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Conclusion: Towards Equitable Global Health Governance

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Introduction: the state of global health

The Millennium Declaration, adopted by 189 heads of state at the United Nations Millennium Summit in 2000, committed governments and intergovernmental institutions to international cooperation on the achievement of eight Millennium Development Goals (MDGs) by 2015. Health figures prominently in these goals, three of which focus on health directly, and four on social determinants of health. Indicators surrounding these goals, therefore, provide a useful metric for assessing the current global health situation, particularly in the global South. As discussed in Chapter 1, there have also been significant transformations in health in the global North, including acute disease outbreaks (SARS, avian flu, influenza, etc.) as well as increases in chronic diseases such as lung disease and neoplasms. In early 2007, a midterm report[1] was released by the United Nations, which tracked each goal's progress and predicted the likelihood of its success. The report indicated mixed results; while considerable progress had been achieved on several goals, it was deemed extremely unlikely that others would be realized by the target deadline of 2015, especially in sub-Saharan Africa.

Regarding Goal 1 (to eradicate extreme poverty and hunger worldwide), the 2007 report acknowledged that the number of people in developing countries living on less than $1 a day had dropped from 1.25 billion in 1990 to 980 million in 2004. However, most of the gains had been made in Asia – Eastern and South-Eastern Asia, in particular – while poverty and hunger in Western Asia, Southern Asia and sub-Saharan Africa remain endemic. Thus, it is highly unlikely that targets will be reached in these regions by 2015. And, although small gains were made in sub-Saharan Africa between 1990 and 2005, the proportion of people living in extreme poverty in this region stands at a staggering 41.4 per cent (UN, 2007). Furthermore, rather than offering the promise of being the 'tide to lift all boats', globalization has ushered in a new era of widening income inequality (Birdsall et al., 2005). We therefore continue to witness not only unacceptably high levels of poverty

S. J. MacLean et al. (eds.), *Health for Some*
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and hunger, but also huge disparities between the poor and the wealthy. Income inequality is particularly acute in Latin America, the Caribbean and sub-Saharan Africa (World Bank, 2000).

Goal 4 aims to reduce the mortality rate of children under five by two-thirds. Every year 11 million children die before they reach the age of five, in most cases from treatable diseases. The UN interim report revealed that child survival rates show only slow improvement and are worse in sub-Saharan Africa. For example, rates have fallen by only 12 per cent since 1990. This poor result is partly a result of low levels of childhood vaccinations; 30 million children worldwide do not receive vaccinations for easily preventable diseases and only 78 per cent of children in the developing world are immunized against tuberculosis and 69 per cent against measles. Ultimately, this means that if this situation is not immediately changed, we will not see Goal 4 realized in sub-Saharan Africa until the year 2165 (UN, 2007). The fifth Millennium Development Goal is to reduce the maternal mortality rate by three-quarters. Approximately half a million women die each year during pregnancy or childbirth; 99 per cent of them come from the developing world and almost all from sub-Saharan Africa and Asia. In fact, women in sub-Saharan Africa are 175 times more likely to die during childbirth than women in industrialized countries (UN, 2007). For the most part, these are entirely preventable deaths. If these women had access to appropriate reproductive health services before, during and post-pregnancy the majority of these deaths would not occur. Furthermore, every year more than 2.2 million women who are infected with HIV give birth to HIV-positive children, when a drug called nevirapine substantially reduces the likelihood of passing HIV from mother to child (UN, 2007). Sadly, this drug is not universally accessible to women in the developing world and thus, year after year, far too many children are born HIV-positive.

MDG Goal 6 is to reduce the HIV/AIDS epidemic as well as tuberculosis and other diseases. In 2006, 37 million adults and 2.5 million children were living with HIV/AIDS, over 95 per cent of them in developing countries (70 per cent in sub-Saharan Africa). In 2006 alone, 3 million people died from AIDS; and over 20 million people have died since 1996. So far, over 14 million children have lost one or both parents to AIDS; and by 2010 the number is expected to reach 25 million (UN, 2007). The UN report (2007) revealed that HIV prevalence has levelled off in the developing world (see also WHO, 2008), but deaths from AIDS continue to escalate, particularly in sub-Saharan Africa. Signs of hope are that we are witnessing considerably expanded initiatives to provide treatment for people living with HIV/AIDS. Access to antiretroviral therapy continues to expand in developing countries. As of December 2006, approximately 2 million people were receiving drugs; however, this represents only one-third of the estimated 7.1 million people who need treatment (UN, 2007). Health systems lack capacity not only to deliver antiretrovirals but also to coordinate the various actors

involved in supplying the drugs. Meanwhile, developing country governments face the extraordinary challenge of developing public and social systems of support and care for millions of children who have lost one or both parents to AIDS. We need immediately to imagine and plan for societies with millions of children who lack adequate access to water, food, shelter, clothing, education, health care, and, perhaps most importantly, the love and emotional support of parents.

