

# Building a Global Health Social Contract for the 21st Century

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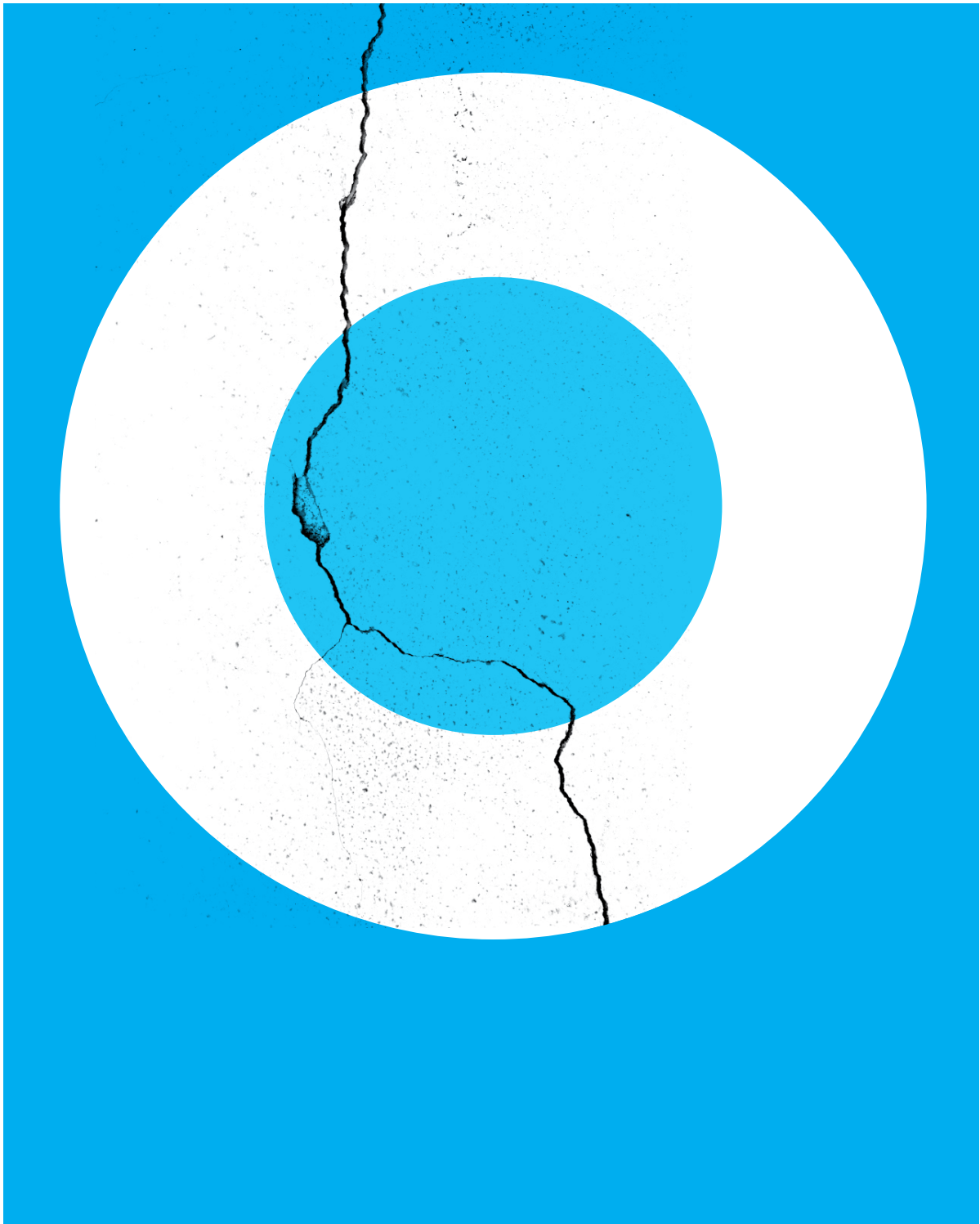
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This paper builds on ideas and suggestions from the seminar entitled Building a Global Health Social Contract for the 21st Century, held in Barcelona on 7 and 8 November 2013. The materials from the seminar are available on our website: [www.isglobal.org/es/thinktank](http://www.isglobal.org/es/thinktank).

## Rafael Vilasanjuan and Gonzalo Fanjul<sup>1</sup>

Director and Associated Researcher  
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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.

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Last December, the International Agency for Research on Cancer announced that more than 14 million people had been diagnosed with cancer worldwide in 2012.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup>

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.<sup>6</sup>

# 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.<sup>7</sup>

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.<sup>8</sup> 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<sup>9</sup> 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.<sup>10</sup>

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.<sup>11</sup>

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.<sup>12</sup> Although no real consensus has been reached on such proposals, the practical and ethical benefits have been demonstrated in numerous academic papers.<sup>13</sup> 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.<sup>14</sup> 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.<sup>15</sup>

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.<sup>16</sup> 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.<sup>17</sup> 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.<sup>18</sup> 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,<sup>19</sup> 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.<sup>20</sup> 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.<sup>21</sup> 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.<sup>22</sup> 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,<sup>23</sup> 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.<sup>24</sup>

## 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,<sup>25</sup> 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<sup>26</sup>, 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](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](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](http://www.isglobal.org/es/web/guest/event/-/asset_publisher/nVsLg5I1q6UT/content/building-a-global-health-social-contract-for-the-21st-century)

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**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>.

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**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](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](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](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](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-ble-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](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](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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**SOMETHING IS WRONG** with global health. While many agree that the agenda should place a priority on improving health and achieving equity in health for all people worldwide,<sup>1</sup> good intentions have not translated into an improved reality on the ground. Despite the promises, the money, the panoply of actors and the political will of States, countless lives are needlessly lost to tuberculosis, HIV/AIDS, sleeping sickness, diarrhoea, diabetes, to name but a few. Even when key ways to address these issues are proposed, they do not see the light of day. Take the critical proposal for a Medical Research and Development Convention to stimulate the research and development of new treatments for neglected diseases. After 14 years of efforts, it was on the brink of success and ready to be negotiated at the World Health Assembly 2013. Yet, it was delayed yet again by a global health governance process driven by political and economic national agendas rather than the interests of people, equity and social justice. As the WHO Director General Margaret Chan has said, it seems that global health is “caught in a crosscurrent, with a potentially lethal undertow.”<sup>2</sup>

Health and equity are compromised both by the power of different players to influence and enforce the governance of global health and by the existing governance mechanisms used to set the health agenda. The existing global governance system has proven unable to respond to global health crises such as the access to health services and medicines. This paper argues that the current system of global health governance is outmoded and inherently unable to provide a comprehensive and coherent approach that guarantees health for all. Addressing this crisis requires new normative and institutional frameworks suited to the global health reality of today’s world and that have equity and social justice at their core. A new framework should (a) ensure inclusive participation which reflects meaningful and collaborative involvement by the plurality of global health actors; (b) rebalance the power asymmetries in global health, including challenging the cooptation of the global health agenda by industry; and (c) ensure that global health remains a meaningful and focused approach, which is not diluted by mainstreaming the concept in every area of the development agenda.

The severity and tenacity of global health challenges compels us to think beyond the status quo. This paper attempts to do that by looking at global health governance from the perspecti-

ve of institutional innovation and political creativity. It explores the idea of a non-State-centric or multicentric global governance framework as a challenge to the current geopolitical power structure, and builds on the practical wisdom drawn from the reality of governance issues encountered through the access to medicines debate. By incorporating the descriptive insights of several scholars on open source anarchy and nodal governance, a multicentric framework is presented as a fresh and pragmatic approach that provides the space for reality and innovation in global governance to respond to the calls for equitable and just global health outcomes.

The paper is presented in three parts: (1) the reality of global health and the three realities of its governance (2) why the current system of global health governance cannot address those realities effectively and sustainably and (3) how multicentric global governance for health can provide a sustainable and innovative framework for global health.

**DESPITE UNPRECEDENTED POLITICAL** and financial interest in global health, and despite the plethora of actors and disciplines involved, poorer populations continue to suffer and die from treatable and preventable diseases. While we have seen progress in some areas of global health, such as reductions in child mortality rates, two major health crises are facing the world today: the spread of infectious diseases and the rise of non-communicable diseases (NCDs). Despite massive human and financial resources dedicated to stemming the tide of HIV/AIDS, malaria and tuberculosis,<sup>3</sup> these “big three” diseases continue to disproportionately strike people living in low and middle income countries (LMICs) and remain critical and urgent issues in global health.<sup>4</sup> Meanwhile the growing burden of cancer, cardiovascular disease, chronic pulmonary disease, diabetes and mental health problems has been recognized as one of the major challenges for development in the twenty-first century.<sup>5</sup>

Globalisation has transformed the focus of what was formerly known as international health from the provision of aid from rich to poor countries across borders, to a “globalised public health” that has largely removed those state boundaries.<sup>6</sup> Globalisation was expected to create certain benefits like economic development for all countries bringing increased access to better living standards and health for more people and less poverty.<sup>7</sup> However, the reality is that we are witnessing is a terrible paradox of spectacular economic growth and medical advances contrasted with the ever-widening gaps between the health of rich and poor people.<sup>8</sup> While on the one hand there is unprecedented commitment by States to deal with these crises, bad health policies have led to almost half of the world’s people living in extreme poverty and deprivation, lacking access to even the most basic health care.<sup>9</sup>

#### **Change the scientific, political, economic, administrative, and legal environment**

The globalisation of public health has led to the globalisation of its governance. The global health landscape is no longer limited to States and IGOs, but also includes hundreds of public and private NGOs and foundations, as well as scores of global health initiatives and celebrities from the world of music and film.<sup>10</sup> In the absence of a world government, global health needs a template of global governance to manage globalisation’s

impact on the spread of infectious and non-infectious diseases that have gone beyond the control of any one State.<sup>11</sup> This template of global health governance uses “formal and informal institutions, rules, and processes by States, intergovernmental organizations and non-State actors to deal with challenges to health that require cross-border collective action.”<sup>12</sup>

Combined with increased funding for global health, this proliferation has spawned a panoply of regimes and initiatives to address global health problems.<sup>13</sup> As part of this revolution in global health governance,<sup>14</sup> access to essential medicines issues have become a lightening rod for exposing the failures of global health governance by revealing that global health has shifted from a largely humanitarian issue to an increasingly political one. Not only is health seen as a domestic and national security issue but it also lies at the intersection of many critical global political issues, including climate change, migration, economics, trade and health, which link economic development and social determinants beyond national borders. This shift has revealed the inadequacies of existing global governance approaches both by highlighting the elevated status of health in global governance schemes and emphasizing the root causes of ill-health and inequitable health outcomes.<sup>15</sup>

While central to any public health and medical system, medicines remain unaffordable for large swathes of the world’s population.<sup>16</sup> Guaranteeing access to affordable and appropriate essential medicines became a global concern when the World Trade Organisation (WTO) adopted the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) in 1994.<sup>17</sup> By adopting TRIPS, WTO members created an inextricable link between trade and health that impacted their ability to provide affordable medicines to their populations. Flexibilities in TRIPS to ensure poorer countries were not disadvantaged by patent terms were rarely used and in 2001, the WTO adopted the Doha Declaration on TRIPS and Public Health to redress the balance and promote “access to medicines for all”.<sup>18</sup> However, today one in three people worldwide still lack access to essential medicines and they live largely in LMICs.<sup>19</sup> As the largest family expenditure item after food, the cost of medicines is the key barrier to accessing treatment.<sup>20</sup> While the United Nations has repeatedly urged countries to improve access to affordable essential drugs in LMICs,<sup>21</sup> the situation has scarcely improved.

Despite the obvious inequity and social injustice in the global distribution of medicines, social justice approaches to health often take second place to market logic of competitiveness or strength. This market primacy can even be considered as a market justice approach to health.<sup>22</sup> This describes how high-income states dominating global health are influenced by their domestic and global economic agenda, which includes the impact of health policy on powerful private non-State actors, creating a strong tendency to define health as a consumer good to be allocated primarily by private decisions and markets. To that end, they adopt measures that define health as a commodity.<sup>23</sup> This “market justice” approach to health focuses on the technological aspects of health, revealed through a commitment to biomedical technology, which admits current predominant economic principles and incentives as drivers for policy.<sup>24</sup> Market justice sees market forces as critical to effective and inclusive development and that, in the global health context, biomedical approaches represent a critical part of that model. This contrasts with social justice approaches to health historically espoused by the World Health Organisation (WHO) and public interest non-State actors like non-governmental organisations (NGOs). In line with social medicine theories key to the creation of the WHO, this vision of health recognizes that social justice and equity should be the key drivers of health policy and action.<sup>25</sup>

The conflicts inherent between the market justice and social justice approaches represent a fundamental challenge the global health governance model.<sup>26</sup> “Grand challenges” to the current governance model have been correctly identified and include a lack of global health leadership by WHO, the inability to harness creativity, energy and resources for global health, the lack of collaboration and coordination between multiple players, the neglect of basic survival needs and health system strengthening, issues around funding and priority setting, and the need for accountability, monitoring and enforcement.<sup>27</sup> However, addressing these challenges effectively to create a coherent and effective framework requires an understanding of the three realities underlying global health governance today.



**Reality I:****A lack of inclusive and meaningful participation by plurality of actors**

The political space for global health has been reshaped.<sup>28</sup> Adding actors to the debate has been critical to many of the advances made in global health, a fact particularly evident in the access to medicines debate.<sup>29</sup> Yet, non-State actors are a diverse sector that present challenges in terms of transparency and potential conflicts of interest. Beyond the public interest groups (NGOs and civil society), it encompasses private interests such as corporations, aligning with market justice approaches to health, and foundations. Pharmaceutical companies are seen to have such a major impact on access to medicines issues that the Millennium Development agenda highlights their role in making essential medicines more widely available and affordable for all who need them in LMICs.<sup>30</sup>

The impact of a lack of attention to the divergent and sometimes conflicting goals existing among non-State actors was revealed in the negotiation of the 2011 *United Nations Political Declaration on NCDs*.<sup>31</sup> UN member states re-affirmed their commitment to the existing global health governance model while acknowledging the need for States to collaborate with non-State actors. At the WHO Ministerial Conference in Moscow,<sup>32</sup> a coalition of civil society groups highlighted the lack of references to TRIPS and Doha in the draft Political Declaration on NCDs that would put access to affordable treatment for NCD patients at risk.<sup>33</sup> LMICs subsequently added references to those documents but a small but powerful group of high-income countries, notably the US and EU, wanted to remove the references.<sup>34</sup> Eventually, the references to TRIPS were heavily watered down in the final Political Declaration presented to the UN General Assembly and references to Doha were removed.

The lack of involvement in the negotiation compromised effective participation by civil society. There was no public justification of the decision to exclude Doha, which made it difficult for non-State actors to respond to the concerns of States and relegated non-State actors to reacting on their best estimate of what happened. This lack of articulation allows assumptions about process to take precedence over evidence-based interactions and gives the sense that decisions are taken with little regard for the discussions occurring in the civil society fora. Informal spaces for civil society become politically correct but normati-



vely impotent. Who participates in which decision ultimately depends on the priorities of States. Given the magnitude of the NCD crisis and politicisation of global health combined with pharmaceutical companies' interest in supplying NCD medicines to poorer countries, it is unlikely that access to medicines and therefore the health of the poor will be the primary concern of States today.

## **Reality 2:**

### **Exploitation of power asymmetries in global health**

The relative power of corporate and civil society actors has been a central dynamic in the access to medicines debate. Pharmaceutical companies have become important drivers of domestic and global economies and many countries rely on them to support their economies. This was evident in the negotiations around TRIPS. It is firmly established that the pharmaceutical industry played an important role in the direction and tenor of the TRIPS negotiations,<sup>35</sup> a role driven by industry's view that pharmaceutical IPR is their "most valuable resource"<sup>36</sup> and that protecting it is key strategy to their economic success. There is compelling evidence of the influence of the pharmaceutical industry in the US trade-based approach to intellectual property policy<sup>37</sup> and the minimum standards under TRIPS are widely recognised as representing important gains for the global pharmaceutical industry.<sup>38</sup>

Beyond the clear asymmetry in the passage and enforcement of TRIPS, evidence of that power asymmetry has become evident during the fourteen-year effort to put in place a Medical Research and Development Convention.<sup>39</sup> Just one example reported is that an expert working group set up by WHO to evaluate the causes of the lack of drug development for people with neglected diseases leaked confidential commission documents to pharmaceutical industry representatives for comments a full month before the final report was made public.<sup>40</sup> As a result the WHA rejected the Commission's report and the process for addressing the critical needs of neglected patients was further postponed.<sup>41</sup> In the NCD process, industry representatives were able to wield influence by participating in and leading panels on policy and planning during "civil society" consultations, even where civil society representatives were not present on the panel.<sup>42</sup>

**Reality 3:****Dilution of global health**

Meanwhile, these two realities have contributed to a third reality, which is that global health is becoming another “something, nothing word”.<sup>43</sup> Global health has a special character and meaning which is at risk of becoming diffuse and uncertain, and therefore of little normative value. Given the impact of non-traditional fields of governance on global health, global health has been “mainstreamed” throughout the governance system. By integrating global health in all areas of governance from economics to education to environment, the global health label opens doors to funding and political traction. As a result, more and more interest groups will seek to include their issue within the definition of global health, which is not so difficult when the definition is boundless.<sup>44</sup> Just as commentators have raised concerns about how the proliferation of new rights has risked devaluing the “currency of human rights”,<sup>45 46</sup> there may be a risk that the uncontrolled expansion of the global health umbrella devalues the currency of global health.

Lying at the intersection of trade and health, the risks of dilution become evident in the access to medicines and innovation debate. Discussions in the NCD process showed examples of market agendas being put up against social justice goals when the WHO solicits the engagement of pharmaceutical companies and other industries in developing policies and plans around how to address NCDs. In this way, trade and market driven objectives become entrenched in the development of health policies and dilute the stated goals of securing equity to ensure good health outcomes. Instead of promoting the social justice goals of the Doha Declaration, which protect access to medicines for all, the trade agendas of rich nations appear to dominate negotiation processes once more, so that social justice protections were removed from the final text. While promoting global health is the ostensible goal of the NCD Political Declaration, the meaning of global health is no longer limited to the health of people but extends to the development of economic agendas.

## Can the current system address the reality of Global Health?

**MANY AGREE THAT** the global health agenda should place a priority on improving health and achieving equity in health for all people worldwide,<sup>47</sup> yet good intentions have not translated into reality on the ground. There are two broad visions of how to address the current deficiencies in the global health governance system: one recognises the primacy of the State and proposes adjustments to address weaknesses, while the other recognises the need to move to a non-State centric system, arguing that the latter is already in progress and showing promise.

