or some of the mechanisms). First, the Fund has demanded (under SAPs) or promoted strongly (under PRSPs) a decrease government funding of the public sector, assuming (often with a degree of misplaced trust in generous terms) that the private sector will step into the breach thus created, because they no longer have to compete with subsidised competition. Second, the Fund has encouraged a gradual reduction in the operational role of the public sector in healthcare, and sought to ensure that the private sector offer these services whilst governments redirect some or all of the saved public funding to disease control programs. Third, and in keeping with piecemeal privatisation strategies in developed countries (such as the UK), the Fund has promoted arrangements by which states subcontract healthcare services to the private sector, but still fund them publicly. Finally, the organisation promotes specific sets of arrangements that facilitate private provision, such as the leasing or sale of public hospitals to the private sector (Marek *et al.*, 2003, p. 5).

Each of these methods is potentially effective in some way. But the first mechanism, which in essence was the foundation of both SAPs and PRSPs programs, forms the standout exception, and has created the most havoc in recipient country NHS, and done most harm to the health of the poor in

these countries. Starving government funded healthcare services of funding, and then hoping the private sector will fill the gap, simply does not work well at all (Unger, 2006, p. 5; Bayliss and McKinley, 2007). Consistently underfunding the public health sector has led many developing countries to an exodus of professional staff to the private sector within developing countries (and the creation of a wide gap, simply in terms of quality healthcare, between a two tier NHS), and to the mass migration of medical professionals to developed countries – a brain drain among doctors and nurses from which Australia and almost all Organization for Economic Cooperation and Development (OECD) countries have benefited from (Unger, 2006, p. 4).

Second, the privatisation of the health sector limits access for the poor. The poor simply cannot afford the costs of privatised care, and typically cannot afford health insurance or other forms of user pays systems. In any event, insurance is often not available, as private health insurance companies tend to ignore rural areas (Sreenivasan and Grinspun, 2002, p. 2). Moreover, in privatised systems, most resources end up going to larger specialised facilities such as tertiary care hospitals, rather than to primary healthcare that has a greater impact on the poor (Sreenivasan and Grinspun, 2002, p. 2).

Before the 1980s, essential drugs were provided free of charge in many African countries via community health centres. After the introduction of user fees and cost recovery, the sale of drugs was liberalised. The result of this was a decline in consumption of essential drugs. With the deregulation of pharmaceuticals, imported brand name drugs were released into the free market and eventually displaced domestic drugs. By 1990, domestic production of pharmaceuticals had virtually stopped as the companies were forced into bankruptcy (Samba, 2004, p. 2). Compounding these problems, SAPs and PRSPs tend to advocate devaluing the local currency in an effort to encourage exports. However, a cheaper local currency dramatically increases the costs of imported pharmaceuticals.

Liberalisation of the health sector tends to shift resources towards specialised centres catering for the affluent few and foreigners, while depriving the people in rural areas, thus creating a two-tier delivery system which worsens the already inequitable distribution of healthcare resources (WHO, 2006, p. 3). Furthermore, the diffusion of new health technologies to developing countries usually only benefits the wealthy at the expense of an underfunded public healthcare system geared towards servicing the poor (Labonté and Tor Gerson, 2005, p. 161).

Researchers have compared the cost per admission and per in-patient day, in southern Africa, between public rural district hospitals and subcontracted private hospitals (Mills, 1998; McPake and Hongoro, 1995). Their study revealed that efficiency did not increase when the hospital was leased to private companies. The research suggested that similar quality of care can be achieved at a lower cost when provided solely by the public sector.

Private care came at a higher cost because the profit margins more than offset any efficiency savings (Unger, 2006, p. 7).

One way to illustrate why private healthcare fails in poor countries is to explain how it can succeed in rich countries, and even here the record is mixed. In Europe and Australia, governments regulate and control the private sector and there are detailed contracts for healthcare providers and detailed oversight of their implementation. In lower- and middle-income countries, this monitoring tends not to happen effectively because of weak public institutions. Even the contracting out of clinical services to non-profit providers such as church hospitals is a very complex operation. It may be that only strong democratic governments in developed countries possess the regulatory resources to properly regulate the delivery of quality healthcare by the private sector (Unger, 2006, p. 7).

Our case studies present this in very bold terms and over a range of crucial health status indicators.

Africa, health and the track record of the IMF

Three key healthcare and health status indicators will be analysed for Sub-Saharan Africa: the under-five mortality rate (U5MR), life expectancy, and infant mortality.

Under-five mortality rate

One of the key goals of the MDGs is to reduce the U5MR by two-thirds between 2000 and 2015 (Bos, 2006, p. 18). The median U5MR in Sub-Saharan Africa is 153 per 1000; that is, more than 15 out of every 100 children die before their fifth birthday. This compares to one in 100 in the developed world (Bos, 2006, p. 9).

The annual rate of decline in U5MR in Sub-Saharan Africa averaged about one per cent in the 1960s, increased to close to two per cent between 1970 and 1985, dropped back to about one per cent between 1985 and 1990, and averaged less than one per cent during the 1990s. These rates of decline pale in comparison to the 4.3 per cent rate required to achieve this MDG (Bos, 2006, p. 20). Indeed, Sub-Saharan Africa is not on track to achieve a single target set by the MDGs for the period 2000–2015 (Bos, 2006, p. 7).

However, it must be noted that these countries have all been seriously affected by HIV/AIDS or have suffered economic crises or political instability (Bos, 2006, p. 20). For these reasons, the numbers are skewed, and progress is hard to track.

Life expectancy

The gap between life expectancy in Sub-Saharan Africa and in Europe and North America in 2000 is larger than it was in 1950 (World Bank, 2006, p. 68). Table 9.1 summarises the life expectancy at birth for the World and United Nations (UN) regions.

Table 9.1 Life Expectancy at Birth for World and UN Regions, 1960–2005

Region	1960–69	1970–79	1980–89	1990–99	2000–04
World	52.5	58.1	61.4	63.7	65.4
Sub-Saharan Africa	42.4	46.3	49.0	47.6	45.9
Asia	48.5	56.4	60.4	64.0	67.3
Europe	69.6	71.0	72.0	72.6	73.7
Latin America and Caribbean	56.8	60.9	64.9	68.3	71.5
Northern America	70.1	71.6	74.3	75.5	77.6
Oceania	63.7	65.8	69.3	71.5	74.0

Source: United Nations, 2005 cited in Bos, 2006, p. 12.

Life expectancy at birth in Sub-Saharan Africa is a mere 46 years, compared to 67 years in Asia, the region with the second lowest life expectancy. In the 1960s, the difference between Asia and Sub-Saharan Africa was only six years. Moreover, where all other regions have experienced continuous increases in life expectancy, Sub-Saharan Africa's life expectancy peaked in the early 1990s at 50 years and has since fallen back by four years (Bos, 2006, p. 12).

Over 35 years of increases in life expectancy were reversed in a mere decade (Bos, 2006, p. 13), and the UN Population Division predicts that life expectancy will continue to fall in Sub-Saharan Africa in the next five to ten years (World Bank, 2006, p. 68). Again this appalling outcome is largely influenced by the AIDS pandemic sweeping the region, so the impact of the healthcare systems on life expectancy is difficult to isolate and analyse.

Infant mortality

The rate of decrease in infant mortality slowed considerably during the 1990s, further indicating that Sub-Saharan Africa has lagged behind other regions in achieving health outcomes.

In summary, and with a fairly justifiable inductive step (not least because of the importance that the IMF credited to the significance of its own measures to development prospects in African countries), SAPs failed to address effectively poverty or poor health in Sub-Saharan Africa. PRSPs have been with us this decade, long enough to assess their impact. They have had at least the potential to be successful because they are designed to address the specific needs of individual countries through a thorough process of consultation and participation in their formulation. This consultative process is supposed to facilitate communication between all interested parties, and increase the responsibility of Ministers of Health to ensure that the funds

Table 9.2 Infant Mortality Rates for World and UN Regions, 1960–2005 (per 1,000 live births)

Region	1960–69	1970–79	1980–89	1990–99	2000–04
World	119	93	78	66	57
Sub-Saharan Africa	149	130	115	107	101
Asia	123	96	77	63	54
Europe	33	23	17	11	9
Latin America and Caribbean	96	75	52	35	26
Northern America	24	16	9	7	7
Oceania	49	43	36	32	29

Source: United Nations, 2005 cited in Bos, 2006, p. 12.

get distributed to the poor. PRSPs should allow greater flexibility to achieve specific health needs because there is no set structure for a PRSP. However, problems can arise because there is a fine balance between country ownership, and Bank and Fund approval, of a PRSP.

Whether PRSPs have been effective, not least in health terms, is another matter. An investigation into specific countries will reveal what has been achieved through the implementation of PRSPs.

Case studies

Tanzania

When Tanzania applied SAPs during the 1980s and 1990s, the economy grew and yet poverty increased. This was primarily because of a heavy fall in public healthcare funding (Turshen, 1999, p. 11). With the introduction of the SAP, government spending on health fell from 7.5 per cent of expenditure in 1978 to 3.9 per cent in 1989 (Kapoka, 2000, p. 11). Under the SAP, non-governmental organisations (NGOs) and the private sector administered the majority of the health services while the public sector was forced to impose user fees to offset its funding cuts. Private clinics gravitated towards major centres where they were most profitable rather than to the poorest areas where they were most needed (Turshen, 1999, p. 11). Compounding this, there was little collaboration between NGOs, civil society and the Bank and Fund on healthcare policy (Buse and Walt, 1997).

Tanzania continues to work with the IMF but it is now focused on restoring the health system that was neglected under SAPs. Evidence of this shift in priority is the increase in health spending as a percentage of government expenditure from 7.5 per cent to 8.3 per cent during the period 2000 to

2003 (The United Republic of Tanzania, 2003). Nonetheless, healthcare funding in Tanzania remains inadequate to fight priorities such as tuberculosis (TB), malaria and AIDS. World Health Organization (WHO) figures show that only 46 per cent of healthcare expenditure is publicly funded. Tracking of program spending is poor, making it very difficult to assess whether and where the funds are being deployed. The commitment to better service women, children and the rural community are outlined in the PRSP (2003, p. 55), but the use of user fees effectively negate this commitment. For example, only 36 per cent of women who give birth in Tanzania are attended by trained health personnel and only 38 per cent of children under five years of age receive adequate water and nourishment when experiencing health problems (World Bank, 2004a, p. 32).

Uganda

Uganda is a good example of a country owning its poverty reduction process, having implemented its own Poverty Eradication Action Plan (PEAP) in 1997, prior to its PRSP. However, poverty levels remain high with only 55 per cent of the population above the poverty line. Within the health sector, there are only five physicians per 10,000 people and only 38 per cent of births are attended by skilled personnel (World Bank, 2004, p. 321).

A primary cause of this problem is that the health sector was ignored under Uganda's SAPs. In 1997, only 20 per cent of healthcare expenditure was funded by the government, with donors, households and employees contributing the rest (The Republic of Uganda Ministry of Health, 2000, p. 9). User fees were implemented in the 1990s to supplement public sector funding and contributed significantly to the fragmentation of the health sector as a whole. The government reduced its role in healthcare to focus on HIV/AIDS and immunisation services rather than primary healthcare distribution (Turshen, 1999). As the government pulled out from primary healthcare, NGOs stepped in but in a disjointed and inefficient manner.

Overall, the health of Uganda's citizens has decreased. Life expectancy fell from 46.8 years in 1980 to 46.2 years in 2005. Additionally, the level of immunisation of children in the last five years has decreased from 47 per cent to 37 per cent (CIA, 2007). Budgetary expenditure on healthcare in 2003 was 9.6 per cent with projections of attaining 15.9 per cent by 2013–2014 (The Republic of Uganda Ministry of Finance, 2003, p. 24). However, while these figures appear to offer real promise, the Ugandan Government estimated health expenditures to be roughly US$28 per capita in 2003 (The Republic of Uganda Ministry of Finance, 2003, p. 24), yet a subsequent WHO study found the true figure to be US$6 per capita (WHO, 2005, p. 7). In 2001, Uganda became one of the first countries to dump user fees under its PRSP, for the purpose of promoting access for the poor. However, without a concomitant increase in funding, this measure merely served to decrease the quality of services and the availability of drugs and

increase the out-of-pocket expenses incurred by patients (Xu, Ke *et al.*, 2005).

