THE SHAPING OF GLOBAL HEALTH POLICY

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The enjoyment of the highest standard of health is one of the fundamental rights of every human being…. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

WHO constitution, 1948

The role of the World Health Organisation in the context of the United Nations system was clearly specified in Article 2 of its constitution: ‘to act as the directing and co-ordinating authority on international health work’. Yet new institutions, networks and operators are increasingly active at the global policy level, often with substantial funding and increasingly limited respect for traditional United Nations operators such as the WHO. One aspect of this is the way commercial interests operating at the international level seek to define global and national health standards and the focus of health policy at both global and national levels. It is also becoming important to consider the institutional background and legitimacy of global organisations, as well as the ways in which global agendas and actors are influenced and shaped by commercialisation and commercial policy priorities set in other sectors, such as trade or industry, outside the remit of ministries of health. This often undermines the remit of the WHO, the normative agency for global health policy.

There are three different ways of understanding what agencies involved in global health policy actually do: first, establishing global regulatory measures and standards; second, setting broader global policy agendas for common global action (e.g. ‘health for all’ primary health care; HIV/AIDS) and third, determining how global policies for health either enhance or limit the scope for national health policies and the global distribution of health resources. The institutions traditionally involved in making global health policy, in
particular the WHO, have shared a common conceptual framework and language derived from medical and public health knowledge and language, and shared priorities. While the ‘medicalisation’ of policy can be a problem, the shared discourse of medicine and public health does permit evidence-based analysis and the assessment of problems across countries. By contrast, when the emphasis in global policy efforts is focused overtly on trade and economic policy, the institutions involved, such as the World Bank, the World Trade Organisation (WTO) and the OECD, become the first and main reference point, with different discourses, priorities and assumptions. These emphases have often dominated policies also within development policy and the so-called development community.

SETTING HEALTH STANDARDS
The role of the WHO in a global standard-setting agenda is crucial. Where global standard-setting for health interferes with key commercial interests, struggles take place aimed at limiting the WHO’s regulatory activities, shifting responsibility for setting standards to other intergovernmental organisations or coalitions (‘forum-shopping’), or directly influencing the standard-setting process and its outcomes. One telling example was the global Framework Convention on Tobacco Control. In spite of the overwhelming evidence on the health impact of smoking tobacco, corporate lobbyists used their power to sidetrack the WHO from, for example, initiating and negotiating the tobacco framework agreement. The argument used to limit the regulatory activities of the WHO or other United Nations agencies is usually that there is no need for global regulatory guidance, or that the organisation in question is inappropriately changing its focus. As Zeltner reported:

The Tobacco companies’ own documents show that they viewed WHO, an international public health agency, as one of their foremost enemies. The documents show further that the tobacco companies instigated global strategies to discredit and impede WHO’s ability to carry out its mission. The tobacco companies’ campaign against WHO was rarely directed at the merits of the public health issues raised by tobacco use. Instead, the documents show that tobacco companies sought to divert attention from the public health issues, to reduce budgets for the scientific and policy activities carried out by WHO, to pit other UN agencies against WHO, to convince developing countries that WHO’s tobacco control program was a ‘First World’ agenda carried out at the expense of the developing world, to distort the results of
important scientific studies of tobacco, and to discredit WHO as an institution.¹

Corporate interests in pharmaceuticals, nutrition, alcohol, infant foods, etc. have also made considerable efforts to limit, influence or undermine the role of the WHO. Forum-shopping has been one key way of limiting the scope of global health policies. One example of this is the transfer of pharmaceutical and research-related regulatory issues from the WHO to the International Conference on Harmonisation,² an organisation with an office in the headquarters of the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) in Geneva. This represents a move by the USA, Japan and the European Union to shift decision making from the WHO towards a more corporate-led forum. Another example of shifting issues from one forum to another can be seen in the broadening of the scope of the work of the International Standards Organisation (ISO), which is more directly linked with the corporate world. However, not only strong global corporate actors, but also governments, or coalitions of governments, likewise influence regulatory measures and priorities. One of the most recent instances of this was the Bush administration’s engagement in a broad variety of global regulatory efforts, e.g. its opposition, alongside the sugar industry, to the WHO’s proposed global strategy on nutrition.³

