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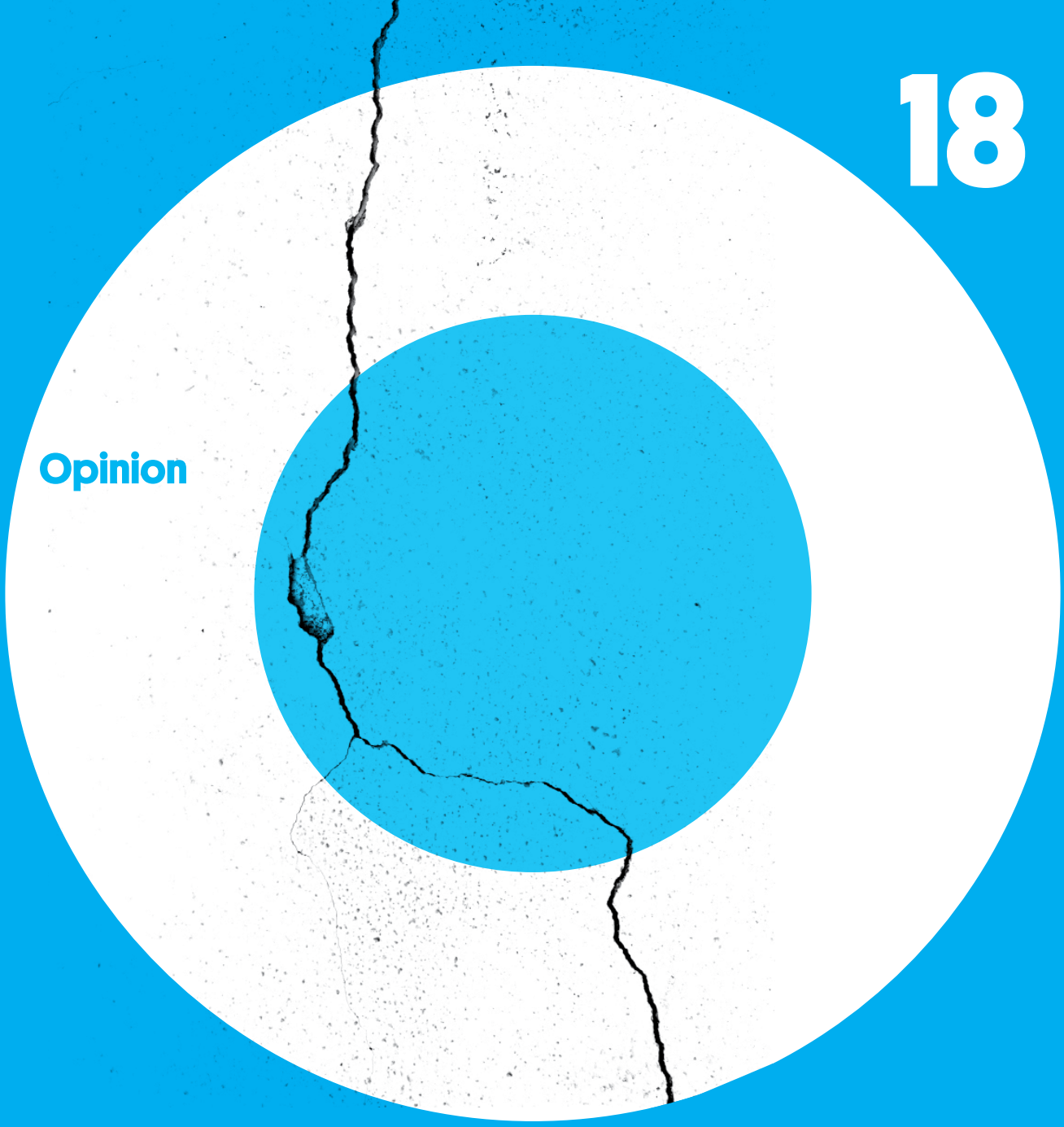
Opinion



The Gap

Notes from the ISGlobal Think Tank on Inequity and Global Health

ISGlobal Barcelona Institute for Global Health

This paper is part of the "Global Health Inequities: Bridging the Gap" project

This paper builds on ideas and suggestions from the seminar entitled Building a Global Health Social Contract for the 21st Century, held in Barcelona on 7 and 8 November 2013. The materials from the seminar are available on our website: www.isglobal.org/es/thinktank.

