

GLOBAL HEALTH WATCH

3



AN ALTERNATIVE WORLD HEALTH REPORT

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REPORT

Global Health Watch



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ACRONYMS

ACTA	Anti-Counterfeiting Trade Agreement
ART	assisted reproductive technologies
BIS	Bank for International Settlements
CBHI	community-based health insurance
CBM	community-based monitoring
CBO	community-based organisation
CCSS	Caja Costarricense de Seguro Social (Social Security Administration in Costa Rica)
CFTC	Commodity Futures Trading Commission
CGHS	Central Government Health Scheme (in India)
CHAG	Christian Health Association of Ghana
CHPS	Community-based Health Planning and Services (in Ghana)
CHW	Community Health Worker
CMS	Cooperative Medical Scheme (in China)
COP	Conference of Parties
CPHC	comprehensive primary health care
CRCAH	Cooperative Research Centre for Aboriginal Health (Australia)
CSDH	Commission on Social Determinants of Health
CSI	Centre for International and Intercultural Health
CSMBS	Civil Servant Medical Benefit Scheme (in Thailand)
DEVTA	De-worming and Enhanced Vitamin A
DfID	UK Department for International Development
DHS	Demographic and Health Survey
DNA	Deoxyribonucleic Acid
DPT	Diphtheria, Pertussis, Tetanus
DSM	Dispute Settlement Mechanism
EBAIS	Equipos Básicos de Atención Integral en Salud (primary health care clinics in Costa Rica)
EFPIA	European Federation of Pharmaceutical Industries and Associations
ELAM	Latin American School for Medical Sciences
ESIS	Employees State Insurance Scheme (in India)
EU	European Union
EWG	Expert Working Group
FAO	Food and Agriculture Organisation
FTA	Free Trade Agreement

GAIN	Global Alliance for Improved Nutrition
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GAVI	Global Alliance for Vaccines and Immunisation
GDP	gross domestic product
GFATM	Global Fund for AIDS, TB and Malaria
GHG	greenhouse gas; global health governance
GHI	Global Health Initiatives
GHP	Global Health Programmes
GHW	Global Health Watch
GISN	WHO Global Influenza Surveillance Network
GNP	gross national product
GOBI	Growth Monitoring, Oral Rehydration Therapy, Breast Feeding Promotion, Immunisation
GPA	Government Procurement Agreement
GPPI	global public-private initiative
GSK	GlaxoSmithKline Pharmaceuticals Limited
GSPOA	Global Strategy and Plan of Action
HDI	Human Development Indicators
HDR	Human Development Report
HLTF	High-level Taskforce for Innovative Financing
IADB	International American Development Bank
ICH	International Conference on Harmonisation of Technical Re- quirements for Registration of Pharmaceuticals for Human Use
ICPD	International Conference on Population and Development
IFPMA	International Federation of Pharmaceutical Manufacturers' Association
IGWG	Inter-Governmental Working Group
IHP	International Health Partnership
IHP+	International Health Partnerships plus
ILO	International Labour Organisation
IMF	International Monetary Fund
IMPACT	International Medical Products Anti-Counterfeiting Task Force
IMR	Infant Mortality Rate
INTERPOL	International Criminal Police Organisation
IPCC	Intergovernmental Panel on Climate Change
IPHU	International People's Health University
IPR	intellectual property rights
IU	International Unit
IVACG	International Vitamin A Consultative Group
IVF	In Vitro Fertilisation
JPMA	Japan Pharmaceutical Manufacturers Association
LIC	low-income country

LMIC	low- and middle-income country
MCH	maternal and child health
MDG	Millennium Development Goals
MMR	maternal mortality rate
MNC	multinational corporation
MSA	medical savings accounts
MSF	Médecins Sans Frontières
MTAs	material transfer agreements
MWS	Medical Welfare Scheme (in Thailand)
NAIHO	National Aboriginal Islander Health Organisation (Australia)
NCMS	New Cooperative Medical Scheme (in China)
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund (in Ghana)
NHIS	National Health Insurance Scheme (in Ghana)
NIEO	New International Economic Order
NRHM	National Rural Health Mission (in India)
NRT	new reproductive technologies
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket
OPT	Optimum Population Trust
ORT	Oral Rehydration Therapy
OTC	Over the Counter
PAI	Population Action International
PDS	public distribution system
PEPFAR	US President's Emergency Plan for AIDS Relief
PGD	pre-implantation genetic diagnosis
PHC	primary health care
PHI	private health insurance
PHM	People's Health Movement
PhRMA	Pharmaceutical Research and Manufacturers of America
PIP	Pandemic Influenza Preparedness
PPACA	Patient Protection and Affordable Care Act (in US)
PPP	public-private partnership
R&D	research and development
REDD	Reduction of Emissions from Deforestation and forest Degradation
ROI	return on investment
RTH	Right to Health
RTHC	Right to Health Care
RUTF	Ready to Use Therapeutic Food
SAM	severe acute malnutrition
SAP	Structural Adjustment Programmes

SDH	Social Determinants of Health
SECURE	Standards to Counter Intellectual Property Rights Infringements
SHI	social health insurance
SIMM	Italian Society of Migration Medicine
SIPRI	Stockholm International Peace Research Institute
SMI	Safe Motherhood Initiative
SOEs	State-owned enterprises
SPHC	Selective Primary Health Care
SPS	Sanitary and Phytosanitary Measures
SWAps	sector-wide approaches
TAC	Treatment Action Campaign
TBT	Technical Barriers to Trade
TFS	tax-financed system
TNC	transnational corporation
TOR	Terms of Reference
TRIPS	Trade Related Intellectual Property Rights
UCS	Universal Health Coverage Scheme (in Thailand)
UEHIS	Urban Employees Health Insurance Scheme (in China)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USTR	US Trade Representative
VAST	Vitamin A Supplement Trial
VHC	village health committee
WCO	World Customs Organisation
WDR	World Development Report
WFP	World Food Programme
WGNRR	Women's Global Network for Reproductive Rights
WHA	World Health Assembly
WHO	World Health Organisation
WIPO	World Intellectual Property Organisation
WTO	World Trade Organization

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Amit Sengupta (on behalf of Global Health Watch, editorial group)

INTRODUCTION

The *Global Health Watch* was conceived in 2003 as a collaborative effort by activists and academics from across the world. It is designed to question present policies on health and to propose alternatives. The previous two editions of the *Global Health Watch*, published in 2005 and 2008, were widely acclaimed as important contributions to efforts to redesign the way we approach issues related to health and health care. *Global Health Watch 3* has been coordinated by five civil society organisations – the People’s Health Movement, Medact, Health Action International, Medicos International and Third World Network.

Global Health Watch 3, building on the two previous editions, is designed to accomplish a number of objectives. It provides analysis of contemporary issues that impact on health and health care. It analyses policies, technical debates and global processes, not just in the health sector, but in a range of human activities that ultimately decide today whether people will live fulfilling and healthy lives or whether they are fated to be counted as mere statistics of the diseased and the dead. It is, thus, an analytical tool for activists, academics, developmental agencies and policy makers. *Global Health Watch 3* does not stop at mere analysis, however, but also argues for the types of action that can change how we, across the globe, go about providing people with the necessary instruments and policies to develop conditions whereby people are in control of their health. It is also, thus, a call for action directed at all those who believe that things need to change, and that the changes need to start now. *Global Health Watch 3* is also an endeavour to inspire, as it includes stories about how people are already trying to change their situation in diverse settings across the world.

Global Health Watch 3 comprises five broad sections. The first section, entitled ‘The global political and economic architecture’, provides an analysis to locate the decisions and choices that impact on health. The second section, ‘Health systems – current issues and debates’, provides a view of current issues and debates on health systems across the world, from which it is possible to draw appropriate lessons and propose concrete actions for promoting health. The third section, ‘Beyond health care’, is a recognition that health encompasses areas beyond the provision of health care. The section discusses some key areas that currently have the potential to impact on the multiple social, economic, political and environmental determinants of health. The fourth section – the core of the *Global Health Watch* – is the ‘Watching’ section, which scrutinises global processes and institutions that are crucially important for health and

health care throughout the world. The final section proposes alternatives and highlights stories of success and resistance that are exemplars of actual actions that have contributed to better health and health care.

Global political and economic architecture

The section provides an overview of the multiple crisis facing the planet. It examines the recent financial, food and fuel crisis (the ‘three Fs’) as well as two ‘slow burn’ crises – the climate crisis and the crisis of development. It explores the connections between the multiple crises and argues that these are not transient crises but indicate a deep ‘systems failure’ that plagues the practice of capitalism, which is informed by neoliberal theory and practice. This failure is manifest in different ways – in persisting and increasing global economic inequality, in the dominant role played by finance capital, in unequal and asymmetric global economic integration, and in a system of ineffective and undemocratic global governance. The section argues that if we want to achieve social goals such as health for all, poverty eradication, universal education, and the fulfilment of human potential, and to do so while simultaneously tackling climate change and achieving true environmental sustainability, then we need to redesign the global economic system to realise these aims.

Health systems – current issues and debates

The section on health systems starts with a chapter that reviews the current debates on primary health care (PHC), especially in the context of the renewed interest in PHC among many global agencies. The chapter discusses the departures contained in the present articulation of PHC from its original vision in the Alma-Ata Declaration of 1978.

The chapter on health financing focuses on the need to have a coherent vision about health financing and argues for a tax-based financing system as the most sustainable and the most likely to promote equity and access to health care. The issues of primary health care and health financing are discussed in further detail in three separate chapters, which examine health systems in the specific context of different countries. Country case studies from Costa Rica, Sri Lanka and Thailand reflect experiences in building sustainable health systems that are premised on public financing and provisioning. The case studies from India, China and the US analyse the underlying reasons for a ‘systems failure’ in the health sector in three of the largest countries in the world. A separate chapter on Ghana contests the recent optimism about the sustainability of the community-based health insurance scheme in the country and calls for larger reforms.

The distressing evidence regarding the very high price being paid by women across the globe, as a consequence of dysfunctional health systems and the neglect of social determinants, is analysed in the context of the persistence of very high levels of maternal mortality in different parts of the world. The

chapter on maternal mortality argues for an approach that locates the problems associated with high maternal mortality and morbidity in a framework that is sensitive to women's concerns and vulnerabilities.

The present research paradigm in the health system is heavily skewed in favour of biomedical interventions, to the almost complete neglect of research on health systems and the social determinants of health. The chapter on research contests the present reward-and-review systems for research as being located in concerns that are often far removed from the concerns of local communities. It argues for the need to reorient the entire research cycle, with changes in the way research is prioritised, funded, reviewed and conducted.

The recent global upheaval of H1N1 influenza was also responsible for calling attention to the deep inequities that persist worldwide as regards access to available tools that can control the spread of diseases. The chapter on 'pandemic influenza preparedness' examines this inequity in the context of the prevailing system whereby developing nations are exhorted to share their biological material but are denied access to health products that are developed from such material.

The final chapter in the section places the problems related to mental health in the context of growing worldwide inequalities. While attention is paid to the growing numbers of those who need care for mental health problems, too little attention is paid to the fact that these problems are often rooted in structural problems of inequity, rising consumerism and the marginalisation of whole communities.

Beyond health care

A striking feature of the global food crisis is that it is almost entirely a result of human greed and not of limitations on resources or capabilities. An analysis of the food crisis links it to disastrous policies that are promoting the replacement of food crops with biofuels, as well as the huge increase in speculative trading of food grains.

A major concern in conflict situations is the very poor availability of information that is vital to the planning of relief and rehabilitation work. Health workers face enormous challenges while attempting to collect and disseminate this information, often in the face of hostile opposition from the military and civil establishments. The chapter on 'conflict and information' focuses on this, often neglected, aspect of work in conflict situations.

The increasing impact of global trade on health is still not entirely understood, especially by people working in the health sectors. There is now a second push, after the WTO agreement, to expand the scope of activities that would be covered by trade – largely through the 'free' trade agreements and also through a slew of international treaties such as the Anti-Counterfeit Trade Agreement (ACTA). The chapter on trade and health examines the continuing concerns related to the agreements under the WTO, such as the

Trade Related Intellectual Property (TRIPS) agreement, and also looks at emerging trends in global trade that impact on health.

The promise of biotechnology and the gap between claims and actual delivery of useful health products by the biotech industry are discussed in the chapter entitled ‘The future is now: genetic promises and speculative finance’. The chapter traces the deep links between the biotech industry and speculative finance, both premised on a ‘future’ that is illusory and often false.

The climate crisis is discussed against the backdrop of the global negotiations in Copenhagen and Cancun. The analysis discusses the ‘carbon debt’ that rich countries owe to the rest of the world and argues for an approach based on ‘carbon budgeting’ that could balance the requirements for decreasing greenhouse gas emissions on the one hand and servicing the developmental needs of developing countries on the other. The final chapter raises concerns about the renewed focus on ‘population control’ in many developed countries, which seeks to fundamentally link the climate crisis with population increases in developing countries. There is a further attempt, today, to link conflicts with the climate crisis and the characterisation of those displaced by conflicts and developmental crisis as ‘climate refugees’. Such reasoning deflects attention away from the contribution of over-consumption by the global elite and resurrects the ‘victim blaming’ approach to the global crisis.

Watching

The section on ‘Watching’ begins with a discussion of the present trajectory of the World Health Organisation (WHO) and the very real challenges that it faces. Two case studies are discussed to foster a better understanding of the situation that confronts the WHO. The case studies describe the recently concluded negotiations in the Inter-Governmental Working Group (IGWG) on Intellectual Property and Public Health, and the continuing ambiguity regarding the role of the WHO in associating with the International Medical Products Anti-Counterfeiting Task Force (IMPACT) – a body with a very strong presence in and influence on the pharmaceutical industry. Both cases raise very strong concerns regarding the influence of large corporations and of a few developed countries, which seek a shift in WHO’s constitutional mandate. This is linked fundamentally to the way the WHO is financed, with over 80 per cent of funding now being accounted for from contributions by private foundations, other multilateral agencies and rich member states – contributions that are dedicated to specific programmes mandated by donors.

UNICEF’s role in promoting an extremely narrow and essentially biomedical approach to the problem of malnutrition in children is discussed, with specific reference to its promotion of ‘Ready to Use Therapeutic Foods’ (RUTF). Of further concern is UNICEF’s association with platforms of agribusiness corporations and private corporations manufacturing RUTF.

There is increasing concern about diminishing health returns from the

activities of the pharmaceutical industry, and even ‘the prospect of a world in which medicines and medicine produce more ill-health than health, and when medical progress does more harm than good’. The chapter on the industry’s present trajectory discusses the distortions inherent in a model that is premised on maximising profits. As a consequence, too few new products are being developed that target the health problems that afflict a majority of the world’s population. Innovation in the industry is severely constrained by the intellectual-property-based model, which directs research to areas where people can pay and not where new products are actually needed.

The rapid demise of international solidarity premised on participation of sovereign nation states, has been accompanied by the rise of ‘alternate’ centres of power that influence global policies on health and also finance a number of initiatives on health and health care across the globe. Prominent among these have been private philanthropies, most of them based in the US. A growing movement, termed as ‘philanthrocapitalism’ aims to harness the power of the market in order to achieve social outcomes, to increase economic growth in impoverished regions, and to make philanthropy more cost effective. The chapter ‘conflict of interest within philanthrocapitalism’ examines the functioning and priorities of the Bill and Melinda Gates Foundation in order to explore how the alignment of corporate interests and philanthropic investment may be having adverse effects on health policy.

Globalisation of almost all aspects of human activity has prompted a debate on the need to have global regulations and structures that secure people’s health, which faces threats from global influences. While this is a legitimate endeavour, ‘global security’ has often come to mean security for the globe’s elite against the much larger number of the global poor. The chapter ‘Health and global security’ discusses how the present concept of security demands total transparency and cooperation on the part of all parties involved, but not equity and solidarity between them.

International partnerships have rapidly replaced the UN system as the principal driver of health aid and health funding. The proliferation of such partnerships has also brought in its wake huge problems related to the ability of resource-poor countries to manage multiple, and often conflicting, demands of compliance from such partnerships. The International Health Partnerships plus (IHP+) initiative is designed to harmonise the efforts of these partnerships and help countries cope better. However, as the chapter on IHP+ discusses, progress has been very slow and there is still insufficient change in the way that the global health partnerships work.

The feminist movement has long questioned the way a biomedical approach to health reduces women’s bodies to receptacles for technological experimentation, especially focusing on women’s ability to produce children. Recent advances in reproductive technologies have now raised further concerns – technical, legal and social. The chapter on ‘new reproductive technologies’

discusses how these technologies lend themselves to commercial appropriation and the victimisation of women, especially women in poor and socially disadvantaged communities.

Resistance, actions and change

The final section, entitled ‘Resistance, actions, and change’, provides both a proposed theoretical framework for movements to intervene and challenge the existing order, and examples of how this is already happening in many parts of the world. The section discusses the People’s Health Movement’s (PHM) global ‘Right to Health’ campaign and provides glimpses of action in such diverse situations as India, Italy and Guatemala. The section, in a final chapter, describes the inspiring role that Cuba has played in promoting global solidarity, through a number of actions. The chapter describes the work of Cuban doctors in providing relief in situations of conflict and humanitarian crisis, including the recent work in Haiti. It also describes Cuba’s role in helping countries to develop their health systems and of the Cuban education system in providing training opportunities to health workers from many poor countries across the globe.

An ‘agent of change’

A book, especially one with the range of concerns and the very broad vision of this one, has its limitations. *Global Health Watch 3* does not claim to have made all the connections necessary to promote global health, in this one document. But it does claim to aspire to be an agent of change, which is both possible and urgent. It is ‘work in progress’, contributed to by activists and scholars from across the globe – people who believe that inequity on a global scale that prevents the flowering of human potential, manifest also at local and regional levels, is deeply embedded in human practice, and needs to be interrogated, challenged and changed. In the final analysis, *Global Health Watch 3* is an effort to give voice to the voiceless. Many of the ideas that are explored in this book are being explored in greater detail on the website of the *Global Health Watch* (www.ghwatch.org). Readers are invited to visit the website and contribute their ideas and experiences, so as also to be part of a global community that believes that change can happen, and we can be part of making it happen.

SECTION A

**THE GLOBAL POLITICAL AND ECONOMIC
ARCHITECTURE**

A1 | ECONOMIC CRISES AND SYSTEMIC FAILURE: WHY WE NEED TO RETHINK THE GLOBAL ECONOMY

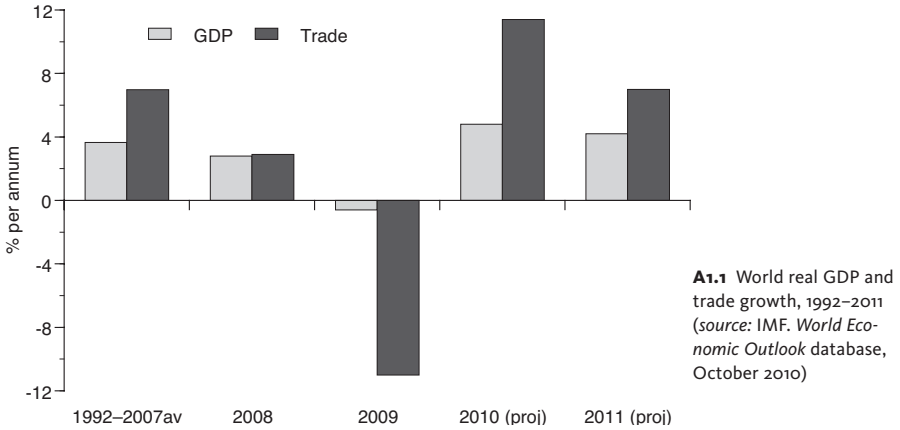
In recent years, the global economy has suffered three acute economic crises – a fuel crisis, a food crisis, and a financial crisis. We might think of these as the three F's. At the same time, we face two longer-term 'slow-burn' crises, those of development and climate change. Taken together, these crises clearly indicate not merely a succession of unfortunate accidents, but also a broader systemic failure, and signal the need for a fundamental change in the nature of the global economy and of economics itself.

Crises and connections

The three F's: the food, fuel, and financial crises Since 2007, the world has been suffering the most serious *financial crisis* since the Great Depression of the 1930s. As of October 2010, bank write-downs as a result of the crisis were estimated at US\$2,200 billion.¹ This is broadly equivalent in purchasing-power terms to the annual income of the poorer *half* of the world population.² World trade, having grown at 7 per cent pa between 1992 and 2007, slowed dramatically in 2009 and fell by 11 per cent in 2009, to a fifth less than it would otherwise have been. And even if global economic growth recovers in line with the International Monetary Fund's (IMF) latest projections – and there are very large downside risks to this happening – the overall loss of production between 2008 and 2015 owing to the slowdown in growth from the average 1992–2007 rate will be in the order of US\$13,000 billion (at 2010 prices).³ This amounts to nearly US\$2,000 for every man, woman, and child on the planet. (See Chart A1.1.)

The *fuel crisis* saw energy prices rise to historically unprecedented levels. The price of oil more than doubled between 1998 and 2000. After stabilising until 2003, it nearly doubled again between 2002 and 2005, and again between 2005 and 2008. At its July 2008 peak of US\$133 per barrel, the price was 94 per cent higher than it had been a year previously, and ten times the 1998 average. Other fuel prices followed a similar trend. Even in the wake of the most serious global financial crisis since the 1930s, fuel prices are higher today than in any year except 2008, and more than four times their average level in the 1990s.⁴ (See Chart A1.2.)

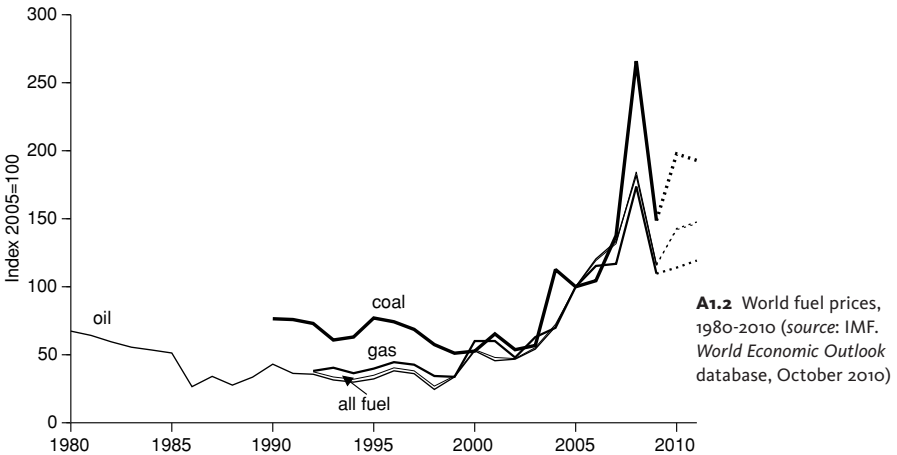
At the same time, rapidly increasing prices of basic foods triggered a *food crisis*. Overall, cereal prices increased by 123 per cent between 2005 and 2008, having already increased by 27 per cent over the previous five years. Rice, an



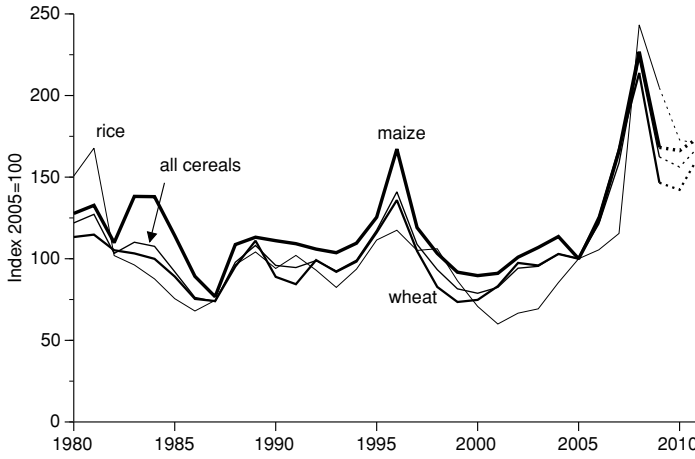
A1.1 World real GDP and trade growth, 1992-2011 (source: IMF. *World Economic Outlook* database, October 2010)

essential staple across much of the developing world, was particularly affected, the price increasing more than fourfold between 2001 and 2008. The price of maize, another critically important staple, increased by 127 per cent between 2005 and 2008. While prices have fallen back from their peaks, they again remain far above their pre-crisis levels. In 2010, rice, maize, and wheat prices remained at their highest levels for at least 30 years, and overall cereal prices were double their level ten years before.⁵ (See Chart A1.3.) The UN Food and Agricultural Organisation’s food price index reached a new historic high level every month from July 2010 to January 2011.⁶

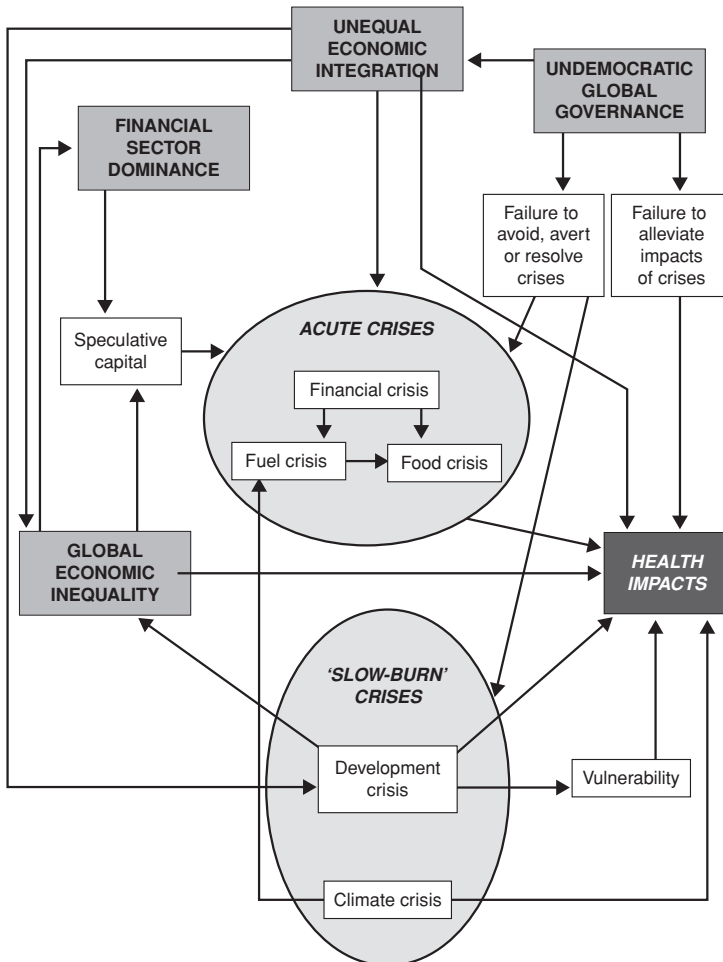
These three acute crises are both closely interrelated and linked to the two longer-term crises discussed later. (See Chart A1.4.) Rapidly increasing fuel prices contributed to increasing food prices, both by encouraging a shift to biofuels in the United States and the European Union (EU), and by increasing prices of nitrogen-based fertilisers. However, a stronger factor was the vast increase in speculative investment in commodity markets, with holdings of



A1.2 World fuel prices, 1980-2010 (source: IMF. *World Economic Outlook* database, October 2010)



A1.3 World cereal prices, 1980-2010 (source: IMF. *World Economic Outlook* database, October 2010)



A1.4 Linkages between crises and root causes

commodity index funds rising from US\$13 billion to US\$317 billion between 2003 and 2008.⁷ Such investment, particularly large-scale ‘momentum-based’ speculation that relies on prices continuing to move in the same direction, played a key role in driving up both food and fuel prices, greatly magnifying price movements and fuelling the development of speculative bubbles. (We discuss the dynamics of the food crisis, including the role of speculative finance, in detail in Chapter CI.)

The central role of speculative investment is clearly demonstrated by the complete contradiction between price movements since 2007 and market fundamentals. As a recent World Bank study of the 2006–08 commodity price boom observes:

Between the second half of 2007 and the first half of 2008[,] production of petroleum increased from 85.8 million barrels per day (mb/d) to 86.8 mb/d. Consumption fell from 86.5 mb/d to 86.3 mb/d. Prices should have fallen. In December 2007, crude oil averaged US\$90/barrel while in June 2008 it averaged US\$132/barrel, almost 50% up. Recent figures on spare capacity give an equally perplexing picture. During 2009, OPEC spare capacity stood at 6.3 mb/d while petroleum prices averaged \$62/barrel. However, similar capacity levels during the early 2000s were associated with \$20/barrel. Stocks of key food commodities are 20% higher in 2009/10 compared to 2007/08; yet the nominal food price index averaged 23% higher in December 2009 compared to a year ago, rather surprising given that an often cited reason for the food price spike of 2008 was low inventories.⁸

According to the UN Special Rapporteur on the Right to Food:

In none of these markets [for oil and gold, as well as food commodities] was there any restriction of supply or expansion of demand even remotely sufficient to explain the full extent of price increases ... *The 2008 food price crisis arose because a deeply flawed global financial system exacerbated the impacts of supply and demand movements.*⁹

The role of speculative investment in the financial crisis is still more apparent. The herd-like behaviour of speculative investors created a classic speculative bubble in sub-prime mortgages (and poorly understood derivatives based on them), giving rise to one of the most spectacular boom-and-bust cycles in economic history.

The financial crisis also played a major role in diverting speculative investment into both the energy and food markets, as confidence in traditional investment instruments evaporated and investors desperately sought safe havens for their assets.

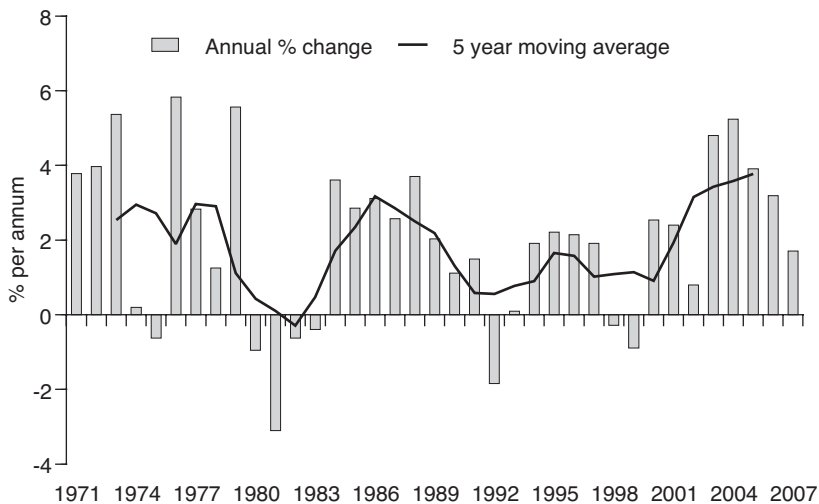
As each bubble burst, these large institutional investors moved into other markets, each traditionally considered more stable than the last ... [I]t was

thought that markets for food and oil could not possibly dry up: people may lose interest in asset-backed securitisation, but they will always have to eat.¹⁰

The 'slow-burn' crises: climate change and the crisis of development These three acute crises come on top of, and are again interconnected with, two 'slow-burn' crises. The first is that of *climate change*. Atmospheric concentrations of carbon dioxide and other greenhouse gases, largely driven by emissions from production and domestic energy consumption, have already reached a level at which they raise the global average temperatures by around 1° centigrade from pre-industrial levels. Continuing emissions will increase concentrations still further. This fact has been widely recognised for about some 20 years, and generally been accepted by the scientific community for a decade.

However, not only did emissions continue to rise until the financial crisis, but they also increased at an accelerating rate until around 2004. (See Chart A1.5.) In the continued absence of effective measures to reduce emissions relative to total production and consumption, a renewal of economic growth would drive yet further increases, and the upward trend is expected to resume (at more than 3 per cent pa) in 2010.¹¹ Even the earlier target of limiting the global temperature rise to 2° centigrade now looks increasingly beyond reach.

The effect, which is already being seen, is not simply a generalised rise in temperatures, but also an increase in the frequency of extremes of (high and low) temperatures and rainfall, and of storms, and (over the longer term) rising sea levels as the polar ice-caps melt. Consequences include floods, inundation



A1.5 Growth of global fossil fuel CO₂ emissions (% pa) (source: Boden, T., G. Marland & T. Boden (2010). *Global CO₂ emissions from fossil-fuel burning, cement manufacture, and gas flaring, 1751–2007*. Carbon Dioxide Information Analysis Center, Oak Ridge National Laboratory, Oakridge, Tennessee, 8 June 2010. cdiac.ornl.gov/ftp/ndp030/global.1751_2007.ems, accessed 11 February 2011).



1 Construction boom in China (Chongqing) (David Legge)

and sea surges, storm damage, and serious losses of production, particularly in agriculture. For geographical reasons, many of the poorest countries are among those worst affected. This vulnerability is increased by their economic structures (notably dependence on the most climate-sensitive sectors such as agriculture and in some cases tourism). They have the least resources to protect themselves through ‘climate-proofing’ and by responding appropriately to extreme weather events. Their low initial incomes greatly exacerbate the impacts on the population. (We discuss the state of play of the climate change negotiations in Chapter C5.)

The second ‘slow-burn’ crisis is the crisis of development across much of the developing world. While some ‘emerging market’ economies, such as China and Brazil, have achieved high rates of growth contributing significantly to development, most of the poorer and least developed countries continue to languish at income levels that do not provide a minimally acceptable standard of living for their people or the public resources needed for infrastructure, public goods, or effective administration.¹²

While this is most conspicuous across most of sub-Saharan Africa, a similar situation prevails in other low-income countries such as Nepal, Haiti, and Laos. The result is an increasing polarisation between (mostly) larger and more powerful ‘emerging market’ economies and a large number of (mostly) smaller and poorer ‘submerging markets’, struggling to keep their heads above the water as the rising tide of global economic growth conspicuously fails to lift all boats.

Tracing the connections These ‘slow-burn’ crises have also contributed to the more immediate ‘three F’s’ crises. Most obviously, a major part of the beginning of the food crisis lay in a relatively small shift towards the use of biofuels in the United States and the EU as a means of reducing carbon emissions in these regions (although the overall environmental impact of biofuels in their current form, and even their net effect on reducing carbon emissions, is open to question).

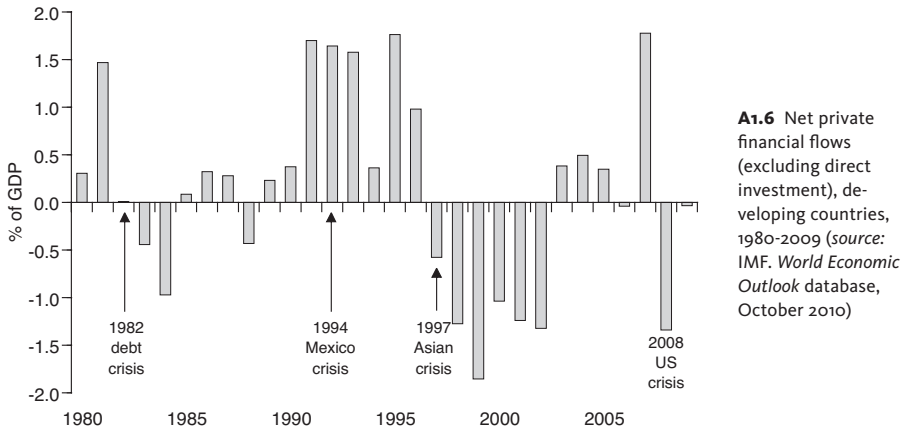
While it is difficult to draw definitive conclusions, the central role of climatic conditions generally in agricultural commodity markets (through effects on global supply) suggests that climate change may have contributed to the food crisis. Australia, a major cereal producer, suffered three major droughts between 2002 and 2008, a highly exceptional weather pattern which may well be attributable to climate change.¹³ A recent study also suggests a significantly negative net effect of climate-change-related temperature increases on rice yields in some locations in Asia.¹⁴

Equally, the failure of the major economies to reduce their reliance on fossil fuels, an essential step to tackle climate change, means that demand for oil and gas on international markets is much higher than it would have been had consumption been reduced in line with the constraints on carbon emissions. Had demand fallen in line with agreed global targets on carbon emissions, it is extremely unlikely that the fuel crisis would have occurred.

The primary effect of the development crisis has been to increase the vulnerability of the poorest developing countries, particularly to the food and fuel crises. Had they been successful in developing more robust and diversified economies, the impact of these crises would have been much more limited.¹⁵ Much the same applies to their economic vulnerability, and to their capacity for adaptation, to climate change.

Conversely, the development path by which the ‘emerging market’ economies have succeeded in escaping the trap of underdevelopment both increased their exposure to the financial crisis (although it may have reduced the impact of the food and fuel crises overall) and arguably contributed to increasing global carbon emissions, and hence ushering in climate change. (It should, however, be emphasised that it is the Northern economies that are overwhelmingly responsible for both the current levels of global carbon emissions and still more for the cumulative historical emissions that have given rise to current atmospheric concentrations of carbon emissions.)¹⁶

A major factor underlying the economic success of many ‘emerging market’ countries, most conspicuously China, has been the development of low-cost manufacturing capacity for export, primarily to the North. This has driven down prices, increasing overall demand for manufactured goods, and hence driving overall industrial production, while also shifting the balance of industrial production from the North towards the ‘emerging market’ economies, where environmental standards (including emissions standards) and their enforcement



are typically weaker. While there have been substantial developmental benefits, this implies an unambiguous increase in global carbon emissions.

This process may also further complicate efforts to deal with climate change at the global level in three ways. First, the capacity for enforcement of emissions reduction is likely to be weaker in the ‘emerging market’ economies than in the North. Second, there is a clear and widely acknowledged need to protect developing countries from the economic impacts of emissions reduction. The relocation of production in ‘emerging market’ economies thus simultaneously limits the potential for reduction if this need is to be met. Third, it gives rise to a potentially serious conflict in the negotiation process, as some Northern countries seek to blame the rapid growth of ‘emerging market’ economies for climate change, and to claim credit for the emissions reduction associated with the reduction in their own manufacturing production.

In reality, however, this last position is at best highly questionable. While production may have been relocated in the South, it is still largely meeting Northern demand, and in many cases (most notably Mexico), it represents in large part a relocation of the operations of Northern-based transnational companies, so that the profits are primarily attributable to the North, limiting the developmental benefits in the South. Moreover, while carbon *emissions* from Northern production may have been reduced, the carbon *footprint* of Northern consumption has been increased, both by higher consumption of (cheaper) manufactured goods and by the need to transport these goods from Southern countries.

A second key feature of the development of the ‘emerging market’ economies has been a substantial reliance on commercial capital, including, in most cases, speculative investment in shares, bonds, and other assets (e.g. real estate and other financial assets). This factor played a key role in the earlier (1997) financial crisis, which started in Thailand and spread rapidly through a process of contagion to affect most other ‘emerging market’ economies, with

the notable exceptions of China, Malaysia, and Chile, which had either limited their reliance on such flows or had taken steps to control them (contrary to the prevailing views of the time).

The substantial volume of accumulated speculative capital from abroad in these countries greatly increased their exposure to the financial crisis. As the crisis hit, there was a ‘flight to safety’ on the part of investors, and investments in most ‘emerging market’ economies, because of their greater perceived vulnerability (even relative to the United States, whose financial markets lay at the root of the crisis), led to major capital outflows. As in the 1982 debt crisis and the 1997 Asian crisis, the result was a major reversal of net private capital flows. (See Chart A1.6)

From multiple crises to systemic failure

As noted above, the fuel, food, and financial crises had an important common factor in the role of speculative capital. While there are also linkages with (and between) the climate change and development crises, these do not amount to a single, common, direct cause or to a set of causes. To understand this, we need to go back another step to the more fundamental roots of the crises.

Here we highlight four common, and closely interrelated, roots of the crises:

- global economic inequality;
- the dominant role of the financial sector;
- unequal global economic integration; and
- ineffective and undemocratic global governance.

Global economic inequality The twin ‘slow-burn’ crises of *development* and *climate change* epitomise global economic inequality. On the one hand, we have a crisis of climate change, which is a classic crisis of over-consumption. Climate change is driven by the high and increasing levels of emissions of carbon dioxide and other greenhouse gases associated with high levels of overall consumption and the production required to satisfy this demand. On the other hand, the development crisis is a classic crisis of under-consumption. A substantial majority of humanity does not have sufficient income to meet what might, by any reasonable standard, be considered to be their minimal consumption needs.

The coexistence of extremely wide gaps in consumption in different parts of the world can only be explained by inequality: that the excessive consumption of the world’s finite resources by the rich minority is not merely beyond an environmentally sustainable level, but is also so far beyond this as to outweigh the under-consumption by the poor majority by a considerable margin.

The scale of global inequality is little short of staggering. As measured by the Gini coefficient, the global distribution of income is substantially more unequal than that in the most unequal country in the world (Namibia).¹⁷



2 Sign on a building in the US, November 2008 (© Karin Hildebrand Lau|Dreamstime.com)

The ratio between the incomes of the richest 20 per cent and those of the poorest 20 per cent is twice as much in the most unequal developed country (the United States) and is double that in the most equal country (Finland).¹⁸ The considerable rise in inequality in the United States between 1976 and 2007 (see below) increased this ratio by about half. Globally, the ratio is nine times greater. Put another way, the difference between this ratio globally and the ratio in the most unequal developed country is seven times the difference between the most equal and the most unequal. And the difference between the global ratio and the US ratio is 14 times as much as the increase in the ratio over a period of 31 years characterised by dramatically increasing inequality in the United States.

The global distribution of wealth is yet more unequal. While those in extreme poverty have little left over after meeting their basic needs, the rich – and especially the ultra-rich – are able to accumulate vast fortunes. In 2000, the richest 10 per cent of the world’s population was estimated to own more than 85 per cent of the world’s total wealth. The poorer half of the world population owned only 1.1 per cent.¹⁹

This inequality underlies the considerable and rapidly growing volume of *speculative capital*, which in turn was a major factor underlying the fuel, food, and financial crises. Coupled with the growing role of the financial sector (see below), investment has been increasingly divorced from production. The lack of spending power of the majority of humanity provides limited incentives to invest in production to meet their needs, while income becomes increasingly

concentrated among the rich, who increase their consumption relatively little as their incomes increase.

As the volume of private capital available for financial investment outstrips the availability of profitable production opportunities, so it is driven into speculative investment in financial instruments, and this is compounded by increasing institutional investment as a result of the shift towards reliance on private rather than social provision, as funds are increasingly channelled into pension funds and health insurance.

As speculative investment increases, the prices of financial instruments and other speculative investments (e.g. real estate, art works, etc.) are driven up, providing artificially high rates of return. And these high rates of return simultaneously increase the profitability of speculative rather than productive investment, and increase the wealth of those at the top of the pyramid (in global terms) still further. This also generates still more resources for speculative investment.

One of the key causes of the rise in food prices, which (vastly compounded by speculation) triggered the *food crisis*, was also fundamentally a reflection of global inequality. Even with increased public subsidies, the shift to biofuels in the United States and the EU was only feasible because people with cars in the developed world can afford to pay far more to drive a few more miles than poor people in the developing world can afford to meet their most basic nutritional needs. As discussed later, this is part of a broader issue that represents a fundamental challenge to orthodox economics.

The roots of the *financial crisis* are also firmly grounded in inequality, though primarily inequality within the United States, the most unequal country in the developed world, rather than globally.^{20, 21} The benefits of growth in the United States in recent decades have been extremely concentrated, giving rise to a growing polarisation between a very large underclass and a very small minority of very wealthy individuals. Between 1976 and 2007, the incomes of the richest 1 per cent grew more than seven times faster than the incomes of the remaining 99 per cent, allowing the former to accrue 58 per cent of the additional income generated by growth over these 31 years. In the period immediately before the crisis (2002–07), their share of the benefits of growth was still higher (65 per cent).²² Distribution of the benefits of growth among the non-rich 99 per cent of the population was also highly unequal, so that the poorest 20 per cent of the population received only 1.2 per cent of the benefits of growth between 1976 and 2007, and the next 20 per cent received only 4.3 per cent, their average incomes rising by only 10.6 per cent and 15.2 per cent respectively over 31 years.²³

The accumulation of ever more income, far beyond their consumption needs, in the hands of a few gave rise to a rapidly growing pool of surplus funds looking for income-earning opportunities. And this has been further magnified by financial deregulation, allowing wealth to be leveraged (e.g. directly



3 Anti-WTO Protests in Hong Kong (© Mike Kwok|Dreamstime.com)

by borrowing money for speculative investment, or indirectly through margin trading), and by very low interest rates since 2001. At the same time, the very limited increase in consumption associated with glacial income growth among those at the lower end of the income distribution (who might be expected to spend extra income) has seriously limited productive investment opportunities. The result is a very large and rapidly growing pool of income-seeking non-productive (i.e. speculative) investment opportunities.

At the other end of the scale, about 40 per cent of the population earned very low and stagnating incomes, falling ever further behind the other 60 per cent of the population, in a very materialistic society where income and wealth are fundamental determinants of social status and self-worth. They had historically been largely excluded from the commercial and financial system, for the simple reason that their low and stagnant incomes meant that they had very low creditworthiness and very limited savings.

It was the commercial opportunity created by this extreme and growing inequality, together with deregulation of the financial system, that set the scene for the financial crisis.

When – as appears to have happened in the run up to both [the 1929 and 2007] crises – the rich lend a large part of their added income to the poor and [the] middle class, and when income inequality grows for several decades, debt-to-income ratios increase sufficiently to raise the risk of a major crisis.²⁴

The dominant role of finance The central role of speculative capital in the multiple crises, as discussed above, largely reflects the rapid growth, global integration, and deregulation of the financial sector. While the financial system played a major role in the food and fuel crises, its responsibility (and its irresponsibility) is clearest and most direct in the case of the financial crisis.

Following deregulation, the US banking system was quick to exploit the market opportunity created by extreme and increasing inequality (see above), doubling the size of the financial sector relative to the economy as a whole from 4 per cent to 8 per cent between 1981 and 2007.²⁵ Increasingly, in the lead-up to the crisis, banks offered mortgages and other loans to ‘sub-prime’ (i.e. non-creditworthy) borrowers, at very high interest rates to offset the very considerable risks, raising the money to do so by bundling loans together into totally opaque financial products, which they sold on to (mostly institutional) investors. By obscuring the true extent of the risks, they were able to limit artificially the cost of the funds, which were also limited by low or negative real low interest rates, following major reductions to counter the economic effects of 9/11 and the bursting of the ‘dot.com’ bubble.

In retrospect, it seems clear that this process was inherently unsustainable – and this should have been apparent at the time. While the debt-to-income ratio of the richest 5 per cent of households fell from 80 per cent to 65 per cent between 1983 and 2007, for the remaining 95 per cent of the population (the poorer and the less creditworthy) it more than doubled from 60 per cent to 140 per cent, closely reflecting developments in the period before the 1929 crisis.²⁶

Despite this evident instability, however, the process proceeded for (at least) four reasons.

- First, like most financial crises, it rested on a myth, that the cost of lending could be reduced by financial manipulation to spread risk across many lenders. While this may offer some benefits, the cost of lending is reduced much more by concealing the true level of risk from the ultimate providers of funds than by spreading the risks among them.
- Second, commercial financial companies are in practice largely driven by the desire to earn short-term returns, with more limited attention being paid to long-term risks. This is partly a consequence of the financial imperatives of the market, but partly also the result of the incentives offered to individual traders. If other traders are generating very high returns in financial products that are generally considered (or at least assumed) to bear an acceptable level of risk, each individual will face considerable pressure to match these returns, and his or her career progress will be seriously compromised by failure to do so.
- Third, the combination of deregulation with the dramatic increase in the possible complexity of the financial crisis opened up a vast gap between

what financial institutions were doing and the ability of the regulatory authorities to control, or even to understand, it.

- Fourth, the US authorities – apart from a strong pro-commercial and anti-regulatory bias – had little incentive to discourage lending to those on low incomes. To intervene to deprive a very large proportion of the population of long-awaited access to credit markets would have been politically suicidal, at least in the short term, and electoral cycles make political decision-making an inherently short-term endeavour.

This last point reflects the importance of political as well as economic inequality: the non-rich majority of the US population had sufficient electoral influence to force the government to pursue lax monetary policies that allowed them to maintain their consumption levels, but they did not have the effective power to force policies that would limit the increase in inequality in the face of opposition from a small but powerful rich minority.

This process was not unlike the lead-up to the 1980s debt crisis experienced by developing countries. In the 1970s, much higher world oil prices resulted in considerable surpluses in the major oil-exporting countries, while other, much poorer, developing countries faced much higher import bills. The international banking system, with official encouragement, ‘recycled’ the surpluses, taking them as deposits from the oil exporters and lending them at commercial rates (with a substantial mark-up) to the developing countries. Through most of the 1970s, interest rates were lower than inflation rates, and funds were plentiful, so borrowers could refinance interest payments from new loans without their debt positions becoming unsustainable. But in 1979, real interest rates rose sharply (as the developed countries responded very differently to a second oil price shock). The debts of developing countries quickly became unsustainable, and each default further undermined confidence, making creditors more reluctant to lend, and thus triggering further defaults. By 1983, virtually all of Latin America and sub-Saharan Africa (and a substantial part of Asia and Eastern Europe) faced acute debt problems.

The growing role of the financial system has also contributed to the development crisis. Commercial financial flows are, by definition, skewed towards those countries and purposes or areas where financial returns to the funders are highest relative to the (perceived) risk, that is, in general, to countries that are already better off and to investments that generate private rather than social returns. Commercial flows to the poorest countries, where capital is the most scarce, are very limited, and where these flows have occurred on a substantial scale (e.g. the recycling of oil surpluses in the 1970s), they have come at a high financial cost, ultimately proving unsustainable and triggering crises with very high economic and social costs.

This reflects a more fundamental inability of commercial finance and capital markets to narrow the gaps in income and wealth, particularly in the



4 Police stop ant-G8 protestors in Rome, May 2009 (© Marco Manieri|Dreamstime.com)

context of extreme inequality such as that which characterises the global (and most national) economies. An associated effect is the tendency of commercial finance, at least in its current form, to increase inequality rather than reducing it, both globally and nationally. (These issues are discussed further below.)

At the same time, the perception that developing countries have access to commercial finance (even though those in the greatest need do not) has arguably weakened political pressure for greater aid flows, and efforts to shift financing from official to commercial sources have contributed to the privatisation and commercialisation of public services, undermining their social benefits. Poorer developing countries are thus faced with a very narrow choice – that between very limited, expensive, and potentially destructive commercial financing, on the one hand, and official financing that is driven by donors’ agendas (including direct or indirect policy conditionality), whose supply is often erratic, unreliable, and unpredictable, on the other hand.²⁷

Commercial finance is also arguably a major contributory factor to the climate crisis. The logic of financial markets rests on maximising rates of return to capital, which (as well as lowering returns to other factors of production, notably labour) implies the exponential growth of output at the maximum possible rate. Climate change and other environmental problems arise because of the tension between exponentially growing production and consumption, on the one hand, and the associated use of natural resources and the production of waste, and the inherently finite eco-space of natural resources and environmental sinks within which it must, by definition, be contained, on the other hand. The result is the so-called lily pond effect.

For those ‘emerging market’ economies that have been successful in securing access to commercial financial markets (and particularly speculative capital), developmental benefits have probably been relatively limited in view of high domestic savings rates in most cases, and have been offset both by the financial crises triggered by these flows themselves (particularly following the Asian crisis of 1997) and by the knock-on effects of the US financial crisis. Had these countries been less integrated into global financial markets, their exposure to the crisis would have been much more limited.

More generally, there has been an enormous increase in the scale of the financial system. In the UK, for example, financial intermediation accounted for 8.3 per cent of total output in the economy in 2007 (7.7 per cent excluding net exports), of which the profits of financial corporations represented nearly half. This is more than half as much again as in 2001 (5.3 per cent), as the sector grew more than three times as fast as the economy as a whole in this period (6.1 per cent pa compared with 1.9 per cent pa). (As noted above, this is similar to the pattern followed by the US financial sector.) It is also substantially greater than either the education sector (5.9 per cent) or the health and social work sector (7.1 per cent).²⁸ Increasingly, the financial tail is wagging the economic and social (and political) dog.

The role of the financial system is essentially one of intermediation: facilitating the allocation of financial resources from those who have more capital than they need at a particular time to those who want additional resources. Even if the system functioned perfectly, allocating resources to those uses that provided the greatest benefit to society as a whole, some 8 per cent of the total value of production every year, would be a high price to pay for the intermediation of a single factor of production (particularly when more than 11 per cent is accounted for by wholesale and retail trading, nearly three times as much as transportation and storage). This means that for every US\$100 of output, nearly US\$20 goes to allocating capital between uses and getting products through various intermediaries, from producers to consumers.

In reality, however, the financial system is profoundly *dysfunctional*, triggering economic crises, increasing inequality, and generating potentially disastrous environmental impacts, while conspicuously failing to meet social goals such as poverty eradication, health for all, access to education, and the fulfilment of basic needs for the majority of humanity. It is at least arguable that it is doing more harm than good. We are not merely paying an extortionate price, but also paying an extortionate price for a system which is at best providing very limited net benefit.

This indicates an urgent need not only for fundamental *reform* of the financial system, but also for a much more radical *transformation* into a system that will serve societal goals and not undermine them.

Unequal and asymmetrical global economic integration The exposure of de-

veloping countries to the various crises (especially the financial crisis) was increased by their integration, to varying degrees, into the global economy through commercial globalisation. A financial crisis that arose from market abuse and a failure of regulation in the United States spread rapidly to other developed economies through the highly integrated global financial market, as European financial institutions, relying on the integrity of the US financial system, purchased large volumes of toxic assets, thereby endangering their own financial position. (By spreading the risk, this also greatly reduced the impact on the US economy, so that the proceeds of market abuse and regulatory failure were retained, while the costs were effectively exported.)

The increased exposure, particularly of ‘emerging market’ economies, to global financial markets made them vulnerable to the shockwaves arising from the resulting financial panic. These shockwaves emanated primarily from the opening up of national financial systems, which was actively promoted under IMF and World Bank structural adjustment programmes and the neoliberal economic model. Similarly, the exposure of developing countries to the food crisis was increased as a result of trade liberalisation and the promotion of export agriculture, thereby increasing dependency on imports of basic foods.

However, the problem is less one of integration as such than it is a problem of the asymmetrical and highly unequal nature of the integration process.

- Financial markets – the market of primary interest to the developed countries and to the rich – have become highly integrated.
- The international ‘market’ for skilled professionals has become moderately integrated as developed countries have increasingly ‘imported’ professionals in priority occupations (most notably health and communications professionals) from developing countries.
- However, the factor market of greatest interest for developing countries – that for unskilled labour – has remained almost entirely segmented, at least as between North and South, as developed-country governments face no constraint on the restrictions they can impose on immigration.

The result is the creation of highly favourable conditions for financial capital and for its owners (by definition, the rich); the creation of somewhat more favourable conditions for skilled professionals from the South (or at least those able to migrate), who are on middle incomes by global standards; and the provision of some degree of protection to Northern unskilled workers. However, all this comes at the expense of the poorest – poor people in poor countries who are solely dependent on unskilled labour for their income.

In principle, the greater mobility of the assets of the rich rather than that of the poor could be offset by greater integration of the markets for goods, that is, freer trade. However, this effect has been limited both by the extreme economic inequality between countries (see below) and the equally asymmetric nature of the global trade regime.

Before the Uruguay Round of trade negotiations (which led to the creation of the World Trade Organization) even began, many developing countries had been forced to open their markets under structural adjustment programmes forced on them by the 1980s debt crisis, yet they received no credit for these liberalisation measures in the negotiations.

International trade agreements in the areas of greatest interest to them were strongly skewed in the interests of the developed countries. The WTO Agreement on Agriculture was specifically designed to minimise the obligations of the United States and the EU, while requiring much more of developing countries. The highly protectionist Multi-Fibre Agreement (MFA) governing trade in textiles was phased out over ten years, and was done in such a way that almost no liberalisation was required until the end of the period. Even then, it was not phased out until well after the deadline. The interests of the poorer developing countries would, in any case, have been much better served by an enlarged and more equitable MFA rather than by its abolition, which merely allowed the largest and most successful countries (notably China) and transnational companies to dominate the market.

Conversely, international trade rules increased protection for the trade of the greatest interest to the developed world, the Agreement on Trade-Related Aspects of International Property Rights (TRIPs) providing monopoly rights in global markets to holders of patents and copyright. In addition to greatly increasing the cost of much-needed technologies (including, for example, medical and production technologies), this effectively sealed off a key element of the route to development that had been pursued by the ‘emerging market’ economies prior to the agreement, and by the developed countries when they were at a similar stage of development.

Throughout the trade negotiation process, the concerns of developing countries have been largely or wholly ignored. There has been no consideration within the WTO process of measures to limit the extreme volatility and chronic decline of prices of primary commodities (agricultural produce and raw materials) on which most of the poorest developing countries are critically dependent. The first step in the current so-called Doha ‘development’ Round of negotiations was to remove from the agenda the primary concerns of the developing countries, particularly their entitlement under the Marrakech Agreement establishing the WTO to ‘special and differential treatment’ (which has been limited to somewhat extended implementation periods for requirements identical to those of developed countries), and the obligation under several of the previous agreements to review their impact prior to further negotiations.²⁹

Beyond these asymmetries in the coverage of globalisation, there are three fundamental flaws in the nature of the globalisation process that would have serious disadvantages for the poorest developing countries even if it were applied more symmetrically.

- First, it focuses almost exclusively on financial and commercial considera-

tions, leaving social and humanitarian concerns to be dealt with (if at all) through separate, discretionary, and much more limited measures.

- Second, it is based on a blind faith in the benefits of market mechanisms, which, by their nature, favour those who have the greatest market power (rich countries, rich people, and large companies) at the expense of those who have little or none (the poor).
- Third, and most fundamentally, it is based on a competitive rather than a collaborative model, in which countries must compete for (market-driven) financing and export opportunities. This competition favours the strong, and excludes the weak; and the success of the former and the failure of the latter widen the gap between them still further, driving the weakest into a never-ending downward spiral. In this sense, the growing number of failed states is not an unfortunate accident, but an inevitable result of competitive commercial globalisation.³⁰

Ineffective and undemocratic global governance The sustained pursuit of an approach to globalisation that is inimical to the interests of the poor majority of humanity is directly attributable to fundamental flaws in the nature of global decision-making. These flaws also explain, to a considerable extent, the failure to prevent the five crises discussed in this chapter, to deal with them effectively, and to avoid unnecessary social and human impacts.

Undemocratic ... The developed countries, although a relatively small minority of the world population (14 per cent), exercise almost complete dominance over global decision-making processes, subject only to the relatively limited influence of the larger and more economically powerful developing countries (notably China, India, and Brazil). Smaller and poorer developing countries have virtually no influence.

In the IMF and the World Bank, this dominance is institutionalised through ‘economically weighted’ voting systems, which give the developed-country governments a majority of the votes, and the United States alone a veto on all major policy decisions. In the WTO, a notionally democratic (one country, one vote) system is subverted by the removal of effective decision-making from the formal institutional framework into a number of processes (‘green room’ meetings, ‘mini-ministerials’, and ‘confessionals’) that have no formal status and are therefore not covered by the WTO’s rules. These processes are totally non-transparent, allowing decision-making to be dominated by developed countries through the exertion of various forms of financial, economic, political, and diplomatic pressure.³¹ While a few larger and richer ‘emerging market’ economies (China, India, Brazil, and South Africa) have achieved some influence in recent years, this remains relatively limited, and their interests are very different from those of the smaller and poorer developing countries, which remain almost wholly excluded.

While other decision-making processes – notably in the United Nations and its specialised agencies (other than the IMF and the World Bank) – are more formally democratic, their financial dependency and that of their developing-country members gives the developed countries a considerable measure of control. As the major funders, the developed countries are able to limit the regular budgetary resources allocated to international institutions, keeping them critically dependent on discretionary funding to individual projects and programmes. WHO’s regulatory budget funds of US\$943.8 million for 2010–11 are enough to finance only one-fifth of its total programmes, leaving 80 per cent dependent on discretionary funding.³² As the major providers of these funds, the developed-country governments can thus control which issues are dealt with by which institutions (e.g. shifting responsibility for large areas of health from the WHO to the World Bank), in what way, and the resources available for each activity. The implicit or explicit threat of withdrawing or reducing such funding also gives the developed-country governments considerable leverage over the secretariats of these institutions.

Equally, the financial dependency of developing countries on aid, debt relief, and/or trade concessions provides developed countries with considerable leverage over them, both in their own policies and in the positions they take in international decision-making bodies, either by offering benefits or through the explicit or implied threat of withdrawing such benefits. This is most obvious in the case of the WTO. There is also evidence that the United States not only uses its own aid to influence the positions of countries in the UN Security Council,³³ but also exploits its own dominant position in the IMF and the World Bank to skew the lending and/or conditionality of these institutions according to the proposed recipients’ positions in international fora.^{34, 35, 36}

The developed countries are able to strengthen their position still further through the coordination of their positions and through mechanisms with no formal status in the international system, which they have established and over which they exert effective control, notably the G7, the G8, and (in recent years) the G20. While there are some fora through which developing countries may seek to coordinate their positions (e.g. the G77 and the Like-Minded Group in the WTO), their effectiveness is limited by lack of resources, by the large number of countries involved, their limited influence (requiring a much larger coalition to be built), and by the much greater disparity in their economic interests. The selective inclusion of the most influential developing countries in some of the developed countries’ coordination mechanisms (e.g. the G20) may also be seen in part as an attempt to ‘divide and rule’ the developing countries by undermining their own coordination efforts.

Non-transparent and Unaccountable ... In all the major international organisations, such accountability as there is, is to the national government. It is the government that appoints the country’s representative to decision-making

bodies, the government that instructs them on the positions they should take and the tactics they should use, and the government that is empowered to remove them should they fail to fulfil their responsibilities. While this is most obviously problematic in the case of undemocratic governments, it also limits accountability in the case of countries with democratic systems.

The accountability of governments, even of democratically elected governments, to their people is often limited, and is shaped by commercial interests (the disproportionate influence of the corporate sector) and financial considerations (reliance on the better-off for contributions to campaign finance and/or party funding). Since electorates typically have limited interest in international decision-making, while the corporate sector has much stronger and more direct interests, particularly in the economic sphere, the government agenda is skewed strongly in favour of social to corporate interests. In the Uruguay Round GATT negotiations, which led to the creation of the WTO, for example, the United States negotiating teams were led by representatives of US-based transnational corporations on a number of issues.³⁷

In the IMF and the World Bank, accountability even to most governments is limited. While five major developed countries appoint, and thus effectively control, their own Executive Directors, the other Directors represent constituencies of countries. Once appointed, these Directors are officials of the IMF or the World Bank, and not country representatives,³⁸ so that even the governments whose votes they control have no effective say in how those votes are used.

Accountability in the economic institutions is further undermined by lack of transparency. In the WTO, the informal fora in which actual negotiations occur, the talks take place behind closed doors, so that only participants are privy to what is said. In the IMF and the World Bank Executive Boards, votes are not cast; rather the Directors say how they would vote if such a vote were held, and the outcome is decided by the Managing Director of the IMF (effectively chosen by the Western European governments) and by the President in the World Bank (effectively appointed by the US government). Since the proceedings of the boards are confidential, this also means that only governments know how their votes were effectively used, allowing them to operate with zero accountability to their electorates for the positions they take.

Antagonistic and Short-termist ... Because the global system is driven by governments, its agenda is dictated by the interests of governments, and particularly by the interests of those governments with the greatest power. These interests are, almost by definition, nationalistic in nature – primarily the promotion of national commercial and financial interests, and that of geopolitical and ideological agendas directed towards achieving these and other national goals. This is the basis on which representatives to international organisations are appointed, the task they are set, and the standard to which their governments hold them accountable.

The result is an essentially antagonistic system, in which each country's representative pursues that country's own national interest in opposition to those of others, rather than seeking the greater common good. This combined with a system in which power is strongly weighted towards the better-off, and in which accountability is both limited and skewed, results in a system oriented to the promotion of the interests of the rich and of the corporate sector, constrained only by the (relatively weak) domestic social and environmental constituencies in the developed world.

Responsibility to governments also gives rise to a short-termism that is inimical to the avoidance of future crises and to attempts aimed at dealing effectively with long-term crises such as climate change. The accountability of democratic governments is strongly driven by electoral cycles. Their concern about issues beyond the next election is greatly reduced by the possibility that they will no longer be in office, and their preoccupation with short-term considerations is further increased by worries about the effect that these will have on their prospects of remaining in office. Many undemocratic governments are also preoccupied with their short-term political survival and with the short-term interests of their constituents.

Toothless ... Despite all the factors discussed above, some international agreements are reached that, if implemented, would serve the interests of the poor majority of the world's population. These include the Universal Declaration of Human Rights, the Covenant on Economic and Social Rights, the UN Framework Convention on Climate Change, and the Kyoto Protocol. However, implementation is prevented by the absence of any effective enforcement mechanisms, particularly with respect to implementation by developed countries.

Such enforcement mechanisms as are available are essentially financial and economic in nature – for example, the provision of finance and the imposition of financial or trade sanctions. The only international institutions with the resources to provide finance on a significant scale are the IMF and the World Bank, which are effectively controlled by the developed countries (largely because these are the only institutions to which the developed countries have been willing to allocate substantial resources). Only in a few cases in exceptional circumstances (e.g. Iceland, Ireland, and Greece in the current financial crises) is such financing required by developed countries, so its effectiveness as an enforcement mechanism is largely limited to the developing world. Otherwise, financial incentives must come very largely from the developed-country governments themselves, and on a discretionary basis. Thus, the granting of financial rewards is entirely in the hands of the developed countries.

Trade and financial sanctions are likewise discretionary, as there is no mechanism (besides the equally discretionary application of trade or financial sanctions against those who do not impose them) to ensure that they are

observed. While the IMF has the power to impose limited financial sanctions by preventing the enforcement of loan contracts in national courts, the use of this power to enforce debt relief agreements or to allow debt standstills pending crisis resolution was blocked by the developed countries during both the 1980s debt crisis and the post-1997 financial crisis.

The only global agreements that have effective enforcement mechanisms are the WTO Agreements, which are ultimately backed by allowing the imposition of trade sanctions by a complainant against a country that has been found to have damaged the former's interests through non-compliance. This results in a serious asymmetry, effectively giving trade agreements precedence over other agreements, including those directed towards protecting rights or achieving social or environmental goals.

Trade and financial sanctions are also extremely asymmetrical in their effects: the imposition of sanctions by a major developed country would have a considerable effect on a developing country; the imposition of sanctions by a developing country against a developed country would damage the former more than the latter. In the latter context, such sanctions are thus unlikely to be applied, and would be largely ineffective even if they were.

Unreformable ... If a national government operated in the same way as the global system, and if individuals within a national government behaved in the same way as the developed-country governments do within the global system, it would be rightly condemned as grossly undemocratic, and would unquestionably qualify as one of the most corrupt in the world. The wholly predictable result would be an increasing concentration of wealth in the hands of a small elite and escalating social and environmental problems – much the same conditions as now characterise the global economy.

If we are to have any chance of resolving the fundamental problems of the global economy highlighted by the five crises discussed in this chapter, it is essential to bring about a radical reform of the global decision-making process in line with generally accepted principles of democracy, accountability, and transparency. However, the skewing of power towards the developed countries blocks the possibility of reform, because they wield enough power to veto any serious attempt at moving towards a more democratic system.

Recent economic crises as systemic crises

Financial crises are by no means new. Prior to the current phase of commercial globalisation, which might be dated from around 1980, the post-industrial era had been punctuated by such crises at (surprisingly regular) 50-year intervals – in the 1830s, the 1880s, the 1930s, and the 1980s. Since 1980, however, their frequency has increased considerably, with major crises in the early 1980s (the debt crisis), the late 1990s (the Asian crisis), and the current crisis beginning in 2008, with lesser (but still significant) crises in

between (notably the Mexican crisis of 1993 and the bursting of the ‘dot-com’ bubble in 2000). The overall frequency of financial crises has also increased substantially during this period.³⁹

The Great Depression of the 1930s was widely seen (at least in retrospect) as a systemic crisis, reflecting the institutional vacuum at the global level and the seriously perverse consequences of the resulting uncoordinated pursuit of national economic objectives. It seems difficult to disagree with this assessment. Together with the Second World War, it was the major driving force behind the Bretton Woods and Dumbarton Oaks conferences of the 1940s, which led to the establishment of the current system of global governance.

If the 1930s crisis demonstrated the disastrous consequences of not having a global institutional framework in a world of increasingly interconnected national economies, the multiple crises since the 1980s have demonstrated with equal force that the institutional framework we now have is fundamentally flawed and almost entirely ineffectual.

Taken together, the recent crises show that the global economic system is spectacularly failing to serve the interests of the majority of humanity, which happens to be poor (the development and food crises), that it is destroying the ecosystem on which the whole of humanity depends (the climate crisis), and that it is harming the interests even of most of those who are relatively well off by global standards (the financial crisis). The main beneficiaries have been those who are most responsible for causing these negative effects (speculative investors), many of whom have also lost.

The roots of these ill-effects can be traced to the institutional framework (undemocratic and ineffective global governance), the economic course to which this framework has given rise (asymmetrical and unequal globalisation and the dominant role of finance), and the direct consequences of these two phenomena (extreme inequality).

In short, the crises demonstrate that the global economic system is fundamentally dysfunctional and that the need for radical reform is every bit as great as it was in the 1940s.

Economic crises and the crisis of (orthodox) economics

The multiple economic crises show the failure not only of the current institutional framework of the global economy, but also of the currently dominant view of economics itself. Here we highlight four issues, each of which is fundamental to orthodox economics, but whose validity is so assumed that they are barely considered worth meriting attention in mainstream economic discourse. In each case, the assumptions on which orthodox economics is based cast the five crises into serious doubt.

The challenge to growth Economic growth is central to orthodox economics. It is, in practice, the primary objective of economic policy, and is widely viewed as

the primary (almost the only) criterion of success or failure. Environmentalists have for many years questioned the desirability of economic growth, at least in the developed world. Climate change represents a much more fundamental challenge to growth at the global level, leading to renewed attention being focused on the concept of the 'steady-state economy'⁴⁰ and to the development of new concepts such as 'degrowth'.⁴¹

Bringing climate change under control requires that atmospheric concentrations of carbon be stabilised, and this requires a very considerable reduction in emissions. Initial estimates indicated that emissions needed to be reduced by 60 per cent from their 1990 levels by the year 2050 to limit the increase in global temperature by 2°C. However, the continued and accelerating increase in emissions has greatly increased the scale of the reduction required, while leaving less time to achieve it. At the same time, the higher emissions between 1990 and 2050 will raise the concentration levels, increasing the temperature at which emissions will be stabilised even if the targets for emissions reduction are achieved.

Carbon emissions may be seen as a product of two factors: the global level of production and consumption; and their carbon intensity (that is, the carbon required for each unit of production and consumption). To date, policy on climate change has been based on technological optimism, the assumption that emission reductions can be achieved through the development and application of technologies to reduce carbon intensity, while allowing economic growth to proceed. To date, however, carbon-reducing technologies have delivered little (as shown by the accelerating growth of emissions), and, as the continued lack of progress in limiting emissions increases the rate of reduction required, the adequacy of known and anticipated technologies to reconcile emissions targets with substantial growth of the global economy becomes ever more questionable.⁴²

While technological progress has conspicuously failed even to slow the growth of carbon emissions substantially, the impact of the financial crisis on global economic growth actually reduced the level of emissions in 2009, but it resumed with the partial economic recovery in 2010.⁴³ This dramatically underlines the scale of the environmental challenge to achieving sustainable global economic growth.

The counter-argument generally advanced is that growth is necessary to reduce poverty and to provide the resources required for essential services, such as health care and education. However, this view is also being increasingly challenged, on the basis of the very unequal distribution of the additional income generated by growth.

If income distribution remains unchanged, each person's share in the benefits of growth is, by definition, proportional to his or her initial share in income. This inevitably means that the rich gain much more of the benefits than the poor, and, where distribution is very unequal – as it is in most national

economies, and much more in the global economy – the share of the poor is extremely small. Worse, assessments of the distribution of the benefits of growth have found that these benefits are much more unequally distributed than even initial incomes. Thus, the richest 1 per cent of the population is estimated to have received 58 per cent of the benefits of growth in the United States between 1976 and 2007,⁴⁴ and the poorest 23.2 per cent of the world population (those below the ‘US\$1-a-day’ poverty line in 1990) is estimated to have received just 0.6 per cent of the benefits of global growth between 1990 and 2001. The poorer half of the world population (those below the ‘US\$2-a-day’ poverty line in 1990) received just 3.1 per cent of the benefits of global growth.⁴⁵

These last figures reveal that the challenge to global growth is much more serious than anticipated. It means that each US\$1 spent on poverty reduction through global growth (based on the ‘US\$1-a-day’ poverty line) requires US\$166 of additional production and consumption globally, along with all the associated carbon emissions and other environmental costs. As a means of reducing poverty in a carbon-constrained world, this strategy simply does not make sense.

There is long-standing evidence that economic growth in developed countries does not increase the well-being of their populations.^{46, 47, 48, 49} Even the most comprehensive critique of this view⁵⁰ poses a serious challenge to the assumption that growth is the sole or primary objective of economic policy, indicating that well-being is determined not by total income but by the sum of the logarithm of individual incomes, which is also highly sensitive to distribution. The primacy accorded to economic growth is based on the assumption that US\$1 of additional income provides the same benefit irrespective of who receives it. But even according to the most pro-growth view, it is clear that US\$1 of additional income provides vastly more benefits to those who have very low incomes rather than to those with very high incomes.

This indicates the possibility of achieving very considerable benefits from redistribution, especially on a global level. To double the incomes of the poorest 10 per cent of the world population without any redistribution of income would, by definition, require 100 per cent economic growth, doubling global production and consumption, and dealing with the associated environmental costs. At a growth rate of 3 per cent pa, it would also take 24 years. Alternatively, the same result could in principle be achieved immediately by redistributing less than one-third of 1 per cent of the income of the richest 10 per cent of the world population to the poorest 10 per cent.⁵¹

The proponents of economic orthodoxy over the last 30 years have argued that measures aimed at redistribution should be sacrificed in the interest of economic growth, that it is more important to have a larger pie than for the poorest to have a larger share of the pie. By limiting the size of the global economic pie, climate change reverses this logic at the global level and puts the emphasis firmly on distribution and not on growth.⁵²

Market efficiency, price mechanisms, and the allocation of goods Another fundamental tenet of orthodox economics is the efficiency of markets in allocating goods between uses and users. Those who value a particular good most, it is argued, will be willing to pay most for it; therefore, allowing consumers to compete in the market (and sellers to compete for their custom) will result in goods being allocated to those areas where they provide the greatest benefit. In addition to market deregulation, this provides the basis for a strong argument for market-based incentives (e.g. taxes, subsidies, tradable permits, etc.) to achieve social objectives, rather than non-market incentives (e.g. quotas, rationing, regulation, etc.).

The food crisis clearly demonstrates the invalidity of this view. By far the greatest benefit of a basic staple such as maize is provided by allowing it to be eaten by someone who would otherwise not have enough to eat. The amount of maize required to produce enough ethanol to drive one mile in an SUV in town is approximately the amount needed to feed someone for a day.⁵³ It seems beyond question that having enough to eat for a day rather than nothing at all provides vastly more benefit than driving one more mile in an SUV. But the purchasing power of poor people who depend on maize as a staple is very limited, while that of SUV owners is much greater. Those whose need is greatest are priced out of the market as prices are forced up by the consumption of those whose use is most trivial – and is offset by the very considerable environmental costs of ethanol production.

So where there are competing uses for the same good with very different implications for well-being, allocating goods to those who are able and willing to pay the most for them clearly does not mean allocating these goods for the most socially beneficial use – rather the contrary. In a context of extreme economic inequality, market allocations are not merely grossly inefficient, but may also be seriously damaging.

This implies a need for much greater caution in the use of price- and other market-based mechanisms in the pursuit of social goals. Take the example of relying on increases in the cost of fossil fuels (either directly through taxation or indirectly through tradable emissions permits) as a means of reducing carbon emissions. This would almost certainly reduce emissions to some extent, but the price increases necessary for achieving the reductions required would be very considerable, as the overall price elasticity of demand is relatively low.

If fossil fuel prices were, say, to double, the consumption of those at the upper end of the global income distribution (e.g. drivers of large cars and passengers on long-haul tourist flights) would be reduced, but probably very little. Between 1999 and 2007 (the latest year for which consumption data are available), world fuel prices increased nearly fourfold, but fuel consumption per person in the developed (high-income OECD) countries still rose by 1 per cent.⁵⁴ At the other end of the spectrum, poor households dependent on fossil fuels for domestic energy would be affected much more severely, both

through increased costs and forced reductions in use to protect other essential consumption. Again, the effect – reducing the most beneficial consumption, with a relatively limited impact on the least beneficial – is anything but efficient.

Failure of international factor markets A fundamental part of the rationale for opening international markets to factors of production (most notably financial capital, but also human capital) is that free markets allow scarce resources to be reallocated from areas of relative plenty to areas of greatest scarcity. In practice, however, as financial markets have become globalised and as the international movement of skilled professionals has become (somewhat) easier, exactly the opposite has happened. Capital and human capital have systematically moved out of the poorest countries where they are most needed for development and into the high-income countries where they are already most plentiful. This is a key aspect of the development crisis.

A number of factors underlie perverse *international capital flows*.

- Commercial capital flows necessarily entail much greater outflows than inflows over the long term, as lenders and investors not only expect to recover their capital but also to generate an income from it.
- Since actual and perceived risks are highest in the poorest and most capital-scarce countries, commercial capital flows to these countries are most limited and come at a substantially higher long-term cost.
- Actual and perceived risks to local holders of capital are also greater in most capital-scarce low-income countries, where viable investment opportunities are also typically limited. This gives rise to a considerable outflow of domestic capital in the form of capital flight.⁵⁵

While some countries – notably the ‘Asian miracle’ economies – have succeeded in attracting substantial inflows of foreign commercial capital, much of this has been speculative rather than productive in nature, and these economies have historically had very high rates of domestic savings. The need for, and the benefits of, these inflows have thus been relatively limited.

Following the inappropriate response of the IMF and the international community to the Asian crisis of 1997 (largely triggered by the reversal of these speculative flows), most ‘emerging market’ economies have also accumulated considerable international reserves to reduce their reliance on the international system in the event of future crises. Since international reserves largely take the form of financial instruments issued by the major developed-country governments, this represents a further reverse flow – lending from poorer to richer governments, thus offsetting commercial inflows.

