Globalisation, Trade and Health

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1. Introduction: the importance of globalization and trade for health

Health and health care matter. They matters to individuals and families for reasons which are at the core of our humanity. They matter to policy makers for reasons of solidarity, security and stability.

Globalization affects health. It affects innovation and the pricing and availability of innovative technologies, including medical technologies. It affects the social environment in which health is shaped, food, transport, jobs, etc. Globalization affects the distribution of social goods: access to health care, living conditions conducive to better health.

The ways in which globalization develops are shaped by a myriad of decisions: technical, institutional, economic and cultural; decisions which are made by governments, corporations, unions and households. These decisions are not focused on globalization per se but they could be influenced through an understanding of their wider implications.

One set of decisions which strongly affects the processes of globalization are those involving trade. These include decisions of corporations regarding corporate strategy and the structure of their value chains. They also include the decisions of governments regarding trade policy, including trade negotiations and the decisions of various stakeholders seeking to ensure favourable outcomes from such negotiations.

Public health and trade have been linked since the earliest merchants and kings sought to gain trading advantage from disease outbreaks through quarantine and import restrictions (or were accused of doing so by competitors). The World Health Organisation (WHO) traces its ancestry back to the International Sanitary Conferences from the mid 19th Century; conferences called by trade and agricultural officials because of concern about epidemics disrupting trade.

2. Globalization, trade and health; describing and understanding

The term globalization is used in different ways, ranging from various versions of the 'global village' to global economic integration. Globalization can be used to describe the compression of time and space through rapid travel, containerised transportation and digital communications and information processing.

The shrinking world has direct implications for health, for example: spread of communicable disease, (SARS, H5N1, yellow fever); access to products which carry health risks (tobacco, food, alcohol, arms, illicit drugs); access to and sourcing of foods; and changes in patterns of living.

'Globalization' is also used to refer to a process of progressive global economic integration; sometimes referred to as 'economic globalization'. Integration is enabled by technological developments (travel, transport, communications and information processing) which in turn enable: rapid movement of product; real time control of global corporations; and instantaneous global financial transactions. Integration is accompanied, and enabled, by regulatory reform, in particular: reduced barriers to the movement of goods, people, services and money across national borders; harmonisation of regulatory norms and practices across nation states; and new international legal

structures (trade sanctions, investor state dispute settlement (ISDS)). In institutional terms the process of integration is mediated by: transnational corporations (managing global value chains, GVCs); international financial institutions (banks, investment funds, insurance, etc); and global consulting and legal firms.

Implications for health and health care include: the potential loss of policy space for national regulation, eg in relation to food or tobacco; the progressive centralisation of governance with a shift of the locus of fiscal and regulatory decision making (from local to provincial to national to international); and reduced tax revenues associated with tax competition and increasing pressure to restrict public funding of health care to the safety net function.

2.1 The global economy: dynamics and perspectives

Global health is shaped by the riches and the voids of global society which are themselves shaped by the waves and tides of the global economy. Global society is presently characterised by: wide regional variation in economic growth, with some regions/countries experiencing rapid economic growth; some regions stagnating and others effectively excluded from the global economy; widening inequalities in income and wealth, within and between countries; deep poverty in low and middle income countries; middle class stagnation in the rich world; widespread violence at many levels; massive population movements; and a seeming inability to manage the entwined crises of climate change, human security, population and biodiversity.

The global economy is complex with many different dynamics operating at the same time. These can be simplified in terms of three 'ideal type' dynamics:

- the dynamics of the emerging economies and economic integration;
- the dynamics of innovation and the global value chain; and
- the dynamic of over-production, under-consumption, and over-accumulation.

Prospects for the future depend on the interaction and aggregation of these different and sometimes contradictory dynamics.

The dynamics of 'emerging economies' and global economic integration involves farmers who are working at low productivity gaining access to new technologies and to capital leading to increased productivity in farming. Since fewer people are needed in farming a low paid workforce is released who move to the cities and are available for low skilled manufacturing and assembly. This new labour force provides the option for transnational corporations to transfer employment and production from high wage to low wage countries. With foreign direct investment comes new opportunities for local business and the possibility of domestic capital accumulation laying the ground for the development of other industries, new export opportunities and (perhaps) an increasingly self-sufficient and integrated domestic economy. Meanwhile the emergence of a new 'middle class' creates new markets for global companies.

The dynamics of innovation and global economic integration involves support for research and development which leads to new technologies, new products and services and new ways of doing business. New technologies lead to increased productivity which releases resources (lower prices release funds for other purchases; workers rendered unemployed are available for new jobs) and new products create new markets, new jobs and further wealth. Entrepreneurial innovation accompanied by neoliberal market friendly policies contributes to the marketization of (what had previously been) family functions (meals, recreation) and privatisation of public sector functions such as utilities, transport, education and health care. These transformations of family and community create new markets for global corporations (convenience foods, packaged entertainment, toll roads, etc). The dynamic of innovation is closely linked to the dynamics of the global value chain. These involve the progressive centralisation of control of economic activity; moving from independent national players to large transnational corporations and the progressive transfer of international trade from open markets into the internal structures of the TNCs.

The dynamic of over-production, under-consumption and over-accumulation is more bleak. Increasing productive capacity means that fewer workers are needed to produce for larger markets. However, consumption slows because relatively fewer workers are employed and therefore able to buy what is being produced. Global economic integration gives TNCs access to global sourcing (including of labour) and global markets; the development of domestic production is blocked because of the lower costs, better quality and more powerful marketing of the global product. Globalised production further slows employment and demand. Sluggish growth leads to low rates of greenfield investment and a flood of cash in the hands of the finance sector contributing to increased speculation (stocks, forex, derivatives, etc), debt-funded consumption, asset price inflation and periodic financial crises. Meanwhile a 'reserve army' of marginalised and unemployed non-consumers is maintained ready to take over as the low wage labour force of preference and thereby discipline those workers who do have jobs. Sluggish growth drives the continued externalisation, to the environment, of the costs of production which contributes to destabilisation of global environment. Tax competition, tax avoidance, and privatisation of social sectors reduces the role of the state in public provision and social protection to a minimal safety net. Deepening economic crisis (fewer jobs, slower growth) and widening inequality contributes to the shrinking of social solidarity - from the human family to the nuclear family.

In some degree these 'dynamics' correspond to different patterns and drivers of change in the global economy. However, they also correspond to perspectives. The dynamic of the emerging economies is a way of seeing the world which puts a particular spin on patterns of trade, investment and migration; a spin which glosses the interests of particular stakeholders and elides the lived experience of the farmers forced to migrate to the cities. The dynamic of innovation and the global value chain celebrates the role of TNCs and the drive for progressive economic integration. The dynamic of overproduction, underconsumption and overaccumulation provides a perspective which makes sense to the excluded and marginalised but because it problematizes the role of the TNCs and

the trajectory of economic integration it is disregarded by the mainstream media, politicians and business leaders.

Global governance

In many ways the challenges of global governance (including global economic governance) are about managing the relative importance of these different dynamics. However, the policy debates are conducted in languages which are intensely contested between these competing perspectives. In some degree the policy outcomes reflect the hegemony of particular ways of understanding the global economy.

Treating globalization as progressive global economic integration highlights the kinds of transformations through which such integration is progressed and trace the interplay of these different elements of global governance in shaping such transformations. Braithwaite and Drahos (2000) provide a detailed history of globalization in a range of industry sectors and regulatory fields including intellectual property, financial regulation, trade, labour standards and many more. These histories retrace the dynamics involving the kinds of forces listed above which have driven globalization in these sectors.

Clearly the structures and dynamics of global governance are a necessary element of any analysis of globalization; the collective choices through which the economic, political and cultural development of globalization is steered. However, scholars have found it necessary to reduce the impossible complexity of global governance to a limited number of different ways of conceptualising global governance as a system. These systemic constructions of global governance include:

- the institutional focus (including the UN, the WB & IMF, the G7/20 and various treaties and agreements (including WTO agreements and various preferential trade agreements, PTAs) dealing variously with trade, climate, waste, biodiversity, etc);
- international relations and geopolitics including the interplay of nation-states: empires, big powers and various nation state groupings;
- transnational capitalism, instantiated by the large transnational corporations, banks and other corporate structures, exercising control directly through the management of their global value chains and indirectly through the influence they (and their industry associations) exert over national and international policy-making, either directly or via their nation state sponsors;
- evolving class relationships; an emergent relatively coherent transnational capitalist class (TCC) TCC confronting a cacophony of much more dispersed nation-state centred working classes, middle classes and marginalised and excluded classes (Robinson 2004, Sklair and Struna 2013).

The class perspective provides an integrative framework which reconciles the otherwise conflicting perspectives of institutions, geopolitics and transnational capitalism. It highlights the role of the institutions which frame ‘market sentiment’ and mediate ‘market discipline’ (financial markets, financial

media, large investors) on behalf of the TCC. It helps to locate the institutions which mediate the creation and flow of information, knowledge and ideology (including the universities, think tanks, news media and entertainment industries). Finally it provides coordinates with which to map the diverse constituencies (defined by class, gender, race, caste, religion, etc); the shifting alliances and antagonisms across these constituencies; expressed through various social, political and religious movements; and the mix of concerns, expectations and demands, variously informed and variously expressed by those movements.

The Earth as a closed system

We need to recognise the implications for our understanding of globalization and global governance of the fact that the Earth is a closed system (the exception being the earth's energy balance).

The closed nature of the biosphere and the implications of this for humanity (including human health) have been widely appreciated. The most sensitive issues here include global warming and greenhouse gas pollution, species preservation and biodiversity, and the health of soil and oceans.

The closed nature of the global economy has been much less discussed, partly because orthodox economics does not have the theoretical resources needed for modelling such closure and partly because of the influence of vested interests who would deny the implications of such closure.

The human security dimension of the globally closed system is in essence a reflection of the environmental and economic dimensions of closure and is expressed in the disasters (slow and rapid) associated with poverty, environmental change, population growth and increasingly powerful technologies of death. This dimension of closure is reflected in violence, from interpersonal violence to regional warfare; mass migration; and the continuing threat of epidemic disease (human, animal and plant).

2.2 Trade

Trade has traditionally been understood in terms of the trade in goods across national boundaries between unrelated parties. Trade policy has traditionally focused on regulation at the border, in particular tariffs and quotas. This has involved the imposition of restrictions and penalties by nation state governments, usually to control the flow of imports.