The majority of global health scholars and practitioners recognise the continuing primacy and ultimate responsibility of States in national and global health governance.<sup>48</sup> The global governance model is based on the classic 1648 Westphalian model installing nation States as the primary actors in international relations.<sup>49</sup> This understanding has led to membership of multilateral health organizations, such as WHO, being open only to States.<sup>50</sup> States have also made it clear that they support a State-led approach in any template for global governance and suggest that the international community must recommit to a multilateral system so that all States “rich and poor, engage with an equitable voice.”<sup>51</sup>

Proponents of working within the state-centric governance model claim the traditional structure can be adjusted to incorporate the new actors as well as the challenges they bring.<sup>52</sup> Evidence shows that powerful States continue to influence the global health agendas according to their domestic policy goals, as witnessed in the most recent twist in the Medical Research and Development Convention story where the US unilaterally put the convention back on course after years of trying to derail it.<sup>53</sup>

When viewed from a perspective of power struggles, an approach aiming to “renovate” existing structures in the same model appears pragmatic since promoting global health through various global governance processes is politically sensitive. It touches on questions of state sovereignty and involves the distribution of economic and political resources as well as a “candid assessment of power structures”.<sup>54</sup> States would stonewall any moves that challenge their sovereignty, and resist creating any harmonising structure, preferring to limit restrictions on their activities so they can act as they wish rather than seek collective action.<sup>55</sup>

Yet, the apparent pragmatism and realism of adapting the status quo displaces attention from the real issue. A review of the justifications for keeping the status quo and adapting it to meet today's challenges revolves around the needs of the seventeenth century structure rather than the needs of people that structure is supposed to serve. In other words, in deciding how to address the failures of the global health governance system, there appears to be a choice between a pragmatism that suits the interests of States or a pragmatism that suits the interests of people.

A second vision of addressing global health failures takes a fundamentally different perspective to look for solutions. Rather than viewing global health governance from the perspective of existing power structures, it looks at global governance from the perspective of the actual innovative interactions, initiatives and events which are shaping new dynamics between the plurality of actors, including States, existing in global health today. There are important descriptions of the existing reality in global health, which provide a springboard to develop a new pragmatic approach to global governance.<sup>56</sup> These descriptions see the new reality testing the seventeenth century governance approach to its limits<sup>57</sup> and that there is a shift underway to a context where both State and non-State actors shape responses to international health threats and opportunities.<sup>58</sup> By developing and deciding global health policy together, both State and non-State actors are already responding to a new approach to global health governance reflecting the revolution led by globalisation.

There are some tangible and relatively successful practical examples of an ongoing move to a more non-State centric approach to addressing global health issues. One example is UNITAID, the International Drug Purchasing Facility that uses an innovative financing mechanism through a tax on airline tickets to raise new funds for global health targeting three diseases: HIV/AIDS, tuberculosis (TB), and malaria. UNITAID has adopted a 12-member Executive Board governance structure that, with its series of advisory and supporting bodies, aims to ensure a broader representation of non-State actors in its decision-making processes. The Executive Board is made up of eight country representatives, two civil society representatives (NGOs and people living with HIV/AIDS, TB or malaria), one representative from a major global health foundation, and one non-voting representative from the World Health Organization.<sup>59</sup> A Consul-

tative Forum provides further support to the Executive Board by serving as a platform for debate, advocacy, fundraising and inclusion of partners.<sup>60</sup> The Executive Board as a whole is also supported by a Proposal Review Committee made up of around 20 independent and impartial scientific, public health, market impact and economics experts, and makes decisions on funding objectives, budget allocation, and action plans.

This structure is innovative in global health governance in that it explicitly seeks out the expertise and experience of civil society by makes formal space on the decision-making bodies for their inclusive participation. Furthermore, those civil society representatives themselves are accountable to a broader range of civil society representatives who ensure that their delegation represents the real voice of civil society. The two civil society members are supported by a broad Civil Society Advisory Group made up of 22 northern and southern NGOs and community groups specialising in access to medicines issues. This group informs the work of the civil society delegations and contributes to policy formulation. A Communities Support Team ensures that one of the civil society delegation is linked directly to the needs of the people in the communities so creating a feedback accountability directly between the communities and the highest decision making body, which is an example of how the voice of patients can directly reach the highest decision making body.

Along with other mixed governmental and civil society governance structures, such as the Drugs for Neglected Diseases initiative (DNDi),<sup>61</sup> the Medicines Patent Pool<sup>62</sup> and the Global Fund<sup>63</sup>, UNITAID is an example of an innovative new approach to global health. It address long standing and fundamental global health problems related in particular to participation and power asymmetries by making use of a mixed government and non-state actor governance model to adapt and react to the reality of global health governance in the twenty-first century. These initiatives all show that global health institutions, if they so choose, can find ways to meet the needs of patients and “shed themselves of the characteristics of state-centricity”.<sup>64</sup>



## A multicentric vision for governing global health

**BUILDING ON A GROUND** up and reality based perspective, the wisdom and insights of history and the reality of global health governance drawn from the access to medicines movement, this paper makes the case for a non-State centric or multicentric system of global governance for health. By embracing the need to challenge the outmoded State centric system and incorporating the descriptive insights of several scholars on open source anarchy and nodal governance,<sup>65</sup> it is presented as a fresh and pragmatic framework that provides the space for the reality and innovation of global health governance in the twenty-first century to respond to the call for equity and justice in global health.

There are three key features of a multicentric vision. Firstly, rather than using “global health governance” language, it adopts the term “global governance for health”<sup>66</sup> to understand and incorporate the vastly changed global health landscape with its multiple sources of governance. As opposed to global health governance, global governance for health reaches beyond traditional approaches and analyses the inter-relations between health and other governance sectors to see how their policies and actions affect global health objectives.<sup>67</sup> This is a critical part of the recognition of the new global landscape brought by globalisation with its new and evolving interdependence between States and non-State actors, where new actors bring new resources as well as their own agendas to the discussion and where health is a cross cutting issue sensitive to a wide range of activities beyond traditional health-related interventions.

Secondly, the multicentric model moves away from a State-centric structure towards a State and non-State actor system. Rather than aiming to create global health architecture, a multicentric approach is a dynamic responsive approach that uses the power of global and local interconnection and networks to achieve health.<sup>68</sup> Trying to capture global health through a single governance structure does not appreciate the fundamental change that health and governance for health is undergoing.<sup>69</sup> With people’s global health needs front and centre, the multicentric model seeks flexibility to innovate and reinforce optimal ways to address those needs. It recognises that addressing those needs requires more than mere tinkering around the edges of the structure of the current global health governance model, but rather a fundamental rethink of the traditional governance system.

There are two interrelated descriptions of practice in global health governance today. Rather than attempting to constrain the freedom of action enjoyed by State and non-State actors, “open source anarchy” recognises that in fact open participation of the type being witnessed today can provide key adapted insights into the search for appropriate governance.<sup>70</sup> An anti-architectural approach to global governance embraces unstructured pluralism as providing the innovation and pathways needed to develop a workable system of global governance for health. Examples from the access to medicines campaign show that when innovation and new ideas are encouraged to meet, interact and develop from different spheres, they can give rise the development of normative approaches such as the Medical R&D convention through the elaboration of policy reasons that drive States, intergovernmental organisations, and non-State actors to protect and promote health in world politics.<sup>71</sup>

Yet, there is an understandable concern about the apparent shift to unstructured plurality suggested by the open source anarchy. Nodal governance theory describes a more structured way of understanding unstructured plurality. It has its roots in the elaboration of the contemporary network theory that explains how a variety of actors operating within social systems “interact along networks to govern the systems they inhabit.”<sup>72</sup> Whereas open source anarchy embraces the confusion of initiatives and actors like so many pieces thrown in the air to see which ones stick, by understanding governance as nodal we can start to perceive and understand a pattern of social phenomena underlying the creation of policy.<sup>73</sup> Nodal theory is a descriptive model and is not automatically a democratic or an equitable system of governance.<sup>74</sup>

A multicentric model goes further and uses the nodal description as a way to manage the open source un-structure and suggests a normative way to make those inter-nodal relationships network for justice and equity. In this way it acts as a bridge between the perspective of a highly centralised and hierarchical State-centric system and the descriptions of unstructured plurality and anarchy.



### **Multicentric governance and the three realities**

Adopting a multicentric approach can provide a framework in which the three realities of global health governance today can be addressed.

Firstly, it is able to address the central importance of inclusive and meaningful participation by recognising the plurality of roles, responsibilities and interests of the multiple and distinct actors. The chaos in global health is indisputable. There is widespread competition among actors and priorities, a lack of structure and the roles of the different actors are not delineated.<sup>75</sup> Global health has become an intricate and complex web of formal and informal relationships attempting to exert their influence through the State-led global governance apparatus, where bilateral and multilateral relationships pull and push towards negotiated agreements. Using the NCD process as an example, we can see that recognising States, national governments, public and private interest groups as multiple and distinct actors with clearly defined roles would have potentially allowed the NCD process to overcome some of the criticisms about participation. A clear understanding of the distinct role of the various sectors of non-State actors may have enabled the policy discussion space to be framed so as to openly incorporate the plurality of actors and to recognise their equal but distinct authority in the process.

A clear framework of the authority and roles of the different actors could have helped to overcome conflicts of interest and provided a transparent framework for addressing the distinct roles.<sup>76</sup> The NGO consultations and informal civil society forum on NCDs made no attempt to distinguish between the different non-State actors. Indeed, *any* organisation or group that was not a State, that had a demonstrable interest in NCDs and that had applied in time to take part in the NCD process could attend the two “NGO” forums. The result was that the highly resourced pharmaceutical and food companies as well as industry-sponsored patient organisations were indistinct from the classic humanitarian and civil society groups. A multicentric approach would ensure that each type of non-State actor would be distinguished, would take part in the decision-making process according to its authority, its vested interests in the outcomes and its capacity to impact the issues to advance global health norms.

Multicentric participation does not become an issue of limiting or restricting the number of actors participating in the global governance for health model, it rather becomes an issue of making sure that every actor and its constituent parts has a clear understanding of its own authority, role and its co-extensive relationship with other actors. This could free any global governance for health system from having to decide or choose who is a representative or not, and allow actors to self-select based on their understanding of their role in the process and the role of others. Transparency and a clear framework could help secure a balance between the types of interest represented. By ensuring that decisions are articulated at each instance and by each actor, participation can move towards equitable and effective decision making which recognises the plurality of actors and their contributions to addressing the global health crisis.

With co-extensive roles clearly defined, rather than appearing as a concession to voices of non-State actors, the negotiation processes could be structured to incorporate those voices equitably. The NCD fora in New York and Moscow were framed as consultative and informal. These descriptors alone undermined any authority that the different non-State actors may have thought they had: a reasonable assumption given their critical role in global health recognised by the States themselves. Furthermore, since it is not clear what authority or power if any non-State actors have in the global NCD policy process, States and the WHO may be seen to be acting inclusively simply by granting any type of ‘consultative’ space for non-State actors, however compromised. A multicentric model would provide a clear role and authority so that participation becomes a right and not a concession.

Secondly, a multicentric approach can address asymmetry and co-optation by economic interests. A market justice driven system of global health requires trade-offs to be made between different actors that are typically driven by trade concerns rather than social justice concerns lying at the heart of public health<sup>77</sup>. A multicentric approach could provide a policy space in which no actor is excluded but where the potential for co-optation is addressed directly by modulating the influence of conflicting interests systematically through definite roles and clear authority. The global health actors make their claims in an open framework where positions would be heard according to the multicentric principles of distinct roles for individual States and for

non-State actors dependent on their authority and their vested interests in the issue at hand. For instance, given the interest that pharmaceutical companies have in protecting IPR, they would therefore not be involved in defining global health policy in which their private interests are at stake. They would not become key actors in a debate on protecting intellectual property as they did in the TRIPS negotiation process<sup>78</sup> and they would not be able to prevent an agreement such as Doha because of their corporate interests in protecting IP<sup>79</sup>. In the NCD debate, while public interest groups saw a need to address IPR as an actual or potential barrier to access, private interest actors focused on prevention and denied that IPR was a barrier. A multicentric approach would have distinguished between the roles of the different non-State actors and allowed the conflicting positions to be openly and critically reviewed to allow a transparent understanding the reasons for the decisions taken. The pharmaceutical companies' role could then for instance be expressly limited to discussing technical aspects of pharmaceutical production and supply to inform policy decisions made by individual States and public interest actors working for the interests of commonly agreed global health norms.

The multicentric approach would require a clear articulation of decisions and positions of all actors and would not have allowed States to exclude Doha from the NCD Political Declaration without articulating their reasons. If States has been forced to explain why Doha had been removed from the Political Declaration, public interest NGOs could have exposed any entrenched interests of the US and EU and allowed them to react either by deciding on a different policy or by using the multicentric framework to challenge the States' decision.

Finally, through providing distinct roles for different actors, a multicentric system could help avoid dilution. For instance, in the NCD process, global health as a normative principle would recognise the relevance of intellectual property to the access to medicines debate. A WHO-type body would be authorised to ensure that non-State actors develop policy focusing on the provision of accessible and affordable NCD medicines for poor patients. While a plan for funding of such a body is beyond the scope of this paper, innovative mechanisms tapping private and public sources to allow an independent and credible institution will be essential. In the NCD process, WHO would be able to

counter the dilution of global health principles demonstrated in the overly-skewed prioritisation of prevention over treatment. WHO could come back on the Political Declaration on NCDs and point out that States had failed to protect the global health needs of poor populations already suffering from NCDs and had unduly been influenced by corporate interests in global health outcomes. It would also be able to require States, civil society and NGOs to develop clear principles to address the treatment of NCDs to prioritise the social justice principles of global health. This would prevent the dilution of global health as experienced in the NCD process to date.

## Conclusion

**THE THREE REALITIES** of global health today – the lack of inclusive meaningful participation, the power asymmetry and co-optation by private interests and the risk of dilution – consistently undermine efforts to reform the existing system. Innovative proposals such as the Framework Convention on Global Health, which suggests a normative framework to govern global health for equity and justice risks being stymied by its reliance on the State-centric system. For example, addressing participation by non-State actors in global health lies at the heart of the FCGH. Yet the FCGH limits participation to those authorised by States, sowing doubts about how the FCGH can promote equity and justice in participation.<sup>80</sup> This would then perpetuate the “seemingly intractable” problems of global health governance that include “powerful forces which seek to perpetuate the gains which they enjoy and could obstruct progressive means to reduce health inequalities”.<sup>81</sup> It is well-known that the State-centric nature of international law fundamentally challenges global health governance because it is unable to incorporate non-state actors in the legal framework for global health governance.<sup>82</sup> In other words, while promoting the participation of non-State actors in global health governance, the authors of the FCGH recognise that the State-centric system may not in fact be able to incorporate that very participation. As a result it is unclear in practice how proposals relying on the State-centric structure would avoid maintaining a status quo that relegates non-State actors to an informal role.

Trying to re-purpose an outmoded State-centred governance model to fit the new purpose of equitable participatory governance for State and non-State actors seems doomed. By “clinging to the old models, working ever harder to fit the phenomena we observe into the forms of the past”,<sup>83</sup> we continue to leave global health issues in the hands of world’s richest and most powerful countries and individuals. To continue this way is simply unethical, given the gross inequities in health outcomes it is causing.

Descriptions of the reality of governance from radically new perspectives today open the door to challenging that perpetuation of outmoded but politically expedient structures on a new and rapidly developing pluralistic and interactive context. A multicentric approach to global governance for health can provide a framework for a system which moves from a descrip-

tion of the globalised reality to an adapted normative approach which bridges philosophical gaps and addresses equity and justice in global health by dealing with the three realities undermining global health governance today. There are some practical individual examples like UNITAID that show how this model is beginning to emerge. However, there needs to be a more systematic approach to incorporate multi-centric principles throughout the system.

It is never easy to challenge the status quo. However, the reality demands that policy makers identify and address the real reasons behind the failure of the architecture to right the global wrongs, preventing people and nations from emerging equitably and sustainably from poverty. It is not enough to simply accept a structure put in place nearly 400 years ago when the world was a completely different place with far fewer recognised states and limited internationalisation.<sup>84</sup> Globalisation has impacted our world in a way not seen since the industrial revolution in Europe and it is time for global governance to reflect that. We need to recognise the shifts in governance already taking place and challenge outmoded structures as the pragmatic option to meet the desperate global health needs worldwide. Moving to a non-State centric system challenges us to embrace a fresh, open perspective and an understanding of a dramatically and rapidly changing world order. If global health needs are to be addressed, we need to start thinking outside the box.

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## Introduction: Interdependence, Empathy and Solidarity

*The world was appalled when HIV/AIDS was ravaging sub-Saharan Africa but lifesaving treatment was priced out of reach of 99% of the population in 2001. It was heartbroken when an earthquake brought unprecedented devastation to Haiti in 2010 and to Japan in 2011. It was outraged when 15-year old Malala Yousafzai was shot in the head for advocating that girls be educated in 2012. And it was shocked when thousands of civilians in Syria were attacked with chemical weapons in 2013.*

**WE LIVE IN AN INCREASINGLY** global society. This global society is one that is marked – like all societies – with diverse and often conflicting values, views and interests, and by societal arrangements that can be grossly unequal, oppressive, or unjust. But it is also marked by new possibilities for solidarity. The social distance between individuals and communities worldwide is arguably decreasing due to the globalization of information and social media, increased travel and migration, and the reality of economic, security and environmental interdependence. To each of the events mentioned above – and innumerable more – there has been a social response marked by empathy and collective action, however imperfect.

However, unlike at national level, this global society is not yet underpinned by a global social contract. The concept of a social contract as the basis for legitimate government has deep roots in political philosophy, dating back at least several centuries to Locke and Rousseau. Stated simply, the concept is that individuals consent to be governed by a state that will, in return, ensure the welfare of its population. Central to the notion of a social contract is the notion of a society – a group of individuals sharing some common bonds of identity, culture, or history. While distinct identities, cultures and histories will continue to characterize the global population, globalization offers the possibility of strengthening a sense of shared history and identity as human beings.

If we consider all members of the human race to belong to a global society, what kind of global social contract of rights and responsibilities could be constructed to promote its overall welfare? In the absence of a global government, how could it be upheld? And why might we need a global social contract at all?

# Global Challenges to the National Social Contract

**PROTECTING THE HEALTH** and well-being of a population is a central objective of the social contract. Within the system of international rules by which we have organized ourselves, primary responsibility for the health of a population lies with the nation-state. However, the factors that affect health are increasingly beyond the control of any single government. National health systems are struggling for money, staff, medicines and other supplies. And they are struggling to regulate powerful actors in order to protect public health.

How can we expect them to function when globally we are not training enough healthcare workers to meet societal needs, and failing to stem the braindrain of highly-educated health personnel from poorer to richer countries? When international intellectual property rules allow drug prices to be set at unaffordable levels, while failing to stimulate research into the diseases primarily affecting the poor? When the global threat of pandemic influenza is not matched by an adequate system of vaccine production and global access? When the rapid movement of capital across borders undermines the national tax base required to finance health systems? When health budgets are slashed by austerity policies and financial crisis? When international investment treaties tie the hands of governments to regulate the marketing of tobacco, for example, or to ban dangerous chemicals? When imported goods are manufactured beyond the scrutiny of national regulatory authorities? When global media make it easy to evade national regulations on the marketing of alcohol or other restricted products to minors? When the changes in climate induced by the greenhouse gas emissions of a handful of countries create unprecedented threats to human well-being in all countries?