Design by Mucho.

A Global Social Contract

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"We should ensure that no person–regardless of ethnicity, gender, geography, disability, race or other status–is denied universal human rights and basic economic opportunities. We should design goals that focus on reaching excluded groups, for example by making sure we track progress at all levels of income, and by providing social protection to help people build resilience to life's uncertainties."

Report of the High-Level Panel on the future of the Millennium Development Goals.

Last December, the International Agency for Research on Cancer announced that more than 14 million people had been diagnosed with cancer worldwide in 2012.[2] The most surprising statistic, however, was that 57% of these cases occurred in middle and low-income countries. This percentage has grown rapidly in recent decades, and two out of every three deaths related to cancer pathologies now occur in poor countries, where this disease kills more people than AIDS, malaria and tuberculosis combined.[3] The prevention and treatment of cancer today raises a number of complex questions that inevitably recall the debate on HIV-AIDS more than 30 years ago.

The devastation caused by a disease until recently associated with the world's most developed societies illustrates the challenges facing global health in the twenty-first century: the boundaries between the 'developed' and the 'developing' world are becoming blurred, giving rise to a much more complex scenario in which the health problems "of the poor" are no longer limited to the risks of childbirth or a handful of tropical diseases. As the average income of the world's countries starts to converge, each nation becomes a small laboratory reflecting the diversity of the planet. The gap between different individuals and social groups within countries and the gap between world regions is widening with unprecedented speed. The place where a person is born or the family they are born into determines their possibilities of enjoying basic good health or of avoiding what health economists call the "catastrophic expenditure" of a disease: the risk that the cost of medical treatment will ruin an individual and his or her family and determine all other aspects of their lives. According to the academic Martin McKee, 62% of all personal bankruptcies filed in the USA in 2007 were directly or indirectly related to medical expenses.[4]

The variables that have until now been used to define the debate on poverty and health have lost some of their usefulness. Rather than using only criteria based on absolute values—such as mean per capita income—policies promoting global health should now also take into account the relative situation of individuals in society.

First, they must take into account the marginal effort required to reach populations in excluded groups and those in the poorest quintiles, even when average progress in the region is reasonable or even high, as may be the case in Europe or the United States. From the deterioration of health services in Greece to the exclusion from health care of hundreds of thousands of undocumented immigrants in Spain and the USA, the economic crisis and the response to the crisis on the part of governments and financial institutions have jeopardised the universal right to health, one of the fundamental pillars of the welfare state. We have seen convincing evidence that while economic growth is part of the equation it is not the only factor and that poverty and inequity can continue to increase despite improvement in macroeconomic indicators.

Second, these new variables oblige us to define poverty (and its solutions) in terms of *vulnerability* to ever more common shocks, such as rising food prices, natural disasters, and serious illnesses. Therefore, the protection of the individual through some kind of Universal Health Coverage (UHC) or a similar mechanism has become a central issue in the debate about the new framework that will replace the Millennium Development Goals (MDGs) after 2015.

The problem is that there is no way to guarantee such protection in the absence of comprehensive solutions that take into account the complexity of the threats facing the international community at this time. From climate change to pharmaceutical innovation, the future of global health will be influenced by funding mechanisms and governance that respond to a common set of priorities. In essence, what is needed is a *global social contract* that will give all the inhabitants of our planet the same basic protection guaranteed by the national social contracts which in the twentieth century opened the door to some of the most important advances in the history of health care.