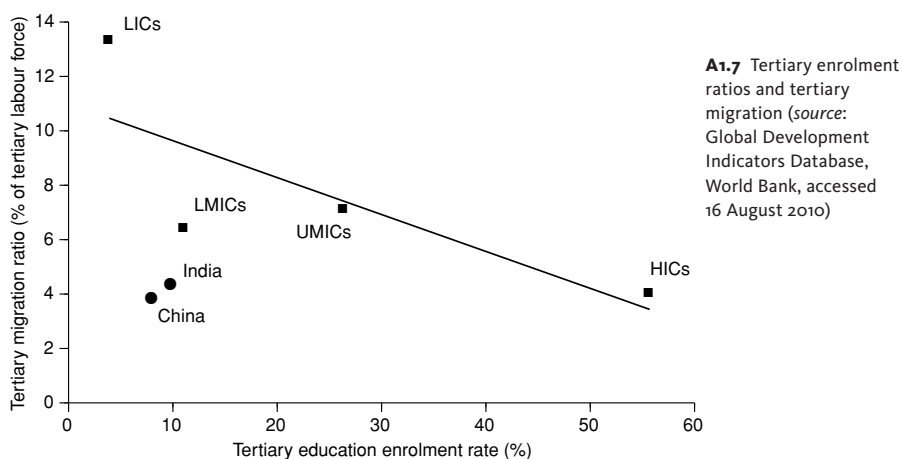
A parallel development has been the growth of sovereign wealth funds in many ‘emerging market’ economies and major oil exporters undertaking financial investments on behalf of governments. Some of these funds have been seriously affected by the financial crisis, losing money from investments

in sub-prime mortgage instruments and financial institutions. Some have also responded to the food crisis by investing in large tracts of land in poorer developing countries, triggering similar investments by Western agribusiness and institutional investors.⁵⁶

Such funds also raise other important issues related to health. Malaysia's sovereign wealth fund Khazanah, for example, while operating primarily as a holding company for domestic investments, holds a 95 per cent stake in Parkway Holdings, the largest private health care provider in Southeast Asia, which has ten private hospitals in Malaysia. KPJ, which operates the largest private hospital chain in Malaysia (18 hospitals), is another publicly owned commercial enterprise that was established by the Johor provincial government. This fusion of state ownership and private capital is characterised by widespread conflicts of interest, as the state attempts to manage public-private interactions in the health care sector, to prevent the poaching of public sector staff by the private sector (internal migration, exacerbated by medical tourism), and to regulate the health care sector as a whole. With the rise of sovereign wealth funds in East Asian countries and with oil and gas exporters playing an increasingly important role, this development might be considered either as 'nationalisation' of private enterprise space or as an extension of the logic of capitalism into strategic adjuncts of the state.

For all these reasons, the net resource transfer resulting from commercial capital flows runs consistently from poorer and more capital-scarce countries to richer countries with more plentiful capital over the long term. The overall outflow from the poorest countries can be very considerable. Capital flight from sub-Saharan Africa alone between 1970 and 1996, together with the income forgone on this capital, has been estimated at US\$285 billion at 1996 prices – far more than the total external debts of this region at this time.⁵⁷ This is in addition to substantial outward net resource transfers on commercial debts through the 1980s and 1990s (despite debt relief) and often strongly negative outward net transfers on foreign direct investment. The latter is itself substantially understated as a result of the concealment of transnational companies' profits through transfer-price manipulation (deliberate mis-pricing of trade transactions between different parts of the same transnational company located in different tax regimes). The value of export and import mis-pricing has been estimated at US\$250 billion in 2005 in the United States alone.⁵⁸ The net result is a sustained haemorrhage of capital as a direct result of the operation of commercial financial markets, offsetting or reversing the benefits of aid and official lending.

Much the same effect is seen in the case of *human capital*, and with a more direct impact on health. Far from correcting imbalances in the availability of human capital by encouraging flows from areas of plenty to areas of scarcity, selectively increasing the migration of highly educated and skilled professionals has the opposite effect, giving rise to a 'brain drain' from countries where acute



shortages of human resources constitute a serious constraint to development and growth, to those countries whose economic advantages allow them to develop much greater and more skilled human resources.

This has been widely recognised since at least the 1970s, and nowhere more than in the health sector. In high-income countries, where 57 per cent of people on average receive tertiary education, only 4 per cent of them migrate. In low-income countries, where less than 5 per cent of people receive tertiary education, 13 per cent of those who do, migrate. (See Chart A1.7.) Middle-income countries fall between the two on both indicators. (It should be noted that the migration rate for lower- and middle-income countries is artificially reduced by the dominance in this group of China and India, which, like other very large countries, have very low external migration rates relative to their economic circumstances.)

In many countries, the figures are much higher. Around 2000, 23 countries had outward migration rates of people with tertiary education of between 55 per cent and 90 per cent. While most were small island economies, these include Jamaica (85 per cent), Haiti (83 per cent), and Gambia (67 per cent). Seven other sub-Saharan countries have rates between 35 per cent and 50 per cent (Sierra Leone, Ghana, Liberia, Kenya, Uganda, Eritrea, and Somalia), as do Laos and Lebanon.⁵⁹

There are 14 developing countries where a majority of doctors born in those countries were working in OECD countries alone in 2000. Six of these countries (Angola, Haiti, Liberia, Mozambique, Sierra Leone, and Tanzania) were identified by WHO in 2006 as suffering critical shortages of health professionals.⁶⁰

Commercial finance and poverty reduction While the development crisis shows the impossibility of correcting imbalances between countries in the availability of capital through commercial financial markets, the financial crisis shows a

similar phenomenon at the individual level, even within one of the richest economies in the world, and that too at a time of exceptionally low interest rates.

Until the 1990s, poor people in the United States (as, in varying degrees, in other developing countries) were almost entirely excluded from financial markets by the (actual or perceived) high risks of lending to them. On the one hand, poverty seriously limits people's capacity to pay for borrowing. On the other hand, high risks increase the rate of return that lenders require to make lending worthwhile, and high interest rates increase the risk of non-payment still further.

The 1990s saw a temporary escape from this logic, but lending only appeared viable because the level of risk was concealed or misrepresented to the ultimate providers of funds. (See above.) Once the true scale of the risk became apparent, the whole system unravelled, triggering the financial crisis.

A similar, and arguably more serious, logic applies in developing countries. Commercial or quasi-commercial micro-credit operations have become a very fashionable response to poverty in developing countries. These entail lending small amounts to poor households to allow them to make productive investments that will increase their incomes. The amounts of the loans are limited by the households' ability to pay; maturities are generally very short and interest rates are very high (an average of 36 per cent pa in Asia and 44 per cent pa in Latin America and the Caribbean (30 per cent and 35 per cent respectively) in real terms).⁶¹ In addition to the high risks, costs are increased because of the very small amounts of the loans (since the administrative cost of the loan rises less than proportionally with the size of the loan). The extremely poor are generally excluded, because for them an approach based on lending is simply unviable.

The combination of high interest rates and short maturities means that a very considerable rate of return is needed to allow the loan to be serviced in full. A two-year loan of US\$100 at an interest rate of 40 per cent would need to generate a rate of return on capital of 70 per cent pa for those two years. The net benefits to the household are limited to the additional income above this level and the income accrued after the loan has been repaid. If the investment fails to generate a sufficient rate of return, the household may well lose the assets, typically land, on which the loan has been secured, and be worse off than before. This danger is particularly acute because of the many serious risks faced by poor households, in addition to market risks, notably the risk of income losses due to ill-health and high financial costs of treatment. The poorer the household is initially, the greater are these risks.

Some moderately poor households may well raise their incomes through micro-credit over the long term, but the net increases are likely to be limited. Many can be expected to become poorer, and the poorest will be excluded entirely. The effectiveness of this approach seems likely to be relatively limited,

and considerably less than that of a non-commercial approach in which funding is provided in the form of micro-grants funded by official sources rather than commercial or quasi-commercial loans.

Conclusion: a crisis of capitalism?

The global economic system is grounded firmly on capitalist principles, and the recent economic crises have clearly demonstrated its failure either to satisfy the most basic needs of most of humanity or to operate within the confines of environmental sustainability.

The current systemic crisis of the global economy demonstrates the non-viability of capitalism in its current form, characterised as it is by extreme inequality and poorly regulated markets, and dominated by the interests of a small rich minority embedded in the corporate and financial sectors.

If we want to achieve social goals such as health for all, poverty eradication, universal education, the fulfilment of human potential, and to do so while simultaneously tackling climate change and achieving true environmental sustainability, then we need to redesign the global economic system to realise these aims. We cannot simply assume that these goals will somehow magically be achieved under an economic model designed to achieve a fundamentally different and, in many respects, contradictory goal – the maximisation of total production and consumption – implemented through the distorted lens of grossly undemocratic decision-making processes in the interests of those with the greatest power and the greatest resources.

This is what has brought us to the current situation, one that is characterised by multiple crises. We cannot realistically expect more of the same to get us out of it.

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SECTION B

**HEALTH SYSTEMS: CURRENT ISSUES
AND DEBATES**



5 Rag-pickers in Nairobi, Kenya: social and economic development are key components of PHC (Azza Salam)

B1 | PRIMARY HEALTH CARE: A REVIEW AND CRITICAL APPRAISAL OF ITS 'REVITALISATION'

Introduction

In 2008, the 30th Anniversary of Alma-Ata, primary health care (PHC) was reaffirmed as the key global strategy for attaining optimal health. Celebratory meetings were held under the auspices of the World Health Organisation (WHO) in all its regions. The WHO World Health Report 2008 (WHR08) was devoted to PHC (WHO 2008). In 2008 *The Lancet* produced a themed issue on PHC.

Notwithstanding these activities and publications there remains confusion, disagreement, and controversy around PHC in terms of its content, emphasis and application.

This chapter analyses the current discourse on PHC, noting different interpretations that threaten its revitalisation as a strategy for both health improvement and the struggle for social justice. The chapter then briefly reviews selected examples of current large-scale (mostly national) experiences that exemplify innovation in PHC implementation. It concludes with some guiding perspectives on the role of social movements in promoting PHC.

Progress and context

In the thirty years since the Alma-Ata Declaration there has been significant progress in global health with an overall increase in life expectancy. However, rapidly widening inequalities in health experience between and within countries – and even reversals in Africa and the former Soviet bloc countries – have led to a re-examination of the current context and content of health policies and why the Alma-Ata Declaration failed to lead to health for all (Commission on Social Determinants of Health 2008).

The key question is whether PHC, as originally elaborated at Alma-Ata, remains a feasible option.

This re-examination shows that a series of reform projects, with some key common features, driven by vested interests and short-sightedness, have perpetuated or aggravated the conditions that underpin ill-health and undermined the ability of health systems to function appropriately. Key among these are selective PHC, health sector reform, and the global health partnerships. These have depoliticised health and undermined the spirit of PHC.

Selective PHC

While progress in implementing the PHC strategy in most low and middle income countries (LMICs) has been greatest in respect of certain of its more medically-related elements, the narrow and technicist focus characterising what has been termed the ‘selective PHC’ approach (Walsh and Warren 1979) has at best delayed, and at worst undermined, the implementation of the comprehensive strategy codified at Alma-Ata. The latter insisted on the integration of rehabilitative, therapeutic, preventive and promotive interventions with an emphasis on the latter two components. Selective PHC (SPHC) took the form in many LMICs of certain selected medical – mostly therapeutic and personal preventive – interventions, such as growth monitoring, oral rehydration therapy (ORT), breastfeeding and immunisation (GOBI). These constituted the centrepiece of UNICEF’s 1980s Child Survival Revolution, which, it was argued, would be the ‘leading edge’ of PHC, ushering in a more comprehensive approach at a later stage (Werner and Sanders 1997). The relative neglect of the other PHC programme elements and the shift of emphasis away from equitable social and economic development, intersectoral collaboration, community participation and the need to set up sustainable district level structures suited the prevailing conservative winds of the 1980s (Rifkin and Walt 1986). It gave donors and governments a way of avoiding the fuzziest and more radical challenges of tackling inequalities and the underlying causes of ill-health. Some components of comprehensive PHC, especially the promotive interventions, have remained marginalised ever since Alma-Ata. These require for their operationalisation the implementation of such core principles of PHC as ‘intersectoral action’ and ‘community involvement’, and, increasingly with economic globalisation, intersectoral policies to address the social determinants of health (SDH) (Sanders et al. 2009).

PHC has been defined (even in the Alma-Ata Declaration) as both a ‘level of care’ and an ‘approach’. These two different meanings have persisted and perpetuated divergent perceptions and approaches. Thus, in some rich countries and sectors, PHC became synonymous with first line or primary medical care provided by general doctors, and simultaneously PHC has been viewed by many as a cheap, low technology option for poor people in LMICs.

The Alma-Ata Declaration was one of the last expressions of the development thinking of the 1970s where the non-aligned movement declared its commitment to a ‘New International Economic Order’ (Cox 1997) and a ‘Basic Needs Approach’ to development. These visionary policies were buried in the 1970s debt crisis, stagflation, and the dominance of global economic policy by neoliberal thinking. This, together with rising unemployment and changes in the labour market, changes in demographic and social trends, and rapid technological advances with major cost implications for health services, has, over the past two decades, driven a process of ‘health sector reform’ in industrialized countries and LMICs.



6 Woman in a shanty in Cape Town, South Africa: persisting social and economic inequity in LMICs (Louis Reynolds)

Health sector reform

While there is no consistently applied, universal package, ‘health sector reform’ reflects and reinforces neoliberal policies. It includes the restructuring of national health agencies; planning of more cost-efficient implementation of strategies and monitoring systems; the introduction of user fees for public health services; introducing managed competition between service providers; and involving the private sector through contracting, regulating and franchising different private providers (Cassels 1995).

Although these aims appear rational, health sector reform has sometimes aggravated inequities (as with user fees in several countries) or led to a deterioration of local health services as decentralisation of responsibility has occurred without the accompanying decentralisation of resources and enhancement of local capacity. The reform process has evolved at different rates and to different extents in different countries. In many LMICs the rhetoric obscures the fact that fundamental change has not occurred (Mills 1998).

The combined impact of recession, deteriorating terms of trade, debt and harsh economic policies and health sector reform had damaging effects in LMICs, resulting in:

- persistent social and economic inequity and lack of progress in addressing the social determinants of health;
- declines in real public health expenditure and increasing donor dependency, including for recurrent health spending on wages, equipment and supplies;
- deterioration of health facilities and equipment;
- shortages of drugs and other supplies;

- dwindling patient attendance at public facilities as the quality of care worsened; and
- a catastrophic loss of morale and motivation of public health workers as the value of their salaries plummeted and as expenditure constraints undermined their ability to work (Segall 2003).

Global health partnerships

In response to this health crisis – starkest in Africa – and in line with greater engagement with the private sector, a plethora – around 100 – of global health partnerships (GHPs) or global health initiatives (GHIs) have emerged in the late 1990s and 2000s (Brugha 2008). These include the Global Alliance on Vaccines and Immunisations (GAVI), the Global Fund to Fight AIDS, TB and Malaria (GFATM), the World Bank Multi-country AIDS Programme (MAP) and the US President’s Emergency Plan for AIDS Relief (PEPFAR). Although these GHIs have brought welcome increased funding for priority diseases, they have at the same time reinforced the selective approach to PHC by privileging vertically implemented and managed programmes that mainly emphasize therapeutic (e.g. antiretroviral treatment) and personal preventive (e.g. prevention of mother to child transmission of HIV) interventions while significantly neglecting upstream determinants of these diseases – such as gender oppression and violence – as well as their broader consequences, such as AIDS orphans.

There is compelling anecdotal evidence that these target-driven, performance-based funding mechanisms pressurise countries to ‘focus on more easily reached target populations and politically high profile treatment campaigns, thereby exacerbating inequities, neglecting population-wide public health programmes’ (Brugha 2008), including shifting health personnel away from general health care, and fragmenting services into a set of parallel ‘vertical’ programmes.

Key points of confusion and controversy in the current discourse

The Lancet series on PHC In 2008, an important and timely series in *The Lancet* reflected the renewed interest in comprehensive primary health care in the last years, and the recognition that mainstream health reforms (many inspired by neoliberal policies) have failed to achieve the desired health gains and have almost certainly contributed to greater health inequity.

While the Lancet Series assembles much evidence supporting the positive impact of primary health care, its bias towards selective PHC is reflected in one of the key articles (Rohde et al. 2008). This article analyses the 30 countries – with more than 100,000 births per year – which have achieved the highest reduction in under-five mortality. All are assessed as having scaled up selective primary health care (SPHC) and 14 are said to have progressed to comprehensive primary health care.

Throughout the series there is inconsistency in the use of the term ‘com-



7 Demise of primary health care (indranil mukherjee)

prehensive PHC'. The above article defines comprehensiveness in terms of the range of clinical interventions which are funded and provided: 'We selected immunisation coverage ... (DPT3) and contraceptive prevalence rate as indicators of selective primary health care implementation, and skilled birth attendance coverage as a marker of the development of a comprehensive primary health care system' (ibid.).

It is clear that 'comprehensiveness' here is used to refer to a larger range of health care interventions compared with a more restrictive 'selective' approach. The analysis of the phased implementation of primary health care is limited to expansion of health services which are predominantly facility-based and curative. The emphasis in this article – and indeed in the whole series – is narrowly on health care, i.e. the supply of more effective service, leaving out the essential elements of PHC, including intersectoral collaboration and community participation. Even health extension workers (including community health workers) are seen as an interim way to increase coverage of services which can then give way to more skilled workers in a more mature ('comprehensive') health system. This approach is really an analysis of a phasing-in of a broader set of selective interventions rather than of a comprehensive primary health care approach.

By contrast, the first article in the series exemplifies a broader and more comprehensive view of PHC in its review of the policy history since 1978 (Lawn et al. 2008). It refers to 'the comprehensive process of local community involvement, and improving health and the social environment through effective intersectoral action'. It is this second construction of comprehensiveness that is correct (Legge et al. 2009).

For example, in addressing diarrhoea in children, a selective PHC approach would focus solely on oral rehydration, breastfeeding and integrated clinical management protocols. A comprehensive approach would also catalyse (or take)

action on issues of water supply, sanitation and food security. The Alma-Ata Declaration projected an image of community mobilisation around the struggle for water supply, sanitation and food security and identified supporting this process as part of a PHC approach.

Another of the articles representing this second, broader and more authentic perspective on PHC is the paper on community participation (Rosato et al. 2008). The authors identify a crucial policy question: Can specific community participation interventions aimed at women and their families have a direct effect on maternal and child health? If so, how do these interventions work most effectively, and how can they be taken to scale? The authors then identify and review 13 intervention trials which are consistent with a definition of community mobilisation as ‘a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others’. Convincing evidence is presented for the eight completed trials of marked improvement in maternal, newborn and child health.

The WHO World Health Report 2008 (WHRo8) The WHRo8 report, although purporting to be devoted to primary health care (its title being ‘Primary Health Care: Now More Than Ever’), is more about health systems framed within WHO’s rather mechanistic and ‘supply-side’ framework than about PHC in its more comprehensive and empowering sense. Indeed, in WHRo8 ‘primary health care’ is often termed ‘primary care’, betraying an overweening emphasis on health services.

While the WHRo8 acknowledges the importance of urbanization, climate change, gender discrimination and social stratification, the health content of school curricula, industry’s policy towards gender equality, and the safety of food and consumer goods, there is no mention of the fundamental role of economic forces represented primarily by massive transnational corporations, which have flourished as trade liberalisation has broadened and deepened, nor of the international financial institutions (IFIs), or the global capitalist economic architecture exemplified by such organisations as the OECD, the G8 summits, or the World Economic Forum (Katz 2009).

The recent WHO Commission on Social Determinants of Health points the way to an understanding of the link between poverty and health, and to the imperative to address the upstream determinants of health that lie beyond the health sector. It notes: ‘The combination of binding trade agreements ... and increasing corporate power and capital mobility have arguably diminished individual countries’ capacities to ensure that economic activity contributes to health equity, or at least does not undermine it’ (Commission on Social Determinants of Health 2008: 133).

Unlike these later versions of PHC, the Alma-Ata Declaration emphasised

the fundamental importance of the economic and political context to PHC's success. Early in the Declaration it is stated: 'Economic and social development, based on a New International Economic Order (NIEO), is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries' (WHO and UNICEF 1978: 2). Indeed, the reference to a NIEO was removed from the abridged version of the Alma-Ata Declaration presented in the first paper of the Lancet Series (Lawn et al. 2008). The call for a NIEO in the Alma-Ata Declaration reflected the aspirations of the Non-Aligned Movement since the Bandung Conference of 1955 and the first UN Conference on Trade and Development in 1964. The significance of an unfair global economic regime in reproducing the health disadvantage of poor people is clearly articulated in the report of the WHO Commission on Social Determinants of Health.

The reference to the need for a NIEO in the Alma-Ata Declaration suggests that popular mobilisation to address unfair economic relationships is a legitimate and appropriate challenge for PHC practitioners. And, as indicated above, the notion of 'community participation' in these influential documents is overwhelmingly restricted to the arena of health care, eschewing the more radical notion agreed to by the member states of WHO in 1978 that health development through 'community participation' necessarily involves action on the broader environmental and social determinants, and that PHC can catalyse such action.

In summary: both the Lancet Series and WHRo8 have been important in contributing to the renaissance of primary health care. However, in the process of revision they have created a version of PHC that has been tamed and depoliticised.

Examples of successful implementation of PHC

Several programmes embodying the PHC principles were initiated before the Alma-Ata Declaration and some still continue to operate. Some of the best known are in India – for example, Jamkhed Comprehensive Rural Health Project and Deenabandhupuram Project (John and John 1984; Arole and Aroe 1994). There are others in Asia and in South America which demonstrate innovative applications of CPHC and achieved significant and durable improvements in health. These have shown consistent commitment to equitable, broad-based and multisectoral development. They include Sri Lanka, Costa Rica (we discuss these two in detail in Chapter B3) and Kerala State in India, all of which invested substantially in the social sectors, and particularly in women's education, health and welfare (Halstead et al. 1985).

The political commitment to social and health provisioning in these countries has been sustained through strong citizen participation. This has been achieved in Costa Rica through a long history of democracy and egalitarian policies and in Kerala through activism by disadvantaged political groups.

In rich countries such as Britain, Canada and Australia, while much of the clinical care remains with medical practitioners operating alone or in group practices, there have been some successful initiatives in comprehensive primary health care through community health centres. Typically these centres have been managed by community boards which have been a mechanism for moving community participation beyond rhetoric. Their activities have included: providing services to individuals (including medical, nutrition, counselling, podiatry, physiotherapy, speech pathology); support groups (e.g. stress management, dealing with violent behaviour, parenting skills, illness support groups for chronic diseases such as cancer, diabetes, asthma); community development and social action on issues such as domestic violence and local environmental concerns.

These centres had their heyday in the 1980s, but have suffered from the trends towards privatization, contracting out of government services and a retreat to 'core business' which is seen as treating disease rather than preventing it. In South Australia and Victoria, for instance, the network of community health centres with local boards of management have been amalgamated and found it more and more difficult to do the innovative primary health care work they engaged in in the 1980s. They have struggled to justify their existence as managerial reforms to the health system have introduced an emphasis on market economics (Baum 1995).

More recently several other countries have attempted to roll out PHC as state- or nation-wide programmes. These include such diverse examples as Thailand (discussed in Chapter B3), Rwanda, Iran and Brazil. Common features of all of these examples are: a coherent focus and consistent efforts to develop integrated health systems, the participation of communities through structures at different levels, use of community health workers (CHWs) and a focus on intersectoral actions to address the determinants of selected major health problems.

Thailand began implementing PHC in 1977 using Village Health Volunteers and Village Health Communicators, who are in high concentration at community level, and who are supported by paid health workers or 'facilitators' in a ratio of one facilitator to 10–20 volunteers. Collaboration in community development with other sectors, notably education and agriculture, was key in this strategy. Child nutritional status improved from 47 per cent in 1979–82 to 79 per cent, showing normal growth by 1989. Similar successes were achieved in immunization status, access to clean water and sanitation, and the availability of essential drugs (Nitayarumphong 1990) and the country is well on track to achieving its Millennium Development Goals and demonstrates much better health indicators than would be expected for a country of its level of wealth (Bureau of Policy and Strategy 2007).

Rwanda's 1994 genocide decimated its fragile economic base, destroyed a large share of the country's human capital, and eroded the country's health

infrastructure, reversing gains made in the previous 15 years. However, Rwanda has made dramatic progress in reconciliation and in reintegration of ex-combatants. Approximately 3.5 million Rwandan refugees out of a total population of 9 million have been repatriated and resettled. Sharp economic growth has occurred, but most remarkable has been progress in primary health care.

Two volunteers (one woman and one man) are elected by each village (100 to 150 households) to serve as CHWs. They are trained to monitor growth and development in children, to care for people living with HIV, to distribute family planning supplies, to treat certain diseases such as malaria and pneumonia, and to refer sick patients to the nearest health facility. In response to the effects at the community level of a mature HIV/AIDS epidemic, Rwanda has dedicated two other village-elected CHWs, one woman and one man, to dealing solely with end-of-life issues. These CHWs help ease the burden on family members by taking responsibility for caring for people in the late stages of any disease. Their care also reduces the number of dying patients brought to the hospital.

As there is still a high maternal mortality rate in Rwanda, traditional birth attendants are also being trained as CHWs to promote delivery at health facilities and are paid for every delivery they transfer to the local health centre.

A decentralised district health service has been implemented using performance contracts with local governments. At all levels of the district, health decisions are made collectively through various committees, which facilitate community participation in the health sector. Communities participate in the planning, implementation and monitoring of primary health care activities, including the provision of certain services at the grassroots level (nutrition, mental health, family planning, etc.) and propose appropriate solutions to local health problems.

Allocation of expenditure on human resources (HRH) to provinces and districts as a proportion of the total has increased between 2003 and 2007 from 37 to 85 per cent. Innovative schemes are being piloted to address the shortage of human resources in the sector, including hardship allowances for work in rural areas and performance-based financing for high impact services. These interventions have shown remarkable results: the total number of health personnel in publicly funded facilities almost doubled between 2005 and 2008 from 6,961 to 13,133. By 2008 80 per cent of nurses and 64 per cent of doctors were working at primary and secondary levels. The improved staffing, particularly at community and primary levels, together with access to health insurance, which is unique in Africa, the number of people covered expanding from 3 to 70 per cent of the population between 2002 and 2007, has resulted in greatly increased use of health services.

As with many other African countries finance for the health sector in Rwanda is dominated by donor project support, with donors contributing 43 per cent of all health sector funding and government 32 per cent. However, in

contrast to many other countries where such donor assistance has contributed to the verticalisation and fragmentation of services, the Rwandan Ministry of Health, through a donor mapping study and a systematic costing of the health sector strategic plan, has managed to direct donors to align their contributions with national policies. Each year all donors meet with government to evaluate progress made and plan future activities.

The results are starting to show – Rwanda become the only African country with near-universal access to HIV treatment. Immunisation rates, at 95 per cent, are among the highest in sub-Saharan Africa. Those using insecticide-treated bed nets increased from 4 to 70 per cent of the population between 2004 and 2007.

The infant mortality rate increased dramatically as a result of the genocide from 85 deaths per 1,000 live births in 1992 to 107 in 2000. As a result of the above interventions Rwanda is demonstrating impressive progress in health. The infant mortality rate had dropped to 62 deaths per 1,000 live births by 2007 and similarly, in the same period, under-five mortality fell from approximately 170 to 103 per 1,000 live births (Paulin et al. 2008).¹

Iran during the last three decades has implemented significant changes in its health system structure and witnessed major improvements in the health status of its population. Health system reform coincided with the Iranian revolution in 1979, which spawned enormous political change within the country.

The new health system was based on comprehensive primary health care and also saw the integration of medical education and health care services (since 1984) in response to health workforce shortages. A particular feature of the PHC reforms was a refinement and expansion of a community health worker (CHW) programme begun decades earlier. The expansion of the programme was specifically intended to extend basic health services to underprivileged areas. Iranian CHWs, called *behtarz* in Farsi, are locally sourced health workers with specialised training in the health needs of the rural population. *Behvarzes* are permanent employees of and paid by the Iranian health system. The village health house is the most peripheral health delivery facility in rural areas and the place from which the *behtarz* works. There are currently almost 31,000 male and female *behtarzes* working in these facilities which cover most of Iran's 65,000 villages (Javanparast 2011).

The country has made remarkable progress in a range of health indicators. Since 1974 the neonatal mortality rate (NMR), infant mortality rate (IMR), under-five mortality rate (U5MR), and maternal mortality ratio have declined dramatically. Life expectancy has increased from 55.7 in 1976 to 71.6 in 2003. Furthermore the rural–urban health gap has been greatly narrowed. In 1974 there was a striking difference in infant mortality rate between rural areas (120 per 1,000 births) and urban areas (62 per 1,000 births), attributable mainly to disparities in income, living standards and access to basic health and social services. This gap narrowed by 1996 (30.2 infant deaths per 1,000 live births



8 Rally for equity in health at Peoples Health Assembly, Cuenca, Ecuador, 2005 (David Legge)

in rural areas compared with 27.7 deaths in urban areas), with rural infant mortality declining further to 23.7 in 2003 (Mehryar et al. 2005).

In the mid-1980s, following the overthrow of the dictatorship and democratisation, Brazil initiated a large-scale community health worker programme, which preceded and contributed to the development in 1994 of the national Family Health Programme (Programa Saúde da Família or PSF in Portuguese). By 2010 this government-funded programme consisted of 33,000 community-based teams of physicians, nurses, nurse assistants and community health workers that cover over 60 per cent of Brazil's population of 190 million. Infant mortality, in Brazil, which was 114 per 1,000 live births in 1970, had declined to 19.3 per 1,000 live births in 2007 and life expectancy at birth increased by nearly 40 per cent, to 72.8 years in 2008.

These impressive advances cannot be attributed to the health sector alone but are significantly the result of several large-scale social reforms. School attendance has increased since 1990, and illiteracy rates decreased from 33.7 per cent in 1970 to 10.0 per cent in 2008. Between 1991 and 2008, Brazil's gross domestic product doubled and its high degree of income inequality decreased substantially as a result of a combination of social policies, including the social security system, the *Bolsa Família* conditional cash transfer programme, which covers 10.5 million families, and increases in line with the legal minimum wage. Living conditions have also improved substantially,

Box B1 PHC and the Aboriginal community in Australia

Aboriginal people pioneered the development of primary health care in Australia. A grassroots Aboriginal movement in collaboration with non-Aboriginal activists led to a referendum in 1967 which, for the first time, gave full constitutional rights to Aboriginal people, and subsequently a new period in Aboriginal affairs was established – the era of self-determination (Anderson 1997: 123). Aboriginal community-controlled health services developed within this context. In the mid 1970s Aboriginal health services developed the first national peak body – the National Aboriginal and Islander Health Organisation or NAIHO (Foley 1982), which developed into the National Aboriginal Community Controlled Health Organisation (NACCHO: www.naccho.org.au/) in 1992 as part of the implementation of the National Aboriginal Health Strategy.

Several years after the emergence of Aboriginal community-controlled health services in Australia, international commitment to primary health care (PHC) as a policy model was formalised in 1978 with the Alma-Ata Declaration on PHC. The significance of the Chinese model of barefoot doctors in inspiring the Declaration is well known; less well known is the participation of NAIHO representatives in the drafting of the Declaration.

Today there is a network of Aboriginal community-controlled health services in Australia which are committed to implementing comprehensive PHC. They offer a full range of PHC clinical and preventive programmes. Many also assume a strong advocacy role (Barlett and Boffa 2005). A recent example is the advocacy from 1995 to the present from the Central Australian Aboriginal Congress about the need to raise the unit price of alcohol to help prevent alcohol abuse (Senior et al. 2009). A recent review of the management and funding arrangements of these services demonstrated that they are overburdened by accountability requirements from the federal and state governments which fund them (Dwyer et al. 2009). This review recommended that the services need much simpler lines of accountability that are based on trust rather than distrust.

with dramatic increases in provision to households of indoor water, sewage disposal and electricity (Paim et al. 2011).²

The above examples comprise a spectrum of PHC experience which reflects the different histories and contexts of each country. In terms of community-based care the spectrum extends from approaches that have a strong emphasis on community-controlled, part-time workers (Thailand, Rwanda) to those where CHWs are formal members of sub-district health teams (Iran, Brazil).

Similarly, intersectoral action in Iran comprises a significant component of CHWs' activities, while in Brazil CHWs act primarily as health care workers and refer clients where necessary to other sectors for assistance. In Rwanda CHWs are permitted to treat illnesses, including childhood pneumonia with antibiotics, while in the other countries CHWs' roles are mainly promotive and preventive. In all the countries community participation occurs through structures within the health sector.

Fundamental to these countries' adoption of PHC and its innovative implementation have been facilitatory political movements and consistent actions by influential leaders and health professionals to support reform, although in Thailand, Rwanda and Iran there are aspects of government that are authoritarian.

Thailand has implemented many innovative health policies in spite of repeated military coups and an authoritarian government because of a progressive movement of social thinkers and health professionals. The Rural Doctor Society, which was formed in 1978, undertook various innovative activities to support rural district hospital directors and in 1982 established the Rural Doctor Foundation to sustain its activities. They were also active in the national movement for democratisation and political reform and played a watch-dog role to counteract corruption in the health sector (Wibulpolprasert 1999). In Rwanda, the determination of its people to overcome the horror of the genocide and visionary leadership have combined to build a strong movement to achieve social justice and democracy.

In Iran a radical revolution, which resulted from prolonged massive mobilisation against a long-standing dictatorship, although characterised by an Islamic authoritarian conservatism, spawned many progressive social reforms in health and welfare. Brazil's long struggle against a military dictatorship gave rise to a popular movement which brought together grassroots movements, trade unions, then illegal left-wing political parties and progressive academics and researchers. Such popular mobilisation has waned somewhat over the past decade, but 'social participation' in local government remains active and is structured through such bodies as the National Health Council, which plays an ongoing role in democratising policy development (Paim 2011).

The role of social movements in catalysing comprehensive primary health care

Notwithstanding the encouraging indications of renewed efforts for the revitalisation of PHC, there remains an overwhelmingly technocratic conception of its implementation. It is often implied that policy development and institutional reform take place because international policy experts and donors have identified the need and have decided to put in place the necessary implementation mechanisms ('scaling up', 'task shifting', etc.). In contrast, as we discuss in the country examples, commitment to universal primary health care reflects both the strength and the perspectives of social movements with

roots in political and social struggles. Simultaneously, in all the high-performing low income countries, these movements have thrown up national leadership committed to equity and PHC. One of the challenges, as the recent negative experience of China demonstrates (discussed in Chapter B4), is to sustain such political commitment and ensure continuing popular participation in health policy development and implementation.

Considerable historical evidence indicates the importance of power and politics in influencing the emergence of policies that have resulted in health improvement. The public health historian Simon Szreter, in analysing the British experience, states: '[w]hile economic growth may be necessary, it is never a sufficient condition for improved population health ... Significant health improvements only began to appear when the increasing political voice and self-organisation of the growing urban masses finally made itself heard ...' (Szreter 2003).

More recent evidence for the role of power, politics and policies, and confirming Szreter's analysis, comes from Sri Lanka, Costa Rica and Kerala State in India, as well as the above-mentioned examples of Rwanda, Thailand, Iran and Brazil. All of these examples demonstrate that investment by the state in the social sectors, and particularly in education, health and welfare, has a significant positive impact on the health and social indicators of the whole population. These examples provide further evidence that a strong, organised demand for government responsiveness and accountability to social needs is crucial in securing healthy public policies. A process of social mobilisation involving broad civil society, which may take different forms in different contexts, is essential to achieve and sustain such political will. 'Strong' community participation is important not only in securing greater government responsiveness to social needs but also in providing an active, conscious and organised population so critical to the design, implementation and sustainability of comprehensive health systems (Sanders 1998).

Notes

1 The above section on Rwanda draws heavily on Paulin et al. (2008), and Paulin, B., personal communication.

2 The above section on Brazil draws heavily on Paim et al. (2011).

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B2 | FINANCING HEALTH CARE: AIMING FOR LONG-TERM SOLUTIONS

In Chapter B1 we discuss the progress (or lack of it) in the introduction of policies that promote primary health care (PHC). A subject of considerable debate has revolved around how health systems would be financed, so that they can sustain themselves. Whilst funding for health has increased significantly, rising from US\$5.6 billion in 1990 to US\$21.8 billion in 2007 (Ravishankar et al. 2009), it has so far remained insufficient for meeting the high burden of disease in the developing world.

Various attempts have been made to estimate the funding gap for the achievement of the MDGs. The High-level Taskforce for Innovative Financing (HLTF), for example, has estimated the cost of reaching the health-related MDGs at between US\$112 billion and US\$251 billion between 2009 and 2015.¹ As the HLTF has proposed, if all donors respect their previous commitments and if all LICs allocate at least 12–15 per cent of their GDP to health, the financing gap would be minimal. In comparison with today's high-income OECD (Organisation for Economic Co-operation and Development) countries, LICs should not need to grow and transform their economies, which only happens after long periods of time, in order to achieve significant improvements in health outcomes. Indeed, the progress attained by a large majority of developing countries in terms of health outcomes and access to health has been much more rapid than that achieved by today's rich countries through their processes of economic development. This is, to a large extent, because improvements in technologies for health care, in available treatments and preventative measures, can be potentially diffused globally despite massive income gaps across countries. In other words, today the potential for convergence among countries in achieving health outcomes is much greater than the potential for convergence in achieving income per capita.

One problem with a system that is premised on international aid is that the level of promised commitment is not forthcoming, both at the international and national levels. In the current climate of fiscal restraint and economic recession, we can also expect that the exponential increases in aid to health that we have witnessed in the past are under threat. Innovative financing mechanisms have the potential to make a valuable contribution to filling this gap, yet they remain an insufficiently tapped resource.²

In addition to the insufficiency of funding for health, its inequitable distribution between countries and between horizontal and vertical priorities

remains a concern. As analysed by the Countdown group to 2015, targeting of aid to maternal, newborn, and child health, for example, has improved, although several countries with high morbidity and mortality rates have seen a reduction in the aid allocated to them (Greco et al. 2008). Certain diseases have also received a disproportionate share of resources. For example, between 2002 and 2006, 75 per cent of the additional funding to health was allocated to HIV/AIDS (Isenman and Shakow 2010). An analysis of the health funding of the Gates Foundation, the Global Fund to Fight AIDS, TB and Malaria (GFATM), the US government, and the World Bank found huge variation in the funding per death across diseases, from US\$1,029.10 for HIV to US\$3.21 for non-communicable diseases (Sridhar and Batniji 2008), despite the reality that more deaths occur in the developing world from the latter (England 2007).

Moreover, LICs cannot hope to deliver on most of the promises for improvements on health outcomes and access only on the basis of aid flows, despite their obvious contribution at present. Indeed, health service delivery can be seen as part of a social contract between states and societies, so that bold efforts to mobilise domestic resources are made with a long-term horizon. The volatility of aid and the growing complexity and fragmentation of aid delivery systems make the need for greater reliance on more sustainable domestic sources a long-term priority. Currently, the delivery of aid in general, and of health in particular, suffers from institutional dysfunctions associated with the coexistence of different mechanisms of aid allocation, monitoring, and evaluation, ranging from traditional ‘project’ approaches, implemented by both state and non-state actors, to programme aid to general budget support more recently. Health ministries in aid-dependent countries are hugely overburdened with complex aid systems and a multiplicity of actors and projects. For example, in Mozambique, over 400 separate projects were located in the Ministry of Health in recent years, a situation that is not uncommon in the social sectors of aid-dependent countries (Riddell 2007). Therefore, donor proliferation and the fragmentation of aid delivery systems with their considerable transaction costs have substantially increased the bureaucratic burden that governments in LICs face in managing aid flows, thereby making policy processes excessively driven by the day-to-day demands of the management of aid (Oya and Pons-Vignon 2010).

Pledges to increase aid commitments have abounded in the past decade, but the current context of global stagnation and severe fiscal austerity programmes in OECD countries may result in these promises remaining unfulfilled. A number of OECD donors have already started reversing increases in aid flows, notably Italy, France, Spain, and Ireland. More may follow in the medium term. This situation adds to the unpredictability of aid flows, whose volatility often exceeds that of export and fiscal revenues in LICs (Fielding and Mavrotas 2005).

Governments facing volatile aid flows and unfulfilled aid commitments

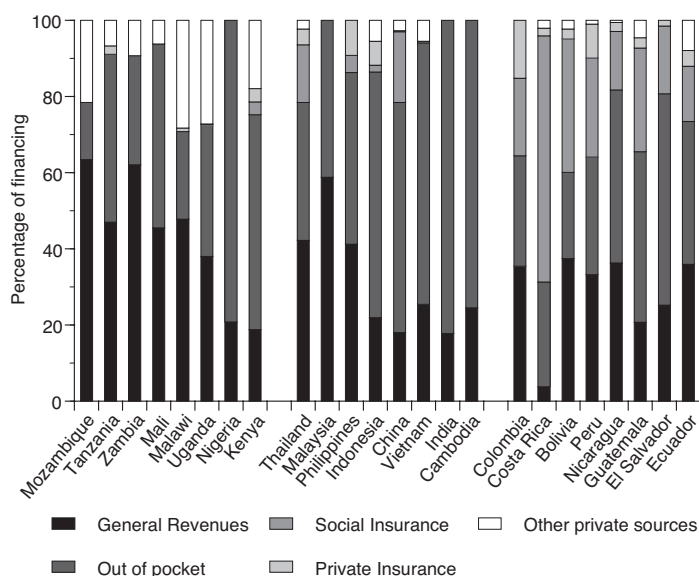
may not be in a position to make substantial commitments to expand health systems through public investment and permanent hiring of health workers, and may therefore be inclined to increase reliance on vertical programmes and temporary work arrangements. This may run against the commitments to achieving sustainability of access to health and health systems (see more below). In addition, many of these countries have programmes with the International Monetary Fund (IMF), usually in the form of Policy Support Instruments, which are now essential for attracting funding from other donors. The IMF has expressed reservations about the scaling up of aid owing to the inherent volatility of aid flows, and therefore has induced caution in aid-recipient governments, which unavoidably affects plans to expand health service delivery via permanent recruitment of health workers (Heller 2005). This can present an additional constraint on long-term health system strengthening based on foreign aid. In sum, if donors do not address the problem of volatility of aid flows, LICs may take much bolder steps to reduce aid dependence and mobilise domestic resources, particularly through taxation, which remains woefully low, especially in least developed countries.

There is a need to press for more international aid, and for international commitments in this regard to be honoured (See Box B2). The international context, however, will increasingly mean that funding at the domestic level must be harnessed. The aim of this chapter is, therefore, to assess how money should be raised at the domestic level to finance universal coverage of a package of health services: What is the best financing mechanism? What are the acceptable current trends that address concerns about equity and universal coverage? Is there one 'best' way of financing health care? Have all the options been given a fair trial or are ideologies getting in the way of finding progressive solutions?

Why we must move away from user fees

The health sector as a whole has gone through a series of reforms in the past four decades at least that saw a shift from comprehensive primary health care (as epitomised by the Alma-Ata Declaration in 1978) to selective primary health care, focusing on a series of cost-effective interventions (Bhatia and Rifkin 2010). The latest wave of health sector reforms, driven by the World Development Report 1997, have been particularly focused on introducing market mechanisms into the health sector, in the belief that the competitiveness and efficiency of the private sector would benefit the achieving of health outcomes.

These reforms had an impact on the methods of delivery (a shift from public to private provision), the role of the state (a shift from provider to steward), among other things, and also on the type of health financing mechanisms implemented in countries (from free care at the point of use to user fees). By definition, health financing systems have three functions: revenue raising,



B2.1 Sources of health care financing, selected low and middle income countries, 2000 (source: Hsiao and Shaw (2007: 6))

pooling of resources, and purchasing of services (WHO 2000). Ideally, these financing mechanisms should fulfil these three roles whilst promoting equity and efficiency.

To date, the dominant form of financing health care in Low and Middle Income Countries (LMICs) is direct out-of-pocket payments, of which user fees are a part (see Chart B2.1). These user fees – the individual payments made for services at the point of use – have been the subject of much high-profile debate in the past few decades. The World Bank used to not only encourage this financing mechanism as a source of income, but even made it a condition to receiving funds at the time of the Structural Adjustment Programmes (SAPs) in the 1980s. The main justification for the introduction of user fees was twofold: to reduce moral hazard – that is, to discourage unnecessary utilisation of health services; and to generate additional revenue. However, in the provision of health care, the underlying market-based assumptions do not hold.

The reality of asymmetric information between the health care provider and the patient, whereby a patient is not fully informed of their needs, means that the purchaser of health care does not know how serious their condition is, nor how much it will cost. Thus, the economic argument fails. User fees deter patients from accessing both necessary and unnecessary health care. Frivolous use of health services is unlikely given the high additional costs of seeking care, such as transport and time. In delaying treatment, conditions may worsen and costs may inflate, thereby undermining the efficiency objective.

This eventuality is more common amongst the poor, for whom access is determined by capacity to pay. Owing to the stochastic, unpredictable nature

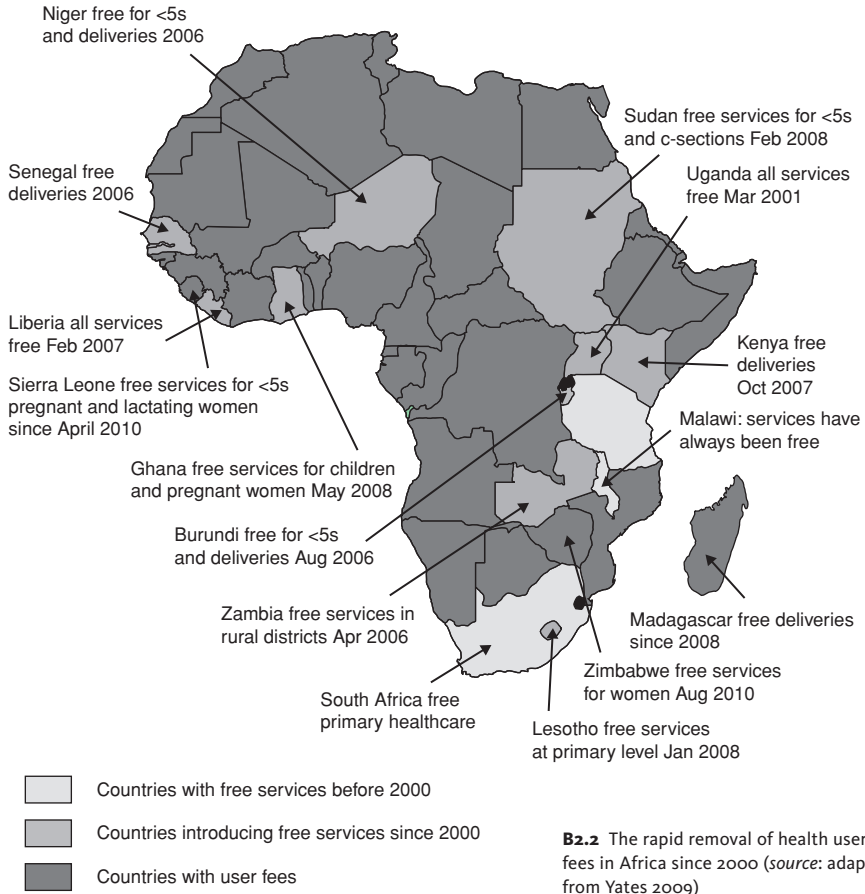
of ill-health and its associated potentially exorbitant costs, making individuals bear the financial burden of their ill-health is regressive and simply unfair. For those who do seek care, the incidence of impoverishment and catastrophic expenditure disproportionately affects the poorest. Health care is also a ‘public good’, with high externalities – that is, with spill-over benefits for the wider society.

As for the second justification – that of the potential of user fees to raise revenue – the evidence is weak. Relative to overall health expenditure, user fees tend to contribute a small share, approximately 5 per cent of recurrent costs after the deduction of administrative costs. Whilst this might facilitate some cost recovery at the facility level, it is inadequate to bring about significant quality improvements, and can actually exacerbate geographic inequity as the quality gap in service provision between wealthier and poorer areas widens (Gilson 1997). In addition, implementing user fees comes with considerable administrative costs, and weak financial management capacities and audit systems at the facility level reduce efficiency further (*ibid.*). Thus, the motivations for introducing user fees at the point of service prioritised efficiency over equity. As the evidence demonstrates, in practice user fees for health services are both inefficient and regressive.

Today, these negative effects are well understood and recognised. Over the past few years, the governments of many LICs, concerned with the implications of these negative effects for their populations, have either totally (as in Uganda or Liberia) or partially (as in Burundi and Sierra Leone) eliminated user fees (see Chart B2.2).

Donors and international institutions have also, sometimes half-heartedly, started to acknowledge the evidence. The UK Department for International Development (DfID) had been for the past five years at least a champion of the removal of user fees, and it is hoped that this commitment will be upheld and will grow under the new coalition government. The World Bank has softened its position from ‘user fees are a must’ to ‘Upon client-country demand, the Bank stands ready to support countries that want to remove user fees from public facilities *if ...*’ (The World Bank Strategy for Health Nutrition and Population Results, 2007, para. 105³). ECHO (Humanitarian Aid department of the European Commission) and the European Union have recommended the replacement of user fees in LICs. The World Health Assembly (WHA) passed a resolution in favour of the abolition of user fees (WHO 2005). The Global Consensus on Maternal, Newborn and Child Health (MNCH), recognised at the L’Aquila 2009 G8, has also supported the removal of user fees.

This could seem like an overwhelming victory for free health care at the point of use. In practice, however, user fees continue to limit the ability of the poorest to access health care. Children are still dying because their families cannot afford the few cents or dollars necessary to see a doctor, and mothers are still dying during delivery because they cannot afford to pay for a C-section



B2.2 The rapid removal of health user fees in Africa since 2000 (source: adapted from Yates 2009)

when they need one. Indeed, whilst the academic argument has been won, the practical implementation of free care at the point of use is proving to be a barrier. Internationally, the debate has moved on from *whether* to remove user fees to *how* to remove them (Save the Children UK 2008).

Further, in the absence of broader social protection policies, the costs of seeking health care for households are not limited to official fees. As mentioned above, transportation is another major expense, especially for poor and remote populations. For instance, in Mpumalanga, South Africa, transport costs accounted for 62 per cent of total household expenditure when treating malaria (Castillo-Riquelme et al. 2008). Other indirect costs include the transport, accommodation, and food expenses for accompanying relatives, which can be particularly high, especially for inpatient care. Unanticipated charges for supplies and drugs, as well as unofficial fees charged by health care providers or ancillary staff, push up overall costs for the household. In Ghana, drugs and medical supplies made up 79 per cent of the total costs for obstetric care (Borghini et al. 2003). There is also the opportunity cost of the time taken to

seek care, which is hard to quantify and often overlooked. In LICs, where large proportions of the population are informally employed, time away from work may deprive a household of their daily income, which is required to feed the family. In some cases, these additional indirect costs can exceed the cost of the user fee, thus becoming more significant barriers to access.

For poor, and often rural, households, the expenditures associated with accessing health services can be catastrophic, and plunge families into poverty. In the event of a complicated delivery, costs to households in Nepal increased tenfold. For the wealthier families, this amounted to 113 per cent of household income, reaching 366 per cent for the poorest households (Borghi et al. 2006). Assets that are essential for a family's livelihood – such as cattle or farmland – may be sold, and huge debts incurred, perpetuating the cycle of poverty. Whilst removing user fees may not be enough to address the variety of barriers to access, and whilst further investment is required to understand better how to alleviate this wider burden on households, where other safety nets do not exist, making health care free at the point of use is a vital first step to increasing coverage.

Private alternatives to user fees

Countries do not finance their health systems through a single mechanism, but rather uses a combination of approaches. There are two broad types of financing mechanisms available: first, private ones (that is, the source of finance is the individual, as is the case for community-based health insurance [CBHI], medical savings accounts,⁴ and private health insurance [PHI]); and second, public ones (that is, services are paid for through taxes or compulsory health insurance), and, of course, a combination of any or all of these.

Private health insurance (PHI) Could PHI provide part of the answer to replace user fees? It only plays as yet a limited role in LICs, although some donors would like to see its importance increase (the International Finance Corporation [IFC] or USAID, for example). PHI currently plays a marginal role in LICs, with coverage usually under 10 per cent of the population (Drechsler and Jütting 2005). Zimbabwe was the only LIC where PHI accounted for more than 20 per cent of total health expenditure in 2001 (Sekhri and Savedoff 2005). However, although this represents a large share of total expenditure (23 per cent), it only applies to a small share of the population (8 per cent), which is likely to have belonged to the wealthiest tiers and those employed in the formal sector (ibid.).

PHI theoretically enables the health care of the relatively affluent to be self-financed, and frees up public resources for those unable to purchase PHI. It can mobilise additional resources for infrastructural development that benefits poor and rich alike, and holds the potential to encourage innovation and efficiency, which may catalyse the reform of the public sector whilst increasing choices

for the consumer (Maynard and Dixon 2002). However, PHI discriminates in favour of the healthy and young adults with low utilisation levels (Baeza and Munoz 1999; Maynard and Dixon 2002; Oxfam International 2009; Mills 2007). The elderly tend to drop out of these schemes after retirement (as seen in South Africa and Chile), returning to the public sector. As these schemes are based on an individual's ability and willingness to pay,⁵ they lead to obvious inequality in access, market segmentation,⁶ cream skimming,⁷ and exclusion of vulnerable groups (such as the poor, the ill, and the elderly).

South Africa has the most extensive PHI schemes in sub-Saharan Africa. Analysis there has shown that these schemes (a) cover only a small proportion of the population; (b) have led to fragmentation of the risk pools; (c) have led to an increase in expenditures; and (d) increasingly capture tax resources (McIntyre et al. 2005: 26). In light of these significant risks, the government must have the capacity to develop robust regulatory frameworks that are able to set the standards and rules by which PHI can operate (Drechsler and Jütting 2005).

This last point – the national cost associated with supporting PHI schemes – is often ignored. In South Africa, for example, the tax deductibility of private scheme contributions reduced government tax revenue by over US\$1 billion in 2001 and higher income earners received a much greater share of the tax benefits (McIntyre et al. 2005). Furthermore, in South Africa, as in LICs in general, the government is the main employer, and a substantial amount of tax resources is devoted to purchasing medical scheme cover for civil servants. 'For example, the South African government spent 12 times more paying for medical scheme cover per civil servant than it spent on funding public sector health services per person dependent on these services in the early 2000s' (ibid.: 26).

It seems obvious, therefore, that PHI can only play a limited role in LICs, one which focuses on catering to only a small segment of the population – the rich.

Community-based health insurance (CBHI) The enthusiasm for CBHI is growing, particularly in sub-Saharan Africa, where the introduction of CBHI schemes is sweeping across the region. CBHI is defined as 'any scheme managed and operated by an organization, other than a government or private for-profit company, that provides risk pooling to cover all or part of the costs of health care services' (Bennett et al. 2004); they are normally voluntary. CBHI differs from PHI in that the administration of the scheme is undertaken by an association or a community rather than a commercial institution.

CBHIs are seen as a positive progression away from user fees towards national health insurance systems because they collect revenue, pool funds, and ensure strategic purchasing to encourage financial protection, equity in utilisation of services, and financial sustainability. These schemes are expected

to 'reach population groups that market based health financing arrangements do not', such as populations in the informal sector and socially excluded groups (Jakab and Krishnan 2001: 53). These schemes used to be widespread in some developed countries such as Germany or Japan, but have since totally disappeared and are now found only in LICs (Rannan-Eliya 2009).

There is some evidence that CBHI schemes provide effective protection to their members by significantly reducing their level of out-of-pocket payments for care (Ekman 2004). Studies comparing the level of financial protection of scheme members with that of non-members have found that belonging to some form of pre-payment scheme reduced the financial burden of seeking care (Arhin-Tenkorang 2000; Pradhan and Prescott 2002; Diop et al. 1995). In that sense, CBHI should be welcomed as an improvement over user fees.

However, even in areas that are 'success stories', such as the Thies and Bwamanda regions, evidence suggests that the poorer segment of the population is much less likely to join CBHI schemes than people with an average or high income, as the poor have no financial means to pay the required insurance premium (Jütting 2003: 284). The same conclusion applies to Rwanda, where, despite exemption systems to protect the most vulnerable, this group remains excluded (Musango et al. 2004).

Therefore, whether the poorest will be able to obtain financial protection will depend on whether or not their premium will be subsidised (by the state or by donors) and on how successful this subsidisation will be in targeting those most in need.

The pooling power of CBHIs has also been mixed. Since membership of the schemes is normally voluntary (aside from the case in Rwanda), adverse selection has led to the fragmentation of pools (various funds for different categories of people), resulting in the wealthiest groups having access to better quality and more comprehensive health care services. (Carrin et al. 2005: 801).⁸

Furthermore, people's willingness to pay the CBHI premium is dependent on a combination of variables: health care prices, disposable income, trust, original quality of care, and who pays the premium in the household.⁹ The extent and level of the benefit package also play an important role in the decision to subscribe. Some schemes offer a basic primary-level health care package, while others cover catastrophic expenditures only. Which is best? Which will attract the most individuals? Setting a premium of about US\$1 per capita per year may well enable the entire population to join (as in the case of Rwanda), but would not buy any meaningful benefit package. On the other hand, offering only catastrophic coverage (for HIV/AIDS, for example) could make the scheme more financially sustainable, leaving the enrollees to continue to cope with the most basic of services (often but not always subsidised by the state), while offering them protection for those events that

would undoubtedly throw them into extreme financial hardship or for which they would be unable to pay. Which solution is the most appropriate is difficult to assess, particularly since the majority of the schemes have defined their benefit packages only vaguely and improperly.

Because the majority of CBHI schemes have been unable to attract large populations, with the exception of schemes in China and a few schemes in India (Rannan-Eliya 2009: 73), they have not been able to bear the financial risks of their members. Hence, they require support from central and local governments; 89 per cent of the schemes investigated by the International Labour Organization (ILO) were subsidised by the government, as 70 per cent of these schemes collected less than 50 per cent of the needed revenue to be sustainable (ILO 2002). This is also the case in China, where the study by Zhang et al. (2006) found that only half of the farmers were willing to join the voluntary CBHI scheme, despite a government-subsidised premium.

Nonetheless, the Rural Mutual Health Care (RMHC) initiative in China, a form of CBHI, was found to increase outpatient utilisation by 70 per cent. This was facilitated by a mixture of demand- and supply-side interventions to provide individuals with first dollar coverage for inpatient and outpatient care, and to link provider payment to service quality rather than drug sales (Yip et al. 2008). The impact of such supply-side interventions may be felt by the entire population, which suggests that RMHC had a spill-over effect on the uninsured population too (*ibid.*). Successful experiences in India include the CBHI offered by the Self-Employed Women's Association (SEWA) in Gujarat, through which the number of patients facing catastrophic health expenditures was reduced from 35.6 per cent to 15.1 per cent. This was facilitated by high pre-payment ratios, as well as a benefit package inclusive of costly inpatient care (Carrin et al. 2005).

Mechanisms to ensure sustainability of individual schemes have been attempted in numerous countries but can conflict with equity concerns: exclusion of high-risk individuals from scheme membership will affect the sickest and most vulnerable members of the population; increasing premium levels will discourage the poor from joining; and placing limitations on a benefit package will enable better financial sustainability but will limit the attractiveness of the scheme (Bennett et al. 2004).

Overall, CBHI offers only a marginal improvement over user fees in terms of financial protection and provides no prospect of universal coverage. We must also recognise that any community approach presents technical solutions and eschews social relations as if all decisions were made by individuals only. Yet power relations within communities exist, and the decision to join a CBHI scheme or not may be forced upon individuals rather than be the result of an individual's choice. It seems that the choice of CBHI relies mostly on a culturally appealing morality tale, but it is no panacea for tax-financed health systems aimed at achieving universal coverage.

Public financing methods: why tax-financed systems offer greater potential

The public mechanisms for financing health care, social/national health insurance, and tax-financed systems (TFSs) are widely recognised as holding greater potential of achieving universal coverage (McIntyre et al. 2005; Mills 2007). Yet the discussion on these approaches is rather limited and revolves around a key argument: progressive taxation in LICs is argued to be extremely complex to implement for various reasons (discussed below), hence social health insurance (SHI) is the only realistic public financing option afforded to LICs today. In May 2005, for example, WHO passed a resolution encouraging its member states to move ahead with this system, promising to provide technical support to help nations develop it.¹⁰ We argue that this is a short-term view, which actually harms the potential for achieving longer-term sustainability.

Comparison between a tax-financed system (TFS) and social health insurance (SHI)

What is a tax-financed system and social health insurance? Tax-financed systems (TFSs) are systems where government revenues raised through various forms of taxation are the main source of financing for government health care expenditures. Social health insurance (SHI) refers to systems where ‘only certain groups are legally required to become members and where only those who make insurance contributions are entitled to benefit from the insurance scheme’ (McIntyre et al. 2005: 25). National health insurance systems, on the other hand, refer to a universal insurance system in which the entire population is covered, independently from contributions, with generally heavy government subsidisation.

Equity and financial protection Both tax-based financing and SHI are a form of tax, the first on general wealth whilst the second focuses only on wages. They relate the initial payment to income rather than risk, detach payment from the experience of ill-health through a pre-payment system, and can create large risk pools, and hence hold redistribution potential. In terms of equity and financial protection, they both represent an indisputable improvement over private mechanisms.

There are, of course, nuances. Whether or not an SHI system will be progressive will depend on the structure of the contribution rates. Will there be a ceiling rate? Will the contribution be flat or will it increase with income? How will the funds be pooled? Will there be a central pooling fund (which would ensure subsidisation across scheme members) or will there be multiple funds (which would limit the subsidisation potential)? The smaller the pool of contributors, the lower the cross-subsidisation that can be achieved, and the less impact of equity and sustainability on the health system (ibid.).

As to a TFS, its relative merit will depend on whether the personal income tax will be structured progressively, whether the overall tax burden will fall on

households or whether it will be widened to include corporations (national and international), and on the relative role of indirect taxes (the lower the VAT, for example, the more progressive the system). Financial protection will be more or less equitable depending mainly on whether government funds are allocated according to the relative needs of the population. For example, various studies on the distribution of benefits from publicly (tax)-funded services in African countries have shown that the rich benefit most from these services (Castro-Leal et al. 1996; Castro-Leal et al. 1999; Demery 1995). This usually occurs when a major ‘share of tax funding is allocated to large, expensive, urban based hospitals rather than to primary care services and services in rural areas’ (McIntyre et al. 2005).

The Equitap project has shown that, overall, where general tax-funding mechanisms are the predominant form of financing health care (such as in Hong Kong, Thailand, and Sri Lanka), the pattern of health financing is more progressive than in countries dominated by a mandatory SHI system (O’Donnell et al. 2005). Where SHI has been introduced in African countries (such as Tanzania or Kenya), it has created ‘a deep divide between the insured, who have excellent access to a wide range of high quality health services, and the uninsured[,] who often are consigned to under-resourced public sector services for the poor’ (ibid.).

The only LICs that have achieved universal coverage and pro-poor access to health services through effective risk protection have done so through a tax-financed, government-delivered approach, complemented by other private mechanisms (Rannan-Eliya 2009: 71).

Efficiency: why taxation offers greater potential SHI is a tax on employment and has often been blamed for leading to higher labour costs (Mossialos and Dixon 2002; Wagstaff 2009) and for encouraging informality in the labour market (Baeza and Packard 2006). Who actually pays the tax, however, is not a straightforward matter. There might be a division between employer and employee. Indeed, it actually depends on the level of competition between products and in labour markets. If markets are highly competitive, then firms will contain the costs of employment and pass on the expenses of contributions to employees through a wage freeze, for example (Normand and Busse 2002). The collection of resources through SHI mechanisms is also more costly, and so is the cost associated with the purchaser–provider split that is typical of SHI (Wagstaff 2009).

Evidence has also crucially shown that SHI systems may not generate enough revenues to achieve universal coverage (ibid.). The fact that the tax base of SHI is limited to the formal sector of employment necessarily limits the resources collected. This is particularly relevant in LICs with large informal sectors.

What matters most in reaching universal coverage in any given country is the size of the pool. The greater the risks and the larger the resources pooled

together, the wider the coverage, the greater the financial protection, and the greater the chances of achieving financial sustainability. By its very nature, the pool of resources and risks of SHI schemes is smaller than that of TFSs, and hence affords less financial protection to its population and is less financially sustainable. Theoretically, therefore, TFSs should be the preferred option in LICs that are attempting to achieve universal coverage. Yet the opposite is true.

The reasons for this preference might lie in the practical difficulties associated with implementing a tax system in LICs.

A way forward for tax-financed systems (TFS)

Political feasibility and desirability The revenue of SHI schemes is determined by earmarked contributions that are collected by independent quasi-public funds. The process is, therefore, perceived to be transparent and independent from political interference (Normand and Busse 2002). The allocation of general tax revenue, on the other hand, is an inherently political activity.

The apparent international preference for SHI over TFS may be rooted in this particular point. If governments in LICs are assumed to suffer from high levels of corruption, or actually do so, the earmarked element of SHI will make it more acceptable, both socially and politically.

A related point is the nature of the relationship between the state and society, its fiscal contract, which will determine the feasibility of implementing a tax system. Tax compliance is based on an exchange between the government and its people. The collection of tax requires substantial coercive power and for the state to be legitimate, since most of the tax is collected where there is a high level of voluntary compliance (Di John 2009: 1). No country, no matter how rich, has sufficient resources for penalising all those who do not respect the tax laws.

The level of social cohesion across socio-economic groups is also an important constraint to the successful implementation of tax systems, particularly in countries with high levels of income inequality, where the rich may feel that they pay too much to subsidise others. For a TFS to function, the crucial group to capture is the middle class, whose needs must be met, or must at least be perceived to have been met (Carrin and James 2002).

To conclude from these political considerations that TFSs are too obscure, cumbersome, or complicated to implement, however, perpetuates this status quo and undermines state-building efforts. Indeed, taxation and tax reform are central to state-building efforts and to increasing the level of accountability of the state towards its citizens.

Taxation is the main nexus that binds state officials with interest groups and citizens. Not only can taxation enhance government accountability, it also provides a focal point around which interest groups [...] can mobilize to support, resist and even propose tax policies. (Di John 2009: 2)

Various studies (Ross 2004; Mahon 2005) have found a strong correlation between increases in the general tax burden and increases in the level of democracy within a few years, and an even stronger correlation between the general tax burden and the extent of liberalism, understood as the existence of constraints on state powers. Timmons (2005) has shown that the more a state depends for revenues on taxing its richer citizens, the more it is likely to pursue policies that are beneficial to the rich to persuade them to continue to part with their money. In the Democratic Republic of Congo, Rwanda, and Uganda, for example, ‘large’ payers contribute between 40 and 70 per cent of the domestic revenue collection (Di John 2008). On the other hand, the more the state depends for revenues on taxing its poor citizens, the more it is likely to pursue policies that are beneficial to them (Moore 2004: 38).

A solution to this transparency concern and sometimes faltering fiscal contract could be the establishment of an earmarked tax for health. This hypothecated tax would ensure a stable and increasing revenue base for health, would address the transparency issues that mar the perception of taxation in LICs, would improve accountability by separating health from competing national priorities (provided that the hypothecation was more than cosmetic), and would be less susceptible to political manipulation (Mossialos and Dixon 2002).

Since health is a wanted public good, the establishment of a health-specific tax might be more acceptable to the population and might lead to greater tax compliance, thereby strengthening the fiscal contract between the government and its citizens.

Size of the informal sector The large informal sector prevalent in LICs limits the tax base and generally leads to the conclusion that TFSs cannot be put in place. Indeed, the larger the informal sector, the more difficult it is to assess the resources that can be taxed and the more difficult it is to undertake the collection of these resources.¹¹ In those African and Asian countries attempting to implement SHI or TFSs, the biggest concern remains how to extend coverage beyond the formal sector (Hsiao and Shaw 2007: 25).¹²

Yet it is recognised that in developing countries, the informal sector is not only here to stay but is also expected to grow. The persistent failure to tax the informal sector is leading to the perception among formal sector workers that the state is unfair in pursuing only them for the collection of taxes. The informal sector is also not as averse to taxation as may be expected (Joshi and Aye 2008: 187), and taxing this group would re-engage the state with those workers and would potentially increase the legitimacy of the state in their eyes. The question, therefore, should be how to tax the informal sector despite its heterogeneity and complexity.

Ghana, Senegal, and Tanzania offer ideas about how to address this issue. In Ghana, the government delegated responsibility for collecting income tax

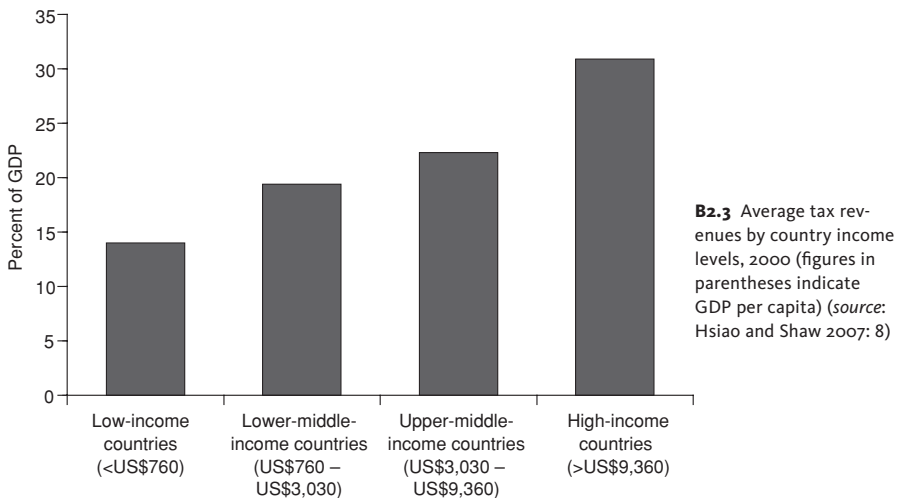
from informal passenger transport operators to their unions (ibid.: 184). As the unions had detailed knowledge of the activities of their members and could easily collect taxes, the scheme was quite easy to administer. ‘Operators were liable for taxes only on the days they actually worked, taxes were collected at the lorry park and the union got a 2.5% share of the total collection’ (ibid: 196). The government has also sought to determine VAT obligations by checking the registration of the value of vehicles (McKinley 2009).

Based on various research studies, it is seen that the ability to tax the informal sector (either employers or workers) depends on the extent of revenue pressure being faced by the government, the degree and nature of association-ism within the informal sector, and the channels of interaction with state institutions (Joshi and Aye 2008: 209).

Crucially, recognising that informal does not mean poor or disorganised might go some way in debunking the myth that informal sectors cannot be taxed.

Economic growth Some economists (Newbery and Stern 1987, for example) argue that economic development is the most important factor affecting the range and size of the tax base. The scarce economic resources, modest economic growth, and economic structure (large share of subsistence farming, large informal sector, and many small establishments, for example) that are typical of LICs imply that resources collected by the state will necessarily be limited.

The level of revenue raised through taxation in LICs is very limited. Total tax levels stagnated during the 1990s in LICs (McKinley 2009).¹³ This reinforces how vital it is that donors provide long-term and predictable ODA (official development assistance) to LICs, whilst the tax base is being developed to eventually allow for domestic sustainability.



Box B2 The politics of aid

Though international aid forms an integral component of several discussions on policy environments at the global level, it is surprising how relatively small the actual quantum of such flows really is. Global flows of overseas assistance are often just enough or less than what poor countries need to pay back to developed countries to service existing debts. It is important to remember that these debts were incurred, largely, because multilateral agencies such as the World Bank and the IMF advised poor developing countries to access loans at high interest rates from capitalist banks in the developed countries. Worldwide, the amount of money returned to high-income countries dwarfs the amount received in development assistance: donor countries receive back many times over in debt repayments what they give in aid.¹⁴ Journalist Ken Wiwa, son of Ken Saro-Wiwa, the activist hanged for opposing Shell Oil's destruction of Nigerian homelands, noted: 'You'd need the mathematical dexterity of a forensic accountant to explain why Nigeria borrowed \$5 billion, paid back \$16 billion, and still owes \$32 billion.'¹⁵

In the aftermath of the devastating earthquake in Haiti, the IMF rescinded an emergency loan of \$100 million to Haiti and reoffered it as a grant. What is, however, not debated adequately is how did Haiti get into a situation where taking on another loan could put millions of lives in jeopardy. It is estimated that, by 1999, the country was paying \$38 million in debt service; while the health budget the same year was \$26 million. Between 1995 and 1996 in particular, Haiti paid 900 million gourdes (approx. US\$25 million) in debt service. During the same period, only 120 million was invested in agriculture. According to the Haitian Central Bank, in 2006 alone, total debt service paid was \$57 million, with 47 per cent going to the International American Development Bank (IADB), 30 per cent to the World Bank, and 10 per cent to the IMF.

The inflow of international aid in many cases is much less than the outflow from developing countries as a result of their trade deficit, largely with developed nations. Of the three regions of the developing world, only in the case of Africa is the inflow of aid higher than the outflow due to trade deficit.

However, just prior to the onset of the global financial crisis, export revenues of many developing countries had risen and the burden of servicing external debt for the developing countries had fallen from almost 13 per cent of export earnings in 2000 to below 4 per cent in 2007. This has now been reversed as developing country exports and commodity prices have fallen starkly as a consequence of the crisis.

The quantum of international aid in the form of development assistance has been a cause for considerable debate, and repeated commitments have been made pledging 0.7 per cent of rich countries' gross national product (GNP) to official development assistance (ODA). First pledged 40 years ago in a 1970 General Assembly Resolution, the 0.7 target has been affirmed in many international agreements over the years, including the March 2002 International Conference on Financing for Development in Monterrey, Mexico, and at the World Summit on Sustainable Development held in Johannesburg later that year. However, most developed countries are nowhere near reaching the 0.7 per cent target, though there has been an increase in the absolute quantum of ODA since the 1980s. Total bilateral ODA commitments from OECD members have increased by more than 50 per cent in real terms since 1980–84, from an annual average of US\$70.5 billion in the period 1980–84 to US\$108.7 billion in the period 2002–06.¹⁶

While the meagre allocation to development assistance is a matter of concern, perhaps of even greater importance is the way such assistance is often linked with the political and economic interests of the donor countries. Aid has often served the political, strategic or commercial interests of donor nations. Aid is often tied to the purchase of goods and services (in the form of technical cooperation) from donor countries, and similar criticisms are made of debt relief priorities.¹⁷ Aid is also accompanied by conditionalities – the 2003 US commitment to increase its annual aid spending to US\$15 billion by 2006, by way of its Millennium Challenge Account, made new funds conditional on 'sound economic policies that foster enterprise and entrepreneurship, including more open markets and sustainable budget policies'¹⁸ (in other words, greater market and investment opportunities for US-based firms).

While the average tax-to-GDP ratio in sub-Saharan Africa has increased from less than 15 percent of GDP in 1980 to more than 18 percent in 2005, the bulk of the tax revenue increase in the region came from natural resource taxes. Nonresource-related revenue increased by less than 1 percent of GDP over 25 years. Even in resource-rich countries, non resource-related revenue has essentially been stagnant. (Di John 2009; Gupta and Tareq 2008)

Some LICs, however, have succeeded in raising their tax-to-GDP ratio. Ghana's direct taxes, for example, rose substantially from 2.7 per cent of GDP during 1990–94 to 6.3 per cent during 2000–06. During the 2000s, Ghana was able to push corporate tax revenue up to about 3 per cent of GDP, and revenue from wages and salaries up to about 2.4 per cent (McKinley 2009).

Unlike the situation in many other LICs, revenue from trade taxes increased significantly in Ghana between the early 1990s and the 2000s.

During 1990–94, trade taxes accounted on average for 3.6 per cent of GDP, whereas by 2000–06 they rose to account for 4.5 per cent. During the 2000s, import duties continued to rise to about 3.5 per cent of GDP. Ghana's tariffs still ranged between 5 per cent and 20 per cent. But Ghana also continued to impose levies on some of its exports, mainly cocoa. As a result, export taxes continued to contribute about 1 per cent to GDP in revenue (*ibid.*: 18).

This demonstrates that whilst economic growth might play a role in raising tax revenue, LICs could improve their tax collection record through a diversification of their tax base. There is clearly an enormous potential to increase tax revenues. Part of this additional revenue could be allocated to health and could help achieve universal coverage.

What Next?

We have argued in this chapter that the move away from user fees is essential if we want to achieve universal coverage. We recognise that any given country will use a combination of mechanisms, and that there is no single best approach. Nevertheless, we warn against relying too heavily on alternatives to user fees that are little more than short-term solutions that offer little prospect of universal coverage. We have argued in favour of public financing approaches, for considerations of both equity and efficiency, and have highlighted the need to oppose the dismissal of TFSs as an unfeasible option in LICs.

Of course, taxation is a long-term issue, and its successful implementation implies structural changes in the relationship between the state and its population. Such structural changes require long-term efforts. We should strive today to build equitable and efficient health financing mechanisms that will enable us to reach universal coverage tomorrow. All these short-term experiments have a value only as short-term bandages and as long as the longer-term goals of universality and equity are worked towards.

Notes

1 For 49 LICs only.

2 The currency transaction levy alone has been estimated to raise an additional US\$33 billion per year off as small a rate as 0.005 per cent (Schmidt 2007).

3 Available at: siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1154048816360/HNPStrategyFINALApril302007.pdf.

4 Medical Savings Accounts (MSAs) may be compulsory or voluntary contributions of payments by individuals, households or firms into individual accounts aimed at covering payments for episodes of illness. There are

many issues pertaining to MSAs, not least their negative impact on equity, the absence of resource pooling, and their attempt to control costs through the demand side. They have been implemented mainly in Singapore, South Africa, and China, and have not as yet been attempted in other LICs, and therefore are not pursued in this discussion.

5 Willingness to pay (WTP) refers to the maximum sum that an individual is willing to pay to acquire some good or service or to avoid a prospective loss.

6 The act of dividing an overall market into groups, or segments, of consumers with similar

characteristics, such as age or average health status. It is usually done to engage in price discrimination.

7 The practice in PHI markets by which insurers select only those individuals with a low probability of needing care or those likely to need only low-cost care.

8 In Rwanda, for example, health centres working with smaller CBHI reported higher levels of use (up to three visits per member per year), suggesting that adverse selection is indeed a risk with low enrolment.