Regulation at the border still plays a central part in the governance of trade relations with the slogan of 'free trade' projecting a progressive reduction in barriers at the border (in particular tariffs and quotas). In fact however, the reduction in trade barriers at the border has been highly selective, in favour of the interests of the more powerful industrialised nations (and their corporations and industries). This has seen pressure on developing countries to reduce import tariffs on manufactured goods but the continued protection and support of rich world agriculture.

In the last three decades the focus of trade policy has progressively expanded to encompass a deeper economic integration through the inclusion in trade agreements of provisions dealing with trade in services, intellectual property, investment, government procurement, state owned enterprises

and behind-the-border harmonisation. However, the implementation of trade policy in all of these areas remains selective in favour of the economic interests of the more powerful countries.

A further set of regulatory fields are subject to separate treaties, agreements and codes; mostly bilateral or plurilateral rather than multilateral. These include the regulation of banking, international accounting standards, migration, taxation, environment and labour standards. Some of these fields do appear in some form in some treaties but there has been no agreement about negotiating multilateral instruments or including them in 'trade' agreements. Braithwaite and Drahos (2000) provide further histories and backgrounds to all of these areas.

Areas of particular relevance to health are trade in services, IP protection and investor protection (discussed below). However, it is the package as a whole which matters because of the interplay of provisions about standards, provisions about particular areas of regulation and provisions dealing with dispute settlement.

It is useful to distinguish between 'trade relations', referring to prevailing patterns of trade, bilaterally and globally; and the governance of trade: trade policy, international power relations, trade negotiations, trade agreements. Trends in trade relations reflect and in part constitute globalization.

The governance of trade, formalised in trade agreements, is a subset of the more general processes of global economic governance. The structures and dynamics of global economic governance generally, as outlined above, also govern the development of trade relations.

Theories of trade

Four broad theories of trade (perspectives on trade) weave their ways through the scholarly literature and policy commentary: imperialism, mercantilism, comparative advantage, and stakeholder pressure. These theories provide useful insights and policy guidance. However, they also have a powerful ideological significance and inform polemics in support or defence against particular trade policies.

Imperialism describes particular configurations of nation state relationships where, as a consequence of unequal power relations, the governance of economic, financial and trading relationships between nation states privilege the interests of the hegemonic power/s. Theories of imperialism generally posit a single hegemonic power at the centre of the imperial system with subaltern powers at the periphery. There may be sub-imperial systems as part of the wider system dominated by sub-imperial powers. Colonialism is a form of imperialism but unequal power relations do not have to be mediated by formal colonial relationships. Other modalities of coercive power relations include: collaboration with corrupt and undemocratic governments and politicians; threats of trade sanctions and financial sanctions (or promises of benefits); covert political intervention, including destabilisation, and armed intervention and establishment of more pliant regimes.

Since trade and investment are mediated by the corporations, rather than directly by nation states, transnational corporations play a central role in mediating the exploitation which characterises unequal trading relationships and, in close association with political elites, planning and sometimes

mediating the coercive power relations. Close links between large corporations (and business associations) and political elites in the hegemon are a key feature of imperialism. Likewise there may be collaborative relations between corporations and the political elites in the subaltern countries.

Imperialism is a powerful theory which corresponds to many aspects of observed trading relationships. However, it tends to be ignored in orthodox commentary because it casts doubt on the morality of prevailing regime and on the morality, integrity and good faith of many of the powerful players in the imperial system.

Mercantilism treats trading relations between countries essentially as win lose relationships. The policy goal is to earn more from exports than the country as a whole spends on imports. As a consequence of the positive trade balance the value of the country's currency might be expected to appreciate which would increase the cost of exports and choke off the export growth. However, profits from exports can also be exported as foreign direct investment, purchase of foreign bonds or retained in the consuming countries to increase commercial presence in those countries (as well as reducing the upwards pressure on the currency). Under such circumstances there may be a lobby 'back home' for more import friendly policies to enable the overseas producers to export back to the mother market. How these relationships play out will depend in part on the power relations between the countries involved and the lobbying power of the corporations and industries involved. Clearly there is scope, in the context of an imperial system, for the parameters of such relationships to be adjusted to favour the imperial hegemon and its corporations.

One of the common criticisms of the mercantile strategy is that it can lead to tariff and currency wars which can lead to real wars. This was a prominent concern during the Bretton Woods negotiations which led to the establishment of the IMF and the GATT (General Agreement on Tariffs and Trade, later to become the WTO). The GATT reflected multilateral agreement to restrict tariff increases and to convert quotas into tariffs. Mercantilism is widely frowned upon because of the risk of tariff wars but the prospects of win lose outcomes continues a powerful motivator of trade policy. The combined pressure of the US, Europe and Japan for increased IP protection (and monopoly pricing) reflects the fact that they are the main global IP exporters so higher prices for IP intensive products (such as medicines) is essentially a win lose deal. The decision of the corporations and the hegemonic powers to move from multilateralism under the WTO to the 'plurilateralism' of 'regional' trade agreements is in essence a return to mercantilism insofar as plurilateral trade agreements privilege the participants at the cost of the excluded as a consequence of the transfer of trade. The WB has pointed out (World Bank 2016) that one of the biggest losers from the TPP is Thailand because it will/would drive the transfer of a slice of the US market from Thailand to Vietnam.

The theory of **comparative advantage** projects mutual benefits which arise from greater overall efficiencies where countries specialise in producing and exporting goods where they have comparative advantages. If the aggregate cost of production under such specialisation is lower than otherwise there will be space for reduced prices for consumers (and increased demand for other products) and labour and capital will be released for other productive purposes.

When the theory of comparative advantage was developed by Ricardo, the relevant advantages were in part related to climate and soil (Portugal in contrast to England). In the present period in many industries the competitive advantages which might yield overall efficiency gains reflect development status (low wages) or are policy choices (IP policies, environmental standards, labour standards, etc). In such circumstances, what appear as 'efficiency gains from trade' may in effect involve externalising the costs of production to the environment or to workers. The comparative advantage of the IP exporting countries arises from their ability to monopolise knowledge and technology through stronger IP protection in trade agreements. Any 'aggregate efficiency' arising from such monopoly is a direct consequence of their ability to coerce other countries to accept higher levels of IP protection.

The theory of comparative advantage also requires that competition reigns (so that prices really are reduced) and assumes that labour and capital are fully utilised before the trading adjustment because otherwise the putative benefit of 'releasing' labour and capital will not be realised. Claims of comparative advantage (and mutual benefit from overall efficiency gains) need to be evaluated in the specific circumstances. In the negotiation of regional trading relationships between countries of comparable power and at similar levels of development the theory of comparative advantage may be useful.

Stakeholder pressure is not an official theory but is a significant driver of trade policy. This may involve particular industries lobbying government to impose or lift tariffs (or to pressure other countries for market access) with a view to benefitting interests associated with those industries; it may involve labour unions concerned about jobs; it may involve professional or other NGOs lobbying against provisions which are seen as damaging to their concerns; or finally it may involve particular consumer interests lobbying for cheaper access to better quality products. Typically, this involves electoral leverage or other forms of political pressure, including money politics.

Transnational corporations and global value chains

International trade has for several hundred years been dominated by large corporations but this trend has accelerated since the Second World War. It is estimated that one third of international trade is conducted entirely within transnational corporations and a further one third involves TNCs and their close affiliates (Ietto-Gillies 2014). Most trading sectors are dominated by a few very big TNCs.

This understates the reach of TNCs because, with progressive economic integration, many TNCs have been able to establish a production or retail presence in various countries with some seed investment (plus local borrowing and re-investment of profits). TNC advantages go beyond access to capital to include technical, managerial and marketing know-how, and beneficial relationships with other branches, subsidiaries and suppliers (insurance, leasing IP, supplies, markets, etc).

The concept of the global value chain (GVC) is critical to understanding the reach and strategy of the TNC. The GVC extends across raw materials, energy, processing, labour relations, marketing, retail, insurance, research and development, royalties, etc. At each point in the 'chain' the corporation has choices about where and how each function will be located, including multiple sources and sites for the same function, and how they will be integrated. Corporate profits and growth can be thus

considered in relation to each step in the chain and in relation to the chain as a whole. TNCs operate in close collaboration with the banks and other financial corporations, transnational insurance companies, and legal and consulting firms. Neilson and colleagues (2014) distinguish between the GVC and the global production chain (GPC). The GVC describes the sites of investment and profit and hence informs corporate strategy. However, the GPC also includes a range of affiliates and suppliers who are variously tied into corporate strategy but not necessarily as subsidiaries.

Corporate strategy will take into consideration prices and wages, tax regimes, environmental and labour standards and similar factors across a range of different countries. While there are benefits for the corporation from economic integration (eg similar standards for consumer marketing across several markets), there are also benefits from having access to different regulatory regimes which can be finessed, arbitraged, levered or otherwise manipulated.

2.3 Health and health care

In exploring the influences of globalization and trade on health a clear distinction is needed between the institutional structures of health care delivery and the social and environmental conditions which shape population health.

Population health

Population health status is measured in death rates, life expectancy, subjective health and a range of other metrics. These indicators can obscure as much as they reveal. Wide disparities in health status are common, across class, gender, caste and ethnicity and between countries. Average or aggregate measures should be viewed critically. Although widely used, life expectancy at birth (LEB) obscures the age distribution of death rates which can differ widely between countries.

Population health gain is only partially driven by health care (and for this reason population health status is a poor indicator of the performance of the health care system). The widest disparities in health status are across countries and in low income countries correlate closely with per capita GDP. However among middle income countries the health gains from improved GDP become less dramatic.

Lower socio economic status within countries are associated with lower levels of health. Causes include: lack of food, unhygienic living environments, occupational risk, and cultural and emotional factors. Textbooks commonly depict ‘levels’ of influence from close to distant, immediate to environmental, downstream and upstream but these metaphors should not be reduced to separate reified ‘factors’.

The chief debates in this space concern the emphasis which is placed on the social determinants of health (including economic, cultural and political determinants) and the degree to which they are regarded as legitimate objects for policy and reform. The conservative position focuses largely on individual factors such as behavioural risk factors and tends to accept as given social and environmental causes. The social and political determinants of population health have been understood for many years but ruling elites are cautious about funding research and giving policy attention to issues which may involve social change. An important breakthrough came in 2005 with

the appointment of the WHO Commission on the Social Determinants of Health (2008). The increasing focus on health inequalities and the social determinants of health has coincided with the rise of structural unemployment, middle class stagnation and policies of neoliberalism and austerity.