Ghana

Ghana implemented structural adjustment in 1984. Ghana's gross domestic product (GDP) per capita was lower in 1998 than in 1975. Seventy-five per cent of Ghanaians currently have no access to health services and 68 per cent have inadequate sanitation (Xu, Ke *et al.*, 2005, p. 16). Average healthcare expenditure from 1995 to 2000 was a mere 4.2 per cent of GDP, with 2.2 per cent funded publicly, and the balance funded privately (World Bank, 2004b, p. 320). Surprisingly, given this funding context, the Bank has reported improvements in lead healthcare indicators. For instance, the U5MR decreased from 185 per 1,000 in 1980, to 160 in 1990, 145 in 2000, and 138 in 2005 (Bos, 2006, p. 12). Additionally, infant mortality has decreased for the last three decades from 96 per 1,000 in 1980, to 77 in 1990 and 63 in 2000. Immunisation rates (per 1,000) have increased from the low 60s to the low 80s between 1991 and 2001.

In 1985, like many other Sub-Saharan African countries, Ghana introduced user fees for its healthcare system. This added expense coupled with falling wages and rising poverty reduced out-patient attendance at hospitals by a third, with the majority of the decrease occurring in rural areas. As one observer put it, 'Patients pay for everything – for surgery, drugs, blood, scalpels, even the cotton wool'. Full cost recovery priced the poor out of healthcare (Ismi, 2004, p. 16). Nonetheless, Ghana appears to have done exceptionally well with very limited resources.

Do PRSPs represent progress?

As the data table and discussion above indicate, if PRSPs are delivering better healthcare outcomes in Sub-Saharan Africa then the improvements are not clear or substantial. Furthermore, there is little evidence that nations are more empowered in policy decision making under PRSPs than their predecessors. If programs were truly national creatures, tailored to each individual nations' needs, one would expect some PRSPs to exhibit strategies that differ from the standard policy prescriptions of the past. But this is not the case – the PRSPs of virtually all countries are strikingly similar. The macroeconomic policies under PRSPs have essentially been a continuation of the policies under SAPs (Gottschalk, 2004, p. 3) and PRSPs do not contemplate alternative approaches to poverty reduction such as resource redistribution (Steward and Wang, 2003, p. 19).

PRSPs tend to be insufficiently integrated with national planning mechanisms such as the budget and there tends to be too little coordination between different levels of government (Sanchez and Cash, 2003, pp. 10–11). A PRSP, no matter who contributes to its conception, is unlikely to be effectively implemented in the absence of such strong linkages.

A further hindrance for PRSPs is the unpredictability of aid transfers upon which the programs may rely. Currently, there are no sanctions on donors who default or delay payment (Sanchez and Cash, 2003, pp. 10–11), and donors are notoriously unreliable in fulfilling their undertakings.

Likewise, if PRSPs were the result of genuine consultation, recipient nations would not be so quick to evade them when they can. For instance, in December 2005 both Brazil and Argentina settled their IMF debts ahead of schedule to avoid adherence to the conditions contained in their respective PRSPs. South Africa, having witnessed the African experience thus far, has refused to borrow from the IMF (Kovach, 2006, p. 1). Indonesia, a few years ago, repaid its IMF loans so as to be able to reclaim control of its domestic policy settings.

The nations that accept the PRSPs are the low-income ones that really have no choice (Steward and Wang, 2003, p. 19). Middle-income countries, as the above examples indicate, are showing an increasing willingness to reject the IMF, and its funding, so as to have control over their own policies (Alexander, 2004, p. 5). In short, the names have changed but the game appears to have stayed the same (Woodroffe and Ellis-Jones, 2000, pp. 2–3).

We commenced researching this chapter in January 2007. Since this juncture there have been at least two significant 2007–08 publications – each of which, happily, serve to reinforce our analysis and conclusions.

The IMF has its own internal evaluation division, the Independent Evaluation Office, and in March it released an Evaluation Report, 'The IMF and Aid to Sub-Saharan Africa' (IEO of IMF, 2007). The Report concluded that there were differences of views among the Executive Board of the Fund about the IMF's role and policies in poor countries, and that

> lacking clarity on what they should do on the mobilization of aid, … and the application of poverty and social impact analysis, IMF staff tended to focus on macroeconomic stability, in line with the institution's core mandate and their deeply ingrained professional culture (IEO of IMF, 2007, p. vii).

In other words, some seven years after the replacement of SAPs with PRSPs, and some seven years after the establishment of the Poverty Reduction and Growth Facility, IMF staff were unclear on the priority to be given to poverty reduction and how to achieve it, and so reverted to that which they knew how to attain, macroeconomic stability. In the first year or two of the introduction of new priorities and programs this would be understandable though still regrettable. After seven years this is simply ridiculous. For an institution that is the subject of unremitting criticism for the impact of its programs and policies on poverty, and which has been maintaining steadfastly in all its press releases and public pronouncements since 2000 that poverty reduction is its highest priority, to still be trying to bed down new

initiatives and priorities on poverty reduction over seven years after their introduction is utterly unacceptable. In most corporate or government settings, one would expect such non-performance to result in the sacking of senior staff.

The Report also found that the Fund's policies have accommodated increased aid 'in countries whose recent policies have led to high stocks of reserves and low inflation', but 'in other countries additional aid was programmed to be saved to increase reserves or to retire domestic debt' (IEO of IMF, 2007, p. 32). In other words, extra aid was channelled by the Fund into foreign exchange reserves or to repay debt in most poor countries. This is a perfect illustration of the damage that overly restrictive policy settings on inflation rates can do in developing countries. Such an approach has two flaws: It diverts extra aid away from healthcare, education or other social welfare expenditures, and, second, it risks being a 'self-fulfilling prophecy' as diverting aid flows into reserves and debt reduction is likely to dissuade donors from giving more aid. Most donors want to give aid to directly assist suffering people, not to improve the macroeconomic profile of the nation in which they live.

The second major report published this year was by the Center for Global Development, entitled rather conclusively for our purposes here, '*Does the IMF Constrain Health Spending in Poor Countries?*' (Working Group on IMF Programs and Health Spending, 2007). It states:

> The evidence suggests that IMF-supported fiscal programs have often been too conservative or risk-averse. In particular, the IMF has not done enough to explore more expansionary, but still feasible, options for higher public spending (Working Group on IMF Programs and Health Spending, 2007, p. x).

The report also concluded that wage-bill ceilings had been overused and should be dropped from IMF programs, 'except in cases where a loss of budgetary control over payrolls threatens macroeconomic stability' (Working Group on IMF Programs and Health Spending, 2007, p. xvi). The Fund should not shoulder the blame for these misguided policies alone. After all, it is governed by an Executive Council on which the balance of power is held by the developed nations (Unger, 2006, p. 9).

Conclusion

The neoliberal policies that underpin PRSPs and focus on a smaller role for government in healthcare need to be rethought. Investing in the health of its people is essential for the growth of a nation. The realisable benefits to a nation of providing healthcare, especially to the poor, far outweigh the costs. The IMF tends to produce over-optimistic growth projections that

inflate expectations of budget revenues, and when governments lack sufficient financing for PRSP priorities, donors and creditors decide the country's priorities for them (Alexander, 2004, p. 6). Quite simply, country ownership of the PRSP process is a mirage.

Viewed as a whole, there is no shortage of GHG but our concern should be over its form. As illustrated through the case studies, there has been a very limited increase in healthcare expenditure since 2000, which suggests health has not been a primary concern of the Fund. The health of the world's poorest and most vulnerable continues to be unprotected by effective policies and healthcare services. Statistical analysis of healthcare outcomes suggests very little has changed, at least for the poor in Sub-Saharan Africa, since 2000 (Poirier, 2006).

Reform is needed at two levels. At the most fundamental level, the IMF needs to be reconceptualised. Its original purpose largely disappeared in the 1970s with the floating of most rich countries' exchange rates. Since then it has taken on the role of developing country crisis prevention and management, yet if one had been designing an institution for that role, it would not look at all like the IMF. Its staff would have different skill sets and backgrounds and the institution would have different (and more extensive) powers. The culture within the Fund, particularly its economic perspective, is simply wrong for this role, as its results consistently display.

In the past 12 years there has been considerable reform of the World Bank, fundamental change we are yet to see any evidence of in the Fund. Probably the simplest and most efficacious step is to merge the much-smaller Fund into the Bank and then proceed apace with the renewal of the World Bank – there is little need, any longer, for a separate international monetary fund. (There is nothing new or novel about this proposition: Shultz, 1998, p. 14; Burnham, 1999, p. 101).

At the operational level, rich countries should continue to increase financial support for initiatives with proven track records, such as the Global Health Fund, and should continue to insist that aid money be spent on the lowest cost pharmaceuticals. Another important measure would be to support public health research initiatives which focus on the diseases and needs of the poor – a field almost completely ignored by the major pharmaceutical companies (Sreenivasan and Grinspun, 2002, p. 13).

However, and overarching, the problem is the lens through which the IMF views economics and development. For as long as an unreconstructed IMF is seeking to control healthcare initiatives in poor countries or is implementing regulations such as wage-bill caps on publicly funded employment that are aimed at macroeconomic stability but impact on healthcare, the poor in those countries will probably endure unacceptable healthcare outcomes. If we are to retain the IMF as a separate institution, its worldview needs to be transformed – a task so massive one may doubt

its achievability, but one that must be undertaken if we are to retain the organisation.

The IMF, as it functions today, is a fundamentalist organisation. It is committed to market fundamentalism as that term is defined by Sparke in this volume. Market fundamentalism is a little like privatisation – arguably sensible in a context of a well-governed, efficient economy with strong institutions, such as the rule of law and courts, and a strong independent media, but often a nonsense outside this institutional framework. Privatisation, in a weak institutional context, will result in the sale of state-owned assets at a vast undervalue to those with political connections and resources as was seen in Russia in the 1990s. Likewise, leaving the provision of healthcare to the market is arguably sensible in a well-governed, affluent country with the capacity to monitor and regulate healthcare provision, but will further impoverish the poor in an already poor country without those capacities.

If we are to retain the IMF the challenge is for this institution to replace the lens through which it views the world and its own role in it. In the field of development and health, the IMF's present perspective is disastrous.

Notes

1 Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.
2 The full text of the Purposes of the IMF can be found in *Article I, Articles of Agreement of the International Monetary Fund*, available from http://www.imf.org/external/pubs/ft/aa/aa01.htm.

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10
The World Bank and Health

Sophie Harman

Introduction

The World Bank has played a central role in the health of individuals since the late 1960s; as such it is now the largest financier of health in low–middle-income countries and provides leadership and direction to global health policy. The Bank has helped to both reduce and expand government health spending through its own model of good debt governance, provided leadership within global health governance, and developed models of privatised healthcare throughout developing countries, specifically within Sub-Saharan Africa. Despite trends towards becoming the environmental Bank, the Bank will adapt to maintain its pertinence and relevance to the practice of global public health. This chapter builds upon what we know about the World Bank's role in global health, how it has led to shifts in public health policy in developing countries, and how its activities can be situated within the wider framework of liberal policy coalescence. Moreover, the purpose of the chapter is to earmark emerging trends towards new models of community-driven development and social protection as a means of exporting and embedding its own brand of market logic. As such, the chapter seeks to bring the political economy back in to our understanding of the role of the Bank within public health by drawing out main issues in regard to two specific health areas – one of 'the big three' health topics, HIV/AIDS, and a 'neglected disease' onchocerciasis (river blindness) – and how it is using this role to produce wider shifts within the state, market and civil society.