9 A study in Ghana, based on a hypothesised WTP, estimated a linear correlation between the price of health care and the percentage of people excluded from the schemes. In this study, data predicted that 'the highest revenue generated for CBHI was achieved when a household premium was approximately US\$2.77, a sum only 35% of the population was ready to invest' (Schmidt et al. 2006: 1327). In Rwanda, any contribution to CBHI greater than US\$1 per year per capita would exceed the monthly income of the poorest stratum. Clearly, the level of income and the price of health care are closely associated in determining the WTP of the population.

10 For full resolution, see apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_33-en.pdf.

11 Whilst this problem is common to SHI and TFSs, it is, of course, much worse for SHI systems.

12 The distinction between formal and informal is sometimes misunderstood. The informal sector here is understood as non-tax-registered business.

13 'While statutory rates for corporate taxes were dramatically reduced, an IMF study finds that the tax base did not increase. In fact, it decreased, and thus corporate taxes fell overall' (UNCTAD 2009).

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18 UN Secretary-General (2002). *Outcome of the International Conference on Financing for Development*. New York, United Nations (Report no. A/57/344 – 57th Session). www.un.org/esa/ffd/a57-344-ffd-outcome.pdf (accessed 1 February 2005).

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B3 | HEALTH FINANCING MODELS THAT MAKE HEALTH SYSTEMS WORK: CASE STUDIES FROM COSTA RICA, SRI LANKA AND THAILAND

In Chapter B2 we have discussed different options available for health financing, in order to secure equity and universal coverage by health systems. In order to deepen our analysis we analyse in this chapter three case studies that examine systems in place in Costa Rica, Sri Lanka and Thailand. Each of them has been proclaimed an exemplar of a ‘well-performing’ health system. They are, by no means, the *only* three such examples (others such as Brazil, Cuba, etc., have also been part of such discussions). Nor are the three cases entirely similar. However, the three cases are a good starting point for visualising the contours of health systems that have the best potential for ensuring both access and equity.

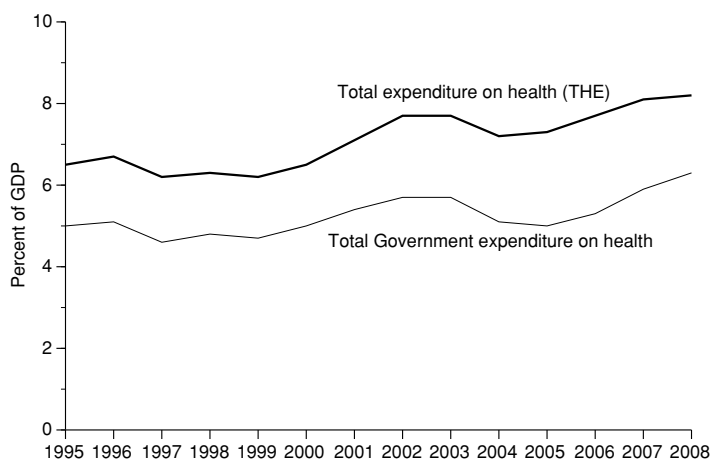
Costa Rica: integrating health financing with service provision

The Costa Rican health system is characterised by strong integration between health financing (through a compulsory social health insurance programme) and service provisioning by the public sector. This has been a cause of contention, over the years, between the Costa Rican government and the IMF/World Bank combine (as we shall see later).

The impact of such a system on health indicators has been almost spectacular. In the Americas, Costa Rica’s life expectancy (78 years) is second only to that of Canada (Unger et al. 2008). It has been argued that Costa Rica’s health achievements are a function of income growth in the country.¹ This is not, however, borne out by evidence. Rosero-Bixby (1986) has shown that only one-fifth of the country’s spectacular infant mortality reduction in the 1970s can be accounted for by economic growth, whereas three-fourths can be attributed to improvements in public health service.

Since the 1970s, Costa Rica’s economic growth rate has been less than one-third that of Chile and similar to that of Colombia and Mexico. But, in the same period, Costa Rica achieved reductions in infant mortality similar to those achieved in Chile and twice those achieved in Colombia and Mexico (Homedesa and Ugalde 2002). The country’s infant mortality rate was 10 per 1,000 in 2008, representing a sixfold reduction over a four-decade span.

Health sector development in Costa Rica A social security system for wage-earning workers in Costa Rica was instituted through the creation of the



B3.1 Total expenditure and general government expenditure on health as a percentage of GDP (source: World Health Organisation (n.d.))

Social Security Administration (CCSS – *Caja Costarricense de Seguro Social*) in 1941. Several progressive measures were adopted during the 1970s. CCSS extended its coverage and expanded the delivery of hospital-based health services. In addition the Rural Health Programme (*Programa de Salud Rural*) and Community Health Programme (*Programa de Salud Comunitaria*) were launched to provide comprehensive primary care services in rural and semi-urban areas (Unger et al. 2010).

The CCSS is the sole provider of public hospital care (23.9 per cent of total health expenditures is targeted at public hospitals and 2 per cent at private hospitals). The CCSS both purchases and provides care services. This unified health care system has helped Costa Rica avoid the social insurance stratification typical of other Latin American countries (ibid.). By 2000 the CCSS covered about 82 per cent of the population.

The government of Rodrigo Carazo (1978–82) introduced major elements of community participation into the health system. Health committees were activated in rural health posts under the aegis of the Unit for People’s Participation (*Unidad de Participación Popular*), a newly created division of the Ministry of Health. The focus on primary health care received a setback during the regime of Luis Alberto Monge. However, a major expansion of primary health care clinics (EBAIS; *Equipos Básicos de Atención Integral en Salud*) commenced in the mid-1990s.² Health committees occasionally co-manage these clinics. While, as part of a World Bank project, the CCSS started contracting out some services to the private sector, this was done only to a limited extent (ibid.).

The health system ensures wide coverage for most services – 90 per cent of women access antenatal care; 94 per cent of deliveries are attended by a trained professional; measles immunisation coverage is above 90 per cent (data for 2008) (World Health Statistics 2010).

Health financing The government is the main source of finance for health care. During the mid 1990s, around 5 per cent of GDP was allocated to health, and this rose to 6.3 per cent in 2008. (See Chart B3.1.) Of the total expenditure on health care, public funding accounts for over 70 per cent (World Health Organisation n.d.). Interestingly, over the years, private expenditure has fluctuated in an almost identical manner to public spending.

To understand better the experience of Costa Rica, let us examine the relative situation in health financing, in selected Latin American countries (see Table B3.1)

Clearly, Costa Rica is one of the best performers – both in terms of high public spending and in terms of low out-of-pocket expenditure. If we leave Cuba out of the discussion (because the Cuban system is so different), Colombia is the only other country that matches Costa Rica's performance. There is, however, an interesting difference. While only 0.12 per cent of Costa Rican households report an impact of catastrophic health expenditure (Unger et al. 2010), the corresponding percentage of households in Colombia is 6.26 (Xu et al. 2003). As the CCSS is both a purchaser and a provider of care services, no purchaser-provider split is evident in the dominant (public) part of the Costa Rican health system. In contrast, Colombia suffers from the consequences of transferring care provision to several private providers, or combinations of private and public providers. The unified system in Costa Rica also ensures better efficiency – the administrative cost has varied between 3 and 4 per cent since 1990, in contrast to double-digit numbers among competing private insurers in Chile and Colombia (Rodríguez Herrera 2006). The health system in Costa Rica also actively promotes equity through progressive targeting of expenditure – 29 per cent of expenditure is targeted at the poorest income quintile and 11 per cent at the richest (figures for 2000) (Unger et al. 2010).

The trajectory chosen by Costa Rica goes against the core recommendations of the World Bank, which has consistently argued in favour of a purchaser-provider split. This dissonance has been a cause for strained relations between Costa Rica and international agencies. When José María Figueres Olsen became president in 1994, he opposed recommendations of the IMF that called for privatisation of public services, and instead favoured greater government intervention in the economy. The World Bank subsequently withheld \$100 million in financing from the country. More recently, in 2003, Costa Rica temporarily abandoned the Central American Free Market Agreement (CAFTA) discussions and hesitated in accepting the US condition of opening up the insurance market (*ibid.*).

Some concerns do exist about the Costa Rican health system. One relates to the sustainability of the system in the face of rising costs of health care. There is also concern that out-of-pocket expenses still constitute almost a quarter of total health expenditure. While this is lower than in most low- and middle-income countries, it still means that vulnerable sections may still not

TABLE B3.1 Expenditure on health: comparison with some Latin American countries (as % of GDP)

	General government expenditure on health			Prepaid and risk-pooling plans			Private households' out-of-pocket payment		
	1995	2000	2007	1995	2000	2007	1995	2000	2007
Argentina	5.0	5.0	4.6	0.9	1.3	2.7	2.3	2.5	2.1
Brazil	2.9	2.9	4.9	1.2	1.5	1.2	2.6	2.7	2.4
Chile	2.5	3.0	3.0	1.5	1.6	1.2	1.6	1.5	1.4
Colombia	4.3	6.2	6.4	0.5	0.6	0.6	2.6	0.9	0.4
Costa Rica	5.0	5.0	5.9	0.0	0.0	0.2	1.3	1.3	1.9
Cuba	5.2	6.1	9.9	0.0	0.0	0.0	0.5	0.6	0.6
Mexico	2.4	2.6	3.0	0.1	0.1	0.2	3.2	2.8	3.3
Panama	4.8	5.3	5.7	0.4	0.5	0.4	1.9	2.0	1.7
Venezuela	2.3	3.2	2.7	0.1	0.1	0.1	2.0	2.5	2.4
Latin American average	3.3	3.6	4.1	0.5	0.8	0.7	2.3	2.4	2.3

Source: Data from WHO (2009), cited in Hernández, L. O. et al., *Progressive Alternatives of Primary Health Care in Latin America*

be adequately secured. A final concern relates to the method of computing budgets for health facilities. These are based on the previous year's expenses, thus providing an advantage to facilities in the capital regions and in big cities.

Conclusions The 2010 *World Health Report* remains ambiguous about direct public provisioning, while emphasising social insurance mechanisms in ensuring universal access to health services (WHO 2010). The experience of Costa Rica, and the contrast with other countries in the region, is clear evidence that health systems that promote equity and universal access are best served by a combination of public financing and provisioning.

Sri Lanka: welfare state under strain

A quarter of a century back, Sri Lanka's remarkable experience in promoting equity in social development was summarized as follows (Herring 1987: 326):

The basic needs performance of Sri Lanka, in the face of classical and severe structural dependency, raises a profound developmental point: extreme national poverty need not entail mass destitution, just as national wealth is no guarantee of well-being for the bottom of the income pyramid. The relative effective mediation between national poverty and individual well-being in Sri Lanka was sustained by extensive public investment in economic processes, with specific politically driven priorities.

The Sri Lankan story has been a subject of considerable discussion. One of the poorest Asian countries with a dependent economy (on export of plantations produce and tourism), it has sustained human development indicators that rival or surpass those of many developing countries. Sri Lanka's paradigm of development, however, has not been linear, and the last two decades have also witnessed the tension between its earlier 'welfare' model of development and the later introduction of neoliberal policies. In the following section we examine the effect of this tension, especially in the health sector.

Welfare state under strain After independence from British colonial rule in 1948, Sri Lanka engaged in developing a welfare state. It was characterised by universal public distribution of food at a very low price, free education and health, labour legislation, pensions, etc. By the 1950s such measures accounted for almost a quarter of the country's gross national product (GNP) (Lakshman 1987). These measures were complemented by extensive land reforms, carried out to alleviate the acute problem of landlessness among peasants (Bjorkman 1987). The results were fairly spectacular (see Table B3.2).

The first three decades after independence from colonial rule witnessed a huge expansion of health units and hospital, directly financed by the government. By 1997, government spending on health was 5.5 per cent of total government expenditure (Fernando 2001).

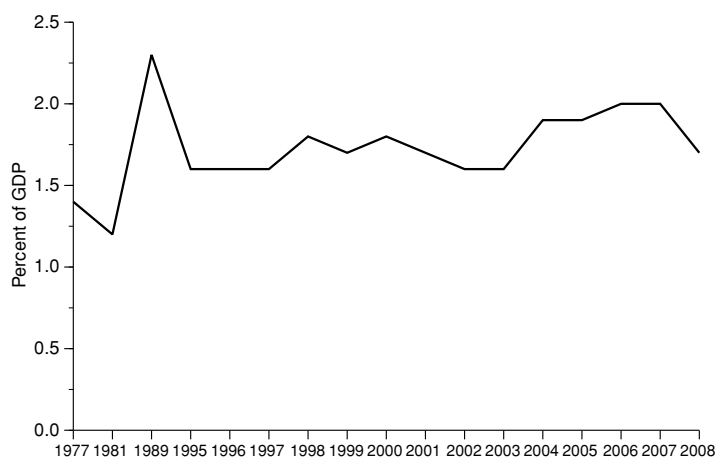
TABLE B3.2 Comparison of development indicators (by the late 1970s)

	Low-income countries	Lower-middle-income countries	Upper-middle-income countries	High-income countries	Sri Lanka
Life expectancy	51	52	62	72	64
IMR	138	98	83	21	42
Death rate per 1,000 population	16	14	10	9	7
Literacy (%)	36	57	67	97	85
GNP per capita (\$)	225	566	1800	8222	270

Source: Hansen et al. (1982), cited in Bjorkman (1987)

A worsening balance of payments situation in the 1970s was the trigger for imposition of a structural adjustment policy in Sri Lanka in 1977, on the dictates of the World Bank and the IMF, with an emphasis on economic 'growth' over measures to promote social well-being (Herring 1987). Social welfare programmes, instead of the earlier universal character, changed to targeted programmes. There were cuts, for example in food subsidy, and food coupons replaced direct provisioning.

A key change in the health sector was the permission granted to medical officers in the public sector to work as private practitioners outside office hours. This was a major factor in triggering an expansion of the private medical sector. In the 1990s, foreign medical service providers and insurance providers were allowed to operate in the country, government facilities were leased out for private operation, and concessional loans were provided to private investors to set up medical facilities in rural areas. In recent years,



B3.2 Public expenditure on health as a percentage of GDP, 1977-2009 (source: Institute for Health Policy (2009) and Fernando (2001))

the clinical and non-clinical services of public facilities have been contracted out to the private sector. This has resulted in a substantial expansion of the private sector (Baru 2003).

However public spending on health stabilised at earlier levels, after initial cuts. By 1989 health expenditure as a proportion of the total health budget had increased to 6.5 per cent (Fernando 2001). (See Chart B3.2.)

Sustaining the early momentum Much of the spectacular health improvement in Sri Lanka had taken place by the mid 1970s. In 1977 its life expectancy at birth (65 years) was comparable to some of the European countries, far better than that of its neighbours in the South Asian subcontinent (India, Pakistan and Bangladesh) and even China (Herring 1987). With very low levels of per capita income (\$200), it could achieve an Infant Mortality Rate (42 per 1,000 live births) lower than in countries with five to ten times higher per capita income. Maternal Mortality Rate (Bjorkman 1987) was also significantly lower than in countries with comparable income.

Health indicators have continued to improve since then, though the improvement slowed down in the last two decades of the twentieth century (Fernando 2001). Clearly, the early momentum provided by expansion of public services still has an impact on health outcomes – which continue to be much better than those of most low- and middle-income countries (LMICs) (see Table B3.3).

TABLE B3.3 Sri Lanka: key health indicators

Indicator	Year	Data
Life expectancy at birth (years)	2001–06	
Female		76.4
Male		71.7
Neonatal mortality rate (per 1,000 live births)	2002	8.4
Infant Mortality Rate (per 1,000 live births)	2003	11.17
Under-five mortality rate (per 1,000 live births)	2002	13.39
Total fertility rate (per woman)	2000	1.9
Maternal mortality rate (per 100,000 live births)	2002	14.3

Source: Ministry of Health (2007)

Health financing The total expenditure on health (as a percentage of GDP) rose marginally between 1990 and 2006 – from 3.8 to 4.2 per cent. This is almost equally shared by public and private expenditures – 1.7 and 1.8 per cent respectively in 1990 and 2.1 per cent each in 2006. The estimated health expenditure per person was Rs5,926 (US\$57) in 2006 (Institute for Health Policy 2009).

The public sector is financed from general tax revenue. Within this (in 2006),

the share of the central, provincial and local governments was 65, 33 and 1.4 per cent respectively. The private sector is mainly financed by out-of-pocket expenditure. Out-of-pocket expenditure accounted for 86 per cent of total private financing, followed by 6 per cent through employers' contributions and 3 per cent through private health insurance (*ibid.*).

Interestingly, while private and public spending are almost equal, there is a large divergence in terms of where this money is spent. Public spending covers 90 per cent of people accessing inpatient care and 40 per cent of those accessing outpatient care, while private spending accounts for only 10 per cent of inpatient care and 60 per cent of outpatient care (see Table B3.4) (Central Bank of Sri Lanka 2008).

TABLE B3.4 Sri Lanka: share of health expenditure by function and source in 2006

Function	Expenditure (Rs million)	Source (%)	
		Public	Private
Inpatient care	39,864	72	28
Outpatient care	24,869	35	65
Medical goods dispensed for outpatients	26,139	10	90
Prevention and public health aervices	6,476	86	14

Note: 90 Sri Lankan Rs = US\$1 approx.

Source: Institute for Health Policy (2009)

Owing to the higher costs in the private sector, actual expenditure on inpatient and outpatient care is shared differently among the actual number of patients covered (see Table B3.4). The private sector accounts for 28 per cent of costs for inpatient care (while treating about 10 per cent of the patients) and 65 per cent of outpatient care (while treating about 60 per cent of patients).

While the government continues to be the main source of finance for new infrastructure creation, the private sector has steadily increased investment in this area. Thus, overall private spending on capital investments in the health sector has grown faster in recent years than public spending (Institute for Health Policy 2009).

The government offers free inpatient care through an elaborate network of hospitals.³ The cost per patient treated in the private sector is over three times that of the public sector (Rs22,504 (US\$240) as against Rs6,431 (US\$70)). It is important to underline that the cost of treatment in the private sector does not include the direct and indirect subsidies that it receives from the government. Such subsidies, for example, include the services of government doctors who are now allowed to practise in the private sector; and fiscal incentives for setting up tertiary care hospitals. These subsidies were estimated to be Rs7,230 (US\$80) per inpatient (during 1990–2003) (Kalyanaratne and

Rannan-Eliya 2005). In other words, government subsidy to the private sector (per inpatient treated) is higher than what the government spends to treat one inpatient! This constitutes direct evidence of how public money is being spent to strengthen the private sector.

Private outpatient care services are the fastest growing segment of health services. The relative shares of total patients treated in private clinics by different providers include: government medical officers and specialists (59 per cent), private general practitioners (26 per cent) and traditional medical practitioners (15 per cent) (Institute of Policy Studies 2000). Again we note the substantial role played by the public sector in strengthening the private sector – through the large presence of government doctors in private sector facilities.

Expenditure per outpatient treated in the private sector (Rs817) is three times that in the public sector. An explanation for the growth of the private sector also lies in evidence that there has been a decline in the standard of outpatient care in the public sector and a rise in indirect expenditures borne by patients accessing the public sector.⁴

During the early post-independence years 20–25 per cent of total health expenditure was allocated for preventive and promotional services. However, by 2003 this figure had come down to barely 5 per cent. The number of persons using primary care facilities has also declined. In 1991 primary-care-level facilities obtained between 30 and 35 per cent of total recurrent patient care expenditures. In 2003 primary care expenditures declined to 25 per cent of total patient care expenditures

Conclusion The Sri Lankan story carries messages that are both good and bad. The good news is that the health system has managed to withstand the onslaught of neoliberal economics and continues to be the major provider of health services in Sri Lanka. The momentum created in the first three decades after Sri Lanka's independence is not entirely lost. The bad news is that structural measures, introduced in the health system, serve to strengthen the private sector – often through government subsidy. The private sector is growing faster than the public sector today and is also responsible for a deterioration in standards of care. Continued vigilance, advocacy and action by health activists, civil society organisations and people's movements is necessary to defend and expand what has been a model of a public-sector-run health system in a low-income country.

Thailand: good practice in expanding health coverage

In recent decades the health system in Thailand has been proclaimed one of the better-performing health systems in the region, as well as at a global level. In this section we examine the evolution of the Thai health system.

Major reforms in the Thai health system commenced around the turn of the present millennium, but these were shaped by several initiatives that date

back to the 1970s. The first major social health insurance (SHI) scheme – the Medical Welfare Scheme (MWS) – was initiated in 1975. It was funded through general taxation and covered those with monthly incomes of less than 1,000 Thai baht (NESDB 2005). Under the scheme, medical services were provided through public health facilities. This scheme was later expanded to cover the elderly, children, veterans, the disabled, monks, and priests (Pannarunothai 2002). This was followed by three other social health insurance schemes. The ‘Health Card Scheme’, a voluntary scheme that required co-payment from beneficiaries, had elements of selection bias (Srithamrongsawat and Torwatanakitkul 2004). Two other schemes covered employees – the compulsory Social Security Scheme, started in 1992, for all private sector employees and civil servants, and the Civil Servant Medical Benefit Scheme (CSMBS), which covered public sector employees and their family members. The former was funded through mandatory co-payment by employers and employees while the latter was fully funded from general tax revenue.

In 2000, the four social health insurance schemes (along with a marginal presence of private health insurance) covered around 75 per cent of the population (Wibulpolprasert 2004). The Thai-Rak-Thai party, after being

TABLE B3.5 Progress in health insurance coverage (%)

Scheme	1991	1996	1998	2001	2003	2006	2007
Universal Coverage	–	–	–	–	74.7	74.3	74.6
Social welfare	12.7	12.6	45.1	32.4	–	–	–
Civil servants	15.3	10.2	10.8	8.5	8.9	8	8.01
Social security	–	5.6	8.5	7.2	9.6	11.4	12.9
Voluntary health	1.4	15.3	13.9	20.8	–	–	–
Private health	4	1.8	2	2.1	1.7	2.3	2.16
Total insured	33.4	45.5	80.3	71	94.9	96	97.7
Uninsured	66.6	54.5	19.7	29	5.1	4	2.3

Source: National Statistical Office (2006); NHSO (2007)

TABLE B3.6 Catastrophic expenditure by households, 2000–06 (%)

Year	Quintile 1	Quintile 5	All quintiles
2000	4	5.6	5.4
2002	1.7	5	3.3
2004	1.6	4.3	2.8
2006	0.9	3.3	2

Source: Tangcharoensathien (2007)

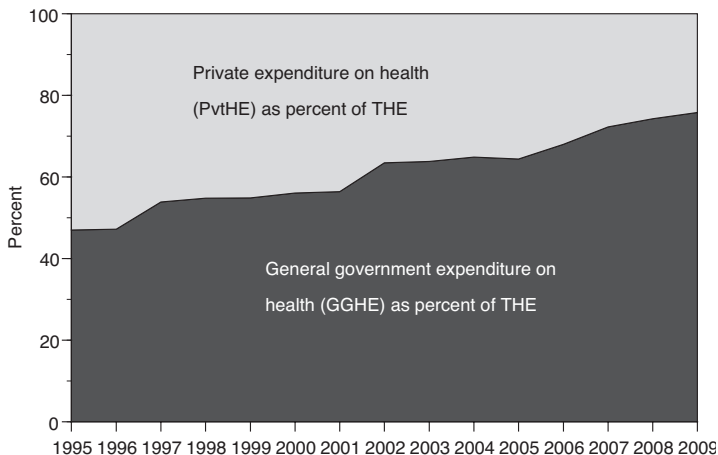
ected in 2000, introduced a universal health coverage scheme (UCS) – the ‘30 Baht treat all diseases’ scheme. Initiated in 2002, the scheme combined the previous Medical Welfare Scheme and the Voluntary Health Card Schemes and expanded coverage to an additional 18 million people. The 30 Baht scheme achieved nearly universal coverage (NHSO 2007) and included a comprehensive package of care, both curative and preventive. After a new government assumed office in 2006, the 30 Baht co-payment was abolished.

Financed entirely from general tax revenue, the main health care providers are public hospitals (covering more than 95 per cent of the beneficiaries). About 60 private hospitals are part of the scheme and cover about 4 per cent of the beneficiaries – mainly from the highest-income groups.

The depth of coverage has increased over the years and services not previously covered have been included, such as antiretroviral treatment (included in 2003) and renal transplantation (included in 2006). Owing to these policies there was a rapid increase in utilization of public health services by all sections of society, especially the poor.

While near universal in coverage, the UCS still leaves out about 4.5 per cent of the Thai population (2.8 million people) (Hughes and Leethongdee 2007). Those not covered are largely migrants and people from indigenous communities, and this is an area of concern that the UCS needs to address.

Evidence of success Several studies point to the success of the UCS in increasing coverage (see Table B3.5), and in reducing catastrophic health expenditures (see Table B3.6). It is estimated that the UCS, by reducing catastrophic expenses for health care, has rescued an estimated one million people from the effects of extreme poverty. Surveys show that a majority are satisfied with the quality of the care provided. (NHSO and ABAC Poll Research Centre 2007). Civil society’s participation has been actively sought in designing and sustaining



B3.3 Share of government and private health expenditure in Thailand, 1995–2009 (source: World Health Organisation (n.d.))

the UCS, reflected also in the large popular participation in the process of drafting of the National Health Security Bill.

Final evidence about the impact of the UCS is provided by data on public and private health expenditures. There is a secular trend of a rise in the former and a decline in the latter (see Chart B3.3).

Challenges before the UCS The increase in demand for health services, as a consequence of the success of the UCS, has implications for the workload of health workers. More than 70 per cent of health workers surveyed claimed that their workload has increased as a result of the UCS (NHSO and ABAC Poll Research Centre 2007). Increased workload, along with relatively poor remuneration in the public sector, have led to a huge exodus of public sector doctors to the private sector. The growth in the private sector has also been fuelled by the growth of medical tourism, with Thailand having emerged as one of the most preferred destinations for medical tourism.

During the initial years of implementation, the UCS was criticised by health care providers for being underfinanced, particularly for inpatient care. Almost a third of the public hospitals, mostly rural community hospitals in the north and north-east, were severely indebted. Such experiences have now prompted the government to increase their budgets significantly. The financial situation of most hospitals has thus greatly improved.

Lessons from the Thai reforms While countries such as Sri Lanka and Costa Rica have a much longer history of health systems based on principles of universal coverage, public sector provisioning and financing, what is remarkable about the Thai reforms is that they have been initiated in a period when neoliberal policies have led to health sector reforms, in many parts of the world, based on increased private sector participation and a decreased role for governments in both care provision and financing.

The Thai UCS was a result of a bold political decision, and its current state shows that the scheme is sustainable – thereby belying the negative expectations of several international agencies.

Learning from the country case studies

The three case studies in this chapter raise very interesting issues. What is common among them is the clear attempt, in all three countries, to minimise the split between provisioning and financing of care. All three countries also put reliance on public financing, largely raised through general taxation. The examples thus might appear to be out of sync with the recommendations of international agencies which today argue forcefully in favour of a split between financing and provisioning of health services. But the evidence from the three case studies appears quite overwhelming, and suggests that it is the international agencies that are out of sync with reality.

The countries operate in a global environment where their endeavours are seen as ‘swimming against the current’. At least two of them – Sri Lanka and Costa Rica – have faced or continue to face strains because the neoliberal trajectory of global policy-making stands in contradiction to the trajectory of the health system in the country. Sri Lanka shows the most clear signs of this contradiction actually starting to fundamentally change the contours of its health system – for the worse.

Clearly there is a need to defend these systems, learn from them (and also from their mistakes!) and make this a basis for the articulation of equitable and accessible health systems in other situations across the globe. This requires, apart from national action, global solidarity.

Notes

1 The *World Development Report* of 2004, while showcasing Costa Rica's achievements, credits economic growth for the health improvements (World Bank 2004).

2 EBASIS comprises health centres with a general practitioner, an assistant nurse, a clerk, a pharmacy assistant, and a primary health technician, and second-line clinics (clinics providing first-referral care in the context of a multi-tiered health care system) located in proximity to the CCSS's area headquarters.

3 A survey on public hospital inpatient discharge reported that the rate of hospital admissions per 100 population is relatively high in comparison with other countries, and comparable with those seen in the Organisation for Economic Co-operation and Development (OECD) economies with the highest rates of hospitalisation. The average length of stay in Sri Lanka (4.2 days) is relatively short, and lower than in most developed countries, but when examined in relation to specific diagnoses the lengths of stay are actually comparable to those in many developed countries (Institute for Health Policy 2009).

4 A study of 158,699 outpatients visiting 12 primary care institutions in three districts in 1988 revealed that prescribing officers were able to use standard treatment schedules based on essential drugs almost exclusively to meet the drug requirements of patients (Ministry of Health 1988). A study done in 2005 on a sample randomly selected from outpatient clinics of public medical facilities reported that at least 30 per cent of the direct cost of treatment is borne by the patient. Depending on the type and level of illness, the patient had to

bear at least 57 per cent of the total cost with a maximum of 98 per cent including indirect cost (Attanayake 2005).

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B4 | DYSFUNCTIONAL HEALTH SYSTEMS: CASE STUDIES FROM CHINA, INDIA AND THE US

In Chapter B2 we discussed the need to develop sustainable financial mechanisms that can adequately resource equitable health systems in low-income countries. Paradoxically, three of the largest countries in the world – China, India and the US – are clear examples of health systems that are dysfunctional, in large measure owing to unsustainable financing systems. The cases are instructive also because they involve two countries (China and India) that are proclaimed the ‘success stories’ of neoliberal economics and the third (the US) is by far the richest country on the globe.

China: health care and financing under economic transition

Economic development and health China’s gross domestic product (GDP) has grown rapidly in recent years (an average of 10.2 per cent per year from 2000 to 2007).¹ This growth is largely taking place in the industry and services sectors. Value added in these sectors (48 and 40 per cent of GDP respectively in 2007) far outweighs the value added in agriculture (12 per cent of GDP in 2007). Household consumption expenditure as a proportion of GDP is quite low by international standards (much lower than in India, Brazil and Russia), while gross capital formation has been very high by international standards; in other words, a relatively small proportion of profit and tax has gone to households; a relatively large proportion has gone to capital investment.²

Average per capita GNP increased from US\$800 in 1990 to \$6,020 in 2008.³ However, income inequality has widened greatly since the commencement of economic reform; the Gini coefficient rose from 0.31 in 1978/79 to 0.45 in 2004, similar to that of the USA.⁴ In 2000–07 around 16 per cent of Chinese were living on less than \$1 (international dollars) per day.⁵ Per capita GDP in 2000 varied from less than 5,000 RMB in Guizhou to over 25,000 RMB in Shanghai, with corresponding differences in life expectancy from 66 in Guizhou to 78 in Shanghai.⁶

In terms of health development, the indicators are mixed. Aggregate data are good by international standards with life expectancy in 2008 (74 years) well above the average for the high-middle-income countries (71 years).⁷ Under-five mortality is just below the average for the high-middle-income countries (21 per 1,000 live births compared with 23).⁸ Stunting among under-fives is comparatively high – 21.8 per cent in 2000–09, which was a very slight improvement over the period 1990–99 (20.7 per cent).⁹ However,

these average figures obscure wide variation, with child malnutrition three to four times more common in the rural areas than in urban areas.¹⁰ Maternal mortality in China is less than half the average for the high-middle-income countries (45 per 100,000 live births compared with 91).¹¹

China spends a relatively small percentage of GDP on health care (4.3 per cent of GDP, US\$233 per head in 2007) with a high proportion of this being out-of-pocket expenditure (51 per cent in 2007).¹² There have been massive increases in government funding for health care since 2007.

In technical terms the breadth and depth of specialist tertiary care in the leading hospitals is world class. However, poor people face significant price barriers to accessing care; resources are inequitably distributed; quality and safety are uneven; and there are significant inefficiencies in service delivery. Primary health care is poorly equipped, staffed by less well-trained practitioners and generally not trusted.

Health care financing and economic transition Under the ‘socialist planned economy’ (1949–76) health care was a responsibility of the ‘work unit’, the factory or school or government department in the city and the collective farm or commune in the country. The work unit employed the primary health care staff (health centre or clinic) and larger enterprises also ran secondary hospitals. The work unit also contributed to the cost of tertiary care if employees accessed such care. The military and the railways and some other sectors administered their own hospitals. Hospitals were budget funded and user charges were very limited. These arrangements were referred to as the Government Insurance Scheme; the Labour Insurance Scheme and the Cooperative Medical Scheme (CMS) in the country. Under the CMS the cost of primary health care (a part-salary for the barefoot doctor or village doctor) was met out of the general revenues of the collective farm or commune, and a small contribution could also be made to meet user fees if the patient needed attention in the township or county hospital.

These enterprise-based welfare arrangements ensured universal coverage at a relatively basic level. Health care was overwhelmingly provided at the primary level with a small proportion of cases being referred to secondary hospitals and a very small proportion being admitted to tertiary hospitals. There was a much greater emphasis on doctors from tertiary and secondary hospitals actually travelling out to provide training and advice at the primary level than on patients moving from primary to secondary to tertiary. However, it was basic care. The village doctors were commonly six-month certificate trained; the doctors in the clinics in the cities and in the hospitals in the country were largely secondary or tertiary diploma trained.¹³ Only in the tertiary hospitals were bachelor-trained doctors employed and in the early years there were very few of either.

With the commencement of economic reforms (from 1978) enterprise



9 Medical college in Tianjin (David Legge)

welfare came to be referred to as ‘all eating from the common pot’ and the reforms included ‘smashing the iron bowl’. The main concern was not enterprise welfare per se; rather it was the low productivity of the planned economy. Pre-1978, enterprises were assigned staff, budget funded and given output targets. Since the prices of inputs and outputs were all administratively determined and surplus revenue belonged to the administering ministry or bureau, there was no incentive to increase volume or reduce unit costs. The reforms sought to improve productivity by giving enterprise management greater discretion with respect to the procurement of inputs, the production process and output levels and keeping ‘profit’. However, state-owned enterprises (SOEs) were still operating within a complex regulatory framework with staffing levels and prices closely controlled by different government authorities, which made the reform of production very slow.

During the 1980s it became clear that internal reform was not moving very fast and the focus shifted to corporatisation and competition; encouraging private enterprises, including joint enterprises with foreign firms, to compete with the newly corporatised SOEs. One of the big differences between the private enterprises and the SOEs was enterprise welfare. Unless the SOEs were able to reduce the ‘burden’ of education, housing, health and aged care for their employees there was no way they were going to be able to compete with the new private enterprises. Smashing the ‘iron bowl’ became a necessary condition for the survival of the SOEs.

Another feature of the ‘iron bowl’ was secure lifetime employment. This

was recognised by the reformers as a major brake on enterprise productivity with overstaffing, often inappropriate staffing (due to lack of hire power) and lack of management levers to encourage greater individual productivity (lack of firepower). It was also a major brake on labour mobility, a key prerequisite for efficiency at the system level. It was recognised by the policy-makers early on that the establishment of autonomous social ‘sectors’ (education, housing, health care and social security) and the divorce of welfare functions from employment were conditions for allowing greater labour mobility.

The move from a planned economy to a market economy had profound implications for government revenues. Under the planned economy government revenues were based on top-slicing economic transactions controlled by the state. Prices and volumes were controlled in accordance with the plan and the plan made provision for transfers to general government revenues. As the SOEs were required to compete with private enterprise within a market economy SOE revenues came to depend more on market demand and market-determined prices and government revenues necessarily moved towards a greater dependence on formal taxation.

One of the earliest and most dramatic reforms was the return to family farming (following the collapse of collective farming). The return to family farming is widely regarded as part of the reason for dramatic improvements in farm productivity in the 1980s, which provided the basis, in terms of food and labour, for the spurt in industrialisation. However, the consequence of the collapse of collective farming also led to a complete collapse of the funding base for rural health care, and it has taken almost 30 years for the policy-makers to put in place an alternative funding base (the New CMS or NCMS). During this time farming families have been largely without any form of health security while the costs of health care have escalated.

The demise of enterprise welfare and the winding back of micro-regulation of SOEs have also been long drawn-out affairs and are far from finished. There was a long delay between the elimination of enterprise-based health care and the development of functioning health insurance. This commenced with the establishment of the Urban Employees Health Insurance Scheme (UEHIS) in the late 1990s.¹⁴ This was a contributory scheme (with employee and employer contributions) administered through the Labour and Social Security portfolio at the municipal level. This scheme extended the existing coverage of the Labour Insurance Scheme (covering SOEs) to other large employers. The UEHIS does not cover the informal sector and many small or struggling enterprises are allowed to remain outside the scheme. It does not cover rural migrants working in the cities, the ‘floating population’.¹⁵ The benefit levels provided are limited and patients commonly face high out-of-pocket costs.

Over the last five years there has been a dramatic increase in government support: for rural health care (through the NCMS); for safety net provision for poor people through the Medical Assistance scheme (MA) and through

budget support for urban community health. The New CMS, based largely on government funding, is moving towards universal coverage (including in some cases urban migrants), although the depth of cover remains thin with high out-of-pocket payments. The Urban Residents Insurance Scheme extends similar coverage and benefits to the floating population and the informal sector in the cities.

The necessary condition for the increasing flow of funds to health care over the last five years has been growth in GDP and the availability of resources. However, of comparable importance has been the rising concern in Beijing regarding 'social instability'. The Chinese government and the Chinese Communist Party are concerned that rising inequality, anger at corruption and frustration with the health care system could contribute to disaffection and instability.

Macroeconomics and health care financing There is also a strong macroeconomic logic for the central government to increase the flow of public funds to health care, particularly for low-income people.¹⁶ During the early period of reforms the policy focus was firmly on economic growth with rising exports and cheap capital. The logic of cheap capital was to encourage investment in export production, but it also encouraged huge infrastructure investments (roads, bridges, airports, urban renewal, etc.). Two factors contributed to the flush of loose capital: high household savings rates and high money supply.

From the early 1990s to the early 2000s, Chinese households had good reason to maintain high levels of savings against the cost of illness, unemployment, retirement, university education and housing. The cost of education, particularly university education, was increasing; retirement benefits were vanishing and the cost of an episode of illness could bankrupt a family. High savings rates were essential for families, and the flow of household savings into the banking system contributed to keeping interest rates low and continuing the flow of resources to investment.

The other reason for low interest rates and loose capital was the rapidly increasing money supply. As export revenues grew the Chinese government was concerned to keep the value of the yuan relatively low so that the price of Chinese products in the stronger foreign currencies was kept cheap. If profits made in dollars (or other tradable currencies) were repatriated to China and converted into RMB the price of the RMB would be pushed up and with it the price of Chinese exports. The government adopted an arrangement whereby the Central Bank purchased the US dollars from Chinese trading enterprises and reimbursed them in RMB (at a fixed exchange rate) in China. The US dollars so acquired were stored by purchasing US government bonds. Several consequences flowed: first, China accumulated huge reserves held in US dollars from the early 1990s to 2008; second, the US dollar remained strong, allowing US consumers to continue purchasing Chinese products; third, the

domestic money supply in China grew rapidly, contributing to loose capital and low interest rates.

With the global financial crisis of 2008, the international market for Chinese exports, particularly in the USA, shrank considerably. It became suddenly urgent to expand the domestic market if Chinese manufacturers were to keep selling and workers were to keep their jobs. Suddenly it made sense to fund health and social security to encourage consumption spending (by reducing the need for high levels of household savings) and to boost the domestic market. This was a critical turning point for the funding of the New CMS, the new Urban Residents Health Insurance Scheme, Medical Assistance and urban community health centres.

However, the situation is not stable. The banks are in some degree dependent on household savings to maintain the flow of low-interest loans to developers. The prospect of reduced export revenues and reduced household savings has implications for the volume and cost of capital available to the banks. Rapidly increasing money supply during the boom years has allowed very low interest rates to prevail, which has allowed ‘developers’ of various kinds to embark on large-scale investment projects, including huge real estate developments, without close regard to long-term returns. Low interest rates have also encouraged medium- and high-income families to move their savings out of the banks (earning nothing) into real estate, often with high levels of leverage, albeit at low interest rates (for the present). The combination of loose money for both developers house purchasers has led to rapid inflation of house prices.

Real estate developers are highly leveraged and are sitting on huge overcapacity which is not earning revenues. If interest rates were to increase, the cost of servicing their debts would start to bite and they would need to reduce sale prices quite rapidly to realise the value of their capital and pay their debts. Falling house prices would mean that mortgaged householders were also carrying debt far in excess of the value of their property and facing increasing costs of servicing that debt. There could be serious flow-on effects, including mortgage defaults and repossessions and the possibility of a banking crisis; not so different from what happened in the US in 2008.

This situation is complicated by China’s international trade. During the decade prior to the global financial crisis China maintained a relatively cheap currency by keeping high levels of its export earnings in US dollars (purchasing US bonds). However, as part of its strategy for managing the financial crisis, the US has resorted to printing money in large amounts. This will stoke inflation in the US (and beyond) and diminish the value of Chinese reserves held in US dollars. However, if China reduces its holdings of US dollars the value of the US dollar will fall, making Chinese imports more expensive in the US. As the Chinese yuan appreciates the cost advantages of assembly and manufacture in China will be reduced and jobs will be lost to lower wage platforms.

Policy interdependence and regulatory dysfunction Throughout the early parts of the reforms era the central government stood firmly against increasing public funding to health care despite the collapse of enterprise welfare and collective financing. Public revenues were significantly affected by the economic transition and the policy priority was to build the economy.

From the late 1980s hospitals depended more and more on fees for service revenues as government subsidies failed to keep pace with rising operating costs. As operating costs increased so the proportion of total revenue derived from direct budget funding fell.

Revenue from user charges has been constrained in some degree by pricing controls, which have retained tight control over labour-intensive service items but much looser control over drug pricing and technology-intensive service items. This has driven seriously perverse servicing patterns with over-servicing (in volume terms) with respect to pharmaceuticals and high-tech service items and understaffing of labour-intensive functions. A model of health care has emerged which includes high-volume, low-margin, rapid-turnover, understaffed outpatient clinics from which are harvested those patients who can be provided with high-margin services, including drugs, tests and other high-tech procedures.

Remuneration arrangements provide further drive for this model of health care delivery. Hospital staff are paid in two forms: official regulated salaries and bonus payments. Official salaries are tightly regulated and have been maintained at relatively low levels. Bonus payments were introduced in the early 1990s as part of the reaction against 'all eating from the common pot'. If low wages with small differentials were a cause of low productivity it was reasonable to expect that bonus payments tied to agreed performance indicators would enhance productivity. As hospital managers faced rising operating costs and fixed government subsidies it made sense to offer bonus payments to those departments (and their employees) which showed improvements in 'productivity' (as reflected in revenue).

Bonus payments were not part of the planned economy and so there was no ministry or bureau with a mandate to regulate them. Each hospital's supervising bureau¹⁷ would be cautious about discouraging such payments if they contributed to the hospital's survival in the face of the inability of the government to provide increased budget funds. However, there is a certain circularity about the use of bonus payments to drive over-servicing to meet operating costs which are increasing, in part, because of increasing bonus payments. Clearly many senior clinicians in the more affluent cities are receiving (and generating) very generous remuneration packages. It is not clear there is any capacity in the system to regulate total remuneration (rather than just the 'basic salary').

Conclusions China's economic transition from a planned to a market economy

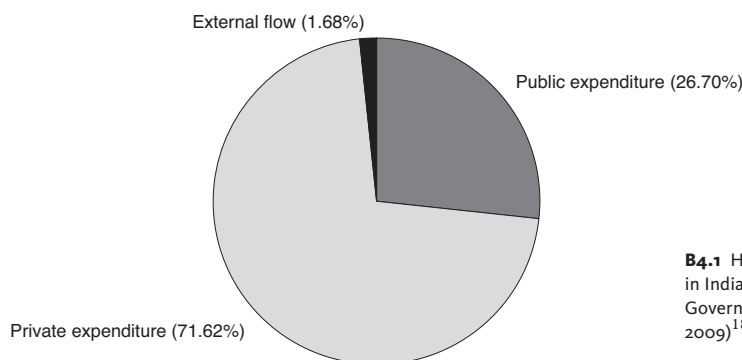
led to three decades of rapid economic growth but widening income inequalities. The institutional reforms associated with the transition ('smashing the iron bowl') precipitated a collapse in collective health care financing with the emergence of high price barriers to access. With changing macroeconomic circumstances and growing concern regarding social instability, the central government is increasing public funding to health care largely through various health 'insurance' schemes, creating a number of large-scale 'purchasers' of health services. On the provider side there remain major problems, including over-servicing, variable quality and low efficiency. These problems arise from the ways the health care providers adapted to the collapse in collective financing in the context of regulatory arrangements persisting from the period of the planned economy.

India: misguided reforms to introduce social health insurance

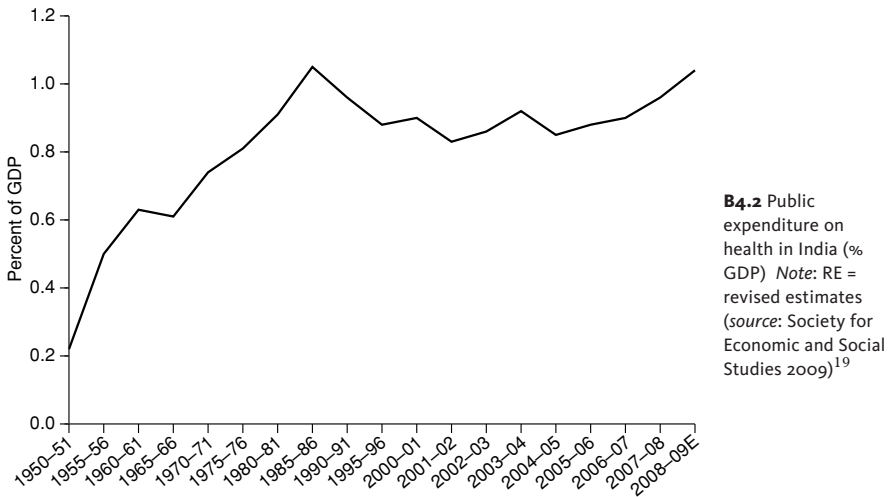
Introduction India is, in many ways, an exemplar of how not to develop and sustain public health services. The country has one of the most privatised health systems in the world (see Chart B4.1) and one of the poorest records in terms of public spending on health (see Chart B4.2).

India's mechanism of budgetary allocation of funds to the health sector has remained archaic, obsolete, and resistant to change over the years. Inflexible budgetary transactions led to the creation of over 4,000 line items that were more suited to auditing than to addressing health needs.²⁰ The primary care system is an extensive network comprising sub-centres (covering population areas of 3,000–5,000), Primary Health Centres (covering population areas of 20,000–30,000) and Community Health Centres (covering a population of 100,000 people). Across the country, as of 2007, there were a total of 145,272 sub-centres, 22,370 Primary Health Centres and 4,045 Community Health Centres. While impressive on paper, in large parts of the country the network barely functions as a consequence of poor resourcing and maintenance. Shortage of personnel and material resources plague the system.²¹

The National Rural Health Mission (NRHM), launched in April 2005, is



B4.1 Health expenditure in India, 2008/09 (source: Government of India 2009)¹⁸



a response to the large body of criticism regarding the performance of the public health system in India. While there has been only a marginal increase in financial allocation during the six years of operation of the NRHM (despite a planned substantial increase), certain ‘innovative’ ways of channelling funding – through off-budgetary transactions involving mission flexipools, untied grants, etc. – have, to an extent, improved the uptake of health services among the population.

Simultaneously, in the past five years several new schemes have been launched to enhance financing of health and secure people against the catastrophic impact of out-of-pocket (OOP) expenditures on health care. In the following sections, we examine in more detail the contributions of the public and private sectors to health financing, analyse financial risk protection measures, and examine the likely outcomes.

Trends and patterns of health financing in India India’s large public health service delivery infrastructure has suffered from sustained underfunding and overall neglect since the 1950s. Except for a brief period in the mid 1980s when public spending showed a consistently upward trend (albeit of low amplitude), it has remained consistently below or around 1 per cent of GDP.²² The public health system, which was already grossly underfunded, faced a further squeeze in the immediate aftermath of the initiation of neoliberal economic reforms in 1991. The severity of ‘fiscal discipline’ during the late 1990s forced the governments in various states of the country to introduce austerity measures, and the ‘soft’ sectors, such as health, were targeted for expenditure compressions (in India 70–80 per cent of expenditure on health care is made not by the central government but by state governments). Therefore, overall allocation by the centre to the states both for the health sector and for overall

TABLE B4.1 Share of households' OOP and drug spending in India, 2004/05 (%)

States	OOP expenditure as proportion of households' overall expenditure			Drugs as proportion of OOP		
	Rural	Urban	Combined	Rural	Urban	Combined
All India	6.30	5.22	5.87	73.90	66.07	71.17

Source: Extracted from Unit Level Records of the National Sample Survey (NSS), 2004/05

transfers was affected, leading to large-scale reduction in health spending in the country.^{23, 24} This, in turn, led to the deterioration of the already ailing public health service delivery system and to the further strengthening of the private health sector.

The very low level of public spending on health in India places a huge financial burden on households. This is characterised by low public spending (less than 1 per cent of GDP) and an extremely high share of burden on households. In 2004/05, per capita public spending on health was Rs242 (roughly US\$5–6), while private spending was almost four times that figure at

TABLE B4.2 Out-of-pocket expenditure on health care: 1993/94 and 2004/05

Impact on households	1993/94	2004/05
ALL INDIA		
Average per capita monthly OOP (Rs) at current prices	16.78	41.83
OOP on health care as % of total household expenditure	5.12	5.87
Percentage of households reporting OOP on health care	59.19	64.42
Households paying more than 10% as OOP*	11.92	15.37
RURAL		
Average per capita monthly OOP (Rs) at current prices	15.28	36.47
OOP on health care as % of total household expenditure	5.3	6.3
Percentage of households reporting OOP on health care	59.94	64.05
Households paying more than 10% as OOP*	12.69	15.82
URBAN		
Average per capita monthly OOP (Rs) at current prices	20.99	57.64
OOP on health care as % of total household expenditure	4.6	5.22
Percentage of households reporting OOP on health care	54.61	65.41
Households paying more than 10% as OOP*		

Note: * OOP as a percentage share of total household expenditure

Source: Based on National Sample Survey Organisation estimates



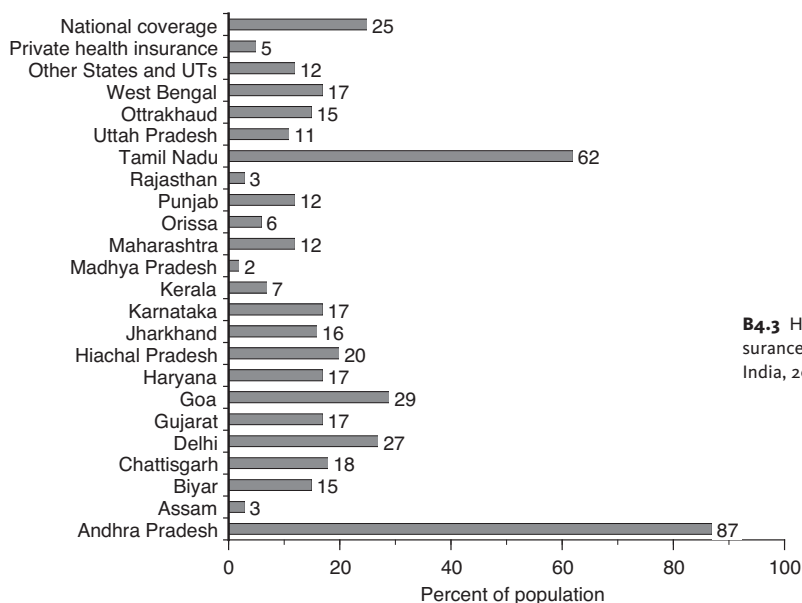
10 Demonstration for free health care in India (Abhay Shukla)

Rs959 (US\$20) (we use figures from 2004/05 because that is the last period when disaggregated data is available from the National Health Accounts). As a consequence, the number of people pushed below the poverty line (as defined by the government) because of catastrophic OOP expenses incurred on health care has risen from about 26 million in 1993/94 to 39 million in 2004/05.²⁵

Indian households, on an average, devote about 6 per cent of their overall consumer expenditure to health care. Rural households spend a larger proportion of household income on health care than their urban counterparts because of poorer access to public health facilities. Ironically, while India is a major manufacturer of generic medicines and exports over half of its production of medicines, expenditure on medicines constitutes the single largest item in OOP expenses incurred by households (see Table B4.1).

Evidence also clearly suggests that lack of access to health facilities and lack of finances are major reasons for the sick not seeking treatment. In 2004/05 over 12 per cent in rural areas reported that they did not seek treatment because of lack of access to health facilities and 25 per cent cited financial reasons for not seeking treatment (up from 15 per cent in 1986/87).²⁶

*Health Insurance in India*²⁷ The penetration of health insurance (of all kinds) remained low till 2007. Private health insurance in particular has had (and still has) very low penetration – accounting for under 1 per cent of total health



B4.3 Health insurance coverage in India, 2010

expenditure in the country. The two social insurance schemes in existence were the Employees State Insurance Scheme (ESIS) launched in 1952 and the Central Government Health Scheme (CGHS) launched in 1954. The former covers employees in the organised sector (about 7 per cent of the total workforce²⁸) while the latter covers employees working for the government. Both are funded through co-payments made by employees and employer.²⁹

There has been, however, a rapid transition since 2007 after the launch of several government-initiated social health insurance schemes. The three largest – the RSBY scheme launched by the central government, and two state-government-run schemes, Aarogyasri and Kalaighnar³⁰ – now cover over one-fifth of India's population (247 million). The RSBY scheme (national in its reach) is limited to specific sections, viz. people who are designated as poor or marginalised in government records.³¹ In contrast the Aarogyasri and Kalaighnar schemes cover a majority of the population in the respective states (87 per cent in Andhra Pradesh and 62 per cent in Tamilnadu – see Chart B4.3). All health insurance schemes, put together, covered about 302 million people in India in 2010 (roughly a quarter of the country's population).

There is a large variance in the depth of coverage (i.e. benefits provided in an insurance scheme) among the different social health insurance schemes. Unlike the older ESIS and CGHS schemes, the new SHI schemes only cover for hospitalisation. The Aarogyasri and Kalaighnar schemes cover for almost all types of inpatient care, including high-end tertiary care (the RSBY is less ambitious and has a ceiling of Rs30,000 – US\$650 – per year for a family of five).

The new SHI schemes are almost entirely publicly funded – through con-

tributions from the central or state governments. They do mitigate against the risk of impoverishment as a result of OOP expenses for inpatient care. However, the protection is relative and not absolute. Moreover, the RSBY particularly puts a cap on the expenses that are covered in a year for a household.

While the SHI schemes are still relatively new, some interesting trends are discernible which are a cause for concern. Data drawn from the RSBY scheme shows that the hospitalization rate is about 20 per thousand beneficiaries. This is much lower than the long-term national hospitalization rate of 31 per thousand – which includes all hospitalized cases, irrespective of whether they are covered by any form of insurance.³² It is also much lower than the hospitalisation rate for private health insurance (about 64 per thousand). The hospitalisation rates for the Aarogyasri and Kalaingar schemes are even lower than that of the RSBY scheme. This indicates that a large number of people, though nominally designated as beneficiaries of the new SHI schemes, do not seem to be benefiting from them.

The new SHIs (as well as, increasingly, the older CGHS scheme) explicitly separate financing and provision of health care. They allow beneficiaries to access care in accredited facilities – which may be in the private or the public sector. In practice, an overwhelming majority of the accredited facilities are in the private sector – almost all providers of hospital care under the Kalaingar and CGHS schemes, and 80 per cent under the Aarogyasri scheme, are in the private sector. This assumes special significance when we examine the data regarding hospitalisation costs (per annum) for beneficiaries of the different SHIs. While the mean hospitalisation expenses of the private health insurance sector were Rs19,637 (US\$450) per annum in 2009/10, they were Rs33,720 (US\$760) and Rs25,000 (US\$560) respectively for the Kalaingar and CGHS schemes. There is thus indirect evidence that private providers not only benefit from these schemes by securing a ‘captive’ market, they also overcharge (with the possible complicit participation of the administrators of the SHI schemes).

Such a trend is likely to have long-term consequences. In 2009/10, direct government expenditure on tertiary care was a little over 20 per cent of total expenditure. However, if this were added to the expenditure on the social health insurance programmes that focus entirely on hospital-based care, the total public expenditure on tertiary care would be about 37 per cent of the total expenditure. Such a high proportion of public expenditure (which is likely to rise further) on tertiary care, largely provided by the private sector, would lead to the following impact:

- 1 The increase in public expenditure would not build or strengthen the public health system but would further strengthen the private sector (especially the large tertiary care sector that increasingly is constituted of corporate-run hospital chains) – which already accounts for 70 per cent of health care in India.

- 2 Distortion of the country's health system, with grossly inadequate funding for primary care.
- 3 Continued cost escalation of the SHI programmes, owing to their being premised on provision of care by the private sector. This may well make the newly launched SHIs unviable, or would lead to a further distortion of health care spending, with the government forced to pump in larger and larger amounts.

Conclusions India's situation is different from that of developed countries, which have been successful in implementing social health insurance programmes that provide near-universal access. Given the very large levels of income poverty in India, the ability to contribute to such schemes in any risk-pooling exercise is limited to a very small portion of the population. Linking such schemes to the workplace is also a marginal option, which could be feasible only in the case of the organised sector of workers, who constitute about 7 per cent of the total workforce.

The recent SHI programmes were initiated against the background of huge existing gaps in the public health system and the distressing phenomenon of poverty linked to catastrophic OOP expenditure on health care. However, as our analysis indicates, these schemes are not only unsustainable, they also further distort the health care system in the country. At best they can be considered interim measures. Even for such interim measures to have an impact, a robust regulatory system needs to be introduced that includes regular financial, technical and social audits of the SHI schemes. Today market mechanisms determine the cost of these schemes, and are unviable.

The only long-term solution that is feasible is to plan for a public health system that is funded through taxation. For such a tax-based system to succeed, the quantum of public spending on health care has to increase very rapidly – from the present 1 per cent of GDP to at least 3 per cent or more.

United States: medicine as politics at the largest scale

'Medicine is a social science, and politics is nothing but medicine on a larger scale' Rudolf Virchow (founding father of social medicine), 1848

Historically, the health care financing system in the US has worked by fragmenting the population into hundreds of patient risk pools and requires no mandatory contribution.³³ The exception is that, in 1965, most legal residents over 65, and many people with disabilities, were included in Medicare, a national social health insurance programme. The rest of the population obtain medical care insurance from private insurance corporations as a benefit of employment, or, if they qualify as poor, in other government-funded programmes. The result is that there are now approximately 50 million people in the US without insurance, and many millions more who are underinsured.³⁴



11 Separation of health financing and provisioning can mean public financing of the private sector (Indranil Mukherjee)

In the US, ‘primary care’ means something different to what it does internationally. Focused on the clinic, rather than the community, US-style primary care emphasizes clinical preventive/early detection services and treatment of common illnesses. Primary care specialities are low-prestige and primary care providers earn much less. Primary care generates less revenue for health care businesses than speciality care. As a result, most health expenditures in the US go towards expensive curative and tertiary-level services.

These characteristics of the health system in the US are among the underlying reasons why the US spends more than two times as much per capita on health than any other country but has relatively poor health outcomes. Both individual and public expenditures go mainly to private corporations such as pharmaceutical and insurance companies, while the health of the US population remains an afterthought.

New reforms in US health care Many misconceptions exist, both in the US and abroad, about the health care reform law passed in the US in 2010. The Patient Protection and Affordable Care Act (PPACA) implements a series of health care and insurance-related provisions to take effect over years – most by 2014.

On the positive side, the law will extend health insurance to 32 million more Americans. Many will get insurance through Medicaid, a federal social insurance programme for the poor, which will be expanded to cover all citizens and some legal residents up to 133 per cent of the federal poverty level. The PPACA will subsidise insurance premiums for lower-income individuals and families, and give financial incentives to businesses to provide health care benefits to employees. It initiates consumer protections from certain insurance



12 Memorial to Rudolph Virchow in Berlin (Amit Sengupta)

company abuses such as being cut off (‘rescission’) and discrimination against those with pre-existing conditions. It will mandate that all legally residing US residents obtain medical insurance, and state-based insurance ‘exchanges’ will be established. It will establish a non-profit Patient-Centered Outcomes Research Institute to assess the relative outcomes, effectiveness and appropriateness of various treatments. Funding for community health centres and payments for primary care services are increased. Cost sharing for preventive care is eliminated. It will also eliminate co-payments for prescription drugs for those with Medicare,^{35, 36}

Despite its claims, the PPACA does little to change the US healthcare system, primarily because it does not challenge the for-profit framework. Larger pools will not be created. Instead, it will create ‘marketplaces’ in each state where insurance products meeting minimum standards will compete for the individual purchaser. These exchanges are new bureaucracies that will add millions of dollars of expense to the system. Surging health care costs will not be contained, and the uncontrolled costs of health care and insurance threaten the sustainability of the reform. Similarly, the mandatory contribution element is fatally flawed in the PPACA. Unlike other national programmes that require that everyone contribute to the health care system based on ability to pay, the PPACA requires that everyone not covered by one of the government health

insurance programmes must purchase, or have purchased for them by their employer, a health insurance product from a private corporation.

Although more people will obtain insurance once the law is fully in effect in 2014, this actually ensures that more public and private funds will flow to pharmaceutical, insurance, hospital and other health care industry corporations. An estimated \$447 billion in taxpayer money from the new law will go directly to the health insurance industry alone.³⁷ While the PPACA creates some important consumer protections and will expand health care coverage for millions, it continues to strengthen a profit-driven and fractured approach to health in the US.

Impact of the PPACA on marginalized and vulnerable groups Poor people, among whom people of colour are over-represented, will benefit from the expansion of Medicaid and increased community health centre funding.³⁸ However, under the new law, an estimated 23 million Americans will remain uninsured. This translates to 23,000 unnecessary deaths annually.³⁹ Many previously uninsured will be mandated to spend a significant portion of their income on health care from private insurers and still may not have comprehensive coverage. On average, poor people will spend 10 per cent of their income to cover 70 per cent of health care expenses, with co-payments and fees still unaffordable for many.⁴⁰ Medicaid expansion will largely be outsourced by the federal government to private insurance companies, raising concerns over for-profit abuse of Medicaid.⁴¹ Federal payments to hospitals with a large proportion of uninsured and low-income patients will be lowered, limiting much-needed services.⁴²

Under the new law, the health rights of women have been undermined. Gender-based higher insurance rates for women will remain legal until at least 2017, and large employer-based insurance programmes will be exempt from the new PPACA provision on gender rating prohibition. Women's reproductive rights have been eroded, as the law seriously restricts access to abortion by requiring segregation of federal insurance funds for abortion from all other medical services. This means that government funds to finance insurance programmes in the PPACA cannot be used for abortion services except in cases of rape, incest, or if a woman's life is in danger.⁴³ Contraception is currently not considered a 'preventive' service, so women may continue to pay for this out of pocket, despite the PPACA law that eliminates fees and co-payments for preventive services.⁴⁴

Under the new law, documented immigrants are subject to the health insurance mandate upon entry to the US, but still face waiting periods of five or more years to qualify for government social services such as Medicaid. This means the large expansion of Medicaid under the new law excludes all recent immigrants.⁴⁵ Undocumented immigrants will be unable to access state exchanges to purchase their own insurance. Nor will Medicaid (except

in cases of medical emergency) or other social services be open to them. This continues a dire and inhumane practice for asylum seekers and undocumented immigrants that denies them essential health care.⁴⁶

How the movement for universal health care became the PPACA Almost none of the benefits the public will receive from the PPACA come at the expense of the hugely profitable medical industries.⁴⁷ To the contrary, many of those benefits were granted only because they also benefit those industries by increasing the amount of public and individual funds that will go to pay for additional products and services.

When the push for health care reform from activists got serious, health care corporations saw an opportunity to get the government to help them address looming threats to their profits and preserve revenue streams. The struggle in the US Congress was really about the different sectors of the health care industry – insurance companies, pharmaceutical companies, organised physicians, the hospital industry, and other smaller sectors – competing for the limited amount by which Congress was willing to increase spending on health and for the most favourable regulations for their sector. Progressive organisations were co-opted by sophisticated public relations campaigns to take national health insurance off the table and to increase public support for whatever legislation finally emerged.⁴⁸

All the health care industry sectors could agree on one thing: more people with insurance means more revenue. Thus there was support for the mandate to obtain insurance, for government subsidies to buy it, and other measures to increase insurance coverage. Each sector also had its particular concerns and the legislation did not fail to take them into account.

Pharmaceutical companies emerged as the big winners. The increase in the number of people with insurance and a restructuring of Medicare drug benefits means more people will be able to buy medications. PPACA increases patent protection for new biotech drugs⁴⁹ just as the blockbuster drugs of the past 15 years are reaching the end of their patents, or, in the metaphor of industry investors, falling off the ‘patent cliff’.⁵⁰ Pharmaceutical industry lobbying prevented negotiated Medicare rates and competition from foreign drug imports from being included in the new law.⁵¹ Thus the pharmaceutical industry will continue to profit far more in the US market than in other countries that use these price control mechanisms.

In spite of increased regulation under the PPACA, insurance companies will still benefit financially. Between 1980 and 2009 the percentage of people under 65 covered by private insurance decreased from 79 to 63 per cent.⁵² The mandate to have insurance, and income-based subsidies for people to purchase insurance, will eliminate this decline. Since a large part of the federally funded programme for the poor, Medicaid, is now funnelled through privately managed care plans, the expansion of the programme also increases insurance company



13 Demonstration for health care reform in the US, October 2009 (© Ryan Beiler| Dreamstime.com)

revenue.⁵³ The new regulations on individual market plans such as no lifetime maximum payout, restrictions on rescission, and elimination of pre-existing condition discrimination, will cut into revenues or require increased prices. However, insurance companies already abide by many of these conditions in the plans people get through their employers. Where insurance companies lost is in the fight over cost control. While cost increases benefit care providers, they cut into the revenues of insurance companies. Future corporate lobbying will seek to mitigate any negative effects of the new rules on corporations as implementation regulations are written over the coming years.⁵⁴

Organized entrepreneurial doctors and hospitals, especially prestigious ones with negotiating power, will have a continued waterfall of money, because PPACA does little to reduce the cost of medical services. Providers lobbied against measures that would have decreased service rates, even though these costs are higher in the US than in any other country. These measures included the public insurance option, which President Obama traded away in a backroom deal with for-profit hospitals.⁵⁵ Although Medicare has reforms that may slow rising costs within that system, most people agree that overall health care costs will continue to increase.⁵⁶ Massachusetts, a state that enacted a similar system to the one in the federal legislation, continues to have the most expensive health care in the country, even though all of its insurers are non-profit.⁵⁷ Like the other sectors, doctors and hospitals will benefit from seeing fewer uninsured patients.

Despite public opinion favouring a social insurance system, existing legislation pending in Congress to expand the Medicare programme to cover everyone was never considered.⁵⁸ Many so-called progressive activists were misled and sidetracked by a sham campaign to include a public insurance plan in the legislation.⁵⁹ Meanwhile, health care corporations overwhelmed Congress with lobbying, campaign contributions to key legislators, hints of future jobs for staffers,⁶⁰ advertising campaigns through disease advocacy groups and Astroturf organisations,⁶¹ and feeding talking points to the media. By the time the reform law was finally passed, about 1,750 businesses and organisations had hired some 4,525 lobbyists, eight for every member of Congress. More money was spent lobbying on this issue than any in history – between \$120 million and \$1.2 billion.⁶² Regardless of one's opinion about the specifics of the health care reform, the policy-making process demonstrated the complete inability of Congress to solve problems based upon evidence and the public interest.⁶³

If Virchow was right, the US health care system has it backwards. Medicine in the US is nothing but the result of our politics on the largest scale. That amounts to capitalist profiteering and has nothing to do with health or healing.

Notes

1 World Bank (2008). *World Development Report 2009: Reshaping Economic Geography*. Washington DC, World Bank.

2 *Ibid.*

3 WHO (2011). *World Health Statistics*. www.who.int/whosis/whostat/en/index.html.

4 Tang, S. et al. (2010). 'Health system reform in China 1: tackling the challenges to health equity in China'. *The Lancet*, 2008(372): 1493–1501.

5 WHO (2011). *Op. cit.*

6 Tang et al. (2010). *Op. cit.*

7 WHO (2011). *Op. cit.*

8 *Ibid.*

9 *Ibid.*

10 Tang et al. (2010). *Op. cit.*

11 WHO (2011). *Op. cit.*

12 *Ibid.*

13 Secondary diploma doctors left school at year eight or nine and completed two years of further study in a health school. Tertiary diploma doctors completed high school and then undertook three years of training in a medical college.

14 Cai, R. (2010). 'Review of employee basic health insurance system reform in China'. In Lin, V. et al. (eds), *Health policy in and for China*. Beijing, Peking University Medical Press, pp. 620–31 (English), 225–30 (Chinese).

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17 Hospitals are largely administered within the health and education sectors (university-affiliated hospitals) at all levels from provincial to municipal to district and county. Many industry-owned hospitals have been transferred to health bureaux. University hospitals receive their government budget through the health bureaux.

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25 Selvaraj, S. and A. K. Karan (2009). 'Deepening health insecurity in India: evidence from National Sample Surveys since 1980s'. *Economic and Political Weekly*, 44(40): 55.

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27 This section draws largely from Public Health Foundation of India (2011). 'A critical assessment of the existing health insurance models in India'. Submitted to the Planning Commission of India (unpublished report).

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29 Rao, M. (2009). 'Health for all and neo-liberal globalisation: an Indian rope trick'. In Panitch, L. and C. Leys (eds), *Morbid Symptoms: Health under capitalism*, New Delhi, Leftword Books, pp. 262–78.

30 RSBY stands for Rashtriya Swasthya Bima Yojana – meaning National Health Insurance Scheme. The two state-government-run schemes, Aarogyasri and Kalaingar, are located in the two South Indian states of Andhra Pradesh and Tamilnadu.

31 Palacios, R. (2010). 'A new approach to providing health insurance to the poor in India: the early experience of Rashtriya Swasthya Bima Yojna'. Draft document. RSBY Working Paper no. 1, October.

32 NSSO (2006). *Morbidity, Health/Care and the Condition of the Aged*. NSSO 60th Round, January–June. National Sample Survey Organisation. New Delhi, Ministry of Statistics and Programme Implementation, Government of India.

33 For a detailed history and review of how insurance functions in the United States see Austin, D. A. and T. L. Hungerford (2009). *The Market Structure of the Health Insurance Industry*. Congressional Research Service, 17 November. www.fas.org/srgp/crs/misc/R40834.pdf.

34 Kaiser Health News (2010). [\[healthnews.org/Stories/2010/September/16/census-uninsured-rate-soars.aspx\]\(http://healthnews.org/Stories/2010/September/16/census-uninsured-rate-soars.aspx\) \(accessed October 2010\).](http://www.kaiser-</p>
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35 Kaiser Family Foundation (2010). www.kff.org/healthreform/8061.cfm (accessed July 2010).

36 Huffington Post (2010). www.huffingtonpost.com/john-geyman/hijacked-stolen-health-ca_b_660904.html (accessed October 2010).

37 Physicians for a National Health Plan (2010). pnhp.org/news/2010/march/pro-single-payer-doctors-health-bill-leaves-23-million-uninsured (accessed July 2010).

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B5 | ACHIEVING A SHARED GOAL: FREE UNIVERSAL HEALTH CARE IN GHANA¹

There has been considerable interest in the progress achieved in Ghana in sustaining its health system through innovative financing mechanisms. This chapter takes a critical look at some recent data to come to an informed conclusion.

‘I still look at the picture of my child and feel a sense of deep sadness. If we could have afforded the hospital or the medicines would my daughter still be alive?’ Samata Rabbi (50), whose youngest child Francesca died recently aged five years. The family could not afford to pay the insurance premium of GH¢15 (Ghana cedis; US\$10) which would have entitled her to free health care. Tamaligu community, in the Tolong-Kumbungu District of northern Ghana.

In 2008 President Atta Mills and the National Democratic Congress came to power in Ghana on a promise to deliver a truly universal health insurance scheme that reflected the contribution of all the country’s citizens. The promise included guaranteed access to free health care in all public institutions, and cutting down the health insurance bureaucracy in order to ‘plough’ back the savings into health care services.

There can be no doubt that the introduction of Ghana’s National Health Insurance Scheme (NHIS) in 2003 was a bold progressive step that recognised the detrimental impact of user fees, the limitations and low coverage of community-based health insurance (CBHI) and the fundamental role of public financing in the achievement of universal health care. The NHIS provides a comprehensive package of services, and for members of the scheme evidence suggests that access and quality of services have improved. Average outpatient visits per member per year were between 1.4 and 1.5 in 2009 against a national average of 0.81 (Ghana Ministry of Health 2010).

However, for Ghana to be held up as a success story for health insurance in a low-income country and a model for other poor countries to replicate is misleading. According to our analysis of the data available, membership of the largely tax-funded National Health Insurance Scheme could be as low as 18 per cent² – less than a third of the coverage suggested by Ghana’s National Health Insurance Authority (NHIA) and the World Bank. Despite the introduction of the NHIA, the majority of citizens continue to pay out of pocket for their health care in the parallel ‘cash-and-carry’ health system,

Box B5 Overview of the health system in Ghana

The current health system in Ghana is unfair and inefficient. It doesn't have to be. The government can and should move fast to implement free health care for all citizens. Our research shows that:

- Coverage of the National Health Insurance Scheme (NHIS) has been hugely exaggerated, and could be as low as 18 per cent
- Every Ghanaian citizen pays for the NHIS through VAT, but as many as 82 per cent remain excluded
- Twice as many rich people are signed up to the NHIS as poor people. Sixty-four per cent of the rich are registered compared with just 29 per cent of the poorest
- Those excluded from the NHIS still pay user fees in the cash-and-carry system. Twenty-five years after fees for health were introduced by the World Bank, they are still excluding millions of citizens from the health care they need
- An estimated 36 per cent of health spending is wasted owing to inefficiencies and poor investment. Moving away from a health insurance administration alone could save US\$83 million each year. Enough to pay for 23,000 more nurses
- Through savings, good-quality aid but primarily improved progressive taxation of Ghana's own resources, especially oil, the government could afford to increase spending on health by 200 per cent, to US\$54 per capita, by 2015
- This would mean the government could deliver on its own promise to make health care free for all – not just the lucky few at the expense of the many

The shared goal of free health care for all in Ghana is within reach. Investing in the health of all citizens will lay the foundations for a healthy economy and help to achieve Ghana's goal of becoming a middle-income country.

or resort to unqualified drug peddlers and home treatment owing to lack of funds. The richest women are nearly three times more likely than the poorest to deliver at a health care facility with a skilled birth attendant.³

The National Health Insurance Scheme: costly and unfair

The NHIS's heavy reliance on tax funding erodes the notion that it can accurately be described as social health insurance; in reality it is more akin to a tax-funded national health care system, but one that excludes over 80 per

cent of the population. The design is flawed and unfair – every citizen pays for the NHIS but only some get to join. More than twice as many of the rich are registered compared to the poorest, and evidence suggests the non-insured are facing higher charges for their health care (Witter and Garshong 2009). Out-of-pocket payments for health are more than double the World Health Organisation (WHO) recommended rate and the risk of financial catastrophe due to ill health remains unacceptably high (World Health Organisation 2010).

The NHIS suffers from an inefficient administrative and registration system, cost escalation and high levels of abuse leading to serious questions about its sustainability. The average cost per insurance claim more than doubled between 2008 and 2009 and total expenditure on claims has increased forty-fold since the scheme first started (Ghana National Health Insurance Authority 2010). Incentives are provided for curative not preventive health and the budget for the latter is on the decline (*ibid.*).

Realising a vision: health care for all free at the point of use

The introduction of free health care for all pregnant women was a major step forward in 2008. In just one year of implementation 433,000 additional women had access to health care (Stewart 2009). But bolder changes are now urgently required to accelerate progress.

The government must move to implement its own aspiration and promise of a national health system free at the point of delivery for all – a service based on need and rights and not ability to pay.

Ghana is one of the few African nations within reach of achieving the Abuja commitment to allocate a minimum of 15 per cent of government resources to health. Malaria deaths for children have reduced by 50 per cent, the success rate for tuberculosis treatment is 85 per cent, and child and infant mortality are on the decline after years of stagnation (Ghana Health Service 2009).

But Ghana is off track to achieve the health Millennium Development Goals (MDGs). One quarter of the population live over 60 kilometres from a health facility where a doctor can be consulted (Salisu and Prinz 2009) and skilled birth attendance is low at only 46 per cent (Ghana Ministry of Health 2010). If current trends persist Ghana will not achieve the MDG for maternal health until 2027.

If the introduction of ‘cash-and-carry’ health care was stage one of health reform in Ghana, and the NHIS stage two, it is now time for stage three:

Step 1: The government must commit to a clear plan to remove the requirement of regular premium payments, abolish fees in the parallel ‘cash-and-carry’ system and make health care free at the point of delivery for all by 2015. A time-bound plan must also be set to reduce out-of-pocket payments as a proportion of total health expenditure to the WHO recommended rate of between 15 and 20 per cent (World Health Organisation 2010).

The change away from a premium-based health financing model means

much of the fragmented, inefficient and costly insurance architecture can be removed and many of the functions of the NHIA will no longer be required. The National Health Insurance Fund (NHIF) should be transformed into a National Health Fund to pool fragmented streams of financing for the sector. The purpose of the fund should be expanded to cover infrastructure and other capital and recurrent expenditure and be placed under the clear jurisdiction of the Ministry of Health, along with the core functions of the NHIA that remain relevant.

Step 2: At the same time a rapid expansion and improvement of government health services across the country is urgently needed to redress low and inequitable coverage and meet increased demand created by making care free. Rejuvenation of the Community-based Health Planning and Services (CHPS) strategy should form the backbone of the expansion plan and the foundation of an effective referral system. At the same time identified gaps in secondary and tertiary facilities, particularly district hospitals, should be filled. Priority should be placed on scaling up and strengthening government and Christian Health Association of Ghana (CHAG) services as the majority health care providers. While much improvement is needed the public sector performs better than the private sector at reaching the poor at scale, particularly for inpatient care.⁴

Significant advances have been made in reaching government targets for nurse training and recruitment. The government must now urgently review the reasons for poor progress in achieving the same for doctors. In 2009 Ghana had just one doctor per 11,500 people, worse than in 2007. A comprehensive review of health worker gaps across other cadres including health sector managers, pharmacists, and midwives is critical to inform a new and fully costed human resources strategy from 2012 to 2016.

The prices of medicines in Ghana are 300 to 1,500 per cent higher than international reference prices (Ghana Ministry of Health 2010). The government should use its purchasing power to negotiate lower prices, including through generic competition, while also tackling corruption, price hikes and stock shortages across the supply chain. To improve quality the government should prioritise investment in the capacity of drug regulatory authorities.