This paper is ISGlobal's first attempt to define a position and a work agenda for inequity and global health. In it we outline our reflections on the subject, the questions we are asking ourselves, and the direction of our programme of work in this area. The paper is in part based on the content of the seminar *Building a Global Health Social Contract for the 21st Century* held in Barcelona in November 2013. The materials from the seminar are available on our website.[6]

Inequity Determines Health

The last 25 years have seen unprecedented advances in health care. Between 1990 and 2012, a combination of factors, in particular policies related to immunisation and maternal health, reduced from 12.6 to 6.6 million the number of children who die from preventable causes before the age of five. The percentage of children under five with low weight problems declined from 28% to 17%, and the total number of births attended by trained personnel has risen steadily. Between 2001 and 2012, new HIV infections declined by 33%. This reduction was supported by a preventive and palliative strategy that is also yielding significant results in other diseases, such as malaria, tuberculosis and polio.[7]

However, when we look more closely at the details a somewhat different picture emerges. The average progress in these indicators conceals substantial differences between population groups in access to health care. Over and over again, the indicator values for the poorest quintiles (20%) and the most disadvantaged ethnic and social groups in our societies are alarmingly low compared to the same values for other groups. Children born into the poorest 20% of households in Africa (often those in rural areas) are almost five times more likely to die before the age of five than their counterparts in the wealthiest quintile. The same disparity recurs systematically across all the key health indicators, including attended delivery, access to essential treatment, and prevention of communicable and non-communicable diseases.

Although the world continues to tolerate a 36-year maximum difference in life expectancy (the gap between Japan and Malawi), the trend is towards a reduction in equity gaps between countries. At the same time, however, gaps within countries are becoming increasingly larger. India, for example, has become a huge paradox: a country where tens of millions of obese people live in a society in which four out of ten children are affected by malnutrition. The resulting health care needs of both groups cover the whole spectrum of possibilities.[8] Even in the most developed economies disparities between rich and poor are striking. In the USA, the wealthiest 1% of the population managed to capture 95% of the economic growth generated by the economic recovery[9] while infants born to African-American women are between 1.5 and 3 times more likely to die than infants of any other race or ethnicity.[10]

In the twenty-first century, we can no longer talk seriously about the universal right to health without considering these gaps and

discussing ways to reduce them. The implications of this debate are, first and foremost, ethical. When the Spanish society accepts for economic reasons that an undetermined number of hundreds of thousands of undocumented immigrants in the country can be excluded by law from the national health system, what that society is doing is opening the door to the commoditisation of a common good: there is a right, but only to the extent that we can afford it. It is only a matter of time before the same logic begins to permeate other key areas of the social contract, such as the pension system, because the decision about what is "possible" and what is not depends purely on the political perceptions of each moment.

But inequity can also be associated with significant economic considerations that affect social mobility and cohesion as well as the fiscal burden of health and its impact on economic growth. A recent International Monetary Fund study on inequality based on the most extensive data set available to date concluded that high levels of inequity undermine progress in health and education, cause political and economic instability, and undercut the social consensus that allows a society to adjust to shocks. The authors also found that inequity tends to slow down the pace of economic growth and reduce the duration of growth cycles and, consequently, of efforts to reduce poverty.[11]

The rapid increase in inequality and the implications of this growing gap for the collective interest have become central issues in the public debate during the economic crisis and in the discussion on the post-2015 framework for global progress that will replace the MDGs. Some authors have proposed that the new framework should include a global goal on the provision of social protection for all in the form of (UHC) or other global social protection mechanism. The global equalisation scheme proposed by Professor Ooms during the ISGlobal seminar follows this line of thinking—the idea of transnationalising social protection obligations and creating funding mechanisms that will prevent aid dependency.[12] Although no real consensus has been reached on such proposals, the practical and ethical benefits have been demonstrated in numerous academic papers.[13] However, the basic details have never been defined: for example, who would be covered, what services would be covered, and how the costs of UHC would be met.