The chapter pursues its aims in the following manner. First, it puts the World Bank's role in global health into context by exploring what we know from existing research within public health and international politics. Second, the chapter unravels emerging trends within the Bank's approach to global health and new forms of financing. This section considers the role of the state, community-driven development and sector-wide interventions in global health in general and how these approaches have been put into

practice in the cases HIV/AIDS and onchocerciasis. Third, the chapter outlines the consequences the Bank's role in global health has upon the state, community, and global agenda-setting; and how these consequences and the Bank's influence can be understood in relation to the Bank's good governance and soft politics agenda. Fourth, the chapter offers some conclusions as to what this means for understanding the role of the World Bank within global health governance, and the political economy of health.

The World Bank and health in context

The World Bank's role within global health came onto the international agenda during the 1980s. The Bank had begun involving itself with healthcare policies through family planning programs in developing countries in the late 1960s under the Presidency of Robert McNamara (1968–1981). The Bank's role in health policy has subsequently grown exponentially since the inception of the Population Project Department in 1969 (Buse, 1994, p. 96). However, it was not until the 1980s that the Bank became directly linked with healthcare through its co-financing of health sector programs, and indirectly through the socio-economic impact of structural adjustment, and neoliberal reform in partnership with the International Monetary Fund (IMF). The relationship between decline in health provision, structural adjustment and debt has occupied the majority of understanding of the Bank in global health. Structural adjustment policies (SAPs) are a form of conditional-based lending, in which states receiving funds from the Bank for a particular project or a loan from the IMF have to adhere to specific policy recommendations towards privatisation of state services. Key to which is the reduction of state intervention, the rule of the market economism,[1] and conditionality (Buse, 1994, p. 98). These policies led to the reduction of healthcare provision through a decline in hospital expenditure and staffing, the introduction of service user fees to be paid by the individual, and responsibility shifting away from the state to the individual (Ugalde and Jackson, 1995, p. 537). These policies shifted policy-makers away from the concerns of the community and placed the onus upon households to address health problems (Loewenson, 1995, pp. 55–56). The impact of these policies was most acutely felt within developing countries.

Privatisation of healthcare services and the subsequent onus placed on the individual facilitated a rise in community and non-state provision of healthcare services (Lee and Goodman, 2002, pp. 97–98; Owoh, 1996, p. 216) that was encouraged and in parts, financed, by the Bank. Community provision of healthcare services can be traced back to the emphasis placed upon community involvement in primary healthcare within the 1978 Alma Ata Declaration (Rifkin, 1986, p. 240). The logic is that community involvement increases the amount of funds that reach the poor due to greater geographical coverage and wider uptake, as well as being less

expensive to users (Gilson and Mills, 1995, p. 219). This has led to a shift in focus towards community empowerment rather than changes in the prevalence of particular diseases (Laverack and Labonté, 2000, p. 256). Community empowerment within health policies exists in relation to specific groups that is health promoters, home-based carers etc with emphasis upon strong community attachments and local knowledge (Labonté and Laverack, 2001, p. 115). Institutions such as the Bank see communities as one cohesive whole in which blueprint projects of community-driven development can be applied to. These empowerment policies, however, become problematic when communities are seen as static entities rather than ever-changing social structures (Labonté and Laverack, 2001, p. 137).

Perhaps the clearest outline of the Bank's approach to global health during this time was its 1993 World Development Report *Investing in Health* (WDR, 1993). WDR 1993 was interpreted as a means of embedding the Bank's market-driven approach to welfare (Owoh, 1996, p. 216). It articulated the need for privatised healthcare, widespread use of user fees, minimal state interference and the role of the market (WDR, 1993). Using health as the focus of the Bank's flagship publication makes a clear statement of both the Bank's role at the centre of global health, and its commitment to privatised forms of healthcare in developing countries.

The decline of health provision through state welfare, the introduction of new forms of co-financing and user fees by the Bank allowed it to make claims to knowledge and expertise in health reform (Buse and Gwin, 1998, p. 666), and consolidate its role as a central actor within global health (Lee and Goodman, 2002). Combined with the decline of the World Health Organization (WHO) as a result of internal wrangling and confusion as to its mandate, the Bank was able to enlarge the space for decision-making and influence within global health policy-making through its 'unrivalled financial resources' and the 'top-down nature' of health policy reform at the time (Lee and Goodman, 2002, pp. 109–110). The Bank used its apparent 'non-political' specialised status and lending expertise within the wider body of the United Nations (UN) to assume this position as opposed to its main rival body, United Nations Development Program (UNDP) (Buse, 1994, p. 98; Ugalde and Jackson, 1995, p. 530).

External criticisms of structural adjustment, and internal Bank reviews as to the effectiveness of its health policies has led to a slight adjustment to the economic liberal values underpinning its health interventions during the late 1980s and early 1990s. Simply put, health services had not improved, and in some countries were on the decline. The Bank's explanation for this was that it had not taken account of the systemic conditions or infrastructure needed for improvement. This recognition combined with wider reform packages occurring within the Bank during the late 1990s[2] led to a re-focus of the institution's global health policies towards systemic reform as to the role of the state and privatised provision, targeted interventions,

and most notably a 'sector-wide' approach (Buse and Gwin, 1998, p. 666). This sector-wide approach refers to the need to involve all aspects of the public and private sectors and the individual in the provision of healthcare. Central to this change in the direction of the Bank was the Director of Health, Nutrition and Population, Richard Feachem (1995–1999), who according to series of articles by Kamran Abbasi in the *British Medical Journal*, directed attention away from user fees and structural adjustment and towards issues of sustainability and working relations with other international actors such as the WHO (Abbasi, 1999a, 1999b).

Existing knowledge of the Bank's role in global health suggests several issues that remain pertinent to our understanding of the institution's role within global health. The first is the introduction of market oriented practice in promoting efficiency within healthcare systems. The second is the shifting role of the state to make way for privatised provision, and the introduction of non-state actors as the main service providers within healthcare. Third, the emphasis the Bank places on 'sector wide' approaches, and the apportion of blame onto the state not the Bank or its policies, is a reason for relationship failure between states and the Bank. However, these issues are often understood in isolation of the Bank's wider project and the activities of other Bretton Woods institutions in global health or how the Bank has developed these policies over the last ten years. Approaches to the Bank and health have thus far been developed by public health specialists, with those studying structures of global political economy and global governance remaining curiously silent on the issue.[3] To understand the World Bank and global health, is to use the basis of what we know about the Bank and health as a basis for understanding current trends in Bank health policy from a political-economy governance perspective that focuses upon its relationship with health interventions, the state and non-state actors, and how this relationship fits in with the wider embodiment of the Bretton Woods institutions in general. The following section will do so by mapping recent developments in the Bank's health policy by drawing upon main themes of multi-sectoralism and social protection and how these have been operationalised through the Bank's programs on HIV/AIDS and onchocerciasis.

Social protection and new forms of health financing

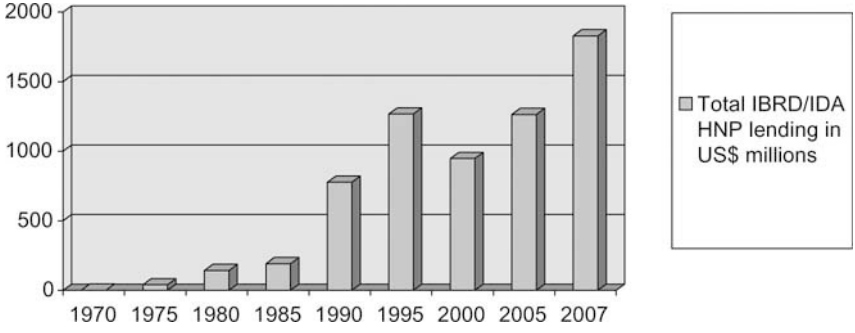
Since 1997 and the introduction of the Comprehensive Development Framework/Poverty Reduction Strategy Paper (PRSP) approach to lending the World Bank has attempted to distance itself from the negative connotations of structural adjustment for health. It has done so by promoting a 'good governance' agenda that facilitates partnership and dialogue between the Bank and its partner state and non-state actors. The aim is to promote participation, accountability, and transparency within borrower states as key mechanisms of good governance. As such, the Bank presents the image

of moving away from the 'top-down' 'hard' politics that have come to characterise the work of the WTO and IMF by promoting a holistic 'bottom up' approach to development. This approach has acutely been felt within healthcare where the Bank has developed its commitment to forms of community engagement, health system reform and sector-wide planning. The Bank's approach to health as a global public good situated within it holistic approach to development is only one explanation as to why it engages with health policy. An alternative explanation would be the role of health in maintaining the Bank's position as a leader in development knowledge and expertise. In positioning itself at the heart of global health policy, the Bank presents alternative approaches to public health that break from the norm of public health interventions. These alternatives fulfil the international community's desire for new, innovative solutions to global health, whilst consolidating the Bank's position at the centre of development knowledge and expertise, and thus its wider relevance to global politics. At the centre of these approaches is the Bank's commitment to liberal economism. The economism approach to global health not only offers alternatives to more traditional forms of public health – in this instance public systems of provision of welfare – but offers a further explanation as to why the Bank involves itself within health policy. The purpose of health policy within the Bank's liberal economism is threefold: i) the global economy requires healthy reproducers, producers and consumers to function and expand effectively; ii) emerging markets are located in countries where poor healthcare may discourage financial investment, lack of investment in key parts of the world will stunt the expansion, completion, and thus logic of the world market; and iii) state-led interventions within global health have failed, and market oriented approaches not only present more effective, affordable healthcare in the long term through competition but implemented sector-wide have the ability to embed this logic at every level of health governance. Developments in these areas reveal not only about the Bank's role within global health, but the current nature and status of global health policy making.

The Bank has developed and expanded its role in global health through: i) increased and new forms of financing; and ii) flagship projects. According to data from the Bank's Health Nutrition and Population sector; total health financing peaked at US$2.4 billion in 1996, and maintained a median average of US$1.4 billion between 1997–2007 (World Bank, 2007). Such data suggests a plateau within the Bank's lending to health over the last decade. What is clear is the steep linear curve within the Bank's health lending from 1970 onwards, as demonstrated in Figure 10.1.

Pertinent to understanding the role of the Bank within global health is not the quantity of finance, but the type of financing and how it develops models of best practice. Over the last ten years the Bank has developed these models through its 'soft' approach to conditional lending as part of

Figure 10.1 Total IBRD/IDA Health, Nutrition and Population Lending in US$ million



Source: World Bank, 2007.

its wider good governance strategy. This gives priority to government 'ownership', community 'participation', a 'sector-wide' approach to health, and new forms of lending. In health terms, this has translated into the following types of programs and directives.

The first shift in approach has been the Bank's relationship with borrower states and a focus away from purely health aspects of government. The Bank's holistic, sector-wide approach to global health has seen a prioritisation of multiple aspects of government systems within developing countries, grouped together under an umbrella coordinating agency located at the centre of government, nominally the Office of the President/Prime Minister. The logic being that many health issues are influenced and influence themselves by a number of development concerns such as education, agriculture, gender; and thus cannot be addressed purely as linear health topics. What we thus see is a trend towards taking health out of the health sector. The Bank's focus has been to continue to help strengthen health systems and maintain emphasis upon privatisation as a form of efficiency and cost-effectiveness, but in terms of planning and vertical health interventions the process is to establish new government institutions that invoke the participation of all sectors of the state. The most acute form of this can be seen in the Bank's HIV/AIDS programs in sub-Saharan Africa, wherein the Multi-Country AIDS Programme has seen the establishment of National AIDS Councils (NACs) in over 30 of the countries that receive the Multi-Country AIDS Program (MAP) funds. These agencies were established within the project, by the Bank, to coordinate the national response to HIV/AIDS across the government at the national and district level, as well as financing and monitoring the activity of local and international non-state actors. Key to which was the emphasis placed on the NACs owning their own mandate, strategic AIDS plans, and MAP programs,

despite the Bank articulating and designing these functions as a condition of lending for this sector. The NACs provide the most explicit example of a shift away from Ministries of Health as the most natural partner for global health interventions by the Bank; however the Bank's involvement with onchocerciasis suggests a more latent expression of this trend. The Onchocerciasis Control Programme (OCP), and its successor, the African Programme for Onchocerciasis Control (APOC) both emphasised the need for regional cooperation between states, and the development of sector-wide interventions to expand its mandate from the health sector to include agriculture (World Bank, 2008b). Whilst this did not show a major shift in the Bank's approach to state partnership it highlights how the Bank began to develop non-health ministry specific interventions with states. What this does reflect is the role of the Bank in breaking with wider strategies in global public health. Sector-wide approaches and regional cooperation have been a central part of global health governance; however activities within the state have been firmly located within the health sector. Organisations such as the WHO have traditionally prioritised health sector strengthening and relations with the Ministry of Health as the central focus of state strategies in global health. The difference in approaches between the two is evident from the institutional rivalries between these new non-health health agencies and Ministries of Health, specifically within HIV/AIDS governance. The Bank's approach further reflects the shift away from traditional discourses of 'public' health, to new forms of state intervention that include multiple non-state actors, as evident from the rise in community and private sector inclusion.