Effective global health governance is critical if these problems are to be solved. The issues of global health governance include traditional ones such as efficiency and accountability of local and national governments, but they also include the emerging, novel structures of governance that have been termed 'global health governance'. The new global health governance architecture is multi-actor (state, inter-state and non-state) as well as multilevel (local, national, international). While this architecture involves multiple nodes of authority, several major players wield a disproportionate amount of authority. The way authority is being wielded, by whom and with what implications for improvements in global health, and reduction in inequities that contribute to poor health, are the issues that the authors in this book have sought to address. Each has attempted to uncover political economic factors that drive and influence the types of governance structures that have emerged. As well, the chapters expose who is winning and who is losing in the current political economy of global health.

New modalities of global health governance

As MacLean and Brown discussed in the first chapter of this book, the nation state has experienced significant transformations in the contemporary era of globalization. These changes, as they relate to both national and global health governance, have included states' increasing participation in multilateral, regional, and/or bilateral health, trade and investment agreements. For example, the Framework Convention on Tobacco Control, the world's first international health treaty under the auspices of the World Health Organization, signified that the globalization of the tobacco industry required international cooperation to contain and mitigate the effects of the global tobacco epidemic. However, contemporary globalization has also entailed changes in domestic policy environments which have had impacts on global health governance. Especially since the 1980s, the competitive environment of neoliberal globalization, increased mobility of labour and capital, and the increased fiscal authority and capacity of private sector actors (particularly corporations), coupled with ideological shifts evidenced in the Washington Consensus, have had important implications for the character and quality of social rights, economic security and governance, and ultimately for health and health outcomes. In many cases, domestic compensation policies were retrenched or abolished as the ideological

climate under contemporary globalization favoured shifting responsibility for welfare from the state to the individual and the private sector. Thus, the state in the era of globalization faced substantial changes.

Richard Falk (1999) coined the term 'predatory globalization' to describe the effects of global capital on the sovereign state. The competitive environment of globalization and the neoliberal ideological climate that dominated for the past several decades created significant pressures and impacts for states in the global North and South. Notable among these are burdens and crises in global health, including acute and chronic disease epidemics that necessitate urgent and immediate action within state and multilateral institutions. This book presented multiple cases of new and emerging governance modalities under neoliberal globalization, describing some of the complex decision-making, service delivery, and governance arrangements that have arisen out of these configurations. Moreover, the chapters explored the interactions, tensions, challenges and opportunities arising out of these arrangements and discussed their impacts on global health. However, as the chapters within the first section reveal, powerful organizations such as the OECD (Schrecker) and countries – especially the US (Loeppky) – have exerted inordinate power in influencing global health governance. Individual states in the North (see O'Manique regarding Canada) and the South (see Fourie regarding South Africa) have been forced to adapt and seek new means for navigating the global health environment dominated by more powerful actors. In this governance framework, it has been clear, as several of the contributors indicated, that social determinants have not been adequately addressed.

Although powerful actors have the ability to influence the agenda disproportionately, the situation is much more complex than one governed by a few central actors. New governance modalities include expanded nongovernmental, civil society and private sector participation as well as mixed actor coalitions. Growing interconnectedness between states and non-state actors in health has the potential to yield improvements in global health outcomes and cooperation. However, as several chapters within this book have demonstrated, there are challenges as well as opportunities inherent in these configurations. Under globalization, private authorities have amassed more power and influence due to the delegation of power by governments to private authorities and/or the retreat of government from certain policy areas such as health care. The rise of private authority under globalization – particularly *moral* authority or authority bestowed upon nongovernmental actors in civil society, such as religious and community-based organizations, as well as *market* authority or the growing power of the private sector, particularly transnational corporations – has received considerable scrutiny in international relations literature (Cutler, 1999; Cutler et al., 2003). Transformations in configurations of power and influence in moral and market authority were instrumental in the transition from international to

global health governance – a transition characterized in part by an increase in the number and type of actors participating in health decision and policymaking as well as in service delivery.