Another strategy is to claim that the standards are too strict, and are in effect protectionist measures. While ‘too strict’ health standards can be used to protect particular corporate or industry interests, this strategy has also been used in some of the most prominent WTO cases involving the adjudication of disputes between advanced capitalist countries in areas concerning asbestos regulation and the use of hormones in cattle raising. Trade-related interests and concerns can be used to undermine legitimate health-related regulatory efforts. In the field of services the role of the WTO and the promotion of the liberalisation of services through the General Agreement on Trade in Services (GATS) is especially problematic for health systems, insofar as it locks in commitments to the liberalisation of health services while diminishing the scope for national regulatory policies. While governments have the option of not making such commitments, and can change them provided that they compensate for doing so through making other commitments, the danger is that, whether deliberately or just through approaching negotiations with insufficient care, governments can make too far-reaching commitments which tie the hands of future governments if they seek to further regulate, or back off from, market-driven healthcare systems.⁴

Another dimension of standard-setting is the commercialisation of
national health systems, making health services much more subject to WTO provisions. Publicly-funded but outsourced health services can become subject to trade regulations. The WTO’s focus on trade in health services is, however, likely to have more relevance for richer countries with better funded healthcare markets. It is less likely that a multinational corporation will seek to utilise WTO provisions so as to take over governmental health responsibilities in very poor countries with inadequate funding in the health sector. Their interest in using the WTO is more likely to focus on countries where money can be made. For their part, developing country governments are likely to be more eager to seek trade liberalisation in order to secure the expansion of health tourism and greater mobility for health professionals, however problematic this is for their national health systems.

Intellectual property rights and related measures have also become an increasingly important part of global trade policy, especially with respect to the interests of the global research-based pharmaceutical industry. While the 2001 Doha declaration is often seen as an example of the successful articulation of health concerns in the context of global trade policies, any real movement in terms of trade policies was limited. Instead, as a result of efforts in support of access to medicines and R&D, global health policy-making in this area has been restructured into a field of myriad coalitions, initiatives and measures, with a lack of coordination or a clear focus on how these relate to global or national health policy priorities. The tensions are particularly strong in relation to trade in generic medicines and the extent to which competition can be maintained in this area, so as to reduce prices. The upward-ratcheting movement of global standards for intellectual property rights, which benefit global corporations, is much stronger than for global labour, health and safety or other standards which have more problematic implications for global corporations.

GLOBAL HEALTH GOVERNANCE

The WHO’s global role in both the regulatory and the development context has always been shared with other United Nations agencies, such as the International Labour Organisation, the FAO, and United Nations funds such as UNICEF and the UN Population Fund. But since the 1980s the OECD and the World Bank have also become involved with health and public sector reform policies which have been more in line with neoliberal policies and priorities. The institutional basis and context of policy discussion in both OECD and World Bank has been more conducive to a focus on economics and on the financing and organisation of health care. The 1980s and 1990s can be seen as a time when epistemic communities with competing agendas
for global health policy engaged in institution-shopping. In health systems, this was reflected in the healthcare reforms promoted through research networks working alongside the OECD and the World Bank.\(^7\)

While the 1978 Alma Ata declaration was based on a joint UNICEF/WHO initiative, these two organisations’ different approaches to global health largely defined their response to neoliberalism in the 1980s.\(^8\) The competing frameworks of more selective health care promoted by UNICEF, and more comprehensive health care promoted by the WHO, were both effectively undermined by structural adjustment programmes and the decline in health financing, as well as by the increasing involvement of the World Bank. Yet while the UNICEF’s focus on selective health care fitted better with the neoliberal economic policies and health reform agenda, it was UNICEF, rather than the WHO, which more vocally took up the issue of structural adjustment policies and their implications for health.\(^9\)