The second shift in the Bank's approach to global health has been community provision. As a wealth of research into global public health interventions would suggest, community participation and inclusion in delivery of health services is not a new phenomenon.[4] However, the Bank has developed processes of community inclusion through new forms of community financing. The first is through more money. As part of its community-driven development approach, the Bank has directed unprecedented funds to non-state actors, specifically grassroots community groups. It has done so through the formation of local state structures designed to identify, fund and monitor community activity, and through making funds available to loose-knit organisations without any stringent conditions or guidelines. The purpose of which was to support those individuals who had bear the brunt of health provision by giving them funds to support their activities and grow into more organised forms of collective action. The overall aim of the funding would be for communities to hold government activity to account, and promote forms of good governance – accountability, transparency and participation in decision-making.

Emphasis upon community-driven health responses can be seen within the Bank's HIV/AIDS programs with community actions funds/initiatives

being an integral part of MAP funding. Here money was directed through the National and District AIDS Councils direct to various types of community groups, be it a grandmother providing food for six of her grandchildren, or a local group of teenagers educating their peers on methods of HIV/AIDS prevention. The crucial distinction being that health money was not necessarily going to clear health activities. Part of this can be attributed towards AIDS Exceptionalism as a non-health disease. However, analysed against the ACOP program, a similar pattern arises. A key part of ACOP was community distributed treatment (ComDT) wherein communities would establish distribution networks alongside local health centres (World Bank, 2008d). These networks followed a similar rationale of being able to monitor and assist with treatment, to make sure the drugs prescribed were reaching the right people and being administered correctly, as well as being able to reach wide rural and geographical locations. What is crucial about the Bank's involvement is the scale to which it elicited community participation. Whilst other international non-governmental organisations (INGOs) and donor agencies have been promoting this form of intervention within healthcare for some time, the scale of the Bank's program and its relationship with borrower countries enabled it to establish this type of health intervention as best practice. Moreover, the Bank has brought community groups in line with state-run systems, got them to collaborate and engage with national and global systems through participation in strategic planning, and build both states' and the Bank's claims to local expertise and knowledge.

The World Bank has come to develop this approach to community financing and forms of community-driven development under the umbrella of 'social protection'. Social protection by the Bank aims to target the needs of specific groups within healthcare. Specifically this has come to mean women, gender and families. This approach has generated a shift in discourse within health elements of the Bank towards conditional cash transfers that direct funds straight to families as a form of comprehensive intervention for orphans and vulnerable children (OVCs). As such the Bank is becoming more targeted in its community interventions, and is showing clear recognition of the individual, and in particular, women in healthcare provision. The role of women here is of particular relevance. As previously outlined, part of the role of healthcare within the Bank's wider economism agenda is the health of reproducers, producers, and consumers within the global economy. Women form a specific function within this as they are not only integral to reproduction, but provide the care, support and upbringing of consumers and producers within the global economy. Social protection funds not only address the core of health provision and ensure healthy workers and consumers, but expand the market by bringing women into its logic through lending, competition and efficiency. Social protection thus reflects the workings of the Bank's liberal economism logic at the most personal level of international intervention: the family and the individual.

The third change in the Bank's global health strategy has been the emphasis placed on sector-wide approaches to health. Sector-wide approaches have been used inter-changeably with multi-sectoral inter-sectoral by the Bank to mean the involvement of multiple actors within responses to global health. This approach is evident in the Bank's emphasis upon the involvement of the non-health sector within the national governance of health issues and with the level of community involvement within these initiatives. The inclusion of community groups alone points to a shift away from not only state centric provision that arose out of lack of public welfare during the 1980s, but the incorporation of these community groups within decision-making. A key aspect to multi-sectoral inclusion has been the emphasis the Bank places on sector-wide approaches, or SWAps that facilitate joint procurement structures, planning exercises, health packages and performance reviews. The purpose being to enhance cross-sector collaboration and address the underpinning socio-economic drivers of particular health illnesses.

Beyond changes within the state apparatus of health provision and community inclusion, sector-wide approaches refer to the inclusion of the private sector, multiple international agencies, and regional organisation. The Bank has promoted these types of health sector directives in the following ways. The first is by developing models for business inclusion within wider privatisation packages of healthcare, and working with the private health sector, most notably pharmaceutical industries, to provide treatment at lower rates and medical equipment to developing countries. As part of World Development Report 2005 *A Better Investment Climate for Everyone* the Bank is further tying health to promoting the investment climate for developing countries, both for external international companies, and by promoting the infrastructure for local investment and the development of business initiatives. Key to which has been the apportion of in-country forms of corporate social responsibility, such as providing incentives for free voluntary counselling and testing for HIV and other Sexually Transmitted Infections (STIs) at the workplace. In the case of onchocerciasis, the Bank's inter-sectoral collaboration with other health donor agencies, INGOs, and most notably Merck and Co. ensured that Ivermectin, to treat onchocerciasis, was provided free of charge for as long as it was needed (World Bank, 2008c). The increase in drug availability and financing for the disease coordinated by the Bank reached 65 million people by 2007 (World Bank, 2008a).

The most notable form of sector-wide approaches relates to the coordination of international efforts around specific health issues. The multiplicity of actors involved in public health often leads to over-crowding of finance, multiple funding structures and systems, projects and people in specific vogue-health issues, burdens on national health systems and government agencies, an imbalance in health financing, confusion, frustration and competition over knowledge, expertise and finances between actors. This has

been particularly acute within HIV/AIDS where the amount of international aid being earmarked for the epidemic in Sub-Saharan Africa has grown to US$10 billion per annum. This funding has been accompanied by a growth in international actors, objectives and policies. The ensuing problems and confusion arising from this growth has resulted in an international concerted effort to coordinate resources and policies at every level of the response. Coordination occurs through general adherence to Joint United Nations Programme on HIV/AIDS (UNAIDS)' 'The Three Ones' principles (UNAIDS, 2008).

The Bank's approach to global health over the last ten years presents a change towards a more 'soft politics' form of intervention. The above examples of state ownership, community participation, and multi-sectoral collaboration present the image of a collaborative Bank that whilst maintaining a level of conditionality is much more friendly-faced than the IMF and its structural adjustment reform. The Bank's economism, conditional-lending, liberal emphasis remain; but whereas these issues were presented as problems in the past, the 'good governance' incarnation of liberalism is presented by the Bank as more adaptable to the needs of states in their ability to respond to global health concerns. However, closer interrogation of these shifts in Bank policy from a political economy perspective suggests these interventions transcend problems of business-as-usual Bank economism and global health, but are leading to shifts within the state and market that has become embedded at every level of health governance. It is these long term underlying factors that reveal the most about the Bank's role in global health, and the future ability of global health governance to fully address these concerns.

Making sense of the Bank and health: the consequences of reform

Trends and developments in the World Bank's global health strategies mark a process of embodiment of the Bretton Woods' liberal reform packages. The function of health policy as integral to the functioning of the global market that underpins the Bank's intervention into public health derives from the liberal consensus at the heart of the Bretton Woods institutions. It is no longer relevant to assess whether the new forms of Bank reform in healthcare is structural adjustment by a different name, this is of little consequence for our understanding of the Bank or its policies; what is relevant is what impact developments within the Bank's health strategies are having upon the political economy of global health. This can be seen in regards to the impact they have upon the state, the market, the community, and the governance of global health. This section will address each of these areas and how it fits in with the wider work of the Bank's partner organisations – the IMF and the WTO.

The Bank's emphasis upon state ownership of health sector reform and sector-wide approaches has several consequences for the state. The first is that the state is not necessarily in decline, its role and position within global health is just shifting. Whereas the state was under decline with the introduction of privatised forms of healthcare during the structural adjustment era of the 1980s, the emphasis of state ownership by the Bank has brought the state back in as a leader in healthcare. What have changed are those state structures which occupy this leadership position. Through vertical lending to specific projects the Bank has prioritised the role of non-health aspects of the state apparatus. Health has become bounded within wider programs on poverty and development, and has thus been integrated throughout different agencies within government under the aegis of a sector-wide or multi-sectoral approach. This has had several consequences. First, it has shifted focus away from the medical aspect of global health towards its socio-economic underpinning. Second, it has created tension between the health sector and these new government agencies. Third, it has fudged the line of who is responsible for the welfare of a country's population. In 'owning' specific health programs, this responsibility lies with the government; however in funding and directing specific programs there is a high degree of responsibility on the Bank itself. This results in a hollow form of health ownership which establishes long term antecedents of future state management of the healthcare of its people. Fourth, distinctions between the state and civil society become obsolete. The removal of global health from health and medicine has marked a shift from the public health approach taken by institutions such as the WHO to the liberal economic approach towards privatised health as a development model by the Bank.

The inclusion of community participation within global health has been led by the Bank. As the examples of HIV/AIDS and onchocerciasis indicate, the emphasis upon community-driven development as a condition of lending has placed emphasis on states to include non-state actors within decision-making and earmark a substantial proportion of their health budgets to fund their activities. This emphasis takes no account of the history or culture of relations between the state and non-state actors in a particular state. As this chapter earlier suggested, non-state actors have been involved in the provision of healthcare for quite some time, and their presence became acute in response to the withdrawal of the state under structural adjustment. However, this involvement was predominantly local communities looking after their sick friends and family unpaid, or INGOs providing services and finance to community operations. The World Bank was the first to direct funds straight to the community through state structures and involve local communities within spheres of influence and decision-making in government. The types of community-driven development or engagement mechanisms used by the Bank suggest specific consequences for non-state activity within health provision and reform. The

first is that communities have come to occupy the position of privileged relations between the state and international organisations that INGOs once occupied. Second, the role and presence of civil society actors within healthcare does not reflect an emancipatory advocacy movement that has arisen out of discontent or the need for change, but is underpinned by the same movement towards privatised activity that led to the emergence of these actors in the first place. Civil society activity within global health is constructed by money and financial flows to community groups. As such, the Bank has brought community members into the liberal market logic of provision and health welfare where community groups have to compete for resources, seek private partnerships, and supplant the role of the state in providing welfare for key demographics. Accountability and transparency – two of the central pillars of the Bank's good governance agenda – exist in such a way as to maintain the status quo of the Bank's program for global health. Civil society groups and the state must be accountable, but the World Bank does not have to be as it does not own the project. However, the ability for civil society groups to hold the state or the Bank accountable are frustrated by the need for resources to keep their activities, and provision for the sick sustained. This leads to a second consequence of the widespread absorption of the Bank's approach to community-driven development: the role of civil society or the community as somewhat separate from the state. Both in the examples of onchocerciasis and HIV/AIDS the Bank and the state has been keen to note the separation between state and civil society as a key tool of accountability within health systems. However, the nature of funding practices by international organisations through the state, and the inclusion of civil society organisations (CSOs) within decision-making structures within the state suggest a Gramscian view of civil society being intrinsic to the formation of state-structures within the global health terrain.