The pathways through which economic development in the rich countries contributed in the past to population health gain included:

- household resources (through jobs and adequate wages) ensuring access to housing, food and education;
- urban infrastructure (roads, rail, power, water, sanitation) and public services (enabled through taxes and driven through a sense of community solidarity);
- social protection (including minimum wages, aged pension, public housing etc) reflecting community solidarity and fiscal capacity;
- regulation (of work, of towns, of environments, of poisons) requiring the development of regulatory institutions, integrity in administration and public trust;
- social marketing for communicating health messages and requiring the development of the institutions of public health;
- immunisation and health care.

Applying the lessons from this experience to the challenges of health development in low and middle income countries (L&MICs) highlights the need, not just for economic development, but also for:

- social inclusion (to ensure access to health, housing, education, food, urban infrastructure and public services);
- community solidarity;
- civil society organisation including unions (fighting for decent jobs, occupational safety, wages) and public interest advocacy;
- institutions of governance, integrity of administration and public trust; and
- tax revenue.

Developing countries which have inherited from their colonial histories wildly unequal societies with oppressive and exploitative class relationships will face significant barriers in building the solidarity, inclusion and egalitarianism that appear to be key ingredients for achieving high levels of good health.

These principles also have implications for the disciplines of global governance which shape the contemporary environment within which L&MICs are pursuing their developmental aspirations including for better health. In reviewing the links between globalization (including trade) and health we need to attend, not just to the conditions for economic growth but to questions about inclusion, solidarity, civil society participation, institutional development, governance and trust. In this context the disciplines of global economic governance (such as the IMF's structural adjustment lending in the 1980s, the financial deregulation which led to the global financial crisis, and the failure to regulate the tax avoidance industry) all need to be interrogated.

Central among the disciplines of global economic governance are the (multilateral and plurilateral) trade 'agreements' which frame the conditions for economic development in L&MICs. A salient example is the Doha Development Agenda (DDA), agreed to by the WTO Ministerial Council in 2001, which was supposed to lead to reforms in global trade rules which would create the conditions for economic development in L&MICs. Such provisions would include 'non-reciprocal' commitments and would provide for 'special and differential treatment' of developing country needs. The DDA had ground to a halt by 2003 and has since been replaced by a new round of PTAs (Trade in Services Agreement or TISA, Trans-Pacific Partnership Agreement or TPP, Trans-Atlantic Trade and Investment Partnership or TTIP, etc) in which there is no place for 'special and differential treatment' for developing countries and reciprocity is firmly in place.

The provision of 'development assistance' (under the broad guidance of the OECD, the World Bank and other rich world agencies) is likewise an important modality of global governance including global economic and global health governance. Conventional commentary on development assistance assumes that it reflects the altruism of the rich for the poor and while altruism is one dynamic which contributes to development assistance, there is also a security agenda (advancing the foreign policy goals of the HICs) and a legitimation agenda (shoring up the perceived legitimacy of the prevailing global regime) which also need to be recognised.

Health objectives figure prominently in international development assistance and since the turn of the century there have been huge increases in development assistance for health (DAH). However, the bulk of DAH since 2000 has gone into paying for the treatment of three diseases (Ravishankar, Gubbins et al. 2009). Both the World Bank (1993) and the WHO (Commission on Macroeconomics and Health 2001) have argued for the productivity benefits of treating conditions, such as AIDS, TB and malaria and undoubtedly it is a boost to economic development if millions of young adults are cured and able to return to the workforce. However, the growth in DAH since 2000 has also served to shore up the perceived legitimacy of the prevailing global regime through attending to three of the most prominent health challenges of the developing world.

Notwithstanding the arguments for productivity benefits, the challenges of economic and social development also involve institutional development as well as a healthier workforce. The various global health initiatives (GHIs) put in place to deliver these vertical disease programs have contributed to fragmentation of health systems (Biesma, Brugha et al. 2009) and imposed significant opportunity costs with respect to coordination.

The security agenda, as one of the drivers of global governance, also has profound influence on global health governance; indeed the concept of health securitisation and the consideration of health in foreign policy are commonplace (Aldis 2008, Price-Smith 2009, Labonte and Gagnon 2010).

Health as a consideration in national security is not new. Sexually transmitted disease as a complication of war has been a concern of military leaders for centuries. The risk to Europe from 'Asiatic cholera' was one of the driving forces behind the international sanitary conferences in the 19th

century which eventually led to the WHO in 1948. Perhaps the outstanding example is the role of US military in research and prevention in relation to malaria and yellow fever.

Health securitisation gained new impetus with the SARS outbreak in 2003 and led to a radical revision of WHO's International Health Regulations (IHRs) in 2005. The concern to protect rich world populations from diseases which were seen as originating in Asia was strengthened from 2009 following outbreaks of highly pathogenic avian influenza (HPAI, H5N1) and some transmission to humans. Since then there has been continuing pressure on low income countries (and some middle income countries) to invest in surveillance, laboratory and border control capacity to contain the risks of pandemic disease. While such disease control capacity is clearly a public good it does have opportunity costs.

Deploying a human rights logic as opposed to the productivity or security logic might have led to more attention to reducing maternal mortality. The human rights paradigm is premised on idea that it is simply wrong that 300,000 young women should die in childbirth each year; not that they represent the loss of productive assets or that their deaths might in some way threaten 'us'; simply that it is wrong (Special Rapporteur on the Right to Health 2008).

Health care

The health systems conversation takes place in two somewhat separate contexts: first, in discussions of development assistance for health (DAH) where the discussion is largely driven by the donors; and second, in relation to health systems in middle and high income countries where much of the discussion is nationally focused but informed by comparative health systems research. Nevertheless, these two fields of policy debate have influenced each other extensively.

Prevailing fashions in international health policy (oriented around 'development assistance') have seen wild swings since the era of decolonisation after the 2nd World War. From 'basic health services' in the 1950s; to primary health care in the 1970s; to 'cost-effective interventions' from the 1980s (in particular breast feeding and immunisation); to the World Bank 'health sector reform' model (stratified health funding, privatisation and safety nets) in the 1990s (World Bank 1993); to vertical disease-focused funding platforms (such as the Global Fund for AIDS TB and Malaria and the US PEPFAR) during the early 2000s. For a short while attention focused on the need for 'health systems strengthening (HSS)' (Alliance for Health Policy and Systems Research and WHO 2009, GAVI Alliance 2009, WHO 2009, World Bank 2010, Warren, Wyss et al. 2013) before the current slogan de jour of universal health cover (UHC) took centre stage from around 2010-11. The fluctuating fashions in health system policy (for developing countries) have been shaped by political, ideological and economic influences more than the social and institutional project of improving health care.

Health systems policy continues highly contested. Some of the most contentious issues are:

- the primary health care (PHC) model versus health systems centred on tertiary hospitals and specialist physicians;

- the institutional relationships between sick care delivery and health promotion and disease prevention; in this space one key debate is whether primary health care practitioners should be involved in prevention and if so how;
- health care financing including: user charges versus pre-paid financing; public financing versus health insurance; competitive health insurance market versus single payer systems; pros and cons of various forms of provider payment;

Permeating all of these debates are contending views about the role of private sector funders and service providers. The World Bank has a strong commitment to private health insurance, a view which arises within a world view preoccupied with the role of private enterprise in driving economic development and therefore public expenditure on social programs is seen as a drag on economic progress. Thus private health care delivery and private insurance (largely serving the richer strata) are good but universal systems based on public funding and public delivery are bad. Given the widely recognised market failures in health insurance and in health care delivery it is hard to argue that competitive private insurance is 'efficient' or that competitive health care delivery offers better quality and efficiency than publicly owned and delivered services with comparable funding. To the contrary, international experience suggests that competitive health insurance markets and private sector delivery make it much harder to institute rational expenditure control, to regulate for quality, and to ensure equitable resource allocation.

Global health governance

The term global health governance (GHG) is used in different ways. Many writers treat GHG as an autonomous domain of global governance without reference to the wider forces contending around global economic governance. An exception is Labonté and colleagues (see, for example, Labonte and Gagnon 2010) who locate GHG clearly within the wider context of global economic governance.

In some usages GHG is treated as the governance of development assistance for health (DAH) and the challenges of mobilising, directing and administering donor funds. This usage includes the GHIs, the multilateral and bilateral donors and policy agencies such as the OECD's DAC. The distinction is sometimes made between GHG and global governance *for health* where the latter refers to the governance structures which shape population health as opposed to the governance of DAH.

A somewhat different usage treats GHG as the governance of a global regime of health security. This is consistent with the origins of GHG in the international sanitary conferences of the 19th century. However, it needs to be recognised that a major concern at those conferences was to protect trade relations from unjustified restrictions notionally based on health security grounds. From earliest times GHG has been intricately part of global economic governance.

A common trope in discussions about GHG is to comment on the fall from grace of the WHO; from being the only intergovernmental institution with health responsibilities to being bypassed by much larger donors (eg World Bank and Gates Foundation) and second having various responsibilities stripped from it (with the establishment of UNAIDS and the various GHIs). In some versions of this story the fall was a consequence of failures of leadership and of administration on the part of WHO.

The fall from grace story makes some sense if GHG is seen as an autonomous domain of global governance. Certainly the creation of UNAIDS reflected in part a failure of leadership in WHO. However, the plethora of GHIs which emerged after 2000 reflected strategic decisions by donors who were unwilling to give financial power to the WHA, where the L&MICs have numerical strength.

When the role played by WHO is contextualised within the wider dynamics of geopolitics and global economic development, inadequacies of the fall from grace story becomes evident. WHO has always been subject to the winds and tremors of big power politics and the imperatives of global economic governance.

The interactions between global health governance and the wider dynamics of global economic governance can be traced in relation to the various elements of medicines policy. These include: IPRs, costs and access; essential medicines; medicines regulation (marketing approval, post-marketing surveillance, policing of substandard products, ethical promotion, rational use); antibiotic resistance; research and development. In all of these fields pharmaceutical corporation lobbying, big power politics, international treaties and trade agreements have all played a central role. It simply does not make sense to treat GHG as if it were somehow insulated from the imperatives of global economic governance.

3. Globalization, trade and health: explaining and prescribing

In Section 2.1 (above) we have highlighted two usages of 'globalization'; first, as the compression of space and time as in the 'global village'; and second, as global economic integration (including trade and finance) and a particular regime of global governance.