Two points are clear – business as usual is not financially viable; and, even if the government moves to a single lifetime payment, as opposed to annual premiums as is proposed, this will not contribute significant funds to the overall health budget if its goal is to increase equity and access. Our calculations suggest that financing universal health care in Ghana can be achieved from three key sources without insurance premiums:

- Inefficiencies, cost escalation, corruption and institutional conflict are costing the health sector millions of Ghana cedis each year. We calculate possible savings worth 36 per cent of total government health expenditure in 2008, or US\$10 per capita.

- With projected economic growth, together with action to improve progressive taxation of Ghana's own resources, especially oil, we calculate that the government alone can mobilise a health expenditure of US\$50 per capita by 2015. This figure assumes a minimum government investment in health of 15 per cent of total revenues.
- An additional US\$4 per capita can be added by 2015 if improvements in the quality of aid are achieved, including that at least 50 per cent of health aid is given as sector budget support.

These sources combined mean that by 2015 Ghana could increase its per capita expenditure on health by 200 per cent from 2008 levels to at least US\$54 per capita, and be well on the way to spending the US\$60 per capita recommended by the WHO.

Notes

1 This chapter is drawn from the published report 'Achieving a shared goal: free universal health care in Ghana' written by Patrick Apoya and Anna Marriott and published jointly by Alliance for Reproductive Health Rights, Essential Services Platform of Ghana, ISODEC and Oxfam in 2011. Available at: www.oxfam.org.uk/resources/policy/health/achieving-shared-goal-free-healthcare-ghana.html.

2 The methodology for our calculation is based on annual NHIA income from insurance premiums and is detailed in Annex 2 of the full report from which this chapter is drawn from. To date we have had no response from the NHIA to our requests for more accurate current membership data.

3 Author's calculation based on figures presented in Garshong (2010).

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B6 | MATERNAL MORTALITY: NEED FOR A BROAD FRAMEWORK OF INTERVENTION

Global burden of maternal mortality

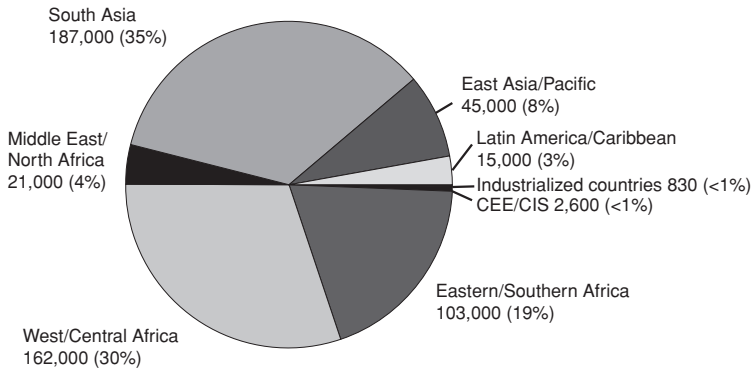
The number of maternal deaths is unconscionably high. An estimated 500,000 women die each year in pregnancy and childbirth.¹ An estimated 10 million more women suffer serious maternal morbidities,² including debilitating and socially devastating conditions such as uterine prolapses and obstetric fistulae.³ In addition, substantial proportions of the 3 million newborn deaths and 4 million stillbirths that occur each year are the result of maternal conditions or of acute events in and around the time of delivery.⁴

The World Health Organisation (WHO) defines maternal mortality as ‘the death of a woman while pregnant or within 42 days of termination of pregnancy or from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes’, with an additional classification of ‘direct’, ‘indirect’ or ‘incidental’.⁵ *Direct* deaths result from obstetric complications, while *indirect* deaths result from a condition that is not directly related to obstetric causes but is aggravated by the effects of pregnancy. In developing-country settings, studies indicate that 20 per cent or more of all maternal deaths are due to indirect causes.

The patterns of maternal mortality reveal large levels of inequity between and within countries – 99 per cent of maternal deaths occur in developing countries, with 86 per cent occurring in South Asia and sub-Saharan Africa alone.⁶ Fourteen countries have maternal mortality rates (MMRs) of at least 1,000 per 100,000 live births, of which all except Afghanistan are in sub-Saharan Africa: Afghanistan, Angola, Burundi, Cameroon, Chad, the Democratic Republic of Congo, Guinea-Bissau, Liberia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone, and Somalia. Wide disparities also exist within countries. Class, too, plays a defining role in maternal mortality and morbidity statistics, with studies in multiple countries showing that the MMR amongst poor women is four times higher than amongst wealthier groups.⁷

Three fundamental causes of maternal mortality can be identified:⁸

- medical causes, consisting of direct medical problems and pre-existent or coexistent medical problems that are aggravated by pregnancy, such as anaemia and malaria;
- health systems laws and policies that affect availability, accessibility, acceptability, and quality of reproductive health services; and
- underlying socio-legal conditions.



B6.1 Regional distribution of maternal deaths. *Note:* Percentages may not total 100 because of rounding (source: WHO, UNICEF, UN Population Fund and the World Bank, *Maternal Mortality in 2005: Estimated developed by WHO, UNICEF, UNFPA and the World Bank*, Geneva, 2007, p. 35)

Globally the five most immediate medical causes of maternal death are: severe bleeding (haemorrhage) (25 per cent); infections (15 per cent); unsafe abortions (13 per cent); eclampsia (12 per cent); and obstructed labour (8 per cent).⁹ Indirect causes (responsible for 20 per cent of maternal mortalities) include coexisting medical problems such as: malaria, anaemia, jaundice, and tuberculosis. There is also a contributory role of increased incidence of domestic violence during pregnancy, associated with cultural and stigmatised notions of sexuality and morality.

Underlying these medical causes is a range of systemic factors. These include discrimination on the grounds of gender, race, ethnicity, religion, and caste, and social factors such as lack of education and employment opportunities, increased workload (both outside and domestic), and political and legal issues. Particularly significant are the underlying patriarchal values and norms that define state policy differently across countries. Moreover, differential legal provisions relating to abortion, family planning, and medical consent, together with coercive and repressive population policies, also account for heightened risks.

Risk factors are not limited simply to demographic variables (age, parity, etc.) but also relate, for example, to issues of social stigma surrounding sexual behaviour and seasonal peaks in women's workload. In addition, gender biases in the structure and culture of health services provision further augment these risks. For instance, a recent Human Rights Watch Report on maternal deaths in Uttar Pradesh, a state in north India, identified four important reasons for sustained high rates of maternal mortalities – barriers to emergency care, poor referral practices, gaps in continuity of care, and improper demands for payment as a condition for delivery of health services.¹⁰ Gender analyses also suggest that maternal mortality is linked to a wide

range of factors in women's lives, including the value placed by women and by their families and communities on women's health, women's economic position, their access to education and information, and their capacity to make autonomous decisions.¹¹

While these socio-economic and legal factors underlying maternal mortality have been pointed out, most interventions directed at reducing maternal mortality have a limited focus on medical causes and on the related factors of service provision.

Addressing maternal mortality: historical interventions, emerging ideas

Maternal child health to family planning In the report on the first 10 years of WHO, maternal and child health (MCH) was a clearly identified area of action.¹² The major thrust in the 1950s was on providing technical support for training a sufficient number of personnel (including domiciliary training for midwives in order to raise the standards of home births), creating administrative divisions of MCH within national health systems, and integrating MCH services with general health services.

International cooperation in the area of maternal health gained prominence in the mid 1960s, when Western donor countries and international agencies first started funding MCH programmes in developing countries. However, in the WHO's report on the next 10 years (1958–67), which overlapped with this period, maternal health featured much less prominently.¹³

By the 1970s, the family planning movement had largely influenced those involved in issues of maternal health. Following the World Population Conference in Bucharest in 1974, the clear adoption and prioritisation of the family planning approach was evident in the WHO's approach to dealing with issues of maternal mortality and health.¹⁴ For other actors, too, such as UNICEF and USAID, the focus on, and funding of, MCH was geared to child health and family planning.

The Safe Motherhood Initiative (SMI) In 1985, two academics from Columbia University¹⁵ wrote a highly influential paper that put the issue of maternal mortality on the international health policy agenda. The first international conference devoted to maternal mortality (Safe Motherhood Conference, Nairobi, Kenya, 10–13 February 1987) was sponsored by the World Bank, WHO, and UNFPA, and led to the launch of the Safe Motherhood Initiative (SMI). International agencies involved in the SMI coalition included five UN agencies (WHO, UNDP, World Bank, UNFPA, and UNICEF) and two NGOs (the Population Council and the International Planned Parenthood Foundation (IPPF)). SMI was aimed at improving maternal health and reducing maternal deaths by 50 per cent by 2000.¹⁶ This initiative led to a series of national and international conferences that made 'safe motherhood' a widely understood term in the public health realm. However, the initiative has been criticised for



14 Women's health problems are often seen only in relation to child-bearing (Indranil Mukherjee)

focusing on only increasing awareness and to a far lesser extent on mobilising resources for safe-motherhood activities (which itself was a narrow agenda).¹⁷ In the decade that followed, safe-motherhood strategies were developed based on the different phases in a woman's reproductive cycle – pre-pregnancy, antenatal, delivery, and post-partum periods.

In 1987, the international women's movement also launched a day of action focused on maternal mortality. The success of this event led to a 10-year campaign (which ended in 1996), coordinated by the Women's Global Network for Reproductive Rights (WGNRR), to reduce maternal mortality.

Towards a universal reproductive rights approach In 1994, the International Conference on Population and Development (ICPD) recommended that countries move away from the traditional family planning projects to a broader perspective of reproductive health. Although not primarily focused on maternal health and safe motherhood, the Programme of Action developed at ICPD placed, and has helped to keep, maternal health within a reproductive health agenda. Other international conventions relevant to safe motherhood include those on age at marriage (Convention on Consent to Marriage, Minimum Age of Marriage and Registration), maternal protection at work (Maternity Protection Convention), and against torture (Convention against Torture). The ICPD Programme for Action and the subsequent Beijing Platform for Action adopted at the Fourth UN World Conference on Women in Beijing in 1995, along with their follow-up conferences, held every five years, have been very influential in shaping policies on maternal and reproductive health in various countries. The importance of maternal health and survival was reinforced in 2000 when it was included as one of the eight Millennium Development Goals

(MDGs) (with a commitment to reduce MMR by three-quarters between 1990 and 2015).

Maternal mortality: a human rights issue More recently, a human-rights-based lens has been used to examine the underlying causes of maternal mortality and morbidity. Maternal mortality and morbidity, under such a construct, are seen as human rights violations, and access to maternal health a universal human right. However, human rights treaties and conventions do not include an explicit right to women's health. Nevertheless, human rights committees have now included a gender perspective in their interpretation of human rights and state that failure to address the preventable causes of maternal death is a violation of women's human rights, for which states can be held accountable.¹⁸ An understanding is now emerging, within the human rights framework, that it is important to highlight the fact that social injustices contribute to avoidable maternal deaths. This approach considers the reduction of maternal mortality as a threshold objective in a comprehensive strategy to ensure a woman's right to a life-enhancing pregnancy and childbirth. As Freedman points out, 'Once an issue is recognised as a human right, there is a legal obligation to take steps that are "deliberate, concrete and targeted toward [the] realisation of the right."¹⁹

UNICEF also emphasises that an overall environment supportive of women's rights is needed in order to enhance health care provisions, to address gender discrimination, and to remove inequities in society through the adoption of human rights approaches. In September 2008, the European Parliament passed a resolution recognising maternal deaths as a human rights issue. In June 2009, the UN Human Rights Council passed a resolution declaring that preventable maternal deaths are indeed a violation of women's human rights.

Maternal mortality: a public health concern

The various intervention strategies – ranging from SMI in the 1980s to the latest implementation of the MDGs – have emphasised the concept of reproductive health, particularly maternal health and safe motherhood, equating this with the concept of women's health. There is no denying the fact that reproductive health constitutes an important aspect of women's health. However, the challenge is to define priorities within this framework according to the objective and subjective definitions of women's needs, and to make these priorities a part of a larger development programme, based not only on equity of distribution but also on access to, and control of, productive resources.

Unfortunately, public health issues in specific contexts and locales have been ignored in an attempt to present a homogeneous framework of 'universal' reproductive health rights. In this quest, however, the epidemiological basis of maternal health, the immensity of women's health problems, and the social constraints on women's lives reveal the inadequacy of an isolated strategy in

Box B6.1 Human rights and maternal mortality

The Convention on the Elimination of All Forms of Discrimination Against Women requires States parties to:

‘ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation’ (Article 12.2).

The International Covenant on Economic, Social and Cultural Rights requires States parties to take steps to provide for:

‘the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child.’

The UN Committee on Economic, Social and Cultural Rights, the body responsible for monitoring this treaty, has stated that this treaty obligation must be:

‘understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information’ (General Comment 14, para.14)

the context of ‘the expressed needs of women for land rights, freedom from atrocities, food, security system, minimum wages and communal harmony along with the need for health services’.²⁰

Such a ‘uniform’ strategy places, within the domain of reproductive problems, issues that could be classified as ‘medical’ causes, but which do not necessarily have their roots in a medical aetiology. For instance, while reproductive health interventions cover nutrition and infectious diseases during pregnancy and childbirth, they fail to address the underlying issues of food security, poverty, inadequacy of public distribution systems, etc. Failure to address these underlying causes raises further concerns of a ‘superficial intervention strategy’,²¹ and underplays the importance of paradigm shifts in local health systems policies.

Further, the life-cycle approach preferred by several new-age maternal health rights proponents continues to identify reproduction as the criterion for defining the stages of life. This strategy leads to simply further medicalising reproduction, with an effort at homogenising the health care needs of women across the globe, with little attention being paid to local needs and social realities.



15 Women patients at a hospital in Madhya Pradesh, India where several deaths took place over a short period (Sarojini.N.)

The increased stress on family planning and fertility regulation as a part of maternal health strategies, and on other technocentric strategies for dealing with social and structural issues, raises concerns about the appropriation of these issues by the population control lobby, a phenomenon that is glaringly visible in the nature and source of funding available for maternal mortality and morbidity programmes in developing countries today. There is, therefore, a need to understand fully the initiatives to end maternal mortality and to see them from a public health perspective.

There is no doubt that safe deliveries, whether these take place in institutions or in homes, combined with safe and effective contraception, access to safe abortions, and freedom from violence, are an important part of maternal health care. However, narrowly focused strategies, particularly those concentrated on increasing institutional deliveries and on decreasing maternal mortality, should instead be looking at providing comprehensive and easy access to health and health care and its determinants. Maternal health needs to be addressed within the larger framework of collapsing health systems further burdened by repressive policies and programmes, affecting the socio-political context of

Box B6.2 Institutional deliveries – not a panacea

The focus of the Indian government's strategy for reducing maternal mortality and morbidity has been on ensuring institutional deliveries – through a scheme known as the Janani Suraksha Yojana (JSY). Women who deliver in accredited institutions are provided with a cash incentive. The findings of a recent report²³ by a fact-finding team investigating a spate of maternal deaths in Barwani district in Madhya Pradesh (one of the poorest states in India) raise doubts about an uncritical reliance on such an approach. Some of the findings of the study are as follows:

- Women are being forced to travel great distances with a lot of difficulty to access care during delivery, in order to be eligible for the incentive provided under the scheme. This is because primary health facilities that are closer to their homes are not prepared to conduct normal deliveries.
- Institutional readiness to handle the increased caseloads of women approaching them for deliveries is an important issue. While the National Rural Health Mission (NRHM) has spent large amounts on preparing institutions to provide emergency obstetric care, it is obvious from the investigation that such care is, in fact, not being provided. Quality of care remains an important issue. Skilled Birth Attendance (SBA) is inadequate; adequate infection control measures are not being followed; irrational use of oxytocin and antibiotics is prevalent; and women are being subjected to abuse and violence during labour. However, none of these factors is measured as an indicator when monitoring success in maternal health interventions. Rather, the number of institutional deliveries is assumed to be the proxy for better maternal health care.
- The exclusive focus on institutional deliveries has resulted in a total lack of attention to either antenatal or post-natal care. In a district with a very high prevalence of anaemia, no concerted efforts have been made to investigate and address the issue. Thus, a 'one size fits all' policy seems to be the norm.

health. This is especially important in a context where privatisation, cutbacks in allocation to the social sector, shrinking wage structures, declining work opportunities, and dwindling food security are hitting women the hardest. In such a situation, basic survival needs cannot be given a secondary status. As Qadeer asserts, 'To do otherwise would mean rejecting women's context, their perceptions and their strategies for survival.'²²

Notes

- 1 WHO (2007). *Maternal mortality in 2005: estimates by WHO, UNICEF, UNFPA and the World Bank*. Geneva, WHO. www.who.int/whosis/mme_2005.pdf.
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- 20 Qadeer, I. (1998). 'Reproductive health: a public health perspective'. *Economic and Political Weekly*, 33(41): 2675–84.
- 21 Ibid.
- 22 Ibid.
- 23 Sri, S., N. Sarojini and R. Khanna (2011). *Maternal deaths and denial of maternal care in Barwani district, Madhya Pradesh: issues and concerns*. Jan Swasthya Abhiyan, CommonHealth, and Sama – Resource Group for Women and Health, February 2011.

B7 | RESEARCH FOR HEALTH

Introduction

This chapter describes the current system of health research and examines what type of research gets funded and the processes through which this happens. It argues that the system is biased towards biomedical approaches and does not pay sufficient attention to the diseases of poor people or to research on the social determinants of health. The second part of the chapter examines the changes that will be needed to make the current system more responsive to the social determinants of health and for it to take up equity-focused research. It proposes new ways of setting priorities, stresses the need for the reallocation of funding, emphasises the need for new ways of commissioning and assessing research, calls for new incentives for researchers, and points to the need for establishing more equitable partnerships.

The current system: what gets funded? And through what processes?

In order for research to have an important impact on the health of disadvantaged people specific conditions must be taken into account in each component of the research cycle, from setting the research priorities, to allocating resources, conducting the research, communicating the results, and translating these results into policies and practices. The main pitfalls of the current system are described briefly below.

Research priorities are not defined in a participatory and systematic way

At the very beginning of the research cycle, setting priorities will allow research to be conducted on topics that have the greatest potential impact on health.

However, most research conducted does not result from a previously defined set of priorities, but is carried out according to other criteria, such as personal interest or availability of funds (Sharan et al. 2007). As a result, there is a discrepancy between research needed and research conducted.

Various attempts have been made in the last decades to define a priority research agenda. However, most of those exercises were not conducted in a systematic and inclusive way, and many researchers have expressed the need for more guidance on the priority-setting methodology (Viergever 2010). A recent review of health research priority-setting exercises performed between 2005 and 2009 revealed that researchers chose to develop their own methodology. Most of them overlooked important elements of good practice in



16 Research on broader determinants of health is neglected (Simon Kneebone)

research priority setting, such as the use of a comprehensive approach, broad stakeholder involvement, and the use of relevant criteria to focus the discussion (Viergever et al. 2010; Viergever 2010).

Stakeholder involvement is of particular importance. Guaranteeing participation and inclusiveness is an effective way of ensuring that the needs of disadvantaged social groups – for example, those categorised on the basis of gender, ethnicity, religion, sexual orientation, ability, and income – are specifically taken into consideration, with a corresponding beneficial impact on health equity (Nuyens 2007; Ghaffar et al. 2009).

On a more global level, 60 ministers of health, science, technology, and education at the 2008 Global Ministerial Forum on Research for Health held in Bamako, Mali (2008) agreed to issue a ‘call to action’. This ‘call to action’ particularly emphasised the need for research priorities to be determined by the countries themselves, not global institutions.

Biases in research funding

Global investment in health research accounted in 2005 for US\$160.3 billion, representing 4.1 per cent of the total estimated health investments worldwide. The relative distribution of health research funding is shifting: the public sector is spending relatively less than before (41 per cent in 2005 compared to 45 per cent in 2003), the private for-profit sector is spending more (51 per cent in 2005 compared to 48 per cent in 2003). Only 3 per cent of the US\$160.3 billion spent on health research is devoted to research conducted in low- and middle-income countries. Most of the 97 per cent of the funds spent by high-income countries goes towards generating products, processes, and services for their own health care market (Burke et al. 2008).

Most investment in health research in high-income countries is funded by the private for-profit sector (pharmaceuticals) rather than the public sector (US\$79.7 billion compared to US\$63.3 billion), while funds for health research in low- and middle-income countries mainly come from the public sector

rather than the private for-profit sector (US\$3 billion compared to US\$1.6 billion) (ibid.).

Overall, the research funding system is dominated by *biomedical research* and *research on individual risk factors*, neglecting the essential areas of health systems research (HSR) and research on the social determinants of health.

The problem with *research on individual risk factors*, such as smoking, alcohol consumption, and eating patterns, is that it often neglects the socio-economic context and the individual's social position. In addition, the *risk-factor* approach fails to reveal multi-causal mechanisms and the root causes of health inequities (Diderichsen et al. 2001; WHO Task Force on Research Priorities for Equity in Health and the WHO Equity Team 2005; CSDH 2008).

A major problem with *biomedical research* is that the health returns on investments in biomedical research are much lower compared to HSR. For example, a study by Leroy et al. (2007) showed that 97 per cent of health research grants from two major US funding organisations were for developing new technologies that could reduce child mortality by 22 per cent. In contrast, only 3 per cent of the grants focused on improving health care delivery and the use of available technologies that have the potential of reducing child mortality by 62.5 per cent. The authors refer to this imbalance as the '3/97 gap' (ibid.).

Why is there such a bias towards *individual risk factors* and *biomedical research*? A major reason is that research on both the social determinants of health and health systems relies on a range of research methods drawn from different disciplines, requires fieldwork as opposed to hospital or lab work, and demands adaptation to local environments. Researchers prefer biomedical research and product development because of the possibility this offers of obtaining patents and gaining increased visibility (Nightingale 2009). Other reasons have been put forward to explain the limited funding of (and for) HSR, such as the fact that few research priority-setting processes properly address HSR, as well as the weak capacity for conceptualising, developing, and implementing HSR in low-income settings (Ranson and Bennett 2009).

Conducting research: equity lens needed

Funders and researchers often lack training in equity analysis and research, as well as in the importance of research on the social determinants of health and health systems. Public health objectives, such as lowering the mortality rate, often do not take into consideration equity issues, such as the distribution of the burden of mortality across social groups, and as such are 'equity-blind'. Some authors have stressed the need to develop and use an equity-adjusted measure that combines both health and equity outcomes into a single dimension (or composite indicator), which can be maximised, thus reorienting the global health agenda and encouraging better resource distribution (Reidpath et al. 2009).

Furthermore, we still lack empirical evidence on how intersections between



17 Health research is not prioritised (Simon Kneebone)

different social determinants operate within disadvantaged social groups. For example, we still do not have much knowledge on how gender affects class inequalities or on how gender relations are modified by class.

Other disadvantages of using an equity lens in research have been identified; for example: studies on how inequities are influenced by policies within and beyond the health sector; the fact that health research is often conducted by ‘experts’ parachuted in, instead of being undertaken by research teams from within each country; and the imperative for disaggregating empirical data into – at a minimum – age group, sex, and specific health outcomes (Evans et al. 2001).

What Changes Are Needed?

New systems for prioritising, funding, conducting, and using research are urgently required. We propose a new architecture for research that is relevant nationally and internationally, with the following elements:

- New ways of setting research priorities
- More funds for research on the social determinants of health and HSR
- New ways of assessing and commissioning research
- New incentives for academic researchers
- Improved capacity to use research
- More equitable partnerships in research

New ways of setting research priorities

Most research priorities are set by researchers in rich countries and reflect the dominant biomedical and behavioural understandings of health, which are focused almost entirely on curing diseases that are prevalent in rich countries (WHO Expert Working Group on Research and Development Financing 2009). Corporations, particularly the food and pharmaceutical industry, also have a considerable control over the research agenda (Knai et al. 2010). Here are some ideas for the ways in which research priority-setting processes can be broadened.

Internationally Involvement of public-interest NGOs (that is, those that do not receive funding from vested interests such as pharmaceutical companies) in the setting of research priorities for international agencies is crucial. It is also important that priority-setting be informed *inter alia* by NGOs and independent researchers with specific understanding of the social determinants of health.

Amazingly, WHO has not had a policy on health research until recently. The Pan American Health Organization (PAHO) adopted a Research for Health Policy in November 2009 and was the first WHO region to do so. The policy calls on ‘countries of the region to work with PAHO to reinforce and monitor their national health research systems and improve the quality, leadership and management of research for health. It recommends establishing governance mechanisms for research for health that will allow coordinating effectively the strategies of the relevant sectors’ (PAHO 2009). PAHO has adopted a regional plan to strengthen research effort on health equity. WHO and its partners have also developed a nine-point checklist for good practices in health research priority setting (Viergever 2010).

Nationally National medical and health research funding bodies need to develop processes for ensuring that policy, community, and citizen voices are heard when setting research priorities and that research for health equity is prioritised. PAHO has called for countries to put in place or reinforce national research management mechanisms and policies on research for health. They have also called on better-resourced countries to assist those with fewer resources in developing and implementing their plans. We call on WHO to adopt such policies in all regions and call on international agencies to fund national health systems to develop health research priorities and strategies to address these priorities.

The Global Forum for Health Research has developed a tool for setting priorities in research for health – the 3D Combined Approach Matrix (CAM) (Ghaffar et al. 2009) – which could be used by national health and medical research bodies in setting their priorities. The CAM methodology has been implemented in several low- and middle-income country settings (Rudan et al. 2010). The Canadian Institutes for Health Research (CIHR)

have developed a policy of Integrated Knowledge Translation that emphasises interaction between researchers, research funding agencies, policy-makers, and other stakeholders in priority settings for research (CIHR 2010). The Child Health and Nutritional Research Initiative (Rudan et al. 2008) is another interesting framework, an evidence-based and consensus-building approach among a range of stakeholders, including policy-makers, donors, students, specialists, health care providers, and NGOs.

Tertiary institution–community partnerships Research priority-setting may also be influenced by tertiary institutions, such as universities, where again biomedical approaches to health research tend to dominate. However, in some countries, the tertiary sector is seeing a growing trend towards institutional–community partnerships and community-based participatory research. Such approaches are demonstrably more likely to recognise and incorporate research on identifying and understanding the social determinants of health and on implementing interventions designed to address these social determinants (see, for example, CBRC 2010; CCPH 2010).

More funds for studies on social determinants of health and health systems research

International and national agencies funding health and medical research need to allocate protected funds for the study of the social determinants of health and HSR.

Health systems research As health systems become increasingly inequitable and fragmented, research on the drivers and effects of the liberalisation, segmentation, and commercialisation of health care systems becomes even more essential (McCoy et al. 2004), yet little research on this crucial topic receives funding (Ranson and Bennett 2009). Detailed research is particularly required on the operation of primary health care services to determine how they can better provide effective, equitable, and accessible services and promote the health of the communities they serve. There is also an urgent need for more research on why available and affordable technology and knowledge are not used – for example, to prevent millions of children from dying of diarrhoeal disease and acute respiratory infections (Fontaine et al. 2009).

Research on the efficacy of interventions in a controlled environment is different from research on the practicability of applying effective interventions in the real world. More action research that involves service providers can help to bridge the gap between research and implementation, and ensure that research is embedded within the day-to-day realities and constraints of under-resourced health care systems (Winter and Munn-Giddings 2001). The use of participatory research methods can also help poor communities shape health systems to meet their needs (de Koning and Martin 1996).

Social determinants of health Far greater research effort is required on studying the social determinants of health and on assessing how these affect health and equity at the international, national, regional, and local levels. This will require the disaggregation of data by a range of variables, including socio-economic status, race, gender, and location (especially rural versus urban). It will also require vastly increased investment in research on how the global political economy affects health and health equity. The Commission on the Social Determinants of Health (CSDH) went some way in leading research in this area by establishing a global knowledge network on globalisation, which enabled CSDH to document some of the negative health effects of economic globalisation, but ongoing research is needed on this topic.

Research on effective interventions Research is needed to understand how action on the social determinants of health can be most effective. This research should be multi-sectoral and should include: (a) comparative policy analysis of the effectiveness of policies on health in a range of sectors, including urban planning, education, social welfare, and employment; and (b) evaluation of the impact of particular programmes in local communities. Much of the new research to be funded would emphasise the ‘science of delivery’ rather than the ‘science of discovery’ (Catford 2009).

Research on the social determinants of health would also benefit from new measures of health and well-being that focus on providing positive health rather than on only measuring diseases, and provide an idea of how well a society is doing. Increased efforts to provide such measures have been made in the past few years (see Box B7.1).

New ways of assessing and commissioning research

The traditional method of assessing research grants, which sees researchers commenting on each other’s proposals in a system of peer review, needs to be altered so that those from the communities likely to be affected by the research are also involved (see Box 7.2)

New incentives for academic researchers

Currently, the research culture and the incentive system encourage researchers to be more concerned with publishing the results of their research studies in academic journals than with ensuring that their research leads to improved policy and practice. Promotion in universities depends largely on an academic’s success in publishing in academic journals with high-impact factors – that is, how much the articles published in these journals are quoted by other academics and researchers. The system has a bias towards medical rather than health research, as medical journals typically have higher-impact factors than public health or social science journals, and the articles they publish are often multi-authored. A study in Australia suggested that the grant system

Box B7.1 Alternative indicators of social progress

Human development index (HDI)

- UN Development Programme
 - Composite index of average achievement in longevity and health, education, and standard of living
- hdr.undp.org/en/

Happy planet index (HPI)

- New Economics Foundation
 - Efficiency of conversion of natural resources into ‘long and happy lives’
- www.happyplanetindex.org/

Stiglitz Commission on Measurement of Economic Performance and Social Progress (2009)

- Production, income, consumption and wealth, and their distribution
 - Physical, natural, human, and social capital, and their sustainability
 - Quality of life: health, education, employment, participation, environment, security, and their distribution
 - Subjective well-being
- www.stiglitz-sen-fitoussi.fr/en/index.htm

Ecological footprint

- Global Footprint Network and Mathis Wackernagel
 - National per capita demand on natural and ecological resources (expressed as land area), relative to global average demand at sustainable levels
- www.footprintnetwork.org/en/index.php/GFN/

Genuine progress indicator (GPI)

- Redefining progress
 - GDP data adjusted for multiple factors, including income distribution and various quality-of-life and sustainability factors
- www.rprogress.org/index.htm

and the journal publishing system were strongly biased in favour of public health researchers conducting relatively straightforward research, such as a cross-sectional survey on behavioural risk factors, rather than those conducting an evaluation of a complex community-based intervention (Kavanagh et al. 2002). Concerted efforts are required to change this situation and to

Box 7.2 Cooperative Research Centre for Aboriginal Health (CRAH)

Facilitated development approach

- The CRAH works with the Aboriginal health sector to identify areas where research may be able to make a real difference. It then brings together researcher and industry partners to design and conduct the research and spread the results or findings. ('Industry partners' means the Aboriginal community-controlled health sector, Aboriginal health organisations, and governments and other organisations with an interest in Aboriginal health.)
- Research transfer means ensuring the research is done in a way that makes it most likely to be relevant and of use – and to be used – to inform and bring about positive change.
- Capacity development involves 'building up the skills and abilities of Aboriginal people, communities and organisations to carry out, direct and use health research; and the capacity of non-Aboriginal researchers to work collaboratively with Aboriginal organisations and communities ...' (CRAH 2006)

ensure that research incentives encourage research that improves the health of the poorest and the most disadvantaged sections of society as a matter of priority. This could be done by ensuring research assessment systems that take into account the effort required by researchers who collect data (as opposed to those who analyse existing data sets), especially if the data are from either health service research or from an intervention affecting the social determinants of health. Academic reward systems could strongly encourage academics to engage in partnerships with governments, civil society, and local communities, and to conduct long-term evaluations of interventions (CCPH 2010). Publication metrics could be downgraded as a means of judging the value of researchers' work, and could be complemented by also assessing their policy engagement with, and their success in, evaluating interventions aimed at bringing about health service delivery and system change and on improving the social determinants of health.

Improved capacity to use research

Policy-makers and programme implementers in developing countries are either sceptical about the value of research or do not have the skills to appraise and use new information (Lomas 2000). The lack of capacity in the public sector has been further exacerbated by the steady brain drain of capable health



18 Flaws in the peer review system (Simon Kneebone)

professionals to richer countries (Vujicic et al. 2004; Pang et al. 2002), or from the public sector to the domestic private and non-government sectors. Efforts at concerted capacity-building are necessary and should be an activity that WHO can lead. PAHO is already leading the way in this regard with their recently adopted policy.

Equitable partnerships in research

A redistribution of power is particularly necessary in the relationship between researchers in rich and poor countries, and between researchers and research participants.

Between researchers in rich and poor countries Many academic and non-government institutions in more developed countries benefit disproportionately from the meagre research funds allocated to health in developing countries (McCoy et al. 2004). This imbalance occurs in a context where academic and research institutions in developing countries are struggling to secure their own funding and finding it difficult to retain good staff. Practical ways of addressing the inequities within the health research community include mapping out the distribution of research funds for health problems between research institutions in rich and poor countries, documenting the obstacles to the development of research capacity in developing countries, and conducting in-depth case studies on the health research funding policies and patterns of selected donor and international agencies. Capacity-building schemes that develop the research capacity in poor countries are essential so that young researchers no longer have to travel overseas to receive research training and instead can do this

within their own countries in their own community settings. Funding also needs to be provided so that researchers from resource-poor countries can attend international conferences and present their results.

Between researchers and participants in the research In the overwhelming majority of research studies, power lies with the researcher rather than with those who are the subject of the research. Research is likely to be more relevant if subjects, patients, and/or citizens are involved in the endeavour. For example, the involvement of patient groups in the design of trials and studies should be possible, especially in the case of health services research, which seeks to study interventions in their real-world setting rather than in a highly controlled environment (e.g. Kim et al. 2005).

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B8 | PANDEMIC INFLUENZA PREPAREDNESS: IN SEARCH OF A GLOBAL ETHOS

In early 2007, the Indonesian government made a controversial decision to withhold its H5N1 avian flu virus samples from WHO's collaborating centres as leverage for a new global mechanism for virus sharing that had better terms for developing countries.

Indonesia was expressing dissatisfaction with a system that obliged WHO member states to share virus samples with WHO's collaborating centres, but which lacked mechanisms for equitable sharing of benefits, most importantly affordable vaccines developed from these viral source materials (*Jakarta Post*, 17 February 2007).

The Indonesian decision, invoking provisions in the Convention on Biological Diversity (1992) pertaining to sovereign rights over biological resources, aroused indignation and accusations of irresponsibility that supposedly endangered global health. But there were also expressions of support and sympathy, including an editorial in *The Lancet* (2007):

To protect the global population, 6.2 billion doses of pandemic vaccine will be needed, but current manufacturing capacity can only produce 500 million doses. Indonesia fears that vaccines produced from their viruses via the WHO system will not be affordable to them ... In November 2004, a WHO consultation reached the depressing conclusion that most developing countries would have no access to vaccine during the first wave of a pandemic and possibly throughout its duration ... The fairest way forward would be for WHO to seek an international agreement that would ensure that developing countries have equal access to a pandemic vaccine, at an affordable price.

On 29 March 2007, immediately following an interim agreement for Indonesia to resume sending flu virus samples to WHO, the health ministers of 18 Asia-Pacific countries issued the Jakarta Declaration (2007), which called upon WHO

to convene the necessary meetings, initiate the critical processes and obtain the essential commitment of all stakeholders to establish the mechanisms for more open virus and information sharing and accessibility to avian influenza and other potential pandemic influenza vaccines for developing countries.

These proposals were tabled at the 60th World Health Assembly in Geneva (14–23 May 2007) as part of a resolution calling for new mechanisms for

virus sharing and for more equitable access to vaccines developed from these viral source materials.

In the course of the deliberations, it emerged that WHO collaborating centres had not abided by the relevant guidelines on sharing of viruses, which required the consent of donor countries before these collaborating centres could pass on the viruses (other than the vaccine strains) to third parties, such as vaccine manufacturers (WHO 2007). While discouraging the use of material transfer agreements (MTAs) at the point when donor countries transferred their virus samples to WHO, WHO's collaborating centres nonetheless resorted to MTAs when they transferred to third parties vaccine strains containing parts of the viruses supplied by developing countries, such as Indonesia, Vietnam, and China. Indeed, WHO's collaborating centres themselves, as well as third parties, had sought patents covering parts of the source viruses used in developing vaccines and diagnostics (Third World Network 2007). In 2007 the World Health Assembly adopted a resolution mandating WHO to establish an international stockpile of vaccines for H5N1 or other influenza viruses of pandemic potential, and to formulate mechanisms and guidelines for equitable access to affordable pandemic flu vaccines (World Health Assembly 2007). The resolution also requested a WHO working group to draft new Terms of Reference (TORs) for WHO collaborating centres and for its H5 reference laboratories for the sharing of influenza viruses, to be submitted to a special intergovernmental meeting of WHO member states.

Global health security or global public health?

In April 2003, as the SARS pandemic was unfolding, Ilona Kickbusch (2003), professor of global health at Yale University's School of Public Health, lamented the weak enforcement mandate of international agencies such as the WHO for securing the cooperation of member states in safeguarding global health security. She issued a call 'to explore sanctions by the UN Security Council, the WTO and the IMF for countries that do not adhere to global health transparency and their obligations under the IHR'.

Similar sentiments, couched in terms of health security and health policing, re-emerged with Indonesia's refusal to dispatch H5N1 virus samples to the WHO's collaborating centres. In a strongly worded op-ed in the *Washington Post*, Richard Holbrooke and Laurie Garrett (2008) castigated Indonesia's assertion of 'viral sovereignty' as 'dangerous folly' and a 'morally reprehensible' threat, which called for 'very strong action' by political leaders around the world.

A year later, in July 2009, as the H1N1 pandemic was unfolding, Garrett (Cohen 2009) belatedly acknowledged the essential point about 'viral sovereignty', that it was above all an exercise of sovereign leverage for more equitable access to lifesaving vaccines in a pandemic situation.

Despite appeals to humanitarian solidarity and to enlightened self-interest, almost all of the first billion doses of the H1N1 vaccine produced in 2009

were allotted to 12 wealthy nations that had placed advance orders. Sanofi Pasteur and GlaxoSmithKline (GSK) pledged 120 million doses to the WHO for distribution to poor countries, but even those pledges could only be fulfilled months after the pandemic had waned.

In Mexico, the epicentre of the H1N1 pandemic where health authorities had promptly shared its viruses with the GISN, Health Secretary Jose Angel Cordova revealed that ‘we had to wait in the second line to buy the vaccine, because obviously the first shipments were for the countries that make the vaccine’ (Associated Press, 12 January 2010). With no domestic production capacity at the time, Mexican officials had ordered 30 million doses of the vaccine from Sanofi Pasteur and GlaxoSmithKline, most of which could only be delivered in February or March 2010. Under the circumstances, they made an arrangement to borrow 5 million doses from Canada, as the pandemic waned in the northern hemisphere.

Access to pandemic H1N1 vaccines: a worrisome preview

In September 2009, President Obama’s administration had brokered an agreement with eight other wealthy nations (Australia, Brazil, France, Italy, New Zealand, Norway, Switzerland, and the United Kingdom) to donate 10 per cent of their vaccine supplies to WHO for use in poor countries, on top of the pledges by Sanofi Pasteur and GlaxoSmithKline (White House press release, 17 September 2009). With accumulating evidence that a one-dose injection would be adequate in place of the anticipated two-dose regimen, three additional countries and four more manufacturers eventually came on board, raising the total pledges to 180 million doses of vaccine (WHO 2009a).

As of early February 2010, however, only two of the 95 countries listed by the WHO as having no independent means of obtaining flu vaccines – Azerbaijan and Mongolia – had received any. WHO had earlier planned to deliver vaccines to 14 of these countries by then, and even then shipments were adequate for protecting only 2 per cent of the populations of these countries (*New York Times*, 2 February 2010). Pledges and exhortations aside, few were really surprised that when faced with perceived national emergencies, countries that could afford vaccines prioritised their own nationals first, and only when the worst had passed did they transfer their leftovers to the poor using the WHO as a clearing house.

As it turned out, the H1N1 pandemic peaked in October/November 2009 in the northern hemisphere, and it furthermore remained mild, more comparable in severity to the 1957 and 1968 pandemics than to the feared 1918 pandemic (Presanis et al. 2009). Many nations cut back on their vaccine orders, while others attempted to sell off excess stock or pending deliveries as the threat perception receded and scepticism about the vaccine’s safety resurfaced among the general public.

In the wake of the mild pandemic, WHO’s alert system for influenza pan-



19 Man with a mask to protect against influenza in a subway in Buenos Aires, June, 2009(© Elultimodeseo | Dreamstime.com)

demics was also subjected to scrutiny and criticism. There were allegations of scaremongering by parties with vested interests in vaccine manufacture and sales, squandering of scarce health resources, and diversion of attention from more urgent priorities in global health. Adding to the unease was WHO's lack of transparency in handling the declared interests of its influential advisers on pandemic alert and response, many of whom had also acted as advisers and consultants for pharmaceutical companies or had investment interests in these companies (Cohen and Carter 2010). The potential for conflict of interest was underscored by the fact that many of the advance purchase contracts for pandemic flu vaccines ('sleeping contracts') had trigger clauses that hinged upon the declaration of a level-six flu pandemic by WHO. Prior to the H1N1 pandemic, other researchers had begun to question the efficacy of seasonal flu vaccines (Jackson et al. 2006; Jefferson 2006).

Pathways to access

Resolution WHA60.28 ('Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits'), which emerged from the 60th World Health Assembly (2007), declared that affordable access

to the benefits of virus sharing in such forms as vaccines, medicines, and diagnostics was the equitable quid pro quo of global virus-sharing arrangements for pandemic alert and response.

Indeed, the WHO Intergovernmental Meeting (IGM) on Pandemic Influenza Preparedness, a process mandated by WHA60.28, included by consensus the following paragraph in the draft framework for reforming the GISN that was tabled at the 62nd World Health Assembly (2009):

Recognise that member states have a commitment to share, on an equal footing, H5N1 and other influenza viruses of human pandemic potential and the benefits, considering these as equally important parts of the collective action for global public health.

In actuality, though, WHA60.28 gave rise to two divergent approaches for achieving these reciprocal goals. Notwithstanding this resolution, developed countries, in particular those heavily invested in pharmaceutical enterprises and associated intellectual property regimes, were opposed to the formal linking of virus sharing with the sharing of benefits, preferring instead ad hoc voluntary arrangements and case-by-case negotiations over technology transfer and contributions in cash or in kind. They were also opposed to any restrictions on patent claims over biological materials or parts thereof received through WHO's GISN system, as well as patent claims over the products developed from the use of these biological materials. Their posture was summed up thus by an observer at the sessions of the IGM on Pandemic Influenza Preparedness: 'We need their virus, they need our vaccine, nobody needs this framework' (Hammond 2009).

Developing countries, on the other hand, insisted on formalising in an explicit and enforceable manner the reciprocal obligations of virus sharing and access to benefits. Their preferred instrument for achieving this was a formal Standard Material Transfer Agreement (SMTA), which would govern the terms of virus sharing as well as any intellectual property claims that may arise from this arrangement.

Building national capacities

In October 2006, WHO invited proposals from vaccine manufacturers in developing countries to establish domestic production capacity for (seasonal) influenza vaccines that could be converted to pandemic vaccine production if the need arose. By late 2008, six developing country manufacturers had received grants of US\$2.0–2.7 million each to establish pilot facilities for the production of influenza vaccines (WHO 2009a) and, as of February 2009, WHO was also processing proposals from five additional establishments.

These modest initiatives will in time augment the existing flu vaccine manufacturing capacity in developing countries. But the gulf between potential need and existing capacity remains daunting.

Since WHO's efforts at brokering new terms of agreement for virus sharing are still bogged down by disagreements over material transfer agreements and intellectual property claims, it may be wise to also consider regional initiatives that could be set in motion without undue delay, within an institutional framework with a functional track record.

Concluding remarks

In a 2003 report on migration and health, WHO acknowledged that:

investing in improving health in poor countries is not a question of altruism but of long-term self-interest. For example, it has been shown by mathematical modelling for hepatitis B that the resources needed to prevent one carrier in the United Kingdom could prevent 4,000 carriers in Bangladesh of whom, statistically, four might be expected to migrate to the UK. Thus, it would be four times more cost effective for the UK to sponsor a vaccination programme against hepatitis B in Bangladesh than to introduce its own universal vaccination programme. (Citing Gay and Edmunds 1998)

But how does hepatitis B rank as a national health priority within Bangladesh? Bangladesh has been categorised as an intermediate endemic zone for the hepatitis B virus (WHO 2002). In Bangladesh, diarrhoea (in synergy with under-nutrition) is the leading cause of death among children under five (excluding neonates) (WHO 2006), and it topped the list for hospital admissions (WHO/SEARO 1997).

Foreign assistance, therefore, can be skewed towards specific diseases and can be driven by the health priorities of affluent countries rather than those of the recipient countries. Is there a similar potential for donor-driven global surveillance initiatives to distort the national health priorities of aid recipients and possibly weaken national health systems via disease-specific funding mechanisms?

Calain (2007) concludes from his review of disease surveillance experiences in Uganda, India, Laos, and Cambodia that among the attributes of a successful surveillance system in developing countries are simplicity, community participation, ownership, feedback and timely interventions, and personal relationships with field surveillance agents. On the other hand, donor-driven, poorly coordinated, and redundant surveillance networks that siphon off scarce human resources from already fragile health systems can further fragment and distort the national health capacities of developing countries. In such circumstances, 'global surveillance strategies seem bound to benefit mainly the most industrially developed nations through the provision of early warning information or scientific data'.

There is clearly an asymmetry in the global system for pandemic influenza alert and response, which asserts a global *need* for surveillance, information exchanges, and virus sharing (essential 'global public goods' to be made

available via enforceable international regimes), but accepts a *demand-based* allocation of key elements of pandemic response (such as vaccines, antivirals, and protective equipment), with all the inequities that this entails.

In the absence of reciprocal benefits, the International Health Regulations (2005), for instance, which impose mandatory disease-reporting obligations on signatory member states, could reduce poorer front-line states to the role of pandemic ‘canaries’ in an early warning system for emergent flu pandemics (Chan and de Wildt 2008).

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B9 | MENTAL HEALTH AND INEQUALITY

Inequality has a significant impact on mental health. It can increase the likelihood of people becoming mentally ill, affect the quality of care they receive, worsen existing mental health conditions, and make recovery harder. Mental health is also related to many other factors, including food insecurity, inadequate housing, unemployment, occupational health, a lack of mental health services, and conflict. These social and economic factors also contribute to widening inequalities, and negatively affect the poorer and more marginalised sections of society to a greater degree.

Global Health Watch 2 (GHW2) described the relationship between poverty and mental health, the importance given to biomedical and individual care, and the relative neglect of action on the social and structural determinants of mental health. GHW2 also drew attention to situations of unequal power in which some forms of treatment and diagnosis take precedence over local and familiar methods of care that may be more effective.

This chapter concentrates on four aspects of mental health and inequality:

- how increasing inequalities are negatively influencing mental health;
- how the global economic system allows profits to be made from people's mental health problems;
- how attempts to influence mental health are used to try to extend power, including in situations of armed conflict;
- how effective responses can be taken to address these issues.

The World Health Organisation's (WHO) definition of mental health is both a reminder of this and of the need to concentrate on mental well-being rather than a list of problem conditions:

Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.¹

Mental health is strongly influenced by the ability to provide the basics of life for oneself and one's family. The 2010 *Human Development Report*² estimates that the basic needs of 1.75 billion people in 104 countries are not met. GHW2 had reported on the substantial increase in suicides among small-scale Indian farmers struggling to survive in a situation of unfair competition, rising prices, erratic weather, and heavy debt.

Inequality is related not only to widely different levels of material resources, but also to the importance attached to them (once basic survival needs are met) and to the degree to which society is hierarchical. The predominant global economic system is built on the need for constant growth and profit, and hence is dependent on a high value being put on material possessions. A stark example of this is the scramble to become a supplier in the luxury goods market in areas such as China, and the promotion of the exclusive individual who is needed to sell these goods.³ In a society such as China, which had previously prioritised community and family loyalty, this promotion of materialism also requires the active promotion of a society made up of separate individual consumers.

Inequality may exist within a region, within a nation, or among nations (at the international level). When individuals live together in a group with relatively equal incomes, it appears both that their mental health can be affected if that group has an unequal standing in the wider society, but also that there can be a protective ‘group density’ effect on mental and physical health. This has been shown in the case of members of minority communities living in an area that is home to a high proportion of their ethnic or racial group. These people have better mental and physical health than those who live in areas where there are fewer people of their own ethnic or racial group, even if they are materially better off.⁴

The causes of mental health are another and significant indication of the need to reduce regional, national, and international inequalities, and this will happen only through adjustments to the global economic model.

Increasing inequalities and their influence on mental health

Globally, inequality is increasing both within and between countries. The GDP ratio between the poorest and the richest countries has almost doubled over the last 40 years, and 59 per cent of the world’s population has been affected by an increase in income inequality.⁵

Globally, the burden of mental illness is huge. It has been estimated that depression will be the leading cause of the burden of disease in high-income countries in 2030, and the second and third cause in middle- and low-income countries respectively.⁶ At present, 14 per cent of the global burden of disease is caused by mental, neurological, and substance-use disorders, and almost three-quarters of this burden occurs in low- and middle-income countries.

Mental health is not only affected by inequalities, but inequalities are also deepened and exacerbated by mental disorders. Stress and depression, for example, can increase poverty by affecting the ability to work effectively. Aspects of poverty, such as poor nutrition, financial insecurity, low levels of education, and lack of access to medical care, can, in turn, increase mental health problems.⁷ A growing body of literature even blames stress, a major cause of mental health problems, on inequality.⁸

A strong correlation has been shown between mental illness and inequality in rich societies. In one study, the proportion of adults who had been mentally ill in the 12 months prior to being interviewed was less than one in ten in Germany, Italy, Japan, and Spain (all more equal countries); more than one in five in Australia, Canada, New Zealand, and the UK (increasingly unequal); and more than one in four in the United States (most unequal).⁹ There is also increasing evidence that those affected are distributed across the income scale, and are not just clustered at the poorer end.¹⁰

Inequalities, wealth, profit, and mental health

Inequalities and legislation Legislative inequalities related to mental health can occur at the local and national levels in criminal justice systems, in interpretations of legal frameworks based on prejudice and stigma, and in mental health legislation that is lacking or that does not reflect the rights and needs of those with mental health problems. At the international level, legislation on a wide range of issues, including international trade, can result in inequalities that have an impact on mental health.

Alcohol and drug-use disorders are two of the categories in the WHO's mental health GAP Intervention Guide 2010, reflecting the huge influence that these disorders have on mental health. In 2007, it was estimated that 4.4 per cent of the global burden of disease was related to alcohol consumption.¹¹

Despite this, attempts to legislate against trade in substances known to be damaging to mental health have been thwarted in the name of fair trade. Until 2007, Chile taxed alcohol according to alcohol content, with a higher tax for higher alcohol content. However, because imported alcoholic drinks from the European Union had a higher alcohol content than drinks produced locally, this was successfully challenged at a World Trade Organization tribunal under the national treatment principle (local goods cannot be favoured).¹²

Mental health problems have also been recognised as an associated problem for many injection drug users.¹³ Young people who inject drugs are particularly at risk of being poor. Up to 30 per cent of homeless young people in San Francisco used injection drugs in 2000.¹⁴ In many countries, injection drug users are a marginalised population because the drug abuse that dominates their lives is illegal and punishable. Because of this, they are unable to access psychological services to deal with their mental health problems, prompting further drug abuse.

Injection drug use can also affect mental health because of high rates of co-morbidity with diseases such as HIV, hepatitis C, and hepatitis B. HIV has been shown to be related to greater instances of depression, suicide, and other mental health problems in Africa.¹⁵ All of these conditions are inter-related: mental health problems are a risk factor for HIV and injection drug use; injection drug use is a risk factor for HIV and mental health problems; and HIV is a risk factor for mental health problems.

Legislation as it affects individuals can also be highly unequal. Taking high-quality cocaine as a successful stockbroker in New York City is very different from stealing to fund one's habit as an unemployed youth in downtown Washington DC. And the care and treatment available to such individuals will also be very different. The stockbroker will be able to afford the purer powdered cocaine, while the unemployed youth is far more likely to be taking crack cocaine. However, the law in the United States is much stricter in relation to crack cocaine, which carries heavier sentences for possession of the same quantity. In March 2010, this disparity was reduced, but even after this change, a user of the more expensive purer cocaine can receive the same sentence as a crack cocaine user, despite being in possession of 18 times the quantity.¹⁶

Inequalities and global employment Financial insecurity, related to lower income, can promote feelings of hopelessness and shame, which increases stress.¹⁷ In Tanzania, a study found that food insecurity and changes in food insecurity across seasons were strong predictors of symptoms of anxiety and depression.¹⁸ In Ethiopia, it was found that stressful life events in addition to food insecurity increased susceptibility to mental disorders.¹⁹

Global inequalities drive people to leave their homes in search of employment. Estimates of financial benefit for their countries of origin ignore the human cost, including to mental health, of leaving home and family and living in an unfamiliar and often uncertain and hostile environment. There has been a steady increase in international migration over the last ten years, involving over 200 million people.²⁰ The circumstances that compel an individual to incur a debt of \$2,000 at an interest rate of 10 per cent a month,²¹ to leave his or her country to work at a job that pays a minimum wage of \$43 a month (Bangladesh), to try to earn money for his or her family in a country where the minimum wage is \$64 a day (UK), are clearly linked to international inequalities. The stress that can be caused by separation, difficult living conditions, dangerous working conditions, and a strange and unwelcoming environment is potentially damaging to mental health, even though those who migrate may be the fitter members of their communities.

Poor mental health outcomes are associated with precarious employment, such as non-fixed-term temporary contracts, employment with no contract, and part-time work.^{22, 23} Work insecurity can have significant adverse effects on the physical and mental health of workers.²⁴

Inequalities in care Global inequalities in mental health services are huge. Traditional healers have been, and continue to be, the mainstay of mental health care in many low-income countries, but very few of those with mental health problems have access to institutional mental health services. A recent WHO report estimated that 75–85 per cent of people with mental health

problems in developing countries do not receive institutional mental health treatment.²⁵ Almost a third of countries have no specific budget for mental health services and another 20 per cent spend less than 1 per cent of their total health budget on mental health services.

In richer countries, services may also be far from adequate and can discriminate against those with fewer resources. In the United States, it has been estimated that there are unmet health needs owing to a shortage of mental health professionals in 96 per cent of counties.²⁶

Pharmaceutical companies: targeting the poor

Pharmaceutical companies have played a key role in the medicalisation of mental health problems in poorer countries, helping to foster a disregard for the economic and social causes of mental health disorders, and placing an emphasis on the individual rather than the community. Even in countries where the number of health professionals may be totally inadequate, there is often an excess of psychotropic drugs. In Pakistan, for example, these are readily available over the counter in a rapidly expanding market.²⁷ In India, people living in marginalised communities influenced by poverty and inequality have been targeted by promotions by drug companies that promise to make them feel ‘happy’, ‘normal’, and ‘like yourself again’.²⁸

By focusing on the medical model of conditions such as depression, pharmaceutical companies offer a treatment that can mask the social and economic inequalities that underpin so many mental health problems. The medicalisation of normal responses to enormous life stresses also avoids asking questions related to the social order and to the effects of global economic processes on individual lives. People are encouraged to buy psychotropic drugs and are assured that they have a problem that is treatable through medication, but the companies that supply the drugs are major operators within the global economic system driving the inequalities that are a root cause of their problems in the first place.

Mental health, inequality, and the conduct of conflict

Disturbing the mental equilibrium or harming the mental health of one’s enemy has always been a part of war. Intimidating the enemy with a show of superior force, and maintaining a constant threat of a surprise attack, are just some of the stress-inducing tactics that have been used for centuries. However, there is a boundary that is crossed when actions are specifically designed to traumatise civilians, to undermine a society’s culture, or to attack what lies at the core of an individual’s self-respect. International humanitarian law defines this boundary under several conventions, including the Hague Convention and its Second Protocol for the Protection of Cultural Property in the Event of Armed Conflict, and the United Nations’ ‘Torture Convention’. The latter defines torture as ‘severe pain or suffering, whether physical or mental’; it

also covers ‘Other Cruel, Inhuman or Degrading Treatment’; as of October 2010, it had been ratified by 147 countries.

Psychological trauma as a weapon The US invasion of Iraq in 2003 included a ‘shock and awe’ operation directed at Baghdad, which involved approximately 1,700 air sorties and the use of 504 cruise missiles.²⁹ Later, Lieutenant Colonel Steve Boylan, the spokesman for the US military in Baghdad, stated that since the start of the campaign they had done ‘everything we can to avoid civilian casualties in all of our operations’.³⁰ The sincerity of this statement has to be questioned after a campaign that was clearly intended to create a huge amount of stress and psychological trauma for the entire population.

Blocking permission to access health care is also a way of creating mental stress and exhibiting superior power in a highly unequal situation. Those who deny passage out of Gaza to those who seek medical care, including for eye treatment to prevent blindness,³¹ must be well aware of the trauma they are causing in addition to the worsening of the physical complaint. As one person trying to cross the Rafah crossing said:

It’s as though they take pleasure as we languish in the uncertainty. The perpetual never-knowing. As though they intend for us to sit and think and drive ourselves crazy with thought. I call an Israeli military spokesperson, then the Ministry of Defence, who direct me back to the spokesperson’s office, and they to another two offices; I learn nothing. As an Israeli friend put it, ‘Uncertainty is used as part of the almost endless repertoire of occupation.’³²

‘New’ wartime strategies in other parts of the world can also have enormous psychological effects. Child soldiers in Uganda are often found to suffer from severe post-traumatic stress and personality disorders.³³ In the Democratic Republic of Congo, rape is used as a weapon to terrorise and dominate.³⁴ The effects of these ‘weapons’ will live on in the form of mental health problems in these communities long after the fighting ends.

Effective responses

Effective responses to mental health problems need to take place at individual, local, national, and international levels, and involve all members of society as well as health professionals. Good policies and effective legislation need to be complemented by programmes aimed at reducing stigma and isolation. The root causes of many mental health disorders lie in inequality, the market economy, and conflict, and need to be addressed at all levels.

Raising awareness of the social and economic causes of mental health problems is essential and can have many benefits. In addition to drawing attention to the need to address the social and economic determinants of mental health, including inequality, it can also assist individuals who suffer from mental health problems in realising that some of their problems are

rooted in issues over which they have very little control. Without this awareness, there is a tendency for people to assume individual responsibility for their ill-health, and if they see it as their own fault, there is a danger that this will worsen their condition.³⁵

There are positive new measurements of human development that now incorporate indicators of inequality. The 2010 *Human Development Report* includes three new measures, including a Human Better Development Index and a new measure of gender inequality. The measurement of the adverse effects of inequality will be a driver for action on many of the social and economic determinants that also have implications for mental health. The recent WHO Mental Health GAP Intervention Guide is a very practical guide on how to deal with a range of mental health problems, providing a ‘full range of recommendations to facilitate high quality care at first- and second-level facilities by the non-specialist health-care providers in resource-poor settings’.

According to a recent study in the UK:

Services from voluntary and community organisations were particularly valued for the provision of opportunities for socialising, befriending and participation in activities such as outings, lunch clubs, exercise and discussion groups.³⁶

However, the responsibility for this type of care cannot be simply left to the voluntary sector. It needs to be incorporated as a standard part of national care programmes in partnership with community organisations. In the UK, at the end of 2010, there is a danger that the state will use community involvement and the benefits of a ‘big society’³⁷ as a smokescreen to cut back on welfare budgets.

Addressing only psychological issues through pharmaceutical intervention will not address the underlying causes, such as inequality. A study in Brazil looked at the problem of ‘*nervoso*’, a mental health condition that was treated by a variety of pharmaceutical regimens. The study found that the underlying problems behind ‘*nervoso*’ were actually chronic hunger, caused by wide inequalities and poverty in the community.³⁸

Community-level action and the integration of mental health treatment into non-specialist health care are key steps for ensuring better mental health for individuals globally. However, these measures have to be complemented by actions that address global inequalities in economic and military power if increasing mental health needs are to be met.

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SECTION C

BEYOND HEALTH CARE

C1 | THE GLOBAL FOOD CRISIS

The global financial crisis drew international attention away from the food crisis, but the latter continues to fester, and even grow. When the global food crisis first hit headlines around the world in 2008, international bureaucrats referred to the current problems in the world food situation as ‘a silent tsunami’. But the truth is that it was not a sudden or unexpected crisis; the signs had been around for some time, and it could easily have been seen to be coming. Even so, its impact has been powerful and devastating, as food shortages and high food prices have adversely affected billions of people, especially the poor in the developing world.

It is also a man-made crisis, resulting not so much from inescapable forces of global supply and demand as from the market-oriented and liberalising policies adopted by choice or compulsion in almost all countries. These policies have either neglected agriculture or allowed shifts in global prices to determine both cropping patterns and the viability of farming, and also generated greater possibilities of speculative activity in food items. Cultivators in developing countries have been ravaged by the fearsome combination of exposure to import competition from highly subsidised agriculture in developed countries, removal of domestic protection of inputs, and reduced access to institutional credit, to the point that even the global increase in agricultural prices after 2002 did not compensate sufficiently to alleviate the pervasive agrarian crisis in much of the developing world.

It is also clear that the global food crisis is not something that can be treated as discrete and separate from the global financial crisis. On the contrary, it is intimately connected with it, particularly through the impact of financial speculation on world trade prices of food.

This is not to deny the undoubted role of other real economy factors that affect the global food situation. While demand–supply imbalances have been touted as reasons, this is largely unjustified given that there has been hardly any change in the world demand for food in the past three years. In particular, the claim that food grain prices have soared because of more demand from China and India as their GDP increases is *completely invalid*, since both aggregate and per capita consumption of grain have actually fallen in both countries (Nuo and Jiao 2008). Supply factors have been – and are likely to continue to be – more significant. These include the short-run effects of the diversion of both acreage and food crop output for biofuel production, as well as more medium-term factors that have affected harvests in different ways,



20 Contrary to claims the food crisis was not brought about by increased demand in India and China (Indranil Mukherjee)

such as rising costs of inputs, falling productivity because of soil depletion, inadequate public investment in agricultural research and extension, and the impact of climate changes.

Impact of biofuels

Two policy factors affecting global food supply deserve a special note. The first is the biofuel factor: the impact of both oil prices and government policies in the United States, Europe, Brazil, and elsewhere that has promoted biofuels as an alternative to petroleum. This has led to significant shifts in acreage to the cultivation of crops that can produce biofuels and to the diversion of such output to fuel production. For example, in 2007 the United States diverted more than 30 per cent of its maize production, Brazil used half of its sugar cane production, and the European Union (EU) used the greater part of its vegetable oil seed production, as well as imported vegetable oils, to make biofuels (Polya 2008). In addition to diverting corn output to non-food use, this has also reduced acreage for other crops and has naturally reduced the land available for producing food.

The irony is that biofuels do not even fulfil the promise of ensuring energy security or retarding the pace of global warming. Ethanol production is extremely energy-intensive, so it does not really lead to any energy saving. Even in the most 'efficient' producer of ethanol, Brazil, where sugar cane rather than corn is used to produce ethanol, it has been argued that the push for such production has led to the large-scale deforestation of the Amazon, thereby further intensifying the problems of global warming. Indeed, recent scientific research suggests that the diversion of land to the cultivation of biofuel crops can produce an enormous 'CO₂ debt' arising from the use of machinery and fertilisers, the release of carbon from the soil, and the loss of CO₂ sequestration

by trees and other plants that have been cleared for cultivation (Beddington 2008). Yet, as long as government subsidies remain in the United States and elsewhere, and world oil prices remain high, biofuel production is likely to continue to be encouraged despite the evident problems. And it will continue to have negative effects on global food production and availability.

Neglect of agriculture

The second factor is the policy neglect of agriculture over the past two decades, the impact of which is finally being felt. The prolonged agrarian crisis in many parts of the developing world has been largely a policy-determined crisis. Inappropriate policies have several aspects, but they all result from the basic neoliberal open-market-oriented framework that has governed economic policy-making in most countries over the last two decades. One major element has been the lack of public investment in agriculture and in agricultural research. This has been associated with low to poor yield increases, especially in tropical agriculture, and falling productivity of land. Greater trade openness and market orientation of farmers have led to shifts in acreage from traditional food crops that were typically better suited to ecological conditions and the knowledge and resources of farmers, to cash crops that have increasingly relied on purchased inputs.

At the same time, both public provision of different inputs for cultivation and government regulation of private input provision have been progressively reduced, leaving farmers at the mercy of large seed and fertiliser companies and input dealers. As a result, prices for seeds, fertilisers, and pesticides have increased quite sharply. There have also been attempts in most developing countries to reduce subsidies to farmers in the form of lower power and water prices, thus adding to cultivation costs. Costs of cultivation have been further



21 Biofuels have taken over agricultural land (Indranil Mukherjee)



22 Ethanol bio fuel Refinery (© Ryan Stevenson | Dreamstime.com)

increased in most developing countries by the growing difficulties faced by farmers in accessing institutional credit, because financial liberalisation has moved away from policies of directed credit and provided other, more profitable (if less productive) opportunities for financial investment. So many farmers are forced to opt for much more expensive informal credit networks, which have added to their costs.

Climate change and food production

In addition, there is the impact of recent climate change, which has caused poor harvests in different ways, ranging from droughts in Canada and Australia to excessive rain in parts of the United States. Scientists are projecting that warmer and earlier growing seasons will increase crop susceptibility to pests and viruses, which are expected to proliferate as a direct result of rising temperatures. Some more arid regions are already more drought prone and in danger of desertification. The rapid melting of glaciers in Asia is of huge consequence to China and India, where important rivers such as the Yangtze, the Yellow, and the Ganga are fed by such glaciers. This will deprive the hinterland of much-needed irrigation water for wheat and rice crops during dry seasons. This is of global significance since China and India together produce more than half the world's wheat and rice. Once again, official policy has been tardy and negligent in considering such problems, let alone addressing them.

The lack of attention to relevant agricultural research and extension by public bodies has denied farmers access to necessary knowledge. It has also

been associated with other problems, such as the excessive use of groundwater in cultivation; inadequate attention to preserving or regenerating land and soil quality; and the overuse of chemical inputs that have long-run implications for both safety and productivity. Similarly, the ecological implications of both pollution and climate change, including desertification and loss of cultivable land, are issues that have been highlighted by analysts, but largely ignored by policy-makers in most countries (Lang 2010). Reversing these processes is possible, and of course essential. But it will take time, and also will require not only substantial public investment but also major changes in the orientation and understanding of policy-makers.

Another important element in determining food prices is oil prices. Since oil (or fuel) enters directly and indirectly into the production of inputs for cultivation as well as irrigation and transport costs, its price tends to have a strong correlation with food prices. So curbing volatility in oil prices would also help stabilise food prices to some extent.

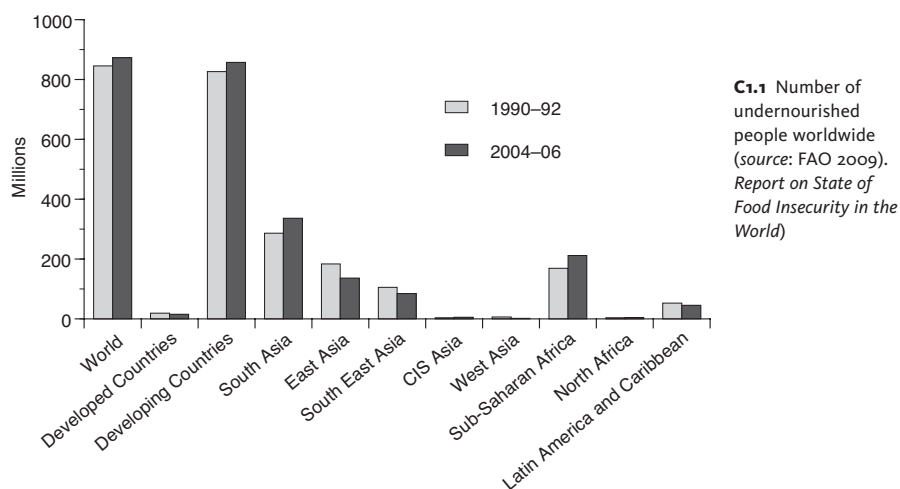
Increase in 'hungry' people

All this has meant that the number of hungry people has actually increased in the world as a whole, and particularly in certain developing regions. Far from halving, or even decreasing, the figure for the number of malnourished people globally increased by more than 50 million between the early 1990s and the mid 2000s.

This was entirely because of increasing hunger in the developing world,



23 Paddy field in Hechuan, China (David Legge)

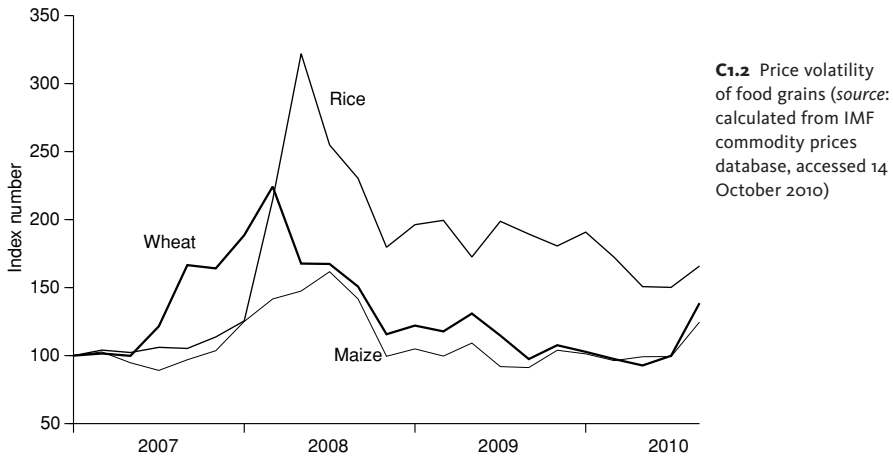


as the numbers declined in the developed countries. East and Southeast Asia also performed well in terms of falling numbers of malnourished people, but such numbers increased quite sharply in South Asia (by 50 million) and in sub-Saharan Africa (by 44 million). The surprise is that the growing prevalence of hunger and food insecurity was associated with relatively high GDP growth in several regions, such as India and countries in Latin America. The contrast with East and Southeast Asia is a stark one, and points to the role of public policy in ensuring that aggregate income growth translates into better provision of basic needs, such as food for the general population.

Speculation drives up food prices

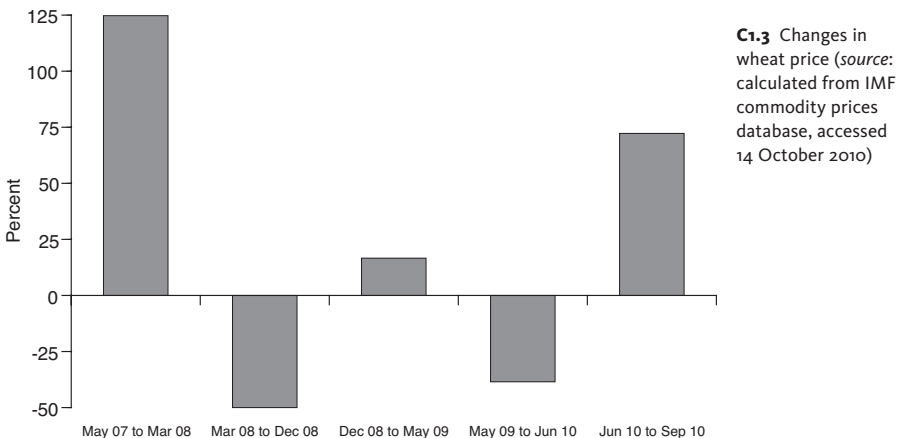
While this was the state before the global economic crisis, the crisis obviously made matters much worse. The intensity of the food crisis that hit many developing countries from 2008 onwards was particularly on account of the very pronounced global volatility in food prices. Globally, the prices of many basic food commodities had not risen faster for more than three decades. Indeed, even in recent years, food prices internationally had shown only a modest increase until early 2007. But thereafter they soared.

Chart C1.2 indicates the extent of price changes in the three most important food grain crops: wheat, rice, and maize. The extent of price variation in such a short time already suggests that such movements could not have been created by the forces of supply and demand, especially as in world trade the effects of seasonality in a particular region are countered by supplies from other regions. In any case, FAO data show very clearly that there was scarcely any change in global supply and utilisation over this period, and that if anything, output changes were more than sufficient to meet changes in utilisation in the period of rising prices, while supply did not greatly outstrip demand in the period of falling prices (see FAO 2009, 2010 and Ghosh 2010).



The extent of the volatility is even more apparent when we look at the changes in the price of any one particular commodity. Chart C1.3 shows how wheat prices have changed in the past three years. It should be noted that after all these very rapid and extreme changes, global wheat prices are now around 40 per cent higher than they were in January 2007. This is related to the very rapid increase in wheat prices in the very recent past, which is significant because it serves as a warning that the possibility of another price spike in important food items still looms large.

It is now quite widely acknowledged that financial speculation was the major factor behind the sharp price rise of many primary commodities, including agricultural items over the past year (UNCTAD 2009; IATP 2008, 2009; Wahl 2009; Robles et al. 2009; UN Special Rapporteur on Food 2010). Even recent research from the World Bank (Baffes and Tassos 2010) recognises the role played by the ‘financialisation of commodities’ in the price surges and



declines, and notes that price variability has overwhelmed price trends for important commodities.

Of course, there continue to be other opinions, according to which these price changes reflected real if temporary changes in demand and supply, such as sudden supply shocks in particular areas, as well as the associated impact on panic buying, or bans on selling, such as export bans in the world trade market. It is then argued that financial activities in the commodity futures markets have had relatively little impact on price volatility, and if anything have operated to stabilise prices rather than destabilise them (for example, OECD 2010).

But this argument dissolved completely in the face of subsequent trends in prices, as shown in Charts C1.2 and C1.3. Clearly, such price variation in relatively short periods of time cannot be explained even by panic buying and selling of commodities, and indeed there is no evidence that actual volumes of commodity transactions mirrored these price movements.

Financial deregulation as a fillip to speculation

So what happened exactly? Global commodity prices have always been volatile to some degree and prone to ‘boom–bust’ cycles, which is one of the many reasons why developing countries have been encouraged to diversify away from dependence on such exports. The 1980s, saw the emergence of commodity futures markets (see Box C1). It was claimed that they allowed for better risk management because producers, consumers, and intermediaries can hedge (i.e. protect against risk) against price fluctuations.

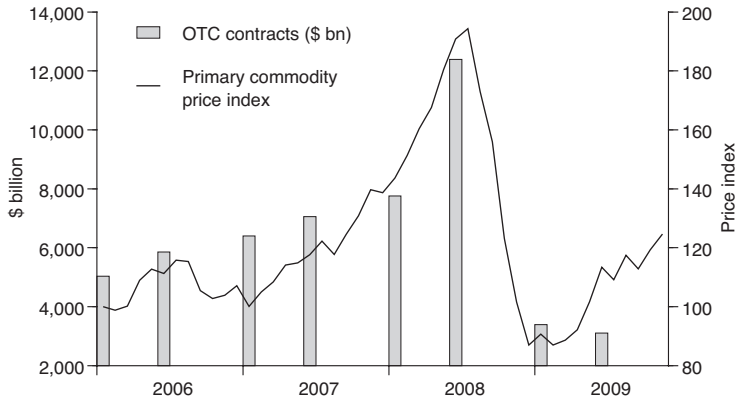
Financial deregulation in the early part of the current millennium gave a major boost to the entry of new financial players into the market for trading of commodities (including food). In the United States, which has the greatest volume of futures commodity trading, a significant regulatory transformation occurred in 2000. While commodity futures contracts had existed before, they

Box C1 What is a futures market?

Futures markets are based on futures contracts, standardised contracts between two parties to buy or sell a specified asset (e.g. oranges, oil, gold) of standardised quantity and quality at a specified future date at a price agreed today (the *futures price* or the *strike price*). The contracts are traded on a futures exchange. The party agreeing to buy the underlying asset in the future assumes a long position, and the party agreeing to sell the asset in the future assumes a short position.

Source: en.wikipedia.org/wiki/Futures_contract

C1.4 Primary commodity prices and OTC futures contracts (source: IMF commodity price statistics and BIS Quarterly Review, June 2010)



were traded only on regulated exchanges under the control of the Commodity Futures Trading Commission (CFTC), which required traders to disclose their holdings of each commodity and stick to specified limits, so as to prevent market manipulation. Therefore, they were dominated by commercial players who were using them for the reasons mentioned above (i.e for hedging against risks), rather than for mainly speculative purposes. In 2000, the Commodity Futures Modernization Act effectively deregulated commodity trading in the United States by exempting over-the-counter (OTC) commodity trading (outside of regulated exchanges) from CFTC oversight. Soon after this, several unregulated commodity exchanges opened. These allowed any and all investors to trade commodity futures contracts without any limits, disclosure requirements, or regulatory oversight. The value of such unregulated trading zoomed, reaching around \$9 trillion at the end of 2007, which was estimated to be more than twice the value of the commodity contracts on the regulated exchanges. According to the Bank for International Settlements, the value of such unregulated trading (other than for gold and precious metals) increased from \$5.85 trillion in June 2006 to \$7.05 trillion in June 2007 and to as much as \$12.39 trillion in June 2008 (BIS 2009).

Unlike genuine producers and consumers who use such markets for hedging purposes, financial firms and other speculators increasingly entered the market in order to profit from short-term changes in price. At the height of the boom, it was estimated by the hedge fund manager Michael Masters in testimony before the US Congress that even on the regulated exchanges in the United States, such investors owned approximately 35 per cent of all corn futures contracts, 42 per cent of all soybean contracts, and 64 per cent of all wheat contracts in April 2008. This excluded all the (unregulated) ownership through OTC contracts, which were bound to be even larger.

As the global financial system buckled under the pressure of the continuing implosion of the US housing finance market, large investors searched for other avenues of investment to find new sources of profit. Speculation in commodity

trading increasingly emerged as an important area for such financial investment. The United States became a major arena for such speculation, not only because of the size of its own crisis-ridden credit system, but also because of the deregulation mentioned above, which made it possible for more players to enter into commodity trading.

This created a peculiar trajectory in international commodity markets. The declared purpose of futures markets is to allow for hedging against price fluctuations. This implies that futures prices would be lower than spot (current) prices. However, throughout much of the period from January 2007 to June 2008, futures prices were higher than spot prices. This cannot reflect the hedging function and must imply the involvement of speculators who are expecting to profit from rising prices.