The third and perhaps neglected consequence of the Bank's approach to community engagement is the impact upon women and gender. Women play a central part in the provision of healthcare services and the link between economism and healthcare through social protection. Within developing countries, women form the majority of home-based carers, take care of sick relatives, and girls are more likely to drop out of primary education to care for the sick, manage family households than boys. Social protection loans account for women's function of producing and ensuring a healthy workforce. In placing emphasis upon the role of communities within health, and prioritising funding to community actors, the Bank's interventions have the following consequences for women and their position within the global political economy. The Bank provides remuneration for women's work that has often been assumed as a gender role for women: care. This in some form embeds the role of women, but as funding increases, attracts men to these sort of role as they become paid employment. What we see then is a movement, albeit a slight one, towards male involvement in

female gender roles. Crucially however, this is a role of finance. Whereas the role of women and micro-finance has been well-documented; the role of women as the recipients of community-driven health funds has been neglected. These funds involve women in an intricate form of global finance, as they export the market logic inherent within specific Bank programs. This does not necessarily remove women from traditional boundaries of the 'private sphere' of political activity, but introduces market logic within it. The movement towards conditional cash transfers direct to families from the Bank embeds women's role as facilitators of Bank liberal market logic further. Not only does it bring women in to this type of economy, it confronts specific roles within communities that have deeply embedded gender norms and practices. The Bank is thus not involving itself in the macro politics of states and markets, but is embedding its own brand of health sector reform within communities and families, and in so doing challenging gender roles. Giving women more power through the market is not necessarily a bad thing in the short term, but becomes problematic when it is the very logic that has undermined gender equality for the last 30 years, specifically within global health.

This view has been adopted and promoted by but is not limited to the Bank. The Bank's government ownership, community participation, good governance approach to global health has been adopted not only by states and community groups bound to the conditions of health programs, but international organisations that have come to promote a similar agenda. As the chapter previously indicated the Bank has supplanted much of the role of the WHO as the lead agency in health provision, and came to the fore at the expense of UNDP during the 1990s. The Bank has consolidated this position by more strategic vertical forms of health financing, its close working relationship with governments – specifically within Sub-Saharan Africa, and its claims to knowledge and expertise. In presenting itself as both a lender to specific health projects, as well as an organisation that can provide expertise and direction arising from its experience direct from the field, the Bank is able to mark itself out from other rival UN agencies. This has specifically been the case within the HIV/AIDS response, where UNAIDS and its 'The Three Ones' organising structures have adopted and followed the principles of the Bank's approach to the epidemic as enshrined within the MAP (Harman, 2007). However, this trend is not only limited to HIV/AIDS. The Bank has used models developed within HIV/AIDS and onchocerciasis programs to export its specific form of community-health responses to health concerns such as avian flu. What is specific to the Bank's approach, however, is the latent expression of this influence upon the international health system. Health specialists acknowledge the Bank plays a central role in global health yet, in maintaining the role of state ownership and multi-sectoral partnership, the Bank presents the image of taking a backseat role within this, and thus to a certain extent,

remains unaccountable to those it affects. Moreover, where new health institutions and funding such as the Global Fund to fight AIDS, tuberculosis (TB) and malaria have appeared to threaten or challenge the Bank's authority within global health, in most instances these institutions have been designed and implemented within the same liberal framework for global health articulated by the Bank. The role the Bank has in global health is thus that of leadership through soft power.

To make sense of the World Bank's role in global health, one must make sense of how it exerts its power and the origins of its approach. Where the Bank once deployed a clear form of economic conditionality in partnership with the IMF as a form of exerting its influence, the Bank has maintained such conditionalities but exerts them through a form of soft power that gives the appearance of promoting state- and community-led health strategies. This form of soft power is expressed through the Bank taking on the role as benevolent lender. The Bank partners states and helps them strengthen and develop specific health strategies and implements its plan through government agents and community groups. States have not retreated or become eroded within this model of global health, but have internalised and promoted the Bank's interests in such a way that the state health concerns are intrinsically aligned with the Bank's health concerns. Health concerns reach individuals on a global scale, thus to imbue reactions to global health with a logic of liberal economism, the Bank is able to extend its global influence to every aspect of the world, and embed its practices at the state to community level whilst remaining unaccountable to those people its policies affect. Disaggregate structures of monitoring, feedback and design distort the position of the Bank and allow it to promote its own form of good governance with little reciprocity. Where health strategies are failing, responsibility is apportioned to all actors but the Bank, with the solution being: more Bank.

The Bank is further able to extend this influence through the filtering of key actors within global health through the Bank system into other international actors working on global health. For example Richard Feachem, the first Executive Director of the Global Fund (2002–2007) was Director for Health, Nutrition and Population (1995–1999) at a strategic time in the Bank's arrival on the global health stage. Bank-staff are briefed in the art of 'paradigm maintenance' (Wade, 1996) wherein they are employed, promoted and recognised for taking an approach to global health that fits in with the Bank's over-arching commitment to economic liberalism (Broad, 2006). As is often the case within the development field, there is much cross-over between professionals in global health organisations. However, this cross-over does not signal a cross-germination of public health and a liberal economism approach to global health. The policy space is one-way, with liberal economism supplanting 'public' health approaches within these organisations. What is specific about the World Bank's role in health is

how it has exerted its influence and embedded its own paradigm for global health through a combination of individuals, state and community partnership.

The Bank's 'soft politics' role within global health exists in partnership with the more 'hard politics' strategies of the WTO and the IMF. Combined, these hard and soft policy options result in a shrinking of policy space for states, international organisations and non-state actors within global health. Regardless of whether it has shifted in expression, the liberal orthodoxy promoted by the Bretton Woods institutions have been at the root of global health since the late 1970s and has become embedded within every aspect of global health strategy. Actors must align their programs, projects, and strategic plans with this orthodoxy to ensure global recognition, finance, and legitimacy. Global health governance is thus not a contested terrain of political activity but an embodiment of liberal market values. While the WTO and IMF have promoted this brand of global health directly to states, it is the role of the World Bank as the soft arm of power that has embedded this logic at every level of global health governance. The Bank is thus the central institution for understanding the governance and political economy of global health.

Conclusion

Over the last 30 years the Bretton Woods Institutions have come to occupy a central role within global health governance. The most complex, far-reaching, and central actor of these institutions is the World Bank. The Bank has been commonly associated with global health for its role within the promotion of structural adjustment policies and the introduction of the market to public health within developing countries around the world. The subsequent impact this has had upon reduced health systems and provision and the ability of countries' respond to 'the big three' diseases has been the focus of much research. However, despite the negative connotations associated with its health policies, the Bank remains the leader of global health knowledge, programming, and agenda-setting. It continues to be the preferred partner to states whose health systems suffered from its previous recommendations, and establishes the mandate for global responses to high profile issues such as HIV/AIDS in which multiple international organisations that used to occupy this role follow.

The Bank has done this by applying its strategy of comprehensive development, and good governance politics to specific global health interventions. These strategies have promoted the use of government ownership of Bank strategies, community partnerships, and sector-wide approaches that the Bank has been able to develop through a mixture of finance, claims to knowledge, individual staff members and the presentation of its status as a non-political, trustworthy agency. In promoting this strategy the Bank has underpinned the current paradigm of global health policy, and thus

maintained its central leadership role despite the emergence of new forms of actors earmarking unprecedented funds towards health. New actors and new forms of finance have to align themselves with the need for coordination and commitment to single Bank-articulated strategic health plans as states do. Any contradiction of this is seen as an affront on state sovereignty or global collaboration. The Bank no longer needs to use large loans with stringent conditionalities to influence global health as through strategic interventions it has established a global agenda with its commitment to liberal market economism at the centre. The Bank's commitment to the principles of good governance has been applied throughout its development programs. However, what makes health specific is the global interconnectedness of policy and impact, the ability to affect and influence the personal, and its relation to the functions of production and consumption within the global economy.

The application of the Bank's strategy has had several implications for the political economy of global health governance. First, the state still has a role within global health. However, application of the Bank's agenda has removed health from the health sector, either taking a sector-wide approach or situating it within more centralised forms of government and the Ministry of Finance. The role of the state has not diminished, but is at the hub of the Bank's promotion of good governance. Second, the role of non-state actors is permanent within healthcare provision. However these non-state actors are primarily community groups which have become imbued with the market logic of state interventions into healthcare. As such remuneration of healthcare at the community level is bringing women to the centre of the political economy of health. Women have played an intrinsic role within global health, but movements towards new forms of social protection by the Bank sees a new form of macro political economy within healthcare. Third, there is a shrinking of political space for alternative approaches to global health to develop. The approach of the Bank, as reflected in the wider agenda of its Bretton Woods partners, has dominated the agenda and is embedded in such a way it will continue to do so.

Financial crises, the emergence of new actors, and institutional inertia all post a threat to the future role of the World Bank within global health. However, its antecedents are intrinsically embedded within every level of global health policy-making to affect the future of global health for the next 20 years. Global health governance is thus not in a state of flux or change, but is an intrinsic part of the World Bank's model of liberal economic global health intervention.

Notes

1 I am principally concerned with one of the first definitions of economism articulated by Matthew Sparke within this book: economism of market fundamentalism, when I discuss economism in regards to the World Bank and public health.

2 The World Bank underwent several reform processes under the presidency of James Wolfensohn (1995–2005). This reform saw the introduction of the Bank's 'good governance' agenda, and a shift away from structural adjustment towards the Comprehensive Development Framework approach that emphasised the role of governments, civil society, and sector-wide approaches to development projects. This period saw the Bank reach out to its critics and involve itself in multiple development topics. Health, and high-profile issues such as HIV/AIDS was a specific priority during this time.
3 This claim is based on a revision of books and articles from leading international politics and development journals over the last 20 years that consider the role of the Bank. Health has mainly been addressed within international politics as an example of shifts in the Bank's institutional development under McNamara (Goldman, 2005) and post-Cold War (Weaver and Leiteritz, 2005); the detrimental impact of structural adjustment (Peet, 2003); or in reference to HIV/AIDS (Harman, 2007; Mallaby, 2004; Woods, 2006). Understandings of the Bank's conception of participation, accountability, good governance, influence and role within the global political economy can be applied to how we understand its role in healthcare, but do not directly use global health as a means of understanding the Bank. In recent years there has been an increase in publications on the political economy and governance of HIV/AIDS.
4 See Lee and Goodman, Rifkin, Gilson and Mills, Labonté and Laverack, Laverack and Labonté.

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11

The Competition State and the Private Control of Healthcare

Hans Löfgren

Introduction

Recent remarkable developments in the life sciences and in the provision and politics of healthcare are described and interpreted in writings on the bio-economy, bio-capital and the 'politics of life itself'(OECD International Futures Programme, 2006; Rose, 2007; Sunder Rajan, 2006). Conspicuous dimensions of these changes, from a political economy perspective, include their global scale and the tendential fusion between science and technology, capital, and the state. Basic biological and medical research, largely funded by governments, is undertaken within international networks permeated by commercial interests, particularly those of the pharmaceutical industry, and economic considerations loom large in the regulation of markets. But politics is not waning – popular expectations, and pressures exercised by civil society organisations (CSOs), impose constraints on the health industries. Indeed, healthcare and pharmaceutical policy are high on political agendas everywhere as governments wrestle with the challenge of reconciling economic objectives – support for the pharmaceutical, biotechnology and related industries – with social policy and the crises of essential drugs and neglected diseases in the developing world. Taken together these contradictory pressures reflect that the state is present and active in the dynamics of the political economy of health, technological development and global health markets.

This chapter explores the role of the state in the emerging bio-economy with particular reference to the politics of pharmaceuticals. Two overlapping but contradictory categories of state activity can be identified. First, states are engaged directly and indirectly in the funding, regulation and provision of access to safe and efficacious medicines. Second, state agencies in many of the developed countries, and increasingly in emerging economies such as India, China, and Brazil, promote growth and profitability in pharmaceutical and related industries through a wide range of interventions, including science and innovation policy. These conflicting

imperatives are played out within and across agencies such as the US Food and Drug Administration (FDA) and the National Institutes of Health (NIH), and in public insurance and reimbursement programs designed to ensure affordable access to medicines. As such, these imperatives and the agencies upon which they impact and motivate are part of the contemporary system of global health governance (GHG).