The technological developments which have contributed to the global village have also had a huge impact on health care including advances in health care technologies and in the organisation of health care (including health care across borders). However, there are unresolved challenges involved in ensuring equitable access to health care technologies, ensuring that the limited resources available for health care are equitably distributed, rationally used and of acceptable quality. Health care is also a huge market with implications for the macroeconomy, employees, local suppliers, specific industries and corporations, and health care R&D is an important driver of technological innovation. Health insurance provides a significant slice of the global financial throughput and investment. The health care market is a major concern of macroeconomic policy makers, industry leaders and corporate strategists. The social objectives of universal and equitable access to efficient, quality health care do not always align with concerns of economic regulators and health care providers, nor with the economic incentives driving various market participants.

The economic developments associated with globalization have been associated with dramatic changes in the social and environmental conditions which shape population health. Where economic growth has contributed to household resources, public infrastructure and public health programs population health has benefitted. However, economic growth does not always contribute to social and economic development and the benefits of economic growth are not evenly shared. Where the costs

of production are externalised to workers or to the environment, and where the products and services being produced are actually harmful to health, the social objectives of population health run directly counter to the economic incentives of market participants. In some circumstances an investment in population health can contribute to industry or national productivity. However, the benefits to productivity of looking after the health of certain populations should not lead to a discounting of the health of populations who are not economically 'productive'.

3.1 Population health and globalization (including trade)

Some of the more obvious pathways through which globalization and trade may influence population health status include:

- economic pathways (household income and wealth; government income and wealth, including taxation; distribution of income and wealth; imposed austerity as crisis management strategy);
- cultural pathways (inequality and social solidarity; materialism, competitivism and individualism; insecurity, xenophobia, patriarchy, racism; alienation and violence);
- political norms and institutions (eg free speech, freedom of information, rule of law, official integrity, the right to organise);
- regulatory institutions (eg regulation of damaging practices and products; workplace relations and occupational health; environmental safety).
- environmental pathways (global warming, extreme weather events, drought; biodiversity);
- technological pathways (innovation, access to technology);
- public goods (culture, housing, education, employment support; social protection, including universalism versus residualism in social programs generally);
- food systems;
- trade agreement provisions which may restrict necessary policy space (in particular, investor protection);
- proscriptions on the use of capital controls which may be needed to defend against speculative attack;
- restrictions on the role of state owned enterprises.

We will not explore all of these links but working through a smaller selection of case studies illustrates the relationships.

Employment, work, jobs, labour

The effects of globalisation and liberalisation on employment, work and jobs is one of the main pathways through which globalisation and trade affect health.

There are two main mechanisms to consider: first, the transfer of production from industrialised countries to developing countries, including in export processing zones (EPZs); and second, the loss of work in farming and the consequential urban migration.

The transfer of production from industrialised countries to developing countries does not mean a net increase in jobs. New jobs in the emerging economies is associated with deindustrialisation in the global North. In many cases the conditions of work are not good and the wages are much lower. Indeed it is the lower cost of production which encourages the corporations to shift production. The health consequences of intergenerational unemployment in the rich world and occupational hazards in developing countries (eg Bhopal) are significant.

The second mechanism involves unfair trade in agriculture including the destruction of small farmers' livelihoods through the dumping of subsidised agricultural product in developing countries and denial of access to rich world markets. The destruction of small farmers' livelihoods leads to rural poverty and urban to rural migration contributing to the mega cities of the South with large informal settlements. In the megacities the risks to health include unemployment and underemployment and social and cultural dysfunction (eg domestic violence, narcoterrorism, etc). These processes often have particular implications for women. It needs to be emphasised that the countries who are suffering from rural poverty and urban migration are not necessarily the countries which are being fast tracked for assembly line work.

The increasing power of capital over labour and of TNCs over nation states are defining features of contemporary globalisation. The ability of capital to relocate production has greatly weakened the industrial unions of the global North. This has contributed to stagnant wages as well as structural under-employment. This has also been associated with negative sentiment in rich world labour unions in relation to workers in developing countries ('stealing jobs').

The increasing power of TNCs vis a vis the governments of L&MICs is likewise associated with the control of foreign direct investment (FDI) by the TNCs (and FDI means jobs and perhaps foreign earnings). This power enables the TNCs to make demands of national governments relating to tax treatment, subsidies, and deregulation of labour and environmental conditions. At worst this constitutes corporate extortion and drives a race to the bottom.

According to some analysts (see above) trade liberalisation contributes to a fundamental imbalance in global economy, described in terms of overproduction, under-consumption and over-accumulation. Increased productive capacity (associated with new technologies of production and of management) means that fewer workers are needed to produce for larger markets. However, fewer workers earning lower wages means lower consumer demand and dampening of growth. Where sluggish demand is managed by further automation and lower wages the underlying imbalance is exacerbated. Free trade means expanding the markets and margins for existing powerful TNCs. It also means structural unemployment for many millions of workers.

Some of the policies and strategies under consideration in this space include: internationally agreed standards regarding decent work (either through the ILO or through including a 'labour clause' in trade agreements). Some argue for binding agreements; others would rely on voluntary codes and corporate responsibility. Labour activists see the potential power of labour solidarity but also recognise the barriers that would need to be surmounted (Hogstedt, Wegman et al. 2006).

Extractivism and mega-projects

Mining, drilling, fracking, damming and land grabbing have in common that they often involve displacing communities, including indigenous communities, and degrading the environment. These kinds of mega-projects are commonly sponsored by large transnational corporations and feed earth wrapping global value chains. The competing claims of economic development, human rights and environmental stewardship are not easy to reconcile, particularly when L&MICs desperate for employment and foreign currency are forced to bid for the favour of TNCs who have other options for sourcing their raw materials.

Some of the questions currently being asked of these deals are as follows:

- are the processes of decision making fair, transparent and inclusive?
- is the price paid fair for the communities; does the price paid fully compensate for loss and put in place the foundations for a new start?
- does the decision to proceed and the price paid properly recognised the environmental values being degraded and put in place appropriate restorative programs?
- is the current rate of consumption of fossil fuels, steel, concrete, energy, forests, soil and rare earths sustainable; is it fair for future generations; are there alternative pathways to good living (including good health)?
- how might we move to proper valuation of established communities and life ways and environmental values?
- how should the human rights of the displaced communities and the obligations of environmental stewardship be weighed against the imperatives of economic development?

Food, hunger and NCDs

The interrelationships between globalization and food systems are complex and contested, and have important implications for human health. The disease burden associated with both under-nutrition and diet-related NCDs is huge. Under-nutrition includes acute malnutrition, chronic hunger, stunting and susceptibility to other diseases due to specific deficiencies, such as maternal deaths due to iron deficiency. The leading diet-related NCDs include ischaemic heart disease, hypertension, stroke, diabetes and some cancers.

Current patterns of investment and trade in food and related commodities contribute in various ways to poverty, hunger, urbanisation, and the NCDs epidemic. These complex dynamics include:

- the provisions of the WTO Agreement on Agriculture (AoA) contribute to the dumping of subsidised food products (and exclusion of developing country farmers from rich world markets) which contribute to collapse of small farming, rural poverty, urban migration, and dependence on imported foods;
- continuing pressures (from the IMF, the WB, and bilaterally from the food exporters) on L&MICs:

    - to reduce import tariffs, including on food imports (which may be dumped at below cost),
    - to privatise and marketise farm support functions (technical support, credit, input subsidies, irrigation, marketing, insurance, public procurement and food distribution programs).

- the corporate restructuring of global food systems in accordance with the imperatives of the global value chain (maximising opportunities to 'add value'; maximising 'productivity' and 'efficiency'; increasing control of small suppliers, and avoiding tax):
    - corporate development of input-intensive, large scale, agro-industry farming models (including through land-grabbing) as required by the GVC;
    - over-consumption of meat products (associated with the diversion of arable land to stockfeed);
    - aggressive marketing of energy intensive packaged foods which are processed (hence have value added); are cheap, because they are light (with a low water content); have a long shelf life and can be transported long distances (because they do not rot);
    - intensively marketing of sweet beverages, snack foods, and convenience foods;
    - supermarket dominance over small suppliers (brand marketing requires standardisation of inputs; monopoly purchasing forces prices down for small suppliers)
- the diversion of arable land to biofuels (because of oil price politics) and to stock feed (because of premium value of meat products);
- income inequality contributes to maldistribution of good food;
- speculation in commodity futures leads to price volatility (damaging for small farmers) and price spikes (contribute to hunger and riots);
- impact of climate change and extreme weather events (associated with global warming) on small farmers;
- water shortages associated with climate change, upstream demand, lack of public investment in irrigation infrastructure.

Policy debates regarding the reform of food systems extend broadly:

- fair trade and re-negotiation of the AoA;
- food sovereignty and recognition of the cultural and ecological values of traditional food systems (agro-ecology in contrast to industrial agriculture);
- closer regulation of food marketing including taxes, labels and subsidies to make healthy eating cheaper and easier than junk diets;
- resistance to extreme trade liberalisation to allow space for protection of small farming;

- restoration of public revenues and resistance to tax competition through a binding multilateral agreement on taxation;
- resistance to land grabbing;
- action on climate change including mitigation and adaptation;
- international regulation of TNCs.

Policy space

Trade in various products which are harmful to health (such as tobacco, junk food, illicit drugs and toxic waste) presents a range of different policy challenges. Trade in tobacco and junk food is largely conducted within TNCs and presents challenges of reducing harm from legal products. Trade in illicit drugs presents both supply and demand challenges. Trade in toxic waste presents regulatory challenges in relation to corporate crooks and their nation state sponsors.

An emerging constraint on regulatory capacity is the inclusion of investor state dispute settlement (ISDS) in trade agreements or investment treaties. The extension of the concept of 'expropriation' to include 'indirect expropriation' (generally interpreted as fiscal or regulatory provisions which impact negatively on profit expectations) places powerful obstacles in the way of public health or environmental regulation. This gives power to foreign corporations to challenge regulations directed in various ways to promoting healthy environments, most notoriously the capacity to challenge tobacco control initiatives.

However, ISDS is not the only constraint on policy space. Transparency provisions being included in contemporary PTAs are designed to enable corporations to intervene in policy making or price setting, for example in relation to pharmaceuticals.

Policy space is constrained by a range of different provisions including the provisions regarding dispute settlement. The ways different provisions interact depends closely on the actual wording used in the agreement.

One of the critical bulwarks to protect policy space is the existence of clear, authoritative international standards which would justify the use of exceptions clauses. This is one reason why it is important to keep corporate stakeholders at arm's length in the deliberations of structures such as the Codex Alimentarius, and to be cautious about moving norm setting out of WHO into 'partnership' structures like the ICH (International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use).