In other words, in a globalized and interdependent world, nation-states acting alone cannot fulfill their national social contracts. But in the absence of a robust global social contract, how can social welfare be protected and promoted?

## Health in the Social Contract

**HEALTH IS A COMPELLING** theme around which a global social contract could begin to take shape. Achieving health for all has long been a shared global aspiration. In 1946, UN member states agreed to the WHO Constitution, which began, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition,” and mandated WHO to pursue “the attainment by all peoples of the highest possible level of health.”<sup>1</sup> Importantly, it conceptualized health in broad terms, as “a state of complete physical, mental and social well-being.” The idea that health is a universal value and human right is reinforced in numerous international normative statements, from the 1948 Universal Declaration of Human Rights, the 1966 International Covenant on Economic, Social and Cultural Rights, to the 1978 Alma Ata Declaration on Primary Healthcare, which declared Health for All as a global goal by the year 2000. More recently, the 2012 Rio+20 Declaration on the Future We Want reaffirmed this value, recognizing health as “a precondition for, an outcome of and indicator of sustainable development.”<sup>2</sup> These ideas have not been limited to words on paper, but rather, have inspired concrete action. For example, the mobilization of considerable human, political and financial resources behind the Millennium Development Goals, a majority of which focused on health or its immediate determinants, posited global responsibility for achieving a minimum standard of life, dignity and well-being for all.<sup>3</sup> Finally, recent momentum around achieving universal health coverage in every country of the world underscores the widespread importance placed on health. These developments suggest that a global society characterized by some degree of solidarity among its members is not necessarily a radical proposition. Traces of it can already be discerned.

Despite the universality of health as a social value, however, current institutions of global governance fall far short of delivering on these aspirations. In other words, although the faint contours of a global society are emerging, there is no coherent social contract undergirding it.

Not incidentally, public health has been central to many national social contracts. Today in the advanced economies, the visible signs of health as an essential component of the social contract include institutions such as: national armies and police forces to provide

physical security; national health insurance to ensure access to at least a minimum level of healthcare; national unemployment and disability insurance, and pensions to provide a minimum level of income; special programs to ensure food, housing, healthcare and education to children; national regulatory authorities to ensure the safety of food, medicines and other goods; environmental agencies to mitigate the harmful health effects of pollution; labor and occupational health agencies to ensure safe working conditions; and national agencies for health research. Most of these institutions, if not all, are financed through taxation – that is, the mandatory transfer of resources from individuals to a common pool intended to serve the public interest.

What does the evolution of national social contracts suggest about what may be required at the global level?

## Function: Four Elements of a Global Social Contract

**WHILE A GLOBAL SOCIAL** contract cannot merely mimic those at national level, existing national experiences offer useful guidance on what might be needed (see Table 1). Building on Frenk and Moon's four functions of the global health system (mobilizing solidarity, managing externalities, providing global public goods, and stewardship),<sup>4</sup> below are four potential elements of a global social contract for protecting and promoting health.

**1. Resource pooling for social protection** (mobilizing solidarity): Social protection (also often referred to as social safety nets or social insurance) is intended to provide a minimum standard of living below which no member of society should be allowed to fall. Social protection measures often include minimum guarantees of healthcare, food, housing, education & training, and income for those unable to work. The concept of a global minimum standard is not new. As noted above, the MDGs included targets on reducing extreme poverty, maternal and child health, infectious diseases including universal access to HIV interventions, and education, among others. Specifically in the health sector, in 2009 the Taskforce on Innovative International Financing for Health Systems defined and estimated the costs of providing a minimum package of healthcare for all.<sup>5</sup> And in 2010 the chief executives of the UN system launched a social protection floor initiative, and created an advisory group led by Michelle Bachelet that published in 2011 a report that further detailed the concept of a global social protection floor, adopted the next year at the ILO Conference.

Proposals for a pooled global social protection fund to support implementation of such a floor have been advanced by scholars, intergovernmental organizations, and the UN Special Rapporteurs on food (Olivier de Schutter) and extreme poverty (Magdalena Sepulveda).<sup>6 7 8</sup> De Schutter and Sepulveda argue for a fund that would serve two functions: subsidizing costs for the Least Developed Countries and providing insurance against risk for all countries. Gradually, as countries graduate out of LDC (or LIC) status, the fund could shift in emphasis to a risk-pooling fund to help countries cope with volatility and shocks such as natural disasters, financial crises, or food price spikes.

As at national level, such funds would need to be predictable and guaranteed, strongly suggesting the need for binding norms and

methods of resource generation – whether through traditional national taxes or innovative financing mechanisms (e.g. financial transaction tax). Though few examples of binding norms for international contributions exist, there are precedents in the system of assessed contributions to UN agencies and other intergovernmental organizations. The 40-year persistence of the norm that wealthy countries should dedicate 0.7% of GDP to official development assistance – even if more honored in the breach than the observance – suggests it is possible to develop international norms for resource-sharing, albeit difficult to enforce.\*

**2. Regulation (managing externalities):** Regulations to protect public health are also needed to ensure well-being. Public health rules, such as on food and drug safety or air pollution, have historically been implemented and enforced by national governments' regulatory authorities. But when national regulation is inadequate, such as in situations of cross-border externalities, global norms and rules may be required. Examples of global rules for public health include the 2005 Framework Convention on Tobacco Control to counteract a globalizing tobacco industry; environmental treaties to regulate trade in harmful substances such as the 1992 Basel Convention on hazardous waste; WHO standards on medicines quality; and health-related provisions in other treaties, such as the 2001 Doha Declaration on TRIPS and Public Health or permissible health exceptions to other WTO agreements. However, in the absence of a hierarchical political authority, sovereign state compliance with these rules can be very difficult to enforce. In jurisdictions with weak regulatory capacity, it is also difficult to ensure compliance of private actors to such norms. Furthermore, despite the proliferation of international rule-making over the past two decades, many important threats to public health remain under-regulated at the international level, such as environmental pollutants (including but not limited to greenhouse gases), marketing of unhealthy food, beverage and alcohol, and migration of health workers. Stronger norms with more robust enforcement mechanisms are likely to be required.

**3. Global public goods:** Ensuring the adequate provision of global public goods, such as information, knowledge, rules, security or financial stability, demand robust forms of cooperation between sovereign nation states – but this remains the rare exception rather than the rule. At national level, governments

play a central role in ensuring the provision of public goods due to widely-recognized failures of private markets to do so. (Public goods are defined as goods that are non-rival (consumption by one person does not reduce the amount of good available to others) and non-excludable (no one can be excluded from consuming the good) – non-excludability makes it difficult for a private provider to recoup the costs of supplying the good, leading to under-supply.) Existing institutions for global public goods include UN peacekeeping operations, early warning systems for natural disasters such as tsunamis or outbreaks of infectious disease, open access policies for scientific research publications,<sup>9</sup> or WHO's rule-making function. Proposals for a global R&D treaty or fund are one example of a missing institution for global public goods. Since all populations are expected to benefit from global public goods, there is a strong rationale for all countries to contribute according to their ability to pay.

**4. Legitimate Global Governance (stewardship):** Building an effective global social contract will require more legitimate approaches to global governance. A social contract involves not only population welfare, but also the consent of the governed, which provides legitimacy and authority to those who govern. This very basic concept has significant implications for how global policy decisions are made. Good governance is not easy, but it's not rocket science. Some of the principles are quite well-established: basic human rights for all, equal participation, fair representation, transparency and public accountability. Yet many, if not most, processes of global governance do not reflect these basic principles. Building a legitimate global social contract will require changes in the norms, rules and decision-making processes of global governance (see also Paper 2 on transparency).

## Form: What Could a Global Social Contract Look Like?

**A GLOBAL SOCIAL** “contract” does not have to mean a written document such as a formal treaty or constitutional text. Rather, a global social contract could be comprised of a set of formal and informal norms and rules that lay out expectations of the rights and obligations of the members of a society. Some of these already exist and are explicitly codified, such as the rights laid out in the major human rights instruments. Some may not reach the status of formal international law, but still have strong normative force, such as the Declaration of Helsinki on the ethics of medical research. Others have yet to be articulated, debated, negotiated or agreed – precisely where gaps in the contract need to be filled in.

In the absence of a global government, for now and the foreseeable future, a single overarching text seems neither realistic nor desirable. The scope of topics is too broad and the willingness of governments to negotiate such sweeping new international laws too limited. Yet, we need new institutions – new funds, new rules and regulations, new courts, new enforcement mechanisms, and new decision-making procedures – to better protect the health and well-being of a global society. A layered, piece-by-piece construction of a global social contract that gradually solidifies norms on universal rights and responsibilities may be the most practical approach.



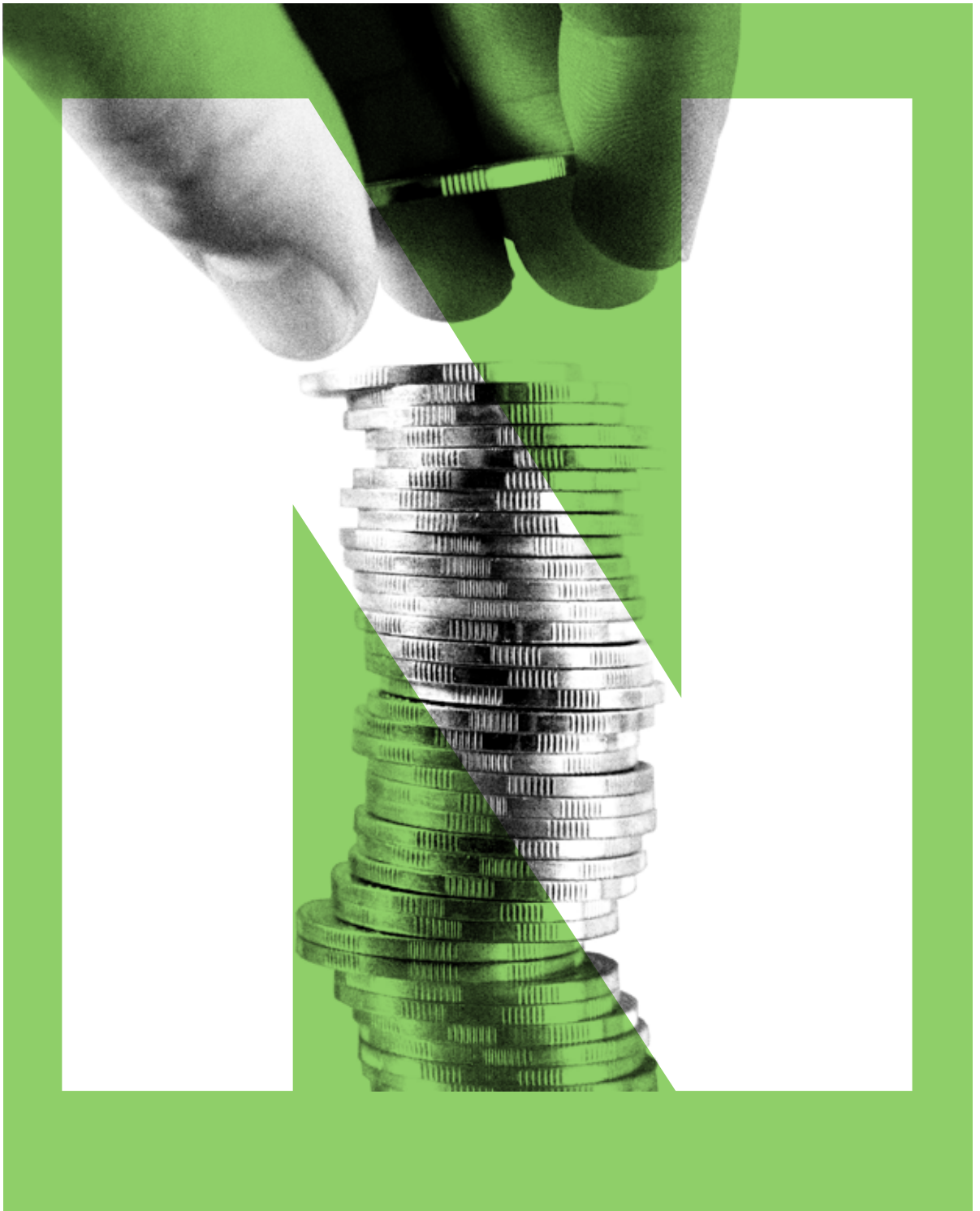
## Conclusions

**THE TRACES OF A GLOBAL** society are beginning to emerge, and globalization may present the opportunity to build stronger social ties between far-flung communities around the world.

While there is not yet a set of institutions that could reasonably be called a global social contract, its contours can be glimpsed in evolving norms around minimum standards of a decent life, universal human rights as well as cross-border obligations, and rules that aspire to create a better-governed world. Because of its universality, health may be a powerful central pillar around which to begin building a more concrete, operational global social contract.

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# Introduction

## By Sudeep Chand\*

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this paper.

**HEALTH SYSTEMS FACE** great challenges identifying needs, raising resources and spending fairly. They need to be adequate, sustainable, efficient, define a clear set of entitlements and above all be acceptable. Equity is an increasing priority, but the history of financing health systems shows this can be elusive. As Universal Health Coverage (UHC) takes centre stage, people who need care find significant obstacles in accessing quality services.

A recent report from the Rockefeller Foundation, Save the Children, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) identifies emerging policy lessons for equity in low- and middle-income countries (Brearley 2013):

- Mandatory, progressive prepayment mechanisms including revenues from taxation and the elimination of out-of-pocket spending.
- Risk and resource pools consolidated to help redistribution.
- A universal benefit package designed to meet the needs of the poorest.
- Enabling factors, notably political leadership and mechanisms for accountability.

This paper explores these themes by asking basic questions to raise issues for debate at the seminar 'Bridging a Global Health Social Contract for the 21st century.'

1. How much does it cost?
2. Who should pay?
3. What should we buy?

## How Much?

**\$5.3 TRILLION WAS** spent on health care across the globe in 2010; 90% in high- and high-middle income countries (Mattke 2011). In low-middle and low-income countries, 94% came from domestic sources, 6% from external sources. Domestic funding is the predominant source of funding even in low-income countries – contributing on average 72% of total health expenditures. Development assistance for health (DAH) accounts for more than 50% of total health expenditure in only four countries; however, in another 21 it exceeds 25% (Moon & Omole 2013).

The last 10 years have seen a threefold increase in spending from both domestic and external sources. However marked variation is seen between countries at similar levels of income, whether grouped as high-, middle- or low-income. A recent report focusing on countries in the WHO European Region showed that while some had been able to maintain their health spending during the current economic crisis, others had seen their health budgets cut; in Latvia, for example, government spending on health prevention and promotion activities fell by 89% between 2008 and 2010.

The situation is more acute in countries home to the ‘bottom billion’. On the one hand, the global financial crisis affected their economic growth much less than rich countries. On the other, their low starting level of national income has limited their ability to increase health spending to levels necessary to assure universal coverage with even a basic set of needed health services, or to ensure financial risk protection for the population. In 2010 low-income countries spent only \$32 per capita on health, including public and private spending and that received from external sources. But it is estimated that \$60 per capita is required to supply a basic package of care (Elovainio & Evans 2013).

# Who Should Pay?

## Domestic Funding

An analysis of 46 vulnerable countries, shows only six would be able to reach the level of per capita spending needed to ensure a basic package from their own domestic sources by 2015, assuming current projections of economic growth. Increased, predictable flows of external funding for health are still needed (Elovainio & Evans 2013). That said, scope remains for raising more resources domestically. Many low- and middle-income countries have already taken steps to do this, and their diverse experiences demonstrate it is possible to do this.

## Raising Domestic Funds

In five of the 46 countries, out-of-pocket payments (OOPs) represent less than 20% of total health expenditure (THE), and in five countries they represent more than 75% of THE. Thus, while countries can raise more revenue for health, they need to do it increasingly through mandatory prepayment mechanisms.

One option is to increase the priority that governments give to health when allocating government revenues. Countries differ markedly in the share of general government expenditure (GGE) going to health: in 25 of the 46 vulnerable countries, health receives less than 10% and in 10 countries it is even below 5%. The 2001 Abuja Declaration, adopted by the African Union heads of state, agreed a goal of 15%.

Countries also have scope to raise more revenue. Some strategies relate to tax reforms. Sierra Leone introduced a single goods and services tax (GST), which led to an increase in the share of government revenues relative to GDP, from 11.7% in 2010 to 14.9% in 2011. Tobacco and alcohol taxes and levies also exist in most countries. In the Philippines, such taxes aim at providing public funding for the current administration's universal health coverage program (Elovainio & Evans 2013).

Several low- and middle-income countries have increased government revenue promoting tax compliance and collection efficiency (e.g. South Africa, Kenya). Capital flight from low-income countries may be as high \$1trillion per year (Kar 2008). Hence, domestic government revenue could dramatically in-

crease through improved global governance on tax competition and tax havens, and increasing transparency, especially on payments related to natural resource extraction (UNSDN 2013).

### **External Funding**

Aid increased rapidly between 2000 and 2010 (from \$76 billion to \$124 billion). DAH rose even faster (from \$11 billion to \$28 billion, including non-governmental assistance). Governments remain by far the largest source of DAH, accounting for 70% of the total. But private sources of funding (including foundations, NGOs and corporations) have grown in importance, increasing from 8% of total DAH in 1990 to 15% in 2010, with the largest single contributor being the Bill & Melinda Gates Foundation (IHME 2012). Critiques of DAH have followed, including amounts falling short of commitments; volatility; conditionality and displacement of domestic resources; priorities diverging between donors and countries; and costs imposed from fragmentation (Ooms 2010, Harman 2012).

### **Raising External Funds**

The plateau of DAH over the last 2 years suggests we are not facing the end of aid as we know it. Alternative external financing mechanisms may at least support current levels. Proposals include new taxes, e.g. on financial transactions or innovative financial mechanisms; ways of reforming the institutions through which aid is channelled; and new proposals that go beyond the current system, including international law to codify mutual obligations and new institutions such as a Global Social Protection Fund.

An international levy on financial transactions (such as trade in equities or currencies) may raise between \$5 and \$400 billion per year, depending on the tax rate, the taxed item, and those countries that implement it. For instance, the recent European Enhanced Cooperation Arrangement between 11 countries, if adopted, may raise \$45 billion (Lopez 2013). However, it is unlikely health will be the primary beneficiary.



Other proposals involve managing financial flows (as opposed to raising more money), including building on the GAVI Alliance's International Finance Facility for Immunization, which front-loads investments by using long-term pledges from donor governments to sell 'vaccine bonds' in capital markets; or the Global Fund to Fight AIDS, Tuberculosis and Malaria's (GFATM, or Global Fund) Debt2Health initiative, which redirects funds for debt repayment by recipient countries to domestic health investments (Moon & Omole 2013). More ambitious is a Global Social Protection Fund to enable long-term resource transfers to poorer countries or populations, based on an expansion of the notion of social protection beyond the nation-state (Ooms et al., 2010).