Then, by around June 2008, when the losses in the US housing and other markets became immense, it became necessary for many speculators to exit with the profits that they could make (book their profits). UNCTAD (2009: 25) notes the sharp decline of financial investment in commodity markets from mid 2008. This caused futures market prices to fall, and this trend was transmitted to spot prices as well.

Thus, international commodity markets, far from protecting against risks, become very effective in determining and manipulating market behaviour. The result was the excessive price volatility that has been displayed by important commodities over the recent past, not only the food grains and crops mentioned here, but also minerals and oil.

Effect on consumers and cultivators

Such volatility has had very adverse effects on both cultivators and consumers of food. It is often argued that rising food prices at least benefit farmers, but this is often not the case, as marketing intermediaries tend to grab the benefits. In any case, with price changes of such short duration, cultivators are unlikely to gain. One major reason is that they send out confusing, misleading, and often completely wrong price signals to farmers that cause over-sowing in some phases and under-cultivation in others. Many farmers in the developing world have found that the financial viability of cultivation has actually decreased in this period, because input prices have risen and output prices have been so volatile that the benefit has not accrued to direct producers.

In addition, this price volatility has meant bad news for most consumers, especially in developing countries. In developing countries in the phase of rising prices, domestic food prices tended to rise as global prices increased, even if not to the same extent. However, the reverse tendency has not been evident in the subsequent phase as global trade prices have fallen. In June 2010, the FAO estimated that around 20 countries faced food emergencies and another 25 or so were likely to have moderate to severe food crises. Even in countries that are not described as facing food emergencies, the problem



24 Activists demanding equitable access to food: US Social Forum, Atlanta, 2007 (David Legge)

is severe for large parts of the population. For example, in India, retail prices of some important food items have risen by more than 50 per cent in the past two years, causing great hardship in a country in which just under half the population is malnourished (Kala Anant 2011).

So the only gainers from this process are the financial intermediaries who were able to profit from rapidly changing prices.

This can easily happen again unless strict regulation prevents such financial activity. Despite reasonably good harvests in most countries and with no likelihood of any serious supply shortfall at the global level, prices have again started rising.

After a period of slight decline, the numbers of futures contracts in the regulated commodity markets (exchanges) have been increasing in the recent past. Clearly, the factors that created the recent food price spiral are still in place.

Need for regulations to curb volatile food prices

Obviously, the need to pass careful regulation controlling such speculative behaviour, and then to ensure that such legislation is effectively implemented, is absolutely crucial if the crazy price volatility in important food items is to be curbed. But the groundswell of public opinion that can force such changes has not yet been formed.

The recently passed Dodd-Frank Financial Reform Bill¹ in the United States

does contain some necessary regulations, bringing all futures contracts into regulated exchanges and requiring some limits for investors (based on proof of actual interest in the commodity). An important proposal in this legislation seeks to plug, at least partially, the loopholes that allowed such frenzied activity in commodity futures markets. It requires that previously unregulated OTC trades be traded on public exchanges. It has been estimated that around 90 per cent of this market in the United States would move from OTC trading to the more transparent exchange trading environment. In addition, the legislation specifies that limits must be imposed on traders in agricultural and energy-related commodities. This should reduce the importance of purely financial players.

However, while financial regulation in the United States is important, it will not be enough. Currently, only 30 per cent of commodity futures contracts are traded in the United States. European exchanges account for the bulk of the rest, followed by Tokyo and Singapore to a much lesser extent. Therefore, appropriate legislation in the EU is essential. Without it, the danger is that the speculative activity that has so disturbed essential commodity prices will simply move to other financial centres. Unfortunately, the proposed legislation that is currently on the table in the EU has some important weaknesses.

Of course, this does not in any way mean that the world food crisis is over, or that commodity prices will not continue to behave in a volatile fashion without other measures being adopted by governments. At best, it may simply mean that developing countries will get some breathing space from excessive price volatility, which should help them to get the relevant policies in place to tackle the real problems in the food economy and elsewhere. The need to put such measures into place, to revive the food economy in countries, and to ensure adequate and universal distribution of essential food items, is more pressing than ever. It is clear that the resolution of the food crisis requires strong governmental interventions to protect agriculture in developing countries, to provide more public support for sustainable and more productive and viable cultivation patterns, and to create and administer better domestic food distribution systems. It also requires international arrangements and cooperative interventions, such as strategic grain reserves, commodity boards, and other measures, to stabilise world trade prices. It has also been persuasively argued (Raffer 2008) that international lending institutions should provide automatic and non-conditional compensatory financing to food-importing developing countries that are adversely affected by such dramatic volatility in global food grain prices.

Note

¹ banking.senate.gov/public/_files/070110_Dodd_Frank_Wall_Street_Reform_comprehensive_summary_Final.pdf.

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C2 | HEALTH INFORMATION, CONFLICT, AND THE RIGHT TO HEALTH

Accurate and reliable health data and information are essential in conflict situations. Without information of a reasonable quality, it is impossible to plan the best or most appropriate response to increased needs, including communicable disease outbreaks and physical and mental trauma, and to evaluate the quality of health care and other assistance that is being provided. Health information can also be used to monitor the effects of certain weapons and the conduct of parties to the conflict. Aggregated data and information can provide an overall regional, national, or international picture, provide evidence of global trends, and be used for comparing different programmes and interventions.

For the people engaged in data collection and analysis, and for the families and communities of the dead, the recording of necessary data is crucial. For the sick and the injured, their diagnosis, treatment, follow-up, and eventual recovery is dependent on it. It can also be crucial when seeking justice or reparation for people who have been ‘wrongly’ attacked, shot, shelled, poisoned, or bombed. For the relatives and the communities of the dead, it is vital for achieving healing, reconciliation, and justice. It is also essential for providing evidence of the longer-term public health effects of conflict, because this proof can contribute to efforts aimed at mitigating the effects of future conflicts and to conflict prevention.

Global Health Watch 2 emphasised the importance of all actors recognising the right to health, including in conflict situations when increased needs due to physical and mental trauma, overcrowding, and a breakdown of infrastructure and services are common. It is a well-established part of international humanitarian law that all civilians in conflict situations have a right to access health care and the essentials of life that are necessary for health. Combatants, as soon as they are wounded or captured, and are ‘out of the conflict’, have the same rights, including the right to medical treatment.¹

This chapter considers access to health information and data from the point of view of the rights of those affected by conflict. Part of their right to health is their right to information and data on how they have suffered owing to conflict. The collection, analysis, and dissemination of this information and data need to be adequate and impartial.

Far too often, this is not the case. This chapter concentrates on four reasons why:

- Those who collect information and data are intimidated
- Health information and data are distorted or reported inaccurately for fulfilling political or military agendas
- Inconvenient health data and information are dismissed by making unrealistic demands for quality, including the lack of proof of a causal link
- A selective and inequitable use of the precautionary principle.

Data during conflict: collection and use

Collecting health information in conflict situations or conflict areas presents particular challenges. It is frequently difficult to estimate the total population owing to population movements, insecurity, and out-of-date census data. Many of those affected may not be able to reach a health facility, and people may decide not to risk travelling in insecure situations unless it is for a dire emergency. Information may be collected intermittently because health services may have to be closed or suspended.

Various methodologies that take these challenges into account have been developed for collecting information in conflict zones. Some of the commonly used methods are rapid assessment techniques, surveys, and surveillance. These also take into account factors such as limited access due to reduced working time (curfew and insecurity) and factor in security considerations for both those conducting the survey and those from whom information is being sought (the respondents).⁶ There is ongoing research into the development of these methodologies, with estimations of mortality receiving particular attention.⁷

An often undervalued source of information is the national health information system, which may be disrupted, but which in some cases can provide a geographical breadth of data that other instruments cannot. In periods of less intense conflict, other tools can be employed, ranging from community assessments to random cluster sample surveys. Sometimes the best that can be achieved is an estimation derived by triangulating all sources of information in a specific situation.

Health information, including information on mortality, morbidity, and disability, increasingly plays a significant role in estimating the damage caused by conflict and in assessing how a conflict has been conducted. This information carries the potential to contribute to future conflict resolution and can potentially provide evidence as to whether parties to a conflict have conformed to, or complied with, international humanitarian law. When these data are aggregated to gain a broader understanding of the larger picture, it should drive learning and should ensure that mistakes and injustices are not repeated. This is essential for ensuring that the right to health is respected, and without it claims that the right to health has been ignored can be more easily dismissed.

The challenges of collecting health information during conflict also make it easier to contest its accuracy. The information may be questioned to support

Box C2 Death and injury in conflict: who, when, and where

A woman is hit in the chest by shrapnel from an exploding shell in Mullaitivu, in northwest Sri Lanka. She thought she was safe as the area had been declared a no-fire zone. Her injury is recorded along with other deaths and injuries by a doctor working in a makeshift hospital. Her details are included in the total number of injured for that day. She is later evacuated by ship from the conflict area. Her name, address, age, sex, and receiving ward at destination are recorded. The receiving ward registers all the standard information on her for a hospital outside the conflict zone.

At this point, all official information about her as a victim of the shelling ceases. The doctors who recorded her initial injuries in the no-fire zone are arrested when the area is overrun and later appear at a press conference organised by the government, where they deny knowledge of the incident.

Source: Constructed from various sources and personal communications

A woman is kidnapped while returning from a trip carrying out development work in Afghanistan. She is killed during an attempt by the US military to rescue her. There is worldwide news coverage of the kidnapping and the subsequent rescue attempt, and then an investigation is launched to find out how she died. When it is revealed that she died from an exploding grenade thrown by a member of the team sent to rescue her, a 10-man joint US–UK investigation team is sent to Afghanistan for two and a half weeks. They conduct interviews and assess ‘hours of video evidence and hundreds of pages of documentary evidence’.² As a result, members of the rescue team are disciplined for ‘failing to provide a complete and full account of their actions in accordance with US military procedure’.³ This is following initial reports that the woman was killed as the result of the explosion of a suicide vest worn by one of her captors.

In November 2009, residents of Korkhashien village drove dead bodies, including the bodies of two children, in a convoy of vans and station wagons to the governor’s office in the provincial capital, Lashkar Gah. The residents claimed that a NATO rocket attack had killed nine people, including the children. They wanted the governor to see the bodies as evidence of this claim. NATO said the rocket was fired because they believed people were planting a bomb.⁴

A week later, a letter from the Permanent Joint Headquarters in the UK said that one of the reasons it was difficult for NATO to estimate civilian casualties was because of the local custom of burying the dead within 24 hours.⁵

political and military agendas regardless of the efforts made to produce the best available estimation in a conflict situation.

The difficulties of collecting accurate data in conflict should not be underestimated. However, the ‘best possible’ data and information are essential, and infinitely better than the chaos caused by having no information at all.

Shooting the messenger

Health information can be disputed because of the perceived partiality of those who have collected or analysed it, and claims can be made that figures are exaggerated or downplayed. Those whose responsibility it is to collect the information may come under pressure not to disseminate it, or may not have been able to collect it in the first place. This can complicate the work of health workers and potentially put them – and in some cases their patients – at risk.

As the conflict between the Sri Lankan government and the Liberation Tigers of Tamil Eelam (LTTE) reached its final stages in early 2009, five Sri Lankan doctors stayed in the ever-shrinking ‘safe zone’ to care for the sick and the wounded. Other actors such as NGOs and the media had been informed that it was not safe for them to stay in the area, so the doctors were the sole source of mortality and morbidity information, which they transmitted using their mobile phones and which they collected as part of their duty of care. When the conflict zone was finally overrun, they were arrested and held in detention on the charge of ‘spreading false information’.⁸ Some months later, they appeared at a government-organised press conference and stated that they had exaggerated the figures.⁹

This case illustrates clearly the dangers faced by health workers in the line of duty. This was information they needed to collect as a regular part of their work, so that those outside the area could understand the health needs of the people caught in the conflict and could respond effectively. Information about the dead and the wounded – particularly those from a ‘safe zone’ – also raised questions about how the conflict was being conducted and whether international humanitarian law was being respected. As all other actors who could have reported this information, including the media and NGOs, had been told that the area was too unsafe for them to be in, there were no other sources to corroborate the information. This left the doctors particularly vulnerable.

Manipulating data for military or political purposes

Health information that emerges from different conflict situations is disseminated, examined, and followed up to varying levels. During the interval, often far too brief, when media attention is focused on an incident, those who have access to the media may use the opportunity to present information in a way that matches their military and political interests. This may involve presenting themselves in a positive light in relation to international



25 Tamil protestors in Geneva demonstrating against military operations in Sri Lanka, February 2009 (© Shuttlecock | Dreams-time.com)

humanitarian law, even when this is at the expense of those who are actually affected on the ground.

In the present conflict in Afghanistan, it is very unclear how many civilians are being killed or what efforts are being made to prevent civilian deaths – despite public pronouncements. In July 2009, it was announced that three civilians had died in Operation Panther’s Claw. This was an operation with an element of surprise in an area with an estimated population density of 200 people per square kilometre. In all, 350 soldiers transported in Chinook helicopters were backed up by Apache and Black Hawk helicopter gunships, a Spectre gunship, Harrier jets, and unmanned drones.¹⁰ When requests were made for information as to how the figure of three dead civilians had been arrived at, there was no clear response. Instead, the replies drew attention to the practical difficulties of estimating mortality figures and the local custom of burying the dead within 24 hours. However, this incident occurred at a time when there were instances of civilians driving dead bodies to the offices of local governors in order to provide evidence of attacks. How the figure of three dead civilians was arrived at was not explained.¹¹

The Senior Civilian Representative in Afghanistan stated in October 2010

on prime-time radio that 90 per cent of civilian casualties in Afghanistan were now deliberately caused by the Taliban.¹² This figure was higher than the figures given in the UNAMA (United Nations Assistance Mission in Afghanistan) mid-year report a few months previously. The UNAMA reports also include clear qualifications regarding the completeness and accuracy of the information they collect and present.¹³ A request for clarification as to how the Senior Civilian Representative knew this figure at the time of making this statement did not receive a reply.

These are just two examples of statements whose accuracy can go relatively unnoticed, but that have the potential to gradually build up a picture in the public mind that favours one side against the other. The general public may then more readily accept the claim about the necessity for the conflict, as well as its more indiscriminate strategies, such as bombing of residential areas.

Health information, cause and effect, and the precautionary principle

The farther in time from the actual conflict, the harder it is to establish a causal relationship, and the greater the number of potential confounders. This is another area where evidence is accumulated, methodologies are developed, and the 'best possible' data agreed upon. However, instead of supporting this process, these confounders and the difficulty of establishing a causal link can be used as sufficient grounds to dismiss the problem, often in support of a political or military agenda. A lack of scientifically conclusive evidence can be used to dismiss indicative evidence that the conflict could have been the cause of specific sickness, disability, and death. It can also result in the delay of further examination, investigation, and research that might both clarify the specific situation and contribute to learning and conflict mitigation in the future.

In 2005, health professionals in Fallujah first started raising concerns about the number of babies with birth defects they were delivering. It was suggested that this development was linked to the highly polluted environment that the mothers had had to endure following two attacks on Fallujah, one in 2004 and one in 2006. These attacks had included the use of depleted uranium shells and other toxic agents and had produced high levels of stress among the population of Fallujah.¹⁴ In the six years since these attacks, civil society had attempted to study the pattern of these deformities. However, these studies have been relatively small, and none has been supported by the coalition forces that carried out the attacks or by the Iraqi government. Reports indicate that the complaints have not been responded to¹⁵ and that the Iraqi government does not want to embarrass the United States over the issue.¹⁶

In 2010, the concerns continue to remain unanswered. At the time of writing, it is still civil society that is trying to investigate the situation, although a major study by the World Health Organisation is anticipated in 2011. In December 2010, a study reported that 15 per cent of all deliveries in the Fallujah General Hospital during May 2010 had birth defects. The study

also examined in detail the family history of a group of families to whom babies with birth defects had been born in the previous two years. The study concluded: ‘These defects could be due to environmental contaminants which are known components of modern weaponry.’ It also said, ‘While the causes of [the] increased prevalence of birth defects are under investigation, we opted to release this communication to contribute to [an] exploration of these issues.’¹⁷

There are numerous instances when the cause of death, illness, or disability during or following situations of violent conflict is disputed, and in many instances considerable time and effort will be required to investigate the matter and reach a conclusion. But this is no reason to dismiss legitimate concerns, and the lack of a proven causal relationship should never be a reason to dismiss such concerns.

The precautionary principle

According to this precautionary principle, the responsibility for showing that certain actions were the cause of death, sickness or disability shifts to showing that these actions were not the cause. It also means that the suspected action should be stopped until it has been proved that it was not harmful. Deciding when the precautionary principle comes into play is also influenced by the severity of what is being investigated; viz. babies born with birth defects in Fallujah.

In March 2010, a spokesman for the US military responded to questions about the level of heart defects among the babies being delivered in Fallujah. He said that the US military always took public health concerns ‘*very seriously*’. He added, ‘No studies to date have indicated environmental issues resulting in specific health issues.’¹⁸ This is just one example of how both health information and professional opinion can be dismissed. While the statement is accurate in itself, it totally ignores the weight of information and professional opinion that should trigger the application of the precautionary principle. If applied, this principle should result in those who used the suspect weapons and materials taking responsibility for ensuring more and better-funded research into the cause of the heart defects among the babies, and a moratorium on the use of the suspected weapons.

There is also a gross inequality as to when, where, and in which situations the precautionary principle is applied. If the concerns expressed by the health professionals at the Fallujah General Hospital had been raised by health professionals in the countries of the coalition forces that had mounted the attacks on Fallujah, it would have led immediately to major investigations being launched.

Recommendations

Based on the above, the major recommendation is that health data and information should not be interfered with in the pursuit of military and political ends.

Health workers are already protected under international humanitarian law. However, it would be useful if this fact were made clearer in relation to their safety while they are collecting and disseminating health data.

It is important to create greater awareness of the way in which health information is manipulated, leading to increased and more probing questioning of public statements and holding to account those who make these statements. Military health professionals and political advisers need to play a more active role in advising their colleagues about the accuracy of data, epidemiological estimations, and the precautionary principle.

The precautionary principle needs to be applied in a more equitable way in conflict situations. While the links between depleted uranium and birth defects continue to be denied by the UK and the US military, in both countries their own soldiers receive health and safety advice about depleted uranium before deployment.

At the present time, it is often left to civil society to support the collection of data, to question how it is used, and to demand accountability when powerful actors use (or abuse) it for meeting their own agendas. While civil society needs to continue playing this role, all actors have a responsibility to ensure that health information and data are as accurate as possible and that they accurately represent all those affected by violent conflict equally.

Notes

1 Geneva Convention relative to the treatment of prisoners of war (Convention III of 12 August 1949), Additional Protocol 1 Part II, www.icrc.org/eng/resources/documents/misc/57jmjt.htm (accessed 15 February 2011).

2 UK Foreign Secretary's statement to the House of Commons, 2 December 2010, Foreign and Commonwealth Office website News, www.fco.gov.uk/en/news/latest-news/?view=PressS&id=280028682 (accessed 1 January 2011).

3 Norgrove, L. 'US soldiers are disciplined not for her death, but poor debrief'. NEWS. [scotsman.com, news.scotsman.com/scotland/Linda-Norgrove-US-soldiers-are.664841.jp](http://scotsman.com/news.scotsman.com/scotland/Linda-Norgrove-US-soldiers-are.664841.jp) (accessed 1 January 2011).

4 'Afghan air strike kills 9 civilians, villagers say'. CBC News, 5 November 2009, www.cbc.ca/world/story/2009/11/05/afghan-air-strike.html?ref=rss (accessed 1 January 2011).

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7 Checchi, F. and L. Roberts (2008). 'Documenting mortality in crises: what keeps us

from doing better?' *PLoS Medicine*, 5(7): e146: 1025–32.

8 'PHR calls for inquiry into detention of doctors and war crimes in Sri Lanka'. physiciansforhumanrights.org/library/news-2009-05-20.html (accessed 3 June 2009).

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13 UN Assistance Mission to Afghanistan (UNAMA). *Mid year report 2010. Protection of civilians in armed conflict*. UNAMA, Human Rights, Kabul, Afghanistan.

14 Doctors for Iraq (2005). 'Fallujah one

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15 'Research links rise in Fallujah birth defects and cancers to US assault'. *Guardian*, 30 December 2010. www.guardian.co.uk/world/2010/dec/30/faulluja-birth-defects-iraq (accessed 15 February 2011).

16 'Fallujah doctors report rise in birth defects'. John Simpson, BBC World Affairs Editor, BBC News. news.bbc.co.uk/1/hi/world/middle_east/8548707.stm (accessed 15 February 2011).

17 Alaani, S. et al. (2011). 'Four polygamous families with congenital birth defects from Fallujah, Iraq'. *International Journal of Environmental Research and Public Health*. 8(1): 89–96. www.mdpi.com/1660-4601/8/1/89/ (accessed 1 January 2011).

18 'Fallujah doctors report rise in birth defects'. BBC News Channel, 4 March 2010. news.bbc.co.uk/1/hi/8548707.stm (accessed 1 January 2011).

C3 | TRADE AND HEALTH

Health professionals generally see trade as a political issue, which is further-more complex and removed from immediate concerns of providing affordable health care to a large numbers of people. Thus, traditionally, the health sector has generally kept away from debates related to trade.¹ It is, however, a fact that trade, directly and indirectly, has a profound effect on the health of the global population.

Neoliberal economic policies lead to the subservience of national policies to the influence of global conditions, institutions, and policies. It is manifested in national policies of trade liberalisation, deregulation of capital movements, privatisation of public services and enterprises, monetarism, elimination of, or cutbacks in, social welfare programmes, and reduction of taxes.

Trade liberalisation operates through policies that countries adopt as part of public policy (autonomous liberalisation), or it could be routed through multilateral and bilateral agencies, bilateral or regional trade, and plurilateral agreements. The remit of multilateral and bilateral trade agreements can extend beyond trade to the health sector. In exchange for proposed trade concessions or market access, these agreements include commitments on privatisation of health care, liberalisation of health services, health insurance, and protection of intellectual property rights (IPR). In addition, of course, the WTO agreement signed in 2004 contains several multilateral trade agreements that have an impact on health: Agreement on Trade Related Intellectual Property Rights (TRIPS), General Agreement on Trade in Services (GATS), Agreement on Technical Barriers to Trade (TBT), and Agreement on Application of Sanitary and Phytosanitary Measures (SPS).

After the signing of the WTO agreement, developed countries have used other avenues, as well, to push up the standard of intellectual property protection through bilateral and regional trade agreements. They have also initiated several initiatives for the enforcement of intellectual property rights, which have an impact on access to affordable medicines.

In this chapter we discuss some of the more recent global developments related to trade liberalisation, especially with reference to the impact on the health sector.

Use of public health safeguards in TRIPS

The TRIPS agreement was premised on the logic that strengthening intellectual property protection is essential for innovation in the pharmaceutical



26 Demonstration by HIV+ve groups against Indo-EU FTA, New Delhi (Amit Sengupta)

sector to take place, thereby improving access through availability of new medical products. This is clearly a false premise, and the rate of innovation and development of new medicines has slowed down since the signing of the TRIPS agreement in 2004. On the other hand, there is mounting evidence that the strengthening of patent regimes will lead to an increase in medicine prices.²

When the TRIPS agreement was signed, developing countries were assured that public health safeguards, available to them in the agreement, could be used to ensure access to medicines.³ However, the post-TRIPS period is testament to the fact that these safeguards have rarely been used. There are several reasons why this is so: a) lack of technological capabilities, in the pharmaceutical sector in most low- and middle-income countries (LMICs); b) lack of capacity in many LMICs to incorporate the public health safeguards available under TRIPS in domestic laws; c) weak institutional and administrative mechanisms in LMICs to make use of public health safeguards, after their incorporation in domestic laws; d) political pressures exercised by developed countries to prevent use of public health safeguards available in the TRIPS agreement.⁴



27 Free trade or unfair trade? (Indranil Mukherjee)

As a consequence the use of public health safeguards in the form of compulsory licence has largely been limited to HIV/AIDS medicines. Only two countries have issued compulsory licences for products that treat other conditions – for avian flu in Taiwan⁵ and for cancer and hypertension in Thailand.⁶

The lack of manufacturing capacity in many LMICs was explicitly recognised as a hurdle to the use of compulsory licences by LMICs, as such licences could not be used to produce cheaper generics in the absence of domestic manufacturing companies. Paragraph 6 of the Doha Declaration on Public Health and the TRIPS Agreement in 2003⁷ had directed the TRIPS council to find a way out of this problem. The TRIPS council, subsequently, issued a waiver that allowed compulsory licences to be issued for export. This meant that countries with manufacturing capacity (developed countries as well as LMICs such as India, Brazil, China, etc.) could issue a compulsory licence to export a generic version of a patented drug to a country that did not have manufacturing capacity. However, the waiver included a large number of procedural hurdles and was, in practice, virtually unusable.⁸ As a consequence the provision has been used only once – to export HIV/AIDS medicine from Canada to Rwanda.

TRIPS plus measures in ‘free’ trade agreements

While the use of TRIPS safeguards remains important as regards efforts to secure access to medicinal products, another concern has taken centre stage in recent years. Through a large number of mechanisms, the terrain of intellectual property protection has shifted to include what are called ‘TRIPS plus’ measures. These measures are defined as those which require higher levels of intellectual property protection than those provided for in the TRIPS agreement. They would, thus, act as a larger barrier to access to medicines



28 The counterfeit confusion (Indranil Mukherjee)

than the TRIPS agreement as they nullify most of the public health safeguards nominally available in the TRIPS agreement. TRIPS plus measures, now being proposed through a number of mechanisms, including prominently the bilateral and multilateral ‘Free’ Trade Agreements, include measures such as: patent term extension; data exclusivity; linkage between the regulatory agencies and the patent office; limiting the use of TRIPS public health safeguards; and higher levels of IP protection (see Box C3.1).

From 1990 to 2007, the number of ‘Free’ Trade Agreements (FTAs) notified to the GATT or the WTO increased from 20 to 159. At present, over 250 regional and bilateral trade agreements govern more than 30 per cent of world trade.⁹ Most developed countries, including the US, the EU, Japan, Australia, Canada and New Zealand, are engaged in negotiating FTAs (or have concluded such agreements) with developing countries. A major driver of the proliferation of regional and bilateral trade agreements has been the perceived failure of the WTO to govern global trade. This, in large measure, has been a consequence of the intransigence of the powerful trading blocs (the US, EU, Japan, etc.) to accommodate the legitimate concerns of developing nations, and also because of differences between the EU and the US in some major areas (especially related to agricultural subsidies). As a result, ever since the WTO ministerial meeting in 1999 in Seattle, virtually every WTO ministerial meeting has concluded without a clear road map. The other driver of the new bilateral and regional agreements is the perception in developed countries that

they need to go beyond the WTO agreement and ratchet up the demand for binding commitments from developing countries.

Most of these FTAs are being negotiated in secrecy (with very little scope for civil society to intervene), and most have some or all of the ‘TRIPS plus’ measures we describe. Impact assessment studies of FTAs that are already in place paint a grim picture as regards access to medicines. A study by IFARMA of the EU-Andean FTA estimates that introduction of ‘data exclusivity’ and ‘patent term extension’ would lead to ‘an increase of 459 million USD in Peru’s total pharmaceutical expenditure in 2025 and a cumulative increase in expenditure of 1267 million dollars for the same year’.¹⁰ Another study on the EU-Canada FTA finds: ‘Payers – consumers, businesses, unions and government insurers – would face substantially higher drug costs as exclusivity is extended on top-selling prescription drugs, with the annual increase in costs likely to be in the range of \$2.8 billion per year.’¹¹ An impact study of the Central American Free Trade Agreement (CAFTA) anticipates huge rises in medicine prices in Guatemala.¹²

‘Free’ Trade Agreements also contain other provisions that have an impact on health. These include provisions in the ‘investment chapter’ of such agreements and provisions related to ‘government procurement’. (See Box C3.2.)

Enforcement of intellectual property rights

Several initiatives are now under way to enhance the standard of intellectual property enforcement. These initiatives widen the scope of the definition of counterfeit (which originally refers to a particular type of trademark infringement) to include infringement of all types of intellectual property rights and also criminalise IP infringements. Further, these initiatives also broaden the scope of border measures and allow customs authorities to seize goods in transit for the suspected infringement of all types of intellectual property rights. These initiatives stand to contravene the TRIPS agreement, by which states are obligated to treat only counterfeit trademark infringement and copyright piracy as criminal offences. Similarly, countries are also obliged to apply border measures only in cases of importation of counterfeited trademark or pirated copyright goods.

The application of border measures on goods in transit has already resulted in denial of access to medicines to people in developing countries. For instance, under the Council Regulation 1383/2003, the EU allows its member-country customs authorities to seize goods in transit citing suspected IP infringement. Using this regulation, customs authorities in the Netherlands and Germany have repeatedly seized medicines on their way to Latin America and Africa. Except one, all seizures were on consignments originating from India. Subsequently, India and Brazil approached the WTO Dispute Settlement Mechanism (DSM) in May 2010¹³ but there is no clear information with regard to the current status of the complaint.

Box C3.1 'TRIPS plus' measures in FTAs

FTAs incorporate provisions that demand higher standards of IP protection, not contained in the TRIPS agreement. Thus developing countries stand to lose the limited public health safeguards that are contained in the TRIPS agreement. Some of the key 'TRIPS plus' measures include:

Patent terms extension: Many FTAs contain provisions that provide for extension of the patent term beyond the 20 years mandated by TRIPS, in cases of what are called 'delays' in granting a patent. Operationally, such provisions extend patent terms beyond 20 years and delay the introduction of cheaper generic medicines.

Limitations on compulsory licensing: The compulsory licensing provision is a key safeguard in the TRIPS agreement. It allows countries to draft laws that allow generic manufacturers to manufacture and sell medicines, even if the medicines are under patent protection. Countries have the freedom to choose the grounds for such licences (for generic manufacture of patented drugs) to be issued. Grounds that can be used to issue a compulsory licence can include high prices of patented medicines, non-availability, non-working of the patent (that is, a patentee does not manufacture after it is granted a patent), etc. Such licences on patented medicines can be issued for non-commercial use as well as for commercial use. There are specific provisions for such licences to be issued in situations of national emergency/extreme urgency, but they can also be issued without such a situation being in existence. However, provisions in many FTAs restrict the grounds and the situations in which a compulsory licence can be issued.

In order to widen the net, the EU has also started providing support in third countries to enhance IP enforcement. It is widely assumed that the EU is primarily responsible for initiatives to introduce anti-counterfeit legislations in many African countries – for example, in Kenya,¹⁴ Uganda,¹⁵ and Zambia.¹⁶ The East African Community (EAC) came up with a regional draft anti-counterfeit policy/bill in 2009. The EU is understood to have funded the Ugandan trade ministry to draft specific IP enforcement legislation, which threatens access to medicines in Uganda.¹⁷ The EU is also using the medium of bilateral and regional trade agreements to enhance IP enforcement standards.

Misuse of 'anti-counterfeit' trade measures

The conclusion of the Anti-Counterfeiting Trade Agreement (ACTA) poses a major threat to access to medicines. ACTA is a secretly negotiated treaty among governments of the United States, the European Commission, Japan,

Limitations on parallel imports: The TRIPS agreement also allows countries to import cheaper patented medicines from another country. FTAs can restrict such importation by providing that such imports will be allowed only if the patent holder agrees (which is tantamount to preventing such imports as a patent holder would never allow import of a cheaper version of its drug).

Providing for data exclusivity: Many FTAs include data exclusivity provisions, though it is not a TRIPS requirement. Data exclusivity refers to a practice whereby, for a fixed period of time (usually 5–10 years), drug regulatory authorities do not allow the data that the originator company files to get marketing approval to be used to register a generic version of the same medicine. It means that if a patent holder gets marketing approval for a drug based on data of clinical trials, the same data cannot be used to register a drug by a generic company. In practice this provides a patent-like monopoly, as the alternative available to generic companies is to duplicate expensive clinical trials in order to get marketing approval. Data exclusivity allows monopoly powers to companies even in situations where a country is not required to provide patent protection. This is true for all Least Developing Countries (LDCs), which do not need to allow patents in medicines till 2016. Further, the US is also pressing for data exclusivity for new use of an existing drug, which can push the monopoly enjoyed by the originator company beyond the 20-year patent period if the new use is ‘discovered’ just when a patent is about to expire. Data exclusivity provisions, in situations where medicine patents are allowed, delay the entry of generic manufacturers when a compulsory licence is issued.

Switzerland, Australia, New Zealand, South Korea, Canada, Mexico and Morocco.¹⁸ The agreement goes beyond the traditional concept of ‘counterfeit’ and includes a wide range of intellectual property enforcement issues. The specific details of ACTA were kept secret until April 2010. On 9 March 2010, the European Parliament passed a resolution¹⁹ seeking transparency on ACTA negotiations. It called on the European Commission and the Council to grant public and parliamentary access to ACTA negotiation texts and summaries. However, it also called on the European Commission to continue the negotiations on ACTA to improve the effectiveness of the IPR enforcement system against counterfeiting.

The ACTA text allows customs authorities in countries to seize goods ‘suspected’ of infringing trademarks, copyrights and other IPRs. It allows for seizures even when there is only a ‘prima facie’ case of IPR infringement. The agreement (ACTA) thus seeks to institutionalise mechanisms that could

lead to a spate of seizures of generic drugs in transit, of the kind described earlier. Further, ACTA's application of border measures to goods in transit negates provisions of the Doha Declaration on Public Health aimed at making effective use of compulsory licensing for countries with insufficient or no manufacturing capacities.

The WTO argues that the TRIPS agreement allows members to establish levels of protection that are more extensive than those it prescribes, provided they do not contravene the Agreement on TRIPS (Article 1.1).²⁰ However, enforcement measures conceived under ACTA clearly violate Article 41.1 of the TRIPS agreement, which spells out the general obligation on IP enforcement. According to Article 41.1, '... These procedures shall be applied in such a manner as to avoid the creation of barriers to legitimate trade and to provide for safeguards against their abuse.'

Another recent development has been the creation of 'public-private partnerships' within multilateral organisations such as the World Customs Organisation (WCO), the World Health Organisation (WHO), and the International Police Organisation (INTERPOL), to enforce intellectual property rights. These include: Standards to Counter Intellectual Property Rights Infringements (SECURE) within WCO, International Medical Products Anti-Counterfeiting Task Force (IMPACT) within WHO (see Chapter D1 for a detailed discussion on IMPACT and its possible consequences), and the Pharmaceutical Crime Initiative within INTERPOL. All three initiatives attempt to conflate IP with quality, safety and efficacy of medicines.

While it is possible for a product to be both counterfeit and substandard, these are nevertheless different problems. Medicines of poor quality, i.e. substandard medicines, represent a threat to public health. However, by confusing the issues of counterfeit and quality, access to legitimate generic medicines (of good quality but which may infringe the patent laws in some countries) is curtailed.

Trade in health services

The importance of trade in health services is reflected in the fact that liberalisation of health and social services has been on the international trade agenda for many years.^{21, 22} According to WTO estimates for 2008, services represented more than two-thirds of the world gross domestic product (GDP).²³

The General Agreement on Trade in Services (GATS) came into force in 1995, as part of the WTO agreement. It aims to eliminate barriers to trade in the services sector, including financial, information technology (IT) and legal services, telecommunications, transportation, construction, and retail, as well as educational, environmental, health, and social services.²⁴ The GATS negotiations cover four types of international activities that pertain to health care: the delivery of health services across national borders, e.g. the outsourcing of telemedicine (mode 1); patients travelling abroad to receive treatment (mode

Box C3.2 FTAs: the devil lies in the details

The devil, as they say, lies in the details. Health activists often miss out on key areas of concern in FTAs that are buried in different ‘chapters’ (FTAs have different chapters dealing with different areas, such as IP, manufacturing, services, investment, agriculture, etc.)

Appropriation clause in investment chapters: A major area of concern related to investment chapters in most FTAs is that they allow private companies to file cases against governments. So they subject countries to the risk of litigation by corporations from or based in another country. This might be based on a company’s objections to the host government’s environmental, health, social or economic policies, if these are seen to interfere with the company’s ‘right’ to profit. The biggest issues relate to the provisions for compensation for ‘expropriation’, which can be direct (as in cases of nationalisation) or indirect (policies or actions that impinge on the profitability of the company concerned).³⁹

These are not imagined consequences. For example, in November 2000 the multinational water infrastructure company AdT filed for arbitration and sought \$25 million from the Bolivian government as compensation for its lost investment, including expected profits, after the government was forced to reverse a disastrous water privatisation attempt in Cochabamba. Similarly, in 2010 Philip Morris International – the world’s second-largest cigarette company and manufacturer of brands such as Marlboro and Red & White – sued the Uruguayan government for its regulation that requires tobacco companies to cover 80 per cent of their cigarette packs with pictorial tobacco-warning labels.⁴⁰

Government procurement: The EU has been prominent in pushing for an agreement on ‘government procurement’ in FTAs. This was one of the ‘Singapore issues’ that were rejected by developing countries in the Cancun ministerial meeting of the WTO in 2003. In a Government Procurement Agreement (GPA) all members have an equal right to bid for tenders in whatever the government of another member country of an FTA procures. So, for example, in an FTA with the EU and a developing country where a GPA is signed, the latter will have to allow companies to bid for contracts for all government procurements. This could mean that when tenders are floated to procure medicines for public health facilities, companies based in the EU would have the right to bid for such contracts. Such a situation can also affect the ability of governments to determine how food for public distribution systems (PDS) would be procured. In addition to such direct impact on the health sector, a GPA affects different sectors of the economy, and hinders the efforts by developing-country governments to plan for the growth of its domestic industry.

2); the presence of a foreign provider in a health services market (mode 3); and health professionals working in a foreign country (mode 4).²⁵

The commitments to liberalise under GATS are made in successive rounds, with each country making individual commitments, rather than agreeing to a collective ‘single undertaking’ to carry out reforms. Theoretically, this gives countries more scope to refrain from making commitments on topics or areas that are domestically sensitive. But the way in which GATS is negotiated – that is, in successive rounds – means that peer pressure can be applied on countries to liberalise in new areas.²⁶

Concerns abound that application of GATS to the health sector will result in inappropriate policies being applied to health services, thereby leading to suboptimal health outcomes,^{27, 28, 29, 30, 31} There is concern that GATS may affect future policy options by pre-empting or preventing reforms that are aimed at providing publicly funded health services^{32, 33, 34}

Here it may be underlined that while the WTO recognises essential government services as lying outside GATS, according to GATS Article 1.3, a government service is one which ‘is supplied neither on a commercial basis, nor in competition with one or more service suppliers’. This creates a definitional problem of exactly what a government service is.^{35, 36, 37}

Conclusion

Trade policies adopted by national governments have profound public health implications. Yet trade negotiations are seldom undertaken by those with a proper understanding of these links. If health policy is subject to trade law, and if it must work within the constraints of trade law, in the absence of health sector engagement, the health policy-makers will have less influence over the policies they make. They will become ‘policy-takers’ who must adapt to the effects of trade law. In this situation, health policy will be made through trade agreements.³⁸

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C4 | THE FUTURE IS NOW: GENETIC PROMISES AND SPECULATIVE FINANCE

This chapter explores the parallels, connections, and disjunctures between the worlds of biotechnology research and development (R&D) and high finance, because ‘one can understand emergent biotechnologies such as genomics only by simultaneously analyzing the market frameworks within which they emerge’ (Sunder Rajan 2006: 33).

The promissory future of biotechnology

‘The future’ is key in biotech R&D. Since the 1980s, biotech scientists and their supporters have promoted visions of the future in which disease, hunger, pollution, biodiversity loss, and industrial waste will all have been vanquished by new biotechnology products and processes.

It is predicted that in the future an individual’s genome – the particular sequences of DNA molecules in his or her body – will be routinely ‘decoded’ from a biological sample and the resulting information stored as electronic medical records. New pharmaceutical drugs will be tailored to a patient’s individual genome, and illnesses, plants, and animals could be genetically engineered to ‘grow’ some of these drugs. Analysis of the information before the appearance of symptoms could assess the probability of the individual succumbing to a disease in the future. A diagnostic test could encourage her to change her lifestyle or to take other new pharmaceutical drugs that it was claimed could prevent this particular future from occurring. By using the concept of public health, by speaking the language of prevention, and by suggesting that anyone, no matter how healthy in the present, might fall ill in the future, means that everyone becomes a ‘patient-in-waiting’ (ibid.: 175) who would presumably benefit from ‘predict and prevent’ pharmacogenetics.

Another much-publicised research avenue combines genetic information and technology with technology dealing with cell behaviour, development, and manipulation (particularly of stem cells, both embryonic and adult), with the aim of regenerating damaged or failing body parts and treating, if not curing, many diseases.

Umbilical cord blood banking stores the present for the future. Stem cells in cord blood have been used for over a decade as an alternative to bone-marrow transplants. But many parents now opt to freeze umbilical cord blood in case future research finds ways of treating their child with it if the child were to become ill. Such commercial banking ‘rests fundamentally on

the future-oriented promissory value of regenerative medicine ... embedded largely in future potential rather than present utility' (Martin et al. 2008: 132).

In sum, 'biotech ... is today synonymous with the language and imagery of futuristic breakthroughs' (Brown 2003: 4). As a result, discussions and decisions about health and biotechnology tend to be based less on facts and evidence and more on hopeful, future-oriented values and abstractions (Brown 2007: 332). Sociologist Sarah Franklin believes that 'imagining a future yet to be ... fundamentally defines the whole issue of the new genetics and society' (Franklin 2001: 349).

Supporters of biotech R&D also depict threatening futures in which more and more people will starve, suffer, and die if the research does not proceed. And it is to gain support – financial, political, and public – that future-oriented abstractions are invariably mobilised. Political support is needed to push through legislative and policy changes, particularly those allowing patents to be awarded on genes and living organisms, and permitting publicly funded scientists to hold such patents on their basic research and to set up private biotech companies spun out of their university work. And public support, albeit tacit or acquiescent, is considered essential, not only for bringing about these legislative and policy changes and for securing financing, but also for supplying human biological material, for participating in clinical trials, and eventually for using any resulting products.

Financial futures on futures

'The range of derivatives contracts is limited only by the imagination of man (or sometimes, so it seems, madmen)' Warren Buffett, quoted in Lanchester (2010: 43)

'The future' has also become key to global finance over the past three decades, or rather 'a' future: a legal agreement to buy or sell a specified asset at a specified price on a specified date in the future. The agreement itself – the future – can be bought and sold, and is therefore classed as an asset. Another similar financial instrument is an option, which confers the right, but not the obligation, to buy or sell an asset in the future at an agreed price in return for a small down payment. A third type is a swap, an agreement to exchange assets at agreed prices on some specified date in the future. The three types of agreement, to do something in the future, are collectively known as derivatives because their value is derived from some external variable. Those who buy derivatives are betting on the future direction of the underlying asset's price.

Farmers have long used derivatives to insure themselves against risks and uncertainties, such as bad weather, so as to get a good price for their crops at harvest time. In their current guise, however, derivatives would be unrecognisable to any farmer of yesteryear. Agreements are now made not only on the

future price of commodities, but also on stock market indexes of commodities, on future differences in interest rates, exchange rates, and currency rates, on the prices of stocks, shares, and bonds, and on the creditworthiness of companies and countries. Derivatives have enabled virtually everything to be priced, bought, and sold. They have been cross-linked and embedded within yet more contracts and agreements; assets have been bundled together and the whole portfolio ‘sliced and diced’ into tranches and sold. Futures on futures can now be bought and sold, ‘accumulating promise from promise’ (Cooper 2008: 142).

Before the 1970s, financial markets for derivatives were marked out as hazardous and were limited in size, or were simply banned. As with the development of the biotech industry, however, active lobbying enabled financial markets in derivatives to develop, leaving their agrarian insurance origins far behind. Today, they provide extensive opportunities for speculation – the practice of trying to profit from changes in fluctuating prices. The scale on which derivatives have been created and marketed is such that speculative capital far surpasses trading capital. Moreover, ‘the rise of speculative capital offers the disquieting spectre of a future emerging as if *ex nihilo* – held aloft by the mere promise of surplus-value’. Speculation is ‘an affective art of promise, expectation and panic where, in a real sense, price is no longer referenced to some fundamental value anchored in the past but surfaces as the emergent effect of “our” collective valuations of the future’ (Cooper 2006: 7).¹

Speculative accumulation of biotech futures

The paths of the promissory futures of biotech and of ‘future-looking financescapes’ (Helmreich 2008: 465) cross each other through speculative capital in the form of venture capital, which usually engages with young biotech companies until they launch themselves on a stock market, and of hedge funds, which buy the shares.

Venture-capital support for early-stage R&D has been the standard pattern of biotech-company development, particularly in the United States. Some contend that biotech would not have emerged as an industry were it not for ‘the willingness of venture capitalists to invest in a technology that had little credibility at the time [1980s] as a successful business model’ (Sunder Rajan 2006: 6). Venture capital is money given to a fledgling biotech company in return for a financial stake and (usually) a management role in the company.² Venture capitalists hope to make a return on their cash by selling their stakes (usually within 6–10 years), either directly to another buyer or through a stock exchange after the company has issued shares for the first time.

But speculating on biotech firms is precarious. Patents are regarded as providing some guarantee at the point of entry, while a stock market flotation is seen as the assured exit route.

Patents, thus, are at the heart of the logic of the speculative capital deployed

in biotechnology.³ A biotech company in its early stages often has no new drug, test, or tool in its pipeline, or in clinical trials, let alone on the market; it has no revenue stream, never mind profits; it has no tangible assets. What it does have, however, is a vision of a promised future. If scientists can capture this future by obtaining a patent on their initial research (even if the research has been paid for from the public purse), the company can offer ‘a proprietary claim over the future life forms it might give rise to, along with the profits that accrue from them’ (Cooper 2008: 28). From the company’s perspective, the patent itself is the valuable commodity rather than the subject of the patent. In the entrepreneurial science of biotechnology, ‘it is more important to own the speculative value of a cell line, through title to its “intellectual property,” than to own the cell line itself’ (ibid.: 190). Just as futures and other derivatives allow a speculator to profit from the buying and selling of commodities without actually owning any commodities themselves, so, too, ‘the biological patent allows one to own the organism’s principle of generation without having to own the actual organism’ (ibid.: 24).

Biotech patents mark a ‘fundamental rupture’ in that history of patents by encompassing not only living organisms but also *future* inventions as well as present ones (ibid.: 189). This rupture is particularly striking when we consider human embryonic stem cells, which have the ability to reproduce themselves indefinitely and to become any one of the 220 or so different kinds of cell in the human body; stem cells tend to be defined speculatively by what they could do rather than what they are (Cooper 2006: 15). Regenerative medicine aims to harness this speculative ability, but there are still substantial doubts as to whether the research will yield any safe therapeutic product. In the context of such fundamental uncertainty, ‘the biological patent responds to the unpredictable potentiality of the ES [embryonic stem] cell line by inventing a property right over the uncertain future’ (Cooper 2008: 144). A combination of stock market and patent reforms ‘transformed the nature of life science research in such a way that the mere hope of a future biological product is enough to sustain investment’ (ibid.: 26).

The next phase of risk-taking comes when shares in the biotech company are bought by investors and speculators unknown to the company. In recent years, hedge funds – largely unregulated financial vehicles catering to the super-rich, pension funds, and university endowments – have started to snap them up. These funds are renowned for exploiting swings in share prices. They profit from drops in share prices through the practice of short-selling: a fund borrows shares in the biotech company and sells them; when their price drops, it buys them back – at a lower price. Instead of the usual speculative practice of buying low and selling high, short-selling involves selling high and buying low.

What speculative health for whom?

The tendency to view the future of health care through the prism of genetic determinism has been censured by many biotech researchers as well as public health activists. Privileging the role of genetic anomalies in causing disease downplays the role of the genes' 'environments' and of the social, ecological, epidemiological, and evolutionary context in which disease emerges and spreads. Given life's capricious complexity and its embedded interconnections with various environments, it is not surprising that genetic research (with a few notable exceptions) has delivered so little. Even the UK geneticist turned millionaire venture capitalist entrepreneur Sir Christopher Evans admitted a few years ago that 'nothing in biotech has ever come to anything yet' (Brun-Rovet 2003: 18).

But the involvement of speculative capital in biotech R&D means that *there is no need for it ever to do so*. Whereas investors will abandon biotech companies when they fail to bring products or services to market, the speculative capital underpinning biotech companies and their futures does not need them to deliver anything at all in either the present or the future. All that a biotech company has to do to generate value in the present is to sell a vision of the future, 'even if it is a vision that will never be realized' (Sunder Rajan 2006: 115–16).

When promised futures repeatedly fail to materialise and doubts over the credibility of such promises surface, public relations become critical. In the world of speculative biotech, successful marketing demonstrates itself not in the articulation and promotion of over-hyped futures but in 'the closure of the gap between what is envisioned and what is (inadequately) achieved' (ibid.: 126). Another response has been to draw attention loudly to the handful of clinical applications that have emerged (some of which are undoubtedly of health-giving and life-saving benefit), while quietly abandoning research lines that haven't delivered. Novel biological drugs, particularly those that address cancer, are considered among the most tangible fruits of biotechnology, while far less is heard today about xenotransplantation or gene therapy (Brown 2003: 4, 9).

Another strategy has been to promote products for conditions other than those for which they were originally developed. To expand markets for genetic technologies (as well as for related reproductive and pharmaceutical technologies), regulatory and public approval is obtained for a drug to treat a medical condition; the drug is then promoted for other uses that many more (healthy) people could be expected to take up for social or cosmetic reasons. Injections of stem cells derived from aborted fetuses were developed to treat Parkinson's disease and blood disorders, but are being advertised as anti-wrinkle treatments. The beneficiaries of stem-cell breast implants are described as cancer patients who have had mastectomies, but promoters are eyeing women who would like breast or lip enlargements.

Colonising the future

What is called for is something like a creative sabotage of the future. (Cooper 2008: 99)

The biotech industry uses the ‘future’ in a very strategic manner. Instead of relying on practice and evidence grounded in reality to plot a route to the future, research starts from what is speculatively possible in an abstract future. It draws ‘an imagined future into the real-time now’ (Brown 2003: 17), so that particular technologies seem obvious solutions to which resources must be directed immediately. Decision-making is channelled towards techno-knowledge-based utopian fixes that harness and commodify genetic and bio-molecular science (Birch and Mykhnenko 2010: 2).

Mobilising an imaginary genetic future not only frames health, disease, and medicine in individualised genetic terms, but also thrusts the present structural causes of ill-health into the background, diverting attention away from the social determinants of health. The colonising power of the future also sidesteps questions about how a genetic approach to health may exacerbate structural causes of ill-health. The inaccessibility of existing treatments and health care services in the present, never mind the future, is considered unrelated to this approach in analytical, policy, or funding terms.

As Ruth Hubbard has stressed, although high-tech treatments can turn out to be a ‘real boon’ to a limited number of individuals, they unfortunately



29 Protest in New Delhi against introduction of Genetically Modified Brinjal (Greenpeace)

‘drain resources away from the kinds of public health and medical measures that could improve the health of a much larger number of people’ (Hubbard and Wald 1993: 112).

GeneWatch UK’s conclusion about the consequences of the speculative approach to health (and agriculture) research is direct:

It has ... exacted a high price in human lives due to wasted opportunity costs by acting as a distraction from more immediate, lower-cost alternatives. This is partly because ensuring that existing treatments and a varied, balanced diet reach everybody would save a lot more lives than any possible technological developments; and partly because the system distorts the research agenda away from human needs as well as from the broader development of scientific knowledge and understanding. The problem is not that commercial interests should not play a role in funding and helping to drive (at least some) R&D investment, or that technology (including biotechnology) has no positive applications, but that the system of policies and incentives created to drive the ‘knowledge-based bio-economy’ is deeply flawed. (Wallace 2010: 10)

The challenge for public health activists is to contest the futures that are presented as inevitable. It is on the basis of our actions in a grounded present that we must build and realise these visions of the future.

Health for all

A focus on individual biological differences is ... unlikely to deliver significant improvements in public health. (GeneWatch UK 2002)

Before trying to fix the system of biotech R&D that has delivered neither health nor wealth, it might be more productive to ask whether speculative finance is the best way to fund health innovation and whether wealth (rather than health) should be the goal of such innovation. It would be more fruitful to reassess and reclaim what is needed for health, and then to consider what role biotech might play.

Research into the human genome has, in fact, consigned the idea of ‘one gene, one condition’ to the history books for the vast majority of diseases and conditions. The substantial findings emerging from genetic research are undermining the notion of genetic determinism as it becomes less and less clear how genes ‘work’. ‘We’ve made the mistake of equating the gathering of information with a corresponding increase in insight and understanding,’ says biologist Jim Collins (Ball 2010: 65).

Even those few conditions clearly linked to single genes often cry out for more attention to be paid to the environment of the sufferers. Consider sickle-cell disease. Chuck Adams, a social worker in a children’s hospital in Philadelphia, points out that living in a cold, abandoned building without adequate food deeply affects those with sickle-cell disease. ‘They just happen

to have a chronic genetic disorder, but being poor was probably the first disorder that they had to deal with,' he says (Sexton 2002). Helen Wallace of GeneWatch UK concurs: 'The big risks for most diseases are not inside your genes but in the world outside' (GeneWatch UK 2010b).

Genetic research is not necessarily providing what is needed by sick people, including those with 'precarious futures ... who are desperate for treatment' (Brown 2003: 8). When the goal is monetary profit from the research process, 'manufactured scarcity' is the result, a situation that is compounded when health care itself is a profit-making centre, determining what tests and treatments are provided to whom (and when and where).

Given the 'absolute scarcity' of treatments for some diseases, how can public health activists judge whether promissory claims of future benefits of biotech research are 'true'? It is widely acknowledged that 'early stage genetic technologies are difficult to analyse, both in terms of the direction of their development and the social and ethical issues they raise' (Hedgecoe and Martin 2003: 355). The task is made harder when these technologies are embedded within 'the knowledge economy of expectations' (Brown 2003: 16) and 'surrounded by too much "hype", speculation and unsubstantiated claims' (Hedgecoe and Martin 2003: 328). A first step would be to engage more with genetic researchers working within 'the privately cautious world of bench science' (Brown 2003: 16) than with their business or PR managers or speculators. Those closer to the research tend to be far more aware of the difficulties, doubts, and uncertainties – past, present, and future – of realising ambitious promises. Many have experienced time and again how unanticipated hurdles have stalled promised innovations (Brown and Michael 2003: 14, 16).

Another step would be to scrutinise the interests behind various genetic findings. GeneWatch UK has documented how the tobacco industry infiltrated top scientific institutions in the United States and the UK to promote the false theory that smokers' risks of lung cancer and the likelihood of their smoking are in their DNA. 'Leading scientists endorsed the hunt for genes that don't exist, creating a vast gravy train of funding for the human genome and a false message about cancer in the press' (GeneWatch UK 2010b; Wallace 2009). The pharmaceutical and food industries have promoted false claims that human genome sequencing will predict killer diseases in an effort to market health care products to healthy people and to create confusion about the role of processed foods in causing hypertension, diabetes, and obesity. The chemical and nuclear industries have also sponsored genetic research (GeneWatch UK 2010a).

Such information, and the knowledge that public health advocates already have, can change the nature and the direction of the conversation. Rather than taking the promised benefits at face value, questions can be asked that turn the spotlight away from utopian future abstractions back to the present



30 Much of Biotech research does not address real needs (Indranil Mukherjee)

realities, messy and complicated as they are. When a South African farmer was asked whether he would welcome crops that were genetically engineered to be drought tolerant, he replied, 'First, we need land reform.' Health for All rather than Genes R Us needs to be placed at the centre of health research, policy, and funding.

Take economics seriously

Biotechnology is a form of enterprise inextricable from contemporary capitalism. (Sunder Rajan 2006: 3)

It is sometimes claimed that it does not matter whether the public or the private sector pays for 'public goods', or how money has been raised to pay for these goods, or whether some interests profit from them, as long as the goods are delivered in the end. Public health advocates have shown that the financing mechanisms do affect what is provided to whom. But when the life sciences and biological materials are subject to the logic not only of commodification, but also of financialisation, no goods need be delivered at all. If biotech research is to serve public health needs, its core structures need to be reshaped, re-employed, and undistorted away from 'the creation of surplus value' (Tyfield 2009: 498).

Although some Western governments (in the wake of the recent financial crisis) have put failing banks into public ownership, the power dynamics involved suggest that the process is not nationalisation but 'a profound deepening of the reverse takeover of the state by finance' (Tyfield n.d.: 1). Something similar has happened in the world of biotech R&D given that the 'symbiotic relationship between industry, university and governments' has blurred the distinction between 'public' and 'private' in many instances (Lynskey 2006: 134–5). Reclaiming health research and finance requires reclaiming the 'public'

and the ‘state’. What form of governance might work best to ensure not simply public control but also the exercise of that control for the public good? What political processes might be nurtured to encourage debate and consensus-building around what constitutes the ‘public interest’? Should the public continue to allow their governments to move away from protecting the public’s health towards facilitating the speculative economy on the back of public health research? Is the primary function of public health agencies to protect the public, or to stimulate the economy through the commercialisation of biomedical research? Should the function of public sector funding and regulation be to assist the goals of speculative capital, or to defend the public interest against them?

Similar questions need to be asked about genetic research. Is the science of human cells and genes there to fulfil the promise of a better life for all, or to serve the ends of some speculators? Drawing attention to how biotech research is financed is not to suggest that researchers and geneticists are simply financial speculators in disguise. Undoubtedly, the majority are interested in a fascinating science and want to save lives, just as the majority of those working within health care services do. But hard commercial realities do not sit comfortably with researchers’ belief that their work will have genuine medical benefits and reduce human suffering (Knowles 1999: 40).

Conclusion

The story of a poor young black tobacco farmer in the United States, Henrietta Lacks, epitomises the promises and pitfalls of bringing biotech futures into the present. In 1951, she developed a vicious type of cervical cancer. Before it advanced, a doctor took a tissue sample (without her knowledge or consent) and cultured it in a lab dish. Her cells doubled relentlessly every 24 hours, even though scientists had tried (and mostly failed) for years to grow human cells in culture. HeLa cells are now found in their trillions in virtually every biomedical lab in the world. An estimated 99 per cent of knowledge about human microbiology is believed to have been derived from them. They were involved in developing the polio vaccine, in vitro fertilisation, gene mapping, and drugs to treat AIDS. Researchers continue to use them in exploring how external agents cause DNA mutations and how the environment triggers genes in normal DNA to turn off and on.

Yet while biotech and pharmaceutical companies have profited from selling HeLa cells or the drugs made possible by them, Henrietta Lacks died at the age of 31, was buried in an unmarked grave, her husband and children were not told about her cells, and many of her descendants suffered ill-health from under-treated medical conditions because they had no health insurance (Skloot 2010).

Notes

- 1 See Hildyard (2008); Lohmann (2009); Lanchester (2010); Singh (2008, 2010).
- 2 Venture capital typically comes from institutional investors and high-net-worth individuals, and is pooled together by dedicated investment firms. A venture capital firm will spread its money around several biotech firms rather than putting all of it into one company.
- 3 An estimated 40,000 patents relating to some 2,000 human genes have been granted. Patents and intellectual property rights, more generally, are also key in financial accumulation (Sikka and Willmott 2010).

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C5 | CLIMATE CRISIS

A great deal of fog has come to surround discussions on climate change, some of it created deliberately to cast doubt on the reality or origins of the man-made crisis or to divert public attention away from the crux of the problematic and potential solutions. This chapter presents an overview of the core issues pertaining to the climate crisis and its resolution. The chapter deals with the current status of the crisis, the main problematic in this scenario, the state of play in global negotiations and the broad prognosis given present and foreseeable trajectories of greenhouse gas emissions.

Unambiguous Evidence

Scientific understanding of climate change has improved enormously in recent years. While the IPCC's (Intergovernmental Panel on Climate Change) Fourth Assessment Report (IPCC 2007a) did not contain any unexpected revelations, it marked a sharp departure from its predecessor IPCC Reports in three important ways.

Firstly, IPCC/AR4 put an end to the constant debate with sceptics over whether or not climate change is attributable to anthropogenic (man-made) emissions of greenhouse gases or GHGs. The Report revised IPCC's assessment of human-activity-induced climate change from just 'likely' or having 68 per cent probability in the Third Assessment Report (IPCC 2001) to 'very likely' with over 90 per cent probability, and declared that 'warming of the climate system is [now] unequivocal' (IPCC 2007a: 3).

Secondly, IPCC/AR4 pronounced that atmospheric greenhouse gas (GHG) concentrations, then at around 425 ppmv (parts per million by volume), were extremely close to a 'tipping point' beyond which changes in climate could become irreversible. The Report held, however, that even at this late stage, it was still possible to pull back to a stabilisation level of around 450 ppmv provided concerted and decisive steps were taken very soon (IPCC 2007b: 14–18). By concluding that the world was confronting not just climate change, but an impending climate *crisis* calling for drastic and virtually immediate action, IPCC/AR4 decisively changed the tenor and urgency of global climate negotiations.

Finally, IPCC/AR4 made specific recommendations as regards mitigation trajectories required to prevent runaway climate change. The Report stated that global GHG emissions should peak and start declining by 2015, and reduce by 50 per cent by 2050, which, in turn, would require Annex-I developed



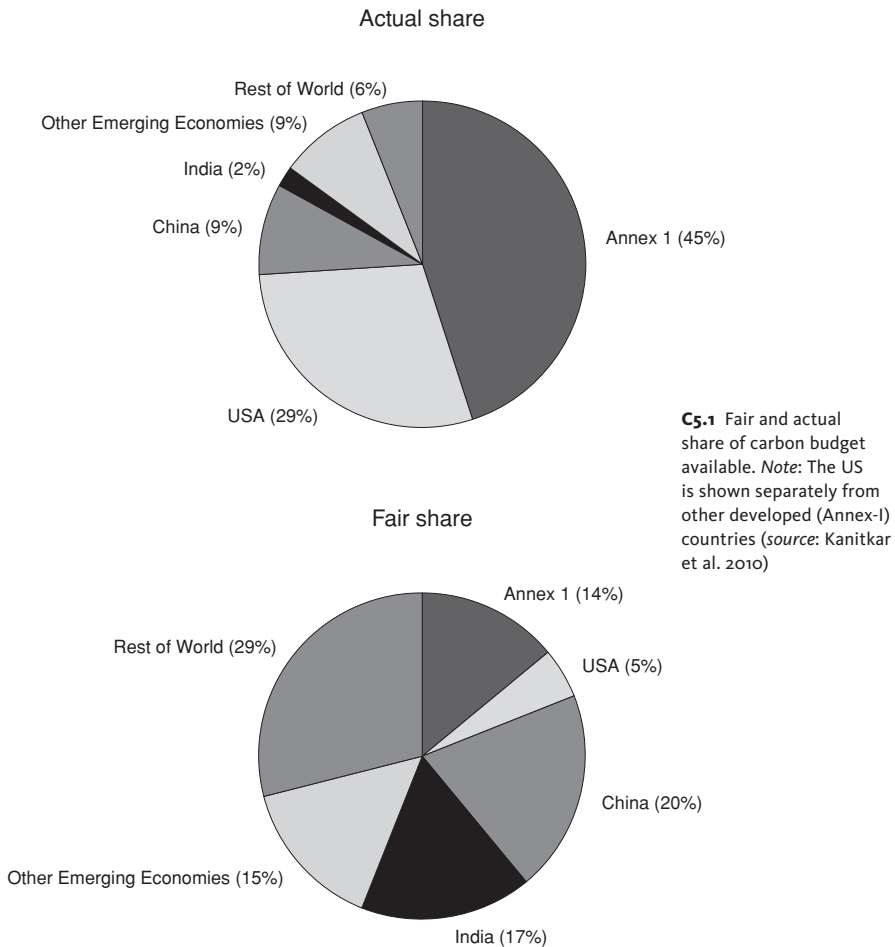
31 Dry and barren landscape (Evgeni Dinev/FreeDigitalPhotos.net)

countries to reduce their emissions by around 40 per cent by 2020 and 90–95 per cent by 2050 (ibid.: 38–9, 90ff.). So the science clearly demanded, for the second commitment period of the Kyoto Protocol currently under negotiation, a steep upward revision of the emission reduction targets set for the first commitment period – that is, around 5.6 per cent reduction by developed countries from 1990 levels.

Political economy of atmospheric GHGs – the ‘carbon budget’ approach

It is clear today that cumulative emissions are a better indicator for limiting temperature rise than emissions trajectories or stabilisation pathways (Matthews et al. 2009; Allen et al. 2009; Meinshausen et al. 2009). This means that we need to look at stocks of GHG gases and not just flows. This is the carbon budget approach – the world has a definite carbon budget within which it has to live if it has to limit global temperature rise. It specifies more clearly what the world as a whole needs to do to limit the global average temperature rise to below 2°C. The world has already emitted 332 GtC (giga tons of carbon) between 1850 and 2009. Of these emissions, 74 per cent have been emitted by only 19 per cent of the global population residing in the developed countries (Annex-I countries). If the world wants to limit temperature increase to under 2°C with at least a 50 per cent probability, then the budget for the period 2010–50 is a further 300 GtC.

We present here (Chart C5.1) one of the results of an exhaustive modelling exercise (Kanitkar et al. 2010) that arrives at a global average budget based on



population, which projects what a ‘fair share’ of the carbon ‘space’ available would look like.

As energy is a prerequisite for human development, an equal amount of *energy availability per capita* is the right of all human beings living in the developed as well as the developing world. The early developers have been able to access this energy from high-carbon, low-cost sources, whereas the late developers might have to use high-cost, low-carbon sources to access the same levels of energy owing to the constraints imposed by the carbon budget. Thus, equitable access to energy naturally leads to an argument about equitable access to carbon space. If population is used as a measure of each country’s share of the total budget (Historical 332 GtC + Future 300 GtC), it appears that Annex-I countries have used their emissions and now actually owe carbon emissions to the world (a ‘carbon debt’). This is the concept of ‘carbon debt’ – it is not a mythical figure but concretely measures the cost of carbon space grabbed by the rich countries over and above their share.



32 Electric Lines criss-cross over a remote village in India; access to energy is still a huge problem in developing countries (Amit Sengupta)

However, even if the Annex-I countries reduce emissions to zero in the next year (which, of course, they will not), the budget remaining for the rest of the world will still be less than what they are entitled to. While some countries such as China might still acquire their fair share of carbon space, others such as India and most of the Least Developed Countries (LDCs) will have to live within a share of carbon space much smaller than their fair share.

The carbon space available to the developing world (and consequently the cost that they will have to pay for later development) will be greatly reduced if the Annex-I countries do not undertake *deep and immediate cuts* in their emissions. While a number of countries use the concept of equitable space in global negotiations, they do very little to reduce the inequity that exists with respect to energy consumption internally. The budget approach is therefore not only a measure of global carbon debt but also a measure of the carbon debt owed by the rich to the poor in each country: the fair-share concept must be used not only externally but also internally.

Despite the grave warnings by the IPCC about the depth of the climate crisis, the developed nations of the global North led by the US cynically manipulated the international negotiations in such a way as to shift the onus for tackling the climate crisis on to the already overburdened shoulders of the developing countries of the global South while maintaining their own economic dominance, regardless of the impact of these actions, especially on vulnerable sections mainly in developing countries. In one sense, the global North has behaved in the climate negotiations much as it has done in trade

negotiations or other multilateral fora, advancing its own geopolitical and economic interests, and pursuing its hegemonic goals.

In the fossil-fuel-based capitalist mode of production, space in the global atmospheric commons for the ‘parking’ of GHG emissions is an important factor of production and, therefore, occupation of the atmospheric commons, analogous to control over industrial raw materials, is an integral part of efforts to maintain global capitalism and the dominance of the political-economic forces that control it.

Global attention has been fixed on controlling future *flow* of GHGs, not only because it is emission flows which can be controlled or regulated and are therefore the focus of the Kyoto Protocol and the global negotiations, but also because the global North has succeeded in framing the issue in this way, chiefly in order to divert attention away from the accumulated *stock* of GHGs and so as to evade responsibility for its historical responsibility for the present crisis. It is not the present *flow* of GHGs which is primarily responsible for climate change but the *stock* of GHGs, especially long-lasting carbon dioxide, which keeps accumulating in the atmosphere after all the processes of absorption, decay and so on are accounted for. It is for this reason that the chief metric for gauging the current status of the climate problem, and for its stabilisation as delineated above, is atmospheric concentration of GHGs.

It is well known that developed countries contribute around 46 per cent of global emissions today despite having less than 20 per cent of global population, and that the contribution of developing countries is projected to rise to around 75 per cent by 2050 since developed-country emissions have plateaued while those of developing countries are growing as they progress. But it is less appreciated that over 77 per cent of the stock, i.e. GHGs accumulated in the atmosphere, has been caused by the economic activities and lifestyles of the developed countries since the beginning of the industrial era, nominally taken to be c.1750 ACE (IPCC 2007a: 15–17). Because of this legacy of historical emissions, whatever the reductions in emissions of developed countries going forward, or limits on emissions growth from developing countries, developed nations will continue to be responsible for the greater part of the accumulated stock of GHGs in the atmosphere. The efforts of the US and its Northern allies in global negotiations have been directed at maintaining their dominant share of the atmospheric ‘carbon space’.

Rigging the global negotiations

In the months leading up to the Copenhagen Climate Summit in 2009, the US (along with the EU and other developed countries) made a planned and systematic effort to kill the Kyoto Protocol and its fundamental basis. (The Kyoto Protocol enunciated the principle of ‘common but differentiated responsibilities’, with developed countries taking on binding emission cuts while developing nations undertook mitigation actions, including low-carbon



33 Climate change demonstration in Copenhagen, December, 2009 (© Ricardo Esplana Babor | Dreamstime.com)

development pathways supported by financial and technological assistance from developed nations.) The US now insisted that large developing countries, especially China and India, also take on binding absolute cuts in emissions regardless of their need for economic growth and poverty eradication, which would necessitate some increase in emissions in the short to medium term.

The Copenhagen Accord that was crudely parachuted into the Summit and hence was not endorsed by the Conference introduced a ‘bottom-up’ pledge-and-review system in place of the Kyoto Protocol. Regrettably, this new framework was later formally endorsed by COP16 (Conference of Parties) at Cancun in 2010 with a fig-leaf explanation that this was not being advocated as a substitute for Kyoto but as an interim measure till the next Summit. Several commentators have argued persuasively that this pledge-and-review framework appears likely to be given *de jure* status at COP17 in Durban (Martin 2010; Raghunandan 2010).

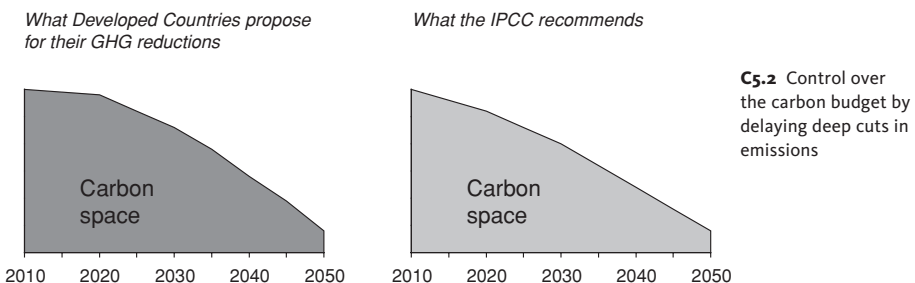
The pledges made by the US and other developed countries at Copenhagen fall far short of the 40 per cent reduction from 1990 levels as called for by the IPCC and are certainly not enough to keep global warming below 2°C. A leaked confidential draft document prepared by unnamed UNFCCC officials during the Copenhagen conference revealed that pledges made by the developed nations including the US amounted to only 11 to 18 per cent

emissions reduction from 1990 levels (UNFCCC Secretariat Confidential Draft Note 2009: 8). The effort was clearly to continue occupation of the atmospheric carbon space, disengage from as little as possible while compelling the developing countries to cede space in the global commons.

One of the big stories of the Copenhagen Summit, almost totally missed in commentaries owing to the collapse of the Summit and because it was virtually blanked out by Western media, was the significant initiative and the enormous emission reductions volunteered by developing countries. Under severe pressure from the US and its allies, China, India, South Africa, Brazil, Mexico and Indonesia made significant commitments leading up to the Summit to cut back on emissions. While these declarations may appear to have enabled these developing countries to seize the moral high ground, it became clear that they were duped by the developed nations. The US and its allies kept pushing developing countries to cut more, while themselves not only refusing to increase their emission reduction commitments but even in some cases diluting them further, as was done, for example, by the EU, Japan and Australia.

Numbers were also juggled to make it appear that it was large developing nations which were intransigent and were demanding the ‘right to pollute’, whereas, in actual fact, the advanced capitalist states were seeking to perpetuate their occupation of the global atmospheric commons and aggrandisement of carbon space so as to extend their economic dominance. The leaked UNFCCC Note drafted during Copenhagen estimated that the mitigation actions volunteered by developing countries amounted to 5.2 billion tonnes of GHGs, considerably more than the emissions cuts pledged by the developed countries, which amounted to a reduction of just 2.1–3.4 billion tonnes (ibid.: 3)! In other words, the US and its allies in the global North, by keeping their own emission cut pledges low and pressurising large developing countries to undertake mitigation actions not binding under the Kyoto Protocol, had succeeded in ensuring that the developing nations took on a larger share of the burden of reducing global emissions and thus ceding the carbon space required for development.

Developed countries have developed a strategy that includes accepting higher emission cut targets for later periods while keeping to lower targets in



the near term. The pathway to emission reductions is crucial, not just the end point. For instance, if one nation keeps to a high rate of emissions for most of the period but reduces its emissions by 80 per cent by 2050 abruptly in the last few years, while another nation gradually reduces its emissions every year till it reaches the same level in 2050, the former would have emitted far more GHGs than the latter. If plotted as a graph (Chart C5.2), the former would show a straight line abruptly dropping off almost vertically at 2050, while the latter would be a gradually downward-sloping curve reaching the end point, with the area under the former curve being clearly larger than the latter. The pledge, by the US, of a 3 per cent cut by 2020 rising to an 80 per cent cut by 2050 is precisely a way in which the US, by avoiding higher cuts in the early period while accepting the higher cuts much later, actually ensures it retains a greater share of the global carbon space.

An ‘Emissions Gap Report’ released by the United Nations Environment Programme on the eve of the Cancun Summit (United Nations Environment Programme 2010) estimates that, even if all the pledges made at Copenhagen and after by 85 developed and developing nations are fulfilled, global emissions would reach 53 GtCO₂ by 2020 compared with the desirable level of 44 Gt, leaving a large gap of 9 Gt and resulting in temperature rise of the order of 3–4°C.

Finally, the Cancun Agreements put the seal on the long-cherished neoliberal dream of commoditisation of the global atmospheric commons. The idea of developed countries transferring finances and technology to developing countries to assist the latter in coping with climate impacts caused by the former has been largely abandoned. The REDD (Reduction of Emissions from Deforestation and forest Degradation) scheme provides for funding to developing countries for preserving forests and permitting developed countries to offset costly emissions cuts against what would be cheaper carbon sinks. Fund transfers will henceforth include private investment, loans, multilateral funding and project assistance, including for offsets, but only if developing countries behave properly and ensure ‘meaningful mitigation actions and transparency on implementation’ (UNFCCC Cancun LCA 2010: para. 98). In other words, market mechanisms will henceforth have free rein and atmospheric carbon space will be bought and sold obviously at prices determined by the global North.

Conclusion

The climate crisis is the direct result of the globalised capitalist mode of production hitherto based on fossil fuels. The ongoing struggle in the global climate negotiations over emission trajectories clearly reflects the determination of the advanced capitalist countries led by the US to maintain their hegemony by continued occupation of the atmospheric carbon space and shifting much of the burden of emission reductions to developing countries to perpetuate

existing inequities. Thus, the global struggle around the climate negotiations is a struggle for ‘climate justice’. This struggle has to be multidimensional, embracing political-mobilizational, scientific-technological and legal-regulatory aspects.

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C6 | CHALLENGING THE POPULATION: CLIMATE CONNECTION

Overpopulation alarmism is back again and gaining momentum, tied this time to climate change. Spearheaded by advocates in the United States and the United Kingdom, a well-funded campaign is spreading the basic message that reducing rapid population growth in the global South is one of the main solutions to the climate crisis, and thus massive investments in family planning will help save the planet.

The comeback of the contraceptive fix

When feminists won passage of reforms of population policy at the 1994 UN population conference in Cairo, many thought family planning had finally been freed from the shackles of population control – that is, the drive to reduce birth rates as fast and as cheaply as possible through top-down, often coercive means that violate health and human rights. However, population control never went away. Today, the population lobby in the US views the urgency associated with the climate crisis as a way to convince legislators and policy-makers to press for more US population assistance.

Driven by foundation funding, Population Action International (PAI), the Sierra Club, and the Worldwatch Institute have taken the lead in pushing what I call the population/climate connection. In the UK, their counterpart is the Optimum Population Trust (OPT).

Instrumentalising family planning to achieve population reduction has a number of negative effects. First, in many countries, health and family planning programmes are already biased against poor women, who receive disrespectful, bad-quality services.¹ When the message filters down to prejudiced providers that controlling fertility is not only a demographic but also an environmental mandate, it will add insult to injury, or injury to insult, depending on the extent of ill-treatment.

Secondly, the renewed focus on contraceptives as the magic bullet undercuts years of feminist activism to pressure the population field to adopt a holistic approach towards reproductive and sexual health and to offer a full range of safe, voluntary contraceptive choices, with proper screening for contraindications and side effects.

Thirdly, the population/climate connection gives countries that grossly violate reproductive rights such as China false moral authority. At the 2009 Copenhagen climate conference, for example, Chinese officials trumpeted

their success in reducing population growth, claiming that the one-child policy decreased emissions of carbon dioxide by approximately 18 million tons a year.²

Last, but not least, the negative view of children implicit in the population/climate connection – babies as future polluters and carbon emitters – plays into the hands of the anti-abortion activists, who are always looking for ways to portray themselves as pro-life and the abortion rights and environmental movements as anti-child. This is the message of a recent opinion piece by Steven Mosher, president of the anti-abortion Population Research Institute.³

Thus, the population/climate connection threatens to derail whatever progress has been made since Cairo in making reproductive and sexual rights and health both the ends and the means of policy.