3.2 Health care

Some of the more obvious pathways through which globalization and trade may influence health care include:

- economic development, national wealth and fiscal capacity;
- taxation policies (total and equity of collection) and public funding;
- inequality, social solidarity, universalism versus residualism; balance between public and private service delivery;

- human rights, including free speech, freedom of information, rule of law, official integrity, the right to organise;
- private insurance markets versus single payers and policy control;
- workforce issues; retention and migration; regulatory frameworks regarding practice, allocations of functions and tasks; and
- IP issues and price of medicines and other medical products.

One of the most direct pathways is the impact on tax collections both as a consequence of the downwards pressure on tax rates (through 'tax competition') and the wide scope available to TNCs for tax avoidance through locating particular functions in tax havens and construction of intra-corporate prices and payments to ensure profit is registered in such tax havens.

Closely linked to the downwards pressures on state revenues is the continuing campaign, led by the World Bank, for private health care financing and a dominant role for private health care delivery. In mixed delivery health care systems, having a multiplicity of private and statutory health insurance funds makes public policy control of quality and efficiency much more difficult than with a publicly owned single payer system. In the presence of ISDS provisions in trade agreements once a foreign corporate presence has been established in either health insurance or health care delivery it would be hard to return to single payer funding.

Under globalization relatively few TNCs in each industry sector exercise effective control over advanced technology in that sector. This has a direct impact on prices, as in pharmaceutical prices. However, corporate control over research and development also skews R&D towards profit rather than need, illustrated by the lack of investment in treatments and vaccines for diseases which largely affect poor countries and populations (such as Ebola).

Professional workforce migration (brain drain) is an important pathway through which globalization shapes health care in poor countries. This particularly affects Anglophone countries whose health care professionals migrate to the UK, USA, Australia, NZ and Canada. The Philippines has deliberately encouraged nurse emigration with a view to the impact of remittances on the domestic economy.

Finally we shall consider the impact of globalization on widening income inequality inside countries and the weakening of social solidarity that this drives. The wider the gap the harder it is to support progressive taxation, and universalist service systems and social protection (in contrast to minimalist safety nets).

Medicines

Globalization has had far-reaching implications for the pharmaceutical industry and its governance. Four key issues are access, innovation, regulation and technology transfer. Conflict over intellectual protection permeates all of these areas.

Policy debate around IP protection of pharmaceuticals involves the interplay of opposed interests; the interests of consumers and purchasers in low prices to ensure access; and second the collective

interest in innovation and technological development and the role of monopoly pricing in retrieving the cost of R&D.

The policy argument for patenting and monopoly pricing is based on the collective benefit achieved through the funding of innovation. The *real politik* is also about the export earnings accruing to those countries (in particular the US, Japan and Europe) who are net exporters of IP protected products (and also happen to have the geopolitical power to insist on extreme IP provisions in PTAs).

The main criticisms of the patenting of pharmaceuticals, in particular extreme protection and low standards of patentability, rest on three main points:

- high prices, associated with patent protection, as a barrier to access and a burden on publicly funded health care;
- neglect of R&D for medicines for diseases which do not promise high returns on investment (for example, because they mainly affect poor people, eg Ebola virus disease) and the over-investment in me-too innovation, particularly in relation to chronic illness (and long term treatment);
- the use of profits from monopoly pricing to fund aggressive marketing which drives over-usage and inappropriate usage.

The access debate has centred around the use of TRIPS 'flexibilities' (such as compulsory licensing and parallel importation); the inclusion of TRIPS plus provisions in PTAs; and continuing the waiver for LICs with respect to implementation of the TRIPS agreement. Debates around TRIPS flexibilities have been central to a wider conflict between WHO and the US over policy coherence across trade and health and the role of the Secretariat in advising countries in the context of trade negotiations.

Much of the debate has centred around a stream of discussion and policy debate within the WHO which started with the Commission on IP, Innovation and Public Health in 2006; moved to the Global Strategy and Plan of Action (see *Velásquez 2011*). There are clearly alternative ways of funding and organising research and development. As more countries move to universal health cover and move away from user charges a larger proportion of the costs attributed to R&D are socialised anyway.

The third main policy issue concerns the regulation of medicines and again the debate is permeated with conflict around IP. Some of the main concerns regarding medicines regulation include: clinical trials, marketing approval (including prescription only or 'over the counter' (OTC) preparations), essential medicines lists (EML), public subsidy schemes (and inclusion and pricing decisions), post-marketing surveillance (of prices as well as adverse events), ethical promotion (including the regulation of DTC advertising) and rational use (including in particular rational use of antibiotics). Some of the flash points in this long saga include:

- recurring battles between WHO (the Secretariat with the authority of the WHA) and Big Pharma (generally with the support of the US, Europe and other rich countries) over the EML, clinical trials transparency, rational use policies, ethical promotion policies,

- debates over the use of the term 'counterfeit' to refer to junk medicines (substandard, spurious, or falsified) and also to refer to generic medicines subject to claims of breaches of IPRs; the use of 'counterfeit' for both classes has the effect of conflating alleged breaches of IPRs with the production and circulation of substandard products with a view to harnessing national regulatory agencies in policing intellectual property claims;
- the progressive transfer of international norm setting (regarding marketing approval and post-marketing surveillance) away WHO and into the International Conference on Harmonisation (ICH) which is essentially a public private partnership of Big Pharma with the rich country regulators; and
- the inclusion of 'transparency' provisions in PTAs with a view to opening up decisions regarding the inclusion of drugs in public subsidy programs and the pricing parameters to lobbying by Big Pharma.

For L&MICs one of the priority issues in this space concerns the development of their own pharmaceutical manufacturing capacity and the acquisition of the necessary technologies. Some of the debates around this aspiration concern the provisions of GMP and whether these are unnecessarily stringent with a view to making full implementation unnecessarily expensive and difficult.

Trade in health services

Trade in health services has potential to markedly influence health care. This may involve cross border transactions (transcription, interpretation of images), consumption abroad ('medical tourism'), commercial presence (foreign corporations involvement in private health insurance and in the management and ownership of hospitals and other health care facilities), and the presence of natural persons (in particular professional migration). These different modes of trade-in-health-services have implications for the health care available on both sides of the trading relationship.

The combination of tax competition, trade in services provisions, the national treatment principle and ISDS in aggregate constitute a significant risk of irreversible privatisation of health systems. Privatised and mixed health care delivery places significant barriers to the implementation of health care policies directed to the equitable and efficient use of resources and high quality care.

3.3 Global health governance reform

In an earlier section we have introduced the usages and field of 'global health governance'. In this section we review some of the debate around options for strengthening GHG, limited in this discussion to those institutions and processes which deal explicitly with health issues. (We return to the wider question of global economic governance reform below.)

The need for continuing development of appropriate structures for global health governance is self-evident given the continuing collective failure to effectively address global inequalities in health and the huge global burden of preventable and treatable disease, injury and limitation. The literatures of particular relevance to GHG reform include discussions regarding:

- WHO;
- global health initiatives and other 'multi-stakeholder partnerships';
- the governance of big pharma;
- the governance of global food systems;
- global regulation for health.

WHO

Since its establishment in 1948 WHO has been subject to periodic bullying by the great powers; their power to demand consideration linked explicitly or implicitly to WHO's dependence on the rich countries, in particular the USA, for most of its funding. Since the 1980s the leash has been progressively tightened.

During the 1970s and 1980s there were a number of decisions of the WHA (and consequent actions by the Secretariat) which upset various corporate lobbies and their rich country sponsors. These episodes included: the Essential Medicines List (from 1977); the 1978 Declaration on Primary Health Care (and the reference to the proposed 'New International Economic Order'); the Code on the Marketing of Breastmilk Substitutes (1981), the Ethical Criteria for Drug Promotion (1988); and others. These initiatives reflected the growing presence in the WHA of newly independent ('non-aligned') countries joining WHO after independence, during the 1950s-1960s, in particular.

From the 1980s the Assembly, led by the USA and the other rich member states, adopted a freeze on assessed contributions (ACs, the mandatory formula based contributions required of member states); initially a relative, later a nominal freeze. From the 1980s to the present the proportion of WHO's expenditure budget which is funded by assessed contributions has fallen from around 75% to around 20%. In other words WHO is dependent on donors for 80% of its budgeted expenditure, including rich member states but also the World Bank and the Bill and Melinda Gates Foundation and other philanthropies. As the donor chokehold has been tightened the control of WHO's agenda has progressively moved from the Assembly of member states to the donors. Almost all of the donor funding it tightly tied to particular programs which the donors support. Decisions of the Assembly which the donors do not like do not get funded.

Rhetorically the donor chokehold is justified in terms of allegations of lack of leadership and administrative inefficiency; the implication (sometimes explicit) is that if WHO can get its house in order the donors might untie their donations and the rich countries might agree to an increase in ACs. WHO is not without its disabilities although certain failures of leadership and many instances of inefficiency are a direct consequence of the donor chokehold.

Historically the donor chokehold has been related to decisions of the WHA which the US and the corporate lobbies did not like. However, there is a further reason for the US, Europe and Japan to maintain a particularly tight control over WHO and this lies in WHO's treaty making powers and the threat these pose to the neoliberal global order.

Article 19 of the WHO Constitution provides that, by a two thirds vote of the Assembly, WHO can 'adopt conventions or agreements with respect to any matter within the competence of the Organization'. The first serious attempt to use this provision was in 1981 in relation to the marketing of breastmilk substitutes; in the event the sponsors of the proposed restrictions agreed to adopt a voluntary code rather than proceed to a binding convention. However, in 2003 after a long struggle the WHA adopted by a two thirds majority the Framework Convention on Tobacco Control (FCTC) which commits member states to a series of policy strategies aimed at discouraging smoking.

The significance of the FCTC in the context of disputes regarding trade and investment agreements is now becoming increasingly clear. Against the background of the WHO's dispute settlement procedures and the plethora of plurilateral trade and investment agreements which have emerged since then, the existence of strong international norms regarding (in this case) tobacco control provides clear authority for claims of an exception on health grounds which can withstand challenge in dispute settlement.

In the context of PTAs which include ISDS and other provisions which impact on *policy space* the (theoretical) capacity of the WHA to adopt binding agreements, perhaps regarding medicines or food, takes on a new significance. Such WHO treaties, while lacking direct sanctions, could nevertheless provide a defence for regulatory action which would otherwise fall foul of restrictive provisions in trade and investment agreements.