### **Searching for Equity**

Pooling resources to protect people from the financial consequences of ill health is central to ensuring equity. In financing, equity means equal health care expenditure for equal need, and equal access to health care for equal need. Pragmatically, in low-income countries it refers to equal use of basic services and goods. But it is also dependent on equity in other factors that determine access, such as information, infrastructure, and service quality. And any reform needs to consider the side effects on vested interests and assess the winners and losers.

Although few governments would actively oppose calls for equity, hostile debates can emerge when establishing equity in health outcomes. Even rich countries with a strong social welfare tradition have struggled to reduce health inequalities in both care and outcome terms. Funds allocated on the basis of need often do not counteract the disadvantages associated with parental wealth, nutritional status, gender and location have had varying effects.

In emerging economies, there have been marked differences in their respective patterns of economic growth and access to health care. Equity within these countries will affect the global picture markedly given their population size and the presence of most of the world's poor. While statistically speaking the global health agenda is their domestic agenda, increasingly they have investment and development ties in low-income

countries. How should we assess the global commitment of large emerging economies that are facing insurmountable health challenges at home?

In poorer countries, the structure of the economy, with a large share of the population outside salaried employment, makes it difficult to enforce either income taxes or payroll taxes on most citizens. Thus, increasing the size of the compulsory prepaid pool of funds requires transfers from general revenues (sourced predominantly from consumption taxes (e.g. value added tax) in most low-and middle-income contexts), and the relative need for this grows in proportion to the size of the so-called “informal sector” of the population (Kutzin 2012).

Indeed it has been argued that equity in itself is required for efficient outcomes. A recent analysis reveals the deaths of 1.8 million children under-five and 100,000 mothers could be averted each year by eliminating within-country wealth inequities in coverage of essential maternal and child health interventions in 47 of the 75 Countdown to 2015 countries. This may reduce maternal and child mortality by one-third and one-fifth respectively (Brearley 2013).

Equity is also central the post-2015 agenda. The World Bank and WHO are proposing two targets relating to UHC — one to end impoverishment from health expenditures and another to achieve 80% coverage in the poorest 40% of the population of two composite measures for MDGs 4, 5 & 6 and non-communicable diseases. But inequities, particularly within fragile states, may expose ambitions of equitable financing. A ‘bottom billion’-focused aid system may arise as the number of emerging economies increases. Given the larger role of non-state actors in where governance is weak, information sharing and coordination between actors is vital if inequities in access are to be addressed, if only partially.

In emerging economies, outcomes such as halving the death-rate gap between the richest and the poorest, between the best-performing and worst-performing region, and between, say, ethnic minorities and the national average may be appropriate. Such equity targets could be calibrated on a country-by-country basis in the light of data available, and informed by national dialogue and the perspectives of civil-society groups working with the poor (Watkins 2013).

## What Should We Buy?

### Searching for Efficiency & Accountability

Without the availability of good quality services, financial risk protection will not be sufficient. At both the macro and micro level it is necessary to make sure that funds are allocated those services which translate into beneficial effects for health. And although a basic package can be defined, where, how and who delivers it can vary wildly.

Access and quality of services are in turn dependent on infrastructure, human resources, medicines, good data and good governance. Strategic purchasing is a useful instrument to optimize the use of available resources based on evidence of population needs and provider performance. However, high-income countries have diminishing returns on health spending. A potent mix of high-cost diagnostics, expensive surgery and new drugs add cost pressures, with mixed, often slight benefits for patients. In low-income settings, drug and vaccine prices can vary 90%. Using off-patent drugs and applying regional mechanisms for financing and procurement can reduce costs. Governments have an important role to play here in the efficient production, distribution and pricing of medicines.

Private-sector expertise may bring improvements in quality and delivery. Public-private partnerships may also encourage investment, protect innovation and support prompt access to new medicines. Governments need to assess what patented drugs they need beyond a basic package. Public health emergencies may require compulsory licenses where alternative interventions are not available and wholesale prices are extreme (Chand 2012).

Despite such complexities, coherent reform is possible. Thailand has been cited as an example where supply-side investments (building and upgrading infrastructure, introducing effective workforce policies) accompanied demand-side investments (monies channelled through the different pooling mechanisms) (Chatham House 2013).

## Conclusion

**THE RATIONALE FOR** an equitable health financing system is based in both human rights and economic arguments. Each year, direct payments for health services exclude 1.3 billion people from gaining access to health services and push 100 million people into poverty. Only when the percentage of out-of-pocket payments falls to 15–20% does the risk of poverty become negligible.

However, other determinants have a complementary role in enabling access, financial risk protection and defining outcomes. In building a global health social contract fit for this century, we must consider the risks that may undermine access to food, water, education and jobs. A key uncertainty is the global economy. Further deleveraging may precipitate a depression with a significant effect on both domestic and external health financing.

Population growth, urbanization, trade and development are in turn driving trends in consumption, physical inactivity and pollution. This means that the crude number of non-communicable diseases is set to rise. If UHC is to be sustainable, it will have to move beyond health care, to a broader, yet complex governance agenda that seeks to do no harm and knows when nutrition or jobs need to take centre stage.

It is best to invest now while costs are low. Community-based care offers improved coverage, sustainability and cost-effectiveness. Countries such as Brazil, China, Colombia, Ghana, Kyrgyzstan, Rwanda, Sri Lanka and Thailand have made great strides in coverage. We must be realistic, but given the marked variation already in place between countries, we have reason to be ambitious (Chand 2012).

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• **IN THE DAYS** leading up to the announcement of the 2013 Nobel Peace Prize, Edward Snowden and Chelsea/Bradley Manning had both made the shortlist of pundits and the public.<sup>a</sup>

• The Nobel announcement preceded the first ever Global Transparency Week from 24-31 October 2013, an international effort by a group of organizations concerned with increasing openness in aid and development to spotlight how transparency could be used as a tool for accountability.<sup>b</sup>

• Before 1990, only 14 countries had right-to-information (RTI) laws or regulations, but over 90 countries have them today, two-thirds of which were adopted since 2002.<sup>c</sup>

These three developments each signal the rapid emergence of a powerful norm around transparency. Information transparency is widely recognized as a central pillar in good governance. Better access to information can strengthen the accountability of decision-makers, enable broad public debate on critical issues, and address power imbalances. In an era in which technology allows for instant, low-cost, global information flows, RTI policies hold tremendous potential for improving the quality of global governance. However, norms on transparency at the national level have not yet translated into analogous policies or practices at the international level.

<sup>a</sup> Snowden was listed by some UK-based bookmaking houses (see <http://www.nytimes.com/2013/10/11/world/europe/malala-yousafzai-wins-sakharov-prize.html>) and Snowden and Manning were front-runners in The Guardian's readers' poll (see: <http://www.theguardian.com/world/poll/2013/oct/07/nobel-peace-prize-2013-pick-winner-malala-yousafzai>)

<sup>b</sup> See more here: <http://globaltransparencyweek.org/>

<sup>c</sup> Country counts vary depending on how right-to-information policies are defined, but multiple sources concur that the total is over 90. See Toby McIntosh 2011: <http://www.freedominfo.org/2011/10/foi-laws-counts-vary-slightly-depending-on-definitions/>. For a discussion of how RTI principles can be balanced with national security, see the Tschwane Principles: <http://www.opensocietyfoundations.org/briefing-papers/understanding-tschwane-principles>. I am grateful to Elina Suzuki for her research assistance on this topic.

**d** While countries are likely to have varied approaches to the degree of transparency they adopt in trade negotiations, confidentiality may be required as a pre-condition of joining certain trade talks, which can then override pre-existing domestic policies favoring transparency. Negotiating parties to the TPP have agreed to keep all documents related to the negotiation confidential throughout the process (<http://www.ustr.gov/about-us/press-office/fact-sheets/2012/june/transparency-and-the-tpp>). Such confidentiality may be used to block the release of documents under freedom-of-information requests. See, for example, USTR refusal to release documents they had classified as confidential, in response to a Freedom of Information Act request from the Center for International Environmental Law in 2000 regarding negotiations for a Free Trade Area of the Americas, a decision that was upheld by a federal court: <http://earthjustice.org/sites/default/files/FOIA.USTR13-06-07DC-CirOpinion.pdf>

**e** See descriptions of various approaches to transparency by the US (<http://www.ustr.gov/about-us/press-office/fact-sheets/2012/june/transparency-and-the-tpp>) and EU ([http://trade.ec.europa.eu/doclib/docs/2013/june/tradoc\\_151381.pdf](http://trade.ec.europa.eu/doclib/docs/2013/june/tradoc_151381.pdf))

**AN IMPORTANT EXAMPLE** is the world of trade policy, where secrecy seems to carry far greater normative weight than transparency. Intergovernmental negotiations over trade agreements have traditionally been carried out behind closed doors, both at bilateral and multilateral levels. For most of the 20th century, trade agreements primarily addressed technical questions such as tariff reduction schedules, were restricted to the least politically-sensitive sectors, and had limited impact on domestic policymaking.<sup>1</sup> However, since the 1980s Uruguay Round of trade negotiations that created the World Trade Organization (WTO) in 1995, the scope and enforceability of trade policy has increased dramatically. Trade agreements now involve a much broader range of issues of public interest, including workers' rights, environmental protection, and public health. Of particular concern in the public health community has been the impact on medicines prices of intellectual property obligations, whether those contained in the multilateral WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) or bilateral or regional treaties such as ongoing negotiations for a EU-India Free Trade Agreement or the Trans-Pacific Partnership (TPP). Recently, several high-profile challenges to domestic laws in Australia and the US filed at the WTO have also raised concerns that trade rules may restrict national policy space to regulate tobacco.

Despite widespread recognition that trade agreements touch on important questions of public policy, repeated calls from civil society, legislators, and scholars for increased transparency and public review of draft agreements have yet to change practices in a significant way.<sup>d</sup> While the degree of public and parliamentary consultation may have increased,<sup>e</sup> draft texts are still generally not released. The main counter-arguments are that too much transparency would undermine a government's negotiating strategy and also prevent any agreement from being reached, since industries that would be hurt by certain provisions would mobilize against them. The only way to prevent the protectionism that would result, goes the argument, is to shield policymakers from the pressures of industry lobbyists by allowing them to negotiate behind closed doors and strike a deal that would best serve the broader public interest. Such an argument, however, suffers from at least three weaknesses. First, it is common practice to involve industry representatives in trade delegations. Second, it is not only industry lobbyists protecting private interests

that may mobilize against a draft agreement, but also broader public interest groups that should be considered legitimate voices in democratic deliberations. Conducting trade negotiations in secret excludes them from participating in these debates. Finally, and relatedly, since trade agreements can create or amend national laws (*de facto or de jure*, depending on the national legal system), basic principles of democratic governance should apply. As US Senator Elizabeth Warren wrote to the US Trade Representative on the TPP, “I have heard the argument that transparency would undermine the Administration’s policy to complete the trade agreement because public opposition would be significant. If transparency would lead to widespread public opposition to a trade agreement, then that trade agreement should not be the policy of the United States.”<sup>2</sup>

The norm of confidentiality has its roots in an earlier era of trade policy. Yet such outdated norms continue to shape practices today. For example, the WTO TRIPS Council is restricted to governmental delegations and does not allow civil society or journalists even to observe the proceedings. The TRIPS Council is not a negotiating body creating new deals, but rather is charged with monitoring TRIPS implementation. Thus, even the main argument for why proceedings must be kept out of the public-eye – to protect delicate negotiations – does not hold. That said, it is important to note that the discussions are not shrouded in secrecy – a summary of the meeting is made available online by the Secretariat, minutes of the meetings are published several months later, and well-connected reporters or advocates can often get access to information much sooner.<sup>f</sup> Nevertheless, the practice highlights one way in which the norm of confidentiality, rather than transparency, continues to permeate trade policymaking.

With the increasing integration of the global economy, the types of public health issues likely to be affected by trade agreements will continue expanding. In addition to access to medicines and tobacco, trade agreements can impact food and nutrition policies, the regulation of toxins and pollutants, policies intended to combat climate change, and the cross-border provision of medical services, among others. At the same time, it is important to recognize that change has been possible. For example, access to information on the WTO (e.g. meeting minutes, disputes, dispute resolution decisions, and even some draft negotiating texts) has improved considerably, particularly in response to critiques

<sup>f</sup>For example, summary of October 2013 meeting available: [http://www.wto.org/english/news\\_e/news13\\_e/trip\\_10oct13\\_e.htm](http://www.wto.org/english/news_e/news13_e/trip_10oct13_e.htm)

regarding a democratic deficit in how it operates. But, with the exception of leaked texts and the occasional *ad hoc* release of draft text – which are a far cry from a system of democratic accountability – the negotiation of new trade rules remain a tightly guarded process. And plurilateral negotiations outside the WTO are far more secretive. Improving the transparency of the trade system will be critical for strengthening the protection of public health within the global economy.

**THE GLOBAL TRADE** system has attracted significant critical attention, but in many ways, there is reason for greater concern regarding the global investment regime. One reason why it hasn't yet attracted such scrutiny may be precisely because of the high degree of secrecy with which it operates. Unlike the trade regime, there is no central multilateral institution like the WTO for the global investment system. Efforts to create a multilateral agreement governing cross-border capital flows have not succeeded, and in its place has emerged a web of over 3100 bilateral, regional, or plurilateral investment treaties and other trade or economic agreements containing investment chapters (generally referred to as International Investment Agreements, IIAs).<sup>3</sup> Countries also seek new investment provisions in agreements such as the EU-India FTA or the TPP.

IIAs are agreements between governments, but generally allow a private party (an investor) to sue the state in which an investment was made for alleged violations of the IIA through "investor-state dispute settlement (ISDS)" arbitration processes. National laws, regulations or policy decisions that can potentially decrease the value of an investment – including but not limited to public health policies – have been challenged as violations of such agreements. ISDS can take place at a number of international arbitration bodies established for the purpose, with the most frequently used being the International Court for the Settlement of Investment Disputes (ICSID) housed at the World Bank. Cases are generally decided by a panel of three arbitrators who frequently come from law firms that also represent clients in other IIA cases, creating potential conflicts of interest.<sup>4,5</sup> The investment regime has recently attracted concern within the global health community because it has been used by firms to challenge national health-related policies: in 2010 tobacco firm Philip Morris sued the governments of Uruguay and Australia over expected losses linked to their domestic laws on cigarette packaging<sup>6</sup>; in 2013 pharmaceutical firm Eli Lilly sued the government of Canada under NAFTA for \$500 million over court decisions that invalidated patents on two of its drugs.<sup>7</sup>

The functioning of the investment regime has been critiqued on a number of grounds,<sup>8,4</sup> but most relevant here is that major aspects of its functioning are carried out behind closed doors. IIAs often give investors a choice between several sets of arbitration rules, and investors may choose which ones to apply to a parti-

cular dispute. Thus, policies and practices vary, but some overall practices dominate (For a more detailed discussion, see Johnson and Bernasconi-Osterwalder 2013<sup>9</sup>): for example, some rules permit the mere existence of a case to be kept confidential, such that the public may not even be aware that a domestic law has been legally challenged at an international tribunal. The proceedings are generally confidential and documents related to a dispute may also be kept out of the public domain. The final arbitration decision may also be kept confidential, even if it requires awards of large sums of public money (rewards have reached \$1.77 billion and claims can exceed a \$100 billion) or spurs changes to national laws. Nor are arbitrators bound by the precedent set by other tribunals or cases, providing significant leeway to a handful of individuals to make decisions with major public policy consequences behind a veil of secrecy. There has been a significant increase in (known) cases, from a handful per year in the 1990s to 30-50 per year over the past decade.<sup>4</sup> However, because of the confidentiality surrounding cases and the lack of a single tribunal or body of investment law, it is not publicly known how many cases have been filed, on what topics, and with what outcomes. Thus, public scrutiny of particular cases, treaties, or the overall system is very limited.

There have been some important efforts to increase the transparency of the system: A few countries – most prominently the US and Canada – have adopted transparency requirements in the IIAs that they negotiate.<sup>10</sup> And in 2013 the UN rules under which some arbitration takes place were amended to address a number of the abovementioned concerns.<sup>8</sup> However, while the new rules are quite progressive, these rules will only apply to treaties concluded after April 2014 and may only apply to new cases arising under existing treaties if the state parties pro-actively adopt them.<sup>9</sup> Nevertheless, the normative shift reflected in the rules is significant – Johnson and Bernasconi-Osterwalder characterize it as “a shift in the underlying presumption toward openness, rather than privacy.”<sup>9</sup> However, the extent to which the system will in fact become more transparent remains unclear. And many disputes arising under IIAs may use entirely different arbitration rules that have no transparency requirements. Thus, despite these important steps forward, overall, the lack of transparency in the ISDS system should remain a serious cause for public health concern.

<sup>9</sup> See 2013 UNCITRAL Rules on Transparency, available here: <http://www.uncitral.org/pdf/english/texts/arbitration/rules-on-transparency/pre-release-UNCITRAL-Rules-on-Transparency.pdf>

**TRANSPARENCY IS NOT** only an issue in transnational policy processes, such as the trade and investment regimes discussed above, but also in the practices of private actors that have significant public health impact. Of particular relevance for global health are the R&D processes for new health technologies such as drugs, vaccines, diagnostics and other medical devices (referred to as “medicines” for brevity). Two important elements of the R&D process are not publicly-disclosed by the pharmaceutical industry: the outcomes of all clinical trials and the specific R&D costs associated with a product, each of which is discussed in turn below.

#### **Clinical trials:**

A few public health advocates have long decried the industry practice of withholding negative clinical trial results from the public domain. This practice means that the body of published information on a product is likely to be positively skewed, painting an inaccurate and too rosy picture of the risks and benefits of a medicine. Concern over this issue has led to some measures, such as calls for registration of the existence of clinical trials in public databases<sup>h</sup> backed by a 2005 policy adopted by the International Committee of Medical Journal Editors (ICMJE) to only publish results of trials that have previously been registered. However, studies have found that these measures are neither enforced<sup>11</sup> nor adequate to ensure that negative results, in particular, are published. While the International Federation of Pharmaceutical Manufacturers’ Associations (IFPMA) has issued a position statement on registering and publishing clinical trial results, the position lays out voluntary norms and also makes exceptions for information that might harm the competitive advantage of a firm – presumably, negative results could fall under the broad umbrella of this clause.<sup>i</sup> The past year has seen increasing momentum pushing regulatory authorities to publish clinical trial results to which they have access following the 2012 publication of medical journalist Ben Goldacre’s book “Bad Pharma,”<sup>12</sup> which reported that half of trial results have not been published, and has helped to raise public awareness of this issue. The All Trials campaign (led by a coalition of health and research organizations) is driving a new push at the UK and EU levels for mandatory public disclosure of all clinical trial results. At the European Medicines Agency (EMA), a draft policy has been developed to disclose all clinical trial data it holds starting in January 2014. Pharmaceutical companies AbbVie

<sup>h</sup> One of the most widely-used registries is [clinicaltrials.gov](http://clinicaltrials.gov), hosted by the US government. WHO has also created an international database through the International Clinical Trials Registry Platform to facilitate searching national databases at <http://apps.who.int/trialsearch/>

<sup>i</sup> See “Joint Position” statement at [http://clinicaltrials.ifpma.org/clinicaltrials/fileadmin/files/pdfs/EN/November\\_10\\_2009\\_Updated\\_Joint\\_Position\\_on\\_the\\_Disclosure\\_of\\_Clinical\\_Trial\\_Information\\_via\\_Clinical\\_Trial\\_Registries\\_and\\_Databases.pdf](http://clinicaltrials.ifpma.org/clinicaltrials/fileadmin/files/pdfs/EN/November_10_2009_Updated_Joint_Position_on_the_Disclosure_of_Clinical_Trial_Information_via_Clinical_Trial_Registries_and_Databases.pdf)



and Intermune have sued the EMA to block release of such data, but on the other end of the spectrum, GlaxoSmithKline has voluntarily offered to publish all its clinical trial data. The EMA policy and GSK's decision signal the possibility of increasing the transparency of a system whose opacity has for decades gone virtually unchallenged – and suggests that the transparency norm is indeed a powerful tool for change.