The WHO’s capacity to undertake research, analysis and action in relation to health systems has been limited, and the organisation has also been struggling with the prominence of ‘vertical programmes’ (programmes targeted at specific diseases or actions).\(^10\) When the OECD began working on healthcare reform issues and public sector reform in the 1980s, as well as on compiling data on health systems, it was filling a gap. The WHO’s lack of a focus on data collection and its limited capacity for global oversight provided scope for OECD and World Bank entry into the area. The World Bank had previously contributed to the establishment of the ‘selective healthcare’ agenda and along with the OECD had more control over the agendas and priorities of development aid agencies.\(^11\) Thus the declining support for health systems development and ‘health for all’ policies within the WHO cannot be accounted for only in terms of a failure to support the idealism embedded in the ‘health for all’ strategy, but was also a result of the politics of development funding and policy amongst key countries active on global health. The lack of funding for health as result of structural adjustment programmes in the 1980s was a key concern, as was the use of loan conditionality, which imposed user charges to generate resources for health care. The greater World Bank involvement in global health policy during the 1990s was also related to the way development funds were allocated through national development agencies, while the WHO remained primarily a terrain of ministries of health. Channelling technical assistance for health through other international agencies with different policy priorities compromised the WHO’s role as the global normative agency.

The World Bank’s focus on healthcare reforms was important, but the policies prescribed under these reforms have attracted widespread criticism.\(^12\)
The Bank’s engagement with health reforms had broader relevance, first of all, in relation to global guidance on policy matters within the development policy community (reflecting to a large extent policies set for developed countries in the context of the OECD); and secondly, in relation to the allocation of global health financing. While much of the Bank’s thinking on healthcare reform was based on work done within the OECD and related epistemic networks, the Bank’s engagement with public sector and healthcare reforms gained substantial attention not only due to the magnitude of the funding involved, but also by virtue of the initiative it took in redrawing the global health policy agenda in its flagship 1993 World Development report *Investing in Health*. Global actors without formal normative powers, such as the OECD or the World Bank, have to a large extent become in practice norm-setting institutions through their role in providing guidance and assessment. A less high-profile but often equally effective part of this normative engagement can be seen in the World Bank’s involvement in various types of policy guidelines and toolboxes for public policy, as well as through the teaching provided by the World Bank Institute.

It was in this way that global health policy in the 1990s was driven by World Bank priorities. If the 1980s was the decade of structural adjustment and lack of concern for health on the part of international agencies, the 1990s were an era of expansion and restructuring of the global policy agenda to fit the implementation of more neoliberal and market oriented policies within the health sector. Meanwhile, the WHO remained weak on health systems research, lacking the capacity to effectively address the issues that were raised with respect to healthcare reforms, even though some efforts were made in the late 1990s to enhance the influence of the WHO through, for example, an ad hoc working group of the WHO’s Executive Board. This lack of capacity in the WHO was accompanied by a move away from the ‘health for all’ strategy. The WHO’s controversial World Health Report 2000 on health systems was in effect largely based on World Bank expertise. While the Director General of the WHO, Gro Harlem Brundtland, formally still endorsed the values of ‘health for all’ policies, the report distanced itself from the strategy, explicitly emphasising that the WHO would need to base its recommendations on evidence rather than ideology.

The early 2000s, however, saw a rehabilitation of the primary healthcare approach within the organisation, an approach which continued to be supported by a large proportion of the WHO’s Member States. The most recent World Health Report on primary health care takes the WHO more explicitly back in support of the ‘health for all’ approach, with further support from the report of its Commission on the Social Determinants of Health,
which addressed issues of equity and a focus on inter-sectoral action.\textsuperscript{15} This shift has also been reflected in World Health Assembly resolutions in support of further WHO engagement in the area.\textsuperscript{16}

Global health policies are, however, also affected by global policy priorities, such as the Millennium Development Goals (MDGs). The MDGs emerged in practice out of seven OECD development goals adopted by the World Bank and the IMF.\textsuperscript{17} These goals are now used to define much of the work that all the United Nations agencies, including the WHO, are supposed to focus on. While there is some merit in highlighting the general aims embodied in the MDGs, as a guiding target they are problematic for global health policy and grossly inadequate to provide any general framework for WHO action.