Subverting climate solutions

The impact of the population/climate connection on the environmental movement is equally problematic – and potentially disastrous. Today, the biggest barrier to an effective international climate policy is the failure of the global North, in particular the United States, to agree to a massive reduction in carbon emissions. By pinning the blame on overpopulation in the global South, the population/climate connection essentially lets the global North off the hook, playing into the politics of denial. At a time when people in the North desperately need to take responsibility for their historical and present contributions to climate change, the population lobby is offering them both a scapegoat (poor pregnant women) and an easy option (support international family planning). In the UK, OPT's Population Offset project even encourages wealthy consumers to offset their luxury carbon emissions by investing in a family planning programme in Madagascar!⁴

The reasoning behind these views is fundamentally flawed. Industrialised countries, with only 20 per cent of the world's population, are responsible for 80 per cent of the accumulated carbon dioxide in the atmosphere. Luxury consumption by the rich has far more to do with global warming than the population growth of the poor. The few countries in the world where population growth rates remain high, such as those in sub-Saharan Africa, have among the lowest carbon emissions per capita on the planet. From 1950 to 2000, the entire continent of Africa was responsible for only 2.5 per cent of the world's carbon emissions.⁵

Rapidly industrialising countries such as China and India will account for a higher percentage of emissions in the future. Indeed, China has recently surpassed the United States as the biggest carbon emitter, although on a per capita basis its emissions are far lower. Instead of population control, effective climate change policies in China, India, and other industrialising countries should emphasise conservation and a rapid transition to green technologies and renewable energies, funded in part through transfers of resources from the global North.

By focusing on the impact of human *numbers* rather than inequitable and unsustainable human *systems* of production, distribution, and consumption, the population/climate connection deflects attention from the role of powerful economic and political interests – fossil fuel corporations, the financial industry, government officials, and militaries – that are actively blocking progressive solutions to climate change in both the North and the South.

The way in which the population/climate connection deploys demographic data is also misleading. Reports often cite unrealistically high projections of future population growth to produce fears of a population explosion. A recent Worldwatch Institute report on population and climate change seeks to drum up alarm about a population of 11 billion people by 2050, as opposed to the more widely accepted projection of 9.15–9.51 billion.⁶ In the last few decades, population growth rates have come down all over the world more rapidly than anticipated; the average number of children per woman in the global South is about 2.5 and predicted to drop to around 2 by 2050. The demographic momentum built into our present numbers, declining death rates, and the youthful age structure of many developing nations are the reasons that world population will reach around 9 billion in 2050, but after that it is expected to stabilise. The real challenge is to plan for the addition of 2 billion people by 2050 in ways that minimise negative environmental impacts.

Serious environmental scholars are questioning and critiquing the population/climate connection. A study by David Satterthwaite, reviewing national emissions and demographic data from 1950–2005, concludes that it is misleading to see population growth as a driver of climate change. Satterthwaite notes that the contribution of greenhouse gas emissions of one individual added to the world's population varies by a factor of 1,000, and that it is mostly nations with very low or slow-growing emissions that have high population growth rates. Meanwhile, in North America emissions have outpaced population growth. While North America contributed about 4 per cent of world population growth between 1950 and 2005, it was responsible for 20 per cent of the growth in global carbon dioxide emissions from 1950 to 1980, and 14 per cent from 1980 to 2005.⁷

Linking emissions to population growth makes for poor science and poor policy, yet the population/climate connection continues to push this research agenda. OPT hired a graduate student at the London School of Economics (LSE) to undertake a simplistic cost/benefit analysis that purports to show that it is cheaper to reduce carbon emissions by investing in family planning than in alternative technologies. Although the student's summer project was not supervised by an official faculty member, the press billed it as a study by the prestigious LSE, lending it false legitimacy. Writing on the reproductive health blog RHRealityCheck, Karen Hardee and Kathleen Mogelgaard of PAI endorsed the report's findings without even a blink of a critical eye.⁸ In a bow to patriarchy and its privileges, pregnant women are portrayed as

the destructive face of climate change rather than the CEO of Exxon-Mobil. The population/climate connection thus directly undermines both reproductive health and climate policies. More indirectly, it interacts with and helps to legitimise other strategic population narratives that focus on climate change, migration, and security.

The greening of hate: targeting immigrants

For several decades now, the anti-immigrant movement in the United States has used population as a wedge issue to win over environmentalists to its cause. Under the leadership of white supremacist John Tanton, a wealthy ophthalmologist, it has twice attempted to take over the nation's largest environmental organisation, the Sierra Club. While it failed in these efforts, it is once again making a major push to recruit environmentalists with the claim that immigration drives greenhouse gas emissions and environmental degradation. When immigrants come to the United States, the reasoning goes, they adopt American lifestyles and consumption patterns, so they should stay home in poor countries where they have a lighter carbon footprint. Meanwhile, 'real' Americans should go on consuming as they always have.⁹

While mainstream groups like PAI, Worldwatch Institute, and Population Justice distance themselves from this greening of hate, their population control rhetoric helps make such beliefs more acceptable. There are also direct links between the anti-immigrant movement and the population lobby. Well-known environmentalist and population control advocate Lester Brown, founder of Worldwatch Institute and now president of the Earth Policy Institute, is a member of the Apply the Brakes Network, which seeks to limit immigration to the United States.¹⁰

That these ideas continue to have such force is testament to the enduring influence of Malthusian thinking in the United States, where the myth of overpopulation is a veritable article of faith taught in schools and colleges across the country.¹¹ This belief system provides fertile ground for the greening of hate, especially in an era when immigrants are also being scapegoated for the economic recession.

The militarisation of climate change

In the national security arena, alarms over potential 'climate conflict' and 'climate refugees' draw on similar racialised fears of overpopulation and migration. In particular, they draw on neo-Malthusian models of environmental conflict developed in the 1980s and 1990s. According to these models, population-pressure-induced poverty makes Third World peasants degrade their environments by over-farming or overgrazing marginal lands. The ensuing soil depletion and desertification then lead them to migrate elsewhere as 'environmental refugees', either to other ecologically vulnerable rural areas where the vicious cycle is once again set in motion or to cities where they

strain scarce resources. In both instances, they become a primary source of political instability. Such models were used to explain away the genocide in Rwanda as the ‘natural’ result of population pressure on the environment and were applied to many other violent conflicts as well.¹²

Even the conflict in Darfur has been blamed on overpopulation of people and livestock, combined with environmental stresses due to climate change.¹³ This is not to deny that environmental changes due to climate change could, in some instances, exacerbate already existing economic and political divisions. However, whether or not violent conflict and mass migration result depends on so many other factors that it is far too simplistic to see either population or climate change as a major cause or trigger.

Moreover, such threat scenarios ignore the way in which many poorly resourced communities manage their affairs without recourse to violence. A substantial body of research also indicates that violent conflict in Africa, for example, is much more connected to resource *abundance* (rich oil and mineral reserves, valuable timber, diamonds, etc.) than resource *scarcity*.¹⁴ Above all, it is institutions and power structures at the local, regional, national, and international levels that determine whether conflict over resources turns violent or not.

In the US, proponents of national security interests are also drumming up fears of potential instability caused by ‘climate refugees’. A 2003 Pentagon-sponsored study of the potential impacts of abrupt climate change painted a grim scenario of poor, starving, overpopulated communities overshooting the reduced carrying capacity of their land and storming en masse towards Western borders. Similar assumptions frame a number of climate and security scenarios.¹⁵

This dire picture of dangerous ‘climate refugees’ is problematic on a number of counts. First, while climate change is likely to cause displacement, its extent will depend not only on how much the temperature rises and affects sea levels, rainfall patterns, and the severity of storms, but also on the existence and effectiveness of adaptation measures that help individuals and communities cope with environmental stresses. Whether or not such measures are in place in turn depends on political economies at the local, regional, national, and international levels that are often conveniently left out of the discussion of so-called climate refugees. And as one report points out, larger climate-related humanitarian emergencies may take place in places ‘where people *cannot* afford to move, rather than the places to which they do move’.¹⁶

Secondly, the label ‘climate refugee’, like ‘environmental refugee’ before it, could further undermine the rights and protections of traditional refugees as defined by the 1951 UN Refugee Convention. Both the UN High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM) caution against using either the term environmental refugee or climate refugee since they have no basis in international refugee law and

could undermine the international legal regime for the protection of refugees. UNHCR further emphasises that much displacement due to climate-related factors is likely to be internal in nature, without the crossing of international borders.¹⁷

From 2007 on, Africa has been the primary focus of climate-conflict discourse. Accidental or not, this development has coincided with the establishment of the US military command for Africa, AFRICOM. By its very institutional structure, AFRICOM represents the blurring of military and civilian boundaries. Among its staff are senior US development officials. In general, AFRICOM seeks to integrate US military objectives more firmly with economic, political, and humanitarian goals.

Constructing climate conflict as a particularly African security threat meshes well with these objectives. While it is highly unlikely that the United States would send in the troops or base strategic development and humanitarian assistance solely on a perceived risk of climate conflict, the promotion of that risk helps to make such interventions more palatable, especially in liberal foreign policy circles. Blaming the poor of Africa for overpopulation and climate change is also a convenient way of obscuring the main mission of AFRICOM: to secure access to African oil and other natural resources for American corporations in the face of stiff Chinese competition.

Conclusion

Clearly, we must keep our critical eyes wide open to the ways in which the population/climate connection functions in these important arenas. We must simultaneously resist them and move forward, finding creative solutions to the urgent issues at hand. There are many progressive synergies between movements for reproductive justice, climate justice, immigrant rights, and peace.¹⁸ Identifying those synergies and working together, across movements, provides the best hope for the future.

Notes

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5 Figures on national per capita carbon emissions from Dow, K. and T. E. Downing (2007). *The atlas of climate change: mapping the world's greatest challenge*. Berkeley, University of California Press.

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and figures, see Population Reference Bureau (2010). *World population highlights: key findings from PRB's world populations data sheet*, 65(2), July. www.prb.org/pdf10/65.2highlights.pdf.

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8 www.optimumpopulation.org/reducingemissions.pdf; also see www.rhrealitycheck.org/blog/2009/09/22/climate-change-population-growth-and-reproductive-health-is-about-more-than-reducing-emissions.

9 Southern Poverty Law Center (2010). *Greenwash: nativists, environmentalism and the hypocrisy of hate*. July. www.splcenter.org/sites/default/files/downloads/publication/Greenwash.pdf; similar arguments are used by the anti-immigrant movement in the UK. See Hughes, B. (2010). *Too many of whom, and too much of what? What the new population hysteria tells us about the global economic aid and environmental crisis, and its causes. A No One is Illegal discussion paper*. NOII pamphlet on population politics, 10/07/2009, January. www.dustormagic.net/NOII/TooManyOfWhom-Jan10.pdf.

10 Center for New Community (2010). *Apply the brakes: anti-immigrant co-optation of the environmental movement*. www.newcomm.org/images/stories/ATB/atb_shortreport.pdf.

11 See www.populationinperspective.org for an alternative curriculum on population issues.

12 See Hartmann, B. in Rao, M. and S. Sexton (eds) (2010), *Markets and Malthus: Population, Gender and Health in Neo-liberal*

Times. New Delhi. And Hartmann, B. (2010). 'Rethinking climate refugees and climate conflict: rhetoric, reality and the politics of policy discourse'. *Journal of International Development*, 22(2): 233–346.

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17 IOM (International Organization for Migration) (2009). *Migration, climate change and the environment*. Policy brief, May. www.iom.int/jahia/webdav/shared/shared/mainsite/policy_and_research/policy_documents/policy_brief.pdf; and UNHCR (2008). *Climate change, natural disasters and human displacement: a UNHCR perspective*. 23 October. www.unhcr.org/refworld/pdfid/492bb6b92.pdf.

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SECTION D

WATCHING

D1 | WORLD HEALTH ORGANISATION: CAPTIVE TO CONFLICTING INTERESTS

The World Health Organisation's (WHO) ability to provide leadership in the arena of global health has been seriously compromised because its mandate has been usurped by multiple agencies, such as the World Bank, the World Trade Organization (WTO), and global public private partnerships (PPPs). In *Global Health Watch 1* (GHW1), the process of marginalisation of the WHO was clearly detailed. In its analysis, GHW1 concluded: 'Woefully inadequate resources, poor management and leadership practices, and the power games of international politics are just some of the forces hindering sustainable change in WHO' (People's Health Movement 2005). Consequently, there is an increasing tendency to characterise the WHO as a 'technical' agency that should concern itself only with issues related to the control of communicable diseases and the development of biomedical norms and standards.

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

GHW2 carried a detailed analysis of WHO's funding. It concluded: 'Instead of being funded as a democratic UN agency, it is in danger of becoming an instrument to serve donor interests' (People's Health Movement 2008). WHO's core funding has remained static because of a virtual freeze in the contributions of member states. A large proportion of WHO's expenditure (about 80 per cent) comes in the form of conditional, extra-budgetary funds that are earmarked for specific projects by contributing countries. The 2011 Executive Board of the WHO (in January 2011) discussed a paper by the WHO Secretariat that talked about the crisis in the WHO's finances (World Health Organisation 2010a). Today, the WHO is sustained through a financing system that undermines coherent planning and that forces the WHO departments and divisions to compete with each other (and with other organisations) for scarce



34 Demonstration in Geneva at the World Health Assembly, May, 2008 (Amit Sengupta)

funds. Consequently, health priorities are distorted, and even neglected, to conform to the desires of donors and to the requirement to demonstrate quick results to them. The WHO is in danger of compromising its own mission and principles because of conflict-of-interest issues that arise as a result of contradictions between the constitutional mandate of the WHO and the interests of individual donors. In this context, GHW₂ commented: ‘The WHO must “speak the truth to power”, as its director-general promises it will. But that means standing up to powerful industries and being more prepared to speak out against its most powerful member state’ (People’s Health Movement 2008).

The earlier analysis sounds almost prophetic as we look back at the different controversies that have rocked the WHO in the recent past. We detail below two instances where the WHO was compromised and held captive to the narrow interests of a few powerful countries and to those of private corporations.

Negotiations on public health, innovation and intellectual property: how a historic opportunity was hijacked¹

The negotiations undertaken by the Intergovernmental Working Group (IGWG) on Public Health, Innovation and Intellectual Property between 2006 and 2008 were the result of a deadlock in the WHA in 2006 where member states were unable to reach an agreement on what to do with the recommendations in the report on Public Health, Innovation and Intellectual Property (also

known as the CIPIH report),² submitted to the WHA in the same year by a group of experts designated by the director general of the WHO. The 59th WHA approved Resolution 59.24, which requested that an intergovernmental working group open to all WHO members be established. The resolution also requested the director general to include in the intergovernmental group organisations of the United Nations (World Health Organisation 2007a) NGOs in official relations with the WHO, expert observers, and public and private entities. These negotiations resulted in the ‘Global strategy and plan of action (GSPOA) on public health, innovation and intellectual property’, which was approved by the WHA in 2008 (World Health Assembly 2008).

The intention of the GSPOA was to substantially revamp the research and development (R&D) system of the pharmaceutical companies in view of the findings that the present system, working within the intellectual property-based framework, had failed to ensure access to medical products where they were most required.

The intergovernmental group held negotiations for nearly two years, between December 2006 and May 2008, with three meetings in Geneva, which were attended by representatives from over one hundred countries, as well as several other meetings in all the WHO regions.

As is usual in United Nations negotiations, there were groups, alliances, and mediators that helped build a consensus. A first group, which was led by the United States and Switzerland, was supported by Australia, Japan, South Korea, Colombia, Mexico, and Canada. A second group, which was led by Brazil, Thailand, and India, was supported by a great majority of the develop-



35 WHO is unfairly characterised as just a technical agency (Indranil Mukherjee)

ing countries. The European Union was led by Portugal during the first part of the IGWG, and then by Estonia, in their capacities as presidents of the EU. The not-for-profit NGOs working in the field of public health played an important role. Representatives and lobbyists of the pharmaceutical industry were permanently present in the hallways and corridors, actively trying to influence the different stakeholders. Unfortunately, several United Nations agencies that fully share a public-health vision, such as UNICEF, UNDP, and UNAIDS, were practically absent from the discussions. WIPO and the WTO participated throughout the negotiations, and the group of industrialised countries, as well as the Secretariat of the WHO, requested their comments and points of view on subjects related to the interpretation and management of intellectual property.

First meeting in Geneva, 4–8 December 2006 The preparations for this meeting and the documents that were to serve as a reference, were not in the spirit of the recommendations of the CIPIH, which provided the basic mandate for the negotiations. Attempts were made to dilute and hide references to intellectual property, which was supposed to be at the core of the discussions during the negotiations.

When the WHO Secretariat presented the key elements of the proposed strategy at the first meeting, the issue of intellectual property had practically disappeared! During the chaotic discussions that ensued, the developing countries managed to force a consensus on the need to introduce issues related to intellectual property in the text under negotiation. The WHO Secretariat decided to isolate this issue in a separate chapter (element 5: ‘Application and management of intellectual property to contribute to innovation and promote public health’). The fact that intellectual-property-related issues were ghettoised into one section, and were not made part of the discussions of all the elements of the text under negotiation, constituted the most fundamental problem in the negotiations henceforth. Another small success achieved by the developing countries was an agreement to include discussions on the possible negative impact of free-trade agreements.

Throughout the negotiations, a group of industrialised countries questioned the WHO’s authority in the area of intellectual property, insisting that this was an issue that should be dealt with by the WIPO and the WTO. According to these countries, the WHO should only be involved in health care aspects (World Health Organisation 2007a), excluding other decisive aspects influencing the health sector. Nor could agreement be reached on the inclusion of a reference to human rights, or on a statement that public health has priority over intellectual property rights.

The first meeting ended abruptly without any conclusion or consensus being reached. In July 2007, the IGWG Secretariat issued a new version of the GSPOA. An additional column was introduced in the action plan to indicate

the ‘stakeholders’ (WHO member states, Secretariat of the WHO, WIPO, WTO, national institutions, academia, industries, PPPs, NGOs, etc.). This initiative by the Secretariat was later used by certain countries as a means to try to exclude the WHO from certain activities, especially those pertaining to intellectual property.

Regional consultations and the ‘Rio Document’ Regional and inter-country meetings took place during the second quarter of 2007. The most important of these, in terms of impact on the negotiations, was the one held in Rio de Janeiro, attended by Argentina, Brazil, Chile, Costa Rica, Cuba, Ecuador, El Salvador, Honduras, Mexico, Peru, Suriname, Uruguay, and Venezuela. The meeting produced what was referred to as the ‘Rio document’. The Rio document included the following principles:

- a) The right to health protection is a universal and unalienable right, and it is the obligation of governments to guarantee that the instruments for implementing this right are available.
- b) The right to health takes precedence over commercial interests.
- c) The right to health implies access to medicines.

Second meeting, 5–10 November 2007 The draft, produced at the end of the second meeting, was clearly influenced by the Rio document. Although substantive progress was made in this meeting, several key points remained in parentheses because no consensus had been reached. A welcome development was an agreement (point 30.2.3.c) to ‘encourage further exploratory discussions on the utility of possible instruments or mechanisms or essential health and biomedical research and development, including, inter alia, an essential health and biomedical research and development treaty’. This is undoubtedly the central and most important point of the Global Strategy, and the one that aroused the most opposition from the pharmaceutical industry, as well as from some industrialised countries. The meeting, however, left unresolved the issue of whether the WHO would be a stakeholder in this project. One and a half years later, at the January 2009 Executive Board meeting, and at the 2009 WHA, a group of nine countries, with the presence of the WHO Secretariat acting as an ‘observer’, used the WTO ‘green room’ technique and agreed to exclude the WHO as one of the stakeholders in this activity of the plan of action. Thus, many of the gains obtained by including this issue in the text were overturned later, as without the WHO as a stakeholder the proposal remains largely toothless and meaningless.

Continuation of the second meeting, 28 April–3 May 2008 After negotiating one sentence at a time, and sometimes even one word at a time, consensus was reached on four of the seven elements. The elements that eluded a consensus

were *element 4*: transfer of technology; *element 5*: management of intellectual property; and *element 6*: improving delivery and access.

Many of the open points enclosed in parentheses pending consensus had been blocked only by the United States, and several countries requested that ‘pending USA approval’ be indicated in the draft with respect to these elements. The most problematic element for the United States delegation was element 5, in aspects such as ‘the need to find new incentive schemes for research’, the role of the WHO with regard to intellectual property, the protection of test data, and the reference to TRIPS-plus measures in bilateral trade agreements.

61st World Health Assembly, 24 May 2008 During the 61st WHA, another meeting was held. On the Friday prior to the close of the WHA, the WHO Secretariat authorised a ‘WTO green room’-type meeting (a closed-door meeting with a group of nine countries). This practice, the first one in the history of the WHO (with the exception of some negotiations on the anti-tobacco convention), was strongly criticised by many countries in public, and they even threatened to not recognise the consensus reached by the nine countries. Such a process and similar criticisms were to be repeated during the 62nd WHA in May 2009, when another ‘green room’ manoeuvre led to the exclusion of the WHO as a stakeholder in the activity related to the treaty on R&D.

As this was the final stretch of the negotiations, the Secretariat and the countries wanted to finish the exercise (only a few NGOs tried to extend the IGWG but were unsuccessful). Hence, this was the moment when the technique of referring to ‘previously agreed-to documents and other forums’ was used most often. Since most of the pending elements belonged to element 5 (intellectual property and patents), the topic of intellectual property was the one that most suffered or profited from this technique.

Certain aspects were deleted, and others were adapted with certain changes that weakened the text. References to TRIPS-plus provisions, parallel imports, the concepts of patent expiration and invalid patents, the patentability criteria, and even test data exclusivity were eliminated.

Exclusion of WHO as a stakeholder from a proposed R&D treaty

On the last day of the WHA, and at the last moment, a resolution sponsored by Canada, Chile, Iran, Japan, Libya, Norway, and Switzerland, and with the support of the United States, was approved. This resolution made reference to, and approved, document A62/16 Add.3, which excluded the WHO from future discussions regarding the treaty.

Several developing countries (Argentina, Bangladesh, Barbados, Bolivia, Cuba, Ecuador, Ghana, India, Jamaica, Nicaragua, Suriname, and Venezuela) expressed their disagreement with the way in which the closed-door informal consultations were carried out, as well as with the result of these consulta-

tions to exclude the WHO as a stakeholder in future discussions regarding a possible international treaty.

Disappointing outcome of negotiations

The GSPOA on public health, innovation and intellectual property was approved by the WHA in May 2008. The final wording of the GSPOA is, in many cases, vague, weak, and full of conditions and nuances. Two examples will suffice to show how the final text was weakened to the extent that its meaning became obscure and largely unusable. Instead of a clear recommendation that the WHO should provide technical and regulatory support to make use of the flexibilities contained in the TRIPS agreement, the final text says:

... providing as appropriate, upon request, in collaboration with other competent international organizations technical support, including, where appropriate, to policy processes, to countries that intend to make use of ...

Developing countries were largely united in asking for an international agreement or convention as an alternative form of funding R&D for the pharmaceutical products to be studied. The final text diluted this intent to say:

2.3 (c) encourage further exploratory discussions on the utility of possible instruments or mechanisms for essential health and biomedical research and development, including inter alia, an essential health and biomedical research and development treaty.

Article 19 of the WHO constitution states:

The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.

Yet the WHA failed to conclusively ratify an agreement that acted decisively in favour of a process that would look beyond the intellectual property framework to make medical products accessible and to incentivise innovations directed at resolving problems faced by the poor in developing countries. In the case of the IGWG negotiations, this happened in spite of a majority of the countries present being in favour of a decisive agreement. Instead, the WHA chose to arrive at a consensus that was driven, in large measure, by a few developed countries.

It is important to underline the role of several developing countries mentioned earlier, and especially the group of African countries, which struggled in the face of intense pressure from a few developed countries to insert useful language in the final text. Mention should also be made of several not-for-profit NGOs (including Essential Action, Health Action International, Health

Gap, Knowledge Ecology International, Médecins Sans Frontières, Oxfam International, and Third World Network) and some invited experts, who toiled hard to make their concerns heard and who managed to make a substantial impact on the final text. It is a testimony to their efforts that the final text, in spite of all the shortcomings, embodies several positive outcomes that remain with us and have the potential to be built upon. They include:

- The scope of the Global Strategy is not restricted to the three diseases (malaria, AIDS, and tuberculosis).
- A consensus was reached on the need for new mechanisms to incentivise R&D.
- A special group of experts to examine the R&D funding systems was established. This group was supposed to report to the 63rd WHA, but now it will report to the 65th WHA in 2012.
- The topic is still on the agenda, at least until 2015, and the Secretariat will have to report to the WHA every two years.
- Finally, for the third time after the adoption of the anti-tobacco convention and the international sanitary code, the idea of the treaty raised the issue (although without much success) of the need for the WHO to exercise the right conferred on it under Article 19 of its Constitution, which allows its 'recommendation' on public health to take on a mandatory character.

An unsavoury postscript

The saga of the IGWG negotiations is followed by a rather unsavoury and bizarre postscript. One of the few tangible outcomes of the negotiations was the decision by the WHO in 2008 to constitute an Expert Working Group (EWG). The EWG was mandated to examine different mechanisms for R&D, financing, and coordination. It was expected that the group would find new ways to pay for, and prioritise, health research and the development of new medical products. In late 2009, Wikileaks carried a story that the report had been leaked in advance to the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) (Lancet 2010). The IFPMA, in its internal communications, had also lauded the EWG report (even before the report was presented to the WHO!) (ibid.). This was subsequently followed by a letter, on 15 January 2010, by a member of the EWG, Cecilia Lopez Montano (also a senator of the Colombian Congress), to the Executive Board members of the WHO, urging the members to refuse endorsement of the EWG's report, stating that the method of work of the EWG was not transparent or participatory, and that she was used for legitimising the EWG process (Shashikant 2010b).

The reason for the IFPMA's advance approval of the EWG report was clear when the report was presented before the WHA in 2010. The conclusions of the report failed to address the impact of intellectual property on access to

medicines, and ignored the need to explore financial mechanisms that could overcome the problems posed by a patent-based system for R&D. The report was rejected by member states, and the WHO Secretariat was directed to constitute a fresh working group, which would present its report at the WHA in 2012.

WHO's anti-counterfeit policy: the strange case of IMPACT

WHO's association with the International Medical Products Anti-Counterfeiting Task Force (IMPACT) is shrouded in mystery. Serious concerns have been raised about how IMPACT, a body with a strong pharmaceutical industry presence, has been allowed to dictate WHO's policy, especially in the sensitive area concerning counterfeit medicines. We recount below the IMPACT story, in order to clarify the threat that IMPACT poses to the credibility of WHO (Third World Network 2010).

Origins and objectives of IMPACT

IMPACT is a WHO-hosted 'partnership' set up 'to promote and strengthen international collaboration to combat counterfeit medical products' (World Health Organisation 2006). IMPACT originated in a series of planning sessions, leading to an organising meeting in Rome on 16–18 February 2006. This meeting, 'Combating Counterfeit Drugs: Building Effective International Collaboration', is described in IMPACT literature as a WHO international conference. It was jointly sponsored by WHO and IFPMA.

IMPACT has a policy of keeping the names of attendees at their meetings secret 'for reasons of privacy and security' (World Health Organisation 2010b), so we can only guess at the identity of the attendees of the Rome meeting, and we are equally in the dark as to the actual deliberations. We do know that many pharmaceutical-industry-affiliated groups took part at various stages of the planning and execution of the meeting, including the International Pharmaceutical Federation (FIP), the European Association of Pharmaceutical Wholesalers, the International Federation of Pharmaceutical Wholesalers, the Pharmaceutical Security Institute, the International Alliance of Patients' Organisations (funded in part by Astra-Zeneca, GlaxoSmithKline, Johnson and Johnson, Lilly, Merck, Novartis, Pfizer, and Sanofi-Aventis), the Pharmaceutical Research and Manufacturers Association, and the International Federation of Pharmaceutical Manufacturers and Associations. Representatives of 57 national drug regulatory authorities (DRAs), seven international organisations, 12 international associations of patients, and 'health professionals' were also present (World Health Organisation 2010c).

Is IMPACT part of the WHO, or merely 'hosted' there?

After the Rome meeting, IMPACT became a hosted 'partnership' within WHO, with WHO acting as the secretariat. IMPACT is described variously

in WHO documents as ‘a task force administered by WHO’; ‘IMPACT is a partnership’; ‘not a legal entity’; and ‘guided by the [IMPACT] General Meeting’ (i.e., under separate governance); with ‘secretariat support’ from WHO. An unusual provision in the IMPACT terms of reference requires WHO to ‘take the necessary measures to ensure the confidentiality and protection of materials and information that are provided to WHO with the request to keep them protected from unauthorized access’ (ibid.). This unusual restriction on WHO would logically characterise IMPACT and WHO as separate entities.

IMPACT is a separate entity, with secretariat functions provided by WHO. This is not an unusual arrangement. However, the WHO’s Department of Essential Medicines and Pharmaceutical Policies (EMP) tells us that ‘IMPACT is also part of the department’ (World Health Organisation 2011a). We are also told that IMPACT ‘... has become the main conduit for WHO’s work on counterfeit medicines’ (World Health Organisation 2010d). This suggests that IMPACT has a direct technical and policy role in WHO. Adding to the confusion, some documents bear only IMPACT’s logo in some editions, and both IMPACT and WHO logos in others (World Health Organisation 2007, 2008).

IMPACT partner INTERPOL has no hesitation in describing IMPACT as part of WHO. IMPACT–INTERPOL raids and seizures of ‘counterfeit’ medicines from pharmacies, distributors, and markets in Tanzania and Uganda are described as ‘combined INTERPOL–World Health Organization (WHO) operations’. Similar INTERPOL police actions in several Southeast Asian countries are described as ‘supported by INTERPOL, the WHO and the World Customs Organization (WCO), under the framework of IMPACT’ (INTERPOL 2008a, b).

There are two IMPACT websites (World Health Organisation 2009; IMPACT 2009). One is the WHO site and the other is in a separate non-WHO location. In the non-WHO IMPACT site, a WHO logo appears at the top of the home page, but it is in a separate image file and disappears when the webpage is printed, making it difficult to document this use of the WHO logo, which is probably in violation of WHO guidelines (‘the use of the WHO emblem on non-WHO websites is normally not allowed ...’) (World Health Organisation 2011b).

The ambiguous position of IMPACT within WHO serves several purposes. Two of the heads of IMPACT’s five ‘working groups’ are full-time pharmaceutical industry employees. An IMPACT organogram (Rägo 2010) shows the working groups as outside of WHO, which provides some ‘plausible deniability’ to charges that industry staff have directly infiltrated WHO. It also allows IMPACT to receive financial support from industry in its guise as a separate entity, thus circumventing WHO’s own guidelines (World Health Organisation 2000).

More importantly, this arrangement has made it possible to receive technical documents from industry sources, which can then be ‘sanitised’ before

transmission to WHO proper. An example is the document ‘A Guide to Anti-Counterfeiting Technologies for the Protection of Medicines’. It proposes a variety of high-tech protections, such as holograms, ‘optically variable devices’, colour-shifting security inks and films, and fine-line printing similar to that used on banknotes, all of which might be useful in protecting high-value branded products, but would be unavailable to low-cost generic producers and low-income producer countries. The priority here is obviously intellectual property protection, not counterfeit prevention. This document was prepared by GlaxoSmith Kline and introduced into WHO’s policy process – a process facilitated by the fact that the chair of IMPACT’s Technology Working Group is also the director general of IFPMA (Third World Network 2010). This process appears to be in violation of WHO’s policies on working with the private sector and on partnerships (World Health Organisation 2000, 2010e).

IMPACT’s terms of reference claim that IMPACT was originally ‘proposed by WHO’, citing a paper (Forzley 2006) presented at the Rome meeting. This paper, marked as a ‘background document’, is identified as originating from WHO’s Health Technologies and Pharmaceuticals unit. However, it was not written by WHO. Its author, Michele Forzley, is a US intellectual property lawyer and consultant who was an early advocate of the concept of framing ‘counterfeit’ as a public health issue (Forzley 2003, 2006; Third World Network 2010). The WHO Secretariat claims unequivocally that IMPACT has a legitimate place in the Organisation: IMPACT ‘... has become the main conduit for WHO’s work on counterfeit medicines’. The Secretariat justifies the existence of IMPACT on ‘discussions at the Sixty-first World Health Assembly and the 124th session of the Executive Board’ (World Health Organisation 2010d). However, no resolutions or decisions were taken on IMPACT at either of these meetings.

WHO member states have questioned IMPACT’s role within WHO. At the 63rd WHA, India and Thailand argued that ‘... IMPACT, or its Terms of Reference, has not been approved by any governing body of WHO and ... there are conflicts of interest in its composition’. India added: ‘Clearly, IMPACT is ... an instrument of IPR policy and market access by some of the largest economies of the world’ and it is ‘one of the prongs of the multi-pronged TRIPS+ enforcement drive of some developed countries and originator pharmaceutical companies’. Concerns about IMPACT were also expressed by Kenya, Venezuela, Bolivia, Ecuador, Bangladesh, Egypt, Iran, and Pakistan. On the other hand, the United States, Switzerland, and Spain expressed support for IMPACT (Shashikant 2010a).

The policy agenda of IMPACT

IMPACT’s approach to the definition of ‘counterfeiting’ is revealing.

The WTO treats counterfeiting exclusively as a form of trademark violation. WHO developed a definition of counterfeit medicine in 1992:

A counterfeit medicine is one which is deliberately and fraudulently mislabelled with respect to identity and/or source. Counterfeiting can apply to both branded and generic products and counterfeit products may include products with the correct ingredients or with the wrong ingredients, without active ingredients, with insufficient active ingredients or with fake packaging. (World Health Organisation 1992)

While quoting the WHO definition in several documents, IMPACT argues elsewhere that a new definition is needed. In 2007, IMPACT proposed rephrasing the first sentence as follows: ‘A medical product is counterfeit when there is a false representation in relation to its identity, history or source’. In a 2008 IMPACT definition, the words ‘deliberately and fraudulently’ were removed. Both these changes increase the ambiguity and broaden the scope of what is ‘counterfeit’. ‘False representation’ could include trademark or packaging similar to that of a branded product. The word ‘history’ is (deliberately?) imprecise, and could encompass incompletely documented distribution channels. The removal of the words ‘falsely and deliberately’ eliminates the element of intent from the definition, so that a variety of minor or unintentional documentation failures could be considered ‘counterfeiting’, and potentially subject to criminal penalties. Together with the push to criminalise ‘counterfeiting’, these definition changes pose a real threat to small producers, generic producers, and even distributors and sellers, who would become liable to criminal prosecution for relatively trivial procedural errors (WHO South East Asia Regional Office 2008).

Also, in 2008, IMPACT produced another definition of ‘counterfeit’:

A medical product is counterfeit when there is a false representation in relation to its identity (name, composition, strength, or any other element that may influence the judgment of health professionals, patients or consumers about the identity of the product) or source (manufacturer, country of manufacturing, country of origin, marketing authorisation holder), or any other element that may influence the judgment of health professionals, patients or consumers about the source of the product. (World Health Organisation 2007b)

This definition is particularly alarming because it could very easily encompass legitimate generic products and their producers, distributors, and sellers, and because it appears on the WHO website in a document bearing both the IMPACT and WHO logos. This document, titled ‘Principles and Elements for National Legislation against Counterfeit Medical Products’, has been picked up enthusiastically by the European Commission and the World Intellectual Property Organization (Third World Network 2010). It is extraordinary that IMPACT was able to produce a new and radically different definition of ‘counterfeit’, have it legitimised by WHO, and then adopted elsewhere, without the knowledge or approval of WHO’s member states or governing bodies.

IMPACT has taken this document and its expanded definition of ‘counterfeit’ to countries in a deceptive manner. At the 63rd WHA in May 2010, the delegate from Kenya reported that Kenya’s law on counterfeit products was the result of advice given by IMPACT, adding that the law has been problematic in providing health facilities and access to medicine (Mara 2010).

Recent IMPACT documents have claimed that IMPACT does not concern itself with intellectual property matters (World Health Organisation 2010c). However, IMPACT’s claim that it is not concerned with intellectual property matters is half-hearted, insincere, and deceptive. One of the main policy products of IMPACT, the ‘Principles and Elements for National Legislation against Counterfeit Medical Products’, does state that ‘principles set out in this document do not specifically address ... infringement of aspects of intellectual property rights (IPR), including patent rights ...’, but only after stating: ‘Counterfeit medical products need to be addressed through different bodies of legislation: on intellectual property protection and enforcement, on pharmaceutical and medical devices regulation and control, and criminal law. All these bodies of legislation should be in place.’

The role of IFPMA in IMPACT is significant in this respect. IFPMA co-organised and co-funded IMPACT’s organising meeting in Rome, co-chaired IMPACT’s first global technical meeting, ‘Combating Counterfeit Medicines: Where the Regulatory and Technology Roads Meet’ (IFPMA 2008), and continues to play a leadership role – for example, heading the IMPACT working group on technology. IFPMA has a long-standing position on ‘counterfeit’. At the 1992 meeting ‘Counterfeit Drugs: Report of a WHO/IFPMA Workshop’, IFPMA’s executive vice-president clearly stated IFPMA’s view of ‘counterfeiting’ as an intellectual property crime to be controlled through enforcement and prosecution:

Counterfeiting of any type of goods is a crime because it is theft and thus deprives the authentic manufacturer of his just rewards. The main answer to control ... must be application of due processes of law ... detection; prosecution; judgment; punishment. (World Health Organisation 1992)

WHO’s approach is, or was, quite different. While recognising that ‘counterfeiting’ is a crime, WHO and its member states see beyond the limited issue of ‘counterfeits’ to the actual public health problem, which is the elimination of ‘substandard/spurious/falsely-labelled/falsified/counterfeit medical products’ (World Health Organisation 2010d). Protection of private property rights has not been a concern. In line with this understanding, WHO has accorded priority to national DRAs in its recommendations for countering counterfeiting (World Health Organisation 1999). DRAs have responsibility for ensuring the quality, safety, efficacy (QSE) and the correct use of drugs. IMPACT places little or no emphasis on QSE or on the role of DRAs (IMPACT 2008). While other units within WHO’s Essential Medicines and Pharmaceutical Policies

Department continue to work on QSE issues, the creation of a well-funded separate body dealing exclusively with ‘counterfeit’ medicines is an incoherent policy from the public health perspective, and was never authorised by WHO’s governing bodies.

Against WHO’s guidelines

If IMPACT’s Rome meeting was a WHO meeting as claimed, and if IMPACT is indeed a part of WHO, then both the co-funding of the Rome meeting by IFPMA and IFPMA’s continued support to IMPACT’s activities appear to be in violation of WHO’s guidelines on working with the private sector (‘... financing may not be accepted from commercial enterprises for activities leading to production of WHO guidelines or recommendations ... WHO should avoid indirect collaboration particularly if arranged by a third party acting as an intermediary between WHO and a commercial enterprise ... funds may not be sought or accepted from enterprises that have a direct commercial interest in the outcome of the project toward which they would be contributing ... WHO may not cosponsor a meeting being held by specific commercial enterprises [or with] one or more health-related enterprises ...’) (World Health Organisation 2000).

IFPMA certainly qualifies as a ‘third party acting as an intermediary between WHO and a commercial enterprise’, since its membership includes 26 pharmaceutical companies (IFPMA 2010). On the other hand, if IMPACT is considered to be merely a partnership hosted within WHO, the arrangement is probably in violation of WHO’s guidelines on partnerships (World Health Organisation 2010c). (‘... risks and responsibilities arising from public–private partnerships need to be identified and managed through development and implementation of safeguards that incorporate considerations of conflicts of interest ... the partnership shall have mechanisms to identify and manage conflicts of interest ... the Director-General shall submit to the Executive Board any proposals for WHO to host formal partnerships for its review and decision ... fundraising by a WHO-hosted partnership from the commercial private sector shall be subject to WHO’s guidelines on interaction with commercial enterprises ...’). Through its ‘half-in and half-out’ position in WHO, IMPACT attempts to evade one set of restrictions on its activities, but encounters another.

Conclusions on the IMPACT Story

The IMPACT episode is not the first time that private commercial interests have had an undue influence on WHO’s work. However, it is the first time that private industry has penetrated directly into WHO’s operations, with the capacity to insert industry messages, directly and essentially unfiltered, into WHO’s policy and technical documents. Was the insertion of IMPACT into WHO’s policy-making done ‘deliberately and fraudulently’? Certainly, some

IMPACT products appear to be ‘mislabelled as to content and source’. *Can we say, then, that IMPACT is ‘counterfeit’?*

Would the IMPACT fiasco have occurred had the WHO been operating strictly within the ambit of its Constitution and guidelines and relying solely on unconditional funding received as dues payments or other unrestricted grants from its member states? Had it done so, the WHO would be 80 per cent less wealthy, but 100 per cent more credible as ‘the directing and co-ordinating authority on international health work’ (World Health Organisation 1946).

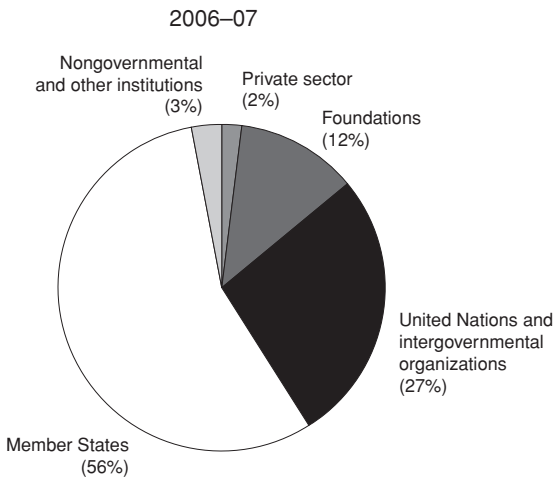
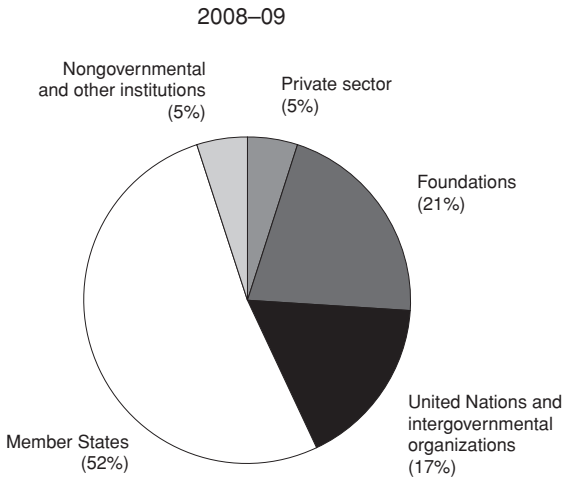
A long-delayed first meeting of an intergovernmental working group to examine, among other things, WHO’s relationship with IMPACT took place in March 2011, but was unable to resolve the issue.³ It was also revealed that the IMPACT Secretariat has removed itself, mysteriously, from Geneva to the Italian Medicines Agency (AIFA), where it is producing documents bearing the IMPACT and AIFA logos. This leaves us with three separate IMPACT websites, only one of which reveals IMPACT’s present location. It is not surprising to find that one document, ‘IMPACT: the Handbook’, contains one of the many unapproved and potentially harmful definitions of ‘counterfeit’ (Agenzia Italiana del F armaco 2011).

As a first step in recovering from the embarrassment caused by the IMPACT episode, it is hard to improve on the recommendation of India and Thailand made at the 63rd WHA:

... replace WHO’s involvement in the International Medical Products Anti-Counterfeiting Taskforce with an effective programme to address the issues of quality, safety and efficacy ... (World Health Organisation 2010e)

Conclusion

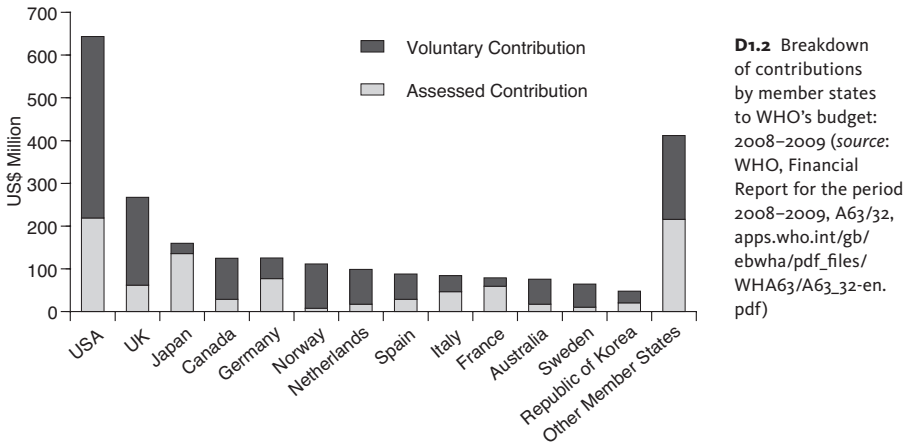
The two case studies discussed here are illustrations of the crisis faced by the WHO today. The crisis in WHO’s finances has reached a stage where only 20 per cent of its budget comes from assessed (i.e. mandatory) contributions from member states (World Health Organisation 2010g). The skewing of WHO’s finances in favour of voluntary contributions (a large proportion of which is not flexible and can be used only for programmes specified by the donors) places the organisation’s role as an independent body at risk. A large proportion of contributions from member states is also ‘voluntary’, i.e. they are for specific programmes (Charts D1.1 and D1.2). The report by the director general of the WHO to the Executive Board says: ‘... given that more than 60% of WHO’s income takes the form of highly-specified funding, an area of work that attracts significantly more, earmarked, voluntary funding than another becomes de facto a priority ...’ (World Health Organisation 2010g). Further, there is a continued push towards restricting the mandate of the WHO to that of a ‘technical body’, with little or no mandate to pursue work in areas seen as ‘developmental’. The director general’s report to the



D1.1 Sources of voluntary contributions to WHO's budget (source: WHO, Financial Report for the period 2008–2009, A63/32, apps.who.int/gb/ebwha/pdf_files/WHA63/A63_32-en.pdf)

Executive Board of the WHO articulates this tension as follows: ‘The global governance role of WHO in the field of development is much less clear. In recent years, development has attracted growing political attention, increasing resources, and a proliferation of global health initiatives.’

Clearly, there is a need to develop a sustainable financing and strategic plan for the WHO that is premised on increased assessed contributions of member states, with a view to securing the independent role of the WHO, its continuing and expanding role in providing stewardship in dealing with global health issues, and to reversing the present 20:80 division in the WHO’s finances. Such a plan should also propose mechanisms for ensuring that voluntary and donor contributions are not channelled for specified programmes, but are free to be used for promoting the overall goals of the WHO that are collectively decided upon by member states. The plan should also propose a



code of conduct on voluntary donations, so as to prevent conflict of interest between donor priorities and the member-state-driven agenda of the WHO. The WHO Constitution mandates WHO to take up the leadership role with respect to the coordination of international decision-making on health matters. This should include holding the large donors to account with respect to the effectiveness and coordination of their technical and funding roles. It cannot be consistent with WHO's mandate to withhold commentary on the large donors because they also provide tied funds to WHO. Health is a political as well as a technical subject. WHO must accept the responsibility of engaging in the politics of health as well as advising on technical issues (People's Health Movement 2011).



36 WHO's role as an independent organisation is at risk (Indranil Mukherjee)

Notes

- 1 This analysis draws heavily from a more detailed analysis in Velásquez (2011).
- 2 Public health, innovation, and intellectual property rights: report of the Commission on Intellectual Property Rights, Innovation and Public Health (2006). Geneva, WHO.
- 3 WHO (2011) Working Group of Member States on Substandard/Spurious/Falsely Labeled/Falsified/Counterfeit Medical Products.

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D2 | UNICEF AND THE 'MEDICALISATION' OF MALNUTRITION IN CHILDREN

Extent and spread of malnutrition

As a result of the current global food crisis, it is estimated that 925 million people do not have enough to eat, i.e. more than the entire populations of the USA, Canada, and the European Union together. Ninety-eight per cent of the world's hungry live in developing countries and 65 per cent of the world's hungry live in only seven countries: India, China, the Democratic Republic of Congo, Bangladesh, Indonesia, Pakistan, and Ethiopia (World Food Programme 2010).

Our nutritional status is influenced by five interrelated factors: political instability; poverty and/or inequality; biased and ineffective development policies; changes in the environment (including climate change); and lack of health, care, and household food security. Sub-Saharan Africa has been under the influence of all these factors, either singly or in varying combinations. Of the countries in sub-Saharan Africa, from what we know objectively, five in particular – Niger, Zambia, Malawi, Rwanda, and Madagascar – are showing rapid deterioration, particularly in stunting, according to recent Demographic and Health Surveys (DHS) (Teller and Alva 2008).

Simultaneously, the rate at which malnutrition had been improving has also declined. In 2001–03, FAO estimated that there were still 854 million undernourished people worldwide, of which 820 million were in the developing countries. Since 1990–92, the undernourished population in the developing countries declined by only 3 million people, from 823 million to 820 million. This contrasts starkly with the reduction of 37 million achieved in the 1970s, and of 100 million in the 1980s (FAO 2006).

Amongst the hungry, the issue of child malnutrition has particular significance as a veritable human rights emergency and a continuing scourge befalling upon humanity. Child malnutrition, an indicator of both the level of food insecurity, care and health in a community and of the nutrition status of future adults (because of malnutrition's intergenerational consequences), continues to be widespread in a population of almost 200 million children under five (one in three children) in developing countries. Twenty-four countries bear 80 per cent of the developing world's burden of undernutrition as measured by stunting (an indicator of chronic hunger). In Africa and Asia, stunting rates of under-fives are particularly high, at 40 per cent and 36 per cent respectively. More than 90 per cent of the developing world's stunted children live in Africa and Asia (UNICEF 2009a).



37 Two malnourished Nigerian children during the Nigerian-Biafran civil war, 1968: Not enough has changed in many parts of the world in the last 3 decades (CDC/Dr. Lyle Conrad; <http://phil.cdc.gov>)



38 Homeless woman with child in New Delhi, 2007 (© Paul Prescott | Dreamstime.com)

The global food crisis has brought about a slowing in the improvements of the nutritional status of under-fives, increasing inequalities (including those in gender), as well as threats to the livelihoods of poor and marginalised groups across the developing world. Once and for all, it becomes imperative to think in terms of much more comprehensive strategies to address child malnutrition. We are talking about strategies that address not only specifically the immediate nutritional needs of children (their right to nutrition), but also the complex socio-economic and political root causes of malnutrition.

Strategies to combat malnutrition

A fair amount of consensus exists on the basic conditions required to improve child nutrition and to prevent malnutrition overall. There is consensus, for instance, that the last trimester of pregnancy and the initial period after birth are the most important; it is proven that interventions should concentrate



39 Child in Senossa, Mali (© Attila Jandi | Dreamstime.com)

on children under two years of age; exclusive breastfeeding for six months is essential; complementary feeding must begin at six months of age; and children require good-quality diverse foods to thrive. However, there is still a debate on the best way of achieving these goals and on the relative investments that must be made foremost in preventive and promotive, as well as in curative, strategies. Therefore, while one end of the debate focuses on technical interventions, the other end emphasises decentralised social interventions that allow for community control. Most people would argue for a judicious mix of these elements. Recent trends, unfortunately, point to a shift in the balance in favour of technical interventions and a neglect of other community-based and social interventions.

The medicalisation of malnutrition – the RUTF story

There has been a relatively recent global focus on severe acute malnutrition (SAM); it has engaged the energies and funds of the most active institutions working in this area, especially led by UNICEF. SAM is a severe and acute condition that increases the risk of mortality significantly and demands urgent action. Some have called it a ‘medical emergency’, thus linking it to medical interventions such as hospitalisation and foods-given-as-medicines, i.e. standardised, commercial, Ready to Use Therapeutic Foods (RUTF).

RUTF are basically energy-dense foods with added minerals and vitamins, and are recommended for the short-term management of SAM (for about six

to eight weeks). They lend themselves well to community-based treatment – a major advance over earlier practices, where those suffering from SAM needed to be hospitalised. Not only do RUTF help children to recover from the effects of SAM, they also reduce the requirements for hospitalisation. UNICEF, along with WHO, now recommend that cases of SAM not suffering from complications be managed at home and treated with RUTF.

The debate on the use of RUTF has centred primarily around the introduction of the proprietary product called Plumpy’nut, which was developed in the 1990s by a French paediatrician, André Briend. Briend was later to transfer the know-how to a French company called Nutriset, which now holds all intellectual property rights related to the product (see Box D2.1). The product came to prominence when it was used in 2005, by the international relief NGO Médecins sans Frontières (MSF), in famine-ravaged Niger. MSF distributed Plumpy’nut to 60,000 children and MSF’s data showed that 90 per cent of the children who were fed Plumpy’nut completely recovered, and only 3 per cent died (Defourny 2007). In 2007, the World Health Organisation and UNICEF declared that this kind of treatment was the best for severe and acute malnutrition in children aged between six months and two years (WHO et al. 2007).

Plumpy’nut was soon being aggressively distributed by UNICEF. In 2009, it bought 10,500 tonnes compared with 4,000 tonnes in 2005. In 2009/10, UNICEF procured 14,500 tonnes of RUTF from Nutriset, France – 63 per cent of its entire procurement of RUTF. Consequently, Nutriset’s profits ballooned – in 2009, Nutriset’s sales were €52m compared with €16m in 2005 (Arie 2010). While Plumpy’nut quickly emerged as the next big thing in child nutrition, so did the controversies.

However, some country governments have refused to go along with UNICEF’s aggressive promotion of Plumpy’nut. In 2009, UNICEF ordered a shipment of Plumpy’nut for use in India without any consultation with concerned Indian ministries. The Indian government reacted by asking UNICEF to send back the entire consignment. A Health Ministry official in India commented: ‘RUTF is used in war-torn countries like Africa. We do not approve of the strategy as there are other low-cost alternatives available in the country itself’ (Thacker 2009).

Are RUTF the only solution?

Doubts have been expressed regarding the need to procure an expensive (about \$30/month) commercial product, largely produced by one company based in France, when there appears to be evidence that similar results can be obtained through treatment with community-produced RUTF (cRUTF). The evidence regarding the superior effectiveness of the Plumpy’nut strategy comes primarily from African studies on populations displaced either through conflict or poverty. There is, however, other evidence that suggests that RUTF

like Plumpy'nut are not necessarily superior to other community-based interventions that depend on and use local foods.

Studies report that, on an average, weight gains with Plumpy'nut range from 3.5g per kg of existing weight per day to 8g/kg/day (Gaboulaud et al. 2007; Diop 2004). The largest weight gain reported so far with this product was 15.6g/kg/day (Diop 2003). This was achieved in a hospital setting, and was not duplicated in any other study. In comparison, a study from Bangladesh provides evidence of the efficacy of home foods in treating SAM even without any nutrient supplements being given. Intensive nutrition counselling during home visits was found to achieve weight gains of 9.9g/kg/day (Ahmed et al. 2002). Another study in Bangladesh reported that 'F100' (Formula 100 – a therapeutic milk product designed to treat severe malnutrition) given along with home food resulted in an average weight gain of 7.7g/kg/day (Hossain et al. 2009). In India, the Child in Need Institute in Kolkata has been using a rice/wheat and legume mix called Nutrimix with micronutrient supplementation in home settings. They report weight gains of 9g/kg/day. Nutrimix is prepared in the community by women's groups (International Baby Food Action Network 2009).

The food–drug confusion

There is a race to the middle between pharma and food. The opportunity is big. The risk is big. The reward is big. (Luis Cantrell, head of business, Nestlé SA [Bagla 2010])

One of the concerns that have accompanied the vigorous promotion of RUTF is that centralised manufacture of packaged RUTF threatens to replace local foods (and thereby livelihoods). As a response, it has been counter-argued that RUTF are meant only for a small percentage of children who are affected by SAM, and even for them, it is recommended that it be used for a brief period, till the affected children overcome the acute phase of malnutrition. However, there is now a discernible push for RUTF to be distributed and used freely as a food, thereby enabling the emergence of a mass market. This 'food–drug confusion' has been successfully exploited by commercial interests to promote the production and adoption of RUTF and has been expanded to the use of Ready to Use Foods (RUF) for all degrees of malnutrition, as well as for its prevention! Therefore, a huge market is being envisaged by the food industry in the management of malnutrition. One of UNICEF's global suppliers of RUTF, Diva Nutritional Products, South Africa, markets its product as Imunut. Its website promotes the product by declaiming:

Traditionally children in this age group have been treated for malnutrition in therapeutic feeding centres, a long process that requires the presence of a care-giver – usually the child's mother – which leaves other siblings unat-

tended at home and the fields untilled. Ideally the child should be treated in their own home environment, but access to clean drinking water – which is required for any water-based nutritional formula – is hugely problematic, and because of unsophisticated home environments, storage and feeding of the formula is difficult to monitor. Simplicity is the key to the solution – an easy to dispense RUTF which is both palatable and effective. Supply and maintenance of the product is simple – it requires no refrigeration, the product has been hermetically packaged and has a shelf life of two years.¹

While introducing another Nutriset product, Plumpy'Doz, to very young children in Somalia, UNICEF has asserted:

The brown paste supplement is made from vegetable fat, peanut butter, sugar, milk, and other nutrients, and is designed to taste good to kids. Critically, it also has a longer shelf life than previous diet supplements and doesn't need to be mixed with water (just like Plumpy'Nut). Three teaspoons of Plumpy'Doz three times a day provides each young child with additional energy, including fats, high-quality protein and all the essential minerals and vitamins required to ensure growth and a healthy immune system. (UNICEF 2008)

The World Food Programme and MSF also use this supplement, not to treat SAM, but unfortunately to provide supplementary nutrition to prevent severe acute malnutrition from developing.

Such an approach, clearly, does not address the underlying structural causes of chronic hunger. Malnutrition has complex roots and any long-term, sustainable solution absolutely needs to address these. In the past, malnutrition was wrongly viewed as a function of shortfalls in agricultural production. However, over the years, it has become clear that, in many situations, access to food in sufficient quantity and quality is not related primarily to agricultural production, but to poverty, i.e. a lack of economic access to food. Equally important as causes are a) the promotion of trade in staple foods over its use for domestic food security, b) the role of futures trading in food commodities, i.e. dealing in food for profit, c) political instability, and d) the lack of political resolve on the part of states to tackle the problems of malnutrition. These causes have led to a spiralling rise in food prices across the globe (discussed at greater length in Chapter C1). Therefore, the overriding priority for programmes aiming to prevent and treat moderate malnutrition has to be to ensure access to the already existing food supply. Without such a focus, no amount of dependency-creating feeding programmes can prevent the disastrous slide into malnutrition. While UNICEF's focus on RUTF is relatively recent, one of its oldest programmes on supplementary nutrition has been the Vitamin A prophylaxis programme. This programme has now been criticised for being premised on inadequate evidence and for actually doing more harm than good in many situations (see Box D2.3).

In a recent article, Jeffrey Sachs and others criticised the use of RUTF to treat chronic hunger. They wrote:

It is critical, however, that we not confuse the many types of hunger and malnutrition (poor nutrition) around the world. Plumpy'Nut is not a miracle cure for global hunger or for global malnutrition. Plumpy'Nut addresses only one kind of hunger – acute episodes of extreme food deprivation or illness, the kind mainly associated with famines and conflicts. Plumpy'Nut is not designed for the other major kind of hunger, notably chronic hunger due to long-term poor diets. ... Plumpy'Nut comes into relevance when an emergency has struck. And while the \$30 per child per month is a very low cost for saving the child, it would in any event be an impossibly high cost for a 'solution' to hunger based on food aid! Suppose that the billion hungry people in the world were put on a permanent Plumpy'Nut diet (a totally misguided idea) at a cost of \$30 per month, or \$360 per year. The result would be a direct cost of some \$360 billion per year, an absurdly high cost compared to the real solutions of improved local agriculture, improved household dietary practices, and expanded access of the poor to basic healthcare. (Sachs et al. 2010)

'Hidden hunger' and the market for micronutrient supplementation

The attempt to use Plumpy'nut or Plumpy'doz to prevent malnutrition is not an isolated misguided case. Rather it is part of a much larger design to mystify malnutrition and create spaces of profit-making opportunities for the food industry. Rather than looking at malnutrition as a result of chronic hunger, corporations are reducing it to deficiencies of small quantities of nutrients such as vitamins and minerals. Doing this provides them with several means of making profits by marketing these micronutrients as supplements. What is never mentioned is that these nutrients would also be available to the child if s/he were exclusively breastfed and, after six months of age, continued to breastfeed and got enough variety of locally available foods (fats, animal protein, green and yellow vegetables, fruits, etc.).

Instead of working to ensure that such diverse foods are indeed available and accessible to every household, the solutions being offered are narrowly based on food fortification and micronutrient supplementation. These processes and technologies promote centralised production and procurement of foodstuffs and detract from local control and autonomy over diets. Sometimes, they even displace local livelihoods such as milling. They promote the notion that special and expensive food, sold as a 'medicalised' solution, is required to deal with micronutrient deficiencies. While governments and global agencies do not hesitate to spend large amounts on micronutrient supplements of this variety, they choose not to spend on promoting fair employment, kitchen gardens and the raising of small domestic animals, which would serve the same purpose as a non-dependency-creating and sustainable alternative solution.

Several groups, such as the Global Alliance for Improved Nutrition (GAIN), which are linked with food and baby-food corporations (the GAIN Business Alliance (BA) is currently chaired by Unilever²), are lobbying governments to introduce micronutrients distribution into national nutrition policies and programmes. The annual report of GAIN (2005/06) highlights that GAIN (along with food giants such as Groupe Danone, Unilever, and Cargill), unlike traditional aid providers, is working to fight ‘hidden hunger’ (a term used for micronutrient malnutrition) by building new ‘markets for nutritious foods’ (Rajalakshmi 2008). UNICEF has been especially supportive of GAIN and UNICEF’s website prominently displayed news about the launch of GAIN with the adulatory message: ‘The Global Alliance for Improved Nutrition (GAIN) – a new alliance of public and private sector partners – will be launched during the United Nations Special Session on Children on the 9th of May. It will work to leverage cost-effective food fortification initiatives that promise to improve the health and productivity of the poorest nations.’ GAIN has secured itself a place in decision-making processes that impact on UNICEF’s policies related to food and nutrition – a clear area of conflict of interest given GAIN’s proximity to the food and baby-food industry.³

UNICEF has been candid about its pursuing corporate partnerships. A mapping of UNICEF’s partnerships and collaborative relationships, conducted by the organisation in 2008, reported that a total of 628 different companies worldwide maintain active collaboration, partnerships and contacts with UNICEF (UNICEF 2009b). UNICEF now actively explores other areas of engagement with the corporate sector beyond resources mobilisation. For example, UNICEF is a partner with Unilever and the Synergos Institute in a programme on child nutrition in India – the Bhavishya Alliance (ibid.).

There is evidence that UNICEF’s focus on ‘quick-fix’ solutions not only does not promote long-term sustainable solutions, but also fails to achieve the stated goals of ensuring the best interests of the world’s hungry children. For instance, between 2001 and 2005 it implemented the Accelerated Child Survival and Development (ACSD) programme in 11 West African countries, but its evaluation showed no difference between intervention and non-intervention areas, despite the expenditure of many millions of dollars. As expected, the weak programmatic areas remained those related to malnutrition, community participation and a host of wider supportive measures. Significantly, there had been a deterioration in the overall socio-economic status in the ACSD focus districts, as well as greater food insecurity in many of the intervention areas (Prasad 2010). The study reported:

Interventions effective in combating under-nutrition, which underlies at least a third of child deaths, were reported by ACSD country teams as receiving low priority in their programme plans. Promotion of immediate and exclusive breastfeeding up to six months of age could have had a large effect on both

neonatal and post-neonatal mortality, but seems to have been promoted more heavily in control areas than in the ACSD focus areas ... There were substantial decreases in exclusive breastfeeding in the focus districts and increases in the control areas ...

It recommended that ‘... the design of child survival programmes should begin with assessing the evidence for the determinants and causes of child deaths ...’

Structural causes of malnutrition and the need for a comprehensive approach

Overall, in poor households, nutritional deficiencies are not related to a lack of will to give mothers and children the right foods in adequate quantities, year round. They are related to their economic inability to procure such foods. Short-term solutions, such as giving enriched foods or micronutrient supplements, are not the ultimate answer to the problems of malnutrition at hand. Instead, each family needs to be enabled to procure enough of the right foods through programmes aimed at eradicating poverty, controlling spiralling food prices, and encouraging the production of food crops (rather than cash crops, as part of neoliberal agricultural policies).

To improve livelihoods and to ensure food security, additional interventions to address child malnutrition need to be put in place. These need to be comprehensive and in line with broader socio-economic objectives, and not be based on centralised, top-down packaged solutions.

Breastfeeding is a major safeguard against early child malnutrition, but rates of exclusive breastfeeding are low in many resource-poor communities. Encouraging exclusive breastfeeding requires not only counselling and support, but also creation of enabling conditions for women to be able to exclusively feed babies for a period of six months. This includes their own nutrition during pregnancy and lactation. Programmes that promote exclusive breastfeeding must recognise women as workers and make provisions to ensure that their dual role as mothers and workers is respected as a matter of human rights during this period. Most poor women work in the informal sector and do not have access to maternity benefits in the form of paid leave, wage compensation, etc. These maternity benefits need to be put in place along with laws and policies that ensure baby-friendly workplaces.

It needs to be recognised that most poor families do not have the time and the resources to ensure a balanced and sufficient diet for children. In many cases, quality foods are not given to children, simply because quality foods are not affordable. In emergency or acute situations, supplementary feeding programmes play a role in providing nutritious supplements to families that do not have access to sufficient and good-quality food for their young children. They may also have a ‘demonstration’ effect by showing what complementary

Box D.2.1 Plumpy'nut and patents

The patent for Plumpy'nut, the leading RUTF, is owned by Nutriset, a French family-run business, and by the Institute of Research for Development, a French public research institute. Manufacturers of similar pastes have been wary of challenging Nutriset. 'The patents are so broad that if you add one micronutrient into a jar of Nutella [a widely distributed brand of nut paste], it will fall within the patent,' said Stephane Doyon, leader of the Nutrition Team at Médecins Sans Frontières (MSF), not long ago.

Plumpy'nut was the first RUTF to be developed and is regarded as the industry standard. Several similar pastes have been developed, but can only be sold in countries where the Plumpy'nut patents are not registered. Nutriset has attempted to broaden the scope of its two patents. Manufacturers of peanut-based RUTFs have received legal letters. 'You have to keep reminding people [by sending letters],' said Nutriset spokesman Remi Vallet. 'We are not trying to protect a monopoly – there is no monopoly. There are other RUTF manufacturers in the market.'

In Kenya, where the Plumpy'nut patents are registered, Nutriset has threatened legal action against Compact, an Indian and Norwegian manufacturer, for storing 25 metric tons of its RUTF, eeZeePaste, which it intended for distribution in Somalia and the Democratic Republic of Congo (IRIN News 2009).

foods can be made locally. But supplementary feeding programmes are not even a medium-term solution for chronic malnutrition.

In the final analysis, the long-term and definitive elimination of malnutrition rests on consistent action to tackle the structural determinants of malnutrition – armed conflict, social injustice, and poverty. Any short-term strategy must, at the minimum, ensure that it does not postpone acting on the long-term goals of peace, right to nutrition, social justice and disparity reduction. Otherwise, short-term interventions risk disempowering poor people further or even compromising their livelihoods. Any minor trade-offs achievable through technical interventions must be accompanied by long-term, sustainable actions that tackle the violation of the right to nutrition, thus paving the way for robust gains for children's nutritional security.

Unfortunately, UNICEF seems to think otherwise. It is a matter of conjecture whether UNICEF's decisions to partner with industry to address child nutrition with proprietary products was in some measure a consequence of former Executive Director Ann Veneman's proximity to the food industry (see Box D2.2). UNICEF's new director, Anthony Lake, brings to the organisation his experience as a top diplomatic negotiator. Sadly, like Ann Veneman, he has

had little to do with strategies related to the core areas of UNICEF's work. It can only be hoped that he will learn fast on the job and do justice to UNICEF's mandate. Surely, the children of the world deserve nothing less!

Box D2.2 From Ann Veneman to Anthony Lake

UNICEF is headquartered in New York, and it is curious that one of the most important and visible organisations in the UN system does not choose its top executive – the executive director – through a transparent and democratic process. Every executive director of UNICEF, since its inception in 1946, has been a US citizen. The appointment of the executive director of UNICEF, although officially made by the UN secretary-general, is traditionally in the gift of the US government (Horton 2009). In recent years the UNICEF executive director has essentially been a political appointee, with scant regard for past experience regarding the core business of UNICEF.

When Ann Veneman was appointed as the executive director of UNICEF in 2005 (chosen by the then Bush administration in the US), it caused consternation among many commentators. The People's Health Movement reacted by a statement which said (World Public Health Nutrition Association 2011):

Ms. Veneman's training and experience as a corporate lawyer for agribusiness is totally inadequate to the task of leading the agency most responsible for the rights of children. There is no evidence in her tenure as US Secretary of Agriculture, director of the California Department of Agriculture, or Secretary for Foreign Affairs of the US Department of Agriculture, that she has the least bit of interest in the world's children or their health and well-being. Indeed, her performance in these positions has been characterized by the elevation of corporate profit above people's right to food (UN Declaration of Human Rights, article 25). Put into practice at UNICEF, this philosophy and behavior will prove disastrous for the world's children.

Why the United States is allowed to choose the Director of UNICEF should in itself be a cause of major debate among all observers. As is well-known, the United States and Sudan are the only two countries who have refused to join the 189 other governments of the world as signatories of the UN Convention on the Rights of the Child. There is no evidence that Ms. Veneman has a negative view of this great failing on the part of her government or that she would work on behalf of the recognition, enforcement, or expansion of children's rights as Director of UNICEF.

Ann Veneman, after her tenure in UNICEF, has remained true to her corporate past. Barely a year after relinquishing her post as executive director of UNICEF, Ann Veneman has been appointed to the board of the Swiss baby food company Nestlé (ibid.). She has also served as a member of the Nestlé Creating Shared Value Advisory Board since 2009. It needs underlining here that Nestlé is not an ordinary company. It is a company that has been the subject of an international boycott for over 23 years – perhaps the longest standing boycott of a global corporation. It has been labelled by activist organisations as a ‘baby killer’ for persistent unethical marketing of breast milk substitutes.

The Lancet, in an editorial, had made a powerful plea that the next executive director of UNICEF should be chosen on merit and based on a transparent process. It said:

UNICEF’s Executive Director is an important global leader in health. The person appointed should not be in the gift of one powerful government. Instead, UN Secretary-General Ban Ki-moon should announce that the next Executive Director of UNICEF will be selected through a transparent, merit-based appointment process. Candidates, nominated by their governments or applying directly, should have to declare themselves, publish manifestos, and be available for public scrutiny and questioning. Most importantly, the next Executive Director of UNICEF should be someone with a proven track record in children’s issues, including child health. (Horton 2009)

Unfortunately, Ann Veneman was succeeded by another political appointee in 2010 – this time of the Obama administration. The new executive director of UNICEF, Anthony Lake, has been a foreign policy adviser to many Democratic US presidents and presidential candidates, and served as National Security Advisor under US president Bill Clinton from 1993 to 1997. Following President Clinton’s 1996 re-election, Lake was nominated to become the director of the Central Intelligence Agency (CIA), but his nomination was withdrawn owing to Republican opposition.

Box D2.3 The great vitamin A fiasco

[The analysis here is an abridged version of a detailed paper by Dr Michael Latham, published in the journal of the World Public Health Nutrition Association in May 2010 (Latham 2010). We take this opportunity to pay our tributes to Dr Latham, who passed away in April 2011.]

Introduction Every year, roughly half a billion capsules of Vitamin A are distributed to around 200 million children in over 100 countries. Covered are children between the ages of six months and five years, in countries with a child mortality rate greater than 70 in 1,000 live births. A large proportion of the children who are receiving these massive doses do not suffer from vitamin A deficiency. The normal dietary recommendation for vitamin A in children aged 6–12 months is 600 IU a day; and for children between one and five years old it is 900 IU a day. The twice-yearly supplements being used to prevent deficiency are of 100,000 units for 6–12-month-old babies, and 200,000 units for children between one and five years.

The programme of vitamin A dosing has been massively scaled up in recent years – between 1999 and 2004 the percentage of children in 103 targeted countries who received one dose of capsules a year increased from 50 to 68. UNICEF states: ‘Vitamin A programming is a pre-requisite for achieving MDG#4’. Yet this massive expansion has taken place in spite of clear indications that the vitamin A programme is based on inadequate evidence, and in many situations it may be doing more harm than good.

1970s and 1980s: the story begins The International Vitamin A Consultative Group (IVACG) was founded in 1975, with its secretariat in Washington DC. It was funded by the US government international aid agency USAID, with the involvement of UNICEF and WHO.

An Indonesian study, published in *The Lancet* in 1986, concluded that children who received massive dose vitamin A supplements, even those without ocular signs of xerophthalmia, had a 34 per cent lower mortality from all causes than those not receiving the supplement. Many researchers had serious questions about this study – randomisation was not done at the baseline; no placebos were used; children in the control group had more clinical signs of vitamin A deficiency and poorer growth to start with; and no causes of death were reported. The study was followed by eight other trials, and a meta-analysis published in 1993 showed that six found significant reductions in child mortality, and two did not.

Most of these studies were conducted in Asian countries with high prevalence rates for xerophthalmia, serious malnutrition, and low measles immunisation rates. A much-quoted VAST (Vitamin A Supplement Trial) study in Ghana using a very large sample reported about 500 deaths in the control children compared to about 400 in the supplemented children – a statistically significant difference.

However, suggestions were made that the statistical difference in deaths might disappear if measles mortality were excluded. Measles is the only

cause of childhood morbidity for which medicinal vitamin A supplements have been shown to reduce the severity of illness and case fatality rates. The most effective way to prevent measles is vaccination. The question asked was: ‘Could it be that the significant reduction in mortality rates in children receiving vitamin A supplements in these studies was due to a reduction in measles deaths?’ This question has never been answered.

The Beaton report From the early 1990s supplementation with massive medicinal doses of vitamin A became increasingly accepted as the main or even the only effective way to prevent deficiency, as well as the most effective way to save the lives of children throughout higher-child-mortality countries. The scientific basis for this change of policy was a report commissioned by the Canadian International Development Agency (CIDA) and published in 1993 (known as the Beaton report, after its lead author), which reviewed the studies undertaken up to that time. It concluded: ‘These studies together suggested that vitamin A supplementation resulted in an average reduction of 23 percent in mortality rates in children 6–60 months of age.’

Unfortunately actions that followed were based on a selective reading of the report. One of its key comments, which was studiously ignored, said: ‘We can offer no conclusion, based on the definitive mortality evidence, about the impact of vitamin A to be expected in populations where there is evidence of depletion but not evidence that depletion is severe enough to produce clinical lesions in at least a small proportion of individuals.’ The report also specifically indicated that the impact it believed existed was not due to the provision of a medicinal dose of vitamin A at one time, and that more gradual, sustainable approaches would be equally effective. The report also concluded that ‘improvement of vitamin A status cannot be expected to impact on incidence, duration or prevalence of general diarrhoeal and respiratory illness as seen in the community’.

So if, as claimed, the capsule programme does substantially reduce child mortality, it evidently does so without also reducing morbidity (with the exception of measles, which is most effectively prevented by vaccination). But how can this be possible? This is a conundrum that has not been resolved.

Adverse effects on respiratory infections There is also evidence that high doses of vitamin A may actually be increasing morbidity in children. A study conducted in Indonesia (published in 1996) concluded that high-dose vitamin A supplements increased the incidence of acute respiratory

illnesses by 8 per cent, and acute lower respiratory illnesses by 39 per cent. They also concluded: ‘These detrimental effects on acute lower respiratory illnesses were most marked in children with adequate nutritional status.’

A 2003 meta-analysis of the impact of capsule programmes on child morbidity from diarrhoea and respiratory infections examined nine randomised control trials. It concluded that ‘the combined results indicated that vitamin A supplementation has no consistent overall protective effect on the incidence of diarrhoea’. It also said that supplementation ‘slightly increases the incidence of respiratory tract infections’.

In spite of such clear evidence, there has been no outcry, or serious scrutiny of this issue. The majority of children receiving medicinal doses of capsules are not malnourished. Can we be certain that capsule programmes are ‘doing no harm’ in many countries?

IVACG and the big agenda Instead, by the 1990s the leadership of the International Vitamin A Consultative Group had almost exclusively come to embrace the top-down, ‘magic bullet’ capsule approach. In 2002, in a formal statement, IVACG declared that any diet-based approach was ‘inadequate to normalise vitamin A status’.

In 2006 IVACG was incorporated into the Micronutrient Forum, which focuses on several micronutrients. Of the 13 members of the steering committee, 10 are from the USA. The Forum secretariat of six people are all from the USA, either from USAID or else the Academy for Educational Development, funded by USAID and more recently by the Gates Foundation.

Two Micronutrient Forum meetings have been held, one in 2007 in Istanbul, and the second in 2009 in Beijing. The ‘platinum’ sponsors of the Beijing meeting included USAID and the International Life Sciences Institute. Its three ‘gold’ sponsors were the Gates Foundation, Coca-Cola, and Pepsi-Co.

Do capsules actually reduce mortality? The largest ever randomised controlled trial, on De-worming and Enhanced Vitamin A (DEVTA), included 1 million rural children above the age of six months in the state of Uttar Pradesh in North India. There was no significant difference in the death rates between children who received massive doses of vitamin A and those who did not. These results were disclosed at the 2007 Istanbul meeting of the Micronutrient Forum. Very remarkably, they still have not been published in a journal.

Donor-driven programmes, such as universal vitamin A capsule distribution, are rarely if ever ‘gifts’. There is always a gradual siphoning-off

of local funds to pay part of the costs for something a government often never really wanted in the first place. A 2009 report from the Micronutrient Initiative admits: ‘Supplementation remains largely a push-driven rather than a demand-driven intervention.’ A USAID-funded analysis published in 2007 points out that funding for capsule distribution will be threatened when governments are ‘allowed’ themselves to make decisions about how donor funds are spent.

Neglect of sustainable solutions The administration of medicinal doses of vitamin A is effective in cases of clinically evident xerophthalmia, which remains a public health problem and even an emergency in some lower-income countries. What is mistaken, and reprehensible, are the claims made for vitamin A capsule programmes, and the indiscriminate scale of these programmes. Evidence for the numbers claimed was never conclusive, and is increasingly embarrassingly lacking as implementation has expanded.

Worse yet is the consequent neglect of national, local and community-based programmes that give less-resourced governments a real chance of sustaining the prevention of vitamin A deficiency, and sustaining food and nutrition security. In 2010 it is indefensible that the huge vitamin A medicinal capsule programmes not only continue, but are being made even more colossal. Much of the nutrition world has simply failed to study and keep up with the evidence and the testimony of those with local knowledge, or, if they have, seem to be unable or unwilling to challenge the status quo. Now is the time for a concerted challenge to this authority.