At issue is the extent to which economic competitiveness has come to frame and infuse health and social policy programs, which in the era of the Keynesian welfare state were relatively insulated from capital accumulation. In this context, the competition state concept, as proposed by Jessop (Jessop, 1993, 2002) and Cerny (Cerny, 1997), has intuitive appeal. The distinctive feature of this type of state is a focus on 'promoting the competitiveness of [its] economic [space] in the face of intensified international (and also, for regions and cities, inter- and intra-regional) competition' (Jessop, 2002, p. 124). Analogously with the welfare state in the Fordist period of mass production, when political and social regulation occurred mainly at the national level, the competition state is the political regime of a distinct growth model – the global knowledge-based economy. It is associated with 'multiscalar' globalisation, entailing phenomena such as 'internationalization, triadization, regional bloc formation, global city network-building, cross-border region formation, international localization, glocalization, glurbanization or transnationalization' (Jessop, 2002, pp. 113–114). It is argued in this chapter that the highly abstract competition state approach offers a tantalising point of departure for a political economy analysis of the bio-economy. But its deterministic connotations must be offset in a more concrete analysis, that gives attention to the contingencies of social and political conflict. In the case of pharmaceuticals, the resilience of domestic insurance arrangements throughout the Organization for Economic Cooperation and Development (OECD), and their extension to emerging economies, and the eruption of global movements for equitable access to affordable medicines, demonstrate the actual and potential power of forces other than capital and the competition state. This theme thus serves as a compliment to Ingram's work in this volume, at least in the manner in which pharmaceuticals and access to medicines are the subject of political and social forces as much as they are to the logic of the globalised market and production structure.

Biotechnology and the global pharmaceutical industry

The biological sciences oriented towards living cells at the molecular level sustain expanding commercial activities across health and medicine, agriculture and food processing, and other areas such as mining and environmental management. They require new forms of health and environmental regulation and trigger an 'insatiable demand for bioethics in the political and regulatory apparatus of advanced liberal societies' (Rose, 2007, p. 30).

Biotechnology is not strictly an industrial sector, though that set of small, R&D intensive, dedicated biotechnology firms, which first appeared in the 1980s around universities in the United States, and later in other countries, has come to be regarded as an industry sector in its own right. There are thousands of dedicated biotechnology companies worldwide, with around 200,000 employees, researching, developing and supplying biotechnology products and applications, operating in close interaction with universities and public sector research organisations, and pharmaceutical, agri-business and other multinational companies (Ernst & Young, 2007). Governments of different political orientations, in developed and emerging economies alike, identify biotechnology as a principal driver of industrial renewal and global competitiveness.

In the drug industry, there has been a technological paradigm shift from chemistry-based (small molecule) products towards bio-pharmaceutical (large molecule) drugs, developed through biotechnology (Henderson *et al*., 1999). Hundreds of biotechnology-based medicines are on the market, and many more are in the pipeline, and there 'is no question that biotechnology is now the engine of innovation for the drug development industry' (Ernst & Young, 2007, p. 1). This has blurred the boundary between large, established firms and the biotechnology sector, with the BigPharma group of companies retaining a dominant role. These firms have acquired, through acquisitions and mergers, in-house biotechnology capabilities, a precondition for effective interaction with smaller biotechnology companies. The 1990 merger between Genentech, the first of the new biotechnology companies (established in 1976), and Roche foreshadowed the symbiosis between the biotechnology sector and BigPharma which has since become a central feature of the bio-economy. There has been a wave of mergers and acquisitions within and across these sectors as corporate structures have been re-engineered to achieve greater flexibility and enhanced R&D productivity (Mittra, 2007). The established drug companies, with resources vastly superior to those of other actors in the bio-economy, operate as 'insider' participants in national policy processes and markets across the world, yet manage globally integrated innovation, production and marketing networks. These networks encompass not only biotech companies but many other types of firms, including specialised suppliers of out-of-patent generics drugs, clinical research organisations (CROs), and suppliers of active pharmaceutical ingredients (APIs).

Close relations between governments and the pharmaceutical industry flow from the role of public health systems as purchasers of medicines, complex regulation at each step of the value chain, and the economic imperative of supporting competitiveness in the bio-economy. The contours of this pattern emerged in the 1940s, when drug firms in the United States worked closely with the government in support of the war effort. The discovery of penicillin, first manufactured during the war by Merck and

Pfizer, provided a major boost to the industry's expansion. In the 1950s and 1960s firms multiplied their R&D spending, resulting in the introduction of several hundred new chemical entities (NCEs). Today the United States, with a regulatory environment well attuned to industry requirements and generally higher prices than elsewhere for 'innovative' (patent protected) drugs, represents around half of the global prescription drug market. At least in this sense, the US has fostered US pharma via its regulatory (and legal) role, and assiduously developed a supportive domestic environment for the firms to develop and prosper. Less obvious, but arguably as important, is the fact that the US government also provides massive public funding for medical research. The world's largest medical research funding organisation, the US National Institutes of Health, has a budget of more than US$28 billion. From the late 1970s, a spate of government R&D programs and legislative initiatives were launched to support the competitiveness of US firms, including

> … the Stevenson-Wydler and Bayh-Dole Acts of 1980, aimed at technology transfer; the 1981 Economic Recovery Tax Act, awarding tax credits for R&D; the 1983 Orphan Drug Act; the 1984 Patent Term Restoration Act; the 1986 Federal Technology Transfer Act; and the 1987 Presidential Executive Order, pushing increased technology transfer on federally-funded research (Loeppky, 2005, p. 268).

US state support for the life sciences culminated with the Human Genome Project, first mooted by the Department of Energy in the 1980s, and massively funded by the National Institutes of Health, which by 2000 produced the sequencing of the whole genome. The Clinton administration determined that the database of the human genome could not be patented but should be publicly available for the benefit of all firms and researchers. In effect, the state had 'assumed the "socialized risk" necessary for the procurement of costly generic scientific information' of particular value for the bio-pharma industry (Loeppky, 2005, p. 268).

The European Union (EU) and its member countries have also invested heavily in life sciences research, but activities are more fragmented and linkages between firms and public sector research organisations are less well-developed. But in order to catch up with the United States, the EU has devised a number of initiatives to enhance coherence and integration within its bio-industrial complexes (European Union, 2007). Five of the top ten pharma companies are headquartered in Europe – GlaxoSmithKline, Sanofi-Aventis, Roche, AstraZeneca and Novartis – but a significant proportion of their R&D is undertaken in the US. For example, Novartis' global research headquarters is in Cambridge, Massachusetts (Informa Healthcare, 2007). While basic biological and medical research remains geographically concentrated to the US, Europe and Japan, manufacturing is more widely

dispersed and R&D activities, including clinical trials, are increasingly outsourced to India and China, and to smaller countries such as Singapore and Israel where governments strategically promote the bio-pharma sector (Cockburn, 2007).

All in all, developments in biotechnology and the pharmaceutical industry suggest that the role of the state in the innovation systems of the bio-economy is not to make markets more 'open', but to ensure conditions favourable for innovation and learning, which in turn is seen as the principal means of promoting economic competitiveness (Fagerberg *et al*., 2005). Thus subsidies and regulatory support capture a market and wider bio-economy which is anything but 'free' or purely subject to the investments and risk taking of firms. Public policy is focused principally on universities and the innovation system, protection of intellectual property, the availability of finance and supportive taxation systems, training and education, support for entrepreneurship and the commercialisation of science (Cooke, 2004). A strong role of the state in the bio-economy is particularly pronounced in countries with major pharmaceutical companies (the US, Europe and Japan).

State regimes and the bio-economy

Does the preceding sketch of government-industry relations in biotechnology and pharmaceuticals have implications for a broader understanding of the contemporary state, and the role of states in the hard edge of the political economy of global health? If the biological sciences are driving a new technological revolution, unleashing 'a profound transformation in "the way of doing things" across the whole economy and beyond' (Perez, 2002, p. 15), making this 'the century of biotechnology' (OECD, 2005, p. 5), the bio-economy should indeed be an important theme in studies of state-society relations and central to appreciating the current political economy of health. Questions about the nature of the state are the province of a branch of inquiry known as 'state theory' (Hay *et al*., 2006). A starting-point for navigating this complex terrain is that the state is not a 'self-evident material object', but a continually reinterpreted conceptual abstraction (Hay and Lister, 2006, p. 9; Skinner, 1997). In the post-1945 decades, the state concept was downplayed 'in much of Western, especially American, political science of the pluralist paradigm' (Cerny, 1990, p. 12), but a concern with the nature and future of the state re-emerged in the 1970s and 1980s, and is a central theme in the globalisation debate which exploded in the 1990s.

The concept of the competition state, or – in Jessop's terms – the Schumpeterian competition state, would appear to capture key dynamics of state-capital relations in high tech industry sectors such as pharmaceuticals. The concept is grounded within a broader 'regulationist' account of the dynamics of capitalist economies and associated state regimes since the mid-20th

century, which identifies the 1970s as a critical juncture (Boyer, 2005; Boyer and Durand, 1997; Jessop, 1997). It is also central to giving purchase to the role of developed states in driving a particular form of healthcare and medicine, and a particular political economy of GHG.

The 1970s are significant as it is viewed as the watershed moment in the crisis of the Fordist model of accumulation and social regulation, which had been underpinned by the technologies of oil, the motor vehicle and mass production, triggered a search for a new growth dynamics, and what followed was a wave of corporatisation and privatisation, de-regulation, and related political and institutional changes (Boyer and Durand, 1997). The state was reconfigured such that public ownership, Keynesian macro-economic management and decommodifying social policy were scaled back in favour of a supposedly minimal state that would achieve a more efficient economy through the 'freeing up' of markets. Information and telecommunication technologies were central to the economy of the post-1970 decades, but the emergence of life sciences-based technologies makes the bio-economy the likely focal point for the next wave of economic expansion (Perez, 2002).

According to Cerny and Jessop, the disintegration of Fordism and Keynesian was associated with a reorientation of state activities towards the fostering of a new capitalist growth mode within conditions of intensified international competition. A large literature characterises possible successor models to Fordism in terms of innovation, flexible specialisation, scope economies, diversification, globalisation and new generic technologies (Amin, 2003). The state took on a more pronounced role as supplier of basic science, and across many countries policy measures are introduced to facilitate the uptake and commercialisation of basic research results. The principal orientation of the Keynesian welfare state, by contrast, was on the management of demand and it did little to stimulate and guide innovation and industrial upgrading. The main concern of the competition state, irrespective of the party political composition of governments, is management of 'the national economy's insertion into the global economy in the hope of securing some net benefit from internationalization' (Jessop, 1993, p. 14). This is exactly why neoliberalism (and neoliberalism as it impacts on health) has not negated the power of states via a process of rolling back states' authority, but rather recast their role and agency with respect to economic globalisation.

Paralleling Keynes' standing as the theorist of a nationally regulated capitalism characterised by full employment and social cohesion, Schumpeter emerged (decades after his death in 1950) as the emblematic analyst of technological change and the capitalism of perpetual innovation (Freeman, 2007). The ideal-typical Schumpeterian competition state:

> promote[s] permanent innovation and flexibility in relatively open economies by intervening on the supply-side and [seeks to] strengthen as far as

> possible the structural and/or systemic competitiveness of the relevant economic spaces. The primary organizing concept for the development of accumulation strategies, state projects and hegemonic visions in this context is the knowledge-based economy … Complementing these new strategic concerns in economic policy has been the rejection, demotion or rearticulation of other, earlier policy objectives (Jessop, 2002, p. 250).