On the other hand the human rights aspect of health, including the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, has once again slowly acquired a higher policy profile. A particular aspect of this relates to issues concerning potential conflicts with intellectual property rights. For example, in his address to the UN’s General Assembly, the UN special rapporteur on the right to health, Anand Grover, has taken a strong line concerning the way intellectual property laws affect access to medicines: ‘Developing countries and LDCs should not introduce TRIPS-plus standards in their national laws. Developed countries should not encourage developing countries and LDCs to enter into TRIPS-plus FTAs and should be mindful of actions which may infringe upon the right to health.’\textsuperscript{18}

THE FOCUS OF GLOBAL HEALTH POLICY: SPECIFIC DISEASES OR HEALTH SYSTEMS

One critical dilemma at the core of global health policy is that between more disease-based ‘vertical’ initiatives and more health systems-based ‘horizontal’ measures. The WHO as an institution is often still considered to be too ‘medically dominated’ and committed to vertical programmes, which reflect recent practice rather than the original (and only recently re-articulated) aims of the organisation. While the HIV/AIDS epidemic and growing concerns over malaria and new, more resistant strains of tuberculosis contributed to a focus on these three diseases, the vertical approach was further enhanced by the focus of the WHO’s Macroeconomic Commission on communicable diseases alone.\textsuperscript{19} The WHO’s role and focus has also become further complicated since the establishment of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. The expansion of funding for health personnel and health systems components within vertical programmes does not resolve
the more fundamental problems of health system financing. Furthermore, proponents of action in relation to non-communicable diseases have called for a similar financing mechanism, and one has already been suggested for maternal and child health.\textsuperscript{20}

The problem is that while HIV/AIDS resources in particular have grown, and have drawn more global attention to the need for finance, there has been criticism with respect to the balance of focus, as ‘the tide has not lifted all boats’.\textsuperscript{21} In some countries HIV/AIDS funding already exceeds other funding on health.\textsuperscript{22} A new balance in health policy is being sought, for example, through an emphasis on ‘diagonal financing’ for health care – i.e. using funding that is available for specific diseases to leverage funding for more comprehensive health care – and proposals have been made to change the role of the Global Fund to provide financing for comprehensive countrywide health programmes, so as to create ‘islands of sufficiency in a swamp of insufficiency’.\textsuperscript{23} However, while efforts to ensure a sufficient basis for primary healthcare and health systems is crucial to the longer-term success of more vertical programmes, in ‘diagonal funding’ the focus on health systems is still wrapped more around vertical programmes than the other way round. The global focus on communicable diseases can also be seen as part of a more ‘security-oriented’ and neoliberal policy position, in which epidemics are perceived as a security threat. It is also compatible with the key corporate concern to divert attention away from non-communicable diseases linked to tobacco, alcohol and food, and from pharmaceutical products for the treatment of non-communicable diseases.

WHO GETS TO MAKE GLOBAL HEALTH POLICY?
The continuity of financing for international agencies such as the WHO is in principle tackled through membership contributions, but as these have remained stagnant the role of other sources of funds has become increasingly important. This is likely to affect the WHO’s global capacity to implement global normative policies, while also giving a disproportionate profile and role to the additional ‘extra-budgetary’ funding the WHO has increasingly come to rely on. While the World Health Assembly may decide on policy priorities, their realisation depends on the organisation’s resources and capacities. In this respect the continuous limitation of the WHO’s core budget has also undermined the accountability of the organisation to its Member States.

Public policies in most countries are increasingly complemented by nongovernmental and charitable work. The growing role of NGOs as delivery agents for aid and development policies has been accompanied by
an emphasis on their role in global governance. In global health policy-making circles, the concept of civil society has always been understood as also including corporate interest organisations such as the International Federation of Pharmaceutical Manufacturers and Associations. The distinction between civil society and business is thus becoming increasingly blurred, not only in the context of the current emphasis on global public-private partnerships, but also where civil-society campaigns have been conducted by front organisations for commercial interests (‘astro-turf’ rather than ‘grass roots’).

In the 1990s the focus of global development efforts was strongly oriented to the role of nongovernmental organisations in social and economic development. This was complemented by the global focus on philanthropic actors, and has become especially marked by the entrance of new actors with substantial resources, such as the Bill and Melinda Gates Foundation (Gates Foundation). One aspect of this change has been the emphasis on ‘global partnerships’, which have been especially significant in the field of health. The focus on nongovernmental actors and networks was also reflected in the establishment of the Global Fund, which gave direct representation to industry and nongovernmental organisations, and was deliberately placed outside the formal remit of the United Nations. However, this has resulted in a situation where international public bodies, such as the WHO, have been underrepresented in the governance of these global health partnerships, while the corporate sector has been overrepresented. In spite of high expectations, corporate funding still accounts for only around 3 per cent of financial contributions to the Global Fund.