What happens in the coming months will determine whether this is a real debate or a purely rhetorical exercise with little practical consequence for the global strategy against poverty. The process should incorporate tangible advances in the equity of income generation and the structure of expenditure, ensuring that the recognition of rights is translated into improvements in health infrastructure and services as well as the provision of affordable drugs and treatments for diseases that affect the world's poorest populations.

How Can We Measure the Differences?

"Leave no one behind" is the bold statement that prefaces the first objective defined by the UN High-Level Panel on the post-2015 development agenda.[14] The panel of experts recognised the need for a toolkit that can monitor progress at all income levels and for all groups. But the task is by no means an easy one. The indicators we use to measure inequality (such as the Gini coefficient) do not necessarily demonstrate the effectiveness of interventions aimed at reducing poverty levels. The new tools cannot be based on the universal criteria that underpinned the MDGs: a gross indicator of income differences, for instance, is of no use.

What we need are simple but useful indicators. Kevin Watkins, Director of the Overseas Development Institute, has suggested that an inequity factor could be applied to the general indicators to act as a kind of corrective mechanism: for example, maximum differences between quintiles could be established and differences in excess of these values would automatically trigger a response. The indicators cannot be the same for all countries because of cultural differences and variations in available data. They should be the result of national dialogues and must be endorsed by the institutions responsible for monitoring the MDGs.[15]

While it is possible to define a set of indicators that specifically measure the impact of policies on access to health care, it will sometimes be difficult not to consider these in conjunction with other policies that directly affect the poorest quintiles in the population, such as those on education or social infrastructure. For instance, a low level of education among women is associated with high risk deliveries at an early age.

It would also be desirable if such goals were not only applied to developing and emerging countries. Ultimately, inequity is a problem that undermines progress in all countries, and in recent years we have witnessed major setbacks in health care in some of the wealthiest countries in the world. The introduction of indicators of inequality in OECD countries would be an attractive option for two reasons: it would help to reduce the growing pockets of exclusion and vulnerability (relative poverty levels) and at the same time would demonstrate that these countries are prepared to make the same commitment themselves that they require of others (enhanced legitimacy).

If any such measures are to be implemented, one of the most significant obstacles that would have to be addressed is the lack of data. Simply put, the data needed to determine the specific conditions under which social subgroups would develop does not exist or is not available. Without such information, it is impossible to design interventions that will reduce the inequity gap. ISGlobal researchers Clara Menéndez and Anna Lucas have recently provided clear evidence of this problem with a convincing example: causes of death among women and children in Mozambique.[16] The simple expedient of performing non-invasive autopsies in a hospital in Maputo provided the data needed to demonstrate that most of the deaths were due to infectious diseases, such as malaria or tuberculosis, rather than obstetric conditions. The autopsy findings also revealed that clinical errors had contributed to almost two out of three of these maternal deaths. Better data leads to more informed policies and increases the effectiveness of interventions.

More Equitable Distribution of Expenditure and Income

Total health spending worldwide was estimated at US$5.3 trillion in 2010, and 90% of this amount was spent in high and upper middle income countries. In lower middle and low income countries, 94% of the budget came from domestic sources (including direct payments from patients) rather than from international development aid. Every year, the right to health of an estimated 1.3 billion people is limited by their inability to make direct payments for health services, and 100 million people are pushed into poverty by catastrophic medical debt.[17] International aid allocated to health care has tripled since 2000 to almost 30 billion annually. Of this, less than half comes from traditional bilateral donors.[18] These figures raise a number of basic questions. How can we reduce the imbalance, ensuring a relative increase in the kind of expenditure that will improve the health of the poorest populations and reduce the financial burden of disease on families? What is the potential of domestic funding? What should be the role of aid and other international funding mechanisms? In other words, what do we want, how much will it cost, and who should pay?