The competition state reconfigures institutional hierarchies within the public sector and programs associated with the model of the Keynesian welfare state, which protected citizens from the market. These types of policies are largely re-branded as dysfunctional. Traditional social programs have not vanished but agencies oriented towards economic competitiveness gain greater sway. As noted, the core institutions of the competition state operate to extend and support capital accumulation, with a particular focus on supply-side measures to foster innovation, including the funding and organisation of R&D.

The depiction of the competition state as the political regime of the archetypical post-Fordist knowledge based economy would seem to find an empirical reference point in the bio-economy, and have wider resonance with the development of a global market for healthcare products and services. Pharmaceuticals and biotechnology typify the 'agglomeration and network economies' of the post-Fordist growth model, within which state agencies seek to achieve 'the mobilization of social as well as economic sources of flexibility and entrepreneurialism' (Jessop, 2002, p. 110). This is not the same as maximising free market exchange, though free markets are embraced rhetorically, particularly in the English-speaking countries of the OECD. Innovation policy entails a wide range of state interventions such as public investments in education and training, support for R&D and the knowledge infrastructure, mechanisms for the dissemination and absorption of basic research, measures to accelerate cluster developments, and so on. That programs to foster high tech industries have little to do with neoliberal free markets is amply documented in the literature on global, national, regional and sectoral 'innovation systems' (Carlsson, 2007).

Many empirical studies of biotechnology and pharmaceuticals detail complex network constellations, the intertwining of public and private research, a central role of scientists and other experts, state support for venture capital and intellectual property rights, and multi-faceted regulation (Benner and Löfgren, 2007; Cooke, 2007; Mazzucato and Dosi, 2006; McKelvey, 2007). Government-industry relations differ markedly from that of the Fordist period, when pharmaceutical companies were relatively self-sufficient, and public research and health services were for the most part detached from commercial activities. Public policy in relation to health and the life sciences extends well beyond R&D funding and the provision of services to citizens to include broader socio-economic and cultural objectives to foster an environment conducive to the industrial dynamics of the bio-economy. Arguably,

therefore, the contemporary political economy of global health can only be understood in the context of these dynamics and the role of public policy and states in mediating its development. For example, public policy is implemented to foster entrepreneurial networks in and around academic life sciences centres (Cooke, 2004). These are developments which bring to the fore the structural imperatives of high-tech capitalism, as captured by the competition state concept.

Competition state tendencies and the indeterminacy of politics

The competition state is defined as the successor regime to the Keynesian welfare state. As noted, this type of state is associated with a post-Fordist growth model grounded in the perpetual innovation of the knowledge economy, in contrast to the Fordist accumulation regime based on mass production and consumption which sustained the Keynesian welfare state. These regimes are archetypical abstractions and the developmental trajectory, at least as far as Jessop is concerned, is 'tendential'. Jessop also qualifies the argument through the identification of countertrends and explores different varieties of both state types (Jessop, 2002). But there is no close correspondence between several real-life states – such as the Nordic countries which combine large welfare states with economic openness and competitive high tech industries – and the competition state trajectory. Pointing to the gap between ideal-typical state regimes and real-life cases, Hay (2004, p. 44) poses the question: 'what is the utility of presenting an account of the development of the capitalist state form at such a high plan of theoretical abstraction and generality?':

> … if the state in Canada for much of the postwar period lacked many of the distinctive institutional features of the [Keynesian welfare state] and is now far from self-evidently in the process of becoming a Schumpeterian competition state … then what greater analytical purchase is offered by analysts of Canadian political economy by presenting the development of the Canadian state in this form? (Hay, 2004, pp. 44–45).

Analogously, the degree of correspondence between the competition state and the real-life dynamics of a major sector such as pharmaceuticals points to strengths and possible shortcomings of this approach. The 'abstract-simple' theoretical edifice presented by Jessop in *The Future of the Capitalist State* (2002) cannot of course be straightforwardly confirmed or disproved through observations of any particular sector. But historical-empirical evidence feeds into the state theoretical analysis as it becomes more 'concrete-complex' and abstract conceptualisation are in the process qualified and revised. An analysis of the bio-economy which considers the contingencies of social and political struggles and the full range of government activities

confirms one of the limitations of the competition state approach identified by Hay (2004, pp. 44, 46), that it is 'starkly apolitical', according 'only a most minimal role to specified agents'. The account presented above has emphasised the extent of state support for capital accumulation in pharmaceuticals and biotechnology, but in the remainder of the chapter the focus will shift to the resilience of the welfare state and the role of politics. It is therefore necessary to develop a political economy of the bio-economy that is more nuanced and reflects the importance of these drivers.

As described above competition state trends are undoubtedly conspicuous in the bio-economy. It is characterised by complex networks linking state agencies, business firms and other actors, and many government interventions are oriented towards business success in global markets. Such public policy programs tend to be depoliticised as far as core stakeholders are concerned. Key actors largely share a technocratic understanding of the role of government as provider of favourable conditions for the growth of science-based industries such as pharmaceuticals. The political ideologies and class politics of the 'industrial' Fordist era are in this context irrelevant, and popular anxieties (such as those associated with genetically modified (GM) foods and other genetic technologies) are seen, from the perspective of such technocratic constellations, as problems of management. The role of the state in the bio-economy thus goes beyond support for industry and innovation, and the protection of intellectual property rights, to encompass regulation of health and safety and ethical standards and 'soft' measures to shape social and cultural attitudes and behaviour.

Indeed, government efforts to monitor and influence consumer perceptions are more conspicuous in biotechnology than in any other techno-scientific domain. In Australia, for example, a federal government agency, Biotechnology Australia, considers one of its core tasks to be the 'comprehensive tracking' through annual surveys of public attitudes to gene technology. It is plainly the case that the bio-economy is critically dependent on a wide range of supportive state interventions, a pattern well captured by the competition state approach.

But the analysis must take account also of the enduring strength of welfare state programs and new interventions for health and social policy purposes and indeed the intensity and indeterminacy of the politics of pharmaceuticals. There is no general trend for a roll-back of the welfare state in this area or for business interests to be consistently privileged in the design and operation of drug insurance and reimbursement schemes which typically constitute the central axle of government – business relations. Public insurance programs subsidising the cost to consumers of prescription medicines, first introduced in the era of the Keynesian welfare state, are firmly entrenched in most OECD countries and are at varying stages of development in many medium-income countries. If anything, the trend is for an expansion of public spending on drug reimbursement programs, including in the United

States. Governments as third party payers have become adept at constraining prices through the application of purchasing power, notwithstanding industry opposition (Lopez-Casanovas and Puig-Junoy, 2000). Again, the welfare state (be it residual or otherwise) is used as a means of subsidising or underwriting health industries.

The rationale for or effectiveness of welfare state interventions in the pharmaceutical sector has not weakened since the heyday of Keynesianism and Fordism. Governments apply a range of policy tools for the purposes of safety and public health, affordable access and cost containment, the precise combination of which reflects domestic policy networks and their intersection with the global industry and international markets. The basic rationale for regulation flows from pervasive market failures, particularly the inability of consumers to make informed decisions about the quality, efficacy and appropriate use of medicines, and the importance of medicines for health and well-being. Recurrent disasters resulting from unsafe drugs have impelled governments to impose progressively stricter safety and efficacy regulation. Government controls affect all stages of the production and distribution chain: basic research, product development, manufacturing, exports and imports, market access, pricing and profits, marketing, wholesaling and retail distribution, and most countries also have direct or indirect regulation of drug prices and profits. Reputable drug approval processes provide firms, which are vulnerable to disclosures of harmful or unethical behaviour, with commercially valuable seals of quality. Yet regulation also imposes costs and constraints on business and there is perennial industry lobbying for approval processes and other regulatory constraints to be made more industry-friendly. Clearly, business perspectives impinge on the design of regulatory arrangements and social programs, but outcomes are determined by conflicts and compromises between different interests and cannot straightforwardly be explained solely in terms of the imperatives of the competition state.

It is descriptively more accurate to characterise the pharmaceutical sector, ever since its early modern phase in the mid-20th century, as an arena for recurring tension and conflict between the agencies, interests and discourses of the welfare and competition states, with no clear trend for the former to wane. As argued by Kay and Williams in this volume, the welfare state and the public in health continue to motivate a range of actors and inform health policies. For example, the competition state runs up against popular expectations for medicines to be available on the basis of need, not ability to pay. If anything, this expectation is more firmly entrenched today than, say, 30 years ago, as evidenced by the failure of neoliberal governments to roll back drug insurance programs. With partial exception of the United States (where close to 50 million people have no health insurance) most consumers across the OECD pay for only a small proportion of the total cost of prescription drugs out-of-pocket. In a group of 11 countries, the out-of-pocket share ranged (in

2004–06) from 0.3 per cent in the Netherlands to 33 per cent in Finland, with the remainder covered through insurance arrangements financed mostly through taxes (Office of Fair Trading, 2007, p. 4). The inadequacy of the competition state concept as an overarching characterisation of the political regime of the bio-economy is illustrated in the following sections which sketch the politics of pharmaceuticals in Australia and the rise of global conflicts around the issues of essential drugs for developing countries and research into new medicines for neglected diseases.

The resilience of welfare state pharmaceutical regulation and policy: the case of Australia

Australia has a tradition of effective and at times innovative pharmaceutical regulation and sophisticated policy analysis and debate, framed for the most part by the ethos of the welfare state (Harvey and Hodge, 1995). This is not a deviant case internationally; health and social policy programs similar to those in Australia remain robust across the OECD, with the United States the significant exception as far as equitable access is concerned (Kanavos, 2001; Office of Fair Trading, 2007). Neoliberalism has made inroads, as evidenced by a rhetoric of government-business 'partnerships' and industry-friendly adjustments to regulatory arrangements, but the trend in Australia and elsewhere is not unequivocally for business interests to be privileged in the design and operation of drug insurance and reimbursement schemes.

Globalisation is certainly associated with the extension of BigPharma controlled innovation and production networks and drug companies are typically strongly positioned to influence regulation and public policy. But globalisation has also brought about more effective international diffusion of policy interventions to rein in the power of the industry and achieve affordable access and appropriate use of drugs. The diffusion of such countervailing public policy models increasingly extends to the developing countries through mechanisms such as the World Health Organization (WHO) and global networks such as Health Action International (HAI). Australia was the first country in the world to introduce as a mandatory requirement that companies include with an application for government subsidy 'an assessment of comparative effectiveness and comparative cost-effectiveness against existing therapies' (Roughead *et al*., 2007, p. 515). This type of 'value-for-money' evaluation, which de facto constrains the pricing freedom of drug companies, has since become standard in many countries.

The policy field of pharmaceuticals, in Australia as elsewhere, encompasses a wide range of actors. In this high-income country of about 21 million people, pharmaceutical firms contend with regulatory agencies, medical and other professional groups, consumer and patient advocacy organisations, a vigorous community of drug policy analysts, and deep-rooted expectations that all citizens should enjoy affordable access to a comprehensive range of

high quality medicines (Löfgren and de Boer, 2004). In the past 20 years, the competition state discourse has been ascendant, and programs have been introduced to promote industry investments in R&D, production and exports and regulatory arrangements have been made more industry-friendly (Doran and Henry, 2008; Morgan *et al*., 2008). But these changes are at the margin of a well-entrenched regulatory architecture and the core social policy program, the Pharmaceutical Benefits Scheme (PBS), established in the period of the post-war welfare state, survived 11 years of the neoliberal Howard government (1996–2007) largely unscathed. Indeed, it remain remains an 'axiom in Australian medicines policy that everyone loves the PBS' (Henry, 2007). Examples of recent industry-friendly adjustments include a new review mechanism, available after a PBS rejection of the listing of a new product or extension of the listing of an already listed drug and the establishment of a Medicines Working Group as an outcome of the 2005 Australia-US Free Trade Agreement (AUSFTA), comprising high level officials of both countries, 'to promote discussion and mutual understanding of issues related to the importance of innovation and pharmaceutical research and development to continued improvement of healthcare outcomes in both countries' (Australian Government, 2008; US Department of Health and Human Services, 2007). But in other areas regulation has been strengthened and industry activities increasingly constrained for example through measures to enhance the 'quality use of medicines' and controls and monitoring of company marketing.