**R&D costs:**

While the price of patented drugs has long been an issue of public concern, industry has kept an important component of that price – the R&D cost of a particular medicine – a tightly-guarded secret. Studies on average R&D costs have produced estimates of over \$1 billion per drug,<sup>13,14</sup> but have also attracted considerable controversy,<sup>15,16</sup> such that there is little agreement on average R&D costs, let alone on costs for a particular product. Public-private product development partnerships (PDPs) focusing on neglected diseases have been somewhat more transparent about costs, given that the bulk of their funding comes from public or philanthropic sources; however, such data are not necessarily applicable to broader R&D processes beyond the special case of commercially-unattractive neglected diseases. In general, reliable data on R&D costs remains elusive. R&D costs are an important piece of data for several reasons: first, R&D costs can help policymakers (e.g. health technology assessment centers) and the public decide on what is a “fair” price for a medicine to ensure the dual goals of efficient use of healthcare funds (whether public or private) and a fair reward for inventors. Second, a more accurate understanding of average R&D costs can help to design appropriate public policies to pay for, incentivize and reward research in a way that is more efficient and/or equitable than the status quo, including alternatives to monopolies such as prizes or patent buy-outs. This issue becomes even more important in light of recent debates among WHO Member States on how countries should share the joint burden of financing R&D.<sup>j</sup> Third, a transparent accounting of R&D investments can clarify when important contributions have come from publicly-financed research, such as government grants or academia – which in turn may inform public decisions on pricing. All of these reasons, however, imply a shift in negotiating- and decision-making power from private to public hands, and it is perhaps no surprise that industry has tightly-guarded its R&D costs. While governments have a strong



incentive and the authority to require disclosure of R&D costs and investments, none has yet done so. Fortunately, recent progress on increasing the transparency of clinical trial results suggests that similar measures should be possible for R&D costs if there is sufficient political will.

# Proposals for change

**THESE CRITIQUES OF** the trade, investment and pharmaceutical R&D systems are not new. But the importance of transparency has arguably not received the attention within the global health community that it should. Here are three simple, interlinked proposals for how to tap into the growing power of the transparency norm in governance:

## 1. “Transparency in all policies”

Civil society organizations (CSO) and health campaigners could consider including a transparency plank in every advocacy platform – that is, to advocate for increased transparency regarding inputs and processes of policymaking in all issue areas (e.g. trade, investment, pharmaceutical R&D, food & nutrition, alcohol, environment, taxation, etc.).<sup>k</sup> The authority of governments to mandate transparency in the practices of both public and private actors should not be underestimated.

## 2. Stronger right to information policies at national level

There is considerable variation among the 90-some countries that have adopted RTI policies. Such policies can include the periodic release of documents, procedures for information requests, justification for any denial of such requests, and appeals procedures. In countries with weak RTI laws, advocates could push to strengthen them. There are also over 100 countries that have not yet adopted such laws, with Latin America, Asia, Africa and the Middle East (in descending order from least to furthest behind) lagging behind Europe and North America.<sup>l</sup> Advocates should push for the strongest possible RTI laws in these countries.

## 3. Stronger right to information policies at international institutions:

Stronger transparency policies at national level will surely translate into more transparency at the intergovernmental level – but that is not likely to be enough. Yet, with several important exceptions (notably the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and the World Bank<sup>m</sup>) major international institutions such as the World Health Organization, Global Alliance for Vaccines and Immunization, World Trade Organization, International Monetary Fund and World Intellectual Property Organization do not have RTI policies. Member States and civil society should push for intergovernmental organizations with important implications for health to adopt strong RTI policies and to operate on the presumption of transparency as the baseline. In

<sup>k</sup>For a useful example of how transparency can be assessed, see the Global Accountability Reports (2003-2008) of the One World Trust: [http://www.oneworldtrust.org/publications/cat\\_view/65-global-accountability-project/83-main-reports](http://www.oneworldtrust.org/publications/cat_view/65-global-accountability-project/83-main-reports)  
<sup>l</sup>See [http://right2info.org/access-to-information-laws/access-to-information-laws-overview-and-statutory#\\_ftnref7](http://right2info.org/access-to-information-laws/access-to-information-laws-overview-and-statutory#_ftnref7)

<sup>m</sup>See the Global Transparency Initiative, which focuses on transparency at international financial institutions: <http://www.ifitransparency.org/>

some cases, RTI policies at the international level may also help to address weaknesses or the absence of such policies at national level. Adopting RTI policies is likely to strengthen the political legitimacy of international institutions, and to help them achieve their public interest goals.

## Conclusions

**THIS PAPER HAS** argued that transparency is critical for global health by offering three illustrations: closed-door negotiations over trade agreements, which can contain provisions that are harmful for public health; secretive investor-state dispute settlement processes of the global investment regime, which can tie the hands of governments to regulate for health; and pharmaceutical R&D, where lack of transparency can lead to skewed information on drug safety and efficacy, and provide a justification for unaffordable pricing. These are certainly not the only areas where transparency matters for health, but they illustrate the types of issues at stake.

The mere existence of an RTI policy does not guarantee disclosure of the relevant information – pro-active use of such policies by civil society, journalists and academics is a crucial piece of the puzzle.<sup>n</sup> And even when transparency and information are available, they are not in and of themselves enough to change the status quo. Nor is perfect information transparency in all cases realistic or necessarily desirable. But in an increasingly interconnected world, they are – as Snowden reminded us – formidable tools for change that should be adopted more systematically in policymaking processes that impact global health. In light of the many intractable challenges in protecting health in global governance processes, the growing strength of the transparency norm means that broader adoption of RTI policies is relatively low-hanging fruit.

<sup>n</sup>See a useful compilation of information on implementation of the US Freedom of Information Act here: <http://www.wcl.american.edu/lawandgov/cgs/about.cfm>

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*WHO defines maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.*

**GLOBALLY, MATERNAL HEALTH** is improving. Since 1990 the number of girls and women dying during pregnancy and childbirth has declined<sup>1</sup> from 543,000 to 287,000 per year. But making quality maternal care a reality for all women remains a major global health challenge. Despite being one of the most pressing problems of the global health agenda it is difficult to understand why maternal mortality has received so little serious attention<sup>2</sup> from the different stakeholders involved (donors, high burden countries, policy makers, health professionals...) until recent times.

The Millennium Development Goals (MDG) agreed in 2000 among countries and development partners to reduce child mortality<sup>3</sup> (MDG4) and maternal mortality<sup>4</sup> (MDG5) have contributed to gain momentum and have accelerated some improvements in access and quality of healthcare through local and global initiatives around the world<sup>5</sup>. However, about 99% of maternal deaths occur in the developing world and most countries<sup>6</sup> are not on track to meet their targets to decrease the maternal mortality ratio (MMR) by 2015 i.e. the number of maternal deaths per 100,000 live births<sup>7</sup>.

Progress has been made: maternal deaths have declined almost 50 percent since 1990. Progress, however, has been slower than expected and uneven: some regions such as Eastern Asia, Northern Africa, South-Eastern Asia and Southern Asia have reported reductions of 40% or more. Southeast Asia has shown a 53% reduction (1990 to 2008), but is still host to a large number of maternal deaths, while the sub-Saharan region showed only a 26% reduction.

What are those women dying from? According to the estimates available<sup>8</sup> more than half of the total maternal deaths are due to (35%) haemorrhage (i.e. blood loss), (18%) hypertension (i.e. high blood pressure) and 8% of the maternal deaths are due to sepsis (i.e. blood infection). Unsafe abortions, whose contribution to the overall toll of deaths is difficult to deter-

mine by its own nature, account for 9% of maternal deaths. About a fifth of the maternal deaths (18%) are due to indirect causes such as malaria, HIV/AIDS, or cardiac diseases, and 11% to other direct causes (e.g. complications of anaesthesia, c-section, postnatal depression suicide). In fact, nine countries in sub-Saharan Africa where HIV infections rates among women are typically high have reported increases in maternal mortality over this time period.

The high proportion of maternal deaths due to entirely preventable and treatable causes reflects the limited access to and poor quality of basic maternity care including emergency obstetric care. Moreover, most maternal deaths result from one or more of the so called three delays<sup>9</sup>: in seeking care, in arriving at a health facility, and in receiving appropriate care. Moreover barriers to implementation of evidence-based practices<sup>10</sup> have also conspired towards achieving better maternal health outcomes. Until very recently despite the evidence that placed the greatest risk for women in childbirth and the postpartum period, interventions such as antenatal care or delivery care from traditional health agents, which by themselves do not contribute significantly to reduce maternal mortality, have been prioritized over more practical and strategic approaches based on proved facts such as providing professional obstetric care at childbirth.

Maternal mortality reduction has been getting more attention in the last decade than ever before, which has led to increased commitment and resources and it is also being promoted through a human rights approach. Achieving this vision involves facing challenges on many fronts and at a large scale: from strengthening weak health systems and changing beliefs and practices deeply entrenched in many societies, to improve education levels or putting into place pro-poor policies. Because gender inequality, poverty and lack of education are key determinants of maternal mortality improvements in these areas can help accelerate progress in maternal health.

Finally, maternal mortality is a key indicator of development because the level and the quality of care given to women before, during and after pregnancy, inside and outside the health system, reflects the relative value a given society concedes to women<sup>11</sup>.

## Maternal Health and the Equity Gap

*Equity is concerned with creating equal opportunities for health and with reducing health differentials to the lowest level possible, by eliminating or reducing those variations which result from factors that are both avoidable and unfair. A possible definition of equity in maternal health could be providing for women a fair opportunity to attain their full health potential as mothers, and not being disadvantaged from achieving it, if it can be avoided<sup>12</sup>.*

*“In most countries, MDG advances are failures from the point of view of inequities. If you look at the distribution, we have decreased maternal mortality, we have increased life expectancy – we have increased almost all outcome indicators – but in none of them has there been a decrease in the inequities.”*

Inequities in maternal health between and within countries remain vast. The maternal mortality ratio in developing regions is still 15 times higher than in the developed regions<sup>13</sup>.

The regions that bear the largest burden of maternal deaths in the world record 640 deaths per 100,000 live births (Sub-Saharan Africa) and 280 deaths per 100,000 live births (South Asia) respectively. In contrast high income countries have only 7-15 maternal deaths per 100,000 live births. Most maternal deaths occur in a small number of regions -- Sub-Saharan Africa and Southern Asia- and countries. Just 6 countries account for half of all maternal deaths worldwide<sup>14</sup>.

Over the last decade both donor and recipient countries have focused on improving national averages – one of the MDGs shortcomings- neglecting inequities within countries where huge inequities persist in access to and use of good-quality maternity care. Thus, despite improvement in almost all outcome indicators (decreased maternal mortality, increased life expectancy...) in none of them has there been a decrease in the inequities. It is the wealthiest segments of society in LMICs that have seen the greatest reductions in preventable mother and newborn deaths. Access to maternal care across social groups and geographic regions within countries is not a reality yet: uneducated women from the poorest households in rural communities and the poorly-served peripheral urban communities are less likely to benefit from life-saving interventions.<sup>15</sup> Although

evidence demonstrates that a set of basic interventions can prevent the majority of maternal and newborn deaths, from family planning for birth control to availability and accessibility to pre- and post-natal care and professionally attended delivery, those interventions do not have the necessary reach and quality, especially across the less well-off in LMICs.

The Countdown to 2015<sup>16</sup> initiative, by measuring the magnitude of inequities in maternity care interventions between richer and poorer populations, both within and across countries, has highlighted that those interventions that are more complex tend to be less equitably distributed<sup>17</sup>. A woman in the richest fifth of the population from one of the maternal mortality high burden countries<sup>18</sup> studied (54) is 4.6 times more likely to have a skilled attendant when giving birth – the most dangerous moment for mothers- compared to a woman in the poorest fifth of the population. Another indication of the magnitude of the problem is that although the median coverage of skilled birth attendance is slightly more than 60% for the countries studied (54), the coverage between these countries ranges from 10% to 100%, making it the least equitable intervention.

Finally, acknowledging that there are many commonalities in the successful implementation of policies and programs between High Income Countries (HICs) and LMICs – it is a body of knowledge that has been successfully applied for decades in the developed world- there is also an urgent need to adapt effective approaches to meet country-specific and low-resource settings challenges and to bridge the existing data gaps in the areas where most maternal deaths occur. Because each country's response varies depending on local epidemiology, existing coverage, health systems, and capacity.

## Is Evidence Informing (Maternal Health) Policy?

*“Progress is especially happening in countries where governments are using evidence to guide investment and policy decisions, and where stakeholders are working together effectively to create real change for women and children” - Countdown to 2015 (2013 Report)*

**RELIABLE AND UP-TO-DATE** information is a necessary component of any strategy aimed at improving health outcomes. Reducing maternal mortality is not an exception. The need for accurate monitoring of maternal mortality has been long recognised both to advocate for more resources and policy attention and to track progress. But the formulation of the MDG5 that set out quantifiable targets (reducing MMR by three quarters from 1990 to 2005) highlighted how challenging it was for a number of countries —namely the countries thought to have the highest mortality burden— to produce timely and accurate data on levels of maternal mortality that can indicate to what extent they achieve progress in reducing maternal deaths.

Measuring maternal mortality accurately is difficult in the absence of comprehensive registration of deaths and of causes of death. While most high-income countries have a nearly complete time series of vital registration data in LMICs many of those who are most vulnerable are never registered at birth or death<sup>19</sup>. As a result they live without having an identity and hence throughout their lives states make no provision for them. Beyond the moral question that this situation poses, it reveals the urgent need to improve the mechanisms to understand medical or social causes of death and to put in place preventive measures to avoid future deaths.

In order to address the gap in data availability on maternal mortality, WHO and other UN agencies published, in 1996, the first estimates of maternal mortality, including MMRs, numbers of maternal deaths and lifetime risk of maternal death. Different methodological approaches<sup>20</sup> have been used to estimate country-specific trends between 1990 and 2010, depending on the type of data available. Thus maternal mortality trends have been estimated from a variety of data sources from vital statistics when possible, to household or causes of death surveys, censuses, verbal autopsies<sup>21</sup>, surveillance systems or reproductive-age mortality studies<sup>22</sup>.

Although the availability of maternal mortality data has improved since the 1990s maternal mortality data are still relatively scarce across the developing world. What are the available data for analysis? The last estimates<sup>23</sup> revealed that 27 countries (15%) out of 180 have no nationally representative data using standard methodologies, 88 countries (49%) lack good complete civil registration data but other sources of national data are available and 65 countries (36% countries) with a complete and reliable civil registration system to determine maternal deaths. Remarkably over 80% of all births occur in countries where maternal cause of death data does not exist or are incomplete.

Trends for many countries are model-based because data are not routinely collected. Global and regional estimates of maternal mortality are developed using regression models approach to take into account the frequent underreporting and misclassification of maternal deaths. As a result there is considerable uncertainty in the estimates released. It is worthy of attention that some of the countries showing 40% or more decrease in their MMR over the 1990-2010 period such as Guinea Equatorial (-81%), Vietnam (-76%), Malaysia (-46) or Papua New Guinea (-41%) are among the group of countries lacking nationally representative data on maternal mortality.

The dearth of reliable information on pregnancies and birth outcomes has also equity implications. Disaggregated data and statistics are a prerequisite to ensure that resources, personnel and supplies are equitably allocated across a population. However where data is available, it is often 'distribution blind', failing to capture the socio-economic characteristics (i.e. education level, wealth quintile, location) of individuals. The quantity, quality and use of disaggregated data is critical to inform planning process, monitoring, evaluation and accountability. Better data may also stir the debate on existing measures that should also be considered reviewing such as the asset indices that are used to estimate wealth quintiles. As it has been noted<sup>24</sup>: *"In countries where 80% of the population is effectively poor, a breakdown by quintiles basically masks this ... because it makes you feel that to prioritise equity you should be focusing on just the bottom one or two quintiles, whereas actually almost the whole population is in need of social protection."*

Available quality cause-of-death data are crucial for health planning, improved decision making and prioritisation in maternal and perinatal health.<sup>25</sup> Considering that only a third of the world's countries have a complete registration system with adequate attribution of cause of death, it is imperative that countries with incomplete registration systems take steps to strengthen them. The High-level Commission on Information and Accountability for Women's and Children's Health has included among its 10 recommendations<sup>26</sup> one that is specific to improving measurement of maternal and child deaths. It requires that *"by 2015, all countries have taken significant steps to establish a system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys"*.

In order to be effective, however, on top of the data there must be a willingness to use the information<sup>27</sup> generated from the data to inform policies to not only improve access to maternal health services, but also the quality of these services. Information should guide actions to improve provision of quality healthcare to prevent future deaths<sup>28</sup>. However, while some progress has been made in identifying deaths, there is still a significant gap in the implementation of response systems for corrective action. Death reviews, the processes that provide opportunities to examine the circumstances around a mother's or child's death, as well as the immediate and contributing causes leading to it, have not been implemented in many LMICs despite its potential to generate evidence and inform action to improve health.

## Maternal Death Determination: the Role of R&D

For any health system a sound health management information system and robust data on vital events (pregnancies, pregnancy loss and deaths, births) that allow identifying gaps in antenatal and post-partum care coverage, quality of care and equity, is invaluable. Otherwise how can countries without civil registration plan, allocate resources, implement the necessary policies or programmes or evaluate them? And after decades of working with the limitations of incomplete data what evidence does the international development community have that funds have the desired effects on either mortality or poverty reduction?

The weakness in recording vital statistics is one of the factors that are hindering progress towards improving maternal and neonatal health<sup>29</sup>. There are critical knowledge gaps that in the short term can only be filled by developing methods to assist countries in bridging vital data gaps for monitoring the situation of women's and children's health. Innovation is necessary to create tools that will lead to better and more effective application of knowledge generated. A scientific approach is needed to identify, and evaluate the most appropriate strategies for scaling up quality data collection in order to strengthen health systems.