Our starting point is that "all effective care should be free" (Archie Cochrane, quoted by Martin McKee). If effective treatments, medications and interventions exist that can meet the essential medical needs of the population—whether to treat an infectious disease or diabetes—they should be made available to everyone who needs them irrespective of place of residence or social origin. However, not everyone necessarily agrees with this logic rooted in the concept that expenditure should follow need. As David Hammerstein has pointed out,[19] the Troika (International Monetary Fund, European Commission, and European Central Bank) in response to the European economic crisis followed the opposite logic: that rights are determined by the available budget (which was reduced as a result of lower tax income). In Greece, allegations abound that patients are making direct payments in exchange for cancer treatment, and in Romania doctors are leaving the country because their salary does not represent a decent living wage.

The cost of guaranteeing people's right to essential health will depend on the minimum level of care we establish. In a recent paper in support of UHC, the World Health Organisation (WHO) makes the point that the High-Level Taskforce on Innovative International Financing for Health Systems has esti-

mated the annual per capita expenditure required to provide a basic package of care at US$60, which contrasts with the average per capita spend of US$32 in low income countries in 2010.[20] This new level of expenditure would represent a burden of over 5% of GDP for 38 countries and over 10% for another 15, meaning that in some areas, aid would play a key role in the introduction of UHC. We also know that this would only represent a first step: in countries that have started to introduce effective UHC, the cost has risen to well above US$60 per capita. This information only serves to emphasise the need to address the issue from a perspective that encompasses national needs and capacities as well as the responsibility of the international community. Moreover, the international community also has a responsibility to reduce the cost of health care by providing reasonable alternatives to the current models of pharmaceutical innovation and the ways new drugs are distributed, two issues discussed in greater detail below.

The distribution of the economic burden will be very different from the current model. In recent years, we have seen an unprecedented rise in the capacity of low income countries to finance their own health spending. Aid has increased, but domestic sources have increased much more. In fact, fiscal reform may offer the best opportunity for financing health care in the future, and recent analyses and studies have provided evidence to support this premise. The Africa Progress Panel, for example, demonstrated that the annual revenue lost through tax avoidance and evasion in the extractive sector alone in Africa exceeds the annual inflow of development funds for the whole continent.[21] The fact that the global tax 'revolution' is also in the interest of the G8 countries means we have a unique opportunity that cannot be missed to improve the legal framework and control mechanisms.

A more sophisticated system of international development aid is also needed. The challenge is twofold: to increase the available resources by way of new funding mechanisms and to bring donor priorities into better alignment with the real health needs of the poorest populations. In the first case, current efforts are focused on implementing a tax on financial transactions, which in its most ambitious form could raise as much as €300 billion per year (although the amount that would be generated by the models currently under discussion would be substantially low-

er). In the second case, there is an open debate about the role of the new global health institutions (such as the GAVI Alliance and the Global Fund) and the major philanthropic foundations that have been involved in their creation and support, in particular the Bill and Melinda Gates Foundation.

Health Governance Reflecting the Interests of Everyone, Everywhere

Reducing inequities not only depends on financial resources but also on the institutions and norms or rules that regulate the global health system. And in this respect our certainties are all negatives. We know that individual countries can no longer control the system by themselves because many global variables are beyond the control of any one country, however powerful. We also know that the international institutions created to govern global health—such as the WHO—are not always able to provide prompt and effective solutions or responses. Finally, we know that one of the priorities of whatever model emerges from this process should be the task of bringing multinational medical corporations under control—both pharmaceutical companies and also businesses that provide medical services. At present, the behaviour of these entities is driven by a balance of risks and opportunities that does not always favour the global health system.

The WHO's current status and agenda illustrate the three main problems of global health governance: a lack of meaningful participation by a large number of actors; power asymmetries; and the dilution of global health goals by broader objectives, including those of intellectual property and fiscal discipline.[22] These factors work together to prevent the WHO from exercising its proper role. In practice, the response to this failure has been the proliferation of partial institutional alternatives, such as UNAIDS, GAVI and a long list of other public-private initiatives. It is essential to take advantage of the democratic character of the organisation to recover the chief value of the WHO, namely, that it should be in a position to develop and promote independent and effective policies and practices that promote global health. The WHO's ability to do this will be put to the test during the debate about the inclusion of UHC in the post-2015 development framework.