Beginning in the 1980s, we began to witness an upsurge in international health collaboration. Collaboration emerged largely as a result of specific interventions for disease outbreaks (that is, Ebola, SARS, HIV/AIDS) and was predominately coordinated by the World Health Organization (Loughlin and Berridge, 2002). Both governments and nongovernmental organizations have participated in these efforts, and, increasingly, the latter have been called upon to contribute to national and international responses and initiatives. Accordingly, new mixed-actor coalitions and networks emerged, often around specific diseases and/or disease treatment. These organizations formed both to share information and resources on a health condition and/or to advocate for changes in funding, research and/or treatment. For example, activist networks[2] around HIV treatment proved instrumental in securing price reductions around antiretroviral drugs, as observed in chapters by Hein and Kohlmorgan and by Brown. Thus, global health governance has increasingly been characterized by a mix of actors in governance arrangements as well as the redirection of service delivery and decision-making functions from intrastate *and* interstate mechanisms to non-state actors.

Hein and Kohlmorgan's chapter demonstrated that non-state actors have played a central role in building subsidiary norms around key global health issues, and, in so doing, have contributed to the expanded access to essential medicines, such as HIV treatments. However, along with the positive outcomes of collaboration, there have also been complications. In her chapter, Siri Bjerkreim Hellevik explored the challenges imposed by growing proliferation of state and non-state actors within global health governance and found that the challenge of coordinating efforts so as to avoid redundancies, fill gaps, and manage decision-making and programming is so great that there is actually a 'crisis of implementation'. While greater numbers of actors have entered the global health governance arena, there are ongoing challenges as well as large gaps to be filled in scaling up health promotion, treatment and support responses. As Hellevik notes, however, there are massive initiatives by state and multilateral institutions that are underway.

Ways forward

In moving forward, there is a clear need for more research and oversight to evaluate and monitor practical and normative contributions to the emerging global health architecture. Hein and Kohlmorgan's chapter demonstrated that, indeed, non-state actors have played a central role in building subsidiary norms around key global health issues, such as access to essential medicines. Hein and Kohlmorgan suggested that it has been the coalescing

of state and non-state actors which has been instrumental in norm generation, diffusion and implementation. Thus, not only have non-state actors played a key role in global health governance and service delivery, but they have also contributed to the development of norms around global health which have effectively expanded access to life-saving HIV treatment. Siri Bjerkreim Hellevik explored many of the challenges of this expanded arena of global health governance, including the often underexplored issue of coordination. With a growing proliferation of state and non-state actors within global health governance, the challenge of coordinating their efforts so as to avoid redundancies, fill gaps, and manage decision-making and programming becomes increasingly overwhelming. Hellevik argued that the challenge of coordination is linked to one of the recurring central themes of this book: that of the 'crisis of implementation'.

The phrase 'crisis of implementation' is perhaps not overstating the situation regarding global health governance overall. Several of the book's contributors, many of whom address PPPs as the most prominent example of the new global governance modalities, echo concerns about serious impediments and bottlenecks that exist in trying to effectively address the global HIV/AIDS crisis. This is only one disease (albeit one in critical need of solution), but there is a serious crisis of implementation surrounding myriad global health issues involving both infectious and chronic diseases. Despite considerable effort, and massive infusions of resources to address several of these health issues, it appears that we have only just scratched the surface on what needs to be done. Moreover, it appears that there is no consensus on where is the most effective place to begin, despite a well-developed, compelling argument that the health of populations is determined more by social conditions than by biotechnological intervention. Indeed, there has been more rhetoric than action to date on addressing the social determinants of health.