Complete Diagnostic Autopsies (CDA) is the current gold standard methodology to inform on cause of death. However conducting CDA is not feasible in many LMICs because of a number of reasons including the large proportion of deaths that still occur outside the health system, insufficient facilities or trained human resources, or cultural or religious barriers about the practice of post-mortem procedures. Several options to monitor maternal mortality have been proposed for areas that lack systems for data collection and analysis: censuses and surveys to measure pregnancy-related deaths at a national level, Reproductive Age Mortality Studies (RAMOS) in representative sample areas for direct measurement of deaths, or conducting large maternal mortality surveys using the sisterhood method, registration of births and deaths in sample areas or detailed health and demographic surveillance sites, nationally representative sample vital registration systems with verbal autopsy<sup>30</sup> (SAVVY). These systems focus on living women and their families rather than mortality statistics to provide data for evidence-based programmes.



However indirect methods like the verbal autopsy and clinical diagnosis are suboptimal is its accuracy, which depends largely on the quality of the diagnostic criteria, the type of diseases involved, the location of death, and the delay between death and verbal autopsy. Deaths associated with non-specific signs and symptoms are the most problematic and are an especially common issue for perinatal and neonatal deaths. Assessment of the cause of in-hospital deaths is generally based on the clinician’s diagnosis of the disease(s) that led to the fatal outcome. However, such estimations entail frequent misclassification errors. Indeed, when clinical diagnoses have been contrasted with post-mortem findings, rates of major clinical—pathological discrepancies have ranged from 10% to above 30%, especially in the diagnosis of infectious diseases.

**Figure 1**  
**An autopsy study of maternal mortality in Mozambique: The contribution of infectious diseases**

**A** Includes ten deaths with mycobacterial disease, two kaposi sarcoma, and one malignant lymphoma.  
**B** Clinically severe anaemia with no other cause of death and signs of cardiac failure in the autopsy.

**Source:** Menéndez C., Romagosa C., Mamudo R., Carrillo C., Saute F., Osman N., Machungo F., Bardají A., Quinto Ll., Mayor A., Naniche N., Dobaño C., Alonso PL., Ordi J. 2008. “An autopsy study of maternal mortality in Mozambique: The contribution of infectious diseases,” PLoS Medicine 5(2): e44.

The aim of the study<sup>31</sup> was to describe the causes of maternal death in one of the regions with the highest maternal mortality rates. The descriptive analysis of maternal death autopsies performed during 2002 - 2004 in the Central Hospital of Maputo, Mozambique, a tertiary reference level for the whole country found that infectious diseases accounted for more than half (56%) of the causes of maternal deaths even though there are effective treatments existed for all of them. Being the first cause HIV/ AIDS infection (13%), followed by bacterial pneumonia (12%), severe malaria (10%) and bacterial meningitis (7%). Obstetric complications accounted for 38 % of the causes of maternal deaths.

Category	Cause	n	(%)
Obstetric complications	Haemorrhage	23	(16,6)
	Puerperal septicaemia	12	(8,7)
	Eclampsia	12	(8,7)
	Post-caesarean septicaemia	2	(1,4)
	Ectopic pregnancy	2	(1,4)
	Acute fatty liver of pregnancy	1	(0,7)
	Amniotic embolism	1	(0,7)
Nonobstetric conditions	HIV/AIDS-related contidions <sup>A</sup>	18	(12,9)
	Pyogenic bronchopneumonia	17	(12,2)
	Severe malaria	14	(10,1)
	Pyogenic meningitis	10	(7,2)
	Neoplasia	4	(2,9)
	Other septicaemia	3	(2,2)
	Fulminant hepatitis	3	(2,2)
	Decompensated cirrhosis	2	(1,4)
	Mycobacterial disease	2	(1,4)
	Pulmonary hipertension	2	(1,4)
	Anaemia <sup>B</sup>	1	(0,7)
	Digestive haemorrhage	1	(0,7)
	Alveolar proteinosis	1	(0,7)
	Unknown	8	(5,8)
Total		139	(100,0)

Despite these key limitations, verbal autopsies are the only source of data for cause of death in many settings, and their practice and improvement should therefore be encouraged.

In the present scenario of unfeasibility of conducting routinely complete diagnostic autopsies in LMICs, and suboptimal indirect methods such as the verbal autopsy<sup>32</sup> or clinical diagnosis, the development of feasible and more straightforward direct methods to ascertain the cause of death has become a research gap to be addressed. The concept of minimally invasive autopsy (MIA) as an alternative to classic complete diagnostic autopsy has been proposed.

MIA includes the use of more acceptable; less invasive imaging techniques such as magnetic resonance imaging (MRI) or computed tomography (CT) scan coupled with the performance of targeted diagnostic biopsies of key organs. Although little experience has been gained with such techniques so far, they have been shown to produce reliable and comparable results to the complete diagnostic autopsy in developed countries<sup>33</sup>. A further advantage of the method is the chance to improve our understanding of the pathogenesis of diseases that need human samples to be studied fully.

However, in its present form, minimally invasive autopsy is not a feasible technique in resource-poor settings. Thus, procedures to make minimally invasive autopsy feasible and acceptable in developing countries need to be defined and standardised, including the use of low-cost and portable imaging devices, the number of organs that need to be sampled, the preferred routes to obtain contamination-free tissue, and the specific pathology and microbiology procedures that can provide relevant information related to the cause that underlies death.

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## Figure 2

The CaDMIA project aims to design and assess the performance of MIA tools for investigation of infectious causes of death, and to evaluate the acceptability and feasibility of using such tools in different cultural, religious and geographical backgrounds.

A validation exercise is being undertaken to compare the diagnostic reliability of a methodically predefined minimally invasive autopsy device against the gold standard of complete diagnostic autopsy in two tertiary hospitals (in Maputo, Mozambique, and Manaus, Amazonas, Brazil), and to explore the potential use of classic and advanced microbiology techniques to further investigate infectious causes of death in patients of any age. Such a minimally invasive autopsy device would need to balance out the best possible practices with the challenges of working in resource-poor settings, and also consider its future global applicability. In this respect, uncertainties related to the communities' perception and acceptability of such a method, and the feasibility of actually implementing it in basic clinics or even in the community, needs to be explored rigorously.

Social sciences research to complement the validation exercise has started in rural and urban areas in five countries (Mozambique, Gabon, Kenya, Mali, and Pakistan) and should provide the necessary answers and approaches for the future implementation of this method in resource-poor settings.

The confirmation that MIA is an acceptable, feasible, valid and reliable tool to inform on the cause of death in all age-groups would be a major public health achievement. It would allow a more robust surveillance of those infectious diseases with major mortality burden, and consequently, improved health planning and more targeted prioritization of available resources.

It would also strengthen the validity of contemporary and future models and cross-disease burden estimates, which are presently hampered by insufficient inputs of raw data. Such a method could conceivably shed a clarifying light on one of the most fundamental, puzzling, and unresolved epidemiological questions: what do people die from in developing countries?

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## Conclusions

**MATERNAL MORTALITY IS** concentrated among the most vulnerable women in LMICs, remaining a global health challenge despite the existence of effective interventions to prevent it. Since the 1980s it has been highlighted the role of complications related to or aggravated by pregnancy and childbirth in death rates among women of reproductive age and noted the inadequacy of attention paid to addressing these largely preventable deaths. Despite renewed interest and momentum global health indicators show that maternal health is still the area in which the greatest inequities persist.

One of the factors that conspire towards achieving progress is the absence of quality data on maternal mortality and morbidity. While for developed countries death registries and/or autopsy procedures generally provide very valuable and updated information, for the developing world very little scientifically based information is available on cause-specific mortality rates.

It is not reasonable to conclude that investment in any single area –such as improvement of data collection– will solve all the maternal health challenges ahead, however quality data on maternal mortality and morbidity are a prerequisite to improve maternal health outcomes. Perfect data are not essential for formulating health policies and programmes but better data collection and analysis when used to implement cost-effective action can accelerate progress in maternal health indicators.

Although the availability of maternal mortality data has improved since the 1990s, continued progress in data collection is critical both to advocate for resources and policy attention and to more precisely estimating country-specific trends to track progress in reducing maternal mortality. However the existing methods used to estimate the number and the causes of death are being increasingly questioned and the resulting uncertainty about the real burden of specific causes of death represents a major limitation in terms of prioritisation of effective public policies, evaluation and accountability.

The research community should and must take its commitment by developing alternative methods and validating new approaches to assist countries in filling data gaps aimed to monitoring the situation of women's and children's health. Only

in this way both the quality of vital statistics and the determination of cause of death data in low resource settings can be improved. This is one of the contributions that can help more accelerate progress in reducing maternal mortality. It would definitely be a step forward towards ensuring that a fair chance to go through maternity is given to any woman.

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**14** India, Nigeria, the Democratic Republic of the Congo, Pakistan, Ethiopia, and Afghanistan

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**22** Reproductive-age mortality studies (RAMOS) use triangulation of different sources of data on deaths of women of reproductive age coupled with record review and/or verbal autopsy to identify maternal deaths. Based on multiple sources of information, RAMOS are considered the best way to estimate levels of maternal mortality.

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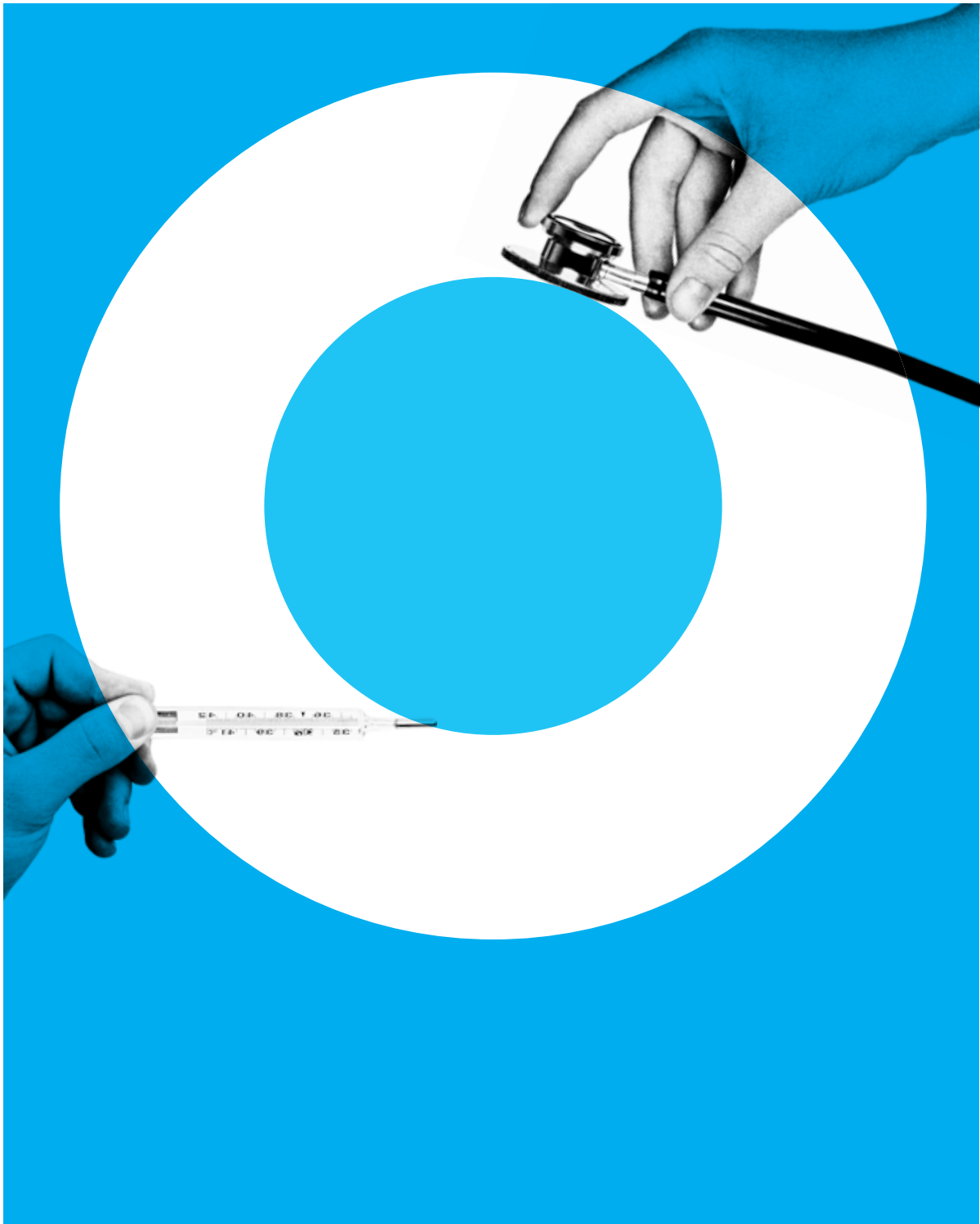
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**Beyond Health Aid:  
Would An Interna-  
tional Equalization  
Scheme for Universal  
Health Coverage  
Serve the Interna-  
tional Collective  
Interest?**



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The conceptualization of this paper started at a workshop on global social protection, organized by the Hélène De Beir Foundation and medico international in Berlin in May 2012, by Alan Whiteside, Attiya Waris, Gorik Ooms and Rachel Hammonds. Gorik Ooms wrote a first draft, revised by Bart Criel and Wim Van Damme. All authors contributed to further revisions and endorse the final version.

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It has been argued that the international community is moving ‘beyond aid’. International co-financing in the international collective interest is expected to replace altruistically motivated foreign aid. The World Health Organization promotes ‘universal health coverage’ as the overarching health goal for the next phase of the Millennium Development Goals. In order to provide a basic level of health care coverage, at least some countries will need foreign aid for decades to come. If international co-financing of global public goods is replacing foreign aid, is universal health coverage a hopeless endeavor? Or would universal health coverage somehow serve the international collective interest?

Using the Sustainable Development Solutions Network proposal to finance universal health coverage as a test case, we examined the hypothesis that national social policies face the threat of a ‘race to the bottom’ due to global economic integration and that this threat could be mitigated through international social protection policies that include international cross-subsidies – a kind of ‘equalization’ at the international level.

The evidence for the race to the bottom theory is inconclusive. We seem to be witnessing a ‘convergence to the middle’. However, the ‘middle’ where ‘convergence’ of national social policies is likely to occur may not be high enough to keep income inequality in check.

The implementation of the international equalization scheme proposed by the Sustainable Development Solutions Network would allow to ensure universal health coverage at a cost of US\$55 in low income countries-the minimum cost estimated by the World Health Organization. The domestic efforts expected from low and middle countries are far more substantial than the international co-financing efforts expected from high income countries. This would contribute to ‘convergence’ of national social policies at a higher level. We therefore submit that the proposed international equalization scheme should not be considered as foreign aid, but rather as an international collective effort to protect and promote national social policy in times of global economic integration: thus serving the international collective interest.



According to Riddell, the principle that underpins foreign aid is simple: “Those who can should help those who are in extreme need” [1]. But Severino and Ray predict the end of foreign aid as we know it: the death of official development assistance (ODA) and its rebirth as global policy financing (GPF) [2]. Sumner and Mallet argue that the future of foreign aid, or ‘Aid 2.0’, will be characterized by co-financing global public goods and fighting poverty as a global public bad [3]. Glennie proposes ‘international public financing’ instead of foreign aid, and argues that international public financing “should not only be seen as support to other countries, but to the global commons” [4]. With regards to global health, Kaul and Gleicher argue that “[a]s the institution of the state has no full equivalent internationally, international cooperation has to happen voluntarily; and as past experience has shown, voluntary cooperation is more likely to happen when it makes sense for all, that is, if it is based on a clear and fair win-win agreement” [5]. For Kickbusch, “the best is yet to come” for global health, if it “strengthens its political ability to produce global public goods for health” [6]. What all these forecasts have in common is an expectation that ‘helping those who need help’ will no longer be the main engine of foreign aid; the international collective interest will drive international co-financing.

Meanwhile, the World Health Organization (WHO) proposes ‘universal health coverage’ (UHC) as a “single overarching health goal” for the next iteration of the Millennium Development Goals (MDGs) [7], but acknowledges that “[i]n lower-income countries, where prepayment structures may be underdeveloped or inefficient and where health needs are massive, there are many obstacles to raising sufficient funds through prepayment and pooling”, and that “[i]t is essential, therefore, that international donors lend their support” [8]. But why would ‘donors’—a misnomer when it comes to co-financing out of collective interest—co-finance UHC in low income countries? The international collective interest of infectious disease control is rather obvious, but it is not self-evident how ensuring “that people have access to all the services they need including those relating to [non-communicable diseases], mental health, infectious diseases, reproductive health etc.” [7], would serve the international collective interest. The ‘Meeting Global Challenges’ report of the International Task Force on Global Public Goods mentions “preventing the emergence and spread of infectious disease” as a “priority global public good”; it does not mention

‘improving global health’ or ‘reducing global health inequalities’ as a priority global public good [9].

The proposal by the Sustainable Development Solutions Network (SDSN) on health in the post-2015 development agenda expects high income countries to mobilize and allocate the equivalent of 0.1% of their gross domestic product (GDP) to international assistance for health [10]. All countries are expected to “make progress to allocating at least 5% of national GDP as public financing for health (with low- and middle-income countries reducing by at least half the gap between 5% of GDP and current public funding)”, domestically<sup>1</sup> [10]. This proposal may come across as yet another foreign aid proposal – coming with domestic financing conditions or expectations – but we contend that it has the characteristics of a (modest) international ‘equalization’ scheme that could serve the collective international interest. (Our examination uses the SDSN figures for illustrative purposes, but this does not mean we support all the proposed levels of allocation of GDP to public financing for health).

Equalization is a word used to describe mechanisms that are common to most federal countries and that are designed to ensure that sub-national jurisdictions (like the provinces of Canada or the ‘länder’ of Germany) can – in spite of their fiscal autonomy and differences in economic activity – provide comparable levels of public services [11]. The Canadian Constitution Act, for example, imposes equalization “to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation” [12].

The SDSN proposal is somewhat similar to an equalization scheme, in that it expects comparable levels of government revenue raising from all countries (instead of provinces), and it would ensure that all countries can provide at least basic levels of public health services. The SDSN proposal would not allow all countries to provide comparable levels of public health services, at least not in the short term. Over time, if GDP per capita levels would converge, and if cross-subsidies between countries would increase, an international equalization scheme would allow all countries to provide comparable levels of public health services.

<sup>1</sup> WHO data on ‘general government expenditure on health’ include mandatory social protection contributions. It is not entirely clear if SDSN includes these contributions as well, when it proposes that all states allocate the equivalent of 5% of national GDP as public financing for health, but we think it does: when it discusses financing in these words: “This has been attributed to the compulsory nature of general taxation and other government revenue sources (e.g. royalties on the exploitation of natural resources) and social health insurance contributions” [10]. We therefore used WHO data on ‘general government expenditure on health’ to assess how far states are removed from the SDSN target for domestic public financing, after excluding external resources proportionally.



Would an international equalization scheme be possible, without an international government? According to Holst, The European Social Fund and the European Cohesion Fund can be seen as equalization schemes, while the European Commission, which manages these funds, is not a government [13]. Nonetheless, we do not have at the global level an international organization with the powers of the European Commission. But the purpose of this paper is not to explore how an international equalization scheme for universal health coverage could be organized; the purpose is to explore one of the arguments for such a scheme – an argument that has received limited attention in the context of international aid.