For decades, the pharmaceutical industry has criticised the PBS for constraining prices and profits (see for example Pharmaceutical Research and Manufacturers of America (PhRMA) 2002). Introduced in 1951 for the purpose of universal access to approved prescription drugs, the PBS today subsidises more than 70 per cent of all prescriptions medicines dispensed in Australia. Until the 1990s, the government was concerned primarily with ensuring access to medicines at low cost, with little regard to industry profitability. This objective was modified in the late 1980s when an industry policy (competition state) program was introduced to promote investments in manufacturing, exports and R&D, triggered by a concern for the future of high-tech manufacturing. In 2001 various industry support initiatives were integrated by the Department of Industry into a single policy framework, the Pharmaceuticals Industry Action Agenda, infused by the competition state discourse. The aim was to facilitate interaction between multinational corporations and local firms and research organisations, drawing on strengths in areas such as basic scientific research and capacity to undertake cost-effective clinical trials (Hill *et al*., 2001). The pharmaceutical industry was designated 'the most innovative, knowledge-based industry in Australia' (Pharmaceutical Industry Action Agenda, 2002, p. 1). The forces driving Action Agenda always considered PBS pricing arrangements to be the major obstacle to the expansion of industry activities in

Australia, but the government made clear that the PBS was to be accepted 'as a given, recognising that the PBS is the cornerstone of equitable access' (Pharmaceutical Industry Action Agenda, 2001).

The most politically charged event in the past decade was the AUSFTA which put enhanced 'rewards for innovation' on the policy agenda, code for higher prices and a roll-back of social policy. The US negotiators sought to achieve 'the elimination of government measures such as price controls and reference pricing which deny full market access for United States products' (Trade Promotion Authority Act 2002, cited in Roughead *et al*., 2007). Notwithstanding several provisions in the agreement relating to Australian medicines regulation, the end result is less than wished for by the US pharmaceutical industry. This turned out to be yet another skirmish in a long history of political, economic and social contention about Australian drug policy, the contours of which emerged as early as the 1940s. AUSFTA dented but did not significantly weaken the political and social constellation around the PBS which was able to withstand another round of pressures for a radical overhaul of drug pricing arrangements. It is not evident that these developments, which point to strong impediments to the competition state in the pharmaceutical domain, are well captured by the notion of a trajectory from one state regime to another.

The global governance and politics of pharmaceuticals

The Australian case illustrates that governments do not consistently privilege pharmaceutical industry growth and profitability at the expense of domestic health and social policy. A somewhat different pattern is apparent at the international and global level where the US government in particular, but also the EU and other states with important bio-economy industries, have traditionally operated in tandem with drug companies on intellectual property and other regulatory issues to protect and promote corporations headquartered within their national territories (Drahos and Braithwaite, 2002). This configuration of government-business relations was not challenged much until the outburst in the mid-1990s, triggered by the Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement, of intense global drug policy conflicts which have since compelled BigPharma to retreat from some of its most outrageous claims and practices and given a boost to international health and social policy programs and institutions.

Pressures have mounted on corporations and governments to address the 'neglected diseases' calamity, that is, that 90 per cent of the global disease burden attracts ten per cent of research investments. There is a vigorous global debate on research incentives other than intellectual property rights and initiatives to make essential drugs available in developing countries. An idea that is attracting attention – put forward by the US-based Consumer

Project on Technology, Oxfam, and other health activists – is for a global R&D Treaty which would commit countries to an agreed level of pharmaceutical R&D expenditure to preclude 'free-riding' on the efforts of others. Countries would be free to determine how to meet their R&D commitment. The patent system (high monopoly prices) would continue to provide one possible way of funding and rewarding R&D but, alternatively, countries could decide to detach the research process from an all-out generics market where competition would result in greatly reduced prices (Hubbard and Love, 2004). Such radical proposals are not of course close to implementation but the global campaign for equitable drug access has been successful in introducing a new dynamic to state-business relations (Sell, 2002).

In contrast, the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH), initiated in 1990, represents the long-established pattern of industry domination in global pharmaceutical governance. The ICH is an international regime established for the purpose of harmonising the complex technical requirements for drug approval registrations, though its focus has been extended to related areas such as the reporting of safety information from clinical trials. Governments and industry associations contribute to the ICH as 'equal partners'. Its six co-sponsors are the regulatory agencies and the associations representing the research-based drug industry in the EU, Japan and the USA: the European Medicines Agency (EMEA) and the European Federation of Pharmaceutical Industries and Associations (EFPIA), from Japan the Ministry of Health, Labour and Welfare (MHLW) and the Japan Pharmaceutical Manufacturers Association (JPMA), and the FDA and the PhRMA. Canada, the European Free Trade Association (EFTA) and the WHO have observer status. The ICH secretariat is provided by BigPharma's International Federation of Pharmaceutical Manufacturers & Associations (IFPMA). The World Health Assembly in 1992 endorsed the objective of international harmonisation, and the WHO every few years, since 1980, convenes the International Conference of Drug Regulatory Authorities (ICDRAs) to provide a forum for drug regulatory authorities to consider matters such as quality issues, herbal medicines, regulatory reform, medicines safety, counterfeiting, access, regulation of clinical trials, and new technologies and e-commerce. To some extent, the participation of the WHO brings the perspectives of the developing countries and issues relating to affordability and access into the deliberations of the ICH. But its highly technical focus and the influence exercised by BigPharma to all intents and purposes insulate the ICH from public debate and scrutiny (Abraham and Smith, 2003).

The most critical aspect of the global governance of the bio-economy today is the harmonisation of intellectual property rights through the TRIPS agreement, which came into effect in 1995, and the reaction against this process which has soared in the past decade (Abbott, 2005). In the bio-economy, monopoly prices during a period of patent protection enable

firms to recoup R&D costs and provide the principal incentive for reinvestments in the development of new products. The objective of harmonisation of patents across developed and developing countries is to ensure – in the terminology of the industry – that R&D costs are shared by consumers everywhere. The story of the TRIPS, as indicated, is illustrative of both the strengths and limitations of the competition state approach. In essence, a group of United States-based multinational companies agreed in the 1980s to pursue strengthened intellectual property standards through the mechanism of the General Agreement on Tariffs and Trade (GATT) and its successor institution, the World Trade Organization (WTO). This group of industry lobbyists, led by Pfizer, 'enjoyed superb access to the highest levels of policymaking' and was successful beyond its own expectations in enlisting the support of the United States government and in reframing policy debate about the rationale for patents, resulting in the global TRIPS regime (Sell, 2002, p. 487). All WTO members, including all developing countries, are obliged (with a grace period for the poorest nations) to introduce TRIPS-compliant national legislation to protect intellectual property, most importantly 20-year patent protection for products and processes in all fields of technology, including medicines and biotechnological products and processes. As a result, the US government now monitors the implementation of TRIPS through

> … a global surveillance network comprising US companies, the American Chamber of Commerce, trade associations and US embassies. All gather and report on the minutiae of social and legal practices that relate to US intellectual property. Corporate America picks up the tab for Section 301 [a legislative provision which authorises the US President to impose trade sanctions on countries deemed not to protect US intellectual property adequately] by providing the global surveillance network, the number for the estimates of piracy, and much of the evaluation and analysis. The US state provides the legitimacy and the bureaucracy that negotiates, threatens and, if necessary, enforces (Drahos and Braithwaite, 2004, p. 15).

In the WTO negotiations pressures were imposed on the developing countries for acceptance of TRIPS and promises were made for compensation through better access to OECD markets for their agricultural and textile exports. But TRIPS only gradually emerged as a global political issue after 1995 when its implications for access to affordable medicines became clear. Much of the debate has crystallised around the HIV/AIDS pandemic and the question of affordable supply of anti-retroviral treatments in national markets where the disease is most acute. Pressures by developing countries and non-governmental organisations (NGOs), and global public opinion, resulted in the Doha Agreement of 2001, which confirmed the right of WTO members 'to protect public health and, in particular, to promote access to

medicines for all' (Doha Declaration, para 4). This was followed in 2003 by the Decision on the Interpretation of Paragraph 6, which specifies the conditions under which developing countries can import ('parallel importation') drugs produced under compulsory licensing (Abbott, 2005; Bradford Kerry and Lee, 2007). The UK and other OECD governments have also through the WTO and in other contexts made high profile commitments in support of access to essential drugs and 'health for all'.

The picture is complicated by the ambiguous role of governments such as those of India, Brazil and South Africa. With relatively small investments, they have established a significant presence in niche areas of the life sciences and bio-pharma production and pharmaceutical policies are influenced by the industry development objectives (Dickins, 2006, p. 10). Biotechnology in India, for example, is largely the result of strategic planning and R&D investments by the central government in New Delhi, 'the most entrepreneurial agent in Indian biotech today' (Sunder Rajan, 2006, p. 102).

The upshot of this sketch of the global governance and politics of pharmaceuticals is that competition state relations between governments and business remain predominant, as evidenced by the case of ICH and the concerted and largely successful push for globally harmonised intellectual property rights. But the escalation in the scope and intensity of social and political struggles for equitable access to essential medicines and funding for research on 'neglected diseases' have produced cracks in this edifice. The pharmaceutical industry has had set-backs including concessions within the TRIPS system and are now expected to demonstrate 'corporate social responsibility' and many OECD governments have proven amenable to public opinion and NGOs demands for global medicines equity.

Conclusion

The BigPharma companies are central actors within an increasingly global system for discovering, developing, regulating and marketing medicines. The pharmaceutical sector has blurred with other actors in broader bio-economy which encompasses firms across many industry sectors engaged in the commercialisation of discoveries in the life sciences. Innovation and production networks and patterns of government-business relations in the bio-economy would seem to quintessentially represent a post-Fordist growth model based on a new wave of scientific-technological transformation. This chapter has explored, with particular reference to pharmaceutical developments in Australia and globally, whether the competition state concept, which posits a pro-business turn in public policy, adequately captures state-industry interdependencies in the bio-economy.

With its dependence on an accommodating regulatory environment, access to public sector research, legal protection of intellectual property rights, and other forms of government support, the drug industry relies more than ever

on the state. Yet the account of this chapter suggests that a structuralist and determinist application of the competition state concept cannot be sustained. Notwithstanding the new network models of innovation and production, and the competition state rationale for state promotion of business competitiveness, welfare state programs and regulation constraining the power of pharmaceutical corporations popular are not waning. If anything, experiences of policy models which constrain the power of pharmaceutical corporations in countries such as Australia are being diffused to the developing world. Outcomes from contestations in the drug policy domain are indeterminate, 'negating the prospects for some worldwide and coherent regime of accumulation' (Palan, 2006, p. 247). There is evidently great scope for political mobilisations to make a difference, as indeed explained by Jessop in writings on the 'strategic selectivity' of the state which qualify the structuralist connotations of the competition state approach. Policy outcomes are not predetermined – the state is a terrain accessible to different forces – but dominant or rising fractions of capital (such as pharmaceutical and biotechnology capital) can be expected to enjoy privileged access to state resources (Jessop, 2008). Strategic selectivity refers to

> ... the ways in which the state considered as a social ensemble has a specific, differential impact on the ability of various political forces to pursue particular interests and strategies in specific spatio-temporal contexts through their access to and/or control over given state capacities – capacities that always depend for their effectiveness on links to forces and powers that exist and operate beyond the state's formal boundaries (Jessop, 2002, p. 40).

In the second half of the 20th century many governments imposed taxes to ensure access for all citizens to de-commodified health services including pharmaceuticals. This model of public provision of health services was weakened with the neoliberal turn from the 1980s and the 'withdrawal of the state from many areas of social provision' (Harvey, 2005, p. 3) but it is striking that states retain extensive regulatory controls in the pharmaceutical domain including robust insurance arrangements. State activities have become more sensitive to the imperative of competitiveness in the bioeconomy but the welfare state has proven resilient in developed countries such as Australia and there is a global movement for state resources to be employed for the purpose of global access to appropriate medicines.

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