In the face of an implied promise of flexible funding in return for WHO reform the Director General of WHO, Dr Margaret Chan, launched another round of reform (programmatic, governance, and managerial) in 2009. While some of WHO's disabilities are directly attributable to the donor chokehold, there are other weaknesses which need to be addressed independently. One of the most critical of these disabilities is the lack of member state accountability for their contributions to the work of WHO and the implementation of WHO resolutions. While the reform program has focused largely on the Secretariat, many of the shortfalls, in terms of progress to global health, are attributable to lack of commitment and political drive from the member states at the national, regional and global levels. In some degree this reflects a lack of seniority of health ministers in their own governments but it also reflects a lack of domestic accountability of ministers for their performance in WHO and in the implementation of resolutions. In part this involves accountability to other ministers but it could also involve accountability to parliamentarians, to the public health profession, to the health care practitioners who work with the communities who carry the burden of disease, and to those communities directly.

It lies within the power of these constituencies to follow ministers' performance more closely and to demand accountability. There are some parliaments, organisations, movements, and networks which are working in this way but there is an urgent need for this work to be strengthened.

The rise and rise of 'multi-stakeholder partnerships'

Since 2000 more than 100 global health initiatives (GHIs) have been established with varying partnership mixtures and for a wide range of purposes. Over this same time partnerships like GHIs

have been established in many sectors of global governance; commonly referred to as global public private partnerships (GPPPs). These partnerships vary widely in their mix and purpose. Some of the common purposes include:

- to address complex problems which stray beyond the mandates of established institutions; to serve as vehicles for intersectoral and inter-organisational collaboration (among GHIs the Global Alliance for the Elimination of Lymphatic Filariasis illustrates);
- to create steering structures which bring donors (national, multilateral and philanthropic) together with other stakeholders to organise funds mobilisation and disbursement, largely in the context of 'development assistance' (among the GHIs the GFATM and GAVI illustrate);
- to create deliberative structures which bring different stakeholders (including corporations, NGOs, and academics) together to work towards consensus around strategies for addressing global problems (among the GHIs, IMPACT in relation to pharmaceuticals and GAIN in relation to food illustrate this purpose).

There is no doubt that many global problems are extremely complex and that there are gaps and weaknesses in existing institutional structures. In such circumstances GPPPs (including GHIs) can help to address complex problems. However, in some cases the existing institutional structures (eg, WHO) have been deliberately weakened to serve the interests of industry lobbies and their national sponsors. In such degree the establishment of GHIs to compensate for such induced weaknesses may more about creating an appearance, for the sake of legitimation, than effectively solving problems. In some cases (discussed below) there have been significant adverse consequences from this circumstance, including further institutional weakening.

In some respects the provision of 'development assistance' (including through GPPPs / GHIs) is directed to compensating for capacity problems at the national level. Poor countries need technical and financial assistance because of weaknesses in governing capacity (financial, technical, administrative). However in many respects such weaknesses are reproduced by the way the global economy and global governance work. In such circumstances development assistance is essentially a strategy of compensation and legitimation.

In some cases the establishment of a GPPP responds to a demand from TNCs for a 'seat at the table' on the grounds that their expertise is needed and that their opposition could be damaging. The pragmatic view is that giving them a 'seat at the table' will help to develop consensus strategies, even if it means eschewing certain options which the corporations would oppose. Accepting the power of the TNCs and taking a pragmatic view of their participation in global governance, notwithstanding their lack of democratic mandate and the policy compromises which such pragmatism requires, will generate the need for further rituals of legitimation.

The same concern applies to the WB and the private philanthropies. Taking the pragmatic view of their participation in global governance, notwithstanding their lack of democratic mandate and public

accountability, ensures access to their resources but may be less effective from a health perspective because of the policy compromises involved.

The role of civil society actors in GPPPs is ambiguous. Certainly civil society actors (NGOs, social movements and networks) have a capacity to inform public debate and shape public consciousness. Involving them in various GPPPs makes sense because they bring a different perspective to the table and have a certain legitimacy arising from their public interest purposes. However, in some circumstances the claims of civil society actors to 'represent' the interests of the diverse global constituencies may be unfounded (indeed in some cases they are corporate funded) and involving them in GPPPs because of the legitimacy which can be gained from their participation only adds to the democratic deficit and lack of accountability.

The legitimation crisis narrative regarding the MDGs and the explosion of GHIs from 2000 starts with the IMFs structural adjustment programs in the 1980s and the disinvestment in health care that was required of indebted countries. In many cases such disinvestment was taking place at the same time as the emergence of the AIDS/HIV crisis. By the early 1990s there was widespread public rejection of structural adjustment and a declining acceptance of the legitimacy of the global regime which gave rise to it. The WB's 1993 'Investing in health' report sought to restore some legitimacy to this regime by emphasising health as an input to economic development. The WB's model provided stratified health care funding (private insurance for the rich, social insurance for those in the formal sector, and a minimal safety net for the poor) and mixed (public /voluntary /private) health care delivery.

However, with the emergence of effective anti-retroviral treatments in the mid 1990s the irrelevance of the WB's model to the AIDS crisis became more and more evident. Added to this the TRIPS agreement (from 1995) was widely seen as creating a new barrier to access to treatment. The controversy in South Africa from 1997-2001 over the use of parallel importation to access drugs for HIV at a lower price contributed to further delegitimation of the neoliberal regime. Against this background the adoption of the MDGs in 2000 and the rise and rise of GHIs in DAH from the same period contributed to the relegitimation of this regime in relation to poor world health.

The explosion of GHIs and associated funding from 2000 undoubtedly contributed to people with AIDS and/or TB getting access to treatment and to the treatment and prevention of malaria and certain other conditions. Significant progress has been made towards the eradication of polio, guinea worm and river blindness. However the opportunity costs of disbursing these funds through these channels included inefficient allocation of the total funds pool, fragmentation of health systems, and a heavy coordination burden on recipient governments.

By the mid 2000s the fragmenting impact of vertical disease focused funding platforms on health systems was becoming clear. The insistence on direct project funding created parallel infrastructure and the better wages and conditions frequently led to a brain drain from the mainstream health system to the vertically funded systems. Several new initiatives were launched by way of response to this initiative including the International Health Partnership Plus (IHP+) from 2007, the WB's Health

Systems Funding Platform from 2009, and WHO's 'Maximising Positive Synergies' project (referring to alleged synergies between vertical disease focused funding and health systems development) in 2009. By 2012 the focus had moved to the campaign around UHC which itself obscures significant differences of opinion between WHO and the WB regarding health funding principles.

An alternative approach to unscrambling the GHI omelette is the proposal for a 'global fund for health' (see), implemented perhaps by broadening the mandate of the existing Global Fund. This could usefully direct more funds to health systems. However it does not problematize the global dynamics which prevent developing countries from developing the capacity to address their own problems.

The demand by the corporate sector for a 'seat at the table' in relation to global health governance continues. The locus of deliberation in relation to medicines regulation continues to move from WHO and the biennial conference of medicines regulatory authorities to the International Conference on Harmonisation in which Big Pharma has a stronger presence. Likewise through IMPACT and other structures the pharmaceutical industry continues to promote the conflation of substandard medicines with breaches of IPRs through its insistence on the use of the term 'counterfeit' to apply to both.

In relation to food and nutrition the corporate sector continues to press for a stronger say in global food and nutrition policy including through the SUN Secretariat (Scaling Up Nutrition) within which the private sector has more influence. See more on *Governance of global food systems* below.

The need to provide a 'seat at the table' for the corporations and philanthropies has had some support within WHO, first, regarding a proposed '*Committee C*' which would complement the two existing committees of the WHA but allow for NGOs, corporations and philanthropies to engage with the agenda of the Assembly. This proposal was opposed by a significant proportion of the member states as was a subsequent proposal for a *World Health Forum* which would precede the Assembly and again provide a platform for these various 'non-state actors' (NSAs).

What has been missing from most of the commentary about 'the changing landscape of global health' (the 'wider range of stakeholders', the 'post-Westphalian' world) is any interrogation of the dynamics of global economy and the structures of global economic governance which reproduce international inequality and the shortfalls in national capacity which require 'development assistance'.

The 'multi-stakeholder partnerships' strategy carries significant risks including: democratic deficit, inequitable use of resources, institutional damage and policy compromise. This package of strategies needs to be weighed against a more considered approach to the dynamics and structures which necessitate and justify such partnerships. In fact there are grounds for concern that the 'multi-stakeholder partnerships' strategy serves to compensate for and legitimate the way the global economy and global governance work while ensuring that the voice of developing countries through the World Health Assembly are muted if not silenced. There is clearly a continuing need for more fundamental changes to global financial relationships (debt, unfair trade, tax competition, tax avoidance, etc).

Governing big pharma

Present arrangements for national and global governance of big pharma are inadequate:

- price barriers to access for individuals in need;
- high prices and over/inappropriate usage driving unsustainable health care cost burden, both public and private;
- lack of R&D for neglected diseases;
- failure to effectively regulate: junk medicines, unethical and aggressive marketing, and inappropriate use (including unsustainable use of antibiotics in intensive livestock farming);
- fraud and corruption in the pharmaceutical industry.

These problems are not new and have been well documented. A wide range of technical and institutional solutions are at hand (see for example the discussion of *qui tam* litigation and equity fines in *Dukes, Braithwaite and Moloney 2014*). These problems continue unabated because of the combined power of the pharmaceutical corporations and their nation state sponsors, in particular the US and Europe, to resist effective regulatory action. Indeed draft provisions under consideration in the current round of trade negotiations (extended data exclusivity, patent linkage, lower standards for patenting) look set to further strengthen the position of the pharmaceutical industry with respect to pricing and regulation.

The support of the US and Europe for the continuing profiteering by the pharmaceutical industry maybe partly because of commensal relations between corporate and political elites but for IP exporting countries the macroeconomic value of 'IP exports' (actually the 'rent' associated with exports incorporating protected IP) is a very significant component of economic growth. The value of such exports is of particular significance in view of the continuing transfer of manufacturing employment to low wage platforms.

It is not serendipity that the drive within WHO and WTO to contain drug prices and regulate Big Pharma is coming from Argentina, Brazil and India all of which are IP importing countries for whom access to medicines while containing health expenditures are big challenges and who have significant domestic manufacturing capacity .

The conflicts within WHO over medicines policies (substandard medical products, R&D for neglected diseases, TRIPS flexibilities, policy coherence, and irrational use of antibiotics) have significant geopolitical and macroeconomic dimensions beyond their particulars as technical health problems. Likewise the debates in the WTO (eg over the TRIPS waiver for least developed countries) and in relation to PTAs (TRIPS plus, 'transparency', lower patent standards) in also reflect these larger geopolitical and macroeconomic dimensions of pharmaceuticals governance.