Recommendations for research

There are significant gaps in our knowledge about many of the new and emerging governance modalities in global health governance. For example, considerably more research needs to be conducted on public–private partnerships, particularly research about the operations of partnerships on the ground (Widdus, 2003). In particular, since funding and programmatic interventions by philanthropic foundations have been sizeable, and because these organizations now play a greater role at policy and decision-making tables, their roles in global health governance deserves more scrutiny and evaluation. For instance, we need to develop criteria and measures of effectiveness for governance arrangements to evaluate their success in meeting their stated objectives, as well as their contributions to cooperation with other actors in achieving overall global health goals. Indeed, the issue of coordination applies to the entire range of institutions and actors of global

health governance; while the literature contains an extensive array of studies examining discrete actors and institutions in global health governance, very few examine the interfaces, conflicts, and methods of cooperation and coordination (as discussed by Hellevik in her chapter) among and between these actors and institutions. Even fewer assess how these contradictions, conflicts, and cooperation affect national health governance, or the normative basis of global health governance. Research into normative frameworks is critical to understanding: why social determinants of health continue to be underresearched (see the chapter by MacLean and MacLean); when research is necessary to investigate the sources and solutions of global inequality and inequity; and to question whether global health governance is becoming a euphemism for Western/Northern privilege in health and dominance in governance. While the global North has an important and necessary role to play in global health research, funding, and intervention, many of the chapters of this book also suggest that greater inclusion by actors from the global South will be critical to improving global health.

Recommendations for practice

The WHO Commission on the Social Determinants of Health (CSDH), launched in 2000,[3] completed its final report this year (CSDH, 2008). The report advances a new normative framework for health that would place the social determinants of health at the centre of research and policy on global health. Such a framework does not replace the currently dominant biomedical model that privileges curative care and technological intervention; rather, it underscores that a disproportionate emphasis on the biomedical model is inimical to producing optimum health outcomes. Instead, there must be simultaneous, adequate attention paid to societal conditions such as social gradient, poverty, education levels, housing conditions, gender inequalities, etc., that shape individual and population health risks and outcomes. The CSDH report includes recommendations that target three main areas to move the global health agenda forward. They include: seeking more accurate information (better monitoring and surveillance); improvements in health systems (developing capacity, competence and infrastructure at local and national levels); greater efficiency in multilevel governance (better coordination of state, interstate and non-state actors). With recommendations such as these, we can see the gradual advancement of the new normative framework noted above, but also a gradual advancement in strategizing about practical ways to approach health governance under such a framework. In doing this, the CSDH perhaps takes us a step closer to realizing the ambitious Millennium Development Goals.

This book has provided an overview of contemporary governance and political economic arrangements, limitations, and impacts on global health research and outcomes. We conclude this book by arguing that existing arrangements, while offering some improvements in global health, still

have a long way to go in order to deliver on the weighty and critical promises offered to the world in the Millennium Declaration, which contains eight goals that each relate to a social determinants approach to human development and health.

The eighth MDG goal reflects the international community's commitment to joining together to provide the necessary energy and resources to support the realization of these critical human development goals. Official development assistance, or aid from developed countries to developing countries, continues to fall well short of the 0.7 per cent of gross national income target which former Canadian Prime Minister Pearson envisioned many years ago. The only donor countries to reach or exceed the 0.7 per cent target were Denmark, Luxembourg, the Netherlands, Norway and Sweden (UN, 2007).

In addition to failing to deliver on financial commitments, too many developed countries have turned a blind eye to the corporate practices of their private sector companies, which charge exorbitantly high prices for life-saving drugs, dump hazardous wastes and products in developing countries, contribute to civil and/or political conflict in their overseas branches and market carcinogenic products to children in developing countries. Furthermore, trade negotiations between the developed and developing countries in the World Trade Organization continue to reflect substantial inequities in terms of agricultural subsidies (namely in the United States and European Union Countries) that impede the ability of developing countries to sell their agricultural products on world markets.

The global patent system (discussed in several chapters of this book), otherwise known as 'TRIPs', which provides 20-year patent protections for newly developed drugs, has meant that pharmaceutical companies have enjoyed monopoly patent protection for many life-saving medications, particularly HIV/AIDS-related medicines. This global rule system has driven up the prices of drugs, making them largely out of reach for developing countries and their populations. Considerable and sustained social activism from groups like Medécins Sans Frontieres, Oxfam, Treatment Action Campaign and other international and domestic groups has pressured drug companies to substantially reduce their prices, which has expanded access. However, in sub-Saharan Africa alone, eight out of 10 people, including many children, requiring access to antiretroviral treatment currently have none and will ultimately die from a virus that can be suppressed for long periods of time with treatment.