Why would high income countries voluntarily enter a international equalization scheme that – at least in the short term – will only cost them financial contributions? Where is the “clear and fair win-win agreement” that Kaul and Gleicher are looking for [5]; where is Kickbusch’s global public good for health [6]? The SDSN emphasizes an expected ‘externality’ of UHC that highlights its global public good value, namely economic growth [9]. Other externalities of UHC have been suggested and examined for their global public good value elsewhere: infectious disease control, demographic control (encouraging the ‘demographic transition’ through improved health care), increasing security and decreasing pressure for migration [14]. They may all be valid and contribute to the political feasibility of the international equalization scheme proposed by the SDSN. In this paper, however, we want to explore a different externality, namely the impact that an international equalization scheme could have on the so-called ‘race to the bottom’.

For this purpose, we explore the double hypothesis that national social policies “face the threat of a ‘race to the bottom’” due to global economic integration, and that this threat can be reversed or mitigated through international social policies [15]. The global equalization scheme as proposed would be, if accepted, an international social policy. If all countries agreed to observe the minimum levels of domestic public health financing proposed by the SDSN, many would have to adapt taxation levels accordingly, and that could mitigate the downward pressure on taxation and social policy levels caused by the quest for competitiveness in a globalized market – or so we will examine.

To be clear, we consider the global equalization scheme proposed by the SDSN first and foremost as a practical implementation of the shared national and international responsibility enshrined in the human right to health [16], and we would support it even if it had no global public good value. But we contend that it would serve the international collective interest, and it should be considered and examined as an international collective effort to protect and promote national social policies, rather than as a new foreign aid proposal.

**An international equalization scheme for universal health coverage: implications for low, middle and high income countries**

The SDSN proposes that all countries “make progress to allocating at least 5% of national GDP as public financing for health (with low- and middle-income countries reducing by at least half the gap between 5% of GDP and current public funding)”, domestically [10].

To understand the financial implications of this proposal, we need to compare the proposed domestic public financing levels with the present domestic public financing levels. The WHO World Health Statistics 2013 report provides us with estimates of average total health expenditure as percentage of GDP in different income groups of countries, and with estimates of average government expenditure on health as percentage of total health expenditure, both for 2000 and 2010 [17]. For low income countries in particular, there is an additional correction to be made to examine domestic public financing levels: external resources for health are reported as percentage of total health expenditure; thus we cannot determine how much international assistance is included in government expenditure and how much international assistance is included in private health expenditure. Table 1 is based on the assumption that international assistance is proportionally allocated to government and private expenditure, and that means that low income countries were allocating, in 2010, the equivalent of 1.5% of GDP to domestic public financing for health.

This table shows that the SDSN proposal is very demanding for low income and lower middle income countries: they are expected to increase government expenditure on health from domestic resources from 1.5% of GDP to 3.25% of GP (to halve the gap between 1.5% and 5% of GDP). Upper middle income countries are expected to make additional efforts as well, while high income countries have, on average at least, already reached their target.

But low income countries – and some lower middle income countries – would also benefit from international transfers under the proposed international equalization scheme. To calculate how much they would benefit, we developed a spreadsheet based on data for 2011 from the Global Health Observatory of the WHO [18], and assumed that the equivalent of 0.1% of

GDP that high income countries are expected to contribute to international co-financing would be distributed in accordance with needs: the poorest countries would come first. First we assumed that all countries that are not yet allocating the equivalent of 5% of GDP to government expenditure on health would indeed halve the gap between their present spending level and 5% of GDP, than we distributed US\$45 billion – the equivalent of 0.1% of GDP of the ‘advanced economies’, according to the International Monetary Fund (IMF) [19] – starting from the poorest countries. Table 2 shows the results.

All low income and some lower middle income countries would receive international co-financing for UHC; the combination of increased domestic efforts and international co-financing would allow them to spend about \$55 per person per year on UHC. All countries not mentioned in Table 2 would be able to spend the same amount or more, from domestic resources only. Would that be sufficient? The Taskforce on Innovative International Financing for Health Systems estimated that, in low income countries, the costs of achieving the current health sector MDGs would be about \$50-55 per person per year [20].

Table 1 already illustrated that the effort expected from low and middle income countries is – in percentage of GDP – far more substantial than the effort expected from high income countries. According to our estimates, all low and middle income countries together are expected to increase general government expenditure by about \$267 billion, or six times more than the effort expected from high income countries.

Figure 1 illustrates the additional domestic effort expected from Uganda and Kenya, two low income neighboring countries in Africa. Figure 2 illustrates the additional domestic effort expected from Bangladesh and India, two neighboring countries in Asia. Figure 3 illustrates the additional domestic effort expected from Argentina and Brazil, two upper middle income neighboring countries in Latin America.

Table 1

Health Expenditure in Low, Middle and High Income Countries  
(Data for 2010)

	Low income	Lower middle income	Upper middle income	High income
Total expenditure on health as percentage of GDP	5.3	4.3	6.0	12.4
General government expenditure on health as percentage of total expenditure on health	38.5	36.1	55.5	61.8
General government expenditure on health as percentage of GDP	2.0	1.6	3.3	7.7
External resources for health as percentage of total expenditure on health	26.3	2.5	0.3	1.1
General government expenditure on health form domestic resources, as percentage of GDP	1.5	1.5	3.3	7.6
General government expenditure on health as percentage of GDP, SDSN proposal	3.25	3.25	4.15	5.00

Source: World Health Organization, World Health Statistics 2013.

Table 2    Distribution of Equalization Transfers (Data for 2011)

Country	Present per capita government expenditure on health at average exchange rate (US\$)	General government expenditure on health as percentage of GDP after reduction of external resources	Minimum domestic general government expenditure on health as percentage of GDP, SDSN proposal
India	18.32	1.19	3.09
Bangladesh	9.71	1.27	3.14
Ethiopia	9.59	1.49	3.25
Pakistan	8.02	0.64	2.82
Democratic Republic of the Congo	6.66	1.98	3.49
United Republic of Tanzania	14.75	1.69	3.35
Uganda	11.15	1.81	3.41
Myanmar	2.92	0.26	2.63
Kenya	14.34	1.09	3.04
Afghanistan	8.72	1.25	3.12
Mozambique	14.70	0.83	2.92
Nepal	12.98	1.83	3.41
Madagascar	11.98	2.11	3.56
Niger	11.09	2.11	3.56
Malawi	22.71	2.93	3.96
Nigeria	29.19	1.85	3.42
Burkina Faso	18.70	1.92	3.46
Mali	20.25	2.29	3.64
Burundi	7.63	1.51	3.26
Guinea	8.13	1.43	3.21
Cambodia	11.50	1.08	3.04
Sudan	29.40	2.27	3.64
Chad	9.55	0.99	2.99
Rwanda	35.58	3.28	4.14
Côte d'Ivoire	21.14	1.60	3.30

Minimum domestic per capita government expenditure on health, SDSN proposal, at average exchange rate (US\$)	Gap between minimum domestic per capita expenditure and US\$55	Equalization transfers required (in thousands of US\$)	Population (in thousands of people)
47.24	7.76	1,220,000	9,463,809.96
22.37	32.63	153,000	4,991,904.92
11.60	43.40	89,393	3,879,572.30
33.37	21.63	176,000	3,806,852.47
8.06	46.94	63,932	3,001,283.16
17.15	37.85	46,355	1,754,549.09
15.29	39.71	35,148	1,395,846.96
29.62	25.38	52,351	1,328,480.95
24.57	30.43	42,028	1,278,957.14
18.24	36.76	29,105	1,069,823.02
15.59	39.41	24,581	968,847.64
20.72	34.28	27,156	931,027.03
16.59	38.41	21,679	832,587.08
13.44	41.56	16,511	686,172.11
14.63	40.37	15,458	624,066.51
51.20	3.80	164,000	623,569.96
19.78	35.22	15,995	563,322.38
23.85	31.15	14,417	449,024.64
8.72	46.28	9,540	441,493.12
16.03	38.97	11,162	434,953.54
27.35	27.65	14,606	403,917.74
44.89	10.11	36,431	368,314.98
24.62	30.38	12,080	366,939.02
24.13	30.87	11,144	344,008.31
38.68	16.32	19,390	316,452.49

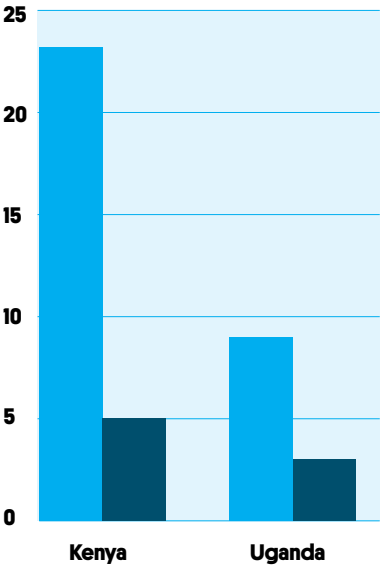
Country	Present per capita government expenditure on health at average exchange rate (US\$)	General government expenditure on health as percentage of GDP after reduction of external resources	Minimum domestic general government expenditure on health as percentage of GDP, SDSN proposal
Haiti	25.20	2.45	3.72
Benin	19.55	1.59	3.30
Cameroon	21.23	1.56	3.28
Sierra Leone	12.34	2.72	3.86
Eritrea	6.78	0.39	2.69
Togo	23.45	3.46	4.23
Tajikistan	15.99	1.46	3.23
Liberia	17.34	2.62	3.81
Central African Republic	9.49	1.27	3.14
Viet Nam	38.25	2.66	3.83
Senegal	39.05	3.00	4.00
Yemen	18.45	1.09	3.05
Lao People's Democratic Republic	18.11	1.04	3.02
Gambia	14.82	1.25	3.12
Guinea-Bissau	9.97	0.92	2.96
Kyrgyzstan	42.52	3.46	4.23
Mauritania	34.95	3.01	4.00
Timor-Leste	33.11	1.78	3.39
Comoros	24.60	1.81	3.40
Zambia	52.15	2.66	3.83
South Sudan	13.46	0.55	2.78
Sao Tome and Principe	39.02	1.92	3.46

Source: World Health Organization, Global Health Observatory data repository (consulted April 2014), SDSN proposal.



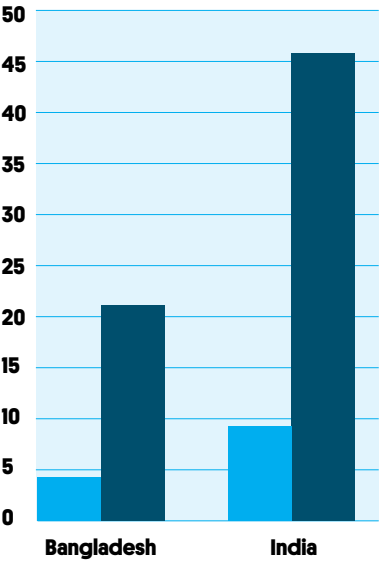
Minimum domestic per capita government expenditure on health, SDSN proposal, at avera- ge exchange rate (US\$)	Gap between minimum domestic per capita expenditure and US\$55	Equalization transfers required (in thousands of US\$)	Population (in thousands of people)
27.01	27.99	10,033	280,808.39
26.47	28.53	9,780	279,012.07
42.78	12.22	21,156	258,549.98
14.04	40.96	5,865	240,231.21
14.62	40.38	5,933	239,554.77
23.70	31.30	6,472	202,574.69
30.24	24.76	7,815	193,501.05
10.74	44.26	4,080	180,582.19
15.12	39.88	4,436	176,923.50
53.33	1.67	89,914	150,470.00
44.78	10.22	13,331	136,176.99
49.27	5.73	23,304	133,454.66
40.09	14.91	6,521	97,238.62
19.52	35.48	1,735	61,566.39
17.53	37.47	1,624	60,854.17
46.44	8.56	5,403	46,269.47
42.87	12.13	3,703	44,920.14
30.99	24.01	1,096	26,316.01
27.53	27.47	700	19,227.96
54.61	0.39	13,634	5,319.01
54.63	0.37	10,381	3,846.39
52.55	2.45	183	448.22
			43,163,622.42

**Figure 1**  
**Present and Expected Public Financing of UHC in Kenya and Uganda, Per Person Per Year**



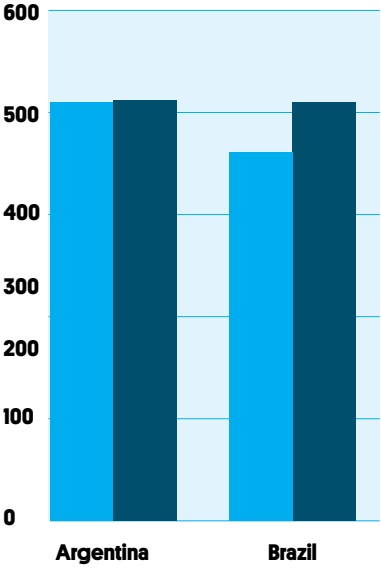
Present  
Expected

**Figure 2**  
**Present and Expected Public Financing of UHC in Bangladesh and India, Per Person Per Year**



Present  
Expected

**Figure 3**  
**Present and Expected Public Financing of UHC in Argentina and Brazil, Per Person Per Year**



Present  
Expected

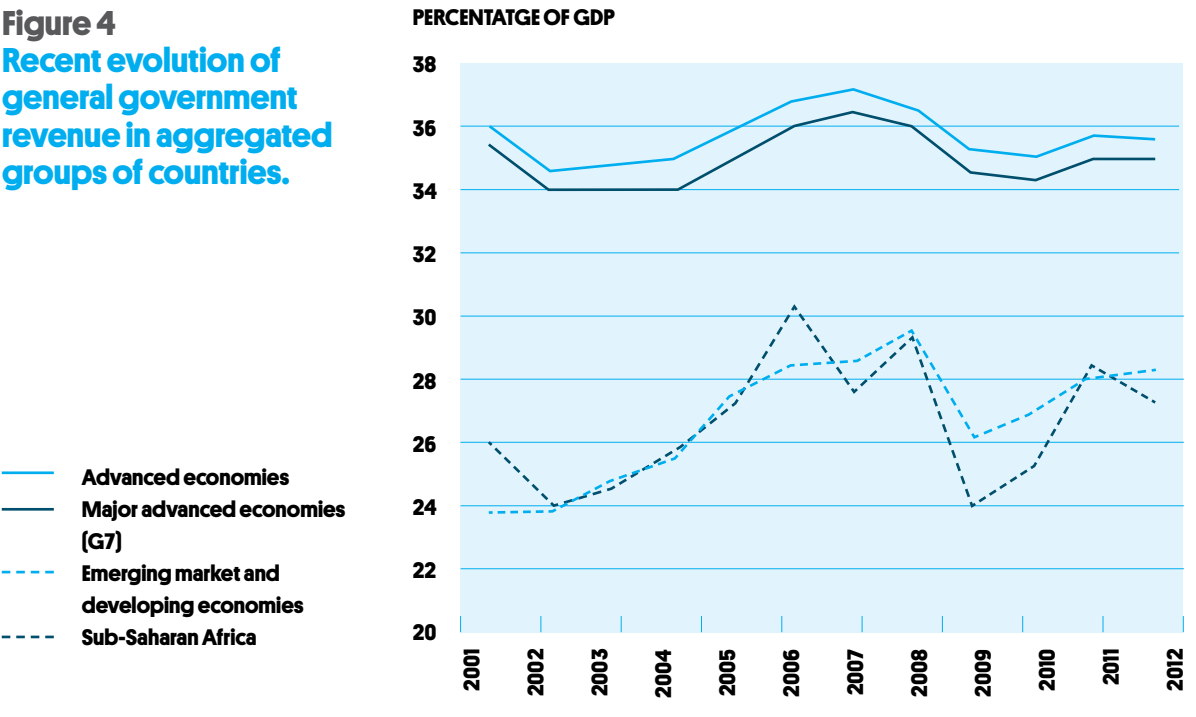
We used three pairs of neighboring countries with comparable levels of economic development because of the race to the bottom theory, which we will examine in the next section.

## Race to the Bottom, True or False?

In 1997, Rodrik warned against “social disintegration as the price of economic integration” [21]. One consequence of global economic integration is that some factors of the economy, like highly skilled workers and capital, can easily move from countries where they (or their owners) consider the tax burden as detrimental to their profits, to produce similar goods and services in countries where taxation is lower, and to sell these products in the markets of the countries they moved out from. Companies based in countries with a (relatively) higher tax burden are forced to compete with those in countries with a lower tax burden, which find it easier to attract investment and highly skilled workers. Governments of countries with higher tax burdens are therefore encouraged to reduce taxation levels, at times at the expense of national social policy. Conversely, governments wishing to enhance their national social policies may not be doing so, out of fear of becoming less attractive for investment. As Manmohan Singh, then Finance Minister and now Prime Minister of India, explained to Friedman: “In a world in which capital is internationally mobile, you cannot adopt rates of taxation that are far from the rates that prevail in other countries and when labor is mobile you also can’t be out of line with others’ wages” [22].

What is the evidence for this ‘race to the bottom’? The World Economic Outlook dataset of the IMF provides information about general government revenue in aggregated groups of countries [19]. As Figure 4 illustrates, the average general government revenue in ‘advanced economies’ (corresponding with the World Bank’s high income economies) seems to decrease very slowly – not a ‘race’ at all – from 35.9% of GDP in 2001 to 35.6% of GDP in 2012: that is a decrease of 0.3% of GDP. That seems may seem negligible, but it is three times the volume of international co-financing of UHC expected by the SDSN. The seven biggest economies or ‘G7’ followed the same path at a similar pace: government revenue decreased from 35.5% of GDP in 2001 to 35% in 2012, a decrease of 0.5% of GDP. But the average general government revenue of ‘emerging market and developing economies’ (corresponding with the World Bank’s low and middle income economies) increased from 23.7% of GDP in 2001 to 28.3% of GDP in 2012. Rather than a race to the bottom, we seem to witness ‘convergence towards the top’.

**Figure 4**  
Recent evolution of  
general government  
revenue in aggregated  
groups of countries.



A closer look at the same dataset – zooming in on the G7 countries – tells a more nuanced story. In France, Italy, and Japan, government revenue increased substantially. In Germany and the UK, it remained more or less stable, but in Canada, and the USA, government revenue decreased substantially. In the USA, representing almost half of the GDP of all G7 countries combined, government revenue decreased from 32.1% of GDP in 2001 to 29% of GDP in 2012: that is a decrease of 3% of GDP. In Canada, the ‘loss’ was even worse: from 45.1% of GDP in 2001 to 41.5% of GDP in 2012, or a 3.6% of GDP decrease.