Governing global food systems

There is a lot at stake in the governance of global food systems: hunger, NCDs, employment, trade, farmers' livelihoods, cultural traditions and ways of living.

In terms of addressing hunger and under-nutrition the most needed transformations would redress global inequality, within and between countries. Households would be able to afford good food; governments would be able to pay for agricultural and transport infrastructure to support local food systems; and poverty as a driver of conflict (which reproduces poverty) would be ameliorated. This is about the reform of global economic governance; not specific to food.

The next highest priority, in relation to both hunger and NCDs would be for a restructuring of trade, investment and financial regulation agreements. The barriers to South North trade legitimised by the AoA would be reformed to open rich world markets to the produce of developing countries and the dumping of subsidised product on developing country markets would be restrained. The legitimacy of publicly owned institutions to support small farmers and to provide food for poor communities would be affirmed. There would be new provisions in financial regulation agreements which serve to protect the small farmers and poor consumers from price volatility associated with futures speculation in food commodities. Investment agreements and chapters would include provisions which prevent land grabbing which displaces small farmers in favour of for biofuels, stock feed and timber plantations. Finally, strong international norms would be adopted in the Codex and other instruments that would support domestic regulations and withstand challenge in disputes under WTO and PTAs. These would include norms regarding labelling, portion sizes and the importance of excise and subsidy strategies.

These kinds of reforms will depend upon a significant paradigm change globally regarding food systems. Current debates which define this paradigm change include:

- food sovereignty and agro-ecology versus food security;
- the role of food aid in addressing hunger and under nutrition;
- small scale versus large scale industrial farming
- the role of small scale farmers: integrated into corporate controlled global value chains or into locally integrated food systems;
- the over-use of agricultural resources (in particular land, water and energy) in the production of biofuels and stockfeed;
- moving away from excessive meat eating.

There are no single pathways through which these policy principles might be implemented. Possible pathways include: reforms in development assistance policy and trade policy and foreign investment guidelines. Climate change policies are critical to contain the loss of arable land but new energy policies would need to avoid displacing farmers to grow crops for biofuels. Climate change policies would need to give increased weight to the energy, water and soil costs of lot fed meat production.

The need for regulation of consumer marketing has been widely recognised including labelling, portion size, and the legitimacy of using excise and subsidies to alter price relativities to make better

diets cheaper. Such regulation should be enacted through domestic policy making but will need increased community support and protection from trade disputes.

All of these will require significant shifts in domestic policy orientation and in the global politics which shape such domestic policies. Clearly there will be (there is) corporate opposition and international disagreement. Building a social movement for this paradigm shift will depend on public information and communications, including making the connections between the hunger issues and the NCDs issues. The principles of food sovereignty need to be understood as part of the solution to both sets of issues. The role of civil society advocacy is critical here including farmers' organisations such as Via Campesina, but also the fair trade movement, global justice and climate change moveemnts. Such social mobilisation will require leadership including from various progressive NGOs and think tanks (academic and other).

There is a complex range of institutional structures operating internationally which variously provide the platforms for some of these debates, stakeholders driving particular outcomes, or instruments to lock in agreement. These structures are not the fount of policy making; rather they are the final common pathway through which analyses are endorsed, policies are articulated, interest group pressures are organised.

The intergovernmental agencies include: WHO, FAO, WFP, UNICEF, and the Codex Alimentarius. However, there is a further layer of inter-intergovernmental organisations through which these agencies communicate and cooperate. The Committee on Food Security (CFS) is hosted by FAO in Rome. The UN Standing Committee on Nutrition was mandated by EcoSoc but greatly weakened when the WFP and UNICEF withdrew funding. Thereafter it remained as a small unit within WHO but neglected by WHO leadership.

SUN (Scaling up Nutrition) is a GPPP with governments, philanthropies, institutes, NGOs and industry organisations. One of this last group, GAIN (the Global Alliance on Improved Nutrition) brings together a host of TNCs involved in nutrition and plays an influential role in SUN.

The Second International Conference on Nutrition (ICN2) was held in Rome in November 2014. The two main (official) outcomes of ICN2 were the political declaration and the framework for action. The final Outcomes Document: Rome Declaration on Nutrition recognises that eliminating malnutrition will require cross sectoral collaboration, including in agriculture and trade. However, there is no reference to dumping of agricultural commodities, to TNC control of food systems, or of food sovereignty. The document includes a raft of 'needs' and 'shoulds' but little in the way of firm direction. The Framework for Action provides a list of 60 recommendations, all of them non-binding.

A Consensus Statement of 170 social movements and public interest civil society organisations was read in the closing plenary receiving wide acclamation. The statement was critical of both the official documents and provides an alternative framework for action including actions in health.

Global regulation for health

The World Health Organization is unique among UN specialised agencies in that its Constitution gives it the authority to negotiate a binding treaty with a two thirds majority in the Assembly and no veto power. Article 19 of the Constitution provides that "The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes."

Only one treaty has been concluded, the Framework Convention on Tobacco Control (FCTC). These negotiations, dealing with a product which kills half of those who use it as advised, were long and difficult and still not all member states have ratified the treaty.

The Code on the Marketing of Breast Milk Substitutes started life with the anticipation that it too would be mandated as a treaty. These negotiations were also fiercely contested and the instrument was reduced to a voluntary code in the final stages of the negotiation.

The strategic significance of Article 19 has grown dramatically with the development and extension of formal dispute settlement provisions in the WTO agreements and various trade agreements and investment treaties. Many trade and investment agreements have exceptions provisions which provide that a particular practice is outlawed except where there is a strong public policy case for an exception to be recognised. These provisions are all worded differently and their interpretation is shaped by various other parallel provisions in other chapters. In the case of a dispute the decision about whether the claimed exception is justified, as required in the agreement, will be made by dispute settlement tribunals (DSTs) constituted as provided for in the agreement. The ability of defend health exceptions is greatly strengthened by having strong authoritative normative statements aligned with the domestic regulations under challenge.

Over the years there have been many calls for the further use of Article 19, in relation to medicines, diet and nutrition, health professional migration and human rights among others. However, Hoffman and Røttingen (2014) are somewhat negative about the effectiveness of such treaties.

3.4 Global economic governance reform

Global health governance is integrally embedded in the structures and dynamics of global governance generally and in particular, global economic governance.

In this section we refer to key resources in three areas of global economic governance which have particular significance for health but have not been discussed earlier. These deal with: need for effective framework for the regulation of TNCs, and the need for reform of the structures of international financial regulation, including the need for a multilateral tax agreement.

Regulation of transnationals

In other sections of this review we have reviewed a number of settings where the lack of accountability of TNCs contributes to damaging population health and health systems. In fact there

are many international instruments with varying levels of compulsion which provide for some degree of governance of international business in relation to particular industries or risks (Braithwaite and Drahos 2000). However, the need for a more comprehensive instrument to regulate TNCs came to the fore in 1974 with the adoption by the UNGA of the Declaration on the Establishment of a New International Economic Order (NIEO) (http://www.un-documents.net/s6r3201.htm). From Para 4. "The new international economic order should be founded on full respect for the following principles: […] g. Regulation and supervision of the activities of transnational corporations by taking measures in the interest of the national economies of the countries where such transnational corporations operate on the basis of the full sovereignty of those countries". The NIEO was driven through the UN by the Non-Aligned Movement (NAM) formed in 1961 and formalised within the UN as the Group of 77 (G77) in 1964. The UN Conference on Trade and Development was also established in 1964 as part of the same agenda.

Continuing concern about the role of TNCs led to the establishment of the UN Centre on TNCs in 1977. The need for some kind of global regulation of TNCs was underlined in 1984 with the Bhopal tragedy and in 1989 with Exxon Valdez. However, the 1980s was the decade of the debt crisis and the rise on neoliberalism and the UN Centre on TNCs was folded into UNCTAD in 1993.

In the late 1990s UN Sub-Commission on the Promotion and Protection of Human Rights commenced work on a corporate code of conduct which was adopted by the Sub-Commission in 2003 (Norms on the Responsibility of Transnational Corporations and other Business Enterprises).

In order to pre-empt this initiative the UN SG developed, in consultation with the International Chamber of Commerce, the ten principles which was adopted by the GA in 2000 as the Global Compact (https://www.unglobalcompact.org/).

In 2005 UN SG appointed a Special Representative on Human Rights and TNCs (John Ruggie) who reported in 2011 with the (non-binding) Guiding Principles on Business and Human Rights, adopted by the HRC in 2011.

Meanwhile there has been continuing organising and agitating within civil society regarding the need for effective and binding regulation of TNCs. The *Treaty Alliance* (see below) brings together a wide range of civil society organisations (CSOs) in advocacy for a UN treaty on business and human rights. In parallel the Global Campaign to Dismantle Corporate Power and End Impunity (see below) is arguing for *An International Peoples Treaty on the Control of Transnational Corporations*.

International financial regulation

International financial regulation has huge implications for public health, exemplified by the health impacts of financial crisis and austerity; hunger from speculation in food futures; the role of tax competition and tax avoidance in forcing the downsizing and privatising health systems; and unemployment associated with the rolling crisis of over-production, under consumption and over accumulation. This includes banking regulation, speculative movements of cash, currency controls and capital controls.

International tax policy is a particularly critical issue for public health to address both tax avoidance and tax competition. One of the key debates here concerns moving from a myriad of bilateral tax treaties to multilateral agreements on principles and protocols for tax harmonisation globally.

3.5 Policy coherence and global health diplomacy

The term 'policy coherence' in relation to trade agreements suggests informed consultation between policy officials and stakeholders from both trade and health to listen to each other's objectives and concerns and to explore ways of drafting trade agreements which minimise contradictions between the two projects.

assumes an institutional conceptualisation of global governance

From a public health point of view the critical barrier to negotiating policy coherence is a general lack of understanding within health policy circles of the implications of trade agreements for health and in particular the ways in which variations in drafting can impact on dispute settlement outcomes. One methodology which has been explored is to apply the principles of health impact assessment to prospective trade agreements. Another approach uses human rights principles as the analytic framework. (See discussion of trade literacy in public health and a public health research agenda below.)

Policy formulation is part of the story, but the outcomes of policy debate and trade negotiations are not solely determined by fact, logic and public interest. To the contrary, industrial and corporate stakeholders with immediate material interests at stake will deploy public relations strategies and where available the levers of money politics to advance their cause. In this degree there is also a need for public health practitioners to help to build a public interest constituency that can take the long term view and give full consideration to health, sustainable development and human rights.