The engagement of the Gates Foundation in global health policy matters has been of particular importance not only by virtue of the magnitude of the resources involved, but also due to its active approach in not only funding, but also seeking influence over organisations and policies. Edwards defines ‘philanthrocapitalism’ in terms of three distinguishing features: 1) the deployment of substantial resources earned by small number of individuals in the IT and finance sectors; 2) a belief that methods drawn from business can solve social problems, and are superior to the other methods in use in the public sector and in civil society; and 3) a claim that these methods can achieve transformation of society, rather than just increased access to socially-beneficial goods and services. Reconciling the social and financial aims of ‘philanthrocapitalists’ with the aims of the member states of the WHO is thus not an easy matter, and systemic change involves social movements, politics and the state, which are often ignored by ‘philanthrocapitalists’. The tensions between different priorities have been reflected, for example,
in criticism by a high-level WHO official of the nature and dominating role of the Gates Foundation in relation to the global governance of malaria research. Questions have also been raised about the Foundation’s focus on technological solutions and particular diseases, as well as its emphasis on private the sector in the context of its support for the International Finance Corporation (IFC).

Other new institutions and mechanisms, from the Global Fund and UNITAID, the international drug purchasing facility, to GAVI (the Global Alliance for Vaccines and Immunization), have been especially prominent in networks and partnerships in the area of access to medicines and support for research and development. The Global Fund has utilised the ‘debt2health’ concept to forego the payment of part of a country’s debt in exchange for commitments of support for health programmes. It is also engaging more with the private sector to increase its share of support, and plans to issue products called Exchange Traded Funds to tap into the wealth of the global hedge fund industry. Another current trend is the promotion of AMCs (‘Advance Market Commitments’) which are favourable to corporate interests and needs and thus have gained substantial corporate support; the World Bank is set to take further responsibilities in relation to the pilot AMC schemes. In terms of global health policies, the first pilot project on pneumococcal vaccines is estimated to cost $1.5 billion. These arrangements have been criticised on the grounds that they offer support for corporate research but are likely to be an ineffective use of public funds.

While some of these arrangements may attract further funds from the corporate sector, they also give further support to the commercialisation of research and development activities as a starting point. In the light of the meagre resources that exist for many health systems and the lack of funding at the national level, there is a danger that the new initiatives become more profitable for the global commercial and consultancy sector than for health. The proliferation of these new initiatives for R&D and the financing of particular products can also be seen as a counterweight to proposals for alternative approaches, such as the R&D Treaty or Prizes. Alternatives include an emphasis on public financing and co-operation, non-profit research trusts, the enhancement of open-source-based licensing requirements and policies for tying pricing to the additional clinical benefits of a new product. However, these alternative mechanisms threaten the current domination of commercial interests in shaping the R&D environment which supports public-private partnerships and stakeholder coalitions, overall policies of tighter intellectual property rights and the extension of monopolies through longer data exclusivity and public subsidies for R&D. It is thus important to
question whether some policy options and choices continue to be ignored and undermined in favour of more commercially-driven choices.

The role of private foundations and partnerships alongside the increasing role of the G8 – or G20 – in global health policy-making also raises concerns in terms of legitimacy and accountability. The rise of health issues onto the G8 agenda, which represents a response to the anti-globalisation movement’s protests at G8 summits, may not be totally unlike what happened with the World Bank’s embracing of health after criticism of structural adjustment policies. The G8’s health agenda has been narrow, as reflected in particular in its concentration on initiatives related to infectious and neglected diseases. The G8 has also been explicit and strong in emphasis on the protection of intellectual property rights.\textsuperscript{39}