Notes

1 www.imunut.com/.

2 From GAIN’s website: www.gainhealth.org/partnerships/how-gain-works-businesses.

3 The World Alliance for Breastfeeding Action (WABA), in an open letter to the UNICEF and the WHO, protesting against GAIN’s inclusion in the list of invitees for a meeting organised by the two organisations on ‘Strengthening actions to improve infant feeding in children 6–23 months of age’, said: ‘... we are deeply concerned that the Global Alliance for Improved Nutrition (GAIN) is participating in the meeting on *Strengthening actions to improve infant feeding in children 6–23 months of age*, taking place

in Geneva right now. They are thus in a position to influence the policy directions of WHO and UNICEF. The Board of GAIN includes among other food giants, DANONE, that systematically violates the International Code of Marketing of Breastmilk Substitutes. The WHO/UNICEF partnership with GAIN constitutes a conflict of interest and is in contradiction with WHO’s own *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes*, with Paragraph 44 of the *Global Strategy for Infant and Young Child Feeding*, and with WHA Resolutions 49.15 (1996), 58.32 (2005) and 61.20 (2008). The presence of GAIN in such

a meeting legitimises its declared aim to build markets for the commercial sector in the developing world especially for commercial foods for infants and young children.’ Available at: www.bpni.org/AACI/Resources/Letter-to-WHO-UNICEF-COI.pdf.

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D3 | CONFLICTS OF INTEREST WITHIN PHILANTHRO-CAPITALISM

The term philanthrocapitalism is used to describe a growing movement which aims to harness the power of the market in order to achieve social outcomes, to increase economic growth in impoverished regions, and to make philanthropy more cost effective.

This chapter explores the origins of philanthrocapitalism and addresses its increasing influence on global health governance and decision-making. It examines the functioning and priorities of the Bill and Melinda Gates Foundation in order to explore how the alignment of corporate interests and philanthropic investment may be having adverse effects on health policy. It looks at the efforts of the proponents of philanthrocapitalism to challenge progressive tax measures that could generate government revenues earmarked for global health. Finally, the chapter suggests that a focus on conflicts of interest could be a useful starting point for the mobilisation of health specialists who are concerned about the influence of the Gates Foundation on health policy, but who have thus far had difficulty, as a result of the immense scale of the Foundation's influence, in highlighting some of its controversial policies.

Spending priorities and governance of the Gates Foundation

The Gates Foundation's influence on global health has become increasingly controversial among policy-makers. A first concern centres on the Gates Foundation's funding decisions. The Foundation directs the bulk of its grants towards organisations in high-income countries, thus exacerbating unequal R&D infrastructures between poor and rich regions. The Foundation has heavily prioritised funding for malaria and HIV/AIDs, while almost entirely omitting funding for chronic, non-communicable diseases from its portfolio. Recent studies have shown, as the editors of *The Lancet* write, that 'grants made by the Foundation do not reflect the burden of disease endured by those in deepest poverty' (Lancet 2009: 1577; McCoy, Chand and Sridhar 2009; McCoy et al. 2009; Sridhar and Batniji 2008).

Within areas that are targeted by the Foundation, such as malaria research, specialists have become increasingly vociferous in claiming that the policy advocated by the Foundation is often divorced from local requirements and needs (Kelly and Beisel 2011). Critics point out that the Gates Foundation-funded Grand Challenges schemes treat vector-borne diseases such as malaria as overly static, privileging instead vaccine and genetic-modification schemes,

which neglect the fact that malaria eradication in Europe was the result of environmental measures, such as the drainage of swamps and improved levels of sanitation, together with large-scale economic development (Birn 2005).

A second concern is the lack of public accountability at the Foundation, which is governed by three co-chairs – Bill Gates, his father, William H. Gates Sr, and his wife, Melinda Gates. The editors of *The Lancet* write:

Sadly, the Foundation has acquired a reputation for not always listening to its friends. Although it is driven by the belief that ‘all lives have equal value,’ it seems that the Foundation does not believe that every voice has equal value, especially voices from those it seeks most to assist. (Lancet 2009: 1577)

A third concern is that the Foundation both invests in and champions corporate actors that have had a detrimental impact on health outcomes. This concern parallels an underlying criticism of the Gates Foundation, which is that its main funding source, revenues accrued from Microsoft, was amassed through labour practices and monopolistic intellectual property strategies that are contrary to the stated health aims of the Gates Foundation.¹

Corporate conflicts of interest

The fields of medicine and public health have long been marked by an emphasis on the need for private or institutional actors to declare any conflict of interest, viewed as an affiliation, relationship, or connection that could corrupt the ability or undercut the motivation to act in the interest or the pursuit of a stated objective. Although conflict is obviously an intrinsic and often unavoidable feature of organisational life, legislation has sought to mitigate particularly egregious forms of conflict, such as the recent provisions included in the US health reform bill that mandate pharmaceutical manufacturers to file annual reports with the government about their financial ties to individual doctors and institutions (Singer 2009).

No similar provisions exist for private donors such as the Gates Foundation, although the Foundation must file endowment disclosures with the US Securities and Exchange Commission, and its tax status is contingent on a number of clauses, such as refraining from ‘self-dealing’, or financial transactions between a foundation and ‘disqualified persons’ such as board members, a measure intended to prevent private individuals from benefiting from a foundation’s resources.²

An established body of literature within the social sciences has examined the links between political power, funding sources, and investment decisions (Fisher 1983; Parmar 2002). Scholars have shown how intellectual enterprises such as think tanks have helped to increase the political salience of economic movements such as neoliberalism by furthering partisan viewpoints or by lobbying for partisan interests while maintaining a veneer of academic and political impartiality (Guilhot 2007; Mirowski and Plehwe 2009).

A recent article by David Stuckler, Sanjay Basu, and Martin McKee (Stuckler et al. 2011) builds on this literature through an analysis of the Gates Foundation's investment portfolio, exploring how institutional factors, such as links between Microsoft and the Gates Foundation, affect the spending priorities of the Foundation. The authors found that a significant percentage of the Gates Foundation's endowment is invested in private corporations that stand to gain from the Foundation's philanthropic support of particular global health initiatives over others. This is the first major study to document where the Foundation's endowment is invested, as well as to explore links between board members and private for-profit companies that have directly benefited from the Foundation's philanthropy (ibid.).

The Gates Foundation's endowment has two main revenue sources: Gates's personal fortune and the stock in Berkshire Hathaway given as a gift to the Foundation by Buffett. Over 10 per cent of the Foundation's endowment is invested in two companies: McDonald's (about 5 per cent of the Foundation's portfolio) and Coca-Cola (over 7 per cent of the Foundation's portfolio). Over half of the total endowment is invested in Berkshire Hathaway, which owns an additional 8.7 per cent of Coca-Cola and has considerable stakes in leading pharmaceutical companies, including GlaxoSmithKline, Sanofi-Aventis, Johnson & Johnson, and Procter & Gamble (ibid.).

The Gates Foundation's investment in Coca-Cola raises a number of concerns. Increased consumption of cola and other artificially sweetened beverages has been directly linked to the global obesity crisis (Schulze et al. 2004). Representatives of the Foundation have been increasingly vocal champions of Coca-Cola's marketing and distribution strategies. In a 2010 presentation at TED, a global forum that highlights the work of social entrepreneurs and philanthropists, Melinda Gates extolled Coca-Cola and suggested that global health policy-makers should seek to emulate the corporation's business tactics.

Barron's, a leading business journal, reported in January 2010 that Bill Gates had bought nearly US\$18 million worth of American depository receipts in Coca-Cola Femsa, a subsidiary of Coca-Cola, through both his personal investment vehicle, Cascade Investments, and through the Gates Foundation (Salzman 2010).

Stuckler et al. report that the Foundation has partnered with Coca-Cola in a four-year, US\$11.5 million partnership to enable mango and passion fruit farmers to participate 'in Coca-Cola's supply chain for the first time', thus encouraging local communities in developing countries to act as business affiliates of the corporation. This championing of Coca-Cola suggests that the Foundation may be using its influence to help financially bolster a company that has been linked to an increase in obesity and diabetes. Gates personally and the Gates Foundation in general are increasingly investing in Coca-Cola, raising questions about whether the Foundation is prioritising health partnerships that could privately benefit individuals chairing the Foundation.

A third concern is the human rights record of Coca-Cola, which has faced allegations that its company executives have conspired in the murder of union workers at its bottling plants in Colombia. In India, the company has been accused of contaminating groundwater and soil, causing water shortages, and having high levels of pesticide in its drinks. At least three high-profile US universities – New York University, the University of Michigan, and Rutgers – have banned the corporation from selling its products on campus as a result of allegations of abusing workers’ rights (Woyke 2006).

The Gates Foundation’s support of Coca-Cola is the most recent illustration of the tendency of the Foundation to invest in areas and in companies proven to have a deleterious effect on health and the environment. In 2007, the Foundation faced censure for investing in Dutch Shell, Exxon Mobil Corp., and Chevron Corp., companies responsible for polluting developing countries, such as Nigeria, beyond levels permitted in Europe and North America (Piller et al. 2007).

The politics of philanthrocapitalism

The links between the Gates Foundation and corporations such as McDonald’s and Coca-Cola underpin a wider problem, which is the tendency of private foundations to engage in political or corporate lobbying while appearing to adopt apolitical or non-political stances. This problem is not unique to private foundations. It is also a marked feature of the new philanthrocapitalism, a movement that presents itself as operating outside of formal political channels, while actually wielding considerable influence over them.

The term philanthrocapitalism was coined in 2006 by Matthew Bishop, an editor at the *Economist* magazine who later co-authored, with Michael Green, a book with the same title. The book describes the activities of a number of leading philanthropists, such as Gates, Bono, George Soros, and Jeff Skoll. The latter is a co-founder of eBay and the founder of the Skoll Centre for Social Entrepreneurship, which funds ventures dedicated to harnessing entrepreneurial acumen to improve social outcomes (Bishop and Green 2008).

Bishop and Green argue that these individuals are at the forefront of the movement to apply the tools of the market for meeting social and economic needs, something similar to what Gates, in a 2008 article in *Time* magazine, has described as ‘creative capitalism’ – the effort to ensure that individuals earn a financial return on their investments in social programmes aimed at improving sanitation, nutrition, and urban and rural infrastructure, and expanding access to financial credit.

Some staff at traditional philanthropic organisations dismiss the suggestion that the new philanthropy is more results-oriented or more efficient than earlier institutions and models. A former head of the Ford Foundation told the media:

I don’t think there is anything more ambitious about the new philanthropy ...

hundreds of foundations worked for decades to address apartheid, hundreds of foundations worked to support the civil rights movement in this country, there is nothing more ambitious than those noble aims. They were extremely results oriented ... and the use of business principles has been in the foundation world for a long time. (Levenson Keohane 2008)

Michael Edwards, a former director of the civil society programme at the Ford Foundation and the most vocal critic of philanthrocapitalism, has suggested that the concentration of wealth and power among philanthrocapitalists may be having a negative influence on the non-profit sector both in the United States and internationally, with civil society groups reporting increasing constraints on their flexibility and independence as a result of an obsession with performance reviews, a complaint echoed by recipients in developing regions who state that the requirement to comply with the rules, regulations, and expectations of donors with conflicting aims impairs project delivery (Edwards 2008).

A third concern about the philanthrocapitalism movement is its conflictive relationships with traditional political channels. Political institutions such as the US federal government and UN organisations are publicly scorned yet privately lobbied, thus weakening public regard for the efficacy of governmental bodies while ensuring that the same bodies are receptive to furthering the interests of leading philanthrocapitalists.

When Warren Buffett, for example, announced his US\$30 billion donation to the Gates Foundation in 2006, he quipped that the money would do more good than the money dropped into the US treasury. His sentiment is common among philanthrocapitalists, who, often for just reasons, champion the usefulness of maintaining their distance from political institutions. As a recent working paper from the Global Public Policy Institute (GPPI) notes:

Philanthrocapitalists, and foundations more generally, claim their work is apolitical and ‘problem-oriented’; they argue that they select programs and projects on the basis of need, and do not need to consider other priorities such as foreign policy or foreign economic concerns. This, in their own view, allows them to focus on problem solving and ‘getting things done’. (Marten and Witte 2008: 15)

In the words of one GPPI interviewee, ‘It is important to understand that foundations are usually problem-driven, they look towards success. They identify an issue, they analyze it, and they try to devise solutions. In the end, it is always about impact. They don’t need to worry about politics’ (ibid.: 15). This view is not without merit or import. Staff of bodies such as the WHO have commended the ability of private institutions to operate free of partisan or ideological constraints, avoiding the likelihood, for example, that domestic religiosity in the United States may be biasing US HIV/AIDS prevention

measures abroad. The problem is that perceptions of foundations as apolitical entities limit the ability (1) to apprehend and question tacit political or ideological stances within foundations that may be particularly intractable for being less open or recognisable; and (2) to understand the ways in which foundations lobby governments even as they disparage their partisan nature. The championing of foundations as apolitical also implies a false premise, which is that health goals can or should be divorced from state-supported, democratically accountable interventions – something that is a questionable political statement in itself (McGoey et al. 2011; McCoy and McGoey 2011).

The public scorn for governments is contradicted by recent calls for individuals such as Gates to lobby governments more aggressively to heed the agendas of private philanthropists. In a recent *New York Times* article, Bishop and Green argue that Gates and others must start ‘exercising disproportionate influence in politics’ (Bishop and Green 2009).

The aim to ensure that political channels are receptive to the agendas of philanthrocapitalism is evidenced by attempts to disparage tax policies that could bolster the finances of governments that have been depleted by the recent global financial crisis. A notable example is Bishop and Green’s criticism of the Tobin tax, a tariff that could generate substantial government revenue by imposing a small levy on international currency exchanges. Prominent economists, including Joseph Stiglitz and Lawrence Summers, have endorsed the tax (Stiglitz 1989; Summers and Summers 1989). Commenting on their website, Bishop and Green dismiss the feasibility of the Tobin tax, calling it a ‘fundamentally flawed’ manoeuvre that encourages ‘people to vote for a free lunch’.³

The criticism is surprising coming as it does from staunch champions of philanthropy, which is by definition giving aid and succour ‘freely’ to those in need. It indicates that at least two of the most prominent advocates of philanthrocapitalism are explicitly battling measures that could increase state spending on areas such as health.

Conclusions

We have examined philanthrocapitalism from a perspective that emphasises the role of conflicts of interest while focusing on the Gates Foundation’s investment in companies such as Coca-Cola. We also wish to draw attention to links between philanthropies and government initiatives, and the contradictions that characterise these links. An oft-voiced refrain of the new philanthropy is that private-sector investment fills the void left by cash-strapped governments. A key objective for health activists could be highlighting the ways in which government revenues are strapped through private-sector support and through a reluctance to embrace tax measures that are disparaged by philanthropists who purport to be operating outside the realm of politics.

Notes

1 Regarding labour practices, Microsoft has been embroiled in legal battles for hiring independent contractors for indefinite periods without offering employee benefits, something the US Internal Revenue Service (IRS) has classified as tax abuse as it limits payroll taxes. In the late 1990s, Microsoft lost a landmark legal case, *Vizcaino v. Microsoft*, requiring it to treat long-term contractors as employees for tax purposes. See Kalleberg, A. (2000). 'Nonstandard employment relations: part-time, temporary and contract work'. *Annual Review of Sociology*, 26: 341–65.

2 See the website of the US Internal Revenue Service, www.irs.gov/charities/charitable/article/0,,id=96114,00.html.

3 These comments are from Bishop and Green's blog, philanthrocapitalism.net, in posts that appeared on 16 February 2010 and 2 March 2010.

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D4 | THE PHARMACEUTICAL INDUSTRY AND PHARMACEUTICAL ENDEAVOUR

The relationship between medicinal drugs and human health cannot be explained simply in terms of the policies and actions of ‘the pharmaceutical industry’, partly because the industry includes many different players, and partly because none of them operates in isolation. In one way or another, companies operate within a complex framework defined by their legal remit and market conditions, government and regulatory activity, professional standards and norms, and consumer expectation and demand. The relationship between medicinal drugs and human health is, therefore, best understood in terms of pharmaceutical endeavour.

The pharmaceutical industry comprises smaller and larger players, ranging from local to multinational enterprises. They may be centrally or peripherally involved in all or some of many overlapping activities, including research, development, testing, approval, distribution, and marketing of either branded or generic medications, and sometimes both.

In the context of world health, leadership of the industry rests mainly with the Big Pharmas, the top 20 or so multinational corporations with annual revenues measured in tens of billions of dollars. In 2007, some 61 companies had annual sales of over \$1 billion each (PRLog press release 2008). Between them, they control well over half of all world pharmaceutical trade and collectively have a dominant and growing influence over drug utilisation and regulation.

The nature of pharmaceutical endeavour and its impact on human health have changed dramatically over the past 100, 50, even 20 years, and, arguably, the rate of change is still increasing. Over the years, the industry, mainly the forerunners of the Big Pharmas of today, has provided many, sometimes remarkable, health solutions. More recently, however, there is increasing concern about diminishing health returns, even a reference to Pharmageddon, ‘the prospect of a world in which medicines and medicine produce more ill-health than health, and when medical progress does more harm than good’.¹

Health climate change

The tide turned probably around 1980, by which time it was clear that we had the technical capacity to check ill-health and relieve hunger on a global scale. The main missing ingredient was political will, but there was also much optimism that it might be found. With its campaign cry, ‘Health for all by the year 2000’, the World Health Organisation (WHO) set the tone.



40 Generic medicines shop in Chittorgarh, India: outcome of an innovative programme by the administration to promote generic medicines (Narendra Gupta)

In 1977, the WHO launched its policy on essential drugs, emphasising the possibility of transforming world health through the effective use of relatively few essential drugs. The medicines identified were overwhelmingly unbranded ('off-patent' and available in generic form) and represented only a small fraction of the many thousands of preparations that the pharmaceutical industry wanted to sell. Importantly, the concept of essential drugs made universal therapeutic sense, even if the need was greatest in developing countries.

The opposition of the pharmaceutical industry was inevitable, all the more so because of the growing realisation of what later became known as 'the crisis of productivity in drug innovation'. The first decade or two following the Second World War had proved to be a golden age of innovation, but thereafter came decline. The cost of innovation has since increased dramatically and the number of really indispensable new drugs has fallen (Medawar and Hardon 2004).

In response, the industry reacted, first by embarking on wave after wave of 'consolidation', growing through mergers and acquisitions into the Big Pharmas of today. Moreover, since around 1980 – thanks to the liberalisation of trade policies under the influence of Reagan, Thatcher, and others – the process of globalisation gathered momentum. That process may not be complete, but might still be described as mature.

The Big Pharmas otherwise responded to the crisis in innovation by greatly reducing investment in basic research and less profitable drug development.

At the same time, they hugely increased investment in drug marketing and in the intensive promotion of inessential (lifestyle) drugs in mass markets. That trend became especially obvious in the USA following the 1997 legalisation of direct-to-consumer advertising of prescription drugs.

National health and drug expenditure in the USA is now substantially higher than in any other country (e.g. twice that in the UK), but with no obvious effect on the classic health indicator, life expectancy. For all the benefits of the existing US health care system, most Americans are either obese or overweight, and only about 3 per cent of the US population is estimated to maintain a normal weight, eat a nutritious diet, take adequate exercise, and not smoke (Centers for Disease Control and Prevention 2001). At the same time, at least 15 per cent of the US population is completely uninsured, and just over one-third of the population is 'under-insured', unable to cover the costs of their medical needs.²

In contrast, WHO estimates that more than one-third of the world's population lacks regular access to the medicines it needs. In low-income countries, 10.3 million children under five years of age died last year; 8.6 million of these deaths could have been prevented if those at risk had had access to essential medicines (Medical Education Cooperation with Cuba 2010). Today, in 32 countries more than half the population lacks regular access to basic essential medicines. At the same time, over one billion people, one-sixth of the world's population, suffer from one or more neglected tropical diseases (WHO 2010). 'Neglected diseases' are those that disproportionately affect the populations of developing countries and which do not represent a commercially viable market for pharmaceutical companies, because those suffering generally cannot afford the drugs produced by these companies.

In short, and for all the progress made, under-medication remains an appalling problem in many parts of the world, while over-medication threatens others. Are these two world health crises related? In symbolic terms – like the contrast between obesity and emaciation from starvation – they clearly are. Beyond this, one may well conclude that excessive demand for medicines in richer countries perpetuates the growth of a global medicinal drug production system that by its nature neglects medical need where people cannot pay.

Over-medication is a world health problem too

To this extent, under-medication and over-medication seem to be two sides of the same coin. Therefore, one should ask whether, and to what extent, the problem of drug deprivation in developing countries might be addressed by curbing the extent of over-medication elsewhere.

There are three main reasons for focusing on the problem of over-medication. The first is simply to encourage a radical reappraisal of the impact of pharmaceutical endeavour on human health. The fact that life expectancy is unrelated to spending on health care underlines the need for this. Moreover,

abundant evidence from richer countries shows that the main determinants of health and mortality have far less to do with absolute levels of wealth and far more to do with equality of income distribution (Wilkinson and Pickett 2010).

Another reason would be to try to contain excessive and inappropriate industry influence. The point is further discussed below. Suffice it here to say that the dominant influence of the Big Pharmas has affected not only doctors' prescribing habits and patterns of consumption, but also the policies of national governments and health organisations, standards of drug approval,³ regulation and enforcement, and the thrust of international legislation on patent law and access to drugs.

The third main reason for focusing on over-medication as a world health problem is to gain a clearer understanding of the relationship between drug benefits and harms. The urgency of this task is underlined by the gross imbalance that exists worldwide between the resources made available for the investigation and reporting of the health benefits and harms that result from drug use. To date, we have yet to develop even a taxonomy, let alone appropriate procedures, to establish the true contribution of medicinal drugs to *ill-health*.

We have still barely advanced from the 1970s, when Illich and Thomas, among others, warned of the dangers that confront us now. The present lamentable state of public health in the USA suggests not only the need to beware of that country's model of health care as a template for other nations, but also the great importance of heeding Illich's warning to guard against the social and cultural iatrogenesis that would result in 'the paralysis of healthy responses to suffering, impairment and death' and lead to a disabling dependence on 'health care' (Illich 1976).

Thomas presciently anticipated the problem beyond that: whatever the gains, the combination of market forces and medical endeavour tends to destroy public health provision. The rising tide of over-medication is clearly linked to unsustainable demand. As Thomas warned 30 years ago:

The trouble is, we are being taken in by the propaganda, and it is bad not only for the spirit of society; it will make any health-care system, no matter how large and efficient, unworkable. (Thomas 1980)

In short, pharmaceutical endeavour has already reached the point at which the relevance of Pharmageddon might be real.

Values of the international pharmaceutical industry

The international industry, under the leadership of the Big Pharmas, walks tall, carries great weight, insists that it behaves responsibly, and is a driver of good health. On this basis, it enjoys a range of rights, privileges, and protections – and increasingly partnerships – granted not only by host governments, but also by health practitioners and professional associations.

Meanwhile, ill-health remains endemic and enduring in developing countries, and the mood of optimism that characterised the 1960s and 1970s has long since disappeared. Certainly, probably every major pharmaceutical company can point to philanthropic programmes and to worthwhile health initiatives in many different low-income countries. Still, the evidence overwhelmingly suggests both that not much is changing and that there is little reason to suppose it will. Existing systems of pharmaceutical endeavour do not and cannot prioritise the development of world health.

Pharmaceutical endeavour is naturally mainly geared to performance in major markets. Thus, while 10 key countries account for over 80 per cent of the global market, developing countries account for about 8 per cent (Holland and Bátiz-Lazo 2004). IMS Health estimated the value of the global pharmaceutical market in 2010 at over \$824 billion, with growth predicted at a 4–7 per cent compound annual rate through 2013 (Roner 2009). The style and policies of the Big Pharmas are framed accordingly.

In this context, it makes sense to look mainly to the USA to get some sense of the values that drive global pharmaceutical endeavour. Twelve of the 20 largest pharmaceutical and biotech companies (ranked by health care revenue) are US-owned and the USA on its own accounts for almost half of the global pharmaceutical market. Moreover, the annual Fortune 500 survey shows that the pharmaceutical industry is, and long has been established as, the most profitable of all businesses in the USA, routinely reporting double-digit returns on sales revenue.⁴

With earnings on this scale, the industry is well placed to invest massively in third parties, to spread influence, and to get its own way. Thus, the Center for Public Integrity records that the US pharmaceutical industry spent \$855 million, more than any other industry, on lobbying activities from 1998 to 2006 (*ibid.*). Payments to doctors – for research services and for drug promotion – are not generally disclosed, although some details are now emerging, both as a condition of legal settlements and by way of anticipating a requirement in the US Health Reform Act (2010), which will require companies, from 2013, to disclose and explain payments above \$10 made to doctors. Meanwhile, the US public interest group Pro-Publica (Journalism in the Public Interest) published in 2010 details of payments totalling \$258 million by seven companies, including the names of recipients (Nguyen et al. 2010).

The wealth of the Big Pharmas, not to mention their compliance record, is further underlined by the scale of the fines paid for illegal activities, especially in relation to drug marketing. The US Project on Government Oversight (2010) reported that since 2004 pharmaceutical companies had paid over \$7 billion in fines and penalties. The largest was the \$2.3 billion paid by Pfizer in September 2009 (*ibid.*) for illegally marketing the pain reliever Bextra (Valdecoxib) until 2005, when it was removed from the market owing to concerns about the risk of heart attack and stroke (Hepp 2010).

Such huge fines are neither exceptional nor as crippling as they might seem. The Alliance for Human Research Protection (2010) reports that every major company (Bristol-Myers Squibb, Eli Lilly, Pfizer, AstraZeneca, and Johnson & Johnson) selling ‘new generation’ anti-psychotic drugs has either settled a recent US government case for hundreds of millions of dollars, or is currently under investigation for possible health care fraud. Eli Lilly, for instance, paid a \$1.4 billion fine in 2009 for illegally marketing Zyprexa (olanzepine), but sales of Zyprexa just in 2008 were \$2.2 billion in the USA alone, and \$4.7 billion worldwide.

Big Pharmas operating in the USA also face substantial costs in settling civil actions in drug injury cases, not to mention the legal fees involved in trying to defuse them. Occasionally, details of a settlement may leak out, although binding secrecy is the general rule. Given the estimated scale of drug injury in the USA,⁵ clearly many more billions of dollars would be involved. Bloomberg reported that GlaxoSmithKline paid out \$1 billion in 2010 to settle about 800 claims relating to just one adverse effect (birth defects) of one of its drug products, Paxil (paroxetine).⁶ (See Box D4.)

The relevance of all this outside of the USA, and especially in developing countries, is not only that all such costs will be reflected in the price of medicinal products. The wider problem relates to the appropriateness and effectiveness of the predominantly US model of drug approval, use, and control, especially in countries with very limited resources and huge health needs. Would one expect Big Pharmas to behave any better in countries beyond their main markets, in the absence of a strong professional infrastructure, and when regulatory and enforcement capacity and provision for redress were conspicuously lacking? The notion that developing countries may benefit from the ‘higher’ standards required in high-income countries seems dubious when most countries have little or no effective regulatory capacity at all (WHO 2004).

For lack of drug regulation

The relevance of all this for developing countries is further underlined by a wealth of evidence that suggests that even in the highest-income countries, the regulators struggle to perform effectively and often fail. An important UK parliamentary inquiry in 2005 ‘revealed major failings in the regulatory system’, detailing concerns about the licensing process, including questions of access to generic drugs, the conduct of clinical trials, control of marketing, post-marketing drug safety evaluations, and product withdrawals. This inquiry reported not only ‘serious weaknesses’ in the regulatory system, but also that ‘the Agency seemed oblivious to the critical views of outsiders and unable to accept that it had any obvious shortcomings’ and that it failed to provide ‘the discipline and leadership that this powerful industry needs’ (Alliance for Human Research Protection 2010). Comparable weakness – ‘This agency can

be dangerous' – has been identified with regard to the US Food and Drug Administration (Angell 2010).

So it is that even in the most regulated environments, pharmaceutical companies routinely resort to a wide range of unsavoury and plainly unscientific practices whose effect is to move goalposts and tilt the pitch, and therefore to greatly distort understanding of drug benefit and risk.

Always with an eye to return on investment (ROI), companies generously fund university departments and chairs, sponsor professional and patient organisations, and support extensive CME (continuing medical education) programmes. In all of these ventures, industry self-interest and promotional messages are never far away.

Companies purchase not only political support and favours, but also the services of 'key opinion leaders', supposedly independent academics, clinicians, and others who are paid handsomely to give product presentations, to troubleshoot, and otherwise to make representations on behalf of the companies (Center for Public Integrity 2008). Conflicts of interest, let alone the details of the payments made, are often not disclosed.

For lack of effective regulation and various other reasons, the quality of *most* clinical trials (and therefore the reliability of their results) are never even adequate. Former editors of the *British Medical Journal* and the *New England Journal of Medicine* agree on this.

We reject over 90% of the papers submitted to us, primarily because the research is of poor quality. The design or methodology of the study may be inadequate to address the hypothesis, the analysis of the data may be inappropriate, the conclusions may not be supported by the data or the data may support alternative conclusions, and so forth. The possible flaws, many of them fatal, are virtually endless. (Angell and Blume 2000; Gore et al. 1992)

The editor of *The Lancet* told a UK parliamentary committee in 2005 that this kind of research would typically end up in the hands of medical publications that are, in fact, 'information laundering operations', in which compliant publishers gain from potentially huge kickback payments, or end up being threatened with terminal loss of business if they refuse to comply.

Beyond this, pharmaceutical companies routinely orchestrate the 'ghost-writing' of the results of clinical trials, employing professional writers to put a gloss on the results, then paying 'independent experts' to be identified as the lead authors. In addition, companies routinely cherry-pick from the available research data, publishing positive results and delaying or suppressing publication of the rest. On its own, this 'publication bias' leads to substantial overestimation of drug benefit and underestimation of harm.

Increasingly, in richer markets, the Big Pharmas are also accused of 'disease mongering' (Moynihan and Cassels 2005), and the lack of any control over the *volume* of product promotion is a relevant factor here. If not through 'direct-to-

consumer advertising’, companies typically buy into soft media and susceptible consumer groups, to provide all manner of ‘helpful’ information, supposedly to give patients more ‘choice’. Underpinning this marketing endeavour, the major companies routinely nominate, sponsor, and convene groups of selected professional ‘experts’ to develop statements of ‘best practices’ and treatment guidelines that have proved to have great influence in defining consumer ‘need’ and prescribing behaviour.

There is much more than this to be said – not least, substantial evidence of unfair attempts to neutralise or intimidate conscientious critics⁷ – but already the question is this. If we were all individually capable of knowing, synthesising, digesting, and processing all available (and obtainable) information on drug benefits and harms, would we not radically revise our views on the relationship between the two, and on where health value is to be found?

The question is rhetorical. The wider point is that – for all the progress seen, mainly in the highest-income countries – secrecy and non-disclosure still generally underpin commercial, professional, and governmental contributions to pharmaceutical endeavour. Lack of proper accountability remains the norm, and systematic and gross overestimation of therapeutic value for money is inevitably the result.

Response to health needs in developing countries

The present system of pharmaceutical endeavour inevitably falls far short of meeting basic health needs in developing countries. Pharmaceutical companies are market driven, by nature, design, and (company) law. They exist to develop and sell products to customers who can pay, and to trump competitors by any legal means.

The gulf between health provision and health need is underlined by the paucity of investment in R&D of drugs for the major neglected diseases. Between 1975 and 2004, only 21 out of 1,556 marketed new chemical entities were indicated for neglected diseases. This represents about 1 per cent of output, a figure unchanged in three decades (Chirac and Torreele 2006; Lexchin 2010). Médecins Sans Frontières (MSF) estimates that of the \$105 billion spent on medical innovation today, 90 per cent is spent on the health problems of less than 10 per cent of the world’s population (MSF 2006).

The underlying problem is acknowledged by some industry leaders:

We have no model which would [meet] the need for new drugs in a sustainable way ... You can’t expect for-profit organization[s] to do this on a large scale. If you want to establish a system where companies systematically invest in this kind of area, you need a different system. (Lexchin 2010)

Indeed, MSF suggests that some companies:

seem willing to explore new ways to be rewarded for their investments into

R&D ... At an MSF symposium on tuberculosis drug development in January 2007, representatives from several major pharmaceutical companies endorsed a statement supporting the UN talks aimed at producing a new R&D framework ... which would address the question of who pays for essential medical R&D, dissociating incentives from drug prices and rewarding innovation according to health care outcomes. (MSF 2007)

The key problem is to establish a system that, on the one hand, provides incentives to stimulate drug innovation in response to the greatest medical needs, and, on the other hand, provides access to affordable medicines. At present, these objectives seem quite incompatible, although various proposals have been made to reform the existing system over time. In the meantime, the main pressure point (and source of friction) relates to removing obstacles to accessing existing generic versions of useful drugs, thus saving millions of lives today rather than tomorrow.

While generic competition is critical to reducing drug prices and improving access to affordable medicines around the world, the patent system and other forms of intellectual property protection at present delay and obstruct the entry of generic medicines on to world markets. The patent system, globalised under the Agreement on Trade Related Intellectual Property Rights (TRIPS), is the dominant incentive framework for the development of new medicines, particularly where there is a profitable market.

Looking to the longer term, a number of proposals have been made for reforming the existing system of pharmaceutical endeavour, with a view to stimulating essential drug R&D and to delinking R&D costs from the price of medicines. Two model proposals are already in operation. But all of them have limitations, and also all face major obstacles, apart from a lack of resources. Seuba (2009) and Lexchin (2010) have identified the main barriers to expanding research capacity as follows: lack of effective prioritisation, coordination of research efforts, and capacity to conduct clinical trials in developing countries; failure to exploit publicly funded research; and stifling of initiative and free exchange of information resulting from the proliferation of intellectual property rights and patent thickets.

Public-private partnerships (PPPs), which exist in several different forms, are at present the most advanced of the various alternative models. They aim to integrate and coordinate industry and academic partners and contractors along the drug-development pipeline; to allocate philanthropic and public funds to appropriate R&D projects; and to manage neglected-disease R&D portfolios. A 2005 survey reported that 47 of 63 new drugs for neglected diseases were being developed under the auspices of a PPP. One-third of these 47 drugs came from PPPs involving Big Pharmas, the remainder from PPPs working with smaller companies (including some in developing countries) and from academic and public sector institutions (Moran et al. 2005).



41 Drugs in search of a disease (Indranil Mukherjee)

Another model, operational since 2008, is the US system of priority review vouchers.

Under this scheme, a company marketing a treatment for a neglected disease in the USA is entitled to a six-month review (instead of the standard 12 months) for any other product that it sells. This faster turnaround could reward a company with up to \$300 million by reducing the erosion of the product's patent life. While this model circumvents the usual obstacles of priority-setting and research coordination, Lexchin and others have suggested that it is otherwise of limited potential (Kesselheim 2008).

Other models to increase research capacity include an R&D treaty that will require governments to pay for essential medical innovation (MRDT 2005). Ambitious and detailed proposals have been made and also discussed at WHO,⁸ but obstacles have arisen and progress appears to be slow (Love 2009). Meanwhile, the main focus of attention is on prize funds. Different schemes have proposed a variety of payment mechanisms. What all these mechanisms have in common is that (potentially substantial) rewards for innovation are geared to the proven therapeutic value of a drug (Faunce and Nasu 2008; Love 2009; Stiglitz 2006; Love and Hubbard 2007). Although controversial, the prize fund mechanism *inter alia* is now acknowledged in the WHO Global Strategy Plan of Action as a viable mechanism for development.

It will be clear that the current challenges are formidable and that time is on no one's side. It remains to be seen whether, and to what extent, the leadership of pharmaceutical endeavour can rise to the occasion. In the meantime, the suffering continues on a breathtaking scale, not for want of technical solutions, as in the past, but for lack of political will.

Box D4 Medicines in search of a disease

In 2010 alone, drug companies paid US government agencies, insurance companies and patients more than \$2.7 billion in criminal and civil fines or settlements over their failure to fully disclose adverse drug effects or for illegal marketing of psychiatric drugs (making false claims about their safety or use).

Big Pharma-psychiatry's marketing to GPs and paediatricians has led to an enormous boost in the sales of psychiatric medicines. In 1989, an American Psychiatric Association (APA) 'Campaign Kit' told APA members, 'An increase of psychiatry's profile among non-psychiatric physicians can do nothing but good. And, for those who are bottom line oriented, the efforts you spend on building this profile have the potential to yield dividends through increased referrals' (American Psychiatric Association Campaign Kit 1989).

With the selling of mental illness to primary care physicians well in hand, the selling of psychiatric drugs follows. Harvard University psychiatrist Joseph Glenmullen, author of *Prozac Backlash*, writes, 'As they gain momentum, use of the drugs spreads beyond the confines of psychiatry and they are prescribed by general practitioners for everyday maladies' (Glenmullen 2000).

Today, through heavy marketing of its diagnoses and drugs, psychiatry no longer fights to emulate and gain acceptance from medicine; it has become an integral part of it. With that marketing, we've seen a dramatic increase in children being labelled with Attention Deficit Hyperactivity Disorder (ADHD), bipolar disorder and autism, thus creating 'false epidemics'.

Today, the US consumes 85 per cent of the international production of methylphenidate (Ritalin).⁹ The Council of Europe Parliamentary Assembly has also found high rates of methylphenidate consumption in Belgium, Germany, Iceland, Luxembourg, the Netherlands, Switzerland and the UK. In Britain, the stimulant prescription rate for children soared 9,200 per cent over an eight-year period, while in Australia there was a 34-fold increase in two decades (Johnston 2003). France reported a 600 per cent increase in the number of children labelled 'hyperactive' during the course of four years (Minde 1998). Sales of methylphenidate in Mexico have increased 800 per cent since 1993. In Spain, one of the largest exporters of methylphenidate, the consumption of this increases 8 per cent every year (Criado Alvarez and Romo Barrientos 1999).

'How can millions of children be taking a drug that is pharmacologically very similar to another drug, cocaine, that is not only considered

dangerous and addictive, but whose buying, selling, and using are also considered a criminal act?’ asks Richard DeGrandpre, professor of psychology and author of *Ritalin Nation* (Grandpre 1999: 177).

It has been argued that the source of ADHD and other mental disorders is a chemical imbalance that requires ‘medication’ in the same way that diabetes requires insulin treatment. This is false. In 2005, Dr Steven Sharfstein, APA president, admitted that there is ‘no clean cut lab test’ to determine a chemical imbalance in the brain.¹⁰ Dr Mark Graff, Chair of Public Affairs of the American Psychiatric Association, said that this theory was ‘probably drug industry derived’.¹¹

Notes

1 ‘Pharmageddon?’ www.socialaudit.org.uk/60700716.htm.

2 ‘Health care in the United States’. en.wikipedia.org/wiki/Health_care_in_the_United_States.

3 Since 1990, for example, the ICH (International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use) has played an increasingly important role in defining the tests and standards used for approving drugs for general marketing. Its members comprise the European Commission, the US Food and Drug Administration, and the Japanese Ministry of Health, Labour and Welfare, together with the three associated trade associations – the European Federation of Pharmaceutical Industries and Associations (EFPIA), the Japan Pharmaceutical Manufacturers Association (JPMA), and the Pharmaceutical Research and Manufacturers of America (PhRMA). At the same time, the Secretariat of the ICH is provided by the International Federation of Pharmaceutical Manufacturers’ Association (IFPMA).

4 ‘Pharmaceutical industry’. en.wikipedia.org/wiki/Pharmaceutical_industry;

5 See, for example, Starfield (2000); Perdomo (2010).

6 ‘Glaxo said to have paid \$1 billion over Paxil suits’. *Bloomberg Businessweek*, 20 July 2010. www.businessweek.com/news/2010-07-20/glaxo-said-to-have-paid-1-billion-over-paxil-suits.html.

7 For example, see David Healy

(psychiatrist), en.wikipedia.org/wiki/David_Healy_%28psychiatrist%29, and Nancy Fern Olivieri, en.wikipedia.org/wiki/Nancy_Olivieri.

8 Proposal by Bangladesh, Barbados, Bolivia and Suriname. Proposal for WHO discussions on a biomedical R&D treaty. www.who.int/phi/Bangladesh_Barbados_Bolivia_Suriname_R_DTreaty.pdf.

9 ‘Evolution of the number of prescriptions of Ritalin (Methylphenidate) in the Canton of Neuchatel between 1996 and 2000’. Dr Jean-Blaise Montandon, Public Health Service, and Laurent Medioni, Chief of Pharmaceutical Control and Authorization Division, Switzerland.

10 *People* magazine, 11 July 2005.

11 Dr Mark Graff, interview, *CBS Studio 2*, July 2005.

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D5 | HEALTH AND GLOBAL SECURITY: REASONS FOR CONCERN

While not overlooking the benefits that have resulted from linking health and global security (such as increased funding for certain health priorities and greater cooperation on some issues), this chapter, building upon the analysis advanced in *Global Health Watch 2*, raises serious concerns about how the relationship between global health and global security is construed and practised by powerful actors. Crucial to this effort is looking beyond the global health agenda itself, or simply defining health as ‘a security issue’, in order to view global health in terms of a three-way relationship between health, economics, and security. The central message here is that what counts as a ‘security issue’ – and who gets to define security – are matters of crucial importance.

Health, military spending, and the global financial crisis

At a time when vast resources have been committed to a rescue of the global financial system via a bailout of major banks in the global North, military budgets have continued to rise and steps towards achieving a nuclear-free world – although welcome – remain tentative, to say the least. As the Stockholm International Peace Research Institute (SIPRI) noted in its most recent report:

The financial crisis and economic recession that have affected most of the globe appeared to have little effect on levels of military expenditure, arms production or arms transfers. On the other hand, the crisis probably did undermine the willingness and ability of major governments and multilateral institutions to invest other, non-military resources to address the challenges and instabilities that threaten societies and individuals around the world.¹

Indeed, SIPRI found that, while in 2009 many smaller countries cut their defence budgets substantially, 65 per cent of countries for which data are available *increased* their budgets and that overall global military spending increased by 5.9 per cent.

How do these trends match with spending on international health and development? According to the Organisation for Economic Co-operation and Development (OECD), total net official development assistance (ODA) for health increased in 2009 by 0.7 per cent in real terms, or 6.8 per cent if debt relief – which spiked as a result of debt-forgiveness packages for Iraq and Nigeria – is excluded. Furthermore, while global military spending has

increased by around half since 2000, so, too, has ODA. It is necessary to take into account three key points.

The first is the vast difference in absolute magnitude as a measure of commitment to military security versus human security. While SIPRI estimates 2009 global military spending at \$1,531 billion,² total net ODA was just \$119.6 billion (7.8 per cent of military spending). This difference is even more pronounced when it comes to the United States, which makes frequent claims to global leadership in both security and health. The US defence budget grew by 63 per cent under the Bush administration and continues to grow under the Obama administration, by 7.7 per cent in 2008/09, with 2009 outlays for 'National Defence' estimated at \$661 billion.³ While US ODA has increased significantly in absolute and percentage terms, it still totalled only \$28.665 billion in 2009 (or 4.3 per cent of military spending).

The second is the relative vulnerability of military versus development spending as many countries seek to reduce overall public expenditure. As SIPRI noted:

Rising military spending for the USA, as the only superpower, and for other major or intermediate powers, such as Brazil, China, Russia and India, appears to represent a strategic choice in their long-term quest for global and regional influence; one that they may be loath to go without, even in hard economic times.⁴

While politicians in the global North are beginning to talk about the need to reduce military spending, there are also signs that global health financing is coming under increasing pressure as many countries reconsider their spending priorities.⁵

There is much to be learnt from a close observation of global trends in military, health, and development spending. While the idea that 'there can be no development without security, and no security without development' has become a popular mantra, it obscures the structural imbalance in spending between military security and global health and development.

Of course, while financial allocations give a clear indication of political priorities, there are problems with relying on a purely financial analysis. Foreign aid is far from being a panacea for global health problems, particularly when this masks – or serves to perpetuate – the operation of an inequitable global political economy and long-term capital outflow from the poorest regions. As a recent report by Global Financial Integrity estimates, illicit financial flows out of Africa in the period 1970–2008, a period covering the most recent phase of global economic integration, amounted to at least \$854 billion and perhaps as much as \$1.8 trillion.⁶ The extent to which foreign aid actually benefits the health of the poorest can also be called into question. Rather than calling for a straightforward switch from military spending to global health spending, then, it is more meaningful to ask how to foster the demilitarisation of global affairs *and* how to achieve a more health-equitable global economy.

Questioning 'global health security'

Global Health Watch 2 noted the efforts by WHO and the global North countries to promote the idea of 'global health security', understood as global cooperation in the detection of, and response to, public health emergencies (a term introduced by WHO in the revised International Health Regulations [IHRs] of 2005).⁷ However, efforts to promote such cooperation under the banner of security have run into serious problems, in part as a result of a failure to include equity in the definition of security.

Concern over emerging infectious diseases and bioterrorism has been growing since the early 1990s, particularly in light of globalisation. While these problems potentially affect all parts of the globe, concern is most strongly focused on those parts of the world that have already made the greatest progress in containing infectious disease threats, that is, the global North. WHO has accordingly made cooperation in this field the centrepiece of its work, developing the concept of 'global health security' from the late 1990s onwards. However, while it increasingly used the term 'security', WHO never secured a consensus on exactly what security means for a body committed to the equal representation of all UN member states.

This issue has become increasingly important. According to the IHRs, which came into force in 2007, member states are meant to cooperate on potential 'public health emergencies of international concern'. This umbrella term, in fact, conflates what are, in important respects, rather distinct phenomena, ranging from bioweapon attacks to 'naturally occurring' epidemics, potentially drawing WHO into the highly contested field of counter-terrorism. But while states are meant to develop detection and reporting mechanisms and to adhere to WHO-sponsored best practices, the IHRs have nothing to say about how the benefits of such cooperation should be shared, or how the obligations of the richer and the more powerful help the poorer and the less powerful.

In Chapter B8 we discuss how the issue of virus sharing in the context of influenza pandemic preparedness, raised first by the government of Indonesia in 2007, points to a fundamental inequity in global relations. We note in the chapter that: 'In the absence of reciprocal benefits, the International Health Regulations, for instance, which impose mandatory disease-reporting obligations on signatory member states, could reduce poorer front-line states to the role of pandemic "canaries" in an early warning system for emergent flu pandemics'.

It is important to highlight the broader implications for the concept and practice of global health security in terms of the global distribution of wealth, power, and resources for health. In particular, this (the virus sharing) episode shows the problems related to a concept of security that demands total transparency and cooperation on the part of all parties involved, but not equity and solidarity between them. It also shows how the political and economic issues of patenting and intellectual property rights lie behind efforts to develop global

health surveillance and security systems. It may be that diplomatic solutions can be found for the most pressing issues surrounding global health security. However, this entire episode has thrown further light on the problematic politics of security in a divided and unequal world. An adequate concept of security for global health must address the inequitable structure and unbalanced working of the global economic order as well as attempts to combat the effects of headline-grabbing viruses. Without this, the concept and practice of global health security will be more likely to divide the global community rather than bring it together.

Global health, foreign policy, and counter-insurgency

A third troubling development concerns increasing efforts to align the idea of health with a particular version of economic development, political organisation, and ultimately freedom, promoted by certain global North countries in general, and by the United States in particular.

The growing interest in global health as a security issue has been paralleled by a growing interest in using health programmes to achieve political objectives. Bodies such as the Commission on Macroeconomics and Health (which was tasked by WHO director general Gro Harlem Brundtland to investigate the relationship between economics and health) have claimed that health programmes can function in a virtuous relationship with economic growth and global security.⁸ Such arguments are being taken up enthusiastically by the US Department of Defense, which accounts for a growing share of US foreign aid spending.⁹

Of particular concern here are signs that health programmes are being pressed into service in support of specific political and military goals, namely the US war on terrorism and the occupation of Iraq and Afghanistan.¹⁰ For example, medical assistance provided by the US Marine Corps to local populations has been described as ‘one of its most effective weapons systems’ in ‘the ongoing effort to win the hearts and minds of Iraqis in Anbar province’.¹¹ Similarly, a review of the role of ‘medical diplomacy’ in stabilising Afghanistan notes that:

Medical interventions are an important component of a diplomatic strategy to regain moral authority for US actions, regain the trust of moderate Muslims, and deny terrorists and religious extremists unencumbered access to safe harbour in ungoverned spaces.¹²

The key rationale behind such initiatives is that medical aid can help in reaching out to populations that might otherwise be unsupportive of, or opposed to, the involvement of outside political and military forces. In sum, health programmes are being seen increasingly, in US foreign policy in particular, as a way to ‘win hearts and minds’ and to ‘drain the swamp’ of support for terrorism.¹³ In US military parlance, health initiatives are touted

as a key component of ‘stability operations’ in conflict and ‘pre-conflict’ zones.¹⁴ As such, they are becoming part of a broader turn towards counter-insurgency operations as an organising frame for military and security policy. Actors whose primary concern is health need to be aware of this trend and its implications.

This raises a number of potential problems. First, it has been widely observed that ‘humanitarian space’ has been shrinking over the last two decades. There are several reasons for this, mostly to do with the nature of post-Cold War conflicts and the collapse of state authority in many regions. But the efforts of external military actors to associate their interventions with humanitarian organisations and humanitarianism more generally have further politicised the role of health actors in conflict situations. While many NGOs have themselves sought to adopt overtly political roles in relation to political conflict and oppression, even a perceived association with military forces can have fatal consequences, as the killing of MSF (Médecins Sans Frontières) personnel in Afghanistan in 2004 showed. Second, the highlighting of health programmes in the context of ‘stability operations’ obscures the obligation to abide by humanitarian law when it comes to war and occupation. These are much broader than ‘reaching out’ to locals by offering vaccinations or running temporary clinics, and include the obligation to adhere to the discriminate, proportionate, and justifiable use of force. However, the most recent evidence from Afghanistan reveals a pervasive failure to do so in the case of US and coalition forces.¹⁵

Such developments take on wider significance when seen together with another trend. This is to emphasise the role of military forces, particularly the globally deployed US military, as ‘contributors’ to global health.¹⁶ To be sure, the US military does play a part in global infectious disease surveillance and has taken on a role in implementing the US president’s Emergency Plan for AIDS Relief. Military forces in other countries likewise may at times function as bellwethers of population health more generally. The idea that military forces are contributors to global health may also help to sensitise some policy-makers to the importance of health as a policy priority more generally. But this must be set against a more systematic appraisal of the relationship between militarism (as an ideology), militarisation (as a process of constant preparation for war), and military forces (as agents in their own right). At a minimum, the appraisal needs to take into account the significant societal resources devoted to the preparation for war; the effects of militarisation on the environment; and the effects of war on the environment, on social and economic infrastructure, and on the health of civilians and military forces.

The impact of migration control

A final concern has to do with the implications of the emerging global security infrastructures for the surveillance and control of human mobility

for health and human rights. In particular, there are concerns that these infrastructures extract a direct toll in terms of the deaths of people trying to migrate; generate large shadow populations without proper access to health services; and enforce social, economic, and political exclusion on a global scale.

It is now widely recognised that migration, driven in large part by the uneven development of the global economy, provides many benefits for migrants as well as for sending and receiving countries. But while migration is often supported on these grounds by economists, by business communities, and by sending countries, and while the right to asylum has been defended by many political actors, politicians in the global North countries have, for a variety of reasons, moved towards an increasingly restrictionist approach to human mobility, with exceptions made only for those deemed to be 'highly skilled'.

The global North countries have over the last two decades increasingly fortified their borders, while also seeking to exert increased surveillance and control over human mobility on a global scale (in part also justified with reference to counter-terrorism).^{17, 18} This, together with the dysfunctional state of the migration and asylum systems of many countries and the absence of a coherent global governance regime, has created a number of traps into which migrants and people seeking asylum have fallen, with a growing list of fatalities among those attempting to enter the United States and the EU by increasingly risky routes.^{19, 20} Human mobility itself has thus become a global security issue, in the sense that vast resources are being deployed in order to secure communities in the global North from unwanted people. The emergence of an increasingly sophisticated and powerful migration control regime along these lines reinforces a global order that remains in many respects inimical to human health and well-being.

Conclusions

This overview reveals serious problems in the relationship between global health and global security. Under a complacent belief that 'wealth buys health', the global community has failed to give health and health systems their due over decades of economic integration and structural adjustment inspired by neoliberal ideology. Indeed, the growing sense of a global health crisis articulated by social movements and security analysts during the 1990s is a marker of the extent to which neoliberalism, underpinned by global US military dominance, has failed to deliver equitable health, development, and security. The implications of financial and military overstretch – which were taken to new heights under the George W. Bush administration – have become glaringly obvious since the onset of the current global economic crisis.

In some ways, social movements for health are better placed than ever before to make the case for a new model of security that takes proper account of equity. But it is by no means certain that any rearrangement in the global balance of power will necessarily produce more health-equitable forms

of globalisation and security. The extent to which the current crisis offers an opportunity for a basic redesign of global health, security, and development remains to be seen.

Notes

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3 Stockholm International Peace Research Institute (2010). *Op. cit.*

4 *Ibid.*

5 Lancet (2010). 'The global fund: replenishment and redefinition in 2010'. *The Lancet*, 375(9718): 865.

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7 See www.who.int/ihr/en/.

8 See extracts in WHO CMH Support Unit. *Investing in health: a summary of the findings of the Commission on Macroeconomics and Health*. Geneva, WHO. www.who.int/entity/macrohealth/infocentre/advocacy/en/investinginhealtho2052003.pdf (accessed 4 August 2010).

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14 US Department of Defense, Force Health Protection and Readiness (n.d.). 'Stability, security, and reconstruction operations'. fhpr.osd.mil/intlhealth/ssst&ro.jsp (accessed 19 February 2009).

15 See www.guardian.co.uk/world/data-blog/2010/jul/25/wikileaks-afghanistan-data (accessed 4 August 2010).

16 US Department of Defense, Force Health Protection and Readiness (n.d.). 'Helping achieve international health stability'. fhpr.osd.mil/intlhealth/ (accessed 19 February 2010).

17 Andreas, P. (2003). 'Redrawing the line: borders and security in the twenty-first century'.

International Security, 28(2): 78–111.

18 International Campaign Against Mass Surveillance (2005). *The emergence of a global infrastructure for mass registration and surveillance*. www.icams.org/ICAMS1.pdf.

19 BBC News (n.d.). 'Record migrant deaths on Arizona desert border'. www.bbc.co.uk/news/world-us-canada-10861985 (accessed 4 August 2010).

20 UNITED (2010). 'List of 13824 documented refugee deaths through Fortress Europe'. 17 June. no-racism.net/upload/785998108.pdf (accessed 4 August 2010).

D6 | THE INTERNATIONAL HEALTH PARTNERSHIP+: GLASS HALF FULL OR HALF EMPTY?

Development assistance for health has risen sharply in the past two decades and continues to be a priority in aid discussions, owing partly to the focus on the Millennium Development Goals (MDGs). Many of the world's poorer countries rely on health aid for sizeable portions of their health budgets. The problems with these financial transfers and the 'aid dependency' they produce are well known: episodic allocations preventing effective planning; donor preferences driven by strategic interest rather than need;¹ aid funding used to pay for the donor country's 'technical assistance' while essentially subsidising foreign contractors; fungibility and (at times) corruption in the misuse of aid funds in recipient countries; a proliferation of new global health initiatives leading to an enormous 'overburden' in recipient-country accountability; and, fundamentally, health issues and means of addressing them being increasingly defined by donor countries or international funders.

These problems are well recognised by donors and recipients. The 2005 Paris Declaration on Aid Effectiveness emphasised three means for allocating aid more efficiently and meaningfully: harmonisation amongst donors; alignment of donors to recipient-country plans; and coherence to ensure that donor policies in trade or intellectual property do not undermine the developmental value of aid (OECD 2005). But where is the donor (and recipient) accountability for such reasonable goals?

IHP+ to harmonise donor funding

In part-answer to this question, and in response to the lagging progress on the health MDGs, the UK government announced the International Health Partnership in September 2007. Its intent, with explicit reference to the Paris Declaration, is 'to better harmonize donor funding commitments, and improve the way international agencies, donors, and developing countries work together to develop and implement national health plans'. Shortly after its launch, it rebranded itself as the International Health Partnership 'plus related initiatives' (IHP+) to promote coordinated health systems, strengthening efforts across a number of other multilateral programmes. Twenty-three of the world's poorest and 13 of the world's wealthiest nations, together with a number of multilateral donors and international agencies, have signed up to the initiative (Box D6). The need for the initiative was argued by the UK's Department for International Development (DfID) at the time of its launch: over 40 bilateral

donors and 90 global health initiatives in operation; only 10 per cent of donor support for health in Zambia (as one example) going to the government to support comprehensive health systems, with the rest going to disease-specific programmes; and 22 different donors providing support for health in Cambodia through 109 separate projects (DfID 2007).²

Insufficient Progress

The IHP+, with its ‘Global Compact’ committing all signatories to support ‘one national health plan’ in recipient Partners, aims to become the grand health-aid coordinator, where sector-wide approaches (SWAps) and other efforts in the past have failed. Three years into the initiative, how well are the Partners delivering on these commitments or holding themselves publicly accountable for their efforts? To its credit, the IHP+ is undertaking a ‘real-time’ evaluation of its work, allowing some partial answers to this question to emerge. The IHP+ Results group, an independent consortium, completed their first evaluation report in early 2010, with a publicly released update presented at the 2010 World Health Assembly (IHP+ Results 2010). The

Box D6 Signatories of IHP+

International donor agencies: World Bank; European Commission; WHO; Global Fund to Fight AIDS, TB and Malaria; GAVI Alliance; UNFPA; UNAIDS; UNICEF; UNDP; ILO; Bill and Melinda Gates Foundation; Africa Development Bank

Bilateral donors: Australia, Belgium, Canada, Finland, France, Germany, Italy, Norway, Portugal, Spain, Sweden, the Netherlands, the United Kingdom

Developing-country partners: Benin, Burkina Faso, Burundi, Cambodia, Democratic Republic of Congo, Djibouti, Kenya, Madagascar, Mauritania, Niger, Nigeria, Pakistan, Rwanda, Senegal, Sierra Leone, Togo, Uganda, Vietnam, Zambia

Developing-country partners with a completed ‘country compact’: Ethiopia, Mali, Mozambique, Nepal

Related initiatives: Health Metrics Network, G8 Providing for Health, Global Health Workforce Alliance, Harmonization for Health in Africa, Innovative Results-Based Financing and the Catalytic Initiative to Save a Million Lives.

www.internationalhealthpartnership.net/en/partners (accessed 6 November 2010)

report and update, while signalling some positive developments, suggest a need for considerable improvement if IHP+ is to become more than another unfulfilled international gesture.

Consider, first, the status of country compacts. These compacts are signed agreements between donor and recipient Partners, and are intended to be the principal tools for aid alignment. Country compacts are meant to include agreements on supporting civil society engagement in the development of the national health plan (this is similar to the idea that civil society should be supported in developing national poverty-reduction plans as part of the Poverty Reduction Strategy Paper (PRSP) process) and to keep both donor and recipient countries focused on the purpose: more rapid progress towards achieving the health MDGs. There is some good news. Having a country compact in place, with good civil society engagement, appears to have helped some recipient countries focus on improving donor practices as well as recipient behaviour. But there is also bad news. Only four of the projected 10 country compacts were completed by the end of 2009.

In fairness, the formal (and unenforceable) country compacts may be less important than the willingness of the Partners to abide by the intent of the IHP+. It is here that the lack of transparency is more troubling. IHP+ Results, for its initial accountability evaluation, developed a method for Partner self-reporting using verifiable criteria and a core set of indicators based on the Paris Declaration and adapted specifically to the needs of the health sector. The Results report found that none of the Partners had supplied the information on the Paris Declaration health sector indicators. Only nine had provided enough self-reported data for the Results consortium to generate a reasonable narrative of the Partners' aid delivery at the recipient-country level. Of these, all but two (AusAID, the Australian development agency, and DfID, the UK development agency) were multilateral agencies, which already tend to comply more with the aims of the Paris Declaration than do bilateral donors.

The Results consortium created a second set of indicators for more detailed accounts of nine selected recipient Partners. Again, much of the information provided by the donor Partners was too sparse to allow the recipient Partners to determine how well the IHP+ was meeting its goals. Limited data suggest that donors are making some efforts to align with national plans. Most of the funding, however, still reflects donor priorities, and recipient countries continue to tailor their national health plans to available funding streams rather than the reverse. Very little evidence of health-system strengthening could be found, or of making aid commitments more predictable and longer-term.

These first-cut findings do not necessarily mean that the IHP+ is failing to deliver. They do mean that insufficient information to make this assessment has (at least so far) been forthcoming. In an era of donor insistence on 'results-based' aid, it is somewhat ironic that those same donors are failing to provide the data that would measure their own performance in meeting

the agreed-upon results. This non-compliance may partly have resulted from disagreements over the initial reporting mechanism developed by the Results consortium, and a working group to refine a consensus set of measures has since been established. The reticence of donors to hold themselves accountable to meeting their commitments, however, is a recurrent theme in aid commentaries and critiques (Sridhar 2010). The Results update itself noted that ‘accountability has yet to become embedded in the ways most agencies work’ (IHP+ Results 2010: 11). It remains an open question whether the IHP+, through the Results consortium, can succeed in gaining agreement on measures that matter and in obtaining reports that are meaningful, especially given the caveat that the Partners’ ‘participation in the IHP+ Results mechanism is voluntary’ (ibid.: 16).

Recommendations to ensure progress

To that end, an independent advisory group to the Results consortium, consisting of experienced international health workers and scholars, called for a number of actions on the part of IHP+ signatories, including:

- 1 Agreement on the Standard Performance Measures against which signatories should report to measure behaviour change in line with the IHP+ commitments. Analysis of these indicators should be conducted for each recipient country as well as for the overall performance of individual signatories.
- 2 Official commitment to incorporating the Standard Performance Measures as part of the joint annual review of the health sector in every IHP+ country, as well as within the Common IHP+ Monitoring & Evaluation Framework. This should reduce the high transaction costs of multiple evaluations and ensure that necessary and appropriate data are being systematically produced each year.
- 3 The production of a narrative report by IHP+ signatories on how well they are increasing coherence across a range of other sectoral policies known to affect health outcomes and the capacities of countries to develop and sustain equitable and effective health systems. Key sectoral policy areas would include: trade, intellectual property, foreign investment, macroeconomic or other conditions associated with aid and debt relief, and may extend to policies related to migration and human rights (ibid.: 5).

A final caution was voiced about the importance of guarding against the erosion of Results’ independence from the initiative’s ‘Scaling-up Reference Group’, a governing body made up of IHP+ Partners and to which the consortium reports. The consortium in its update expressed concern that it had ‘been significantly restrained from publicly reporting findings or the information that has been reported by agencies’ on the argument that these releases need ‘to be “signed off” at the senior level’ (ibid.: 22). This does not bode well for the initiative’s ambitions.

Nor does the emphasis placed by IHP+ on aid *effectiveness*, at least without reference to the acknowledged need for considerably greater levels of health-aid financing. A 2008 task force report, released in 2009, estimated an annual health funding gap of US\$10 billion to meet the health MDGs (Taskforce on Innovative International Financing for Health Systems 2009). This estimate preceded the 2008 global financial crisis, which has created a much larger budget shortfall of US\$65 billion in low- and middle-income countries, which aid transfers have failed to fill (DFI 2010). There is concern that absolute levels of official development assistance (ODA) from donor countries will decline as they deal with the consequences of bank bailouts, toxic debt, and stimulus spending. Against 2005 G8 commitments to aid increases, now abandoned by most donor nations that made them, OECD-DAC is predicting a shortfall of between US\$18 and 22 billion in 2010 (OECD-DAC 2010b), and a drop of 3 percentage points relative to GNI (OECD-DAC 2010a). Preliminary OECD-DAC figures for 2009 nonetheless found that overall aid levels crept slightly upwards (by 0.7 per cent) compared to 2008, with IHP+ donor Partners outperforming the average with a group increase of 3 per cent (OECD-DAC 2010c). The IHP+ positive tally was due to increased financing generosity on the part of just six Partners: Belgium, Finland, France, Norway, Sweden, and the UK. Other donor Partners saw their aid levels fall. Despite this modest increase, aid funding by IHP+ donor Partners, even in the aggregate, remains below globally committed levels, and several donor Partners (France, Italy, Canada) have announced reductions or caps on future aid expenditures.

Action by recipient partners

None of this diminishes the parallel need for improvements on the part of recipient Partners. One of the consortium's proposed measures here is the portion of the national budget allocated to health, a straightforward marker of a country's intention to use health aid to support, and not substitute for, domestic efforts. The 2001 Abuja Accord committed African Union members to a target of 15 per cent of annual government budgets to their health sectors, a target that only six of the 53 African Union nations have met so far (Campbell 2010). Earlier in 2010, African finance ministers rejected even this budgetary commitment, arguing that it was too constraining on their policy choices; it was later reaffirmed, reportedly the result of civil society pressure. A singular but not exceptional case is that of Zambia, an IHP+ recipient country, which has had much of its health aid suspended owing to 'whistle-blower' evidence of substantial embezzlement of donor funding, including that earmarked for government health programmes (Usher 2010). The risk of corruption and the lack of capacity for transparent accountability in (at least some) recipient Partner countries reinforce the channelling of health aid by donor Partners into non-governmental organisations or global health initiatives, undermining the very premise of the Paris Declaration and the IHP+ initiative.

Lack of coherence between aid and trade policies

But of all the concerns about aid adequacy, effectiveness, and accountability, the most troubling one (for both the IHP+ and the Results consortium) is the lack of coherence between the aid policies of the donor Partners and their trade or national security policies. As far back as the 1969 Pearson Commission, which launched the concept of ‘official development assistance’ (ODA), there was a clear warning that ‘it is futile ... to nullify the effects of increased aid by inconsiderate trade policies’ (Pearson 1969, cited in World Bank 2003). That caution has not been well heeded. The Economic Partnership Agreements (EPAs) still being negotiated between the European Union and its former colonies in Africa, the Caribbean, and the Pacific (ACP countries) contain many WTO+ provisions (on government procurement, intellectual property rights, agricultural liberalisation, and services trade), as well as schedules to lock in tariff reductions.

One study estimates that these EU demands could eventually cost ACP countries as much as €550 million annually in lost revenues, with as little as €12.7 in offsetting gains through increased Eurozone market access (ODI 2008). All projections of net gains and losses from the completion of the Doha ‘Development’ Round of WTO negotiations similarly calculate net income gains to developed countries that are four- or fivefold greater than those to developing nations, with the latter bearing the brunt of losses associated with tariffs reductions (Labonté et al. 2010). There is also the persistence of offshore financial centres (tax havens) under the protection of some donor Partners and the use of transfer pricing or illicit trade mispricing by multinational corporations (most based in donor Partner countries) that cost developing nations far more in lost tax revenues than they receive in aid disbursements (GFI 2010). And then there is the recent working paper from the IMF Research Department that argues that low-income countries should not spend their ‘scaled-up’ (MDG) aid monies as intended because of the attendant risk of currency inflation; rather, they should put all or at least some of it in foreign currency reserves (Berg et al. 2010). This reflects long-standing IMF policy advice (or conditionality) that developing countries ‘sterilise’ aid transfers through a number of means that essentially reduce domestic demand for goods or services and sustain a reliance on exports for economic growth (Balakrishnan and Heintz 2010).

Conclusions

These problems are not unfixable, but their persistence feeds a certain fatigue with the discourse on the need to reform the global aid architecture. The MDGs themselves, for all the aid promises they have engendered, suffer from the same vertical approach to health that the IHP+, in improving delivery on the health MDGs, is supposed to overcome. From the perspective of social determinants of health, *all* of the MDGs are health goals, and those

supposedly identified as such (extreme hunger, maternal/child mortality, HIV/malaria/TB) are in large measure manifestations of the success or failure in achieving others (extreme poverty, education, gender equality, environmental sustainability, global partnership). There is now some acknowledgement of this interconnectedness, with the UN in its September 2010 meeting on MDG progress identifying health as a cross-cutting outcome of all of the goals rather than being a stovepiped sector (UN General Assembly 2010). But, in unsurprising UN-speak, the September declaration, on the one hand, acknowledges that countries must individually assess the trade-offs between international disciplines (e.g. trade rules) and policy space (e.g. fiscal capacity and regulatory authority), while, on the other hand, it identifies global trade as the engine of development and as being important to the achievement of the MDGs (which is empirically contestable) and calls for rapid completion of a Doha round of the World Trade Organization (WTO) talks (which, as previously noted, will disproportionately reward already wealthier nations).

The two challenges confronting IHP+ (and its Results' accountability consortium), then, are the extent to which the Partnership's agreement to allow meaningful scrutiny of its efforts to put teeth into the goals of the Paris Declaration is honoured, and the depth to which that scrutiny will plunge below the surface of disease interventions and into the policies and practices of donor and recipient Partners that influence the social determinants of health.

Notes

1 Chapter D6: The international health partnership+: glass half full or half empty?

2 A recent study of the four major donors in global health noted that in 2005 funding per death varied widely by disease area, from \$1,029.10 for HIV/AIDS to \$3.21 for non-communicable diseases (Sridhar 2010).

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D7 | NEW REPRODUCTIVE TECHNOLOGIES

Introduction

While all societies in the past developed techniques to both avert and assist conception, and created and invested cultural meaning in and through processes of gestation, labour, birth, and breastfeeding, the rapid proliferation of reproductive technologies in the latter half of the twentieth century has redefined reproduction in unprecedented ways. The era that began with the birth of the world's first test-tube baby in 1978 and reached its zenith with the cloning of a higher vertebrate from an adult cell in 1997 continues apace today, marking a dynamic phase in the development of reproductive and genetic technologies.

New reproductive technologies (NRTs) are a broad constellation of technologies aimed at facilitating, preventing, or otherwise intervening in the process of reproduction. This includes, for example, contraception, abortion, antenatal testing, birth technologies, and conceptive technologies. The constant advancement and development in the world of NRTs is not without challenges and dilemmas.

NRTs as a range of technologies have come a long way, from ultrasound to assisted conception. Technological progression is both horizontal and linear. Thus, while new and different technologies emerge, there is a simultaneous endeavour to advance the already existing technologies, thereby resulting in different variations of a particular technology. This constantly evolving nature of scientific innovation has become the hallmark of contemporary biomedicine. The expansion of the realm of biotechnology in general, and of NRTs in particular, has also brought in new actors. Indeed, there is an entire industry based on and around these technologies, especially assisted reproductive technologies (ARTs) today. It is in this context that this chapter explores the implications of NRTs in a globalised world.

Contraception and women's health

The contemporary version of reproductive technologies is not without a past. Hence, it is important not to see these technologies as isolated scientific breakthroughs, but rather to historicise their modern avatar. With the unprecedented expansion of these technologies, accelerated also by developments in the field of biotechnology, an interrogation of issues that lie at the interface of technology, health, and society – and their implications for women – has become all the more urgent.

International agencies, family planning organisations, and governments have justified the use of invasive medical interventions in developing countries – hormonal contraceptives, anti-fertility vaccines, chemical sterilisation, and tubectomies performed in unsafe conditions – with arguments about ‘out of control’ fertility rates and the imminent ‘population explosion’. Scientists have collaborated in this enterprise, testing contraceptives on poor women without their consent, despite evidence of the serious health consequences of this practice. When research towards the approval of these contraceptives has been opposed, regulatory authorities have permitted their introduction through the back door.¹ There has been a long and dubious historical association of ‘family planning’ with ‘population control’. Feminists and health activists in different parts of the world have raised their voices against the harmful effects of contraceptive technologies in the form of implants, vaccines, and injectables. They have questioned the safety of hormonal contraceptive technologies, the ways in which clinical trials are conducted, the ways in which informed consent is collected, and the inadequate efforts of family planning programmes in securing women’s health in general. Furthermore, health activists have protested the inclusion of women in the health care system as essentialised reproductive beings, to the exclusion of their other health needs.²

‘Desired sex’ to ‘desired traits’: technologies for ‘selection’

What started with technologies like ultrasound, amniocentesis, and sperm sorting has acquired a new meaning with advanced technologies like pre-implantation genetic diagnosis (PGD). This technology, which was first developed to detect genetic abnormalities in the embryo prior to implantation, is now in rampant use to pre-select the sex of the embryo during the IVF procedure. Therefore, positing these technologies as the ‘right to family balancing’ has given rise to more questions than answers; patriarchy, son preference, and social prejudice have framed serious ethical concerns around their use. In India, for example, despite the legal prohibition on sex selection, the practice is widely prevalent, resulting in highly skewed sex ratios in most parts of the country. It is also not surprising to find couples going abroad to countries like Thailand in pursuit of PGD for sex selection.³

Similarly, reports in countries like the USA have highlighted the use of these technologies (mainly) by couples of Asian origin. For instance, up to 30 per cent of the patients at Dr Jeffrey Steinberg’s Fertility Institute, a Los Angeles-based clinic known to provide PGD, are women of Indian and Chinese descent. It is not difficult to see why. In countries where the sociocultural construction of motherhood (and related issues of access and validation) are inextricably linked to the birth of a son, couples may want not just a biological child, but also a child of a particular sex.⁴

Further, the eugenic concerns posed by these technologies have compounded the accompanying ethical challenges. In addition to the selection of the sex of

the child, other traits like eye colour, skin colour, and hair colour can be, and are being, chosen. Thus, the re/production of ‘designer babies’ or ‘tailor-made babies’ has become a distinct possibility.

Notions about the kind of embryo considered ‘desirable’ and ‘worthy of implantation’ have also been contested from the perspective of disability rights. Given that societal and structural frameworks determine the norm for what can be an ‘able/d’ life, the decision to eliminate a disabled fetus is not an innocent technological fix, but one with political causes and consequences. Thus, it becomes important to question both the nature and the deployment of technologies that promote one ‘standard of life’ over another.

While arguments have been made on either side, the discussion vis-à-vis ‘selection’ or ‘non-selection’ points to the significant role played by society in both designing and shaping the idea of the ‘desirable’. What is preferred and valued by society is what becomes internalised as the ‘ideal’, with the technology on offer becoming a means for its achievement. Therefore, what is ultimately selected is what reinforces and re/produces societal prejudices, structural biases, and power imbalances, thus propelling a market-driven and state-mandated eugenic discourse.

Biological to contractual motherhood: surrogacy

ARTs are perhaps the most visible and recognised of medical technologies. The ART industry has exploited the social pressures on women to have children. It claims to offer women new choices when in fact it increases the pressure on women to use these technologies, despite the high costs, poor success rates and risks to their health.⁵

With the advent of ARTs, notions of parenthood, family, and kinship have undergone significant change, with new ties – material, psychosocial, and otherwise – being formed. Commercial surrogacy has become a highly visible and contentious issue in the globalised ART industry. Although surrogacy is not a technology in itself (it is an arrangement, involving the use of ARTs), and has been practised historically in India in other forms, what has undergone significant change is the character of surrogacy arrangements, with cross-border surrogacy becoming popular in this age of rapid globalisation, including of medical services.

In particular, recourse to ARTs with third-party reproduction (including gamete donation) has been seen as opening a Pandora’s box of ethical dilemmas. While most of the discussion on the issue has seen divided views ‘for’ and ‘against’ surrogacy, the increasing commercialisation of this arrangement has also led to the suggestion that commercial surrogacy should be banned and only altruistic surrogacy allowed. However, altruistic surrogacy cannot be said to be without coercion and risk, material, physical, social, and emotional. The very notion of altruism is a construct, deployed in and through discourse, with particular interests, including commercial, at stake.

The larger questions remain: Can surrogacy be considered an acceptable form of livelihood? Or is it simply a temporary survival strategy for some economically vulnerable women in countries like India?

In looking at commercial surrogacy as a new form of reproductive labour, Amrita Pande argues that one needs to understand (commercial) surrogacy as ‘sexualised care work’.⁶ Surrogates recognise that their bodies are the receptacles without which the birth of the child would not be possible, thus connecting them in a critical, if limited, manner with the child; some even consider the womb (or ‘blood’) as more important than the genetic material (oocyte). In redefining everyday forms of kinship ties, the body is used as a metaphor for establishing a separate identity, often challenging the societal perceptions around surrogacy.

The separation of reproductive body parts – wombs and oocytes (that is, different women acting as genetic and gestational mothers) – also has implications for the global economic market. Through the commodification of women’s bodies, it is now possible for a California-based couple of Japanese origin to hire a surrogate in India to have a ‘biological child’, possibly through the use of donor sperm or oocyte. A mapping of this reproductive market reveals long international chains of varied actors and agencies, often employing aggressive promotional strategies.

The exchange of money for services (in this case, gestation) and goods (the child, possibly?) across international boundaries raises other questions. How do international trade laws function between two countries like the USA and India in the absence of any related national legislation in either? And what implications does this have? As Christina Stephenson points out about the United States with respect to trans-border surrogacy:

The ethical questions provoked by surrogacy are the same that are involved in the sale of organs, tissues and other elements of human life for pecuniary gain. Since there is no indication that these markets will disappear, the US must face the question of how to balance these questions against the ever expanding mandate of free trade.⁷

The market for ARTs and surrogacy has blurred geographical boundaries and has created global ‘consumers’ of modern reproductive technologies. While at one level these are held up as signifiers of scientific progress, at another level commercial forces exploit the desire for a biological child, despite the low success rate, health risks, and high costs of ARTs. Through the language of choice, innovation, and right to parenthood, ARTs portray infertility as a disease and infertile people as patients requiring technological intervention. Questions of equity and access further complicate this already complex situation, with the ‘reproductive rights’, including to ARTs, of people from HIV+, LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Questioning), and poorer communities being strongly debated.

What make these technologies controversial, apart from their inherent nature, are their social, ethical, and legal implications. Not only do they ‘crystallize issues at the heart of contemporary social and political struggles over sexuality, reproduction, gender relations and the family’ (Stanworth 1987 in Shore et al 1992: 295), but they also ‘challenge our most established ideas about motherhood, paternity, biological inheritance, the integrity of the family, and the “naturalness” of birth itself’.⁸

Beyond ARTs: the other facet of this bio-economy

ARTs are just one facet of a growing bio-economy that also has large pharmaceutical companies, equipment suppliers, and research organisations as stakeholders in emerging bio/genetic technologies.