Secrecy and coercion

Contemporary trade negotiations are conducted in secret with the close involvement of corporate stakeholders and little or no scope for parliamentary/congressional revision. The notorious 'green room' process in WTO negotiations is a process for locking in 'agreement' with caucuses inside caucuses like Russian dolls.

Many of the provisions have far-reaching effects (eg TRIPS+ provisions and ISDS) and there are high barriers to repeal (the 'ratchet effect'). There is a significant risk that the trade negotiators adopt positions which turn out to have net costs for the country because trade relations and macroeconomics generally are complex and unpredictable and because policy was shaped by of the influence of specific stakeholders.

Such practices run counter to democratic principles. However, operationalising democratic principles in relation to such a complex and contested policy area is not easy, particularly in jurisdictions where politics are polarised and combative and where intensely interested and well organised stakeholders, with immediate risks and rewards in view, can exercise more influence than

much larger but more diffused constituencies for whom risks and rewards are less immediate and less obvious, but no less significant for that.

The non-democratic nature of trade negotiations is a reflection of a much larger challenge of operationalising democratic principles generally. Some obvious directions include: increasing community literacy in relation to trade and macroeconomics; improving the quality of research and commentary available in the public domain; developing institutional mechanisms to support meaningful communication and deliberation; organising more effective engagement of those constituencies for whom the risks and rewards of particular trade policy directions might be less immediately salient.

Capacity building

For health care and population health to be given proper consideration in trade negotiations will depend on the analytic, communications and negotiating skills of several different constituencies: health officials, trade officials, and public health advocates.

Health ministry officials are busy and sometimes unaware of the health implications of trade negotiations. Assuming that there is public concern about such implications the health ministry will face difficult intersectoral relation before being able to contribute to trade policy. Negotiating around health care issues will also involve finance and perhaps other ministries. Public health concerns around the social conditions which affect population health will have implications for virtually all other ministries as well as the trade negotiators. If health officials identify high priority negotiating parameters (eg the price of medicines or tobacco control) they may need to find ways of working cooperatively with other stakeholders from health care professions and civil society.

Working across all of these interfaces (with trade negotiators, other sectors of government and civil society) calls for a knowledge of the world of the trade officials (macroeconomics, industry prospects and risks, dispute settlement, and trade law language). They also need access to evidence and expert judgement regarding the implications for health care and population health of various provisions. There have been a number of initiatives directed to capacity building for health officials in the field of global health diplomacy or more specifically of trade negotiations.

A separate discussion of capacity building is focused on the trade negotiators themselves, in particular, trade negotiators from low and middle income countries. When trade negotiators from smaller and poorer countries attend negotiating sessions they can expect to come across large teams of highly trained experts representing the rich countries. In some circumstances access to content expertise and negotiation skills can be urgently needed.

From the perspective of global players in macroeconomic policy (WB, ICC, South Centre, G77, UNDP, OECD, academic centres) there is much to be gained from developing training capacity as part of building support for their analysis and preferred directions.

4. Action agenda for public health

Trade and globalization present the public health community with a significant challenge. Clearly globalization (including trade) has a powerful influence on health care and population health. It appears that the public health community is not well prepared to meet this challenge. Attention is needed with respect to teaching, research and practice.

4.1 Teaching (undergraduate, postgraduate and continuing professional development)

In recent years there has been strong student demand for more and better teaching in global health, both at undergraduate and postgraduate levels. Academia is slowly responding although not always with the broadly multidisciplinary programs that are needed.

There is no claim that everyone should be a globalization and trade expert but every health practitioner should be aware of the global dynamics shaping their field, the global dimensions of their policy priorities, and possible avenues for advocacy and mobilisation. Supporting this kind of engagement by generalists, there is a need for a strong cadre of practitioners who are experts in the linked fields of globalization, trade and public health. High priorities in developing such a cadre should be macroeconomics, international political economy and international law.

The neoclassical economics provides the scriptural base for neoliberal policies. However, there are robust critiques of neoclassical economic which if acknowledged would greatly weaken the neoliberal project. These critiques relate to:

- the role of finance, debt and banking in macroeconomic modelling;
- the unreal assumptions upon which dynamic stochastic general equilibrium models depend;
- the failure to explore the implications of complexity theory in modelling the macroeconomy (eg Keen's 'Minsky'); and
- the neglect of power relations and politics in setting the parameters within which economic relations are conceived as operating and rendering invisible such power relations.

Public health practitioners need to have a degree of scepticism regarding the truth claims of neoclassical economics and the policy imperatives of neoliberalism which they support.

International law should also be a priority in terms of advanced training in global health and in research and policy cooperation. Trade agreements and dispute settlement processes are highly complex. The interpretation of an apparently clear provision will depend on the qualifications and conditions set out in widely separated parts of the same suite of agreements as well as precedents and other instruments of international law.

4.2 Research

The material covered in this review points to the many priorities for public health research engagement in this area:

- understanding the many pathways through which economic activity, globalisation and trade affect health and vice versa;
- defining the real risks to public health associated with the idea of shrinking policy space;
- understanding the structures and dynamics of global health governance (eg the governance of food and of medicines);
- understanding the logic of regulatory design;

These kinds of research confront familiar problems associated with real time real world research such as the lack of a relevant comparator and the challenges of attribution. Nonetheless there are appropriate methodologies which can exploit 'natural experiments' or construct clever longitudinal comparative studies. Other challenges include creating institutional settings which support multi/interdisciplinary studies and persuading funding agencies that the health implications of globalization matter.

4.3 Practice

One of the familiar challenges in public health practice is working across professional boundaries. In engaging with global health issues this involves working across sectoral boundaries at all levels from local communities (PHC) to government policy making (HIAP). It also requires skills in community engagement; working with community organisations and social movements around globalization and health issues.

Building the global into regular practice will involve strengthening the international voice of the public health community/profession. There are rich and varied global networks working in research but often in quite narrow territory. There is a need for richer networking across networks through organisations such as the World Federation of Public Health Associations (WFPHA).

Following the work of WHO is a core element of global health practice; notwithstanding the funding crisis and other disabilities WHO remains the pre-eminent international organisation in global health and also provides a window on the wider field of global health governance. The tension between member state sovereignty and donor control is a central issue for WHO but also reflects the underlying confrontations in global health. A critical weakness of WHO is the lack of accountability of member states for their contributions to WHO and their implementation of WHO policies and guidelines. A core responsibility for the public health community is to strengthen the accountability of member states to the people whose health is at stake.

There are global influences and considerations which affect most public health programs and policies and public health practitioners need to be conscious of these. The greater challenge however, is finding ways of addressing the local and immediate needs in ways which also contribute to global change.

The judgements and actions which comprise the work of public health include ethical choices as well as a technical considerations. The principles and instruments which have been established in the human rights field provide the public health community with a unifying ethical framework for public

health work. There is a range of contending paradigms of global health - charity, security and productivity as well as human rights - and while there are occasions when the logic of security or productivity makes sense, human rights provides an over-riding framework for public health practice. The imperatives and proscriptions understood as 'human rights' are an expression of historical struggles over millennia to define and affirm what is right and what is wrong in the conduct of human affairs. They provide a narrative which has a broad reach and which provides an important counter to more instrumental constructions of public health.

References

Aldis, W. (2008). "Health security as a public health concept: a critical analysis." Health Policy and Planning **23**(6): 369-375.

Alliance for Health Policy and Systems Research and WHO, Eds. (2009). Systems thinking for health systems strengthening. Geneva, WHO.

Biesma, R. G., R. Brugha, A. Harmer, A. Walsh, N. Spicer and G. Walt (2009). "The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control." Health Policy and Planning **24**(4): 239-252.

Braithwaite, J. and P. Drahos (2000). Global business regulation. Cambridge, Cambridge University Press.

Commission on Macroeconomics and Health (2001). Macroeconomics and Health: Investing in Health for Economic Development. Geneva, WHO.

Commission on Social Determinants of Health (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Geneva, WHO.

GAVI Alliance (2009). GAVI health systems strengthening support evaluation 2009 (Vol 1: key finding and recommendations; Vol 2: full evaluation report).

Hoffman, S. J. and J.-A. Røttingen (2014). "Assessing the Expected Impact of Global Health Treaties: Evidence From 90 Quantitative Evaluations." American Journal of Public Health **105**(1): 26-40.

Hogstedt, C., D. H. Wegman and T. Kjellstrom (2006). The Consequences of Economic Globalization on Working Conditions, Labor Relations, and Workers' Health. Globalization and Health. I. Kawachi and S. Wamala. New York, Oxford University Press.

Ietto-Gillies, G. (2014). "The Theory of the Transnational Corporation at 50+." Economic Thought **3**(2): 38-57.

Labonte, R. and M. Gagnon (2010). "Framing health and foreign policy: lessons for global health diplomacy." Globalization and health **6**(14).

Labonte, R. and M. Gagnon (2010). "Framing health and foreign policy: lessons for global health diplomacy." Globalization and Health **6**(1): 14.

Neilson, J., B. Pritchard and H. W.-c. Yeung (2014). "Global value chains and global production networks in the changing international political economy: An introduction." Review of International Political Economy **21**(1): 1-8.

Price-Smith, A. (2009). Contagion and chaos: disease, ecology and national security in the era of globalisation. Cambridge MA, MIT Press.

Ravishankar, N., P. Gubbins, R. J. Cooley, K. Leach-Kemon, C. M. Michaud, D. T. Jamison and C. J. L. Murray (2009). "Financing of global health: tracking development assistance for health from 1990 to 2007." The Lancet **373**: 2113–2124.

Robinson, W. I. (2004). A Theory of Global Capitalism: Production, Class, and State in a Transnational World. Baltimore, MD, Johns Hopkins University Press.

Sklair, L. and J. Struna (2013). "The Icon Project: The Transnational Capitalist Class in Action." Globalizations **10**(5): 747-763.

Special Rapporteur on the Right to Health (2008). Promotion and protection of all human rights, civil, political, economic, social and cultural rights, Human Rights Council.

Warren, A., K. Wyss, G. Shakarishvili, R. Atun and D. de Savigny (2013). "Global health initiative investments and health systems strengthening: a content analysis of global fund investments." Globalization and Health **9**(1): 30.

WHO (2009). Initial summary conclusions: maximising positive synergies between health systems and global health initiatives. Geneva, WHO.

World Bank (1993). World Development Report: Investing in health. Washington, The World Bank.

World Bank (2010). Health systems funding platform: frequently asked questions. Washington DC, World Bank.

World Bank (2016). "Potential Macroeconomic Implications of the Trans-Pacific Partnership " Global Economic Prospects(January): 219-255.