The role of funding, and in particular the funding role of the Gates Foundation, needs to be understood in the context of the magnitude of its contribution to the overall financing of global health, estimated as almost US$9 billion between 1998–2007.\textsuperscript{40} WHO extra-budgetary financing has increased substantially: the voluntary share of the WHO’s budget for the years 2010–2011 was estimated at $4.5 billion, while the estimated core budget share from Member State dues was just under $1 billion.\textsuperscript{41} In other words, more than 80 per cent of the WHO’s funding is dependent on voluntary or so called extra-budgetary resources. But private global financiers have their own agendas. The Gates foundation has come under increasing criticism for being focussed on specific technological solutions, and on the allocation of financing to research in the North.\textsuperscript{42} New initiatives on financing have also been used predominantly to enhance access to medicines and vaccines: UNITAID utilises air taxes in support of access to treatment for HIV/AIDS, malaria and tuberculosis, and the International Financing Facility for Immunisation raises funds through issuing bonds in capital markets in support of GAVI. The promotion of public funds and new incentives in support of corporate sector research for specific diseases is, however, problematic. A new initiative such as the recent US fast-track voucher can be criticised for essentially providing public subsidies to the global pharmaceutical industry,\textsuperscript{43} while being represented as a great and innovative measure for the benefit of the poorest in the developing world. Some of these tensions are reflected explicitly in James Love’s critical commentary on ‘orphan drugs’ legislation:

The Orphan Drug Act is used to privatize something that is in the public domain, such as an invention paid for by tax dollars, or a patent that has expired. It is particularly important to a company
when they have done the least to deserve the benefit. Companies use the Orphan Drug Act to stop other companies from investing in clinical research, or from bringing new innovative products to market. Orphan Drug exclusivity is broader than patent protection, for a given indication… Lobbying on Orphan Drug Legislation is funded by the pharmaceutical and biotech industry, with significant and often enthusiastic assistance from patients groups, many of which receive a wide variety of financial benefits from industry groups, and which typically represent consumers whose expenses are paid for by third parties, such as taxpayers or employers who pay insurance premiums. The results are legislative programs that make sense only if money isn’t scarce. What is needed are more targeted incentives to conduct essential medical research, with greater public accountability.  

RECLAIMING GLOBAL HEALTH POLICIES

International agencies and their legitimacy and accountability remain important for global health policies. However, we need to ask what kind of global policies we wish to have in the field of health, as well as what kind of organisations at both global and national levels are likely to be best equipped to realise these aims.

While the United Nations system of one-country-one vote can be criticised, it still remains the most representative global forum for global policy-making, and the most legitimate one because of both its mission and its membership basis of work. The shift to other types of partnerships and coalitions in global health governance has taken place without sufficient attention being paid to how they are formed and operate, blurring accountability and often giving these institutions, coalitions or networks substantial policy influence merely on the basis of their funding and ability to operate at the global level. While recognising the importance of transparency and the role of civil society we also need to be more explicit and clear about the policy aims, priorities and background of those representing civil society and making claims on behalf of it.

Defining the priorities of global health policy has never been an easy task. There is a need for global health policies to go beyond a mere focus on funding and technical guidance for developing countries. There are global common interests in health and health policies, but at the moment these are being undermined by the role of substantial commercial interests in key areas. The re-emergence of the WHO’s emphasis on ‘health for all’, primary health care and social determinants of health, is important, but is unlikely
to have broader relevance so long as the WHO continues to be starved of resources and unable to develop the capacity to further these policy aims. Furthermore, so long as global funding continues to be primarily allocated to vertical or disease-based programmes and institutions both within and outside the WHO, substantial moves towards more comprehensive policy approaches at the national level will be unlikely. Moreover, the emphasis on partnerships and corporate philanthropy in global health will continue to blur the boundaries of public and private decision-making, raising further problems of legitimacy and accountability.

NOTES

7 K. Lee and H. Goodman, ‘Global Policy Networks: The propagation of health


22 M. Lewis, ‘Addressing the challenge of HIV/AIDS: macroeconomic, fiscal and


32 McCoy et al., ‘The Bill and Melinda Gates Foundation’s grant-making programme’.


40 McCoy et al., ‘The Bill and Melinda Gates Foundation’s grant-making programme’.


42 McCoy et al., ‘The Bill and Melinda Gates Foundation’s grant-making programme’; Birn, ‘Gate’s grandest challenge’.