There exists a nexus between the medical profession and the drug industry, driven primarily by profiteering, with little or no commitment to social responsibilities. In India, such companies sponsor the annual conferences of professional bodies like the Mumbai Obstetrics and Gynaecological Society and the Federation of Obstetric and Gynaecological Societies of India. They determine conference programmes and offer free trips abroad for advanced training in ARTs, thus securing a market for the supply of medicine and equipment.⁹ The following market research report also confirms India’s potential for the ART market, liable to grow in the future:

With infertility treatment stabilizing in the major markets, pharmaceutical companies are exploring other markets where assisted reproduction technologies are in growing clinical supply and demand ... India is an attractive market because of its highly pronatalist culture, ART-seeking South Asians living abroad and preference for branded products.¹⁰

Additionally, India is also emerging as a crucial market for oocytes for research. Women’s ova are at the centre of the industry’s planned development of an embryo-based genomics industry that promises to provide products that will engineer genetically inheritable characteristics. This is made clear in a report in the Bulletin of the Indian Council of Medical Research:

IVF ... has not only opened up novel ways of treating infertility involving [a] third and sometimes fourth party parenting a child in a tandem manner, but also advanced our understanding of the basic biology and pathology of human reproduction. With new developments occurring in the potential use of embryonic stem cells in the development of bio-therapeutics, IVF is the only way to obtain pluripotential embryonic stem cells.¹¹

To foster the growth of a viable biotechnology and stem cell research industry, a successful collaboration between public support and private profiteering is being advanced. The high demand for oocytes both for ARTs and biotechnology, within the framework of an unregulated market, poses a seri-



42 Patient undergoing egg retrieval procedure (© Monkey Business Images | Dreamstime.com)

ous threat of exploitation for women. Countries like India and China, which have large populations of the economically vulnerable, have become the sole source of biotechnology research capacity, with extensive networks of fertility clinics, a burgeoning stem cell industry, and a lack of effective oversight or regulation. Ethicist John Harris opines that anyone living in a society that has benefited – or expects to benefit – from medical research has a ‘positive moral obligation’ to participate in it. But women end up burdened with a double duty, to sacrifice themselves for the greater good of both family and society.¹²

Somatic cell nuclear transfer research or therapeutic cloning research is hampered by the lack of good-quality oocytes and reliance on those oocytes that have been rejected as non-viable for IVF. Ian Wilmut, the creator of Dolly the sheep, has urged young British women to donate oocytes to assist in stem cell research into motor neuron disease. Wilmut has appealed to the altruistic ethos whereby the donor ‘acts not out of self-interest but out of a collective sense of belonging’. On the other hand, the Human Fertilisation and Embryology Authority (HFEA) in Britain has increased the level of reimbursement for reproductive donation and has also made research donors eligible for discounted IVF services. Perhaps the concept of ‘altruistic donation’ does not provide an adequate framework for meeting the ever-expanding worldwide demand for oocytes. Women may be unwilling to donate oocytes unless they are undergoing procedures for infertility (through IVF) as the process of oocyte retrieval is difficult, painful, time consuming, and risky.

Thus, increasingly, concepts of ‘duty’ and ‘citizenship’ are being invoked in relation to genetics, reproduction, and fertility.¹³

In this quest for research material, the medical risk borne by women is sidelined, as is the question: How and under what conditions are eggs being sourced for research? Emily Galpern of Generations Ahead (a US-based organisation that works on social justice issues in human genetic technologies) points out, ‘One of the primary issues in the debate is whether women should be paid for their eggs. Paying women will likely be a financial inducement for economically vulnerable women to undergo a process in which the long term effects are not clearly understood.’¹⁴ These, amongst others, are concerns that lie at the intersection of regenerative and reproductive genetic technologies, thus constituting a grey area for women’s rights and health.

Conclusion

Reproductive technologies are of particular significance to women, as not only do their bodies provide the raw material for the unregulated development of these ARTs, but also because women are sought as consumers of these and other emerging biotechnologies.¹⁵ Particularly in the sphere of human reproduction, women may find themselves at the crossroads of science, society, industry, and policy, with their bodies being claimed by several sectors, and their voices being heard by none. Life-saving health care technologies are still not available to most women in the world. *Our bodies, ourselves* (1994) emphasises: ‘We must judge the value of the reproductive technologies in the context of the social, political and economic setting ...’¹⁶ Thus, it is of critical importance that mandated protocols of informed consent and counselling, and the provision of adequate health infrastructure and care, should not be overridden or ignored. Women’s health and rights, including their reproductive health and rights, must be located and addressed within the larger context of determinants that affect their lives, such as poverty, curtailment of capabilities, lack of livelihood rights, lack of health rights, illiteracy, and multiple forms of discrimination based on caste, class, gender, religion, ethnicity, sexual orientation, and on many other power structures. These are matters not just of ethics, but also of human rights and social justice.

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SECTION E

**RESISTANCE, ACTIONS, AND
CHANGE**

E1 | THE MOVEMENT FOR CHANGE

The People's Charter for Health is a call for action: 'To combat the global health crisis, we need to take action at all levels – individual, community, national, regional and global – and in all sectors.' In this chapter we review the strategies, structures and practices of the People's Health Movement and related social movements in responding to this call. Our review is structured around a series of basic questions:

- How is the global health crisis stabilised and reproduced?
- How does historical change take place?
- What can we do to intentionally shape our collective destiny?
- What are the main strategies which social movement activists can deploy to drive social change?
- How can social movement activists build their capacity to effect social change?

How is the present regime reproduced?

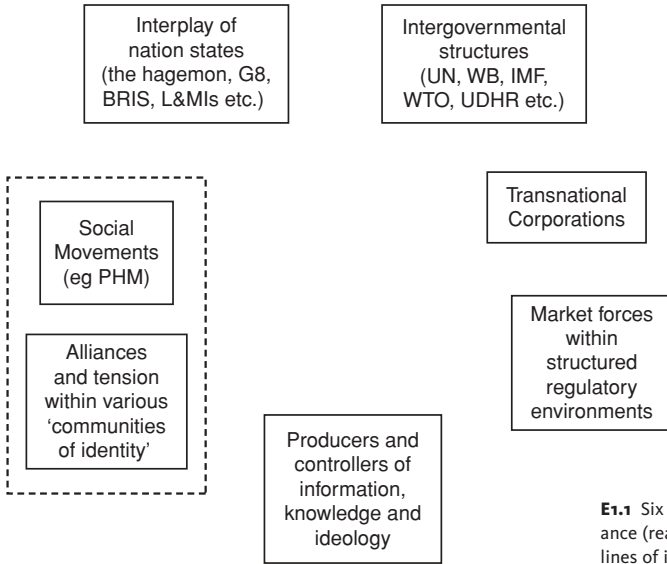
The global health crisis referred to in the Charter has many faces: food insecurity (Holt-Giménez 2008), preventable child and maternal deaths (Hogan et al. 2010), price barriers to accessing medicines ('t Hoen 2009), collapsing health systems (WHO 2007) (many of these we have discussed in preceding chapters). There are enough resources on the planet to provide for 'health for all' but the necessary resources flow instead to overconsumption, military expenditure and obscene wealth for a small elite (Milanovic 2009; Davies et al. 2008). How is this situation stabilised and reproduced?

The fact that resources are not so deployed to address the global health crisis is a consequence of the prevailing governance structures of the globe, and particularly global health governance (GHG). Global health governance encompasses the social determinants of health and health system development.

There is no simple way of representing the structures of global governance. It is necessary to look at it from a range of different but overlapping perspectives: nation-states, intergovernmental institutions, the corporate sector, the marketplace, civil society and social movements and knowledge, information and ideology.

Domains of global governance

Nation-states Global governance, among other dynamics, involves the interplay of nation-states (or their different alliances and blocs). Nation-states project



E1.1 Six domains of global governance (readers are invited to draw the lines of influence)

their power by military and other means. The role of US trade law (Super 301) and the US trade representative (USTR) (Drahos 2001) in pressuring small countries to adopt restrictive intellectual property (IP) policies is an example of the use of the power that nation-states wield (Knowledge Ecology International 2011a).

Intergovernmental structures Also important are the formal institutions of global governance and regulation: such as the UN, the WHO, the World Bank and the IMF; laws and agreements such as the Universal Declaration of Human Rights or the 23 enforceable trade agreements administered through the WTO. The role of the WTO’s Agreement on Agriculture in sanctioning dumping of subsidised foods into low- and middle-income country (LMIC) markets, destroying small farmers’ livelihoods, illustrates the role of such institutions (Hawkes 2007).

Within this terrain, of increasing importance today are the various global public-private initiatives (GPPIs) which disburse aid and advice, mainly to poor countries. These include the Global Fund for AIDS, TB and Malaria (GFATM), the Global Alliance for Vaccines and Immunisation (GAVI) and over 100 others (Sanders n.d.). In terms of the immediate needs of sick people and poor countries, the funds mobilised by GPPIs are life-saving. In the context of the politics of intergovernmental organisations, the separation of these GPPIs from WHO reflects the ongoing project of the rich countries to contain the influence and reach of the WHO. From a more critical perspective the role of the GPPIs is to shore up the legitimacy of the regime of global governance which reproduces inequality, exclusion and marginalisation.

Corporate sector An obvious big player in GHG is the corporate sector, in particular the transnational corporations (TNCs). Included here is the power of the financial corporations which are ‘too big to fail’ (Bello 2008; Stiglitz 2009); the pharmaceutical giants and others which shape US trade policy; and the global food corporations which destroy indigenous food systems and force junk foods onto global markets (Schrank 2008). The freedom of the TNCs and their lack of accountability is a consequence of their nation-state sponsors ensuring that the global regulatory environment is TNC friendly (Knowledge Ecology International 2011a). The levers that harness the nation-state in the interests of the transnationals also need to be explored. In some circumstances this is electoral leverage (e.g. the influence of the US auto industry on Capitol Hill); sometimes it involves the purchase of influence (e.g. campaign contributions by big insurance in the US to prevent health care reform and by big oil to prevent action on global warming); and sometimes it reflects a confluence of interests between the corporation and its nation-state host (e.g. highly protected intellectual property, which enables Big Pharma to inflate profits through monopoly pricing and helps to maintain US export revenues and reduce the trade deficit).

The market The market is one of the key structures of global health governance; separately from the power of the big corporations. Markets operate within regulatory frameworks which are erected through national governments and intergovernmental structures. The environment within which markets operate is created through deliberate policy. While individual companies may lobby to be exempt from regulation, equally important are the wider ideological pressures associated with neoliberalism for deregulation, small government and the continuing denial of any limits to growth.

Information, knowledge and ideology The field of information, knowledge and ideology is another domain of global governance. The structures of this domain (including universities, think tanks, publishers and media barons) shape who shall access what information; who shall create or access knowledge and how we shall understand the world we live in. A simple example lies in the role of the financial press in shaping how we understand the global economy and in determining what analyses of the global economy shall be privileged and which shall be discounted (Herman and Chomsky 1988). The control of information is equally powerful; illustrated by the quality of information released by WikiLeaks, which would otherwise have been kept secret.

Civil society Finally we need to recognise civil society as a key domain of global governance (Thompson and Tapscott 2010). This domain is where the People’s Health Movement is located, along with familiar civil society institutions such as churches and unions, and sporting and cultural and advocacy organisations.

A social movement is a collectivity that shares a common set of concerns, understandings and claims and a sense of shared identity (Pakulski 1991). It is bigger than but includes formal organisations. Examples include the environment movement, the women's movement and the People's Health Movement (fundamentalist religions are also social movements in this sense).

Within this domain of 'civil society' we need also to recognise the fluctuating alliances and tensions within and across the many diverse 'communities of shared identity' both within countries and internationally (variously analysed in terms of nationality, class, race, gender, income, ethnicity, sexuality, religion, etc).

One of the important dynamics in this analysis is the emergence of a global middle class with a shared interest in consumer goods and the good life and negotiable loyalties to poorer people in their own and other countries. The power of this global middle-class identity may be illustrated by the support among the middle classes of low- and middle-income countries such as India for tariff reductions so that imported consumer goods might be cheaper (Ghosh 2002). The 'free trade' bandwagon would not have made the progress it has without this shared perspective across the global middle class. Unfortunately the sense of shared identity among farmers or workers in different countries is sometimes much looser.

The dynamics of global health governance

This listing of the structural domains of GHG takes us only so far. We also need to understand how they interact to reproduce the prevailing regime and how the health crisis inheres in this regime. We can approach this question through an exploration of the 'access to medicines' case, described in detail in previous GHW volumes (PHM et al. 2005, 2008a).

With the advent of highly active antiretroviral drugs (ARVs) in the mid 1990s the plight of people suffering from AIDS became politically critical. At a time when Big Pharma was selling a year of treatment for \$US10,000, the Indian generic manufacturer Cipla was able to supply the same to Médecins Sans Frontières (MSF) for \$350. When the South African government sought to procure ARVs through parallel importation (buying them in countries where the prices were lower than in South Africa), Big Pharma, supported by the US, took the South African government to court. After three years of mounting civil society protest in South Africa, in the US and in many other countries, the US and Big Pharma withdrew their suit in May 2001 (and paid costs) (Sen 2001; Raghavan 2001). Later that year the members of the WTO affirmed that trade rules should not be an impediment to public health (WTO Ministerial Council 2001).

The perceived legitimacy of the TRIPS regime (the WTO's Trade Related Intellectual Property agreement) was damaged by this episode, and the US project of further tightening of global IP laws suffered a significant setback.

The setback was only temporary. The Global Fund for AIDS, TB and Malaria and the US President's Emergency Fund for AIDS Relief (PEPFAR) stepped into the breach with massive funding (from 2003 from GFATM and from 2005 from the US (OECD 2011) and a charity model was put in place (as opposed to access at reasonable prices based on a reformed IP regime).

The macroeconomic context of this episode deserves closer attention. With the move of manufacturing from the high-wage economies to 'emerging' economies, the 'post-industrial' economies of North America, Europe and Japan have become increasingly dependent on the export of products with a high IP rent. The US economy has come to depend, more than that of any other country, on rent from intellectual 'property' through royalties, licence fees associated with pharmaceuticals, seeds, software, music and film, consumer goods and arms. In 2007 the surplus earnings from royalties and licence fees (exports – imports) comprised \$57 billion, without which the US trade deficit would have been 7.5 per cent greater (WTO 2008). Thus, for the US to maintain national income from the export of products with a high IP rent, two policy objectives became critical. One was to establish and entrench a global IP regime with lax patentability standards. The second was to access the middle-class markets of the 'emerging' economies. The former has been advanced through the TRIPS agreement and the TRIPS-plus provisions in bilateral and regional trade agreements (Oxfam 2002). Opening LMIC markets has been progressed through the continued promotion of the ideology of neoliberalism (universities, media, think tanks, etc.); through the brutality of IMF conditionality; and through the sanctions associated with the dispute settlement procedures of the WTO.

This exploration of the medicines and IP case provides insight into how the structures of global governance work and how global *health* governance is embedded in the wider structures of political and economic governance. The story also shows how such policies and 'truths' can be resisted and alternatives promoted through combinations of nation-state diplomacy, civil society advocacy and social movement activism (such as the AIDS movement in this case).

All kinds of activism, which seeks a fundamental change in the iniquitous social and economic relations that prevail in most parts of the world, need to be rooted in local and national endeavours. However, unfortunately, national (and even local) dynamics are increasingly determined by the requirements of the global regime.

We may take the *human resources for health* crisis as a case study to better understand how this is happening. Health systems in many LMICs are in crisis. There are many elements to this health systems crisis, but problems in the production and deployment of human resources for health care are quite central.

There is much that can be done at the national level, notwithstanding the global pressures. Ministries of health can put in place universal publicly funded health systems (as we discuss in Chapter B1). Ministries of education can struggle for relevant curricula and a workforce mix which meets com-



43 Statue commemorating end of slavery, Goree Island, near Dakar, Senegal (Hani Serag)

munity needs. Social movements need to keep the pressure on governments to eliminate corruption, control moonlighting, contain the export of ‘human capital’ and adopt appropriate health and education policies.

But there also loom the wider global forces: promoting the ideology of neoliberalism (rationalising the privatisation of health care and education; picturing widening inequality as unfortunate but necessary); the various GPPIs promoting hierarchically controlled vertical health care programmes rather than comprehensive primary health care; and the articulations of the global medical elites (discounting the role of nurses, community health workers and other health professions).

Thus, clearly, the governance of health, at the national and global levels, is complexly embedded in the structures and dynamics of global governance. The challenge before social movements is to find a balance between continuing to struggle for local and national change while also building links with global movements that confront the global dynamics.

How does historical change take place?

Health activism needs to be informed by an understanding of the structures, forces and dynamics which shore up the prevailing regime. Also critical is an understanding of how historical change takes place. There are many different and overlapping dynamics of historical change; these include:

- conflict and military power (colonisation, decolonisation, wars of imperial policing);
- rise and fall of political ideologies (deflation of communism, rise of neoliberalism and religious fundamentalism);
- technological innovation (steam engines, internal combustion, computers, solar energy collectors, dry composting toilets);
- environmental opportunities and limits (desertification, global warming);
- population and migration.

Conflict and military power, in the form of colonisation, have shaped the health chances of most people who are alive today. The role of colonial exploitation in funding the Industrial Revolution, and therefore the privileged health status and health care of the rich world, is mirrored in the continuing challenges faced by the countries that were colonised. The role of conflict and military engagement in national liberation struggles must also be recognised as contributing to progress towards Health For All through the positive role played by newly liberated countries (Metzi 1988). Though, for many countries, the shackles of colonisation were quickly replaced by a new form of subordination through the workings of economic imperialism.

The rise of neoliberalism and the related ideologies of individualism and consumerism have been powerful influences on health over the last half-century. Neoliberalism normalises inequity and with its faith in markets and distrust of government discounts collective control of our future (Kelsey 1995). The doctrine of neoliberalism is a big challenge to the Enlightenment vision of humanity steering our destiny, and it may be that the negativity of neoliberalism has contributed to the rise of various religious fundamentalisms (John and Legge 2011). However, there are different streams of cultural development which avoid the nihilism of economic and religious fundamentalisms. In Latin America an Indigenous Cosmvision is re-emerging as a spiritual framework which can guide the struggle for a better life (Ward 2008).

Undoubtedly, the progressive improvement in human health over the last century reflects in part the impact of new technologies. However, technology without democratic social control, and in the hands of global capital, is a very uncertain bet. The uncertainties regarding the directions and implications of technological development underline the importance of activists maintaining a close engagement in this field. Technology will shape social, economic, cultural and institutional development as well as being shaped by them.

Environmental resources and limits have shaped and continue to shape human development. The Easter Island Syndrome hovers over our future pathways (Diamond 2005). This syndrome refers to a society that destroys its environmental supports (in the case of Easter Island, all of its trees) because its culture does not have the adaptive capacity to understand, predict and change (Rees 2002). Self-evidently humanity has the technologies to move



44 Indigenous People celebrate at the Peoples Health Assembly in Cuenca, Ecuador, 2005
(David Legge)

to a more equitable, sustainable and convivial civilisation. Again the question is whether we will find the cultural competence and be able to create the institutional machinery.

Large-scale migration has been a powerful driver of human history. The health consequences have been varied, from the devastating, for displaced indigenous peoples, to the flourishing, where new technologies in new environments have created new societies. Technologies are at hand to assist in managing the challenges of living in harmony, but the institutions and cultures for wise decision-making are sorely lacking. The issues of population and migration raise particular issues concerning human solidarity which are major challenges for health activists today. (We discuss one such example from Italy in Chapter E2.)

The above are not separate ‘dynamics’ of change; rather they are interrelated processes. By understanding them, we gain useful insights into the past and ways of thinking about the current challenge.

Projecting scenarios of change

The processes that we describe above can be projected to characterise future scenarios of historical change in terms of optimistic and less optimistic trajectories.

An optimistic scenario (or vision) could be characterised by: rapid development of solar technology and techniques for restoring depleted soils and oceans; democratic and transparent regulation of the global economy; return of confidence in collective decision-making; rejection of competitive consumerism; reducing pressures of migration; fairer distribution of economic resources; and rapid reversal of population growth associated with improved standards of living, etc.

Of course, other, less optimistic scenarios are also implied by this optimistic scenario. Perhaps we have already passed the projected climate change tipping points; perhaps the robber barons will successfully stall effective regulation of the global economy; perhaps the promise of personal salvation through apocalyptic religious fundamentalism will critically weaken the movement towards a more deliberative control over human destiny; perhaps divide-and-conquer strategies will continue to fan communalism, racism and nationalism and distract the democratic sentiment.

The optimistic scenario provides us with a clear vision of the kinds of directions that progressive social movements need to work towards, while also highlighting some of the uncertainties to be negotiated on the way.

The critical insight for the activist is that human agency has a powerful role to play in determining which scenario is realised. This is not a matter of wishful thinking or individual heroics; rather it calls for the building of movements and social institutions that mediate the process of change. We need to ask what we, as individuals, groups, and social movements, can do to *intentionally* shape our collective destiny.

In the following section we discuss social movement activism in terms of, first, the strategies for social change, the logic of activism and, second, the elements of daily practice – what activists do on a daily basis in the pursuit of those strategies.

Strategies focused on achieving social change

Change-focused strategies deployed by social movements, such as the People's Health Movement, include: practising differently; policy critique and advocacy; service system reform and development; institutional reform and innovation; delegitimation; and inspiration. Of course, the naming and separation of these strategies is quite arbitrary; they all work together.

Practising differently We use the idea of 'practising differently' as a way of recognising how the 'big structures' are constituted by the acceptance and participation of 'ordinary people'. Junk food, understood as a regime of production and marketing of low-nutritional-value, high-margin foods, is constituted by the purchasers as well as by the transnational corporations and retail networks. Patriarchy, understood as a regime of unequal power relations, institutional inequality and a set of assumptions and practices, is constituted

by the participation of the men and women whose lives it touches. Global warming is driven by individual and household practices as well as by the corporate interests that profit from carbon-based energies and the culture of consumption.

The idea of ‘practising differently’ reorients our thinking away from ‘behaviour change’, which objectifies the people whose behaviour will be changed (while rendering invisible the agents who will ‘intervene’, as if from outside, to encourage such behaviour change). Practising differently underlines the choices involved in refusing or affirming particular ways of practising. Practising differently is collective as well as individual and is political as well as personal. It involves actively reworking our values and cultures. It involves political as well as personal change.

Examples of ‘practising differently’ in the struggle for health include: innovation in primary health care practice; primary health care (PHC) practitioners working with communities to resist corporate appropriation; fair trade; patient literacy in the AIDS/HIV movement; alternative technologies (including alternative farming); and gender-neutral language and other forms of anti-patriarchal practice.

Practising differently in primary health care settings is well illustrated by *Health by the people*, published in 1975 by WHO and edited by Ken Newell. This collection of case studies of primary health care from Cuba, China, Indonesia, India, Guatemala, Iran, Venezuela and Tanzania was influential in the framing of the 1978 Declaration of Alma-Ata, which in a sense represented a distillation of the experience of these cases. It is a profound illustration of the ways in which practising differently can change the world.

Unfortunately the PHC example also illustrates the resilience of transnational capitalism in resisting the call for a new international economic order and in continuing to advance stratified models of health care and vertical disease-focused programmes (Sanders 1985; Werner and Sanders 1997). It is clearly inadequate to talk about these different ways of practising differently except in the context of the wider structures of global governance and other strategies of social change.

Policy critique and advocacy Policy critique and advocacy is one of the central strategies of the social movements for change. The struggles over access to medicines and IP policies (’t Hoen 2009) illustrate both the power of social movement policy advocacy and also the resilience of Big Pharma and its nation-state partners.

Some other major policy controversies in which the People’s Health Movement has engaged include: the return to PHC and universality (Labonté 2010); the social determinants of health (Anon. 2007); the destruction of people’s living environments by big mines and big dams and the role of PHC in working with communities to defend and create healthier environments.

The defeat of Big Pharma in South Africa was achieved through the mobilisation of people living with AIDS and HIV both in South Africa and in other countries (Sen 2001); through international solidarity, which was able to support direct action in the US (e.g. through Health GAP (2011)) as well as in South Africa (Treatment Action Campaign 2011); and through the detailed and timely exposures and analyses of a small number of websites and email lists (in particular, CPTech (now Knowledge Ecology International (2011a) and Médecins Sans Frontières (2011)).

Let us look at environmental struggles for other examples of the role of advocacy by social movements. Community struggles against the destruction of their environments by unregulated mining and the destruction of lives and lungs through working in unsafe mines are one of the sharpest points of conflict between corporate greed, political corruption, the culture of consumption, climate change and community health. A dossier of complaints about the mining giant Vale has been compiled by the International Movement of People Affected by Vale (Fair Deal Now 2011). The dossier includes cases reported at the first meeting of the International Movement, held in 2010 in Rio de Janeiro, with about 160 people from over 100 organisations, unions, social movements and communities from 13 countries and nine states in Brazil. This illustrates a highly focused community-based advocacy action backed up by activists operating at a more global level, such as the website named Mines and Communities (MAC 2011), which provides a searchable data source covering mining in many different countries.

The role of Shell in the Niger Delta has been described in detail in GHW2 (PHM et al. 2008b) – a story of corruption, denial of human rights, extrajudicial killings and environmental disaster. In the Central Indian state of Chhattisgarh, Dr Binayak Sen, a well-known civil rights activist, has been sentenced to life imprisonment on trumped-up charges of terrorism. In fact Dr Sen's crime is his continuing support for the struggles of tribal peoples to prevent their forests and lands from being expropriated (Analytical Monthly Review 2007). Dr Sen has said, 'I am being made an example of by the state government of Chhattisgarh as a warning to others not to expose the patent trampling of human rights taking place in the state' (Sen 2011). The forests that provide the livelihoods of the tribal people cover rich mineral resources and there are many cement and steel manufacturers (national and transnational) and state politicians who are keen to drive the tribal peoples from their lands.

The struggle against environmental destruction and abuse of workers rights illustrates the breadth of the struggle for health and the fact that it is not solely the province of people who identify as 'health activists'. There are many such parallel movements which should be understood as part of the People's Health Movement.

Service development reform

The pioneering examples of early primary health care models (discussed above) illustrate the contribution that service development reform can make to social change. Since the Newell collection (Newell 1975) many further inspiring examples of health care organisations developing new approaches to PHC have attracted attention. Since 2007 the Canadian-funded Revitalising Health for All project has been working with research groups in Latin America, India and Africa and with indigenous health researchers in Canada, Australia and New Zealand to document and analyse contemporary initiatives in PHC (Labonté 2010).

At the national level the health care reforms in Brazil and in Thailand (discussed in Chapter B3) have been inspirational, showing that despite the global pressures for fragmented health systems and widening inequalities it is possible to confront these directly at the national level.

Institutional reform Change is also being driven through institutional reform. Again the IP field provides examples of reforms that are being proposed, such as for new methods for funding pharmaceutical innovation (we discuss in Chapter D1 how these reforms are being contested by the rich countries).

The student-based Universities Allied for Essential Medicines (UAEM) illustrates another approach to institutional reform in this area (UAEM 2010). The organisation started at Yale in 2000 at the height of the South Africa stand-off over the drug stavudine – an antiretroviral drug. The drug had been developed by a scientist at Yale and the university had licensed it to the drug company Bristol-Myers Squibb. The students at Yale launched a powerful campaign at the university (including a ‘TB die-in’) and managed to persuade Yale and Bristol-Myers Squibb to export the drug at much lower prices than was currently being charged – almost 95 per cent lower. That success inspired students elsewhere in the United States and Canada, and UAEM was set up two years later. Now over 50 universities are involved. Three universities in the United States and Canada have since embedded UAEM’s core principles in their university constitutions (numerous others are planning similar measures). Those universities that have signed up still grant exclusive licences to pharmaceutical companies for their discoveries, but written into these licences is the requirement that any drug or medical technology relevant to developing countries be made accessible to them.

The UAEM provides a useful model for thinking about how a focus on systems and institutions can help to drive change, in particular the link between (i) mass action through a concerned constituency (the TB die-in by students); (ii) the detailed analysis of university IP policies (involving considerable legal expertise); and (iii) the value of an inspirational example which can be replicated in other similar settings.

Delegitimation The appearance of legitimacy is a critical defence structure for any governance regime. Habermas discusses the nature of legitimation crisis in relation to the financial crisis of capitalism and the recurring need to divert public resources to prevent collapse (Habermas 1975). Although he was writing in 1973 he could have been describing the global financial crisis of 2008, when banks were too big to fail and billions in taxpayers' money was drawn on to pay their debts. Habermas argues that while the prevailing cultural expectations and narratives naturalise such transfers, legitimacy is secure, but when people start to question those expectations and narratives and government has to act to deliberately shore up its own legitimacy, a legitimation crisis is in place. It is the role of the merchants of ideology to maintain the cultural expectations and narratives that naturalise an unsustainable and inequitable governance regime. These merchants include the media proprietors, the elite universities and the private think tanks.

The collapse of the Soviet Union in 1989 and that of Mubarak's regime in 2011 illustrate how quickly an apparently stable governance regime can crumble when its curtain of legitimacy falls. The transformation of the apparatchiks of Soviet Russia into the oligarchs of present-day Russia reminds us that institutional collapse is not necessarily the forerunner of a better regime.

The concept of legitimation and delegitimation can be usefully applied in the context of global economic and global health governance. It suggests the importance of identifying the cultural assumptions and narratives that are projecting an inequitable regime as legitimate and identifying the merchants of ideology who are promoting those narratives. Delegitimation is a central strategy for social movement activism but it is necessary to be wary of the speed with which the regime governors can respond in terms of shoring up their challenged legitimacy. This is illustrated in the South African medicines case we discussed earlier. Though the perceived legitimacy of the TRIPS regime was damaged, the setback was not permanent.

A similar two-step was danced in the 1980s and 1990s over the IMF's Structural Adjustment Programmes (SAPs). From the onset of the debt crisis in the early 1980s the IMF imposed brutal conditions on governments that were forced to borrow from it as lender of last resort. These included cutting government expenditure and other policy conditions directed solely at forcing governments to pay their debts (SAPRIN 2002). By the late 1980s the impact of SAPs in health was becoming evident, and in 1987 a UNICEF report was published entitled *Adjustment with a human face* (Cornia et al. 1987), clearly implying that the IMF was being inhuman. A similar report was published by WHO in 1992, entitled *The health dimensions of economic reform* (WHO 1992). However, the delegitimation of SAPs led to the World Bank becoming more active in structural adjustment and reinventing SAPs as PRSPs (Poverty Reduction Strategy Papers) with the appearance that countries were designing their own SAPs.

The Alma-Ata Declaration of 1978 and the announcement of PHC as a new paradigm for health development was ‘delegitimated’ almost immediately by the accusation of unaffordability in the context of the debt crisis and structural adjustment (Werner 1995). Selective PHC was promoted as an alternative ‘viable’ model. By the end of the 1980s privatisation and safety nets were facing increasing criticism (delegitimation) as part of the general reaction to SAPs and *Adjustment with a human face*. This led the World Bank to commission the 1993 World Development Report *Investing in health* (World Bank 1993), which offered a much more sophisticated version of stratified health care (relegitimation). With the advent of highly active antiretrovirals (ARVs) from the late 1990s and the explosion of global public–private initiatives in the new century (itself partly a reaction to the delegitimation of TRIPS in 2001) a new regime of vertical disease-focused programmes emerged cutting across the stratified health care promoted by the Bank. In recent years this regime has been subject to increasing criticism (and ‘delegitimation’) because of the fragmenting of health systems, and so the regime governors are responding with a new discourse of Health System Strengthening (WHO 2011).

Delegitimation is a powerful strategy for health activists but must be accompanied by positive policies for institutional reforms which will lock in any gains that can be achieved from such delegitimation. Otherwise the dance of delegitimation will proceed one step forward but two steps back.

Inspiration Delegitimation is in some respects a negative strategy. Anger at injustice is a negative although powerful motivator. We also need to project alternative and inspiring visions; partly to guide our analysis, partly to maintain our enthusiasm, partly to assist people to move from passivity into movement activism.

Alma-Ata is an example of inspiration. Many health workers and policy officials have been inspired by the vision of comprehensive primary health care (CPHC). Such examples can be found in other sectors, such as alternative energy (Rocky Mountain Institute 2011) or alternative farming (Permaculture Institute 2011). These in aggregate constitute a coherent vision of a better world. However, they gain traction only if people see them as achievable. Objectives, strategies and models are inspiring when their underlying logic makes sense, when they offer practical entry points and when they are seen as powerful in effecting change.

Many people have found that the rights framework can be inspiring. PHM’s Right to Health and Health Care Campaign (PHM 2011a) highlights the various formal statutes upon which the Right to Health is based (Human Rights Council 2008) and acknowledges that in many situations the legal mechanisms for realising this right are weak. The inspiration that many people derive from the affirmation that their burdens constitute a denial of recognised rights can provide the drive to put in place these necessary institutional mechanisms.



45 Participants at the International Peoples Health University in a march in Dakar, Senegal, January, 2011 (David Legge)

We discuss in some detail the PHM's Right to Health global campaign in Chapter E2.

Conclusions

It is not preordained that humanity at large will avoid the fate of the Easter Islanders. There are trends and projections which suggest that we will not. However, there are very real grounds for hope and determination.

Hope and determination are necessary but not sufficient. We also need strategy, solidarity, mobilisation and activism. Strategy requires an understanding of the dynamics of historical change and the ways intentional action for change can shape outcomes. Solidarity requires that, like the many communities struggling against Vale, we come to appreciate more the shared pain and the common dynamics of the different struggles in different sectors and countries. Mobilisation requires that we have a clear analysis of why the world is the way it is and a plausible account of how it could be changed. Activism requires collective intelligence and hard work.

Above all we need to spend energy in building movements that can channel the hope and determination. We have reserved for another day a discussion on the strategies and tactics that need to go into movement building. The People's Health Movement, like many other social movements, continues to grapple with different options as it endeavours to build a truly global movement. We hope that the analysis provided in this chapter will stimulate debate on this

Box E1.1 The International People's Health University

The International People's Health University (PHM 2011b) provides learning opportunities for people's health activists around the world. Between 2005 and 2010 IPHU, in association with local PHM networks and its funding partners, ran 18 short courses (one to two weeks' duration) for activists in many different countries, mainly in the global South. The IPHU courses are subtitled *The struggle for health* and aim to cover some of the key areas of theory and practice that health activists need. The curricula include: health systems, social and environmental determinants, globalisation, the right to health, working across difference, research for social change, and applications of information and communications technology.

There are some similarities between the IPHU curriculum and conventional public health and global health courses but there are also important differences. Conventional public health training prepares health professionals for a set of existing roles (programme manager, university researcher, project coordinator, outbreak investigator, etc.) which are essentially framed by the prevailing governing structures. They are important roles in which people can do good works, but the concepts of the social movement as an agent of social change and the health activist as part of a grassroots social movement are not well recognised in such training.

IPHU is not just about individual training. There is a focus in the courses on building the people's health movement locally, nationally and regionally and globally. One example is WHO Watch (PHM 2011c), which brings together IPHU alumni in monitoring the WHO governing bodies and advocating for the adoption by WHO of policies, programmes and practices that are aligned with perspectives of the People's Health Movement.

critical aspect of our collective endeavour to effect change that is sustainable, democratic and premised on the principles of equity and human rights.

Many of the ideas and issues that we explore in this chapter form the core of the curriculum of the International People's Health University (IPHU) (see Box E1.1).

BoxE1.2 Changing from within

Challenging the conservatism of Italian medical schools As in many other countries in the world, universities in Italy are traditionally conservative and mainly structured around rigid hierarchies – more dedicated to perpetuating their own power and privilege than a commitment to

producing and transmitting innovative knowledge for societal advancement.

In recent years, cuts in public expenditure, exacerbated by the ongoing economic crisis, forced universities – which in Italy are mostly public – to increasingly orientate their activity in a manner that can attract private funds. This necessarily means investing in market-oriented, patentable research, which seldom matches the real needs of the community.

The dissatisfaction with the limits and inefficacy of the biomedical approach, of which most medical schools are champions, has given rise to a desire for change in medical education, often coming from students. Especially in the last decade, in several countries, medical students have been requesting a radical reorientation of their curricula. Global health (GH) – looking at health as a complex issue, scrutinised amid the shaping forces of globalization – is an emerging field that attracts many students. GH recognises the urgency for trans-disciplinary and multifaceted approaches, capable of analysing the root causes of challenges faced by the health sector.

In the experience of the University of Bologna, the need felt by students to widen their academic and conceptual horizons, and the interest shown by a professor in the university, led to the creation of the Centre for International and Intercultural Health (CSI) in 2006 within the Department of Medicine and Public Health.

CSI strongly supports a vision of health rooted in the approach of its broader determinants, as well as a commitment to work with the community, closing the gap between the academic world and society as a whole. In order for this to happen, a cultural change is required that enables professionals to understand and manage the interdependency between the global and the local contexts. Therefore, CSI operates to:

- facilitate students and health professionals in undertaking field experiences and participating in community action-research projects – in Italy and in low-income countries – mainly focused on the social and cultural determinants of health and their impact on health inequalities;
- promote the introduction of new subjects and teaching methods into medical education;
- develop research and training activities in the GH field at local, national and international level.

Presently, CSI is composed of university professors, researchers, PhD and undergraduate students from different fields (medicine, anthropology, sociology, political sciences, law, etc.).

CSI is a laboratory for the integration of disciplines, participation and

peer-led work. CSI has adopted a horizontal and participatory approach in teaching (through peer-led teaching/learning in small groups under the supervision of qualified tutors) and research (through the planning and implementation of participatory action-research projects), as well as in decision-making (discussing and planning all activities through a consensus method). Such an approach allows mutual knowledge exchange between teachers and students, and among students themselves, despite different levels of expertise. Finally, it is different from the hierarchic and rigid university environment, avoiding reproduction of the dominant power structure in favour of a more equal learning and working environment, consistent with the principles and values of GH.

In order to translate its vision into practice, working often against the academic mainstream, CSI actively promotes the creation of networks at local, national and international level, involving different stakeholders (such as university professors and students, health workers, policy-makers, non-governmental organisations, civil society associations). At the local level, networks help connect the university with health institutions, community and civil society organisations, to plan and implement the action-research projects. On a bigger scale, examples of this approach are CSI's participation in the creation of the Italian Network for Global Health Education, as well as a similar European network, which is now taking its first steps. These networks allow collaboration and synergy between social actors and exchange between different experiences.

CSI is an intellectual and a social laboratory for experimenting with new approaches to both medical research and education. When trying to innovate, CSI has faced resistance to change within the university environment (when adopting a counter-hegemonic perspective, you don't expect the 'hegemony' to be supportive!). Adopting an 'activists' attitude' – ethical commitment and a strong correlation between theory and practice – has helped CSI go beyond existing norms and values.

In practice, this allows CSI to face the scarcity of human and economic resources – while addressing innovative, complex and non-market-oriented issues. CSI's orientation involves choosing collaborative rather than competitive approaches, based on common commitment and shared values.

CSI is in many ways a unique experience in the academic world, almost a 'leak in the system'. Nevertheless, it shows that 'another university' is not only desirable and necessary, it is also truly possible.

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Note

1 The People's Charter for Health is the pre-eminent directions statement for the People's Health Movement. It was adopted at the first People's Health Assembly in Dhaka, Bangladesh, in December 2000. See phm.org.

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E2 | THE RIGHT TO HEALTH: FROM CONCEPT TO ACTION

The People's Health Movement initiated a global Right to Health campaign in 2007. In this chapter we discuss how health activists can engage with this framework. Examples are presented from some regions, illustrating how this approach has been used (in some cases by social movements outside the PHM). Finally the emerging PHM global Right to Health and Health Care campaign has been briefly described as an attempt to promote this approach in a coordinated manner and on a global scale.

Using the right to health approach while developing it¹

The Right to Health (RTH) approach is a critical conceptual perspective, as well as a practical framework which can help to develop health movement actions. Combined with complementary approaches, it offers us concrete direction and strategies to wage struggles and campaigns (from local to global levels); it provides a framework to critique existing health-related policies; and it offers a vision to help shape alternative, people-centred health systems and social services. This approach needs to be wielded as part of a broader socio-political perspective for transformation, rather than being constrained by 'apolitical', consumer-oriented versions of human rights.² Here we will focus on the functional aspects of this framework, not dealing with valuable theoretical debates on critical use of the rights framework, which have been dealt with in detail by others.³

Why use a rights-based approach to health?

- The rights language has a *strong universal appeal*, and can enable large masses of people, beyond health professionals and activists, to relate to key health issues and to get involved.
- The approach helps to directly *empower individuals, communities and organisations*, enabling them to demand specific outcomes.
- The health rights approach *focuses on functional outcomes*, and measures all general policy declarations or system commitments in terms of *what people actually receive in terms of real entitlements*.
- When the idiom of health rights pervades the overall discourse, health services become understood as important public goods, which should be universally accessible without conditions.



46 Children demand Right to Health at a demonstration by Peoples Health Movement in South Africa (Louis Reynolds)

- Once certain rights are obtained through struggle by a few groups, it can become a precedent for other groups to demand similar rights.
- The approach *strengthens the claims of the most disadvantaged and vulnerable* sections of society, and helps to challenge discrimination while demanding certain entitlements.
- *Rights once granted cannot be easily reversed.*
- *The rights approach talks in terms of obligations and violations*, thus squarely placing the responsibility to deliver on the system.

Contextualising the right to health approach

The rights approach is not understood as a static framework – rather, with evolution of the movement and changes in context, the way it is used may also be reshaped. Today, in many situations the fight for health rights (in the domain of health care) is primarily a form of *resistance and accountability* in a context of stagnation, weakening or privatisation of public health services. Moving forward from resistance, the rights framework could also form the basis for *policy critique*, exposing specific health policies and programmes designed within the neoliberal framework. Further, we may want to use the rights approach as the basis for *counter-hegemony*,⁴ challenging the entire dominant conception of the ‘market-oriented approach’ to health and its determinants. Finally, the rights approach gives us a *vision* of a society that promotes health in the broadest sense.



47 Public hearing on right to health in Maharashtra, India (Abhay Shukla)

There are different interpretations and versions of human rights, ranging from liberal and essentially status-quo-oriented approaches to more radical perspectives which definitely locate the establishment of rights in the context of social movements.⁵ It is necessary for health activists to think in terms of the need to socially and politically contextualise the rights approach while engaging in health movement work.⁶ The rights approach, while useful in its own sphere, must be complemented and supported by analysis of the wide range of conditions and structures which shape the fulfilment or denial of rights. Such a contextualised approach to health rights may have some of the following features:

- It would be based on a vision of collective (along with individual) health rights, emphasising the rights of communities (such as people living in a village or an urban settlement) and hence *should strongly promote community mobilisation*.
- It would be informed by a critical understanding of the health sector crisis, including the underlying political economy of the impact of neoliberal policies, weakening of public health systems, privatisation and their impact on health services.
- It would not hesitate to *identify and challenge the social and political barriers that block the fulfilment of health rights*.

- It would combine demands for the *Right to Health Care* and the *Right to Health determinants* as part of a holistic approach.
- It would *facilitate alliances of the health movement* with other social movements.

To conclude, health activists might fruitfully utilise the Right to Health approach as an important strategy of the health movement, provided that this approach is appropriately contextualised, is clearly linked to social mobilisation, and is complemented by deeper analysis of national and global structures and policies. We must begin the struggle for rights here and now, in the deeply iniquitous and unjust world of today; but we should wield rights in a manner that will move us towards a different world, a much more just and equitable world of tomorrow.

Wielding the ‘right to health’ approach: some experiences of PHM-India

The Indian Right to Health Care (RTHC) campaign was initiated in 2003/04 (we discussed the campaign in *Global Health Watch 2*). The RTHC campaign was an important initial phase of mobilisation, when stagnation and decline in the public health system in India had reached a crisis point, and it was necessary to highlight large-scale denial of services. This campaign included documentation of large number of cases of denial of health care, organisation of a national public consultation with presentation of testimonies of denial of health care to the chairperson of the National Human Rights Commission, participatory surveys of rural public health facilities, local ‘*Jan Sunwais*’ (public hearings) in some states, regional public hearings in all regions of the country followed by a national public hearing on health rights, the last two organised in collaboration with the National Human Rights Commission. While this campaign was focused on demanding provision of quality public health services as a right, the PHM-India network has simultaneously been actively involved in the nationwide ‘Right to food campaign’ since its inception in 2002, considering food security and nutrition to be key determinants of health.

Community-based monitoring of health services in Maharashtra

Prior to the national elections in 2004, PHM-India organised a national dialogue with various political parties, and published a policy brief, ‘Make health care a fundamental right!’ Subsequently, a ‘National Rural Health Mission’ (NRHM) was launched by the new government in 2005, which has proposed increased public health financing as well as strengthening of rural public health facilities. In this situation, PHM-India’s health rights activities entered a new phase, attempting to shape NRHM in a pro-people manner while trying to assess to what extent the proposed improvements were actually being implemented, by way of conducting a ‘People’s Rural Health Watch’ in seven northern states during 2006–08.

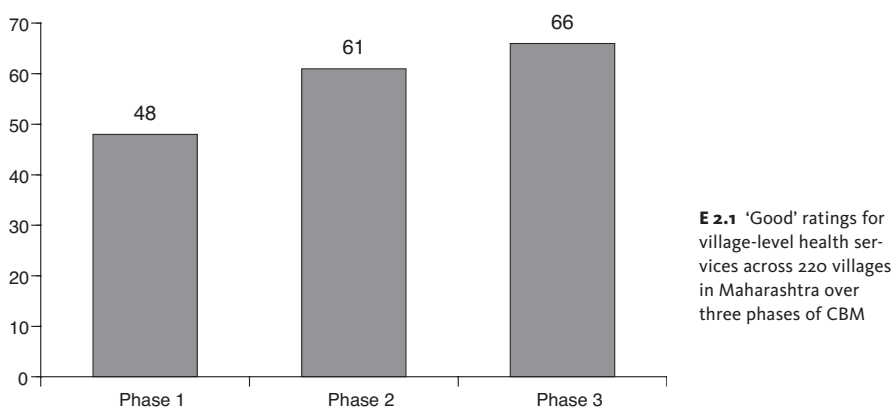


48 Community based monitoring of health services, India (Abhay Shukla)

In parallel with this, advocacy was carried out by certain PHM-India-associated activists to provide an institutional form for the health rights campaign. Carrying this forward, and based on coordination by the NRHM Advisory Group for Community Action, from 2007 onwards an innovative process of ‘community-based monitoring of health services’ (CBM) was developed; in the pilot phase during mid 2007 to early 2009 this was implemented in 35 districts of nine states. PHM-India member organisations have anchored this activity in certain states. Although this is a broad, publicly organised and funded activity, groups and individuals associated with PHM-India continue to play a key facilitating role in this process in certain states.

It is led by networked civil society organisations from block to state levels, with the following key features:

- *Community awareness and activation around health entitlements* have been generated by village meetings, display of health rights posters, expansion and strengthening of village health committees (VHCs), and training of VHC members.
- *Multi-stakeholder community monitoring committees* have been formed at primary health centre, block and district levels, including community members, NGO/CBO representatives, elected political representatives and public health staff.

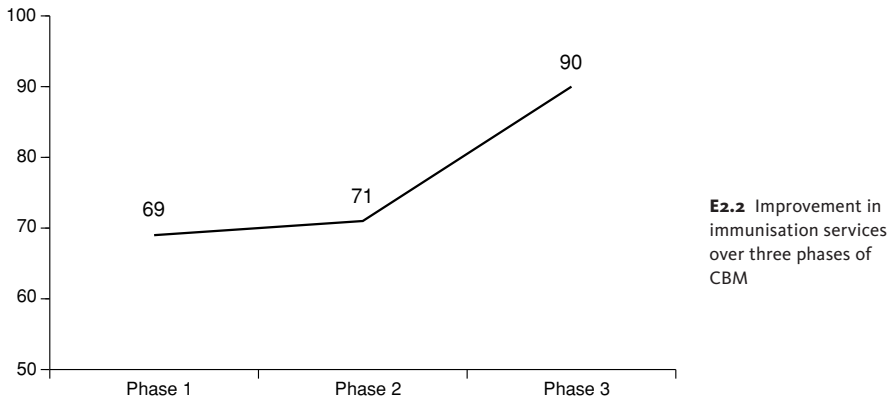


- *VHC and other committee members periodically collect information about health service delivery* using objective semi-quantitative tools, and rate these through publicly displayed *report cards*, each service being rated as 'good', 'partly satisfactory' or 'bad'. This data is collected at both village level (concerning outreach services) and health facility level.
- *Public hearings with mass participation are organised* at primary health centre, block and district levels, where report cards and cases of denial of health care are presented, and public health officials need to respond regarding remedial actions.
- *Periodic state-level events* enable dialogue between civil society monitoring committee members and the state health department, seeking resolution of critical, unresolved and systemic issues, and help reinforce government support for the CBM process.

As an example of this process, one may consider the western state of Maharashtra, where CBM is being implemented in over 500 villages spread over 23 blocks in five districts of the state.⁷ A network of 15 civil society groups including mass organisations, mostly associated with PHM-Maharashtra, have developed this activity to enable people to claim their rights related to rural public health services.

Three rounds of community-based collection of information were organised between mid 2008 and end 2009. Over these one and half years, the *overall proportion of village level health services rated 'good' by communities increased from 48 to 66 per cent* while the number of services rated as 'bad' has declined from 25 to 14 per cent. Community-based data showed that overall PHC services rated as 'good' improved from 42 per cent in the first round to 74 per cent in the third round.

This has been accompanied by significant increase in utilisation of PHC services, as people have started shifting from dominant private providers to improved public facilities. In Thane district of Maharashtra, during the period 2007/08–2009/10, outpatient, inpatient and delivery-related utilisation



of primary health centres in CBM areas increased by 34, 73 and 101 per cent respectively; this was *one and half times to twice as high* as average utilisation increases for PHCs in the district as a whole. Corresponding to this, a wide range of qualitative improvements have also been documented: in most CBM areas, attendance by field staff and doctors has increased, illegal charging by providers has been checked, functionality of PHCs and sub-centres has gone up, and provider behaviour has improved.

Initiatives in Other States in India

Similar processes of community-based accountability have been developed in other states where CBM has been implemented with a strong rights-based perspective. In Tamil Nadu, CBM processes have been facilitated in 446 panchayats (village councils) in six districts.

In Rajasthan, CBM was implemented during 2007–10 in 445 villages in five districts of the state, where major improvements in rating of village-level services were documented during the period of community-based monitoring.

In the southern state of Karnataka, the PHM has intensified its earlier work, which focused on denial of health rights. In 2009, after two years of continuous work at the district level, bringing to light the denial of health care, PHM members organised a public hearing at the state level, to bring to the notice of the state health officials the large-scale denial of health services (attended by over 1,500 participants from 17 districts). This was followed by public hearings in eight districts during 2009/10, where studies and recordings of testimonies were discussed at public forums, involving health authorities and civil society representatives. In May 2010, during the panchayat elections, a health manifesto was presented to over 50,000 households in 12 districts, urging people to take up issues of primary health care and health rights with the local candidates. In parallel, sets of questions on health rights were given to 6,000 panchayat candidates, asking for their commitment to act on these if they were elected.

Box E2.1 Campaign on patients' rights

The private medical sector is the major provider of inpatient and outpatient care in India; however, this dominating sector is almost totally unregulated and functions in an often irrational and exploitative manner, its services being unaffordable for the majority of people. PHM-Maharashtra has been active in forming patients' rights forums in various cities and towns. These are citizens' bodies with participation of people from broad sections of society. In several cities, 'Patients' Rights Conventions' have been organised, with demands being made for immediate implementation of legally enforceable patients' rights. PHM-Maharashtra conducted a state-level consultation on patients' rights in February 2010, where activists from different parts of Maharashtra presented cases of patients' rights violation before a member of the National Human Rights Commission, and raised the issue of provision of free health care for poor patients in trust hospitals. The event was followed up by a press conference and media coverage.

A related front has been *engaging private doctors in dialogue on patients' rights*. The Patients' Rights Forum-Pune and PHM-Maharashtra have conducted several rounds of discussion with the Indian Medical Association and have drafted a 'Joint Charter of Patients' Rights and Responsibilities', which has been circulated and publicised. This is a strategy to reduce doctors' opposition, increase civil society mobilisation on the issue of patients' rights, while creating awareness among the public regarding the need for regulation of the private medical sector.

Protecting undocumented migrants' right to health in Italy

At the end of 2008, during the discussion of a bill on 'security' among a group of bills called 'Security Package' (Act 733) in the Italian Senate, six senators of the Lega Nord party (a member of the ruling right-wing coalition) presented two amendments that severely threatened the guarantee of access to health services for undocumented migrants. The two amendments proposed to change Article 35 of the law on immigration (n. 286 of 1998). The article established that access to health facilities (both hospital- and territory-based) by foreigners in non-compliance with residence rules does not lead to any kind of alert or registration except in those cases where a report is mandatory by law, putting foreigners on an equal footing with Italian citizens. This regulation had existed since 1995.

Being reported to the police while seeking treatment can create an insurmountable barrier to access, encouraging 'clandestine health behaviour', which



49 Signature campaign on patient's rights in India (Abhay Shukla)

may be extremely dangerous for the individual as well as for the community (diseases do not make any ethnic, legal or racial distinctions). The denial of the right to health and health care to a part of the population opens the doors to further discriminations for other groups. Moreover, it results in the establishment of a parallel, 'illegal' health care system, and deeply undermines the state's capacity to promote individual and community health and security.

Despite fierce opposition led by the Italian Society of Migration Medicine (SIMM), one of the amendments was approved by the Senate in February 2009. Backed by the position of the National Federation of Medical Boards, by several statements from scientific societies and by the legal support of prominent jurists, SIMM mounted a struggle to influence the Italian parliament's decision. In many Italian regions a day of protest was organised, asking for the amendment to be withdrawn. Civil society associations, non-governmental organisations, university scholars, migrants' groups, church groups, activists and citizens joined the actions, often led by young doctors and medical students and with the support of local medical boards.

Soon after, several Local Health Authorities and Regional Health Departments instituted formal moves against the amendment. As the protests grew, 101 members of parliament, belonging to the ruling coalition that had voted for the Act, issued a letter in support of its withdrawal. On 27 April 2009, the amendment was removed from the law.

Ingredients of a success story The struggle has been one of the most successful and effective campaigns on health-related issues in Italy in the past several years. It was poorly funded, organised by non-professionals, yet extremely timely and focused and had a major impact.

The key reasons for success included:

- *The ‘untouchable’ right to health:* In Italy, having a universal health system that guarantees health care and prevention for the whole population is a reality that the majority of people value. It is probably one of the few rights that people still perceive as ‘untouchable’.
- *Doctors in the front line:* In Italy, as in many countries in the world, doctors are a highly powerful and influential group. Their position on the issue, backed by a formal statement by the National Federation of Medical Boards, was crucial in its impact.
- *Cooperation and networking:* Unlike a majority of scientific societies, SIMM is not funded by pharmaceutical companies. Two distinctive features make SIMM different from other scientific societies: willingness to share and cooperate, and proactive networking. Both of these proved to be extremely effective during the campaign against the amendment.

The migrants’ right to health in Italy: to be continued ... We cannot, however, forget the broader context in which the struggle took place. The ‘Security Package’ became law in July 2009. Among many discriminatory rules against migrants, one provision stated that entering or staying in Italy without a legal permit is a criminal act, punishable with detention (earlier, it was an administrative offence). It obliges any functionary (including doctors) to report violations to the police. Therefore, even if the amendment (which forced health personnel to report undocumented migrants who sought medical attention) had been withdrawn, this provision still threatened the right to health of undocumented migrants. Fortunately, the enthusiasm and support for the campaign did not fade and a clarifying note from the Home Office, in December 2009, stated that the obligation to report did not apply to personnel working in health facilities.

The war against discrimination, however, has not been won. Undocumented migrants are one of the most disadvantaged social groups in Italy. They are prey to different inequalities affecting the social determinants of health: employment, work, housing, education, social networks, welfare, etc. This is why doctors and health professionals in Italy need to build on the example of SIMM, advocating for all human rights – social, economic and cultural ones. If this is not taken forward – hiding behind the assumed neutrality of science – the battle for the right to access to health care for undocumented migrants will not have helped much.⁸

The global right to health and health care campaign

The People's Health Movement states in its founding document, the People's Charter for Health, that 'Health is a social, economic and political issue and above all a fundamental human right'. This understanding of the Right to Health includes rights to the full range of the social determinants of health (clean water, food security and nutrition, education, housing, a clean and safe environment, among others), as well as more specifically the Right to Health Care.

While few would disagree that the Right to Health is a justifiable goal, the actual attainment of the entire spectrum of health rights in today's world would obviously require a large-scale, sustained struggle and social mobilisation. Keeping this context in mind, over the past five years PHM has been carrying out a global Right to Health and Health Care campaign, supporting a number of coordinated activities directed at strengthening these rights; in this PHM tries to collaborate with the existing human rights campaigns of various partner coalitions.

PHM's global Right to Health and Health Care campaign is a step in the direction of proposing remedial actions to the health system crisis. The campaign seeks transformations in a large number of countries, adding an element of global solidarity, indispensable to resolving the whole range of inequities found in health systems the world over. The campaign has a focus on strengthening the Right to Health Care; it further documents violations of the right to the underlying determinants of health (for example, showing how denial of food security leads to worsening malnutrition, increased morbidity and mortality) and seeks to strengthen efforts and campaigns that enable people to attain these important health-related rights. Furthermore, PHM pursues reversing the tide promoting 'health care as a commodity'. Through the campaign, PHM addresses the absolute need to establish a global consensus on 'health as a right' and 'health care as a right'. PHM's understanding of human rights violations is thus based on the broader analyses of power and social inequalities and their social, economic and political determinants.

The campaign has been carrying out diagnostic assessments reporting on actual RTH violations. For this, many PHM country circles have been using the PHM RTHC Assessment Guide⁹ to produce reports with some consistency and comparability. The country reports produced so far address health care systems and also look at other health determinants of concern. Going through the assessment process has led PHM national circles to better understand the human-rights-based framework – which will now be applied to demand concrete changes. The process has included the participation of several grassroots organisations in the respective countries and has aimed at PHM movement-building, providing an opportunity for in-country coalition-building and, to the greatest extent possible, fostering rights holders' ownership of the campaign process.



50 Right to Health campaign in South Africa (Louis Reynold)

In the last four years, the campaign has advanced significantly with RTH activities under way in the Democratic Republic of Congo, Congo, Benin, Burkina Faso, Mali, Togo, Gabon, Cameroon, Senegal, South Africa, Zimbabwe, Kenya, Morocco, Uruguay, Guatemala, Bolivia, the UK and India. Eleven of these countries have already finalised assessments reports on the Right to Health. New PHM circles have been formed in several countries that have joined the campaign. A case study of the campaign in Guatemala is briefly mentioned as an example.

Various Right to Health assessment reports¹⁰ are now being used by PHM country circles to design and carry out action plans to address the major violations that have been documented. This has been done in a participatory manner with input from grassroots organisations. The rationale behind this mobilisation of rights holders is that when the state does not respect human rights, these groups have to demand their rights from the duty bearers in government, particularly by interacting with all potential agents of accountability (e.g. human rights commissions, ombudspersons, etc.) who oversee the procedures put in place by government to make duty bearers fulfil their obligations (including remedies and restitutions). Through such activities, PHM groups seek to overcome the culture of silence and apathy surrounding human rights violations in health.

At the end of 2009, PHM set up a commission to assess the progress of the campaign and to help plan the campaign in its next phase. This commission has conducted an internal evaluation and has identified key health sector issues that are campaign priorities for various country groups.¹¹ The commission is also recommending that national campaigns link their activities and focus them

Box E2.2 TH campaign in Guatemala

The Movimiento Ciudadano por la Salud (Citizens' movement for health) used the support from PHM to implement the process *Monitoring and evaluating health, equity and human rights: a citizens' perspective*. This used an action-research design in which community-based organizations from 12 rural indigenous municipalities were trained to collect and analyse data on barriers to access to health care and other issues related to social exclusion and discrimination. Concomitantly, data was collected and analysed assessing the performance of the health system, including its financing, equity aspects, health outcomes and policy development and implementation.

The assessment of the Right to Health in rural areas resulted in an action plan for advocacy. The grassroots organisations gave inputs into the design of the assessment tools; they were trained to apply the respective human rights and Right to Health tools and to carry out the analysis of the data, together with the core team of the five organisations of the Movimiento Ciudadano. The assessment of public facilities in rural areas included interviewing health care workers.

The relationship of the Movimiento Ciudadano with the Ministry of Health has had highs and lows. This reflects, in part, the constant changes in public authorities. Some of them respect this work and maintain a good relationship with the Movimiento, whereas other authorities see the work as a problem since it frequently points out the weaknesses of public health policies.

Based on the assessment, a public event was organised, which received wide media coverage. The assessment of the situation used indicators recommended by the UN, but also the perspectives of the population, and this is where the manual adapted from PHM was helpful. At the end of the study, the Movimiento had reliable, proven tools for monitoring the Right to Health, and community groups and civil society became involved in the issues, making a significant political impact.

The RTH assessment is now being replicated in new municipalities.

www.cegss.org.gt

primarily on four overarching themes, which could now become a unifying thread for PHM Right to Health activities around the world.

PHM has no illusions that systematically raising the issue of the Right to Health will by itself lead to actual achievement of this right in countries across the globe. However, PHM expects to work on certain achievable objectives that can take us towards the progressive realisation of the Right to Health.

Box E2.3 Fighting for the human right to health care in the United States

A pioneering grassroots campaign for the human Right to Health Care has made Vermont the first US state mandated by law to establish a health care system based on human rights principles. For the past two years the Vermont Workers' Center, a community-based workers' rights organization, has led a statewide campaign for universal and equitable health care. The Healthcare Is a Human Right Campaign was initiated in 2008, and in May 2010 the campaign's signature human rights principles – universality, equity, accountability, transparency, and participation – were enshrined in a new law that commits the state of Vermont to design and implement a health care system based on these norms.

The campaign kicked off with volunteers going into communities and talking with hundreds of Vermonters about health care. People from different regions and diverse backgrounds shared their experiences of suffering from a lack of access to care, often caused by financial barriers. The campaign then held a series of human rights hearings across the state, putting the health care system on trial. Many people came forward to testify how the market-based system had failed to meet their health care needs. By documenting these human rights denials in a video and a report – *Voices of the Vermont Healthcare Crisis* – the Workers' Center was able to reach out to even more people and set up organising committees in all regions.

Grounded in community-based mobilisation, the campaign's mass organising efforts – collecting surveys, postcards and petition signatures, and holding an annual May Day rally – have directly engaged over 7,000 Vermonters (more than 1 per cent of the state's population), and indirectly reached a far wider segment of the population through grassroots-driven, volunteer-led media strategies. The Workers' Center also used the human rights framework to forge solidarity among different groups and struggles, including through collaborations with progressive labour unions (especially nurses' unions), faith community groups, and disability rights organisations.

As the campaign developed the critical mass capable of changing

Some of these 'achievable' to be considered are, among others: (a) the explicit recognition of the Right to Health and Health Care at country level in several countries; (b) the formation, in several countries, of health rights monitoring bodies (accountability agents) with PHM and civil society participation; (c) a clearer delineation of health rights at both global and country levels; and (d)

what was considered ‘politically possible’, it started pushing state legislators to act. Representatives were invited to attend public accountability sessions across the state and asked to use human rights principles as guidance for health care reform in Vermont. During the 2010 legislative session, a People’s Team had a daily lobbying presence on the floor of the Statehouse, blogging about their progress and sending advocacy alerts to activists in legislators’ constituencies.

Throughout its efforts, the campaign kept the focus on a principled approach to reform. This was particularly remarkable when compared to the federal health reform debate taking place at the same time. While the national discussion remained stuck in a market-based approach, the Healthcare is a Human Right Campaign emphasised that health care must be provided as a public good shared by all. Vermont’s new health care law, which was ultimately passed with an overwhelming majority, recognises this.

The process of designing a new system is under way, with a single payer model in the mix. According to the law, implementation should begin no later than July 2012. The Vermont Workers’ Center is keeping up the pressure to ensure that the promise of universal, equitable health care becomes a reality in Vermont. They hope that their model of rights-based grassroots mobilisation offers inspiration for activists elsewhere who seek to turn health care from a market commodity into a public good.

We really need to stop thinking of health care as a for-profit venture and start treating it as a right and a public good. (Peg Franzen, President, Vermont Workers’ Center)

Video: www.workerscenter.org/node/449 A 10-minute video about the campaign, starting with stories from the health care crisis, explaining the campaign principles, and ending with examples of actions.

Report: www.workerscenter.org/healthcare-report *Voices of the Vermont Healthcare Crisis* is the outcome of extensive human rights documentation involving over 1,000 Vermonters.

Photos: www.flickr.com/photos/nesri/sets/72157617738857712/

Campaign website: www.healthcareisahumanright.org

regional and global solidarity on common health rights concerns, manifested in coordinated campaign demands and actions.

The bottom line of the RTH approach is that rights are never given, they have to be fought for! And this is the vision with which PHM’s global RTHC campaign is contributing and moving forward.

Notes

1 Several ideas in this section are adapted from 'The rights approach to health and health care – a compiled review' by Abhay Shukla, published by MASUM for Beyond the Circle, 2008.

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6 For a range of articles adopting an analytical approach to the Right to Health, see 'Health and human rights readers' by Claudio Schuftan at www.humaninfo.org/aviva/ch72a.htm#Health_and_Human_Rights_Readers.

7 For further information and a detailed report, see www.sathicehat.org/CurrentProjects/CommunityBasedMonitoringOfHealthServicesUnderNRHM.

8 More information from: Centre for International and Intercultural health – CSI (www.csiunibo.org).

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E3 | CUBA'S INTERNATIONAL COOPERATION IN HEALTH

'Cuban medics in Haiti put the world to shame' was the headline of an article in the *Independent* in December 2010.¹ Cuban health care workers have been working in Haiti since 1998. So when the earthquake struck in January 2010, the 350-strong team jumped into action and within 24 hours about 700 colleagues arrived from neighbouring Cuba to support them. However, the international press barely mentioned this Cuban presence. On 15 January 2010, the Spanish journal *El País* published an article on the 'financial and material assistance to Haiti', in which Cuba's name was absent in the list of 23 states that were collaborating in relief efforts. Fox News confirmed that Cuba was one of the rare neighbouring countries that did not send any help. But within two months, the teams from most countries were gone, again leaving the Cubans and Médecins Sans Frontières personnel as the principal health care providers for impoverished and devastated Haiti.

International solidarity has always been at the centre of the Cuban societal project. Cuba is also known for its effective and efficient health care system, which continues to be free and of good quality, even in the context of continuous economic strain since 1990.^{2, 3} The country's exclusively public health system – embedded in a socialist system that has transformed all aspects of society since the revolution of 1959 – has achieved health indicators that are among the best in the world. Cooperation with other countries has been a fundamental part of the efforts aimed at developing Cuba's national health system.

As early as 1962, Cuban doctors went to Algeria to work in the newly independent country, although enormous efforts were needed at home to build the country's own national health system. Step by step, a structural international collaboration programme was put in place.

Until 1990, Cuba's political participation in the non-aligned movement, and its military efforts in southern African front-line states in the war against the apartheid regime, were made in collaboration with efforts in the health field. During this period, Cuba was relatively isolated in the Latin American region, but with one important exception: the Sandinista revolution in Nicaragua (1979–90). The Sandinista government benefited from close cooperation with Cuba, not least in the health sector.

After the collapse of the Soviet Union, Cuba entered a 'special period' of economic hardship, worsened by the impact of an increasingly restrictive



51 Cuban doctors in Haiti after the earthquake, 2010 (© 2010 Medical Education Cooperation with Cuba [MEDICC])

economic blockade by the United States. From 1996 onwards, the country's economy started to recover gradually, but at a slow pace, and important limitations and problems persist even today. Nevertheless, from 1998 onwards, Cuba's international cooperation increased dramatically, not only in the region but also all over the world. This international cooperation is based on the family-doctor model that exists in the Cuban health system, whereby the doctor works and lives in the neighbourhood.

We give an overview of the main achievements of these initiatives and discuss their importance and impact.

Emergency assistance

Cuba's emergency experts have been leading teams of medical professionals to numerous countries for decades. In Latin America, this happened in the case of earthquakes (Chile 1960, Peru 1970, Chile 1971, Nicaragua 1972, Mexico 1985, El Salvador 1986, Ecuador 1987, Colombia 1999, El Salvador 2001); hurricanes (Honduras 1974, Nicaragua 1988, Dominican Republic 1998, Guatemala 1998, Honduras 1998, Nicaragua 1998, Haiti 2004); intense rain (Nicaragua 1991, Honduras 1999, Venezuela 1999); volcanic eruption (Nicaragua 1992); and dengue epidemics (El Salvador 2000, Honduras 2002).⁴ Cuba's solidarity with nearby Haiti is a clear example. The combination of structural health cooperation and massive emergency aid during various

moments of crisis (floods, earthquake, cholera epidemic, etc.) makes Cuban efforts essential for the survival of tens of thousands of Haitians.

After the tsunami struck Asia in December 2004, Cuba sent a medical brigade to Banda Aceh, the capital of the Aceh province in Indonesia, and to Sri Lanka.⁵

A special moment for Cuba's emergency programme was the country's response to Hurricane Katrina, which devastated New Orleans on 29 August 2005. Cuba reorganised its emergency assistance and created the Henry Reeves Contingent, ensuring the possibility of a quick and massive deployment of hundreds of medical doctors abroad to provide emergency health care. However, the US government turned down Cuba's offer to send 1,500 doctors to assist the affected population of New Orleans.

The first important mission undertaken by this new contingent was to Pakistan to assist the post-earthquake relief efforts in 2005.⁶ The first 85 Cuban doctors arrived in Islamabad within 48 hours of the disaster. In response to assessments revealing the enormous need for assistance, Cuba stepped up its collaboration. Eventually, more than 2,500 disaster response experts, surgeons, family doctors, and other health personnel were working in 30 field hospitals, provided by Cuba, along with equipment and drugs, in seven refugee camps, in dozens of communities in the mountains, and in Pakistani field hospitals and regular hospitals. The Cuban brigades stayed for more than six months, until the end of the winter. Then a long-term collaboration programme was initiated, including a clinic for orthopaedic rehabilitation and prostheses for disaster victims, and scholarships for young Pakistanis from rural areas for medical and specialist training in Cuba.^{7, 8}

We have already mentioned the Cuban presence in earthquake-hit and cholera-infected Haiti. The Cuban medical brigade of 1,200 is operating in 40 centres across the country. The Cubans constitute the largest foreign contingent, treating around 40 per cent of all cholera patients. The Cuban collaboration is becoming increasingly strategic. In November 2010, Cuban officials held talks with Brazil on developing Haiti's public health system, which Brazil and Venezuela have both agreed to help finance.

Structural cooperation

For half a century now, Cuba has been sending health workers to almost 100 countries to work in structural cooperation programmes. A third of Cuba's 75,000 doctors, along with 10,000 other health workers, are currently working in 77 poor countries.

Cuba's cooperation with the Sandinista government in Nicaragua is a good example. During the 1980s, hundreds of teachers and doctors worked in the literacy campaign and in the development of a national public health system. The Nicaraguan experience proved that an adequate public health policy and system with integrated curative, preventive, and promotion activities,

complemented by comprehensive economic development initiatives, could dramatically change the health status of a country in a relatively short time.⁹ But this example of revolutionary and innovative change was actively and aggressively undermined by the US-organised and supported Contra war.¹⁰

Cuba's structural collaboration in the field of health care was reorganised in 1998 into the Integrated Health Programme (IHP) for Latin America, the Caribbean, and Africa. IHP focuses on first-line health services. Depending on local needs, it can be complemented by technical assistance at the hospital level or with training programmes. Most doctors working in this programme are family doctors from all over Cuba, and they receive support from specialists and logisticians according to specific needs.¹¹ The main objective is to ensure the basic right to health care on a structural and durable basis. Cuban family doctors go to rural areas or peripheral urban areas where no or very few local doctors are working. The IHP currently covers more than 25 countries.

Venezuela: Mission Barrio Adentro¹²

Since his election in 1999, President Hugo Chávez of Venezuela has made considerable efforts to develop and implement social policies, including decent health services covering the entire population.¹³ The Mission Barrio Adentro ('In the neighbourhood'— MBA) relies on the participation of more than 20,000 Cuban health professionals, mainly family doctors. The approach to health is comprehensive and includes a series of preventive and educational health activities, with direct participation of the people. Health committees assist family doctors during home visits and organise activities for disease prevention and health promotion. Free dental care and ophthalmologic services are also offered.

The second phase of MBA began in 2005 with the installation in peripheral and marginalised neighbourhoods of diagnostic centres (one per 30,000 inhabitants), with emergency services and an intensive care unit. These centres are equipped with necessary diagnostic, therapeutic, and rehabilitation facilities to ensure an adequate first-line back-up for the family doctors working in the communities.

Encouraged by the massive Cuban collaboration, the Venezuelan government decided in a very short time to ensure health care as a basic right for all citizens.¹⁴ Many Venezuelan doctors joined the programme. In addition, a special programme was started under which tens of thousands of young Venezuelans from poor neighbourhoods entered university to study medicine. However, right from the start, Venezuelan medical organisations have opposed the presence of Cuban doctors. This opposition is based not on a health needs analysis, but on their political opposition to Hugo Chávez's Bolivarian revolution.

The Venezuelan health system is extremely fragmented, with different social security systems, separate national and local public health services, and private health facilities in the cities. The Cuban presence in Venezuela, through the

Mission Barrio Adentro, has had an enormous impact on increasing accessibility to health care for millions of people from the poorest strata of society. Nevertheless, the programme added to the further fragmentation of health care. Tensions with other parts of the public health care system and with the local social security systems remain unresolved.

Special international health programmes

In addition to the development of first-line health care based on the family-medicine concept, a series of specific health programmes exist in the fields of nutrition, specialised care, research, etc. We describe two of these programmes as examples.

Chernobyl's children

For the last 20 years, Cuba has been treating children who suffered from the radiation fallout from the Chernobyl nuclear disaster. Cuba receives and treats these radiation victims at a special treatment facility near Havana. More than 20,000 children have been treated since the programme started.¹⁵

Operación Milagro

Under 'Operation Miracle', thousands of visually impaired people are receiving eye surgery for free. In a first phase (2004), these patients were sent to Cuba. But from 2005 onwards, ophthalmological surgery facilities were set up in Venezuela, Bolivia, and other Latin American countries.¹⁶ By the end of 2010, Operation Miracle had restored the eyesight of 1.8 million people in 35 countries, including that of Mario Teran, the Bolivian sergeant who killed Che Guevara in 1967.

Medical training programmes

From 1963 to 2004, Cuba was involved in the creation of nine medical faculties in Yemen, Guyana, Ethiopia, Guinea-Bissau, Uganda, Ghana, Gambia, Equatorial Guinea, and Haiti. In addition, during the same period, the country had long-term cooperation programmes with 37 medical faculties abroad. Complementary to this academic collaboration abroad, Cuba always had an important programme of medical scholarships for foreign students at its medical faculties. As early as October 1961, the first 15 Guinean students arrived in Havana to study medicine. Many thousands followed their example in the following decades.

Medical scholarships in Cuba (ELAM)

As part of the IHP programme, the Latin American School for Medical Sciences (ELAM) was opened in 1998 in Havana, on the seaside campus of what was once a naval and merchant marine academy. In the first year, the school had 1,900 students. Black and indigenous peoples of Central and South



52 Health activists before the Latin American University in Havana (David Legge)

America are well represented among the students, half of whom are women. The Cuban state provides board and lodging and covers other educational expenses. The final four years of work and study are spent at other Cuban medical schools, alongside Cuban students. Just like the Cuban students, the foreign students will also spend a lot of time learning by engaging in actual practice in neighbourhood doctors' offices, clinics, and hospitals.^{17, 18}

A French-language medical school was set up in the eastern city of Santiago de Cuba, located near Haiti. In 2003, 381 Haitians studied medicine there.¹⁹

In July 2005, the first medical doctors graduated from ELAM. Some of them continued their training as family doctors while working in the Cuban health system. But most returned to their home countries, where many of them can reinforce the efforts of Cuban doctors working there, or even replace them.

In 2010, 8,281 students from more than 30 countries, mainly from Latin America and Africa, were enrolled at ELAM. There were also 171 American students, of whom 47 had already graduated.

Decentralised teaching

Another 49,000 students are enrolled in decentralised training programmes for foreign medical students that are integrated into the missions abroad. This system of decentralised teaching is becoming increasingly important. It organises medical education in basic health services under a central plan and implements it under strict supervision, thus bringing medical students nearer to patients and their environment. In Cuba and Venezuela, decentralised



53 Students at the Latin American University in Havana (David Legge)

medical training began in 2005. Thereafter this programme was extended to other countries.²⁰

Discussion and concluding remarks

Cuba is one of the very few important players in the international health arena that actively opposes the dominant neoliberal discourse that advocates the privatisation of health care and profit-driven health services. The quality and accessibility of Cuba's public health services make it possible to disprove the prevailing claims that public services are not effective and efficient.

Cuba's contributions to this international debate are inextricably linked to its economic and political policy choices.²¹ It acknowledges the need to fight the deplorable socio-economic conditions in which billions of people are living all over the world. Providing adequate and accessible health services is part of this struggle.

It is true that Cuban personnel sometimes develop a 'system within the system' in the partner countries. The well-organised Cuban interventions often target regions with very weak and disorganised local structures. This contradiction between the pressing need to ensure quality health services for people in need, on the one hand, and the existing weaknesses of local systems, on the other hand, is difficult to manage. Coordination at the national level does not always ensure sufficient integration at the local level. Moreover, Cuban international cooperation can be caught in political contradictions in the receiving country, as is the case in Venezuela.

By sending doctors all over the world, Cuba not only addresses immediate humanitarian needs but also demonstrates that alternative development strategies are available, and that these methods are often even quite successful. At the same time, this international collaboration contributes to Cuba's diplomatic strategy to counter the attempts of the United States to isolate it.

In the case of Cuba's collaboration with Venezuela, the important humanitarian dimension of the cooperation is intimately linked with political and economic objectives, and with the aim of developing an alternative form of Latin American political and economic integration, in opposition to US-imposed globalisation. Here, the solidarity is clearly reciprocal. The economic agreements with Venezuela help the Cuban revolution to improve its economic capabilities, notwithstanding the tight US blockade and the changes in the world oil market. Cuban–Venezuelan collaboration has become the cornerstone of coalition-building efforts in Latin America aimed against US domination of the region. Cuba and Venezuela, and since 2006 also Bolivia, have been advocating a 'Bolivarian' alternative for Latin America, as an alternative to the US-imposed Free Trade Agreement of the Americas. The above-mentioned plans of Brazil, Venezuela, and Cuba to help Haiti in the development of its public health system are a concrete example of this new South–South collaboration.

Notes

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