Reconsideration of the governance model will require more than an adjustment of the existing institutions. Some authors have proposed alternative representation and decision-making models aimed at ensuring the kind of participation, balance of power and focus required by the global health agenda in the twenty-first century. One example is the multicentric model for global health governance proposed by Rachel Kiddell-Monroe. Whatever the model, it is important to make the point that rethinking the status quo and existing structures is possible, and necessary if we are to achieve more just and effective mecha-

nisms of government. The fact that it will take decades to consolidate new structures is not sufficient reason to justify the current paralysis.

As Professor Suerie Moon highlighted,[23] transparency is another critical component of any reform of the system because it affords protection against power asymmetries and the distortion of global health priorities. While some countries have made considerable advances, which in many cases have resulted in the release of data on issues of public interest, opacity still prevails in certain crucial areas, such as trade and investment, fiscal issues, and the management of intellectual property. A lack of transparency makes it impossible to have an informed public debate on issues that decisively affect the health of individuals and the democracy of states.

Finally, it is possible that achieving broad global governance is not a feasible objective. Even when we restrict ourselves to specific areas of global health, the complex interaction of incentives and interests is so great that it is rare that we get very far. Some authors have argued in favour of less ambitious mechanisms of governance, which would make it possible to circumvent the eternal impasse currently affecting such issues as therapeutic innovation and the development of essential drugs.[24]

The Impact of Inequity On Therapeutic Innovation and Access to Treatment

Therapeutic innovation and the development of new pharmaceutical products is the third important area in which inequity determines the right to health of poorer populations in developing countries and, increasingly, in developed countries. It has been thirteen years since the report *Fatal Imbalance* denounced the effects of the intellectual property system on access to essential drugs,[25] and the question asked then is still relevant today. What determines the model of innovation and access: the needs of those who use the drugs or the profits of those who produce them?

If our aim is to build a global social contract, the current innovation model (R&D) is definitely a failure. The system generates new products only if they promise to be profitable for the private sector. However, much of the investment in research is funded by public money. Driven by innovation, the current model fails to take into account the needs of public health or the importance of improving existing products and making them more accessible. Innovation in turn is chiefly driven by profit. This model gives rise to significant gaps in the research agenda and is detrimental to genuine innovation because the focus is on marketing new products that represent little real therapeutic progress.

What can be done to change the system? Among the NGOs working in development—and even among less activist institutions such as the Product Development Partnerships—there is a general feeling that the current model for funding innovation does not work. But is this a sentiment shared by the industry? And is it accepted in academia, which is where most basic research takes place? There are signs that the pharmaceutical industry itself is questioning the single model. The last decade has seen a marked increase in collaboration on the development of products of only marginal interest to investors. The pharmaceutical industry is also conscious that new business models are necessary because health has become both a global threat and a global opportunity, but it does not know what form they might take.

The advances made in the last ten years have shown that profit and patents are not the only obstacle in the case of the treatment of most infectious diseases and, to a lesser degree, even for that of neglected diseases. What happens in the area of publicly-funded non-profit research? What are the incentives? How can products be developed outside of the charitable or philanthropic model?

The key question is how to encourage innovation while maintaining the cost at a reasonable level so that the new treatment is accessible to all those who need treatment. One possible approach would be to separate the cost of research and development from the final cost of the product, ensuring that the cost of R&D and that of production respond to different incentives. But it may be necessary to go even further. Eliminating the huge gap that deprives millions of people of a treatment that could improve or save their lives means changing the parameters and implementing a model of innovation driven by patient access to treatment. To move beyond the current confrontation, we must initiate a frank and open discussion to assess what has been achieved through the creation of Product Development Partnerships and funding by philanthropic institutions. While in that sphere patents have not been the main obstacle, the entry of non communicable diseases into the global health arena and the need to find solutions for an ever larger population has once again focused the debate on the original problem: how to ensure access to treatments for which there is a market and which, therefore, can be a source of profits.