The MDGs represent an important achievement by the international community; that is, the commitment of countries to come together with the United Nations to transform the human condition essentially and fundamentally. There is no more serious commitment than the promises and hopes that these goals represent; indeed, billions of people in the world are relying on states, institutions and private donors to put forth the requisite energy and resources necessary for their realization. In addition to the

renewed energy and commitment required by all global health actors, this book has put forward the argument that there needs to be significantly greater emphasis on a social determinants of health approach to global health. Over 20 years ago the Ottawa Charter for Health Promotion (www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf) fundamentally transformed traditional notions of health that saw health as both the absence of disease and a product of individual decision-making and lifestyle choices. The Charter affirmed that the determinants of health were social, economic, political and environmental in nature, and, accordingly, that responsibility for health was not solely in the purview of individuals and the health sector. The Charter also stipulated that health equity must be built into the strategies for health promotion, and that men and women must be able to equally avail themselves of opportunities to protect and promote their health – opportunities which extend beyond, but include, access to health care. The Charter acknowledged the important role of healthy public policy in creating favourable conditions for health. While there have been indications of renewed commitment to the principles contained in the Ottawa Charter (for example, CDSH, 2008), fundamental changes to state, multilateral, and nongovernmental research, policy and funding priorities and interventions will be critical to shifting focus to a social determinants of health approach.

Prospects for such a shift are uncertain, at best, especially given the current financial and economic collapse. Certainly, there are strong pressures to rethink the ideology that has dominated for the past several decades and ultimately to dismantle neoliberal policies and structures. For instance, US President-elect Obama has indicated his intention to push for a 'big-spending, FDR-type solution' (Krugman, 2008, p. 7) to the crisis, and this strategy is supported by several economists, including recent Nobel Prize recipient, Paul Krugman, who is calling for a new economic order based on Keynesian prescriptions of 'large-scale deficit spending by the government' (ibid.). Meanwhile, other leaders of industrialized countries are calling for similar reforms. Germany's Chancellor, Angela Merkel, recently argued publicly 'that the world ought to be looking for its example in Germany's "social market economy" – a model involving heavy state intervention and tacitly bridled competition to find new rules for capitalism' (Vinocur, 2008, p. 2).

However, it is too soon yet to predict whether government support will extend beyond 'bail-outs' to the financial and business sectors to increased social spending, and hence greater health equity. Rather than moving toward a new Keynesian moment, governments may instead scale back on both domestic and foreign health commitments. The financial crisis is now reaching all corners of the world; oil and gas prices are plummeting, consumer spending is down, unemployment is on the rise, and there are major fluctuations in world financial markets generating insecurity in pensions, investments and employment. In this climate, not only governments,

but also the private investors that have become significant players in global health governance, may significantly reduce their commitments to causes in developing countries and to initiatives such as the Global Fund. Presumably, it is fears about the likelihood of this scenario that prompted Margaret Chan, current Secretary-General of WHO, to observe in a recent speech that 'impoverishing health care expenditures – that in "good" times push more than 100 million people annually into poverty – are likely to increase dramatically. … [And, therefore] stronger social safety nets are urgently needed to protect the most vulnerable in rich and poor countries' (Chan, 2008).

In the same speech, Dr Chan makes the point that support for the social sector will not only protect the most vulnerable, but will also generate efficiency; such support, she argues, is one of the most cost-effective strategies to stimulate economic recovery and equitable distribution of resources (as through policies designed to achieve heath equity) and to encourage social stability and security. Obviously, navigating the financial crisis will require some careful management by the governmental, intergovernmental and nongovernmental actors that make up the global governance system; now, however, perhaps more than ever, it is critical that the central actors take note of overwhelming evidence that healthier populations make for wealthier populations. Thus, planning and investments for health must be a key priority of governments, and, supported by a strong, sustainable and committed multilateral strategy, the emphasis must be on achieving a fundamental shift towards a social determinants of health approach to create a healthier, wealthier world for all.

Notes

1. http://www.un.org/millenniumgoals/pdf/mdg2007.pdf
2. Some of the most notable are the South Africa-based 'Treatment Action Campaign' (www.tac.org.za), the US-based 'Health GAP' (www.healthgap.org), Oxfam (www.oxfam.org) and Medécins Sans Frontières (www.msf.org) campaigns.
3. The CSDH website is at http://www.who.int/social_determinants/about/en/.