As it appears, countries with a government revenue level hovering around 50% of GDP (e.g., France) are able to ‘coexist’ within a relatively open trade relationship with countries with a much lower government revenue level hovering around 30% of GDP (e.g., Japan), without facing a massive exodus of investment. Ambitious social policy can also improve competitiveness. Intergenerational social mobility – or “the extent to which individuals move up (or down) the social ladder compared with their parents” – is influenced by many factors, some of which

are “heavily affected” by social policy, including “policies that shape access to human capital formation, such as public support for early childhood, primary, secondary and tertiary education, as well as redistributive policies (e.g. tax and transfer schemes) that may reduce or raise financial and other barriers to accessing higher education” [23]. In other words, higher levels of taxation can allow for social policies that encourage intergenerational social mobility. Intergenerational social mobility indicates that more people succeed in developing and using their talents, and therefore one can intuitively expect that in countries with relatively high intergenerational social mobility, in part due to relatively high tax revenue and social policy, the average productivity would be relative high too. That could explain how countries with a government revenue level hovering around 50% of GDP are able to coexist within a relatively open trade relationship with countries with a much lower government revenue level. So, the premise on which the race to the bottom theory is built seems incomplete.

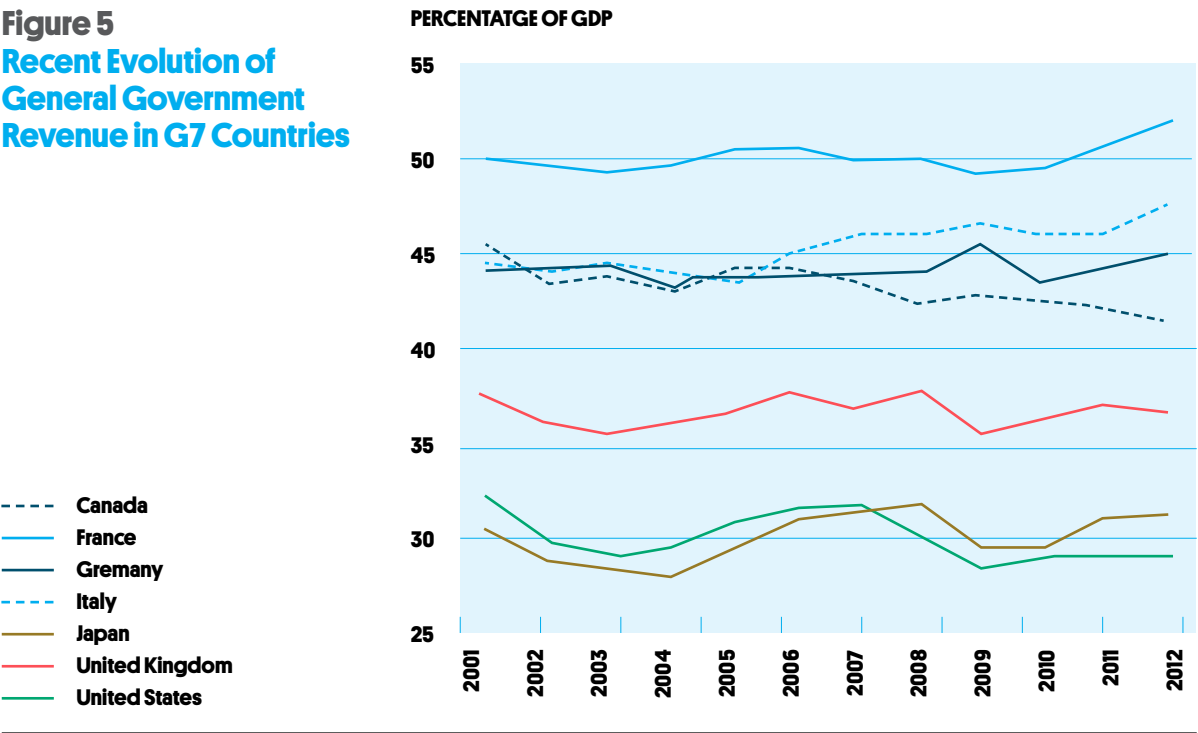
However, at least at some times, some governments decided to cut back on social policy with the intention of increasing the global competitiveness of the companies based in their countries. For example, in the early 1990s, John Major, then Prime Minister of the UK, admitted to “having created a paradise for foreign investors”, saying: “Europe can have the social charter. We shall have employment” [24].

According to Boix, there are two very different stories about the historical relationship between global economic integration and national social policy. One is based on the race to the bottom theory, already discussed above: “According to this position, the advanced world will end up adjusting its welfare state downward, forced by the competition of emerging economies” [25]. In the other story, “equally possible and empirically more compelling”, or so argues Boix, globalization promotes growth in all open economies, and “as soon as each economy reaches a certain level of prosperity, it expands political rights and democratizes”, which “in turn, leads to the creation of a social insurance system” [25]. But he concedes that because of global economic integration, “more mature economies may have to implement some policy adjustments in the short and medium run” [25], and mentions the UK and the USA as examples of countries with “quite flexible labour markets that adjust readily to world prices”, which “has resulted, so far, in lower levels of

structural unemployment yet higher levels of income inequality”, while “long-term unemployment, sustained by labour regulations and unemployment benefits, has rocketed in Europe, especially in those countries in its periphery (such as the Mediterranean basin), which combine weakly competitive industries and very generous welfare systems” [25]. Read in conjunction with Figures 4 and 5, Boix’ comments seem to confirm the argument that there has been a downward erosion, if not a race to the bottom, at least in high income countries.

Still according to Boix, the proponents of the race to the bottom theory are “split into two political camps”: the ‘protectionists’, who “would rather stop or even undo the process of international integration”, and the ‘federalists’, “by now mostly limited to parts of the academic world and some policy elites”, who “defend the construction of global political institutions to unify national regulations (such as labour or environmental standards) in order to counter the effects of excessive capital mobility and inter-state competition” [25]. Based on our support for the SDSN proposal, Boix would probably count us among the ‘federalists’.

**Figure 5**  
**Recent Evolution of**  
**General Government**  
**Revenue in G7 Countries**



But one does not have to be a firm believer in the race to the bottom theory, to argue for international social protection standards. Even if one agrees with Boix, one can still consider that it may be a smart economic option for high income countries to ‘invest’ in international social policy standards, to allow the ‘temporary adjustments’ to be shorter and less invasive, and to promote the transition towards higher social protection levels elsewhere. Even if global economic integration were indeed leading to convergence towards the top in the long term, it may be possible and wise to invest in the acceleration of that process.

Furthermore, even if government revenue in low and middle income countries seems to increase faster than the coinciding decrease in high income countries, it may not increase fast enough to mitigate income inequality. According to Milanovic, international income inequality is declining, if measured by comparing average income of countries, weighted for population size [26]. But if measured by comparing household income across borders, the data do “not show any clear trend over the period 1988–2005 for which we have detailed household survey data” [26]. The explanation is that while average income inequality between countries decreases, income inequality within countries increases. Firebaugh comes to similar conclusions and warns that “the transfer of inequality from across nations to within nations is likely to create new problems or exacerbate old ones within nation”, and that “[g]rowing income inequality within nations might raise the specter of growing civil unrest and terrorism by nonstate actors at the very time that the effectiveness of national governments is weakened by transnational structures” [27]. If we want declining income inequality between countries to lead to declining income inequality between people, social policy levels in low and middle income countries would have to increase faster than they currently are, while social policy levels in high income countries would have to be stopped from further declining.

## An International Equalization Scheme for UHC: Feasible or Wishful Thinking?

As discussed above, the international equalization scheme proposed by the SDSN comes with substantial incentives for low income countries like Uganda and Kenya. Uganda would be expected to double its domestic effort – from \$8 to \$15 per person per year – and Kenya would be expected to almost triple its domestic effort – from \$9 to \$24 per person per year. But Uganda would receive \$40 per person per year from the equalization scheme, while Kenya would receive \$31 per person per year from the scheme.

There would be an additional benefit for both Kenya and Uganda. The Government of Kenya may be reluctant to increase government revenue, out of fear that investments will move to neighboring Uganda, for example. And the Government of Uganda may be reluctant to increase government revenue, for exactly the same reason. According to the Tax Justice Network Africa and ActionAid, Kenya, Rwanda, Tanzania and Uganda already are involved in a regional tax competition [28]. If all these countries progress together at a similar pace, none of them would benefit, and none of them would have to fear that their neighbor would benefit to their detriment.

Neither Argentina nor Brazil would receive international cross-subsidies under the international equalization scheme. But Argentina would benefit from Brazil being expected to increase government revenue, while the Government of Brazil may feel more comfortable in doing so – considering expectations from constituencies in Brazil – if it were assured that the Government of Argentina would not use the opportunity to lower its government revenue for the sake of luring away investment.

The real challenge seems to be a problem of ‘free riding behavior’. We can consider the problem of maintaining or increasing competitiveness at the expense of social policy – either decreasing social policy, or not increasing social policy to levels desired by most people – as ‘a tragedy of the commons’. The commons, or ‘common pool resource’ (CPR), is ‘global potential government revenue’. Governments that reduce taxation levels or delay the increase of taxation levels are obviously not trying to get rid of government revenue, they are trying to attract potential government revenue – taxable economic activity – from elsewhere, or trying to prevent it from fleeing. Even if we consider the present evolution of government revenue as a convergence rather than a race to the bottom, there probably is a loss of



global potential government revenue due to governments holding each other back. That means that the international community needs a ‘collective choice arrangement’ [29]; countries need to agree on what reasonably comparable levels of taxation and social policy are, which is exactly what the SDNS proposal is proposing (if only for health care). It would only work if all countries participate: Argentina and Brazil need to be sure that Uruguay and Paraguay join the collective choice arrangement, Kenya and Uganda need to be sure that Rwanda and Tanzania join, and so on. But some countries are likely to opt for free riding: every country would benefit from a collective effort of increasing government revenue and social (health) policy, but an individual country could benefit even more from adopting a slightly lower level than the agreed level, thus enjoying the benefits of somewhat higher social policy and improved competitiveness.

Let us assume for a while that many countries are interested to join the collective choice arrangement, but some are not – and cannot be forced. Can we solve that? Rodrik, a ‘protectionist’ and a ‘federalist’ at the same time, proposes “two different paths, one appropriate for the short to medium term, and the other for the long term” [30], to reduce the downward pressure from global economic integration on national social policy. His path for the short to medium term is one of reversing global economic integration: countries would be allowed to opt out of international trade agreements and present World Trade Organization (WTO) rules, if that is required to protect their social policies. His path for the long term is “global federalism”, in which “politics and jurisdictions expand to match the scope of a truly integrated global economy” [30]. We would argue that his proposal can be used to stimulate convergence towards the top as much as for avoiding downwards erosion, and that the chronology proposed by Rodrik can be reversed – advancing global social integration first, reversing global economic integration second (if still needed).

Allow us to imagine, for the sake of the exercise, that the United Nations General Assembly does not embrace the SDSN proposal, but that the countries of the African, Caribbean and Pacific (ACP) and European Union (EU) partnership do. That partnership was created with the first Lomé Convention of 1975, and it has a Joint Parliamentary Assembly that unites representatives of 78 ACP and 28 EU countries. About 1.4 billion

people live in one of these 106 countries – 20% of the world’s population, 50% of the world’s countries. The Joint Parliamentary Assembly has a standing committee on social and environmental affairs, where the SDSN proposal could be discussed and adapted. If we apply the thresholds for domestic efforts and international transfers proposed by the SDSN to the countries of the ACP-EU partnership (excluding all other countries), we find that they could aim together for a minimum level of UHC at almost \$50 per person per year in all countries of the partnership. The ‘advanced economies’ of the EU would, together, contribute to equalization transfers at 0.1% of GDP: \$16.8 billion per year, as Table 3 illustrates.

**Table 3**  
**Contributions to**  
**Equalization Transfers**  
**ACP-EU (Data for 2011)**

Country	GDP, current prices, in billions of US\$, 2011	Contributions to equalization (in thousands of US\$)	Percentage of GDP of all 'advanced economies' of the EU
Germany	3,631	3,631,435	21.76
France	2,785	2,784,761	16.68
United Kingdom	2,465	2,464,639	14.77
Italy	2,198	2,198,350	13.17
Spain	1,456	1,455,867	8.72
Netherlands	834	833,519	4.99
Sweden	536	536,001	3.21
Belgium	514	513,790	3.08
Austria	416	416,365	2.49
Denmark	334	333,744	2.00
Greece	290	290,153	1.74
Finland	263	262,620	1.57
Portugal	238	238,106	1.43
Ireland	226	226,242	1.36
Czech Republic	216	216,061	1.29
Slovak Republic	96	95,971	0.57
Luxembourg	58	58,063	0.35
Slovenia	50	50,299	0.30
Latvia	28	28,480	0.17
Cyprus	25	25,017	0.15
Estonia	23	22,564	0.14
Malta	9	9,314	0.06
	16,691	16,691,361	100.00

Source: International Monetary  
Fund, World Economic Outlook  
Database, April 2014.

On the distribution side, several beneficiaries would ‘disappear’ because they are not ACP members, thus reducing the need substantially. Even so, \$55 per person per year would not be possible, but \$50 would, almost – it would require \$17 billion per year, as Table 4 illustrates.

Table 4    Distribution of Equalization Transfers ACP-EU (Data for 2011)

Country	Present per capita government expenditu- re on health at average exchange rate (US\$)	General government expenditure on health as a percentage of GDP after reduction of external resources	Minimum domestic general government expenditure on health as a percentage of GDP, SDSN proposal
Ethiopia	9.59	1.49	3.25
Democratic Republic of the Congo	6.66	1.98	3.49
United Republic of Tanzania	14.75	1.69	3.35
Uganda	11.15	1.81	3.41
Kenya	14.34	1.09	3.04
Mozambique	14.70	0.83	2.92
Madagascar	11.98	2.11	3.56
Niger	11.09	2.11	3.56
Malawi	22.71	2.93	3.96
Burkina Faso	18.70	1.92	3.46
Mali	20.25	2.29	3.64
Burundi	7.63	1.51	3.26
Guinea	8.13	1.43	3.21
Sudan	29.40	2.27	3.64
Chad	9.55	0.99	2.99
Rwanda	35.58	3.28	4.14
Côte d'Ivoire	21.14	1.60	3.30
Haiti	25.20	2.45	3.72
Benin	19.55	1.59	3.30
Cameroon	21.23	1.56	3.28
Sierra Leone	12.34	2.72	3.86
Eritrea	6.78	0.39	2.69
Togo	23.45	3.46	4.23
Liberia	17.34	2.62	3.81
Central African Republic	9.49	1.27	3.14
Senegal	39.05	3.00	4.00
Gambia	14.82	1.25	3.12
Guinea-Bissau	9.97	0.92	2.96
Mauritania	34.95	3.01	4.00
Comoros	24.60	1.81	3.40

Source: World Health Organization, Global Health Observatory data repository (consulted April 2014), SDSN proposal.

Minimum domestic per capita government expenditure on health, SDSN proposal, at average exchange rate (US\$)	Gap between minimum domestic per capita expenditure and US\$50	Population (in thousands) total	Equalization transfers required
11.60	38.40	89,393	3,432,607.30
8.06	41.94	63,932	2,681,623.16
17.15	32.85	46,355	1,522,774.09
15.29	34.71	35,148	1,220,106.96
24.57	25.43	42,028	1,068,817.14
15.59	34.41	24,581	845,942.64
16.59	33.41	21,679	724,192.08
13.44	36.56	16,511	603,617.11
14.63	35.37	15,458	546,776.51
19.78	30.22	15,995	483,347.38
23.85	26.15	14,417	376,939.64
8.72	41.28	9,540	393,793.12
16.03	33.97	11,162	379,143.54
44.89	5.11	36,431	186,159.98
24.62	25.38	12,080	306,539.02
24.13	25.87	11,144	288,288.31
38.68	11.32	19,390	219,502.49
27.01	22.99	10,033	230,643.39
26.47	23.53	9,780	230,112.07
42.78	7.22	21,156	152,769.98
14.04	35.96	5,865	210,906.21
14.62	35.38	5,933	209,889.77
23.70	26.30	6,472	170,214.69
10.74	39.26	4,080	160,182.19
15.12	34.88	4,436	154,743.50
44.78	5.22	13,331	69,521.99
19.52	30.48	1,735	52,891.39
17.53	32.47	1,624	52,734.17
42.87	7.13	3,703	26,405.14
27.53	22.47	700	15,727.96
			17,016,912.94

If the 106 countries of the ACP-EU partnership were to agree on an ACP-EU equalization scheme for health, along the lines of the SDSN proposal, they would have enough influence within the WTO to negotiate less preferential treatment for non-adhering countries. This presupposes, however, that WTO members that are not ACP-EU countries are also allowed to adhere – they would have the choice between adhering and enjoying preferential trade status, or not adhering and not enjoying the preferential trade status. Thus global economic integration would be reversed, but only for countries rejecting the collective choice arrangement. The collective choice arrangement would not be imposed upon sovereign states, but it would come with an additional benefit. If such a solution can be found for international standards of intellectual property protection – the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) – why not for international standards of social policy?

Obviously, more research is needed to be able to predict the potential impact of the SDSN proposal on national social policy, government revenue, investment and trade, but we submit – for further debate and research – that the proposed international equalization scheme should not be considered as a foreign aid proposal, but rather as an international collective effort to protect and promote national social policy in times of global economic integration.

## Summary

The interaction between taxation, social policy, and economic growth is not an exact science. Nonetheless, efforts are being made to examine how global economic integration affects the space for national social policy. Most often, however, these do not include models or scenarios considering the option of an international social protection regime.

In 1994, de Swaan considered “a transnational social system in which rich countries collectively pay for benefits to poor people in poor countries” and argued “the question of its feasibility and efficacy merits serious discussion among students of social policy which, to my knowledge, it has so far not received” [31]. But de Swaan was skeptical himself, commenting that “[t]he rich were ready to shoulder the care for the poor only if they believed they could pacify those who might otherwise constitute a threat to them or if the continued presence of the poor in their midst held some opportunities for them” [31]. In the 21st Century, ‘in their midst’ should no longer be considered in geographical terms but in economic terms: if the common people of the wealthier countries want the benefits of global economic integration without losing the benefits of social policy, they will have to support social integration beyond borders.

Although we believe that ethical arguments alone should be sufficient to consider a global social protection regime, what we propose here, for debate, is the hypothesis that global social integration would both support social policy in low income countries, and may help avoid the gradual erosion of social protection in high income countries. The additional cost for high income countries would, in most cases, be limited to their contributions to international transfers as most already expend domestically the minimum required under this proposal.

Finally, we can anticipate the critique that a global social protection regime for health alone will not produce the benefits in terms of mitigating a race to the bottom or promoting convergence towards the top. While we agree that a global social protection regime will only reveal its fullest global public good potential if it aims for a comprehensive package of social protection, we believe that in the area of health, some progress has been made that does not (yet) have its equivalent in other areas of social protection, like unemployment allowances, child benefits or retirement pensions.

Given the orders of magnitude of government revenue at stake due to global economic integration, we conclude that the global equalization scheme for UHC proposed by the SDSN should not be examined as a new form of foreign aid, but rather as an international collective effort to protect and promote national social policy in times of global economic integration.



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