One important issue that must be resolved is who should set prices. Although pharmaceutical companies have for some time seen the potential benefits of selling into emerging markets and applied differential pricing the barriers to treatment are still insurmountable. To take the example of hepatitis C, a course of treatment with the new drugs coming onto the market costs $38.000 per person in the USA. Although differential pricing policies are being negotiated in countries such as Egypt[26], these high prices ensure that a vast number of patients will remain untreated in middle and even high income countries so that the profits of a small minority can be maintained. If part of the research has been funded by public capital, why is the return on investment not also determined by the public interest?

In the case of infectious diseases, the emergence of AIDS as a threat to safety at the end of the last century gave rise to the creation of new tools and mechanisms. Epidemiological findings show that the difference has narrowed between rich countries and those with low and middle income. The relationship between poverty and infectious diseases is no longer as strong as it was, but the rates of mortality and morbidity due to chronic diseases in developed and low income countries are converging. Cancer is a case in point; with new treatments that are difficult to ac-

cess because of their enormous cost, new global solutions will be needed to meet the challenge. In Africa, breast cancer still represents a death sentence while the mortality associated with this disease in developed countries has been reduced dramatically.

Conclusion: Elements for an ISGlobal Work Agenda

In the coming months, the world will witness an intense debate about inequity and the best strategy for combating poverty after 2015. The right of millions of people to basic health care is one of the keystones of this debate. Based on the ideas discussed in this document, ISGlobal has drawn up a work agenda incorporating the following elements:

• **Taking the objectives of equity into practice.** Through our platforms in Mozambique and Bolivia, we will work with other organisations to assess what it really means in practice to incorporate equity objectives into development and health strategies. Our work programme will cover three specific aspects: the funding of health care policies, equity in the provision of services, and the impact of social determinants.

• **An equitable model of innovation and access to essential medicines.** Old and new challenges have brought back to the table the problem of an innovation and access model that does not respond to the needs of the poorest, irrespective of where they live. ISGlobal will use its experience in scientific areas such as malaria, antibiotics resistance or child-maternal health to work with others in the exploration of new innovation models and bridging the gaps between different actors in this debate.

• **More just and generous funding for development.** The debate on the future financing of international development is closely linked to the reduction of inequities. Our first priority will be to recover Spain's aid budget and direct it towards global health policies consistent with the principles of equity. However we will also continue to play an active role in the debate on the financial transactions tax, the details of which are to be decided by the Spanish Government in the coming months.

• **Quality information to improve equity in health programmes.** Abundant and reliable data are the basis on which we can assess the effectiveness of programmes and stakeholders' compliance with their commitments. ISGlobal devotes part of its efforts to generating such data and to demanding transparency from the public institutions responsible for its generation and management.

References

1 The authors would like to thank Laia Bertrán and Joan Tallada for their contribution to this report and helpful comments.

2 *Latest world cancer statistics.* WHO press release N° 223 (12 December 2013) http://www.iarc.fr/en/media-centre/pr/2013/pdfs/pr223_E.pdf

3 The Economist (1 March, 2014).

4 Statistic cited by Martin McKee in his keynote speech at the ISGLOBAL seminar *Building a Global Health Social Contract for the 21st Century* (Barcelona, November 2013). See more details on this topic at http://www.businessweek.com/bwdaily/dnflash/content/jun2009/db2009064_666715.htm

5 In this paper we differentiate between the terms inequality (inevitable differences, such as being born in a country having more or less natural resources) and inequity (unfair differences that are the result of avoidable decisions and situations).

6 Complete information is available at http://www.isglobal.org/es/web/guest/event/-/asset_publisher/nVsLg5I1q6UT/content/building-a-global-health-social-contract-for-the-21st-century

7 WHO *Millennium Development Goals (MDGs) Fact sheet N°290.* Updated October 2013. Available at http://www.who.int/mediacentre/factsheets/fs290/en/

8 See more details in the Overseas Development Institute (ODI) publication *Future Diets* (January 2014). Available at http://www.odi.org.uk/future-diets.

9 See the Oxfam briefing paper *Working for the Few* (January 2014). Available at http://www.oxfam.org/sites/www.oxfam.org/files/bp-working-for-few-political-capture-economic-inequality-200114-en.pdf

10 See the US Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report —United States, 2011.* Available at http://www.cdc.gov/mmwr/pdf/other/su6001.pdf.

11 Ostry *et al.* (2014): *Redistribution, Inequality and Growth.* Available at http://www.imf.org/external/pubs/ft/sdn/2014/sdn1402.pdf

12 *Beyond health aid: would an international equalization scheme for universal health coverage serve the international collective interest?* Available at http://www.globalizationandhealth.com/content/10/1/41/abstract

13 A recent summary of this body of work can be found in the WHO publication *Arguing for Universal Health Coverage* (March 2014). Available at http://uhcforward.org/sites/uhcforward.org/files/UHC_ENvs_BD.pdf.

14 High Level Panel: *A new global partnership: eradicate poverty and transform economies through sustainable development.* Available at http://www.post2015hlp.org/wp-content/uploads/2013/05/UN-Report.pdf

15 *Leaving no-one behind: an equity agenda for the post-2015 goals.* Available at http://www.odi.org.uk/opinion/7924-leaving-no-one-behind-equity-agenda-post-2015-goals

16 *Tracking Maternal Mortality Through an Equity Lens.* Available at http://www.isglobal.org/en/web/guest/publication/-/asset_publisher/ljGAMKTwu9m4/content/tracking-maternal-mortality-through-an-equity-lens

17 Martin McKee's keynote speech at the ISGLOBAL seminar *Building a Global Health Social Contract for the 21st Century.*

18 Sudeep Chand, *The Challenges of Financing. The fundamentals of an equitable health financing system,* available at http://www.isglobal.org/documents/10179/25254/13.The_Challenge_of_Financing.pdf/a356bca6-89ec-4c34-9c9a-1aec1d03c1c7) and Institute for Health Metrics and Evaluation (IHME), Financing Global Health 2012, available at http://www.healthmetricsandevaluation.org/sites/default/files/policy_report/2011/FGH_2012_chapter_1_IHME.pdf)

19 David Hammerstein's presentation at the ISGLOBAL seminar *Building a Global Health Social Contract for the 21st Century.*

20 Elovainio and Evans (2013) cited by Sudeep Chand (see note 18).

21 *Equity in extractives*. Available at http://africaprogresspanel.org/publications/policy-papers/africa-progress-report-2013/

22 These ideas form the basis of the proposal presented by Rachel Kiddell-Monroe at the ISGlobal Seminar. Her work is

available at http://www.isglobal.org/documents/10179/25254/A+Non-State+Centric+Governance+Framework+for+GH.pdf/eee78339-2163-4f24-a118-724957b56556

23 *Transnational Transparency: Why Does it Matter for Global Health.* Available at https://www.isglobal.org/documents/10179/25254/Transnational+Transparency/c419e-b1e-731d-4bee-86ff-a783ef5eedcb

24 See, for example, the article by Stewart Patrick in Foreign Affairs *The Unruled World: The Case for Good Enough Global Governance.* Available at http://www.foreignaffairs.com/articles/140343/stewart-patrick/the-unruled-world#cid=soc-twitter-at-essay-the_unruled_world-000000.

25 Available at http://www.msfaccess.org/sites/default/files/MSF_assets/NegDis/Docs/NEGDIS_report_FatalImbalance_CrisisInR&D_ENG_2001.pdf

26 See more detail at http://www.reuters.com/article/2014/03/21/us-hepatitis-egypt-gilead-sciences-idUSBREA2K1VF20140321 (for Egypt) and http://www.npr.org/blogs/health/2014/02/06/272519954/maker-of-1-000-hepatitis-c-pill-looks-to-cut-its-cost-overseas (for India).

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